Editorial **5**

Research reports

- Anders Bergmark** Risk, pleasure and information – notes concerning the discursive space of alcohol prevention ____ **7**
- Toivo Hurme** Jumping out of Harm's way – harm reduction in Finnish drug policy: conceptual problems and contradictions _____ **17**
- Steven Riley Thomsen & Dag Rekve** Television and drinking expectancies – the influence of television viewing on positive drinking expectancies and alcohol use among US and Norwegian adolescents: A comparative analysis _____ **29**
- Thomas Heikell & Elianne Riska** Men's emotional inexpressivity – advertising for psychotropic drugs in Scandinavian medical journals _____ **53**
- Maria Abrahamson** When I drank too much – young people in their 20s tell their stories _____ **63**
- Thomas Karlsson & Christoffer Tigerstedt** Testing new models in Finnish, Norwegian and Swedish alcohol policies _____ **79**

Overviews

- Ragnar Hauge** Changes in Norwegian alcohol policy – from social welfare to market economy _____ **92**
- Mats Ramstedt** The role of alcohol in the global and regional burden of disease _____ **97**

Policy, research and the industry

- Kerstin Stenius** Conflicting interests _____ **108**
- Ellen Gould** Negotiating under the influence – the WTO and corporate interests _____ **111**
- Harry A. Lando** Strategies to reduce the global burden of tobacco _____ **118**
- Thomas F. Babor & Ziming Xuan** Alcohol policy research and the grey literature – A Tale of Two Surveys _____ **125**
- Anders Ulstein** Lunch with the industry? _____ **138**

Buprenorphine in the Nordic countries

Pia Rosenqvist New winds sweeping the clinics and the streets _____	149
Henrik Thiesen & Morten Hesse Buprenorphine treatment in Denmark _____	152
Airi Partanen & Jukka Mäki Buprenorphine more common as a problem drug in Finland _____	156
Astrid Skretting & Catherine Dammen From methadone to medicine-assisted rehabilitation _____	162
Anders Romelsjö Subutex treatment in Sweden – an initial description _____	167

Book reviews

Robin Room (ed.) The effects of nordic alcohol policies – what happens to drinking and harm when alcohol controls change? (by Helgason, Tómas) _____	171
Thor Norström (ed.) Alcohol in postwar europe. ECAS I. Consumption, drinking patterns, consequences and policy responses in 15 European countries	
Håkan Leifman & Esa Österberg & Mats Ramstedt (eds.) Alcohol in postwar Europe. ECAS II. A discussion of indicators on alcohol consumption and alcohol-related harm (by Gabriel Romanus) _____	172
Thomas Karlsson & Esa Österberg (eds.) Alcohol policies in EU member states and Norway (by Bernt Bull) _____	175
Bühringer, G. et al. Alcohol consumption and alcohol-related problems in Germany (by Esa Österberg) _____	177
Thomas Babor (ed.) Alcohol – no ordinary commodity (by Sven Andréasson) _____	179
Thomas Babor (ed.) Alcohol – no ordinary commodity (by Pekka Sulkunen) _____	182
Espen Houborg Pedersen & Christoffer Tigerstedt (eds.) Regulating drugs – between users, the police and social workers (by Tuukka Tammi) _____	185
Keith Humphreys Circles of recovery: self-help organizations for addictions (by Klaus Mäkelä) _____	186

Note

Johan Sandelin Drug use as a social indicator of well-being? Reflections on the conference “Globalization, youth cultures and drugs” _____	190
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Nordic alcohol statistics 1993–2003 _____	196
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Changing landscapes

THE FIRST YEARS OF THE NEW MILLENNIUM will without doubt be noted as a turning point in the history of Nordic alcohol and drug policies. Like settlers we, researchers and policy makers, seem to find ourselves, having lost some of our most important tools, in a new world that looks only vaguely familiar.

Many of the articles in this issue of Nordic Studies on Alcohol and Drugs reflect these changes in our environment and toolkit.

Our views on the alcohol and drug problems and beliefs about how they can be tackled are being reshaped. Anders Bergmark analyses how the concept of risk has succeeded the moral arguments as the foundation for prevention activities and what may be the reasons for and implications of this. Toivo Hurme looks at the many and pragmatic uses of the only recently very controversial concept “harm reduction” in Finnish drug policy.

On a more concrete level, Ragnar Hauge gives a perspective on the present liberalisation, by describing how the mobility and trade argument has taken on different shapes in the longer history of Norway’s alcohol policy. Thomas Karlsson and Christoffer Tigerstedt analyses how the Finnish, Norwegian and Swedish administrations have re-organized, all in their slightly own way, as a response to the challenges for the national restrictive policies. A set of country reports on the use – and abuse – of buprenorphine in the Nordic countries indicate a recent move away from the drug-free treatment and society, towards some kind of acceptance of chronic drug dependence.

It is no coincidence that two of the main articles in the issue focus on young people’s drinking habits - a topical theme in Europe today. Maria Abrahamson analyses young men’s and women’s stories about experiences of heavy drinking. Steven R. Thomsen and Dag Rekve discuss the influence of television watching and advertisements on young persons drinking. Thomas Heikell and Elianne Riska on the other hand present an analysis of the hitherto more or less invisible men in Nordic advertisements for prescribed psychotropic drugs. To summarize,

the medication is presented as a route to ontological security for the weak men or as a vehicle to gain emotional security within the (extended) family. Does this indicate a more general change in the gender roles?

A few of the articles in this issue show the need for a global perspective on the alcohol and drug policy issues. Mats Ramstedts gives a clear summary of the methods and findings of the WHO report on alcohol's role in the global burden of disease. This is a report, with dramatic findings, that will be quoted and used in many situations and policy discussions around the world. One section of articles takes up different aspects of the growing role of private economic interest on the international alcohol policy arena.

Taken together, these texts depict a re-orientation in a changed and enlarged policy and research landscape. Many threats to public health and social well-being in the present situation are identified. But yet the situation does not look altogether depressing. Perhaps the optimist can even discern some kind of pioneering spirit?

Risk, pleasure and information

Notes concerning the discursive space
of alcohol prevention

Introduction

In a study of the Swedish alcohol policy discourse (as articulated in administrative and government texts between 1970 and 1990), Bergmark and Oscarsson (1992) observed a distinct pattern of repetition. By and large, all the texts that were studied opened with the statement that the alcohol problem constituted the most serious social and medical problem in Swedish society. Viewed as a succession of statements, such a pattern suggests – from an activist viewpoint – a devastating possibility: that nothing has happened, i.e. that the measures taken have had no effect on the problem in hand. The repetitiveness of the statements concerned not only the size and seriousness of the problem but also the type of measures deemed appropriate. The above inference, that “nothing has happened”, was valid here in the sense that everything that was said (in a given text) had been said before. Bergmark and Oscarsson (op. cit.) suggested that the basic conditions for the Swedish alcohol discourse were such that they restricted discussion to a series of ahistorical repetitions (the failure to recognise this repetitive pattern necessarily lends the discourse its ahistorical character). The limits of dis-

ABSTRACT

A. Bergmark:
Risk, pleasure and
information – notes
concerning the discursive
space of alcohol prevention

In this paper the notions of risk, pleasure and information are discussed with reference both to their utilization within the prevention discourse and to their relation to a process of de-traditionalization. It is suggested that the current lack of options for moral discourse directed towards the individual's freedom of choice, restricts the vocabulary of prevention to deal only with the harm produced by alcohol consumption. Prevention discourses cannot address the motivational structure connected to the individual's pursuit for pleasure and self-fulfilling experiences.

This constraint can be seen as a contributing factor to the centrality of risk in alcohol prevention discourses. Although risk-information is produced within the scientific community by a logic of its own, it is also related to the individuals expanding menu of choices that

follows with subject-centered individualism with little or no room for moral discourse concerning the individual's construction of lifestyle and identity. When morality is no longer present, it is only risk that can fill its traditional role, that of being a reason for renouncing. It is not by chance that the most important actors on the alcohol policy scene in traditional temperance societies now are professionals and bureaucrats and not voluntary temperance organizations and that the latter have increasingly adopted their arguments from the former.

■ KEY WORDS

Prevention, risk, pleasure, information

course are set by the interplay between the forms of problematization, the level of policy measures already in hand, and the character of the measures perceived as impracticable. Between what is conceived as impracticable and what is already in place, we find the discursive space within which policy ambitions are to be articulated and transformed into policy measures. In the present case, the policy measures proposed in the various texts could be classified as belonging either to a strategy of information/persuasion, or to a strategy of "more of the same" (the reinforcement, improvement and development of policy measures already being applied). In a society such as the Swedish one, where a high level of alcohol taxation and a retail monopoly are already in place, information/persuasion is the only option that remains viable. In contrast to taxation and other structural restrictions on alcohol availability, information can be repeated over time (at least for as long as the lack of impact is not recognized). Although this analysis specifically focuses on a rather limited cultural context, the information/persuasion strategy could arguably be described as one of the most important categories of alcohol policy measures in most western societies.

Traditional alcohol policy is likely to develop in the direction of a more limited repertoire.¹ The course that the European Union is embarked on clearly makes it increasingly difficult for governments to apply policy measures directed at alcohol availability (such as taxation). The most obvious example of this development is probably found among some of the Nordic countries, where both taxation and retail alcohol monopolies have been substantially weakened (Tigerstedt 1999). Room has summed up the general situation for the prevention of alcohol problems in the phrase, "popular approaches are ineffective, effective approaches are politically impossible" (Room 2001, 21), which suggests that information/persuasion is one of the most frequently applied alcohol problem prevention strategies, albeit not an effective one.

In the following I intend to discuss the information strategy of alcohol prevention in terms of both content and context. The focus of the discussion will be related to the concepts of risk and pleasure and directed towards analysis of the discursive space for the prevention of alcohol problems.

Risk and modernity

In an analysis of alcohol policies in the Nordic countries, Tigerstedt (op. cit.) described the public health approach as being related to a liberal tradition in the sense that it represents a liberal way of organizing the relationship between a society and its citizens. One of the most distinctive characteristics of the public health approach is – according to Tigerstedt (op.cit) – that responsibility is transferred from the expert to the informed individual. The main factor behind this displacement of responsibility is the presence of a new consciousness of risk. In Tigerstedt's analysis, this development is described as a new form of "remote control" based on the individual's internalization of health values.

Although it is easy to agree with Tigerstedt and others that risk has become an important concept for our general understanding of contemporary modern society (Beck 1999; Giddens 1994; Lupton 2000) as well as for the organization of alcohol prevention, the validity of his ideas concerning the internalization of risk information as a new form of remote control remains open to discussion.

In order to address this question, it might be worth considering what type of impact a flood of risk assessments might have on the everyday life of the modern individual. One of the most elaborate theories in this area has been put forward by Beck (1992; 1999). Risk, according to Beck, is a "modern approach (designed) to foresee and control the future consequences of human action, the various unintended consequences of radicalized modernization. It is an (institutionalized) attempt ... to colonize the future" (Beck 1999, 3). Beck views risk, together with globalization, individu-

alization, gender revolution and underemployment, as one of the basic processes that transforms modernity into "second modernity" or "reflexive modernity". Seen in this perspective, risk may be understood as an integral part of the radicalization of modernity which transforms the "logic of control" of first modernity into an expanding horizon of uncertainties.

In this type of context, expert and scientifically produced knowledge has a central role in impelling the radicalization of modernity further. The process of modernization goes hand in hand with an accumulation of knowledge concerning all parts of a society and its practices. The more knowledge that is accumulated, the more de-traditionalized society becomes. The prevailing institutionalization process deteriorates and is replaced by knowledge-dependent structures that force the individual to face new types of problems and decisions. What type of food is safe (enough)? How much can we drink without risk? Which car should we buy if we want to survive an accident? Which types of television programs will make our child more aggressively inclined? How do we protect ourselves from terrorism?

Thus information (knowledge) about risks connected with alcohol consumption becomes part of the general flood of risk information. The individual parts of this type of information are all intended to counter risks but, taken together, they create a risk society where the side-effect, not instrumental rationality, is becoming the motor of social history. In trying to colonize the future, we create a society of options or scenarios. The point here is that a narrow perspective on alcohol (and, for that matter, drug) prevention based on the

idea that individuals interpret risk information in terms of instrumental rationality, overlooks the fact that such information is embedded in the general flood of risk information. Risk information, taken together with the effects of globalization and individualization, dissolves traditions as a way of organizing the future and opens up a world of unending choices.

In this perspective, risk information is not simply internalized and does not – as a rule – represent a form of distant, remote control, as suggested by Tigerstedt (op. cit.). On the contrary, risk information tends to extend the degree of uncertainty: expert judgements are called into question by counter-experts, various risk discourses cut across one another and create uncertainty (or, put differently, a world of options). An example of the latter is the recent connection between information on the risks associated with alcohol consumption and information on risks for developing cardiovascular disease. Here, renowned scientific experts offer support for highly varying lifestyles as regards alcohol consumption. To some extent one could argue that the scientific production of risk information, by its own logic, will continue to expand into a scale of information that will be impossible to grasp for non-professionals. The dietary guidelines from the American Heart Association (2000) embody 12 dense pages of recommendations based on more than 200 scientific references. The total mass of the scientific body of knowledge related to risk information for cardiovascular disease forces such recommendations to become more and more elaborate over time. But the exponential growth of scientifically produced risk information is also accompanied by a

growing distrust of the accuracy and meaningfulness of this information. The website “www.junkscience.com” comprises a huge database of alleged “junk science” and offers “junk science judo” as self-defence against health scares and scams.

Tigerstedt (op.cit.) is by no means alone in his interpretation of risk as a main strategy whereby neo-liberal governments can discard old policy regimes in favour of voluntary self-discipline. What is termed the “governmentality perspective” (Lupton 2000) has drawn attention to the importance that governments tend to place upon the self-management of risk, thereby moving away from older notions of social insurance and welfare policy. But although this might be true as regards the intentions of policymakers, it has not been properly shown that the second part of the “governmentality perspective” – the internalization of risk as a guiding principle of behaviour – is present in accordance with those intentions. Empirical studies of how individuals *de facto* perceive information about risk tend to display a more context-dependent pattern.

Risk in context

The notion of a risk society (Beck 1999) mainly emphasises the effects of a shift from tradition and institutionalization to knowledge-dependent structures based on a growing network of expert discourses. It does not explicitly address the question of how different types of risks may vary.

Empirical studies of how individuals actually perceive specific risks have shown a number of important distinctions between different categories of risks. Two important dimensions are new versus old risks and the presence or absence of a “dread re-

action". Fischhoff et al. (1978) have shown that alcohol risks are regarded as old and well-known and low in "dread reaction". This can be contrasted with the public reaction to the discovery of BSE (mad cow disease), influenced as it was by the novelty of the risk and the predominance of a "dread reaction" (Pfister & Bohm 2001).

Another important dimension is the distinction between general and personal risk. In most cases it has been shown that personal risk is perceived as smaller than general risk, i.e. the risk to individuals other than oneself (Weinstein 1989). The difference between the individual's perception of general and personal risk is also correlated with his or her perception of the risk control involved (Sjöberg 1998) – the more control the individual associates with a specific risk, the larger the difference between general and personal risk. Thus, the difference between general and personal risk tends to be small for such risks as global warming and the deterioration of the ozone layer and larger for risks involving agency.

Although there is evidence of a positive correlation between alcohol consumption levels and risk perception (Sjöberg op. cit.), and thus of a degree of rationality², there is also strong evidence of a clear tendency for people to perceive the effects of alcohol on others as greater than the effects on themselves. This is especially valid for negative effects (Leigh 1987). Risks associated with alcohol consumption often display a unique difference between general and personal risk. In a study of a large, representative sample of Swedish respondents' perceptions of different types of risks, alcohol is perceived as one of the largest general risks whereas personal risk associ-

ated with alcohol is rated as one of the smallest risks (Sjöberg op. cit.).

In a study of risk behaviour and risk information among students, Cook and Bellis (2001) recently showed that a greater volume of risk information did not necessarily lead to a reduced level of risk behaviour. On the contrary, individuals with a good understanding of risk information were more likely to be high risk-takers, while individuals who overestimated the risks were more likely to be low risk-takers.

The modern pleasure principle(s)

If risk can be said to constitute one of the most central concepts in contemporary discourses on alcohol and drug prevention, "pleasure" (or other possible equivalents) stands out as its dialectical counterpart. Although pleasure has an obvious relation to risks associated with alcohol and drug consumption, it seems to be structurally excluded from prevention discourses (Bergmark & Oscarsson 1992; Room 2002). There is a striking absence of any acknowledgement of the fact that pleasure seems to be one of the main motors for a great deal of alcohol and drug consumption in most modern societies.

Furthermore, there is reason to believe that the radicalization of modernity has increased the importance of pleasure as a central concept for the understanding of the lifestyles of individuals in contemporary modern society. The famous connection between the Protestant ethic and the development of capitalism made by Weber (1968) began to dissolve with the development of mass production and mass consumption. For the Weberian Puritan, work

and asceticism were the central values underpinning the development of wealth and industrialization. But this value structure could not be upheld within the context of mass production where society is built upon the satisfaction of wants instead of needs. Bell (1976) has described this as a transformation of society where “the cultural, if not moral, justification of capitalism has become hedonism, the idea of pleasure as a way of life. And in the liberal ethos that now prevails, the model for a cultural imago has become the modernist impulse, with its ideological rationale of the impulse quest as a mode of conduct” (Bell 1976, 21). In a society of this type, individuals are less concerned about whether or not they are good, focusing instead on — and worrying about — whether and to what extent they are having fun.

The role of pleasure or hedonism — in a broader sense — is also central for many perspectives expressed in research relating to consumption and “the new consumer society”. Maffesoli (1993) has suggested that Western societies have entered an era of orgies where sensuality and emotions provide a sense of community. Sulkunen (1997a) writes: “As the situational determinants of lifestyle grow weak and the inwardly directed drive for the beautiful life is increasingly imposed on us by the necessity to choose, individual happiness and pleasure are elevated to the centre of our existential order” (Sulkunen 1997a, 15). The consumer society is based on a fundament of consumer preferences and the individual’s right — or even obligation — to search for pleasure. Taking a similar line, Schulze (1991) has coined the term “*Erlebnisgesellschaft*” (1991) in emphasising that contemporary modern society is directed

towards the consumption of subjective mental states. There is a clear connection between Schulze’s idea of the *Erlebnisgesellschaft* and earlier work focusing on the shift from production to consumption as the main engine of societal change. In “The Cultural Contradictions of Capitalism”, Bell (1976) elaborates the connection between what he designates as “fun morality” and the development of a “consumer society”.

In some versions of contemporary psychoanalytical theory, the pleasure theme is present in the identification of a new role for the superego. Žizek (1991; 1995) connects the transformation of modern society — with its dissolution of symbolic prohibitions and its expanding freedom for individuals to consider only the social rules that enhance their opportunities for self-expression and the pursuit of pleasure — with a parallel transformation of the superego. Instead of being a case of negotiation between the unconscious and the demands of culture, the superego has become the producer of the doubly binding imperative “Enjoy!”. Thus, in Žizek’s (op. cit.) view the individual is not restricted by institutionalized rules of conduct but is governed by the demand for a maximal amount of pleasure, originating from the superego. Such a transformation should not be mistaken for liberation of the individual. On the contrary, argues Žizek, there is no more effective way of inhibiting enjoyment than demanding it. The imperative form means that the full message is “Enjoy whether you want it or not”. Such hedonism also entails the externalization of pleasure in the sense that the individual cannot trust his or her own feelings but always relies on the other to decide whether or not they are valuable or authentic enough.

The pleasure-seeking individual constantly needs the approval of others since he/she can never establish an “objective” value of his/her experiences, and thus fears that his/her “pleasure” is not enough — compared with the experiences that he/she has missed. Western tourists in Southeast Asia are often engaged in a hunt for the perfect beach, and invest time and money in the search for information on where it may be found. But when they finally arrive at the remote island in the Andamandean Sea they are unable able to enjoy it (enough) since the most recent version of the Lonely Planet guide has identified an other island as the ultimate beach experience.

The limits of prevention

In the introduction to this paper, it was stated that the interplay between the forms of alcohol problematization, the level of policy measures already in place and the character of measures perceived as impracticable sets the limits for the prevention discourse. Although this formula is obviously valid only within specific cultural limits, it does represent an attempt to explain why ineffective approaches are popular (Room 2001), i.e. why the information/persuasion strategy remains a principal alternative in spite of scientific recommendations to proceed in other directions. As an explanation, however, further elaboration is possible with respect to some of the themes discussed concerning pleasure and risk.

The transformation of individualism, from its universal form to its subject-centred version, also entails an important shift in terms of the meaning of morality. The lack of objective references concerning what is interesting or fulfilling enough re-

stricts the scope for moral discourse. What is left is the endless repetition that everyone is free to do what he or she wants, or — put in Zizek’s more demanding terms — that everyone must fulfil their wants. Schulze (op. cit.) argues thus: “The last moral position discussed with the claim to be binding is that nobody should be bound. Thus, the general structure of moral arguments is pure self-reference: legitimization by subjectivity” (Schulze 1991, 47).

In such a context, where there is almost no opportunity for a moral discourse concerning individual freedom of choice, the vocabulary of prevention is reduced to dealing only with the harm caused by alcohol consumption. Prevention discourses cannot address the motivational structure underpinning the individual’s pursuit of pleasure and self-fulfilment.

This limitation may help explain why risk holds such a central place in alcohol prevention discourses. Although risk information is produced within the scientific community through a logic of its own, it is also related to the individual’s expanding menu of choices, a result of subject-centred individualism with little or no room for moral discourse concerning the individual’s adoption of lifestyle and identity. When morality is no longer present, only risk can fill its traditional role as a reason for renouncing alcohol. It is no coincidence that the most important actors in today’s alcohol policy scene in traditional temperance societies (such as the Nordic ones) are professionals and bureaucrats and not voluntary temperance organizations (Mäkelä 1983; Sulkunen 1997b), and that the latter category have increasingly taken their arguments from the former (Mäkelä, op. cit.).

Even if a moral vocabulary seems to be lacking in the discourse on preventing alcohol consumption in the general population, it can be found in discourses that deal with certain “subproblems”. Roizen (1993) has identified four such subproblems as particularly characteristic of recent history: drunk driving; foetal alcohol syndrome; youth drinking and criminal justice populations. Roizen points out that both drunk driving and foetal alcohol syndrome “define victims other than the drinker himself/herself” (op. cit., 13). To some extent this is also true of the other two subproblems. Drinking youths could be viewed as victims of the fact that they are not yet capable of being “informed consumers”. The problematization of alcohol consumption among individuals in criminal justice populations is primarily concerned with the possible harm such consumption might cause in terms of new crimes, rather than with the risks to the individual consumer. Thus, morality is a factor in prevention discourses in modern western societies, but usually in relation to how we are to protect ourselves against harm caused by others and not as a restriction of individual freedom of choice.

Risk information is mainly produced within the scientific community and is characterized by a logic of its own in terms of how it is communicated. It is expected to be objective in the sense that it should not be associated with any ideology but based on facts produced with the accuracy that scientific method demands. Hence, risk information is commonly presented in the form of probabilities (such as relative risk), which tend to be difficult to grasp. Although risk probability is related to risk perception it is not the major factor

behind a demand for risk reduction (which is crucial to the legitimacy of any preventive programme). Demand for risk reduction is mainly driven by the severity of the consequences (Sjöberg 1994)

Another aspect of the limitation of the discursive space of prevention is the fact that information strategies are based on the assumption that a *de facto* lack of information exists in a given target group. But to the extent that the information in hand is not new — as in the case with most information concerning risks associated with alcohol consumption — information is no longer information but redundancy. As pointed out above, empirical studies of risk perception identify the distinction between old and new risks as one of the most fundamental. It is in situations where the information is truly new (and the consequences are severe) — as in the case of HIV in the 1980s and BSE in the 1990s — that more substantial effects can be expected and observed.

There is an awareness within the alcohol research community of the dilemma surrounding alcohol policy in contemporary western societies. Sulkunen (1997b) has discussed the “public health predicament” resulting from the conflict between free consumer choice and the risks associated with actual consumption. Room (2002) has described prevention as limping on one leg due to the fact that research tends to leave out the positive effects that the consumption of different substances has on people. Room points out that a concept such as dependence seems to presuppose that a consumer of alcohol or drugs is as anxious to be “cured” as a person with a broken leg or an infection. He suggests that we might benefit from studying alcohol

and drug consumption from the perspective of “performance enhancement”.

It is clear that such a shift has already begun to some extent among alcohol researchers and some of their neighbours. But it remains unclear — at least to the present writer — to what extent this type of research can influence prevention programmes. With what kind of vocabulary,

arguments and legitimacy — besides risk information — can preventive measures intervene in the individual's pursuit of pleasure and self-expression?

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NOTES

1. A thoughtful and anonymous referee has pointed out that the present article is built upon a pronounced conventional conception concerning the content and demarcation of alcohol policy. This is a correct observation and a different and more elaborated conceptualization of alcohol policy could have made my discussion more interesting. However, for the time being I have chosen – with reference to an ambition to make my argument more clear – to refrain from this interesting invitation.
2. The use of the concept rationality is not unproblematic in this context, the observed j-shaped correlation between disease and mortality on the one hand and alcohol consumption on the other undermines a clear-cut and unambiguous meaning. In the present case the term is used to point to the broad positive correlation that exists between alcohol consumption and the perception of the risk associated with that consumption.

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Jumping out of harm's way

Harm reduction in Finnish drug policy:
conceptual problems and contradictions

Ever since the second drug wave in Finland in the 1990s (e.g. Partanen & Metso 1999), the concept of *harm reduction* has begun to appear more and more frequently in the vocabulary of Finnish drug policy. Nikolas Rose (1999, 9) says the interest-value of the concept lies not so much in what it means as in what it does. Our attention, therefore, is drawn to the contexts in which the concept is used and to the actual measures and programmes that are carried out in the name of "harm reduction".

In this article my intention is to explore the ways in which harm reduction was used in contemporary Finnish drug policy programmes and declarations during the first four years after the creation of the National Drug Strategy in 1997. Specifically, my aim is to demonstrate that harm reduction, as it stands today, is neither a clear and coherent term of drug policy nor an exact analytical tool, but rather a slogan that is used to motivate and justify a wide range of different measures. I begin by looking at how harm reduction is represented in official Finnish drug strategy documents (Drug strategy 1997; Statsrådets principbeslut om narkotikapolitiken 1998). Then, I proceed to identify two main perspectives in the harm reduction debate, i.e. the public

ABSTRACT

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The article discusses the use of the term "harm reduction" in Finland's contemporary drug policy. The focus is not on the meaning of the term, but rather on its actual use, on how "harm reduction" has been put into play in the governing of the drug question and what is done and has been claimed in the name of "harm reduction". This brings to light the problems and contradictions that arise if "harm reduction" is taken as a standpoint for policy making or as an analytical tool for drug policy research.

The paper reviews different connections and situations where "harm reduction" has been defined or used as an argument for general or specific goals and interventions. Harm reduction is often seen as a general strategy for national drug policy, as opposed to the traditional repressive and punitive strategy. On the other hand, it is also represented as pragmatic, reactive and situational work without general ideals or principles challenging repressive politics.

Two main perspectives can be distinguished in the discussion on harm reduction: the human rights perspective and the public health perspective. From a human rights perspective harm reduction is advocated by stressing the rights and equality of drug users. The focus is on the harms that the strict policy of control is causing to abusers. Harm reduction from a public health perspective stresses the harms that drug abuse causes to the nation's population, such as HIV, accidents etc. On the side of these main trends, there are however a wide range of practices which are represented in the name of "harm reduction", among these tighter police control and surveillance to efface the nuisance problems.

The article concludes that in Finland, "harm reduction" is neither a coherent political approach to the drug question nor an exact concept for analytical social research. It is rather a slogan that is used in very different occasions by various political agents as an argument for different interventions, aiming for ideals and goals that might easily contradict each other.

■ KEY WORDS

drug policy, harm reduction, drug users, public health, human rights, governance

health perspective and the human rights perspective, and next review the various practices that have been described as exercises in harm reduction. It is clear from the very diversity of these practices that it is difficult to establish any consistent content for harm reduction, and furthermore that the definition of this content is very much a political issue.

Harm reduction and repression in Finnish drug policy

Harm reduction is often represented as a *general strategy for national drug policy* and as such as an alternative to another, *repressive drug policy*. Thus infused with an ideological content, harm reduction has also taken on the shape of a political movement (most notably the International Harm Reduction Association). On the other hand, harm reduction is often mentioned without any ideological overtones in connection with a wide range of *concrete practices*; these include needle and syringe exchange programmes for intravenous drug users, health counselling schemes, substitution and maintenance therapy as well as increased police presence and intervention on scenes of drug use. These various harm reduction approaches define both the harms they propose to tackle and the ways in which they expect to reduce them in different ways.

The Finnish national drug strategy of 1997 observes that there are two main lines of European drug policy, i.e. the policy that is geared to repression and the policy that is aimed at harm reduction (Drug strategy 1997, 12). The object of repressive policy, according to the strategy document, is to "uphold the social condemnation of drug use as a marginal phenomenon", whereas harm reduction has the object of "minimising the harms caused by drug use and drug control to the various parties involved: the users themselves, their immediate environment and society at large" (Drug strategy 1997, 13). A repressive drug policy, the strategy document continues, is often pursued in countries where drug abuse is relatively uncommon. Harm reduction, on the other hand, is more typically found in countries and cities with an "extensive and established" drug abuse problem. In countries that favour a repressive policy, punishments for drug use can be quite harsh, whereas harm reduction countries often refrain from punishment altogether, at least in the case of so-called

soft drugs. Repressive policy tends to emphasise the importance of control, which is thought to be reflected in the demand for drugs. The harm reduction strategy, by contrast, tries to separate drug use from drug sales and to focus its control effort on smuggling and drug trafficking.

If harm reduction and a repressive drug policy that seeks total prohibition are viewed in this way as general strategies of drug policy, the two approaches clearly have different, even contradictory aims and means of pursuing those aims. Advocating the adoption of harm reduction as a general strategy, Ari Saarto (1998, italics by TH) of the Finnish A-Clinic Foundation writes as follows:

"Harm reduction represents one approach of *comprehensive* drug work.[...] Harm reduction is primarily about minimising harms and only secondarily about the goal of a drug-free society and 'curing' drug users, i.e. getting them to quit drugs. [...] The harm reduction debate can be taken to comprise *almost all* contributions that do not out of hand denounce and condemn drug use and users, but that seek to encourage ways of thinking and create environments that are conducive to the effective prevention and treatment of drug-related harms and to helping people with drug problems."

Repressive drug policy seeks to prevent all kinds of drugs use, using police control and harsh punishments to convey a message of condemnation. The ideal that is pursued under this policy – either implicitly or, as in the case of Sweden, for instance, explicitly – is that of a drug-free society. If, on the other hand, society does

nothing to intervene in drug use, then clearly it has dropped the goal of a drug-free society. It is accepted that drugs have come to stay and are an integral part of society: this view will be accompanied by calls to abandon resource-consuming forms of police control and to develop instead different ways of *adapting* to the new situation where, to paraphrase criminologist David Garland (1996, 447; 2001, 113–130), drug use has become *normalised*.

Seen from this vantage-point, the policy of harm reduction appears as a critique of and an alternative to repression. In some instances (the comment by Saarto above is a good example), harm reduction is defined so broadly that it is taken to comprise *all* critical commentary on negative drug policy. This obviously has the effect of watering down the concept of harm reduction: if all criticism of prevailing drug policy is placed under this umbrella, the concept will inevitably lose much of its weight.

The practices of both repressive drug policy and harm reduction have increased in Finnish drug policy during the latter half of the 1990s (Tammi 2002). The authorities have stepped up their control by adopting new police techniques (e.g. technical surveillance, undercover operations and purchases), by making more resources available for border control and by providing training to uniformed officers for the purpose of street-level drug control. These kinds of activities are generally regarded as signs of a repressive drug policy, especially as the control measures are heavily focused not only on professional crime but also on drug use (Tammi 2002).

Substitution and maintenance therapy for drug users has increased considerably

during the 1990s. Anonymous health counselling, including needle and syringe exchange programmes, started up in Helsinki in 1997 and has rapidly expanded to cover the whole country. These practices are based on the assumption that there is nothing that can be done to prevent drug use; drugs are used and will be used in any case.

So in spite of the fact that they are based on different principles and have different goals, both of these approaches have gathered strength. The drug policy objectives set out in the Government's decision in principle and the 1997 national drug strategy include *both* total repression and prohibition *and* the goal of minimising harm caused by drug use and the regulation of the drug problem. During the preparation of the National Drugs Strategy, advocates of the former, repressive approach – primarily the Ministry of the Interior and the police force – made clear their objections to the harm reduction approach and vice versa, but even so the two conflicting lines of practice have continued to gather momentum side by side (Tammi 2003).

One of the reasons that has facilitated the co-existence of these conflicting practices, I think, is that harm reduction has *not* always been used in Finland as an alternative strategy to repressive drug policy, but rather as a purely *practical* motivation for various kinds of measures. Since there has been no serious attempt at an ideological defence of harm reduction in connection with drug policy practices, the opposition with the repressive policy has never developed into a full-blown conflict. As the Finnish Medical Association Duodecim observes in its consensus statement of 3 November 1999:

“Harm reduction efforts are aimed at minimising the various nuisances and costs arising from the drug problem rather than merely at a drug-free life. This is not antithetical to the perspective of repressive drug policy, but involves establishing contacts as dictated by practical needs as well as reducing the health risks associated with drug use, which supports the effort of restricting drug use (Konsensuslausuma 1999).”

This is a pragmatic perspective. As a matter of principle it might still be possible to adhere to a repressive policy that is based on total prohibition, but in practice, when there are no other options, harm reduction measures will also be adopted that are aimed not at a drug-free life, but simply at reducing the associated health risks.

Human rights perspective and public health perspective

Harm reduction is based on the logic of risk. The drug problem is thought to present various risks to society, and the idea is to apply appropriate policy measures that it is thought will curb their effects. The definition of drug-related harm is based on assessments of the relationships between different causes and effects, which require a complex process of calculating and weighing different mechanisms of social impacts (see e.g. Virtanen 1997). In the case of harm reduction policy, the harms that are usually mentioned in connection with drug use include HIV, hepatitis C infection and overdose fatalities (Partanen et al. 2000). Harms may also be described in terms of the number of drug addicts as a proportion of the population or the number of young heroin addicts, for

instance (Drug strategy 1997, 15).

Harm reduction based on the logic of risk thus serves to justify the regulation of drug-related epidemics that threaten *public health*. Seen from this vantage-point, drug abusers are regarded as risks to public health, and harm reduction advocates will call for *population-level* interventions designed to contain these risks. The most important practical application of this *public health perspective* is represented by needle and syringe exchange programmes. The public health perspective on risks does not look upon the drug problem as an individual, but rather as a population-level phenomenon of which the individual is part through his or her membership of the population organism. Here, harms are seen as consisting of epidemics threatening the population's general health and functional capacity, and harm reduction consists in a reactive effort to prevent such epidemics.

If, on the other hand, harm reduction is pursued as a general strategy of drug policy, as a matter of principle (e.g. Sarvanti 1997; 1998; Saarto 1998), it is stressed that the harms caused by the drug problem should not be regarded as being confined to the public health problems caused directly by drug use; instead it should be accepted that they also comprise the *costs of control* associated with the drug policy pursued. On these grounds, the repressive drug policy has been criticised, for, among other things, the unreasonable suffering it causes to drug users as well as for its tendency to cause more crime: since the prohibition of drugs has the effect of pushing up prices, users are driven to stealing in order to finance their habit.

This kind of perspective draws attention to the status of drug users as *citizens* in so-

ciety and calls for the recognition of their human rights and for their fair and equal treatment. The individual is seen first and foremost as a citizen, and any practices undermining his or her civic rights are harms in exactly the same way as those associated with health. The main concern of harm reduction, in this perspective, is to guarantee equal rights and opportunities to all individuals. This may be described as the *human rights perspective*. It is heavily oriented to the individual, who is regarded primarily as a free legal entity rather than a population unit (Sarvanti 2000):

"It is obvious that in spite of efforts to the contrary, illicit drug users do not in all respects receive equal treatment with other groups who are in need of care. Drug control has assumed forms that have been considered to erode civil rights. [...] Indeed drug policy, where it is concerned with the development of care and control, should be more firmly grounded in the protection of human rights."

Following Michel Foucault, these two main perspectives on harm reduction – the public health and the human rights perspective – may be taken to represent two different understandings of the individual that appear simultaneously in the western welfare state (Dean 1999, 82). The human rights perspective which emphasises the rights of drug users is associated with the classical idea of the individual as a free citizen with full rights as a member of the political community that is based on law, political order and equality among all citizens. The public health perspective, then, looks upon the individual from the Christian shepherding point of view (see

Foucault 1988) as a *living creature*, as a member of a social community whose physical health is dependent on the general well-being of the population and that must be looked after by means of *social integration*.

As we just saw, the public health perspective that is geared to harm reduction is not necessarily antithetical to repressive drug policy and its restrictive policy control. By contrast, the human rights perspective that is geared to harm reduction and that is also concerned with the harm caused by *control itself* does stand in an antithetical relationship to repression (Sarvanti 1998, 269):

"The extension of drug control in the direction of criminal justice will increase the costs incurred to society and add to the suffering caused by control, yet the international experience suggests it does little in the way of reducing actual drug use."

One explanation for why the human rights perspective does and the public health perspective does not challenge the traditional crime perspective in the name of harm reduction lies precisely in the two different understandings of the human individual. That is, the public health perspective looks upon the individual as part of the population, as a unit of a socio-biological entity whose life-processes it seeks to regulate. On the other hand, both repressive drug policy that is based on legal order and that views the drug user as a criminal, and the human rights perspective that wants to reduce the costs of control will look upon the individual as a legal entity, as a citizen whose existence is determined by political rights and freedoms. In other words the public health perspective does

not engage in direct exchange and dialogue with the human rights and crime perspective because it operates with a different definition of the individual. It therefore represents itself merely as practical and corrective action that does not directly interfere in the drug user's human rights position or in legislation, but rather has a supportive or supplementary role to prevailing legislation within its own narrow area of expertise.

Together, the public health discourse and the human rights discourse create a kind of discursive space for understanding the harms associated with the drug problem and harm reduction. Although their relationship to repressive drug policy is different, they are often closely interwoven; therefore measures introduced in the name of public health (such as needle exchange programmes) are often motivated by reference to human rights as well. The International Harm Reduction Association, for instance, often refers to both public health and human rights motivations as it sets out its goals against repressive drug policy. The relationship of the harm reduction discourse to punitive drug policy depends crucially on how much weight and prominence is given to the human rights perspective and to the costs of control when talking about harm reduction.

The fragmented practices of harm reduction

The past few years have seen a very rapid increase in substitution and maintenance therapy as well as health counselling for drug users, including needle and syringe exchange programmes, all of which are public health minded activities justified by reference to harm reduction.¹ Advocates of

the human rights perspective, for their part, have continued to call for more lenient criminal justice control of drug use and non-prosecution for minor drug offences. However neither more lenient sentencing nor the option of non-prosecution has been used in the manner intended by the legislator (Drug strategy 1997, 45). In other words, the pragmatic policy of harm reduction that concentrates purely on public health problems has had much better success than the human rights policy which is aimed at reducing the harm caused by control.

In addition to these perspectives and measures, there has been a diverse range of other practices that have been applied at the local level in the name of harm reduction. For instance, following a number of overdose fatalities in autumn 1998, the ambulance service at the Turku Fire Department began handing out to drug users a simple safety guide which explained the signs of a drug overdose and what one has to do in the event of an overdose. The National Public Health Institute produced a brochure which tells intravenous drug users how to clean a drug syringe using a chlorite solution in order to destroy the viruses in the spent syringe. In Helsinki, anonymous health counselling centres (known as 'Vinkit' or 'Tips') have produced a brochure which describes in graphic detail the safest way to inject a drug. Finally, the Institute of Occupational Health has published a guidebook for staff working with drug abusers, giving advice on how to prepare for safe encounters.

In addition to these various harm reduction measures that are mainly concerned with health hazards, there are a number of situational or local practices aimed at pre-

venting disorder, crime or vandalism by drug users. Examples of this kind of *situational prevention* (see e.g. Clarke 1980) include the installation of blue neon lights in public lavatories and drugs testing in the workplace. Threats associated with drug users have also reinforced many common routines of crime prevention, such as the use of alarms and security locks to protect private property and the use of CCTV cameras in public places. These are just individual examples of techniques aimed at "reducing harm" and cannot be seen as a comprehensive drug policy strategy or even as action programmes comparable to public health work or human rights campaigns, but rather as situational reactions to local problems.

As was noted above, substitution and maintenance therapy has also been motivated by reference to harm reduction. The Finnish Medical Association Duodecim says in its consensus statement of 3 November 1999: "There is evidence that substitution therapies reduce mortality, health problems, social harms, crime and the use of illicit substances, particularly injected drugs." On the other hand, it has also been pointed out (e.g. Mäkelä & Poikolainen 2001) that extensive substitution therapy using medical drugs can in itself give rise to new harms. For example, drugs intended for medication may end up being sold by street dealers, and people committed to intensive medical treatment because of their drug habit may in the end never be able to lead a life without drugs. In such cases medical treatment aimed at harm reduction has been considered a harm in its own right.

Street-level drug control by the police has also been motivated by reference to

harm reduction (Kinnunen 2002). Interventions in drug use and house searches, interviews and interrogations have all been carried out in the name of harm reduction. In these situations harm has been understood in terms of disturbances caused to the local environment, or nuisance problems that are caused by drug use and sales (e.g. disorderly behaviour). These kinds of problems have been tackled by means of direct control to try and encourage drug users to quit altogether or at least to cut down and in this way to cause less disturbance or move elsewhere. In the short term this has in fact worked. (Kinnunen 2002.) "Harm reduction" has thus served to justify tougher forms of repressive control of crime. The difficulty here with regard to the concept of harm reduction is that these measures of police control that are justified by harm reduction are in themselves one example of the kind of unreasonable harm inflicted on drug users that advocates of the human rights perspective consider problematic. Not only is the understanding of *harms* different, but the notion of *reduction* also takes on a different meaning with shift from one perspective to another.

Analysing harm reduction

It seems then that a change of perspective or a different understanding of harm can profoundly affect the kind of measures that are taken in the name of harm reduction. They may even work in completely opposite directions and assume an entirely different content depending on whether the focal concern is with the harm caused by drug use to public health, to drug users themselves, to the immediate environment or with the harm caused by drug con-

trol to users and/or society.

Table 1 provides an overview of the different measures and practices of harm reduction discussed herein: they are organised according to the perspective from which harm reduction is approached and considered. The drug user who is targeted by these measures assumes a different subject position in these different categories, and the harms targeted are understood in different ways. A different understanding of harms means that the measures proposed for reducing them are also different.

The *crime perspective* emphasises the harm that is caused by drug use to the rest of society; the *illness perspective* the harm that is caused to the drug user himself; the *public health perspective* the harm that is caused at the population level; and the *human rights perspective* the harm that is caused to users by drug control. The individual drug user appears in a different light in each of these perspectives. The human rights perspective looks upon the drug user primarily as a *legal subject*, as an equal citizen equal whose human rights must be respected in exactly the same way as the rights of other citizens. The illness perspective, then, looks upon the drug user first and foremost as a *patient-subject* struggling with the disease of addiction: the aim should be to cure this patient and normalise his or her life as far as possible. Services representing the public health risk perspective, for their part, approach the drug user as a *client*, a responsible partner who is capable of autonomous action; the aim here is to shape the environment and living conditions of this client with a view to improving them from a public health point of view. The traditional crime perspective looks upon the drug user as a

Table 1. Four perspectives on harm reduction

Perception of reality	Harm reduction perspective			
	<i>Human rights</i>	<i>Illness</i>	<i>Public health</i>	<i>Criminality</i>
<i>Drug user's subject position</i>	Legal subject	Patient subject	Client subject	Criminal subject
<i>Primary target of harm reduction</i>	Harms caused by control to users	Harms caused by drugs to users	Harms caused by drugs to population	Harms caused by drug use to immedi- ate environment
<i>Measures proposed</i>	More lenient punishments, non-prosecution	Substitution and maintenance therapy, other therapies	Needle and syringe exchange, health counselling, substi- tution and mainten- ance therapy	Police raids, drugs testing, neon lights etc., situational prevention

criminal, a morally distorted individual and a potential source of danger or harm to other people. It is important to stress that these perspectives do not appear in a pure form in reality; on the contrary the different approaches involved always overlap and intertwine in what is a dynamic space of drug policy practices. However, since they are more or less contradictory with each other, this interweaving at the practical level is certainly problematic to some extent.

The politics of harm

As we have seen then, harm reduction, in the Finnish case, is best described as a slogan under whose umbrella we find a whole plethora of different practices. It is not a coherent strategy or approach for dealing with the drug problem, nor an exact tool of drug policy analysis, but rather an assembly of different kinds of temporally and spatially specific techniques that often emerge in response to locally problematic situations. Since these techniques vary in shape and in the ways they are implemented, it is extremely difficult to identify any consistent content for harm reduction.

Harm reduction may be described as consisting in adaptive reactions to a situation where it is felt that the problems concerned cannot be contained by means of centrally co-ordinated, government strategies of regulation. Social problems will in this situation be tackled by means of various fragmented and local techniques that are based not on centralised welfare state mechanisms, but rather on the activity and responsibility of local authorities, NGOs, private companies as well as the groups who are the targets of the policies concerned. (Garland 1996; 2001, 113–129; Dean 1999, 170; Rose 1999, 173–179.)

It is very difficult to identify and define the harms that are caused to different parties in society. If the assessment of harms is extended to those that are caused by the measures of harm reduction themselves, there is a real risk of a vicious circle developing where new harms will continue to appear, and the reduction of those harms then leads to new harms, etc. The problem, then, is not just the harm itself, but also the efforts that are made to reduce the harm, which may become a harm in themselves.

The identification of harms, like the

identification of risks in the risk society described by Ulrich Beck (1992), is an never-ending project which opens up a horizon of endless calculation, rationalisation and regulation and which requires an intensive, continuous effort to identify, monitor and calculate social impacts and their mutual relations. This endless project of regulation opens up a political space in which different instances of power engage in battle over impacts, reasons, causes and related valuations. Referring to Colin Campbell, Jukka Gronow (2000) has observed that this kind of risk-calculating rationality is reminiscent of the theory of rational choice where the collective good is articulated through individual preferences. Underlying it is the assumption of the individual (and state) that maximises its

benefits (or minimises its harms) by means of rational cost-benefit analysis in the same way as the idealised consumer of economic theory.

Regulation based on the logic of risks and harms and the social reality produced by that regulation is not, however, predetermined, but the identification and assessment of harms as well as the working of those harms are dependent on social power positions. Like risks, harms are not an existing, self-evident reality that is just waiting to be perceived and recognized. The recognition of something as a harm implies evaluation. Any talk about harm always involves value choices; there is no such thing as a neutral harm.

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NOTE

- 1) The first anonymous health counselling centres were set up in the Helsinki area in spring 1997. By 2002, they had spread to 19 different towns around the country. In 2000 the centres saw a total of 4 800 clients, exchanging 565 000 syringes and needles. In the same year pharmacies sold a total of some 500 000–600 000 syringes and needles (Partanen 2002). The Ministry of Social Affairs and Health gave the go-ahead for medical substitution and maintenance therapy at central university hospitals in 2000 and at all community health centres with qualified staff and the necessary facilities and other resources in 2002 (Baas & Seppänen-Leiman 2002).

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Television and drinking expectancies

The influence of television viewing on positive drinking expectancies and alcohol use among US and Norwegian adolescents: a comparative analysis

A growing body of research has linked exposure to portrayals of alcohol use in the mass media with the development of positive drinking expectancies by children and adolescents (Aitken 1989; Aitken & Eadie & Leather & McNeill & Scott 1988; Austin & Knaus 2000; Austin & Meili 1994; Austin & Nach-Ferguson 1995; Austin & Pinkleton & Fujioka 2000; Dunn & Yniguez 1999; Grube & Wallack 1994; Kelly & Edwards 1988; Kotch & Coulter & Lipsitz 1986; Martin et al. 2002). This literature suggests that portrayals of incidental drinking in entertainment media and cleverly persuasive messages and images in advertising influence beliefs and behaviors in those who are under the legal drinking age (Aitken 1989; Atkin 1990; Connolly & Casswell & Zhang & Silva 1994; Jones & Donovan 2001; Martin et al. 2002; Waiters & Treno & Grube 2001; Wyllie & Zhang, & Caswell 1998).

Because they are so ubiquitous and pervasive in some parts of the world, particularly in the United States, alcohol advertisements have been

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ABSTRACT

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Television and drinking expectancies

■ OBJECTIVE

Exposure to incidental portrayals of drinking on television and cleverly crafted advertisements has been linked to the development of positive alcohol expectancies in children and teenagers. Researchers hoping to demonstrate this connection, however, have difficulty in finding adolescent groups with little or no exposure to alcohol advertising for comparative purposes. One of the cornerstones of Norwegian alcohol policy has been a government-enacted ban on all forms of advertising for alcohol products containing more than 2.5% alcohol by volume. As a consequence, Norwegian youth have almost no experience with alcohol advertising. This study represents a comparative analysis of Norwegian and US teenagers that seeks to improve our understanding of television's and alcohol advertising's potential role in shaping attitudes about alcohol.

■ METHOD

Self-report data on television viewing, normative beliefs about teenage drinking, and alcohol expectancies were collected from convenience samples of 972 junior high students in the US and 622 junior high students in Norway.

■ RESULTS

Although students in both countries watch about the same amount of television and about equal numbers have tried alcohol, the Norwegian students were more likely to see drinking as a normal teenage behavior and to have more positive outcome expectancies. For students from both countries who had no personal experience with alcohol, frequent television viewers were more likely than light viewers to see drinking as a normative behavior with positive outcomes. This was particularly true for Norwegian students who viewed large amount of US and British programs as well as music videos.

■ CONCLUSION

The absence of alcohol advertising in Norway may be overshadowed by the general cultural acceptance of adolescent and young adult drinking. For students with no personal experience with alcohol, however, television may be functioning as an important socializing agent, providing them with portrayals of drinking behaviors, cultivating normative beliefs, and presenting opportunities to cognitively model and rehearse the behaviors shown.

■ KEY WORDS

Alcohol, adolescents, television, advertising, expectancies, social norms

the primary focus of the vast majority of studies exploring socio-cultural influences on the development of alcohol expectancies and have drawn most of the attention in public discussions. Many of these studies, however, have been criticized by researchers who argue that they have not provided sufficient empirical support to assert a causal link between media exposure and attitudes and behaviors (Kohn & Smart 1984; Smart 1988). In addition, several of these studies have reported very small effect sizes, leaving the door open for continued debate on the media's role in adolescent drinking (Beccaria 2001; Grimm 2002; Nelson 1999; Strickland 1983).

One of the challenges faced by researchers in the USA may be the inability to study adolescent groups with little or no exposure to alcohol advertising messages (Atkin 1990). The Center for Alcohol Marketing and Youth (CAMY), for example, estimated that in 2001, US teenagers saw an average of 245 televised alcohol advertisements, with nearly one-third of youth between the ages of 12 and 20 seeing at least 780 ads (Center on Alcohol Marketing and Youth 2002b). CAMY has also reported that a substantial percentage of print advertising for alcoholic beverages appears in magazines with large percentages of readers under the age of 20 (Center on Alcohol Marketing and Youth 2002a).

Alcohol advertising in the US is regulated by a combination of voluntary codes developed by the three major alcohol beverage industry trade associations and by individual state regulations (Center on Alcohol Marketing and Youth 2003a; 2003b; Federal Trade Commission 1999; International Center for Alcohol Policies 2001). The voluntary codes adopted by the Beer Institute, the Distilled Spirits Council of the United States, and the Wine Institute prohibit advertising that would appeal to underage consumers or encourage irresponsible drinking (Federal Trade Commission 1999). At the state level, Alcohol Beverage Control (ABC) agencies have enacted regulations (based on state statutes) for the distribution, promotion, and sale of alcohol (Center on Alcohol Marketing and Youth 2003b). For example, many of these regulations prohibit the use of outdoor advertising in certain locations (such as near schools), product giveaways, and the portrayal of minors in ads (Center on Alcohol Marketing and Youth 2003b). In addition, the Federal Trade Commission periodi-

cally investigates alcohol industry marketing practices as a part of its overall responsibilities to regulate product advertising (Federal Trade Commission 1999).

These industry codes, however, evolve over time. The voluntary ban on televised advertising of liquor and spirits by the Distilled Spirits Council, for example, was lifted in November 1996 – five months after an NBC network television affiliate in Corpus Christi, Texas, aired an ad for Canadian Whiskey (Snyder & Milici & Mitchell & Proctor 2000). Although the television networks have been reluctant to carry ads for these products, local affiliates and cable stations have not (Snyder et al. 2000). In general, the alcoholic beverage industry in the US is relatively free to advertise its products via most media channels and, as a result, may reach large numbers of underage consumers (Center on Alcohol Marketing and Youth 2002a; 2002b).

In many parts of Europe, however, alcohol advertising is regulated by a combination of industry codes and legislative mandates (Sewel 2002; International Center for Alcohol Policies 2001). One of the cornerstones of Nordic alcohol policy (Norway, Sweden, Denmark, Iceland, and Finland) has been to place legislative restrictions on alcohol advertising (Holder et al. 1998; Rantanen 2003; Sewel 2002; Ugland 2001). In 1975, the Norwegian government enacted a ban on the advertising of alcoholic beverages containing more than 2.5% alcohol by volume (Holder et al. 1998). The ban prohibits advertising on billboards, in magazines and newspapers, on radio, and on television (Holder et al. 1998; Sewel 2002). These restrictions are the product of government policies concerned with the health and social conse-

quences of drinking (Holder et al. 1998; Sewel 2002; Ugland 2000; 2001; International Center for Alcohol Policies 2001). As a result, Norwegian youth would be expected to have substantially less, if any, experience with alcohol advertising compared to US teenagers. Their only exposure might come from the promotion of brand names (e.g. sponsorships), watching satellite and cable channels originating in the UK (such as MTV Europe) or from reading magazines published outside of the country¹.

Like their US counterparts, Norwegian teenagers would also be exposed to incidental portrayals of alcohol use occurring on entertainment programs originating from both within and outside of Norway. A large number of US-produced television programs and films are broadcast on Norway's primary channels, NRK1, NRK2, TV2, TV Norge, and TV3. During recent and current seasons, the television programs have included *Temptation Island*, *The Bachelor*, *Big Brother*, *Meet the Parents*, *Friends*, *The West Wing*, *Boston Public*, *Everybody Loves Raymond*, *Grounded for Life*, *CSI: Miami*, *The Simpsons*, *Sex and the City*, *Providence*, *Alias*, *The District*, *Will and Grace*, and *Crossing Jordan*.²

Despite the fact that they are generally not exposed to alcohol advertising, Norwegian youth drink at approximately the same rate as US adolescents.³ In addition, both countries are characterized as "dry" based on drinking patterns and sociocultural factors (Bloomfield & Stockwell & Gmel & Rehn 2003)⁴. As a result, we felt that these two countries would present us with an interesting opportunity for comparison. Therefore, our objective was to conduct a comparative analysis of Norwe-

gian and US teenagers that would 1) improve our understanding of television's potential role in shaping attitudes about alcohol, and 2) determine the impact of the presence or absence of alcohol advertising on the development of alcohol expectancies, particularly among those teenagers who have not yet begun to drink.

Media exposure and adolescent drinking

A number of researchers have attempted to understand the process by which exposure to alcohol advertising and incidental portrayals of drinking on television influence alcohol-related beliefs and behaviors in children and adolescents. Aas and Klepp (1992), Atkin (1990), and Austin and Meili (1994) have argued that alcohol use is a learned behavior, part of the adolescent socialization process. They contend that adolescents, particularly those who have not yet begun to experiment personally with alcohol, actively and deliberately seek information about alcohol from cultural sources as well as family and peers. One of the primary sources is television, which may present only a distorted view of the realities of alcohol use (Atkin 1990; Austin & Nach-Ferguson 1995; Christenson & Henrikson & Roberts 2000; Grube 1993; Kelly & Donohew 1999; Mirazee & Kingery & Pruitt 1989; Wallack & Grube & Madden & Breed 1990).

■ Incidental portrayals

Content analyses of portrayals of alcohol use on US television suggest that incidences of drinking occur frequently and that these portrayals present drinking as a relatively consequence-free activity (Christenson et al. 2000; Grube 1993; Mathios & Av-

ery & Shanahan & Bisogini 1998; Wallack & Grube & Madden & Breed 1990). Grube (1993) reported, for example, that 55% of the 168 episodes studied from the 1991 prime time television season, portrayed at least one character drinking alcohol and that 81% of the episodes made at least a visual or verbal reference to drinking. Grube also noted that 13% of the episodes examined depicted positive consequences for drinking and that only slightly less than 12% presented any warnings about drinking in hazardous or high-risk situations. Television characters who drink tend to be "high status" characters who are wealthy, successful, attractive, and in senior-level occupations. Their drinking is often associated with happiness, social achievement, relaxation, and camaraderie (Christenson et al. 2000; Hundley 1995; Wallack et al. 1990).

Christenson et al. (2000) analyzed 4 consecutive episodes of each of the 42 top-rated (based on audience size) comedies and dramas for teenagers (12–17) and adults (25–29) airing during October–December 1998 in the USA. They found that 71% of the 168 programs they examined included alcohol use. Fifty-three percent of the major characters in the 20 programs most popular with teenagers consumed alcohol, often in bars, restaurants, or at parties. Although portrayals of underage drinking were relatively infrequent, such depictions often addressed the situation in an overly simplistic or humorous manner (Christenson et al. 2000; See also DeFoe & Breed 1988).

Music videos, which are among the most popular types of television viewed by adolescents, also model alcohol use (DuRant & Rome & Rich et al. 1997; Robinson & Chen

& Killen 1998). In their analysis of the content of 518 music videos appearing on *MTV*, *BET*, *VH1*, and *CMT*, DuRant et al. (1997) found that slightly more than a quarter of all rock and rap videos included a portrayal of alcohol use. In two-thirds of the portrayals the drinkers were young adults and in nearly 80% of the portrayals alcohol use is associated with sexuality (DuRant et al. 1997).

■ Alcohol advertising

Content analyses of the persuasive appeals used in alcohol advertisements suggest that drinking is portrayed as being an important part of sociability, physical attractiveness, masculinity, romance, relaxation and adventure (Grube 1993; Finn & Strickland 1982; Madden & Grube 1994). Many alcohol advertisements use rock music, animation, image appeals, and celebrity endorsers, which increase their popularity with underage television viewers (Aitken 1989; Grube 1993; Jones & Donovan 2001; Martin et al. 2002; Waiters & Treno, & Grube 2001). Research also suggests that alcohol ads are pervasive, particularly on television. CAMY estimates that the US alcohol industry spent more than \$811 million to place nearly 209,000 advertisements on US television in 2001 (Center on Alcohol Marketing and Youth 2003b). Other studies have found that 2.4 alcohol ads appear during every hour of sports programming and that at least one alcohol ad appears every four hours of fictional programming on television in the USA (Madden & Grube 1994). Not surprisingly, then, alcohol commercials are among the most likely to be remembered by teenagers and the most frequently mentioned as their favorites (Aitken 1989; Aitken et al. 1988; Aitken &

Leathar & Scott 1988; Grube 1993).

■ Social cognitive theory

Atkin (1990), Austin and Meili (1994), and others (see for example Aas 1995), have suggested that social cognitive theory (Bandura 1977; 1986) provides a useful theoretical framework for exploring the effects of media exposure on adolescent alcohol expectancies. Social cognitive theory posits that children learn social information vicariously through observations that shape their definitions of normative social practices and standards of appropriate conduct. As a result, they are able to create cognitive representations of behaviors that can then be symbolically rehearsed in anticipation of desired consequences (Atkin 1990). This process, which Atkin (1990) describes as “anticipatory socialization,” allows children and young adolescents to learn about alcohol and develop normative beliefs and expectancies about the outcomes of drinking prior to actual experimentation.

■ Norms

Social norms reflect one's beliefs about both the normality and appropriateness of particular beliefs and behaviors and, as a result, often create pressure to conform and behave in a particular way (Aas 1995; Aas & Klepp 1992; Austin & Johnson 1997a; 1997b; Austin & Knaus 2000; Austin & Meili 1994; Austin & Nach-Ferguson 1995). In most cases, this pressure is internal and reflects what we think others will expect of us in particular situations. As suggested by social cognitive theory, social norms are often learned through observation and vicarious experiences. Teenagers, for example, who see other teenagers drink

– on television or in a real-life setting – may come to believe that all teenagers drink, in turn creating pressure to conform to this normative standard (Aas 1995; Aas & Klepp 1992). The problem is that teenagers tend to overestimate the frequency of drinking by other teenagers, thus creating beliefs and related pressures that are out of sync with reality (Aas & Klepp 1992). Aas and Klepp (1992) reported that normative beliefs, regardless of their accuracy, were predictive of actual drinking in their study of Norwegian adolescents. They reported that nearly half the variation in self-reported drinking was explained by the estimated number of friends who drink and the opinions regarding the appropriateness of drinking attributed to both friends and parents. Atkin (1990) argues that television plays a major role in the shaping of normative beliefs:

Television may shape teenagers' perceptions of normative standards toward the pro-drinking norms projected by televised models; to the extent that they learn that drinking is pervasively practiced and socially appropriate, they will develop conceptions of other people's expectations as supportive of their drinking, even when approval is not explicitly expressed. (p. 14)

■ Expectancies

Alcohol expectancies are elaborations about the effects of drinking on people's behavior, moods, and emotions (Aas 1993; Brown & Christiansen & Goldman 1987; Christiansen & Goldman & Inn 1982; Christiansen & Smith & Roehling & Goldman 1989; Goldman & Del Boca & Darkes 1999). For children and adolescents who

have not yet begun to drink, expectancies are influenced by normative assumptions about teenage drinking as well as through the observation of drinking by parents, peers, and models in the mass media (Aas 1993; Ary & Tildesley & Hops & Andrews 1993; Cumsille & Sayer & Graham 2000; Curran & Stice & Chassin 1997; Grube & Wallack 1994; Jackson & Henriksen & Dickinson 1999; Webb & Baer & Getz & McKelvey 1996). A number of studies have reported associations between exposure to alcohol advertising and televised portrayals of alcohol use and positive alcohol expectancies (Andsager & Austin & Pinkleton 2002; Austin & Johnson 1997a; 1997b; Austin & Knaus 2000; Austin & Meili 1994). Positive alcohol expectancies, in turn, have also been linked to current adolescent alcohol use (Aas 1993 & Aas & Klepp & Laberg & Aarø 1995; Aas & Leigh Anderssen, & Jacobsen 1998; Austin & Johnson 1997a; 1997b; Brown et al. 1987; Connelly et al. 1994; Grube & Wallack 1994; Kotch et al. 1986). The importance of alcohol expectancies and their relationship to actual drinking, was explained by Aas et al. (1998):

Briefly, the decision to initiate a drinking episode is assumed to be driven at least partially by the individual's belief that alcohol will serve certain functions or result in certain desirable consequences, such as relief from tension or enhancement of mood. Drinking behavior is then maintained by ongoing expressions of alcohol's ability to result in these desired outcomes. (p. 373–4)

Aas et al. (1998) have described the relationship between expectancies and drinking as being reciprocal in nature. Expectan-

cies, they explain, not only operate an incentive to drink but also lead young drinkers to perceive drinking situations as a confirmation of the expected. "Partly through a self-fulfilling process," they argue, "expectancies are confirmed, which further reinforces the incentives to drink" (Aas et al. 1998, 374). In their longitudinal study of 924 Norwegian teenagers, Aas and his colleagues found that expectancies predicted alcohol use longitudinally and, in turn, alcohol use predicted subsequent expectancies. In fact, as drinking became more frequent, expectancies became more positive.

This reciprocal model implies that for novice drinkers or those with little experience with alcohol, expectancies are most likely to be influenced by observational and vicarious learning via external sources, which include mass media portrayals of drinking. As personal experience with alcohol increases, the influences of those external sources may decline. In their 18-month study of 2,609 9th graders, Robinson et al. (1998) reported that among those students who were non-drinkers at the beginning of the study, hours of television and music video viewing were positively associated with the subsequent onset of drinking.

These findings lead us to formulate the following initial hypotheses:

- H₁: Frequent television viewers will be more likely than infrequent viewers to believe that drinking is a normal teenage behavior.
- H₂: Frequent television viewers will have greater positive expectancies regarding the consumption of alcohol than infrequent viewers.

H₃: Normative beliefs about drinking will be more positive for non-drinkers than drinkers.

H₄: Frequent television viewers will be more likely than infrequent viewers to believe that drinking alcohol will make them more popular with their classmates.

H₅: Frequent television viewers will be more likely than infrequent viewers to believe that most students in their grade at school drink alcohol.

H₆: Frequent television viewers will be less likely than infrequent viewers to believe that someone their age could harm themselves by drinking alcohol.

H₇: The influence of television viewing frequency on normative beliefs will be greater for those with no personal experience with alcohol (they have not tried alcohol nor report having friends who drink).

H₈: The influence of television viewing frequency on positive alcohol expectancies will be greater for those with no personal experience with alcohol (they have not tried alcohol nor report having friends who drink).

Differences between Norwegian and US teenagers, however, may provide additional insights into understanding potential media effects. If exposure to alcohol advertising, not just general television viewing, plays a major role in the development of normative beliefs and expectancies, as posited by previous research, then its absence in Norwegian media would suggest that the relationships proposed in H₁, H₂, H₃, H₄, H₅, H₆, H₇, and H₈ should not exist, or at least be substantially weaker, for our Norwegian students. In other words, we would expect to find notable differences in

normative beliefs and expectancies between US and Norwegian teenagers. If, on the other hand, incidental portrayals of alcohol use in general television programming are as potentially influential as advertising, we might expect to find similar beliefs and expectancies for both groups, regardless of the absence of alcohol advertising on Norwegian television. In particular, we would expect this to be true particularly for Norwegian respondents who are frequent viewers of US and British television programs and music videos, where drinking is commonly portrayed. Therefore, we also expect that:

H₉: Norwegian adolescents who are frequent viewers of American and British television programs will have stronger normative beliefs about teenage drinking than those who are infrequent viewers, particularly among non-drinkers.

H₁₀: Norwegian adolescents who are frequent viewers of American and British television programs will have more positive alcohol expectancies than those who are infrequent viewers, particularly among non-drinkers.

H₁₁: Norwegian adolescents who are frequent viewers of television music videos will have stronger normative beliefs about teenage drinking than those who are infrequent viewers, particularly among non-drinkers.

H₁₂: Norwegian adolescents who are frequent viewers of television music videos will have more positive alcohol expectancies than those who are infrequent viewers, particularly among non-drinkers.

Method

■ Sample

Data were collected via a self-report questionnaire administered to two convenience samples of junior high students in the United States and Norway. The questionnaires were administered in the US during the 2001–2002 school year and in Norway during the fall 2003 semester.

■ The US sample

The US survey was administered to 7th and 8th grade students enrolled at six junior high schools (2 urban and 4 rural) in the Salt Lake City and Pocatello, Idaho areas. One to two weeks prior to the administration of the questionnaire, consent forms were sent home with students in the participating classes. Participation in the survey was limited to those students with parental consent. Forty surveys were excluded from the final analysis because of missing or incomplete data, thus only producing a final usable sample of 972 (a 55% response rate). This response rate is consistent with those obtained in similar alcohol-related surveys requiring active consent (see, for example, Austin et al. 2000; Wyllie & Holibar & Casswell & Fuamatu 1997; Wyllie & Zhang & Casswell 1998).

The final US sample was 73% white, 14% Hispanic, 4% Asian, 4% Native-American, 3% African-American, 2% Polynesian, and 0.3% other, which parallels the overall ethnic breakdown of the combined student population for these schools. The racial composition of our sample included a slightly higher representation of racial minorities than would normally be found in the Salt Lake City-Pocatello regions and closely approximated the ethnic composition of children un-

der the age of 18 in the USA.⁵ The mean age for the respondents was 13 (SD = 0.5). Four hundred and thirty (44%) of the subjects were male and 542 (56%) were female.

One important characteristic of our sample should be mentioned here. The Northern Utah-Southeastern Idaho region from which our US sample was drawn has a large population of adherents to the Mormon Church (Church of Jesus Christ of Latter-day Saints), which discourages its members from consuming alcohol. About 40% of Salt Lake City's population (181,266) are members of the Mormon Church (Online: www.uwec.edu/Geography/Invogeler/w188/utopian/Salt-Lake-City.htm [ref. 11.6.2004]). Approximately 27% of the residents of Idaho are members of the Mormon Church, although that number varies greatly by region within the state. According to the American Religion Data Archive about 47% of the residents of Bannock County, which includes the city of Pocatello, are Mormon (ARDA 2000). Based on the number of congregations in Pocatello, the percentage of LDS in that city is probably closer to 30% (See, for example, Online: www.cumorah.com [ref. 11.6.2004] & Online: www.lds.org/units/find/lsit/0,12835,2311-1-ID,00.html [ref. 11.6.2004]). To minimize this influence, we purposively selected inner-city schools within the Salt Lake City area that have in recent years experienced a substantial influx of minority students, a large percentage of whom are of Hispanic origin and members of other religious faiths.

Statistics on alcohol consumption reported by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) indicate that while Utah is a relatively "dry" state, Idahoans drink slightly more than the USA

average. According to the NIAAA, the annual per capita alcohol consumption for individuals age 14 or older in the USA is 2.18 gallons. The average per capita consumption is 1.29 gallons Utah and 2.28 gallons in Idaho (Nephew & Williams & Stinson & Nguyen & Dufour 2000).

■ The Norwegian sample

A Norwegian version of the survey instrument was administered to a convenience sample of students enrolled in 8th and 9th grade classes at 10 junior highs in the Oslo, Bærum, and Porsgrunn communities in southeastern Norway.⁶ The schools represented a mix of urban, suburban, and rural schools located in the Oslo metropolitan area. Only two of the schools required active consent. To accommodate these schools, consent forms were sent home one week prior to the administration of the survey. The remaining schools used passive consent. Five surveys were eliminated because of incomplete or missing data. A final sample of 622 students was obtained (a 92% response rate). The mean age of our Norwegian respondents was 13.2 (SD = 0.5). Two hundred and ninety-three (47%) of the Norwegian participants were male and 329 (53%) were female. The Norwegian schools prohibited us from asking the respondents to indicate their ethnic origin.

■ Measures

■ Television exposure

Television exposure was assessed by asking respondents to indicate how many hours they viewed television during a typical weekday and during a typical Saturday or Sunday, using a 6-point scale (0 = "never" to 7 = "more than 6 hours"). To create a score for total exposure we multi-

plied the weekday measure by 5 and the weekend measure by 2 and then summed these scores. On the Norwegian version of the survey, the respondents also were asked (in addition to the two previous questions) to indicate how many hours they viewed two specific categories of programs (British and American programs, and music videos), using the same scale.

■ Social norms

Both the US and Norwegian respondents indicated their agreement, using a five-point scale (1 = strongly disagree to 5 = strongly agree) with three statements adapted from the normative beliefs items used by Austin and Johnson (1997a; 1997b), "Most teenagers drink," "Most teenagers I know drink," and "Drinking together is a sign of good friendship." Internal consistency for this scale was adequate ($\alpha = .63$). The respondents also used a five-point scale to indicate their agreement with four additional statements reflecting normative beliefs: "Drinking alcohol will make me more popular at school," "Most of the students in my class/grade at school drink alcohol," "Students who drink alcohol risk harming their health," and "It's OK for someone my age to drink alcohol."

■ Expectancies

US and Norwegian respondents used a five-point scale (1 = strongly disagree to 5 = strongly agree) to respond to four statements adapted from the drinking expectancies items used by Austin and her colleagues (Austin & Johnson 1997a; 1997b; Austin et al. 2000): "Drinking alcohol positively affects the way you feel about yourself," "Drinking alcohol enhances your ability to have fun," "Drinking alcohol

makes you feel more like an adult," and "Drinking alcohol makes you feel more sociable/likeable." The final expectancies score was created by summing the scores to these four items. Internal consistency for this scale was good ($\alpha = .77$).

The survey instrument used in Norway also included 11 statements from the Alcohol Expectancies Questionnaire for Adolescents (AEQ-A) (Brown et al. 1987; Brown & Goldman & Inn & Anderson 1980; Christiansen et al. 1982; Christiansen & Goldman & Brown 1985) which were adapted from the original AEQ-A for Norwegian adolescents by Aas (1993). Aas developed a 27-item version of the original 90-statement scale that maintained the basic factor structure. The 11 items used in the current survey represent the AEQ-A's transformation (AEQ-1) and sociability subscales (AEQ-2), which have been shown to be highly predictive of drinking intentions and current drinking (Aas 1995; Aas et al. 1995). Respondents indicated their agreement, using a five-point scale (1 = strongly disagree to 5 = strongly agree), with each of the 11 statements. The transformation subscale (also referred to as global positive expectancies) includes statements such as: "Youth come up with new and exciting things when they drink alcohol," "Annoyances and worries disappear when one drinks alcohol," and "Youth don't feel so alone when they are drinking and become a little drunk." Internal consistency for this subscale was good ($\alpha = .81$). The sociability subscale, which reflects the belief that drinking can enhance social behavior, includes statements such as: "Youth become more friendly when they have been drinking and are a little drunk," "Parties become more fun when

alcohol beverages are consumed there,” and “Youth get into better moods when they are a little drunk.” Internal consistency for this subscale was good ($\alpha = .78$).

■ Peer drinking

Subjects were asked how many of their four “best friends” drink alcohol without a parental knowledge (range = 0 to 4).

■ Personal alcohol consumption

Respondents were asked to indicate if they had ever consumed an alcoholic beverage (defined on both versions of the survey as consuming a normal-sized serving, by glass, can or container, of any type of beverage) and how many alcoholic beverages they had consumed in the past 30 days (0 = none, 1 = 1–2 drinks, 2 = 3–5 drinks, 3 = 6–9 drinks, 4 = 10–19 drinks, or 5 = 20–30 drinks).

■ Demographics

The students in both countries were asked to indicate their age and gender. US students were asked to indicate their ethnic or racial identity.

Results

■ Overall alcohol consumption

Slightly more than one in three (34.1%) of the respondents reported that they had had at least one drink of alcohol during their lifetime and 14.2% said they had consumed alcohol during the past 30 days. Overall, relatively equal numbers of Norwegian (37%) and US (32.2%) said they had tried alcohol. The most pronounced difference, however, had to do with recent drinking. Nearly one in four (24.8%) Norwegian students said they had at least one drink of alcohol in the past 30 days, compared to only 7.4% of their US counterparts.

■ Television viewing

Overall, the respondents reported watching slightly more than 3 hours of television on a typical weekday ($M = 3.45$, $SD = 1.70$) and 3 hours on a typical Saturday or Sunday ($M = 3.37$, $SD = 1.63$). Norwegian and US students were relatively similar in their viewing frequencies, with Norwegian students watching more television overall and averaging only slightly more on weekdays and weekends than the US students (See Table 1). Respondents who indicated they had tried alcohol at least once in their lives watched slightly more television on weekdays than the students who had never tried alcohol ($M_{\text{yes}} = 18.71$, $SD = 8.47$; $M_{\text{no}} = 16.49$, $SD = 8.41$) and this difference was statistically significant ($t = 4.99$, $p < .01$). This also was true for weekend television viewing ($M_{\text{yes}} = 7.04$, $SD = 3.35$; $M_{\text{no}} = 6.59$, $SD = 3.21$; $t = 2.59$, $p < .01$).

■ Normative beliefs and expectancies

As can be seen in Table 1, the Norwegian and US students differed in their beliefs and attitudes about alcohol and teenage drinking. The Norwegian students were more likely than the US students to perceive drinking as a normal teenage behavior (Norms) and to believe that drinking would produce positive outcomes (Expectancies). In addition, the Norwegian students were more likely to believe that drinking would make them popular (Popular) with their friends and to agree with the statement that it is OK for teenagers to drink (OK to Drink). This is consistent with the finding that the Norwegian teenagers also reported having more friends who drink alcohol without their parents' knowledge (Friends) than their US counterparts.

Table 1. Comparisons between US and Norwegian adolescents (n = 1,594)

	All subjects (n = 1,594)		Norway (n = 622)		USA (n = 972)		<i>t</i>
	M	SD	M	SD	M	SD	
Norms	6.82	(2.58)	7.42	(2.51)	6.43	(2.54)	7.57**
Expectancies	8.12	(3.79)	8.74	(3.83)	7.72	(3.71)	5.31**
Popular	1.50	(.88)	1.66	(.93)	1.40	(.83)	5.55**
Students	2.41	(.94)	2.04	(1.06)	2.64	(.77)	-13.08**
Friends	1.07	(1.43)	1.58	(1.59)	.74	(1.21)	11.82**
Total TV	23.99	(10.68)	24.75	(9.59)	23.50	(11.29)	2.36**
Total Weekday	17.25	(8.49)	17.83	(7.65)	16.87	(8.97)	2.31*
Total Weekend	6.74	(3.27)	6.91	(2.88)	6.64	(3.49)	1.73*
Harm	3.38	(.89)	3.60	(.88)	3.24	(.86)	8.11**
OK to Drink	1.84	(1.09)	2.15	(1.17)	1.65	(.98)	9.16**

* $p < .05$; ** $p < .01$

On the other hand, US teenagers were less likely to believe that a person could harm themselves by drinking (Harm) and more likely to believe that most of the students in their grade at school drink alcohol (Students). This latter finding was somewhat surprising, given the fact that the US teenagers reported having fewer personal friends who drink, and were less likely to see alcohol use by other teenagers as an acceptable behavior than the Norwegian students.

Of particular interest to us in this study is any potential influence television viewing might have on normative beliefs and alcohol expectancies. We had originally hypothesized that television viewing would influence both normative beliefs and positive expectancies and that these beliefs would be the strongest for the most frequent viewers. To test these assumptions, a post-hoc analysis was preformed by dividing the respondents into two groups based on the total television exposure measure. Those respondents who scored at or above

the median for all respondents were placed into the "frequent viewer" group and those who scored below the median were placed into the "infrequent viewer" group. Table 2 presents the results of this analysis. As anticipated, frequent viewers were more likely than infrequent viewers to believe that drinking is a normal teenage behavior and to have positive alcohol expectancies. They also were more likely to believe that drinking would make them more popular with their classmates, to have a greater number of friends who drink alcohol, and to agree that it is OK for someone their age to drink alcohol. They were less likely than infrequent viewers to believe that a person could harm himself by drinking alcohol.

When we examined these outcomes for the Norwegian viewers only (See Table 3), we found statistically significant differences between frequent and infrequent viewers on normative beliefs, assumptions about drinking and popularity, and the number of their friends who drink. We

Table 2. Comparisons between frequent and infrequent viewers (n = 1,594)

	Infrequent viewers (n = 815)		Frequent viewers (n = 779)		<i>t</i>
	M	SD	M	SD	
Norms	6.58	(2.59)	7.05	(2.54)	3.62**
Expectancies	7.93	(3.75)	8.32	(3.82)	2.04*
Popular	1.42	(.81)	1.58	(.94)	3.55**
Students	2.40	(.92)	2.41	(.96)	.34
Friends	.93	(1.35)	1.21	(1.50)	3.87**
Harm	3.42	(.85)	3.34	(.92)	-1.84*
OK to drink	1.80	(1.07)	1.89	(1.11)	1.78*

p* < .05; *p* < .01

were surprised to find that no significant differences existed for alcohol expectancies. For the US respondents (See Table 3), significant differences were found between frequent and infrequent viewers for normative beliefs, expectancies, and assumptions about the relationship between drinking and popularity.

As previously discussed, personal experience with alcohol strongly influences both normative beliefs and outcome expectancies. Of interest to us, then, was the impact of television among those with little or no personal experience with alcohol.

Table 4 presents the results of the comparisons between all frequent and infrequent viewers, from both countries, for those who reported having tried alcohol at least once in their lives and for those who have not. We had originally proposed that viewing would have an impact on non-drinkers but not on drinkers. As can be seen in Table 4, this appears to be the case only for the development of normative beliefs and assumptions regarding alcohol and popularity. No significant differences were found for any of the dependent measures for those who had tried alcohol. These results

Table 3. Comparisons between Norwegian and US adolescents by television viewing (frequent versus infrequent)

	Norway (n = 622)					USA (n = 972)				
	Infrequent viewers (n = 309)		Frequent viewers (n = 313)		<i>t</i>	Infrequent viewers (n = 506)		Frequent viewers (n = 466)		<i>t</i>
	M	SD	M	SD		M	SD	M	SD	
Norms	7.09	(2.57)	7.74	(2.42)	3.23**	6.28	(2.56)	6.59	(2.52)	1.91*
Expectancies	8.69	(3.69)	8.79	(3.97)	.31	7.46	(3.71)	8.00	(3.68)	2.25*
Popular	1.56	(.87)	1.75	(.98)	2.67**	1.34	(.76)	1.46	(.90)	2.23*
Students	1.97	(1.04)	2.11	(1.07)	1.55	2.66	(.72)	2.62	(.82)	-.72
Friends	1.34	(1.53)	1.81	(1.62)	3.75**	.69	(1.15)	.80	(1.26)	1.51
Harm	3.65	(.81)	3.55	(.94)	-1.39	3.28	(.84)	3.20	(.89)	-1.54
OK to drink	2.12	(1.16)	2.18	(1.18)	.60	1.60	(.96)	1.70	(1.00)	1.67*

p* < .05; *p* < .01

Table 4. "Have you ever had a drink of alcohol?" (yes or no) by television viewing (frequent versus infrequent). All subjects (n = 1,594)

	No (n = 1,051)					Yes (n = 543)				
	Infrequent viewers (n = 576)		Frequent viewers (n = 475)		t	Infrequent viewers (n = 230)		Frequent viewers (n = 313)		t
	M	SD	M	SD		M	SD	M	SD	
Norms	5.82	(2.13)	6.14	(2.01)	2.50**	8.44	(2.67)	8.48	(2.64)	.16
Expectancies	6.91	(3.26)	7.21	(3.32)	1.50	10.40	(3.72)	10.04	(3.91)	-1.07
Popular	1.30	(.69)	1.41	(.83)	2.49*	1.74	(.96)	1.84	(1.04)	1.22
Students	2.26	(.89)	2.23	(.91)	-.55	2.73	(.90)	2.70	(.97)	-.35
Friends	.48	(.97)	.60	(1.01)	1.80*	2.03	(1.49)	2.17	(1.56)	1.08
Harm	3.47	(.83)	3.43	(.86)	-.72	3.31	(.87)	3.20	(1.00)	-1.37
OK to drink	1.49	(.87)	1.49	(.84)	.08	2.52	(1.16)	2.52	(1.18)	.00

*p < .05; **p < .01

provide modest support for our belief that television may have greater influence on those with no personal experience with alcohol. That influence, however, appears to be limited to social norms. This also appears to be the case when we compare frequent and infrequent viewers, who have not tried alcohol, by country (See Table 5). Significant differences between frequent and infrequent Norwegian viewers were found for only the outcome measures Norms and Friends. For the US respond-

ents who had not tried alcohol, statistically significant differences were found for the Expectancies and Popular measures, but not for Norms.

In addition to personal experience with alcohol, having friends who drink can also shape normative beliefs and expectancies. To account for the combined potential confounding influences of these two factors, we examined the differences between frequent and infrequent viewers among those who had not tried alcohol and who

Table 5. Comparison of Norwegian and US adolescents who have not tried alcohol by television viewing (frequent versus infrequent) by beliefs and expectancies (n = 1,051)

	Norway (n = 392)					USA (n = 659)				
	Infrequent viewers (n = 211)		Frequent viewers (n = 181)		t	Infrequent viewers (n = 365)		Frequent viewers (n = 294)		t
	M	SD	M	SD		M	SD	M	SD	
Norms	6.19	(2.06)	6.66	(1.88)	2.31*	5.60	(2.13)	5.82	(2.02)	1.35
Expectancies	7.55	(3.26)	7.36	(3.38)	-.57	6.54	(3.20)	7.12	(3.28)	2.31*
Popular	1.38	(.76)	1.51	(.88)	1.49	1.24	(.66)	1.35	(.80)	1.97*
Students	1.71	(.92)	1.83	(1.00)	1.32	2.58	(.71)	2.47	(.76)	-1.87*
Friends	.78	(1.21)	1.03	(1.33)	1.95*	.31	(.76)	.33	(.79)	.34
Harm	3.61	(.86)	3.54	(.98)	-.75	3.39	(.80)	3.36	(.77)	-.36
OK to drink	1.69	(.91)	1.69	(.95)	.07	1.38	(.82)	1.37	(.74)	-.16

*p < .05

Table 6. Norwegian adolescents who have not tried alcohol by having a friend who drinks alcohol (yes or no) by television viewing (frequent versus infrequent) by beliefs and expectancies (n = 392)

	No (n = 226)					Yes (n = 166)				
	Infrequent viewers (n = 116)		Frequent viewers (n = 110)		t	Infrequent viewers (n = 63)		Frequent viewers (n = 103)		t
	M	SD	M	SD		M	SD	M	SD	
Norms	5.57	(1.91)	6.18	(1.83)	2.46**	7.03	(2.01)	7.23	(1.79)	.67
Expectancies	6.70	(2.81)	6.75	(3.00)	.12	8.78	(3.16)	8.28	(3.82)	-.91
AEQ	21.33	(6.90)	22.31	(6.11)	1.13	25.87	(5.92)	26.17	(6.97)	.29
AEQ-1	11.82	(4.06)	12.15	(3.70)	.63	14.24	(3.44)	13.82	(4.33)	-.64
AEQ-2	9.51	(3.35)	10.17	(3.09)	1.53	11.64	(3.19)	12.35	(3.37)	1.35
Popular	1.22	(.53)	1.40	(.80)	1.93*	1.57	(.87)	1.65	(.99)	.52
Students	1.47	(.81)	1.58	(.85)	.98	2.06	(1.05)	2.11	(1.02)	.26
Harm	4.08	(1.13)	4.03	(1.33)	-.36	4.22	(1.13)	4.05	(1.32)	-.87
OK to drink	1.49	(.79)	1.48	(.82)	-.09	2.00	(.95)	1.94	(1.04)	-.36

*p < .05; **p < .01

reported having no close friends who drink (See Tables 6 and 7). Table 6 presents the results of this analysis for the Norwegian students and Table 7 presents the results for the US students. Table 6 includes three variables not appearing in previous tables: AEQ, AEQ-1, and AEQ-2.⁹ These are included here because of their usefulness in the analysis.

For the Norwegian students who have not tried alcohol but who have at least one friend who drinks (See Table 6) no significant differences between frequent and infrequent television viewers were found for any of the 9 outcomes. For those non-drinkers who have no friends who drink, statistically significant differences were found for only two of the outcomes: Norms

Table 7. US adolescents who have not tried alcohol by having a friend who drinks alcohol (yes or no) by television viewing (frequent versus infrequent) by beliefs and expectancies (n = 659)

	No (n = 535)					Yes (n = 124)				
	Infrequent viewers (n = 297)		Frequent viewers (n = 238)		t	Infrequent viewers (n = 68)		Frequent viewers (n = 56)		t
	M	SD	M	SD		M	SD	M	SD	
Norms	5.23	(1.89)	5.70	(1.94)	2.76**	7.18	2.42	6.34	(2.27)	-1.97*
Expectancies	6.31	(3.12)	6.89	(3.22)	2.09*	7.51	(3.37)	8.01	(3.38)	.97
Popular	1.14	(.45)	1.30	(.75)	2.79**	1.68	(1.09)	1.59	(.97)	-.46
Students	2.55	(.68)	2.44	(.78)	-1.66	2.74	(.82)	2.61	(.68)	-.93
Harm	3.45	(.75)	3.38	(.74)	-1.12	3.09	(.96)	3.29	(.91)	1.16
OK to drink	1.26	(.70)	1.28	(.64)	.31	1.91	(1.09)	1.77	(.95)	-.77

*p < .05; **p < .01

Table 8. Comparisons of frequent and infrequent viewers of both US and British television programs and music videos by normative beliefs and alcohol expectancies. Norwegian subjects only (n = 622)

	US/British programs					Music videos				
	Infrequent viewers (n = 326)		Frequent viewers (n = 296)		<i>t</i>	Infrequent viewers (n = 346)		Frequent viewers (n = 276)		<i>t</i>
	M	SD	M	SD		M	SD	M	SD	
Norms	6.99	(2.48)	7.89	(2.46)	4.50**	6.97	(2.42)	7.97	(2.52)	5.05**
AEQ	25.74	(8.28)	28.22	(8.27)	3.72**	26.10	(8.08)	27.95	(8.60)	2.76**
AEQ-1	13.75	(4.61)	14.97	(4.67)	3.28**	13.94	(4.47)	14.83	(4.89)	2.36*
AEQ-2	11.99	(4.21)	13.24	(4.17)	3.72**	12.16	(4.17)	13.12	(4.26)	2.84**

p* < .05; *p* < .01

and Popular. Similar results occurred for the US students with one notable exception (See Table 7). Among the US students who had not tried alcohol and who reported having no friends who drink, significant differences were found between frequent and infrequent viewers for Norms, Expectancies, and Popular. For those reporting having at least one friend who drinks alcohol, no statistically significant differences were found between frequent and infrequent viewers for 5 of the 6 outcomes. The exception was for the variable Norms. In this case, the infrequent viewers were more likely than frequent viewers to believe that teenage drinking was a normal behavior. One possible explanation may be that the infrequent viewers may be spending more time with friends who drink (because they are spending less time watching television), thus reducing any residual influence television might have in shaping normative beliefs.

Finally, we hypothesized that viewing specific program types might also impact normative beliefs and expectancies regarding alcohol for the Norwegian participants. Specifically, we identified US/British programs and music videos, based on our review of the literature, as two types

likely to exert an influence due, in large part, to their frequent rates of incidental portrayals of alcohol consumption. Given the absence of alcohol advertisements on Norwegian television, these incidental portrayals also would be the most likely source of information used in the anticipatory socialization process.

Nearly 85% of the respondents watched music videos on weekdays and 80% on weekends. Typically they watched 1-2 hours on weekdays (*M* = 1.59, *SD* = 1.38) and weekends (*M* = 1.36, *SD* = 1.33). US and British-produced programs also were quite popular. Slightly more than 90% watched US or British-produced programs on weekdays and nearly 89% on weekends. Typically they watched 2-3 hours on weekdays (*M* = 2.55, *SD* = 1.64) and weekends (*M* = 2.37, *SD* = 1.67).

Table 8 presents the results of our comparisons of infrequent and frequent viewers for both program types. As indicated, the differences between frequent and infrequent viewers were statistically significant for each of the four outcomes (Norms, AEQ, AEQ-1, AEQ-2). The frequent viewers had stronger normative beliefs and more positive outcome expectancies. When we re-examined the data to account

Table 9. “Have you ever had a drink of alcohol?” (yes or no) by US and British television program viewing (frequent versus Infrequent). Norwegian subjects only (n = 622)

	No (n = 392)					Yes (n = 230)				
	Infrequent viewers (n = 223)		Frequent viewers (n = 169)		<i>t</i>	Infrequent viewers (n = 103)		Frequent viewers (n = 127)		<i>t</i>
	M	SD	M	SD		M	SD	M	SD	
Norms	6.17	(2.04)	6.74	(1.87)	2.85**	8.78	(2.43)	9.41	(2.32)	2.01*
AEQ	22.83	(7.03)	24.63	(6.54)	2.59**	32.05	(7.24)	32.98	(7.94)	.93
AEQ-1	12.51	(4.22)	13.25	(3.81)	1.82*	16.46	(4.28)	17.28	(4.72)	1.36
AEQ-2	10.32	(3.44)	11.38	(3.36)	3.05**	15.59	(3.40)	15.71	(3.83)	.24

p* < .05; *p* < .01

for whether the respondents had ever tried alcohol, we found significant differences between frequent and infrequent viewers who had never tried alcohol (See Table 9) for all four outcomes. For those who had tried alcohol, significant differences existed only for normative beliefs.

Discussion

Underage consumption of alcohol results in significant social and health problems throughout the world. Cleverly crafted messages in the mass media, in the form of advertising and drinking portrayals in entertainment programming, have been identified as possible sources through which children and adolescents learn about alcohol and, in turn, develop positive expectancies about drinking. In this study, we conducted a comparative analysis of Norwegian and US teenagers that we hoped would improve our understanding of television's potential role in shaping attitudes about alcohol and, in particular, help us assess the impact of the presence or absence of alcohol advertising on the development of alcohol expectancies.

Several important key findings emerge from our data. First, it appears that the absence of alcohol advertising in Norway

may have limited impact on the overall development of normative beliefs and positive expectancies in Norwegian youth. In fact, despite the general absence of alcohol advertising, Norwegian youth had stronger beliefs about the normality of teenage drinking and about the potential for positive outcomes associated with alcohol use than their US counterparts in this study.

While this finding appears to strike a blow against the generally held belief that the pervasiveness of alcohol advertising on television has a deleterious effect on adolescents and should thus be controlled, a closer examination of our findings might suggest an interesting possibility. For the Norwegian students, particularly for those with little or no experience with alcohol, the impact of television was generally limited to the development and reinforcement of normative beliefs about teenage drinking. For the US students, however, television viewing appeared to influence not only non-drinkers' normative beliefs but also outcome expectancies associated with drinking. One possible explanation for this difference between the non-drinking students from these two countries actually may be the presence of alcohol advertising on US television as we had originally hy-

pothesized. A primary function of advertising is to persuade audiences that the use of a particular product will lead to a desired, beneficial outcome. Incidental portrayals of alcohol use in entertainment programming, on the other hand, typically come without persuasive commentary and are shown merely as a part of normal social behavior. As we anticipated, then, teenagers exposed to frequent alcohol advertisements (US respondents) were more likely than those who rarely saw advertising (Norwegian respondents) to develop positive outcome expectancies, particularly when they had little or no personal experience with alcohol.

Another possible explanation for the findings here may be that incidental portrayals of alcohol use during entertainment programming, particularly during programs popular in both countries, resonate, reinforce, and thus strengthen Norwegian cultural norms and expectations that are more accepting of teenage alcohol use (Sande 2002) and more likely to view abstinence as a deviant behavior (Holtung & Rossow 2000) than in the USA. According to Sande (2002), alcohol use in Norway has long been associated with culturally accepted rites of passage into adulthood. In rural Norway, for example, religious confirmation, which usually takes place in one's early teen years, marks the initiation into adulthood. The consumption of alcohol by those who have been confirmed is widely accepted (Sande 2002). In urban settings, "russetiden" has historically marked the transition from adolescence into adulthood since its inception in 1905. During "Russetiden" graduating high school students celebrate the completion of compulsory schooling. The 17-day cele-

bration, begins on May 1 and terminates on May 17. Norway's national constitution day, is often marked by excessive drinking and partying, which is generally accepted by parents, police, and local authorities as a part of the passage into adulthood. Within this cultural context, teenagers may not need alcohol advertising to help them form their beliefs about alcohol. Furthermore, the strength of these normative cultural influences may make it impossible in a correlational design, such as ours, to tease out any incremental differences that presence or absence of alcohol advertising might have on the development of positive beliefs regarding alcohol use among our Norwegian respondents.

Nonetheless, we contend that our findings, as well as the preponderance of research cited in this study, support the belief that advertising shapes norms and expectancies in young television viewers. Our findings suggest the need for future research, particularly among Nordic populations, that continues to examine the interaction of media use with cultural norms and outcome expectancies. Experimental, or even qualitative, designs may be required to assess alcohol advertising's incremental contributions to these norms and beliefs.

As previously discussed, the findings of this study corroborate past research suggesting that television's general influence, regardless of culture, is strongest for those with little or no personal experience with alcohol. In the case of both the Norwegian and US participants, frequent viewers differed significantly from the infrequent viewers in their beliefs and attitudes about drinking. Students who were frequent television viewers were more likely to per-

ceive drinking as a normal teenage behavior, think that drinking would make them more popular among their peers, and believe that drinking outcome would produce positive outcomes. In addition, frequent viewers were less likely to believe that an adolescent could harm himself or herself through underage drinking. For those who drink or who have friends who drink, television viewing frequency did not appear to impact the strength or intensity of normative beliefs and expectancies. For those who had not yet experimented with alcohol and who had no friends who had begun to drink, however, some significant differences existed among heavy and light viewers. For these non-drinkers, television appears to function as an important socializing agent, providing them with portrayals of drinking behaviors, cultivating normative beliefs, and presenting opportunities to cognitively model and rehearse the behaviors shown.

In interpreting our results, a potentially important limitation should be considered. As discussed in the methods section, our sample in the USA was drawn from a region in which the dominant religious culture discourages its adherents from consuming alcohol. Although nearly two-thirds of our USA sample come from a region (Idaho) in which alcohol consumption is slightly above the US average, and one-third of the sample from inner-city schools with greater racial and religious diversity than is typically found in the Salt Lake City metropolitan area, we cannot exclude the possibility that religious factors might have some confounding effect on our findings. Even though relatively equal numbers of students in the samples from both countries have tried alcohol, re-

ligious influences may have some impact on the normative beliefs and attitudes of our US respondents. Conversely, this influence on our findings also may have been minimized by the fact that some Mormon parents in the US may have declined to sign participation consent forms because of their discomfort with the topic, although there is no evidence that this was a substantial problem.

Finally, one of the limitations of a non-experimental research design is our inability to infer a pattern of causality from the data. Although we have operated as if television viewing were a causal agent, we must nonetheless acknowledge the possibility that our findings may be reflective of a teenage subculture in which children who are already inclined to experiment with alcohol also watch a great deal of television. Our results, for example, indicate that those who had already experimented with alcohol watched more television than those who had not. If a disproportionate number of drinkers were also frequent television viewers then it would not be unlikely that comparisons of frequent to infrequent viewers would produce results similar to ours, particularly given the previously demonstrated association between personal experience with alcohol and alcohol-related normative beliefs and expectancies. This association can also be observed in our data. Even though no differences existed among those who had already tried alcohol, infrequent viewers who had personal experience with alcohol consistently scored higher on the normative beliefs and expectancies measures than the frequent viewers who had never tried alcohol. As previously argued by Robinson et al. (1998), personal experi-

ence provides the strongest inputs to adolescents' beliefs and expectations about alcohol. To account for the possibility that teenagers who drink may be more frequent television viewers than those who don't drink, we chose to focus a substantial part of our analysis on our respondents who had not yet tried alcohol. For these non-drinkers, the level of television viewing, as previously discussed, appears to have an

impact on normative beliefs and positive outcome expectancies.

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NOTES

- 1 The United Kingdom follows a self-regulation model similar to the United States. Advertisers follow the codes proposed by the Portman Group, an industry-funded organization, the Advertising Standards Authority, the Independent Television Commission Advertising Standards Code, and the British Code of Advertising Practices (Sewel 2002; International Center for Alcohol Policies 2001).
- 2 Based on the authors' personal observations and from program listings in the *Aftenposten* and *Dagbladet*.
- 3 For example, in their 2-year longitudinal study of 974 adolescents in Norway, Aas, Leigh, Anderssen, and Jakobsen (1998) reported that 48% of the participants had consumed alcohol by the time they were in the 8th grade. The National Monitoring the Future study (Johnston & O'Malley & Bachman 2000) found that 52% of the US 8th graders surveyed said they had tried alcohol. Both studies suggest that Norwegian teenagers who drink may do so more frequently than their US counterparts.
- 4 According to Bloomfield et al. alcohol consumption in "dry" countries is "not as common during everyday activities (e.g., it is less frequently a part of meals) and access to alcohol is more restricted. Abstinence is more common, but when drinking occurs it is more likely to result in intoxication; moreover, wine consumption is less common. Examples of traditionally dry cultures include the Scandinavian countries, the US, and Canada" (p. 96).
- 5 Statistics for Utah, for example, indicate that within the state 86.4% of the children under 18 are white, 8.7% are Hispanic, 2.2% are Asian, 1.5% are Native American, 1% are Hawaiian/Pacific Islander, and .7% are African-American (source: <http://www.acf.dhhs.gov/programs/cbpublications/cwo99/statedata/ut.htm>). Overall in the USA, 64% of the children under the age of 18 are white, 16% are Hispanic, 15% are African-American, 4% are Asian/Pacific Islander, and 1% are Native American (US. Bureau of the Census).
- 6 Because of the age differences by grade in the schools in the US and Norway, we include 9th grade students in the Norwegian sample. This allowed us to create groups that were approximately the same age.
- 7 Eleven items representing the transformation (AEQ-1) and sociability (AEQ-2) subscales of the shortened Norwegian version of the Alcohol Expectancies Questionnaire for Adolescents were included on the Norwegian version of the survey instrument. These items have been adapted to reflect Norwegian culture.

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Men's emotional inexpressivity

Advertising for psychotropic drugs in Scandinavian medical journals

Introduction

Sociological research on the use of and the advertising for psychotropic drugs has primarily focused on women, and for obvious reasons: women constitute a majority of the users and the key focus of the gender portrayals in psychotropic drug advertising (Ettorre & Riska 1995). The overrepresentation of women has been given two sociological interpretations. One is based on sex-role theory, which assigns women the emotional attributes easily recognized as needing medical attention (Cooperstock 1971). Another is derived from the medicalization thesis, which suggests that women's everyday concerns and anxieties are medicalized, i.e., viewed as medical problems, and therefore to be medicated by means of psychotropics. A corollary to these assumptions is that medicalization serves as a means of the social control of women and of keeping them in a subordinate social position vis-à-vis men, within the family and in society at large (Pugliesi 1992; Riessman 1992).

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ABSTRACT

T. Heikell & E. Riska:

Men's emotional inexpressivity

■ AIM

Men's use of psychotropics and the portrayal of men in psychotropic drug advertising have been underresearched and undertheorized in past research on psychotropics. The focus on women's health as the primary target of medicalization and commodification has scanted the same processes for men. This study aims to illuminate the construction of patienthood in the patient portrayals of men's mental health.

■ METHOD

A quantitative and qualitative analysis was done of all the advertisements (N=366) for psychotropics that appeared in the national medical journal in Denmark, Finland, Norway, and Sweden in 2000.

■ RESULTS

In the gender portrayal of men in the psychotropic ads two images of men's patienthood were constructed: men's relational problems with family and men as victims of ontological insecurity.

■ KEY WORDS

psychotropics, gender, advertising, patienthood

Meanwhile, men's use of psychotropics and the gender portrayal of men in drug advertising have been underresearched and undertheorized. The focus on women's mental health as the primary target of medicalization and commodification has scanted the same processes for men. In the mappings of the use of psychotropics, men often serve merely as a dummy variable so as to highlight women's high use of psychotropics. This has resulted not only in a homogenization of men as a group but also in a failure to inquire into what characterizes men's use and what kind of gender images are used in portraying men in psychotropic drug advertising. In short, men as users of psychotropics have been invisible.

It is not only the invisibility of men as users that is of concern but also the undertheorization of men's use. This lack of theorization is related to at least two implicit and contradictory assumptions. The first one is that men's level of use is a reflection of a "proper" level of use and an "objective" evaluation of men's mental health. The second is the assumption that men's low level of use of psychotropic drugs is explained by their use of other substances: men self-medicate their problems by resorting to alcohol or even illicit drugs. This substitution-hypothesis – i.e., men use other substances than women do for the same problems – has been so taken for granted in past research that, in fact, there is hardly any research that has empirically tested this assumption. But, rather than simple substitution, men's use seems to be dual in nature – men use both alcohol and psychotropic drugs more than women do when they have severe mental health problems (Ettorre & Riska 1995; 2001).

Unlike the feminist critique of the medi-

calization and overmedication of women's health issues, the public health approach to men's psychotropic drug use has stressed the opposite: a lack of recognition of men's psychological problems and hence the undermedication of men's mental health problems. The latter view stems from sex-role theory of illness and health. According to sex-role theory, women have been assigned the emotional tasks and skills, while men perform the instrumental tasks in the social division of labor in the family and in society at large. A frequent argument is that men are "emotionally handicapped" or "emotionally illiterate" because they have not been socialized to express emotions and therefore do not have the skills and a full cultural repertoire of affective behavior when encountering an emotionally taxing situation. In fact "emotional inexpressivity" has been seen as the "cost of masculinity," which in the long run is assumed to have health costs as well (Sabo & Gordon 1995; Robinson 2002, 208).

In the 1990s, the psychotropic drug scene changed. In the late 1980s, a new generation of antidepressants called SSRIs (selective serotonin reuptake inhibitors) came on the market, and there was a veritable boom in the sale of these drugs in the Western world. Four of the ten drugs, leading the pharmaceutical sales in the world, are for mental illness: three of these – Prozac, Paxil, and Zoloft – are SSRIs; and one – Zyprexa – is an antipsychotic. Each had a global sales revenue of over US 2 \$ billion in 2000 (Busfield 2003, 598).

A cultural interpretation has been offered for the growing sales of antidepressants. Some tend to see the new antidepressants – Prozac, especially – as serving the

needs of a hedonistic culture and a new generation that no longer suffers from the pharmacological Calvinism of past generations (e.g., Kramer 1993). The biomedical-ly oriented interpretation, on the other hand, suggests that depression has been grossly underdiagnosed in the past, and with the new cultural climate of awareness and permission to treat, the "real" level of depression has now been identified. It is the latter argument that is increasingly used to bolster men's use of psychotropics.

In this new age of depression, how is men's need for psychotropic drugs portrayed in medical journals? What kinds of representations of masculinity appear in advertisements? What are the underlying assumptions of the etiology of men's mental health problems in the advertisements? Do the advertisements appeal to men's emotional inexpressivity? In exploring these questions a social constructionist approach is used: we are interested in unraveling the gendered representations in the portrayals of males in the advertisements. For this purpose advertisements for psychotropic drugs in four major Scandinavian medical journals are examined.

Drug ads contain visual and textual information that constructs patienthood for the readership of the medical journal (Lupton 1993, 808). The readership is the prescribing physician and not the actual consumer of the drug. Psychotropic drugs are prescribed drugs and cannot be bought by the consumer over the counter, like Tylenol or Bufferin. The general practitioner or a psychiatrist prescribes the kind of psychotropic drug, the dosage, and the duration of the treatment that are considered medically appropriate for the patient.

The ads have to attract the physician's attention. They therefore use visual signs that relate to the referent system of medicine as a body of knowledge and as a profession (Williamson 1988, 40). The discourse of drug advertising has to resonate with the reader-physician, who has to find the media representation convincing (Cook 2001, 3–4). The discourse of advertising – its content and context – has therefore to appeal to medical discourse. The ads have to use the language and signs of medical discourse as an already existing structural system. So, an ad contains a signifier that suggests the signified – a mental concept or reference (Dyer 1982, 118). Our analysis aims to identify how male patienthood and masculinity are embedded in the discourse of psychotropic drug advertising.

The drug industry itself uses several channels to provide information about new drugs. Promotional material is provided directly to the physician's office, at professional meetings, and to the profession's own journals in the form of drug advertisements. The exact contribution of this kind of information to the physicians' overall knowledge of the existing stock of drugs is still an underresearched area. Studies that have grappled with the issue have found that advertising constitutes a major source of information on new drugs for practicing physicians and that this information tends to be deficient (e.g., Lexchin 1987; Caudill et al. 1992; Herxheimer et al. 1993; Wilkes et al. 1992). Today the Internet supplies physicians with new medical and pharmacological information, although there are few studies so far on this subject.

Method and material

All the advertisements for psychotropics (N=366), which appeared in the issues of the major national medical journal of each of the Scandinavian countries in 2000, were examined: the Danish *Ugeskrift for læger*, the Finnish *Suomen lääkärilehti*, the Norwegian *Tidsskrift for den norske lægeforening*, and the Swedish *Läkartidningen* (supplementary indices were not included in the analysis). The drugs were classified according to the Anatomical Therapeutic Chemical classification (i.e., ATC-codes), and the major drug categories listed by generic names in the Finnish annual statistics on medicines were used (Finnish Statistics of Medicine 2002). The drugs were coded into four groups: anti-psychotics, tranquilizers, hypnotics, and antidepressants.

The number of ads for psychotropics per issue was highest in the Finnish journal, followed by the Swedish journal. The Norwegian journal and the Danish journal had

a rate barely half the Finnish and Swedish rate. In the Scandinavian journals, advertising for psychotropic drugs in 2000 was largely for antidepressants (Table 1).

The pictures in the ads were coded according to the leading theme of the picture. The diagnostic images in the ads are either in the form of metaphors or photographs of persons, who are indicated to need the drug. The pictures were divided into two types: *user* and *other*. In the category *user* are portrayals of a person either experiencing the symptoms the medication alleviates or the effects of the medication. The category *other* is represented by two major subcategories: a) photographs or drawings portraying something other than the specific medication or the user of it, e.g., birds, a landscape, a flower; or b) ads that show a drug bottle, a diagram of the effects of the drug, or only textual information. This report examines only the ads that portray users (no providers were portrayed among the persons appearing in the ads). A major-

Table 1. Characteristics of the advertisements for psychotropics appearing in the national medical journals in Scandinavia in 2000

Medical journal	Number of advertisements for psychotropics per issue	Total number of advertisements for psychotropics	Advertisements for psychotropics with a picture of a user		Advertisements for antidepressants	
			%	N	%	N
DENMARK:						
Ugeskrift for læger	1.1	60	43	26	93	56
FINLAND:						
Suomen lääkärilehti	2.8	134	28	37	44	59
NORWAY: Tidsskrift for den norske lægeforening						
	1.3	39	72	28	59	23
SWEDEN:						
Läkartidningen	2.5	133	58	77	76	101
Total	2.0	366	46	168	65	239

ity of the Norwegian and Swedish ads showed a user, while the proportions were lower in the Danish and in the Finnish journal (Table 1).

The social characteristics of the persons depicted were classified according to gender, age, working status, and social context (i.e., private or public context). The gender of the person(s) was classified as: 1) *men*, if only men were depicted in the picture, 2) *women*, if only women were shown, 3) *men and women*, if both men and women were portrayed in the same picture. If men or women were depicted with a small child, the picture has been classified according to the gender of the adults. In all these cases, it was evident that the adult was the potential user. All those portrayed were Caucasians. This is a noteworthy finding in itself, because the Scandinavian countries have an increasing immigrant population with a diverse ethnic and racial background, among whom mental problems tend to be more prevalent than in the majority population group (e.g., Riska et al. 1993).

The advertisements were coded by two coders. The analysis of the material has been done by means of a quantitative and qualitative method. In the qualitative analysis the visual signs and the supporting text were the focus (Williamson 1988; Lupton 1993; Cook 2001).

Results

Men appeared in 77 percent of the ads for psychotropics in the Danish and in 66 percent in the Swedish journal, while men appeared in about a third of the ads in the Finnish and in the Norwegian journal. As Table 2 shows, the Swedish journal has an almost even distribution between genders,

Table 2. Distribution (%) of advertisements for psychotropics by the gender of the portrayed persons in the major medical journals in Scandinavia in 2000

Gender	Denmark	Finland	Norway	Sweden
Men only	50	3	32	36
Both women and men	27	27	—	30
Women only	23	70	68	34
Total				
%	100	100	100	100
N	26	37	28	77
Ads in which men appeared				
%	77	30	32	66

and the Danish ads differ from the other journals, with half of the pictures showing men only. For men, the drugs were gendered – a little over half of the Scandinavian ads (51%) for antidepressants depict a male. There were variations between the journals: 76 percent of the antidepressant drug ads in Denmark and 63 percent in Sweden contained men, against 24 percent in Finland and 12 percent in Norway.

The qualitative analysis looked at the advertisements that portrayed male users, and at the character of the social setting, social interaction, and gendered situation. In the gender portrayals of male users the medication is shown to restore the man to being an active agent and having the social and emotional capacities to face the external world. The drug is pictured as a safe and efficient way to reinvigorate a masculine self.

Male patienthood was constructed around the representation of men as suffering from depression. Men's mental health problems were mainly located in the pri-

vate sphere or else decontextualized. In the portrayal of men's emotional problems two major themes appear: 1) a restoration of men's ability to bond with family, and 2) the medication of men's ontological insecurity. By contrast, for women, the sphere of work, especially in the Swedish and Finnish ads, was suggested to be one in which women were not able to cope with the pace of modern life.

■ A restoration of men's ability to bond with family

A major category of the pictures of men showed a man in the company of other people, a social situation portraying the man as able to interact with either his wife or his parents because of the prescribed drug. Men were shown as having a relational problem only in the private sphere – no men were pictured in a similar situation at work. They were indeed pictured at work with others but in that case as the external gendered framework of women's problem at work – as a kind of gendered frame in the periphery of the picture – so as to highlight the structural constraints and hence problems of the woman at work and her need for an antidepressant to medicate her anxiety about countering hegemonic masculinity (Connell 1987; 1995). In contrast, men's patienthood was constructed as residing in the private sphere and in their incapacity to bond with close family.

The Danish ads have two types of portrayals of men interacting with others. One picture portrays three generations of men on a picnic together – an older man, a middle-aged man, and a boy – all smiling. The picture contains a smaller picture of the younger man, who is suggested to be the user. The text in this ad for the antidepressant

(the generic component is reboxetin) runs: "Freed from depression: A richer social life," and in smaller type: "[Drug X] improves the patients' social capacities – with it, especially their energy, interest, and motivation increase." Another shows a middle-aged man helping an elderly couple with yard work, and the older man seems pleased with the assistance of the younger man, perhaps his son (the text is the same).

The Swedish marketing for an antidepressant (venlafaxin) is based on a series of two-page ads. On the left page is a picture of men in social situations: men fishing and a couple on vacation. On the opposite page is the picture of a worried male face, and the text lists thoughts about economic responsibilities, e.g., paying the mortgage. The text informs the physicians that men who suffer from generalized anxiety can be cured with an antidepressant.

In the foregoing pictures of men portrayed in relation with family, the ensemble of the pictures and the text suggests the hiddenness of his problem. The ads show the man in a social situation in which his mental problem is invisible to the others. In a separate picture – either a small picture in a corner of the larger or on the opposite page – the man's qualms and his anxieties about his dysfunctional social self are portrayed.

■ The ontological insecurity of men

In the pictures in which men appear alone, the diagnosis of generalized anxiety is not related to the external environment but portrayed as related to men's existential being. The ads convey an essentialist view of the inner core of men as something primordial and given that should be in equi-

librium. There is a notion suggested by these pictures that a man who is in control of his inner self has a healthy male identity, a state that defines his ontological security as a man (see Whitehead 2002, 210). In the pictures, the men's ontological insecurity is represented by laughing devils who have the man under their spell. Men's mental health problems are visualized as these metaphorical devils disconnecting the reasons for men's ontological insecurity from a social context.

The most frequently occurring picture in the Danish advertisements is a drawing of a man surrounded by two laughing devils holding him in a tight grip. The text informs the reader that "60–90% of patients with major depression also suffer from anxiety." Some other versions of this ad show a drawing of a man who is getting ready to hang himself. The text suggests that the drug "reduces the number of suicidal thoughts significantly." Other ads indicate that "65% of depressives who also suffer from anxiety would rather be dead," and that "depression seldom comes alone." The same devils seem also to plague Norwegian and Swedish men. The Norwegian ads for an antidepressant (paroxetine) shows a gloomy-looking man in suit and necktie and struggling with demons, a set of five blue laughing devils dancing around him. The drawing indicates that the drug can cure his wounded self and restore his social confidence. The text reads, "Social phobia needn't destroy a whole life." The Swedish advertisement shows a man in the grip of two laughing devils, and the text says "60–90% of patients with depression suffer from anxiety." Another Swedish ad shows a man in the grip of two laughing boa constrictors,

and the text reads: "Lessen suicidal thoughts in patients with simultaneous depression and anxiety." Incidentally, these kind of demons seem to stay away from Finnish men (at least in the ads).

In the Danish ads showing men only, men are portrayed as depressed or anxious. The men in these pictures are decontextualized. One picture of a slightly moody middle-aged man looking out of a window suggests, "From a negative ... to a more positive view – one can be caught in isolation in many ways." And another shows the washing of (male) hands (suggesting obsessive compulsive disorder) and the text reads: "Some wash their hands continuously – and it's not only the politicians." The latter photograph is a case of "cropping" (Dyer 1982, 107): the dismembered male hands stand for the whole body, but they also reinforce the mechanistic view of the body inherent in medical discourse (see Lupton 1993, 810).

The Swedish ads indicate that young men are pressed by work demands. A relatively young man, perhaps 30–35 years old, is shown as the victim of stressful work demands. There are two versions of this ad for an antidepressant (venlafaxin). One version covers two pages. The first page shows a rock band, and the text reads: "Rehearsal." On the opposite page is the face of a young man, and the text reads: "This will never work. I can't take it any longer." Another version shows the picture of the face of a young man, and the text says lyrically: "To be anxious is to dare less. To dare less is to hesitate more. To hesitate more is to live less. And to live less is to die a little." This kind of portrayal of young men is a new feature in Swedish psychotropic advertising over the past twenty-

five years and in advertising for psychotropic drugs in the other Scandinavian medical journals as well (Lövdahl & Riska 2000).

In short, men are shown, especially in ads for antidepressants, as struggling alone with their feelings of ontological insecurity. Men are displayed as weak and the victims of their status as men. Nevertheless, the problem is the problem of individual men, whose masculine self and social position in the gender order can be restored with a drug.

Conclusion

The results of the quantitative analysis of this study can briefly be summarized as follows: in 2000, a majority of the ads for psychotropic drugs in the national medical journals in Denmark, Norway, and Sweden, and almost half in Finland, were for antidepressants. In Denmark and Sweden, a majority of the ads for psychotropic drugs contained pictures of men; in Finland and Norway only a third did.

The discourse of drug advertising has to use the content and context of medical discourse in order to get the physicians' attention. This process is not gender neutral. Besides constructing patienthood, psychotropic drug advertising also constructs masculinity. Our analysis of psychotropic drug advertising, which appeared in Scandinavian journals in 2000, suggests that male patienthood centered around certain themes.

Men were shown as harboring a wounded masculine self, which crippled them as men and prevented them from embodying an expected active agency and self-control, the core values of traditional masculinity. The antidepressant was suggested to rein-

state men as active subjects with full control over their life situations. In the gender portrayal of men, two images of male patienthood were constructed. The first representation is of men's relational problems. The pictures suggested that men had problems in this sphere, a deficiency that could render them dysfunctional. The suggestion is that the emotional sphere of the family and extended family – called by Hochschild (1997) the second shift – is a problem for middle-aged men. This state could be medicated and changed into an emotional functional self able to bond with family.

The second representation is of men as victims of ontological insecurity, a state signified by metaphorical devils that tease, torment men, and challenge men's existential selves. The pictures have a humorous tone that pokes fun at the threat to masculinity. But to mark men as weak would seriously threaten the unmarked character of masculinity in society at large: masculinity is generally confirmed by constructing and marking the Other as weak (Robinson 2000, 1). The medication is indicated to restore the essential "healthy" inner core of men's existence as men.

The two representations are linked to the general view of healthy men as instrumental and active agents whose repertoire of emotional registry is problematic. The advertisements show men to have relational and emotional problems, and these problems are medicalized. The psychotropic drug is shown as overcoming men's emotional inexpressivity.

The gender portrayal of men in the psychotropic ads could be viewed, in Foucauldian terms, as part of a therapeutic culture. The rise of the scientific discourse

of psychology constructed a self-governed subject, capable of handling his or her own emotions and behaviour with the assistance of psychological expertise and its language of interpreting the wounded self (e.g., Rose 1999; Danziger 1997). The Foucauldian notion of the technology of the self (Foucault 1988) implies that psychotropic drugs are part of the broader disciplinary regime of self-control expected to guide the individual's conduct, and at the same time this technique of self-management and emotion control is tied to the broader regime of social control delegated to the medical profession. Extending this argument further, psychotropic drugs could be interpreted as the pharmacological technology for governing the masculine self. The ads promised a prescription for the governing of the masculine self.

Although women's patienthood appeared more often, the representation of

male patienthood in Scandinavian psychotropic ads indicates that mental health problems of men have been identified. And there was a difference in the classification of the representation of the two genders and their position as subordinates and superordinates (Kress & Leeuwen 1996, 8). While the medicalization of women's problem in these advertisements generally restored women to a subordinate female position, the medicalization of men's problems aimed at restoring men as superordinates and as dominant actors in the gender order.

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When I drank too much

Young people in their 20s tell their stories

Background and purpose

More alcohol is consumed in present-day Sweden than at any time in the past 100 years (Leifman & Trollidal 2002). Young men and women between the ages of 18 and 25 are the group who drink the most and are also the ones who most often drink enough to become intoxicated. The project *Perceptions of drinking and intoxication and the prevention of alcohol problems among young adults*¹ was undertaken for the purpose of understanding the valuations of and thoughts on alcohol of young people between the ages of 18 and 25. Thus, nine groups of young men and women from different parts of Sweden and from different social groups were interviewed using a focus group methodology.

Many of the experiences that young people share during the group interviews are presented in the form of narratives about things they themselves have experienced. To tell about something that one has been through is also to tell about oneself and one's attitude toward that which is being discussed, as well as the culture and value system in which the experience is embedded. A narrative about a personal experience is thus something more than an individual creation: It comes from a larger group and is tied

ABSTRACT

M. Abrahamson:

When I drank too much – young people in their 20s tell their stories

Young males and females aged 20 from different social groups who live in different parts of Sweden were interviewed with a focus group methodology. The groups were formed by various friendship networks. As alcohol consumption has increased steeply in this age group during the past few years, our aim was to examine the ways in which young people informally reason about alcohol. This sub-study shows how they communicate their experiences of occasional excessive drinking in the form of stories. The value systems underlying the stories are studied by analysing the accounts offered for excessive drinking. The moral conveyed by the stories is that those who drink too much risk being regarded as morally questionable in our culture. At the same time, the extent to which the listeners accept the accounts shows the conditions under which this kind of behaviour can be met with understanding and seen as an involuntary, reasonable reaction to an outer pressure or other circumstances that the storyteller cannot control.

■ KEY WORDS

narratives, alcohol, values

to a cultural, ideological, and historical context (Denzin 1989, 73).

Therefore, one way to investigate young people's valuations of and thoughts on alcohol can be to more closely examine personal experiences as they are conveyed via narratives of their own drinking. Of particular interest in this context are times when one had too much to drink. One can expect the system of values to which drinking belongs to become apparent when the speaker provides an account of reasons why the drinking became excessive (Buttny 1993; Järvinen 2001; Schlenker & Pontari & Christopher 2001; Scott & Lyman 1968). Whether it is necessary to provide explanatory excuses, and whether or not they are accepted, is based both on the culturally founded reasons for drinking and culturally specific expectations about the effects of alcohol (MacAndrew & Edgerton 1969). A well-established area of research within alcohol studies is concerned with the way people attribute an explanatory value to drunkenness with regard to, among other things, aggressive actions and sexual activities (e.g., Bullock in print; Critchlow 1985; Graham, Wells & West 1997; Paglia & Room 1998; Room 2001). However, very little research seems to have been done on how people explain why they drink more in the first place than is acceptable for the social situation in which they find themselves.

It seems to be a fairly general and widespread phenomenon that people drink more than they intended, without it necessarily having to be a clinical indication of loss of control over alcohol. In a comparative Scandinavian study of alcohol use in Finland, Iceland, Norway, and Sweden that looked at attitudes toward alcohol, and the

consequences of alcohol use, it emerged that, at some time during the previous year, from 40–49% of the population had imbibed more than what they intended initially. However, how people explain to themselves and those around them that they drank too much thus far seems not to have been researched before.

Thus, the purpose here is partly to investigate young people's experiences as conveyed in stories about having drunk too much, and partly to investigate the reasons they provided to explain why they drank too much, and by this means to catch sight of the value system in which young people contextualize their experiences of alcohol.

The emphasis in a focus group discussion is on a joint activity for creating meaning within a group or culture. Therefore, it is advantageous for focus groups to be recruited from naturally occurring groups and to be fairly homogenous in composition (Bauer & Gaskell 1995, 175).

The nine focus groups are spread out across the entire country and the participants are members of naturally existing social networks. They are friends from the workplace, student environments, and various organizations. The sample was selected from environments where high levels of alcohol consumption could be expected to occur. The interviewed groups were: media and communications students, conscripts, construction workers, IT engineers, ice hockey players, police academy students, students in social work, hotel and restaurant employees, and media and advertising salespersons. The three last-named groups were made up of young women and the six other groups of young men. All but two persons interviewed had grown up in Sweden. A total of 54 persons

took part in the group interviews.

To drink and become intoxicated is a collective experience, particularly for young people. It is therefore appropriate to make use of the way in which collective experiences are rendered in pictures, films, or texts, by using this as a form of stimulus materials during interviews. The use of stimulus materials is a means of minimizing the moderator's influence upon the discussion. Previously, this method has been used, by among others, Abrahamson (1999), Sulkunen (1997a, 1997b), and Törrönen (1998), to study opinions about alcohol. McFadyen et al. studied young people's opinions about tobacco and their reception of tobacco advertisements with similar methods and for similar purposes (2003).

In the project presented here, seven short excerpts from different films² were used to direct the group discussions and as a basis for discussion. Another basis for discussion was the questionnaire³ that participants filled out prior to watching the film excerpts. After participants had filled out the questionnaires, the group discussion began with each person providing a short presentation of the answers he or she gave to each of the questions on the questionnaire.

Each interview took between three and four hours. Interviews resulted in extensive and information-rich material in which the young people discuss their experiences with alcohol and alcohol-related problems – experiences that they often report in the form of narratives about something they themselves have experienced.

Stories and points

A model that has had great impact upon the study of verbal narratives originates in just

two papers by William Labov and Joshua Waletzky (Labov 1972; Labov & Waletzky 1967). Labov's model is used or quoted by most researchers who analyze narratives, both in interview situations and in conversational contexts (Toolan 1988, 146).

Labov's point of departure is that narratives have two central functions: a referential and an evaluative function. By the referential function it is meant that narratives recount events so that the order of events experienced is reproduced in the order of events in the narrative. By the evaluative function it is meant that the narrative presents a special occurrence, worth reporting, and that the speaker uses various evaluative means to demonstrate this (Labov 1972, 359–362).

According to Labov (1972) and Labov & Waletzky (1967), a fully formed narrative consists of six elements, which answer six different questions or perform six different functions in the narrative: 1) *Abstract*: What is the main point of the narrative in a nutshell? 2) *Orientation*: Who/what is the narrative about? 3) *Complicating action*: What happens? 4) *Evaluation*: And why is this interesting? 5) *Resolution*: What happened in the end? 6) *Coda*: A concluding comment that brings the listener back to the present. The first and last elements – abstract and coda – may be present, but are not necessary⁴.

The evaluation often appears just before the resolution, but can also be spread throughout the entire narrative. The evaluation is composed of those parts of the narrative in which the teller shows his or her attitude and feelings about the events presented. The evaluation consists of all the means the teller uses to indicate and emphasize his or her points. The closer the

teller comes to the point, the greater the number of evaluative means ordinarily used (Toolan 1988, 156).

Through the telling of an event, a narrative can be entertaining and amusing, but it is more important that, by means of its point, the narrative give the listener and teller the chance to share experiences with each other and to demonstrate mutual understanding. The actual intention of narrative is to convey a point about the world that the teller and listener share (Eggins & Slade 1997, 227-272; Polanyi 1989, 16).

The point of a narrative must contain culturally rooted values and be based on a general agreement among those who perpetuate the culture that the point is important, valuable, or true (Polanyi 1979, 207). The points in narratives are therefore culturally bound and often have a moral content. Riessman (1993, 3) notes that in qualitative interviews it is common for respondents to often recreate their experiences in the form of narratives when they describe a breach between ideal and real, or between themselves and their surroundings.

An ordinary everyday conversation among friends is filled with narratives. A narrative is made possible by the conversation that preceded the narrative. One participant is given permission by the others to dominate the conversational space with a narrative for a longer time than usual for an ordinary contribution to the conversation. In this way, all the participants collaborate to set the stage. Thus, the narrative has more contributing participants than just the narrator. The point of a narrative therefore should not be understood as a given and fixed aspect of the narrative, as if it was told for the first time (Polanyi

1979, 207). The point is both culture- and context-dependent.

One way to uncover the value system that surrounds drinking can be to review the sorts of things that are accounted for and thereby neutralized, so that a disadvantageous picture of the speaker is not presented (Buttny 1993, 10; Järvinen 2001, 267–269). Usually, behaviors that could be viewed with disapproval are accounted for with the help of a small repertoire of probable and generally acceptable causes (Lamb & Lalljee 1992, 26). Narratives about when one's own drinking was excessive are therefore interesting. From which repertoire of causes do tellers pluck their accounts of why they drank excessively?

What one presents as accounts, excuses, or explanations is dependent upon cultural conceptions of behavior that are acceptable from a moral point of view. Through reviewing these accounts, a further point can be uncovered – the narrative's moral – that can be seen as the underlying point, in addition to the point of the story itself (Adelswärd 1997, 228).

Result

The aim of the study was to investigate the value system in which young people contextualize their experiences of alcohol, and, therefore, the point of every narrative will be illustrated in the results. Further, the neutralizing accounts that occur will be emphasized. In conclusion, the underlying point (or moral) of the story from the content of the neutralizing accounts will be discussed.

A total of fifty narratives from nine different genres were identified in the transcripts of the nine focus group interviews. Not all narratives include all the elements

that, according to Labov, make up the complete narrative. Rather, certain narratives constitute that which Eggins & Slade (1997, 227-272) describe as anecdotes, exemplums, or recounts. Nonetheless, they are filled with evaluations and have clear points. Of the situations that are described in the fifty narratives, fourteen are about the teller being intoxicated and nine of those, moreover, about drinking becoming excessive.⁵ Speakers show that the drinking became excessive by presenting various neutralizing accounts of the drinking. The types of explanatory and excusing circumstances that occur include personal problems and that “everyone drank.” The last category includes explanations about how alcohol was easily accessible and that the teller was younger at the time and now has changed his or her habits. One additional narrative states that it is easy to become intoxicated when beer tastes so good.

These three kinds of circumstances will provide a comprehensive outline for the rest of the presentation. Some narratives in each category will be presented in their entirety; others in the form of short excerpts. Each narrative is classified with its main point.

■ Personal problems

Some narratives come up in connection with the presentation of the group members' answers to the questions on the questionnaire. Two statements on the questionnaire led several people to tell of their own experiences of situations in which their drinking became excessive. They are: *Sometimes I abstain from alcohol because I am afraid of becoming addicted* and *Alcohol helps me to forget everyday troubles*

for a while.

In this context, Ludvig, one of the young men from the group of soldiers, tells how much he drank during one summer.

Text 1. I had no control – no one else had either (excerpt 160):

[...] there was a fear of becoming addicted, for a while I drank an unbelievable amount, I felt as bad as the devil, that was a summer and my girlfriend dumped me, and everything was shitty, and school went to hell, so I started to drink a hell of a lot, and like spin around in different groups of friends and drink, so that there was never anyone who noticed right away, it took a while before people noticed, I myself had no idea that I was doing it, I was not conscious of it, but it got to be like that, until one of my best friends took hold of me and said that: *now you have to pull yourself the hell together!* and I am damn glad about that today, I am damn thankful to him today [...]

Strong feelings are conveyed in Ludvig's narrative. In several ways, listeners are made aware of how poorly he was doing during a certain period of time. Prior to the resolution, he marks the point of the narrative by repeating two observations twice: that no one noticed that he drank so much and that he himself was not aware of it. Ludvig's best friend is responsible for the solution of the problem as presented. In the narrative's resolution, he reports what his friend said in the form of a direct quotation, in which the friend tells him off properly. Ludvig then leads the listeners back to the present with a concluding comment about what happened, in which he expresses his thankfulness to his friend.

The point the narrative makes is that one can have problems with alcohol without understanding that this is the case, and that the problem can be hidden from others; it can sneak by almost unnoticed. Neither Ludvig's friends nor Ludvig himself noticed what was happening. In the narrative, Ludvig provides the background for why he drank so much, which helps listeners to understand and excuse him. He also explains why his friends did not intervene earlier. The reason they noticed nothing did not lie with them. The narrative thus has two underlying points. The first one is that it is not good to drink so much. The other underlying point in the narrative is about friendship and the content of friendship. Friendship means caring about each other so much that one takes action when a friend is doing poorly. Ludvig expresses great joy about and gratitude toward the friend who stepped in and changed the course of events. Logically, the same person is one of his best friends.

Two additional and similar narratives have as their point that alcohol problems can sneak up on you, without great drama.

Katarina, one of the young women who work in the hotel and restaurant industry, also introduces her own narrative by repeating one of the questions from the questionnaire.

Text 2. Alcohol helped me forget (excerpt 137):

[...] alcohol helps me to forget everyday troubles for a while," maybe that really depends, I studied a few years ago, it was terribly trying, so I drank wine every day because I thought it was so trying, so that it helped me forget, yes, I was actually starting to become a little bit depend-

ent, but not any more, I studied economics for two years, it was terribly trying, there was such tough competition, and you were supposed to be the best all the time, and there was a lot of work all the time, so then I bought wine, sat and studied and drank wine, it went well, but certainly, I can understand people who, like, stumble there, I do, now I'm not dependent, I can, like, drink, without it being either, maybe I'm afraid, that in the future, if something happens to me, like that, when I think back, when I studied, that it was easy to put myself in that situation, that it maybe could happen again, I think it can [...]

The narrative's point is that alcohol helped Katarina manage a situation, when she was forced to study hard. She was close to becoming dependent. This core in the narrative is already contained in the introductory abstract. During the course of the narrative, Katarina returns to the point that she used alcohol in order to forget troubles during the time she studied, which was starting to make her dependent.

The neutralizing account she uses to explain why she drank so much is how difficult her studies were, something that recurs several times during the narrative. It is also neutralizing that it was easy to end up in that situation, which enables her to have understanding for others who do. It happened to her. It can easily happen to others. It was so easy that she is not sure that it could not happen again.

Several times during the focus group discussions, one participant's narrative encourages another to tell about their experience of a similar situation. Johanna, from

the same group, introduces her narrative by pointing out similarities with what Katarina reports.

Text 3. Drank beer all alone (part of excerpt 150):

[...] but that was the way it was for me too, or when I moved to Stockholm, then I was 19 years old, and then I felt so awfully lonely, so I had my little pub that I went to, where I could, like, sit with a book, and sit there and drink beer all by myself, so I saw everyone around, they weren't sitting by themselves, but it was just me, and then when I talked with my friends, or like me, of course people came and moved up after I did then, but the people who were here then in any case, it was of course just a few, so they of course didn't always have time for me, they studied, they worked and all that stuff, then they said like: *it isn't normal for a 19-year old to sit alone at a pub four times a week and drink three beers*, I just: *but there's, like, no harm in it, I come here after work and think it's nice to relax*, but then, I thought about it: *what the heck am I doing?* but it took an awful lot of money, too, of course it wasn't, like, happy hour at 9 o'clock at night (laugh) [...]

The narrative's point is the similarity with Katarina's experience of drinking alone to forget troubles. Johanna emphasizes her loneliness by returning to that subject several times. As in several of the narratives, the point is indicated by a direct quote, here from a dialogue between Johanna and her friends. Even in the narrative's resolution, Johanna quotes herself and how she finally saw what she was up

to. She leads the listeners back to the present with the concluding commentary that it also was expensive.

The neutralizing account about why Johanna drank so much and so often is that she had just moved to Stockholm. She was only 19 and felt lonely. Even in Johanna's narrative there is an underlying point about friendship. In her narrative she does not just account for why she drank so much. She also accounts for why she was so lonely. She tells about friends who were in Stockholm, but who did not have time to meet her. The reason was that they were fully occupied with studies and work. Others, however, who gradually came later, reacted.

In a fourth narrative, alcohol's role in deadening troubles is described as completely positive, apart from the hangover. Peter from the construction workers' group reports below.

Text 4. Getting plastered as a cure for troubles (excerpt 234):

[...] I thought about, that there, about troubles, actually in fact I drank once because a pal had one of these brutal lows, there was someone who was coming on strong to his woman, and we had talked about it before, a year before or so, that actually we should just try to sit like that and just brutally go drinking like that, sit like until our foreheads hit the table or something, that was really well-timed because I had won the spirits lottery at work, I had like, yeah, I had whiskey, there was Campari, and then there was that some of this gin, and I had lots of beer, so we had like really like this, we had set everything up on the table there, and

we had lot of glasses, and so we sat and drank that there, and he just: *shit how I hate women! yes, damn it!* I said, and drank a lot, then I think we managed for three hours something, then I don't remember anything in any case, but I've never felt so bad as the day after, but then a week afterward, it felt like, it felt like we'd done something, I don't know if we convinced ourselves, or what it is, it felt like that anyway, we got like plastered, we got totally plastered and it felt like that, and my buddy felt a little better, he had forgotten the woman in any case, that felt a little like this, now I've done that, so now I don't need to do that again [...]

The point of the story is that alcohol has a place to fill in deadening troubles, because Patrik's good friend, with Patrik's assistance, forgets his unfortunate love.

Patrik provides several reasons why he purposely got so drunk. A close friend was depressed. The action had been planned for a long time and was executed with experimental aims. Moreover, he had won the spirits lottery at work at approximately the same time. A series of explanations contribute to making the behavior acceptable for the listeners. That which possibly most of all justifies the morally dubious activity of getting blind drunk is the good purpose of helping a friend who is not doing well to do better.⁶

There is a similarity between the points in the narratives in that they talk about how alcohol is used as a problem solver, at least temporarily. In the last narrative, a single event is described, which the teller does not plan to repeat. Here there is no anxiety about dependent-provoking hab-

its. In the remainder of the narratives there is an anxiety about a need that imperceptibly steals upon them, associated with the relaxation and relief that alcohol provided.

Even the narrative's neutralizing accounts have several similarities to each other. First and foremost, all tellers provide similar extenuating personal circumstances as to why they drank so much, although it is true in one case that it is presented indirectly in the form of a representative. The theme of friendship is also prominent. Texts 1 and 3 account for why friends did not intervene and how they eventually did so. In text 4, it was the activity of helping out a friend that first and foremost justified the drinking.

The remaining narratives that describe situations in which one's own drinking became excessive are similar overall in that the accounts are about how everyone else drank, which excuses the teller. In addition to this, the accounts show that alcohol was easily available and that the teller was younger.

■ Alcohol easily available and everyone drank

Two narratives neutralize the narrator's excessive drinking with the easy availability of alcohol. The first of them is similar to texts 1–3, because the teller's point is fear of addiction. The circumstances, however, are different. Lisa, from the group of young women who work as media and advertising salespersons, talks about why she has sometimes abstained from alcohol.

Text 5. This is getting to be too much! (excerpt 144):

[...] Because I am afraid that I could become dependent, too, that is

a big reason, I have partied pretty hard because I was in London for half a year, and there it was really a bit unbelievably much, we were a hundred Swedes who were there studying in London with all those pubs and bars and discothèques, and, yes, it was several times a week, and even though we were working, we also worked for three months, of course it also happened there, there I actually abstained a couple of times, because I felt: this is getting to be too much! And I started like feeling a need for it, almost, and then I abstained, so that it is not at all impossible to become dependent on alcohol, I don't think so [...]

The point of the narrative is that Lisa abstained out of fear that her drinking was becoming excessive, when she began to feel a need for alcohol. She emphasizes the point when she renders her feelings in a direct quote.

The explanatory accounts Lisa gives about why she partied several times a week despite working are London's nightlife and all the opportunities she had to drink together with her friends who were also studying.

Yet another narrative explains a situation in which alcohol got to be excessive through the ease with which alcohol could be obtained. One of the social work students, Jenny, also reports an incident abroad. When she was in the U.S.A. at an outdoor party, the alcohol she and her friends had with them ran out. The neutralizing accounts, which introduce the narrative, describe a situation in which the group actually lacked alternatives. They had nowhere to go. They were supposed to

be picked up at a certain time. There was a 21-year age limit at bars. They were at a big outdoor party, where everyone was drinking and everybody was in high spirits. A part of the narrative's conclusion, in which a person comes up with a solution, is reproduced below.

Text 6. Dangerous to drink what we drank (part of excerpt 408):

[...] then there was some genius who: *but of course they're open: the liquor store*, they were open until 11:30, and then we went in and bought, we bought a lot then, and what we bought, I thought about this, that it was dangerous, because we bought alcoholic cider and that kind of alcoholic soda, or whatever it's called, wine cooler, and it's delicious, it is really dangerous to drink something like that, when we actually already were drunk, it is really dangerous to drink exactly that, because it's like soda, it's delicious, it is really dangerous, because we could drink a lot, even though we had already had a lot to drink [...]

Jenny clearly shows her reaction to what happened. In the short excerpt above the word *dangerous* appears four times. Here is the point of the narrative: how dangerous it was to drink what they drank, when they already had had a lot to drink.

In addition to the neutralizing accounts that appear in the narrative's introduction, Jenny gives several additional explanations for their drinking so much. The liquor store was open late. The idea to go there was not Jenny's. It was easy to buy a lot. What they bought tasted like soda, and because they were already drunk, they didn't notice anything.

■ Was younger and everyone drank

Several additional narratives neutralize drinking with “everyone drank,” with the addition that the teller was quite young and has changed his or her drinking habits since the events described.

In the group of construction workers there is a discussion about alcohol’s advantages and disadvantages when one goes out in order to meet women. Someone jokes about waking up and wondering who is beside him. This leads Bosse to tell about a personal experience of exactly that kind.

Text 7. Waking up not knowing where you are (part of excerpt 391):

[...] when I was younger I actually drank a whole lot, I have actually calmed down a lot now, I have a lot of friends who are out in that danger zone, it is really sad when you go home and talk with your old friends [...]

The narrative continues with how poorly things have gone for many, how much, and how often they drank when they were younger. The neutralizing orientation takes up more than ¾ of the entire narrative, before Bosse approaches the point the listeners are waiting for.

[...] all the way up until I was 18, I think that I went out bar-crawling an awful lot and then of course it happened sometimes, that when you started to go to the tavern, that you woke up in an apartment and you had no damn idea about where you were and so there was some girl lying there: *shit!* And so you just ran,

As a direct follow-up to that confession, another participant tells about someone he knows who had the same thing happen, and walked two (Swedish) miles (20 kil-

ometers) through a forest in hung-over despair.

The point of the narrative, that Bosse had the uncomfortable experience of waking up not knowing where he was and also not knowing who was lying beside him, first comes quite near the end of the narrative and is very compressed in relation to the length of the narrative.

The neutralizing accounts are long and have a serious content. All friends from youth drank a lot. It has gone badly for many. Some of them are dead. Extenuating circumstances for Bosse are that he has changed his attitude towards alcohol and now drinks much less. Additionally, one of the listeners helps Bosse appear in a better light by telling about a similar situation, seasoned with a little exaggeration. The narrative’s detailed accounts are intended to neutralize both the extensive drinking and Bosse’s behavior toward the girl with whom he went home.

Another narrative neutralizes extensive drinking in youth with social pressure from an environment in which everyone drank. Apropos that from which alcoholism can arise, this is Kaisa, one of the social work students, talking about her school days.

Text 8. My role was to be the most drunk (excerpt 319):

[...] then too it can also be that some people get, like, a certain role, that is to say you get it really early in youth, I was always the one who was the most drunk when we went to school, it was always that way, Friday, Saturday, then I was always the most drunk, but everyone knew that, and I knew that too, so that it was of course just a matter of me arranging it

(smile), but that's how it was, but somehow I realized that I couldn't keep this up, in every way possible, I didn't have enough money, and there were all sorts of things, but of course it took several years, then I realized, that really wasn't so cool, so then I moved, but no, that people get like different roles and then live up to them, totally cold as ice, because you feel like this: *yes, but I'll put up with it, because how else will I explain, should I say that I was sick on Friday, or, or what should I say, or?* of course people still want you to be that person [...]

By way of the present tense in the narrative's most dramatic section, Kaisa renders her feelings about not having any alternative other than to live up to the expectations of being the one who should be the most drunk. Here is the narrative's point: exactly like for Kaisa during her school years, an alcoholic can have an altogether difficult time going against other people's expectations that he or she will drink.

The two narratives in texts 7 and 8 have another thing in common, in that they repeat the extenuating circumstance that the main characters are not yet grown up. Youngsters do not have the same freedom as adults to make up their minds about alcohol. The social milieu and the drinking habits of others exercise a strong influence. It is difficult to make a different choice, because one has not come in contact with other alternatives. In both narratives, however, the main character eventually breaks the pattern.

■ Intoxicated because it tastes good

The last of the narratives in which narrators describe over-extensive drinking have

neutralizing accounts of another type than the previous ones. The narrator generally drinks too much just because he likes beer so much.

Some of the questions in the questionnaire are about why people occasionally abstain from alcohol. When the members of the group of ice hockey players talk to each other about how they answered the questions, Frederik says that he would rather abstain from drinking than drink just because there is alcohol. Drinking to get drunk was something that he did when he was young, when he took alcohol from his mother's drinks cabinet and used it to mix drinks. To his surprise, he has met people who still drink that way. Below, a part of Fredrik's narrative is reproduced, as are a listener's reactions to it.

Text 9. Force it down in order to get drunk (part of excerpt 94):

Fredrik: [...] but then, that is to say, there are also some people who still make those damn witches' brews, a friend of some woman you meet, like, who sits and forces it down, it tastes like shit, but he sits and forces it down his throat anyway, of course it's just to get drunk, I mean I don't get it, I always manage to get shit drunk, but that's just because I like beer, so I don't want to stop drinking beer just because I feel a little tipsy,

Lasse: no, though you might not drink as many beers if they were alcohol-free, beer,

Fredrik: no, that is possible, but I drink often, it's good as hell to drink a low-alcohol beer on a warm summer day,

Lasse: yes, that's true, but of course people don't like to drink, like, ten

low-alcohol beers in a row (laugh)

Fredrik: that's true,

The point that makes the narrative worth telling is found in the astonishment over the idea that someone can drink something they think is disgusting just to become drunk.

Frederick neutralizes the fact that he, however, gets drunk all the time with how good beer tastes. Hence, he does not want to stop drinking just because he feels affected. He even thinks that beer that contains almost no alcohol is good. To neutralize intoxication due to the good taste is, however, not accepted by the listeners as a legitimate excuse.

Conclusion

In conclusion, (1) neutralizing accounts, (2) underlying points, and (3) narrative points that appear in the narratives are summed up here in order to illuminate (4) the value system – or the everyday logic – in which the young people contextualize alcohol and problems with alcohol, in order eventually to (5) discuss implications for preventative messages aimed at young people.

Narratives give us information about the world, both about how we expect it to be and how it deviates from our expectations. One way of discovering ideas about how the world should be organized is to review how violations of these ideas are explained. Situations come up, which should not happen, but they occur anyway.

(1) Narratives' neutralizing accounts provide an answer as to why something that shouldn't happen happens and what the culturally acceptable causes are. The narratives that are presented here contain different types of accounts, the purpose of

which is to neutralize an altogether over-extensive drinking and present the speaker in a less negative light. A further mitigating factor for the speakers is that in every case, except in text 9, they indicate that they now have other drinking habits. No narrative is about the speaker having present-day problems. In this sense, the stories that are told are success stories about having escaped ongoing problems.

The accounts also contain information about why friends or others nearby did not react the way they should have done. The narratives show that friends are expected to intervene and help each other in situations like those described.

In the excuses as presented, the reasons why drinking became excessive are for the most part unintentional, and are placed outside the speaker's will and control. External circumstances are decisive. The most prominent causes are personal problems, easily available alcohol, and being young in surroundings in which everyone drinks, all causes that reduce the speakers' chances of handling the situation. Valid causes of problems due to alcohol are collected in this limited repertoire of excuses (Lamb & Lalljee 1992). Thus, the drinking cannot be blamed on the moral character of the speaker, which is the main purpose of neutralizing accounts (Buttny 1993, 3; Goffman 1971, 99; Schlenker, Pontari & Christopher 2001, 15).

(2) The underlying point or moral is that, in our culture, those who drink too much risk being regarded as lacking moral character. In no narrative and in no other way in the interviews was doubt cast upon drinking itself. The ideal is to drink, but not too much (see also Room 1998). However, moral codes that have survived for a

long time often contain expedients that limit responsibility when things go wrong (Buttny 1993, 8). Listeners' reactions show the reasons for which excessive drinking can be met with understanding, and instead be perceived as an involuntary and reasonable reaction to external pressures or other circumstances over which the speaker has no control.

(3) The *points* included in the narratives can be summarized as: alcohol is a powerful drug, with which people, through no fault of their own, can develop problems. It comes across in the points that it is important to be cognizant of one's habits. Speakers link dangers with alcohol to drinking often and in large quantities.

The narratives' points and the neutralizing accounts therefore constitute an answer and a reply to the moral of the narrative. This is also the area of tension within which the question of alcohol has been found during the past century – in the tension between what can be laid at the door of the individual and what can be attributed to the surrounding environment (Abrahamson 1989; Blomqvist 1998).

(4) The narratives' points, neutralizing accounts, and morals are therefore part of a *system of values*. They are further located within a cultural context and have a range that extends beyond the specific context of the narratives presented here. The conditions that appear in the narratives are also

those that are culturally accepted as causes of problems with alcohol. They constitute an *everyday logic* about the causes of the problem.

(5) Based on the everyday logical thinking, this study provides support for the sort of *preventative messages* that focus on habitual drinking and the kind of harm that can arise from extensive drinking.

Further, the study provides support for viewing alcohol in a social context. Particularly among young people, drinking occurs within a social context, in which social relationships can play a meaningful role in drinking.

The everyday logic endorses intervention by friends and talking with the person who drinks too much. Everyone can develop problems caused by alcohol. They can come about imperceptibly and for no other reason than that the drinking was too excessive during a certain period of time or on a special occasion. The situations described are the kinds that come up in young people's lives and that listeners recognize. It is all about the consequences of drinking too much here and now, and not in the distant future.

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NOTES

1 The project was undertaken by the Centre for Social Research on Alcohol and Drugs (SoRAD), Stockholm University, and was financed by the Swedish

Ministry of Social Affairs. Two reports in the series have been completed to date (Abrahamson 2003; 2004).

2 The films are: *Ska vi gå hem till dej eller*

till mej eller var och en till sitt? (Shall we go to my place or your place or each go home alone?). Lasse Hallström, Sweden, 1973, *The Snapper*, Stephen Frears, Ireland 1993, *The Deer Hunter*, Michael Cimino, USA 1978, *Black Jack*, Colin Nutley, Sweden, 1990, *Välkommen till festen (Welcome to the Party)*, Ella Lemhagen, Sweden 1997, *½ glas vin (½ a glass of wine)*, NTF (Nationalföreningen för trafiksäkerhets främjande, Sweden 1998, *Systemet, vad är det bra för? (The state-controlled company for the sale of alcoholic beverages: What's the use of it?)* Systembolaget, Sweden 1992.

- 3 The questions in the questionnaire come from a Finnish national survey about drinking habits and attitudes that was used by the Finnish Foundation for Alcohol Research in 1992 and that (with small changes) was also used by Abrahamson (1999).
- 4 Eggins & Slade (1997, 227–272) distinguish several additional narrative genres that people normally use in conversation with one another: 'anecdotes,' 'exemplums', and 'recounts'. Irrespective of the narrative genre, evaluations run through the narrative, hold it together and create its particular contextual meaning (ibid., 236). The difference is that in the fully formed narrative, according to Labov's model the teller solves a problem, a crisis, or a conflict. In an anecdote, on the other hand, the teller does not solve a problem, but rather presents his reaction to a problem. In the exemplum, the teller presents an event in order to use it as a background to make a moral point about how the world is or ought to be. Ultimately, recounts are not necessarily about a problem. The purpose is solely to retell events in order to assess the events together with the listeners.
- 5 The remainder of the narratives are about a friend who was intoxicated or had had too much to drink (9), about drinking at parties, in pubs, etc. (9), about alcohol in professional life (5), about alcohol in the family (4), and finally about alcohol and

drug information in school (2).

- 6 It is common to make distinctions between excuses and justifications in the literature concerning accounts (Read 1992, 4; Scott & Lyman 1968, 47). With a justification, a person that has done something wrong accepts his responsibility for the action. With excuses, no personal responsibility is admitted for the bad behaviour.

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Testing new models in Finnish, Norwegian and Swedish alcohol policies

Introduction

Major changes in recent Nordic alcohol policy have been extensively documented (Holder et al. 1998; Sulkunen et al. 2000; Tigerstedt 2001; Ugland 2002). These texts have analysed the collision between a powerful and protective Nordic alcohol policy model, on the one hand, and the free trade policy endorsed by the European Union (EU) and the agreement on the European Economic Area (EEA), on the other.

It is our impression, however, that the wide scope of the ongoing transformation in Finland, Norway and Sweden is only partly covered in this research literature. Until now, little has been said about important choices that have been made after the principal shift in the mid-1990s. For example, new policy concepts and operational models have been tried out. Some of them are already disqualified, others seem to be more durable (Tigerstedt & Karlsson 2003).

In this text we describe strategic prioritisations and organisational solutions in the alcohol policy field in each of the three countries. To begin with we take a look at Finland and Swe-

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ABSTRACT

T. Karlsson, C. Tigerstedt:
Testing new models in
Finnish, Norwegian and
Swedish alcohol policies.

In the last ten years major changes have taken place in Nordic alcohol policy. Until now, however, research has said little about the important policy choices that have been made in the new situation. In this text we describe strategic prioritisations and organisational solutions in the alcohol policy field in Finland, Norway and Sweden. First, we take a look at Finland and Sweden, two EU countries acting quite differently at the current time. We examine the new policy strategies which the countries have decided to invest in at a moment when measures affecting prices on alcohol and availability have become significantly weaker. Next we look at organisational solutions that have been implemented in order to handle the new situation. Adding Norway, a non-EU country, to this analysis allows us to comment on whether Finland's and Sweden's membership in

the EU has brought about more extensive changes than in Norway. As an appetizer, we offer a perspective on how the displacement of the alcohol field is reflected in everyday terminology in each country.

■ KEY WORDS

alcohol policy, alcohol programme, public administration, Finland, Norway, Sweden.

den, two EU countries acting quite differently for the moment. In this section we examine new policy strategies which the countries have decided to invest in at a time when measures affecting prices on alcohol and availability have become significantly weaker. Next we look at the organisational solutions that have been implemented in order to handle the new situation. Adding Norway, a non-EU country, to this analysis allows us to comment on whether Finland's and Sweden's membership of the EU has brought about more extensive changes than in Norway.

As an appetizer we serve a perspective on how the displacement of the alcohol field is reflected in everyday terminology in each country.

Wobbling terminology

One way of summarising the radical changes is to claim that a shift is taking place in the key terminology of the policy field. This observation is based in our reading of recent official documents on alcohol policy and prevention, supplemented with Internet searches of alcohol policy and related terms. In short, the traditional terms *alkoholpolitiikka* (Finnish), *alkoholpolitikk* (Norwegian) and *alkoholpolitik* (Swedish) – approximately equivalent to the English expressions “alcohol policy” or “alcohol politics” – are changing semantically.

For an Anglo-Saxon audience it is important to note that the term and the very idea of “alcohol policy” are of Nordic origin (Room 1999, 10). Alcohol policy signifies a control discourse based firstly on a broad and administratively integrated concern of the negative effects of alcohol consumption on social and health problems. Secondly, alcohol policy builds on a broad governmental engagement in the sales and consumption of alcohol. That is, alcohol policy has been connected to strong governmental and institutional interests.

The term alcohol policy came into English in the late 1970s and 1980s, “more or less as an import from the Nordic languages” (ibid. 11) and, it should be added, as a fairly diluted version of the Nordic original. Contrary to Finland, Norway and Sweden, in English-speaking countries alcohol policy is a term used by a dedicated expertise rather than an everyday expression employed by the man in the street. In the political discourse applied by the European Union the term is only occasionally operative. We may now ask whether the term, due to

social transformation, is losing hold in the cultural region from which it originated.

As high taxes and the restricted availability of alcohol have been challenged or slackened in Finland, Norway and Sweden, two things seem to happen. Firstly, the meaning of “alcohol policy” shrinks and tends to become less robust. Presently the term seems to focus more on specific contexts and situations. Accordingly, in Sweden one fresh definition of alcohol policy covers the so called four alcohol-free zones: alcohol should not be present at all during adolescence, in motor vehicle operation, at workplaces and during pregnancy. Secondly, since the 1990s the traditional term *alkoholpolitik* is paralleled by complementing and competing terms. Ultimately, these new terms lean on a different view of how people can and should be governed.

These shifts can be noticed in all three countries studied. However, the three languages – Finnish, Norwegian and Swedish – demonstrate some peculiarities. In *Finland* professionals and volunteers have largely adopted the diffuse term *ehkäisevä päihdetyö*, which might be unidiomatically translated into preventive substance work (cf. social work). Compared to the customary term alcohol policy, “preventive substance work” brings with it several new nuances: the distinction between alcohol and other substances is removed, and the image of prevention is more local in character and less oriented towards the regulation of (national) economic markets.

In *Sweden* the term *alkoholpolitik* is still very dominating, but the adjectives *alkoholförebyggande* (alcohol preventive), *drogförebyggande* (drug preventive), as well as the combination *alkohol- och drogförebyggande* (alcohol and drug pre-

ventive) are mushrooming. In addition, two completely new terms have been introduced lately. The historical paradox is that this time both terms are more or less direct imports from the Anglo-Saxon world. The first one, *alkoholpolicy* (alcohol policy), might actually be termed “Swenglish” and refers to a concrete policy approach, an action plan, or the like. The second one, *alkoholprevention* (alcohol prevention), is associated with preventive activities limited in time and space (for example, the STAD community action project in Stockholm, see Wallin 2004).

In *Norway*, as in Sweden, the term *alkoholpolitikk* is still strongly preferred. However, since the early 1990s Norwegians have increasingly put alcohol and drugs under the same roof, thus using the term *rusmiddelpolitikk* (substance policy/politics, or alcohol and drug policy/politics). Correspondingly, the adjective *rusmiddelforebyggende* (substance preventive, or alcohol and drug preventive) is widely used in brochures, journals and official documents, either replacing or completing the traditional term *alkoholpolitikk*.

Such terminological wobbling shows that the new reality we are confronted with in regulating alcohol consumption and alcohol-related harm is hard to capture using conventional nation- and state-oriented vocabulary.

Finland and Sweden

In the further analysis it seems convenient first to single out the two EU member states Finland and Sweden. This may be justified in two ways. Firstly, Finland and Sweden are directly subordinated to EU regulations, while Norway is not. Consequently, some recent EU events have played a deci-

sive role in moulding the alcohol policy system in Finland and Sweden. For example, there was the EC legal issue in 1997, the so called Franzén case, concerning the legality of the retail monopoly in Sweden (with consequences for the rest of the EU, read: Finland) (Ugland 2002, 128–130). Another major example was the abolition 1 January 2004 of restrictions on travellers' imports of alcoholic beverages for personal use within the EU (Österberg & Karlsson 2002a, 62–63). Also the enlargement of the EU especially in the Baltic Sea region affects Finland and Sweden differently compared to Norway. We ask, therefore, what are the Finnish and Swedish responses to this new operational environment.

Secondly, separating Norway from Finland and Sweden allows us to discuss in some detail to what extent changes in Finland and Sweden may be attributed to their EU membership. What if Norwegian alcohol policies behave more or less in the same way as its Finnish and Swedish counterparts? Would this be due to European economic integration put into effect by the European Economic Area agreement (EEA) – the stripped-down economic alternative to EU membership – signed by the Norwegian state? Or has Norway, by staying outside the EU, succeeded in maintaining autonomy in its alcohol political decision-making?

■ Strategic prioritisations

Finland has been more favourable than Sweden towards international demands concerning the re-orientation of their national alcohol policies. In the EU-negotiations in the early 1990s Finland saw the adjustment of its alcohol policy system to the

challenges posed by the European integration mainly as a technical and judicial task (Alkoholilain ... 1992; Alkoholilain ...1993). During the process of re-organising the Finnish alcohol policy system the state made no attempts at trying to argue either on behalf of or against the old alcohol policy system. When the justification for the reigning alcohol policy had worn thin, the institutional memory of the alcohol policy system, which previously had been strong, also became distorted and withered away. The major changes that occurred in the alcohol policy field in the mid-1990s should have deserved a more profound reflection over the justification and self-consciousness of the whole alcohol policy system. This was, however, never done and the effect of this neglect has become painfully apparent during the past decade (Tigerstedt & Karlsson 2003).

Sweden on the other hand has tried to prevent this “amnesia” from happening. Both before and after becoming a member of the EU, the Swedish state has continuously, almost exhaustively, reflected upon the justification of its alcohol policy and its national ethos (e.g. Alkoholpolitiska kommissionen ... 1994; OAS i framtiden 1998).

In the mid-1990s Finland slimmed down its previously comprehensive alcohol policy system to better fit European standards, whereas Sweden tried to retain the sovereignty of its alcohol policy system and even made attempts to raise the priority of alcohol policy issues on the EU agenda. A concrete example of this is the European Comparative Alcohol Study (ECAS) (cf. e.g. Norström 2002; Österberg & Karlsson 2002b), which started as a Swedish initiative. Another initiative primarily instigated by Sweden was the WHO European

Ministerial Conference on Young People and Alcohol in Stockholm in February 2001, which can be seen as part of a process that resulted in the adoption of the European Council Recommendation on adolescent drinking (Council Recommendation 2001/458/EC).

Finland has not been as active as Sweden in trying to influence the formation of alcohol policies on the international arena. Instead Finland has been quite receptive to international influences in the alcohol policy field. This has especially been true in the case of the World Health Organization, and in particular its European office (WHO-EURO), which has played a significant role in the formation of Finnish alcohol policy ever since 1995. WHO's European alcohol action plans have served as models for the first two national alcohol programmes that, at least formally, have steered the formation of the national alcohol strategy. In Finland these fixed-term national alcohol programmes have, more or less, all advocated a shift in the focus of alcohol policies from the national to the local level (Tigerstedt & Karlsson 2003).

A trend of decentralisation of power and

responsibilities is also present in Sweden, and even there periodic alcohol action plans are used in order to implement the goals of national alcohol policy strategies. A clear shift in focus can be detected in the 1995 national action plan for alcohol and drugs (Nationell ... 1995) that strongly emphasised the importance of alcohol policies on the local level.

The main reason for this change in focus can be credited to the countries' EU-membership in 1995. This also becomes apparent when looking at the timetable in which alcohol policy documents have been prepared in both countries. In Figure 1 we can clearly see how the EU-membership has influenced the appearance of alcohol policy documents. Corresponding official documents in Finland and Sweden have emerged almost simultaneously (Figure 1).

After joining the EU, a general conception in both Finland and Sweden was that the conditions for a national alcohol policy based on restricting alcohol availability and maintaining high alcohol taxes were severely restricted, whereas more possibilities and opportunities were created for the development of regional and local al-

FINLAND						
Working group for reforming the Alcohol Act, Part 1 and Part 2			Proposition for a national alcohol programme	Proposition to implement the national alcohol programme	Proposition for an alcohol programme for the 2000s	Alcohol programme 2004–2007
1992	1993	1994	1995	1997	2001	2004
		Alcohol policy committee	National action plan on alcohol	Independent alcohol co-operation (OAS)	National alcohol action plan (Alcohol- committee)	
SWEDEN						

Figure 1. Alcohol policy committees, working groups and alcohol action plans and programmes in Finland and Sweden, 1992–2004

cohol policy activities. Both countries have also put more emphasis on promoting situational sobriety, for instance promoting abstinence for women during pregnancies or total abstinence in motor vehicle operation.

Since the mid-1990s Sweden also began to develop and evaluate local prevention measures, as for instance responsible beverage serving (RBS) efforts and also other community mobilisation measures. A good example of an extensive community action project performed in Sweden is the STAD project, which has been implemented and evaluated in Stockholm since 1996 (cf. e.g. Wallin 2004).

In 1997 a close co-operation called the Independent Alcohol co-operation (OAS), was started in the alcohol policy field between public sector authorities, insurance agencies and the alcohol industry. The temperance movement was not included nor did they want to be a part of this coalition. The co-operation was, however, plagued with conflicts and stranded prematurely, already in autumn 2000. The main legacy of the co-operation was an active media campaign targeting illegal alcohol that was carried out in the late 1990s. Since 2001 the so called Alcohol committee has been responsible for implementing the Swedish alcohol strategy outlined in the 2001 Alcohol action plan. The Alcohol action plan has, besides active information and education campaigns on different alcohol-related issues, been focused on professionalising alcohol prevention especially on the municipal level (Tigerstedt & Karlsson 2003).

In Finland the emphasis since the mid-1990s up until 2004 has mainly been on promoting the importance of general so-

cial and health care services in the prevention of alcohol problems rather than alcohol-specific measures. The new Alcohol programme published in April 2004 (Alkoholihjelma ... 2004) does, however, more directly focus on the prevention as well as reduction of alcohol-related problems. The programme emphasises the importance of co-operation and voluntary partnerships between the public sector, NGOs and industry organisations in the alcohol field. The local level is still the focus of prevention, and the programme also includes a large quasi-experimental research project for the development and evaluation of local alcohol prevention measures in two Finnish regions (Local Alcohol Policy "PAKKA"-project). The programme is not as rigidly steered as the Swedish alcohol action plan nor does it have nearly the same financial resources. Despite this, the programme can be perceived as the first serious attempt the Finnish government has made in tackling alcohol problems since 1995.

Finally, it should be noted that neither Finland nor Sweden anymore relies on the long tradition of Nordic co-operation that prior to 1995 was perceived as an integral part of national policy-making in the alcohol policy field.

■ Organisational and administrative solutions in the alcohol policy field

The organisational and administrative changes that have occurred in the alcohol policy field in Finland during the past ten years have been extensive. In 1995 the alcohol monopolies on production, import, export, and wholesale were abolished, leaving only the monopoly on off-premise retail sales of alcoholic beverages intact

(Holder et al. 1998). At this time also the alcohol monopoly's (Alko) vast tasks and responsibilities in the field of alcohol policy were dismantled and its position as the main alcohol policy authority was lost. Due to Alko's sovereign position in the Finnish alcohol administration prior to 1995, there were no clearly designated successors to take over its alcohol policy responsibilities at this time (Karlsson & Törrönen 2002). Instead these tasks were transferred, in what in hindsight seems to have been quite random, to less experienced, politically weak or newly established public sector agencies, and to NGO's in the public health field.

In Sweden the administrative changes have not been as radical. This is because no alcohol policy actor has been as dominant as the Finnish alcohol monopoly previously was. However, also in Sweden the alcohol monopolies, except for the retail monopoly, were abolished and many tasks in the alcohol policy administration were redistributed.

Despite these somewhat unequal starting points, both countries have shown a tendency to change their administrative focus from the national to the local level. The ways the countries have tried to get about this change in focus, however, differ significantly from each other (Tigerstedt & Karlsson 2003).

For instance, in Sweden the alcohol action plan that is currently steering the alcohol policy can be perceived as a serious effort in educating and creating a new profession of local level "prevention workers" (cf. social workers) within the public health field. If, and to what extent this effort will be a success, however, is too early to predict. Much depends on how alcohol

prevention succeeds in competing with other prevention tasks in the local public health field that in the future undoubtedly will be added on these co called prevention co-ordinators agenda (e.g. drugs, obesity).

In Finland, on the other hand, the alcohol policy experts in charge have been characterised by a firm belief in the strength of network building. Networks are built horizontally, vertically and between professions. In this respect the development in Finland resembles that in Sweden, at least on the surface. What is altogether lacking, however, from the Finnish activities is the strong ambition that exists in Sweden to educate prevention workers with the ultimate goal of formalizing local alcohol prevention as a profession. Examples of attempts to educate and support the contact persons of the Finnish network of prevention have been mainly concentrated on a web portal being set up to support them in their work as well as giving them the possibility to attend occasional expert seminars in the field of alcohol policy and prevention (Warpenius 2002).

Also regarding the political importance of alcohol issues, the situation in Finland is significantly different from that in Sweden. In Sweden alcohol-related questions have throughout the past decade had a fairly high political status. Action plans are regularly adopted by the parliament and/or the government. By contrast, alcohol issues in Finnish politics have been of second-class importance. A good example of this is the low status the national alcohol programmes have had in the state machinery until recently. Between 1995 and 2003, the national programmes were only propositions for programmes and they were never properly processed or adopted by

the Ministry of Social Affairs and Health or by the government (cf. e.g. Figure 1; Tigerstedt & Karlsson 2003, 411). In this respect the new Alcohol programme (2004–2007) is a clear exception, as it is initiated and confirmed by the government.

■ Economic resources

Sweden has during the past ten years invested substantially more money on the implementation of its alcohol action plans compared to Finland. For instance, in 2001 Sweden invested over 75 million euro on the implementation of its alcohol action plan over a four year period, whereas the corresponding figure for the Finnish equivalent was only 0,3 million euro for a three year period (Tigerstedt & Karlsson 2003).

In 2003 the Finnish government granted a sum of EUR 1 million for the implementation of the new Alcohol programme 2004–2007. To ensure a successful implementation of the programme the government has also promised some additional financing for actions directed to furthering the goals of the programme. Although it now seems that the Finnish government is determined to increase its financing of the national alcohol programmes, the financing is still, compared to the corresponding Swedish action plans, on a very modest level.

Based on our comparison of the two countries, we can conclude that after becoming members of the EU, Finland and Sweden have chosen different paths in re-organising their previously closely related alcohol policy systems.

Norway

■ Does the non-EU status matter?

In the negotiations about EU membership, Norway even more than Sweden defended

its sovereignty concerning national alcohol policy arrangements. One could therefore expect that Norway's decision to stay outside the EU would have decelerated the liberal trend that had occurred some years earlier in Finland and Sweden (Sulkunen et al. 2000).

It turns out, however, that Norway – without any formal pressure from EU bodies – has slackened its alcohol policies in a surprisingly similar way to Finland and Sweden. The only exception is that the Norwegian liberalisations have occurred somewhat later and less gradually. For almost 20 years (1980–1997) the amount of alcohol monopoly stores increased by roughly one store per year. Since 1998 the speed has been on average 10 additional stores per year. Contrary to Finland and Sweden, self-service stores for alcohol sales were firmly rejected in Norway up to the late 1990s. The first self-service stores, introduced in 1999, were a genuine surprise for many consumers, but five years later almost half of Norway's 200 liquor stores work according to this principle. Also opening hours have been considerably extended during the last few years.

While Norway does not belong to the EU, it has not been affected by (the gradual adjustment to) the abolishment of restrictions on travellers' imports of alcohol for personal use from one EU country to another. Free trade in this domain came into force 1 January 2004. Nevertheless, Norway's very high prices on alcoholic beverages are certainly sensitive particularly to the somewhat lower prices in neighbouring Sweden. In order to meet expanding border trade Norway lowered its taxes on spirits in 2001 and 2002 all in all by 25 per cent.

Through its membership in the EEA Norway has also been forced to defend the sovereignty of its alcohol policy against international influences, and in some cases not so successfully. For instance, for years Norway has been struggling to defend its strict bans on alcohol advertising (see Karlsson 2001). Moreover, Norway was forced to surrender and allow sales of alcopops in ordinary grocery stores since 1 October 2003 which may, in turn, be a precedent for Finland and Sweden. In this context, it should be noted that both through the government and NGOs Norway has played an active role on the international alcohol policy arena.

Consequently, the overall situation with regard to the gradual liberalisation of the Norwegian alcohol policy shows many similarities with the Finnish and Swedish ones. Next question is, then, whether Norway has also felt a strong need to reorganise its policy administration and to search for new policy concepts during the last ten years. Our impression is that this is indeed the case.

■ Strategic prioritisations and organisational solutions

Several Norwegian governmental documents correspond to the Finnish and Swedish ones presented in Figure 1 (see Figure 2). In 1994 an alcohol commission was appointed "due to increasing international relations, among others Norway's inclusion in the EEA and its possible membership in the EU" (NOU 1995). Although heavily concerned with the changing international conditions, the commission report might be called a scholarly apologia of traditional alcohol policy. However, already in 1996 new policy practices were

announced in a Parliamentary proposition. After years of quiet waters in the Norwegian alcohol sales system at the national level, this document suggests that the distribution network should be improved, the amount of retail shops raised and opening hours extended (Om lov ... 1996). In subsequent years all these intentions and more, have been carried out.

Gradually, the role of local communities also seems to be subject to a redefinition. This includes a paradox, because local alcohol policies based on municipal referendums used to be a major pillar in Norwegian alcohol control up to the 1950s and 1960s. As voters favoured liberal solutions in subsequent decades, this arrangement lost its "temperance effect", and in 1989 it was abolished (Andersen 2000, 161–162; Nordlund 1998). In 2001 local alcohol policies are resolutely backed up in a Government strategy followed by an action plan. However, now the context is different. Referendums, abolished a decade earlier, are 'replaced' by knowledge and professional skills. A new phase is started: "As a professional field alcohol and drug prevention is a new phenomenon and a considerable part of prevention is still in an experimental stage" (Regjeringens... 2002, 17). According to the action plan this tendency should be promoted.

How, then, should these strategic considerations be put into practice? Two primary channels have figured when discussing the operative responsibility of alcohol policy measures. First, similar to Finland and Sweden the slackened Norwegian alcohol policy system is complemented with alcohol (and drug) action plans, released by each government separately. With the rapidly alternating Norwegian governments,

Alcohol policy in motion? NOU 1995:24 – committee report	Parliamentary proposition Ot prp nr 7 (1996–1997)	Action plan for reduction of alcohol and drug use St prp nr 58 (1998–2000)	Government strategy for work against alcohol and drug problems 2002–2005	Government action plan against alcohol and drug problems 2003–2005
1995	1996	1998	2001	2002
Council for alcohol and drug policy				

Figure 2. Alcohol policy committees, working groups and alcohol action plans and programmes in Norway, 1995–2002

this practice has produced three action plans in five years.

Second, in recent years the Norwegian regional “Competence centres for alcohol and drug issues” are assigned a key role in the emerging strategy based on professional skills. This is noteworthy because these seven regional centres, established since the early 1990s, were primarily aimed at working with the treatment of alcohol and drug problems. Nevertheless, since the late 1990s the Competence centres have gradually been endowed with a whole range of preventive tasks. These tasks include:

- supervision of pupils and students in schools and the education of personnel in the prevention field
- production of educational material
- funding preventive measures in the municipalities
- supporting municipalities in their efforts to achieve their political alcohol and drug goals
- advising the government in the development of national alcohol and drug policy.

Moreover, presently the Competence centres are more strictly tied to the Norwegian Directorate of Social and Health (*Sosial- og helsedirektoratet*). This suggests that the originally regional and substantially different centres are being profiled as centrally directed national instruments

with a varied regional mandate. In principle, this solution should enable the National Directorate to conduct a centralised distribution of financial resources within the alcohol policy field.

We can now summarise our findings concerning strategic prioritisations, organisational solutions and economic resources in all three countries in Table 1.

Discussion

The *Finnish* Alcohol programme 2004–2007 is the first serious attempt since 1995 to back up alcohol matters on a national scale. In particular, it is authorised by the government, it is better prepared than its predecessors, and – albeit abstract – it contains a vision of large-scale co-operation between sectors, administrative levels, industry organisations and NGOs. Considering the acute external pressure brought about by the year 2004, this make-over is easy to understand. But strictly speaking the Finnish government woke up very late, only half a year before it had to decide how to tackle the fact that, first, the EU would abolish national derogations on travellers’ rights to bring in alcohol for personal use 1 January 2004, and, second, Estonia would join the EU on 1st May 2004.

If Finland acted with a sleepy head, on the surface *Sweden* seems to have been

Table 1. Characteristics of the present alcohol policy field in Finland, Sweden, and Norway

	Finland	Sweden	Norway
Strategic solutions	Internationally reactive Local prevention Governing by networks and partnerships Situational sobriety	Internationally active Local prevention Governing by professionalisation and education Situational sobriety	Internationally active Local prevention Governing by professionalisation and education Situational sobriety
Organisational & administrative solutions	National alcohol programme 2004–2007 (adopted by government) Local contact persons (network building) Web portal by state authorities (Stakes)	National alcohol action plan 2001–2005 (adopted by government and parliament) Alcohol committee Local prevention coordinators Monthly e-mail newsletter by Alcohol committee Professionalisation	National action plan for alcohol and drug problems 2003–2005 (adopted by government and parliament) Regional competence centres National bulletin by Competence centres (AproposRus) Professionalisation
Economic resources	Poor	Excellent	Good

more far-sighted. In 2000 Sweden realised that something robust had to be done in order to prevent the situation that the country was to face in 2004. This offered Sweden some time to initiate the creation of a professional nationwide organisation three years before the major alcohol policy changes. It is true, however, that Sweden also acted under acute external pressure. This was because the Swedish government, still in the beginning of 2000, stubbornly believed that it would manage to prolong its derogations from the EU free trade practice beyond 2004. Not only did the EU Commission reject this requirement, it also forced Sweden to extend personal import quotas at a more rapid pace than originally planned.

In terms of protecting fiscal borders and thereby defending national autonomous decision-making Norway, being outside the EU, has had more leeway. Thus, Norway's action plans have followed internal

timetables and considerations. However, it should not be forgotten that price reductions on alcohol in neighbouring countries (Denmark, Finland and Sweden) will result in increased private import and smuggling, which will probably lead to problems with customs control in Norway. The conclusion is, therefore, that in alcohol policy Norway's status as a non-EU country works only as a partial buffer against EU and other commercial influences.

Sometimes far-reaching, viable decisions are stimulated by compelling situations. Is this the case now in Finland and Sweden?

What is new in Finland is that the fresh Alcohol programme is backed up by the government. On paper the programme makes a serious attempt to commit public, voluntary and market agencies within partnerships crossing horizontal sectors and hierarchical levels. This cooperative model indicates a strikingly loose organi-

sational structure, implying that the government takes the shape of an utterly dispersed network. This may be seen as a continuation and strengthening of the previous, much poorer, alcohol programmes in Finland (1997–2000 and 2001–2003).

In the Swedish case the introduction of prevention workers, including formal education, is purposely planned as an organisational structure to operate for years to come. It is easy to imagine that this professional structure may persist in one form or another in subsequent government programmes.

In Norway the new administrative model for national alcohol policy is only now under construction. The financially relatively well-equipped action plan (2003–2005) is still in its initial phase and the coordinating role of the newly established Norwegian Directorate of Social and Health Care has been subjected to intense discussion. Shortly the position of the regional Competence centres will also be clearer.

Finally we note that researchers have been conspicuously indifferent to the often fumbling attempts to reorganise national alcohol policy since the mid-1990s. However, the fact that alcohol policy has become more fragmented and lost most of its national aura does not necessarily mean that the prevailing plans, organisational models and financial solutions would not be interesting when pondering how alcohol consumption and related problems will be governed in the years to come.

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Changes in Norwegian alcohol policy

From social welfare to
market economy

When the alcohol policy was formulated in Norway during the latter half of the 19th and the beginning of the 20th century, it was built on an ideological and social welfare point of view in alliance with the religiously-oriented temperance movement and the labour movement. Alcohol use was seen as reprehensible and morally improper by the temperance movement, while the labour movements argument was that drink led to poverty and suffering for the drinkers' families and to crime and disorder in the community.

Alcohol policy was therefore fashioned with the specific aim of getting people to drink less – and hopefully to abandon drinking altogether. The most important means of reducing drinking were to restrict physical and economic availability. The retail of alcohol became subject to licensing laws, and high taxes should make people think twice before spending money on drink. The local councils were authorised to grant licenses for the sale of beer or the serving of beer and wine. The idea was that the problems caused by alcohol were essentially local, and local councils would therefore be more restrictive when it came to distributing licenses. If a municipality allowed the sale of alcohol within its borders, it was the council that decided how many licenses would be available, and also who got them. If licensees breached drinking laws by selling drinks to people who were either drunk or under the legal age limit, or if they committed other offences under that law, the council could withdraw their licence. Licenses for the serving of spirits and the sale of spirits and wine could only be granted in towns of a certain size, and only given to the state monopoly for spirits and wine.

From the mid-1950s these two pillars started to crumble – first the limitations in the physical availability and later the use of the price instrument. This may of course be due to a number of factors; among others to the fact that the new public health perspective came to the forefront. This implied *inter alia* that interest was to a greater extent directed towards the health problems suffered by the drinker, rather than on the social problems imposed on third persons. As long as the justification for measures in the area of alcohol policy is to prevent harm to third parties, however, they are more easily accepted than if the justification is to prevent users themselves developing health problems (Hauge 1999).

A precondition for enabling new arguments and attitudes to get a foothold is usually that they are supported by changes in material circumstances. And the claim is that this liberalisation can be traced back to the fact that living up to the traditional, restrictive alcohol policy has had such bad economic consequences for the municipalities and the government that they have been pressured to give it up.

Let me start at the beginning. As long as most of the population lived in scattered and isolated rural communities, a restrictive retail system was relatively easy to maintain. And Norway stayed like this until well into the 1950s. The rural communities were built up around local centres. When people needed commodities not provided by their local store, it was to these centres they travelled, by bus, boat or train. Cars were the privilege of the few – in 1950 only one in fifty owned a car. Roads were poor, and long winters made them worse. But change was underway. Increasingly people found they could afford a car – by 1970 one in five people had one, and by 2000 every

second person had one. And as car travel developed, great effort was put into upgrading the road infrastructure. People could therefore get to centres in neighbouring municipalities or towns with increasing ease and efficiency. They were no longer isolated within their local communities.

Now, one major reason for travelling to nearby municipalities was precisely to buy alcohol. Within the jurisdiction of most local councils, the sale of alcohol was banned, but some had approved the sale of beer, and in some urban centres you could even get hold of wines and spirits. In terms of percentages, beer could be bought in a mere 18 per cent of Norwegian municipalities in 1950, and they were mostly in towns or relatively urbanised communities. Of this 18 per cent, only a sixth (3 per cent of the total) had allowed the sale of wine, while spirits were available in even fewer places still. As car ownership grew, people drove from the “dry” municipalities to the “wet” ones to fill up on alcohol. And since they were there already, they often purchased other items too. The “dry” municipalities started losing money, and merchants began to lobby local politicians to allow the sale of beer. This argument became even more urgent as shrinking trade led to job losses, which naturally affected council revenues from taxes. In an effort to address the situation, local councils voted increasingly to permit beer retailing. By 1970 beer was sold in 61 per cent of Norwegian municipalities, and the rise continued despite a slight downturn in the 1970s: by the end of the 1980s, the figure had reached 88 per cent of local councils who had approved beer retailing, and by 2000 this had risen to 99 per cent.

Originally, local councils were as reluctant to grant licences to restaurants, hotels

Table 1. Municipalities without alcohol outlets, and municipalities with licence for sale and serving of beer respectively 1950–2000

	Municipalities with licences				Municipalities without licenses		Number of municipalities
	to sell beer		to serve beer				
	N	%	n	%	n	%	n
1950	136	18	94	13	528	71	746
1955	177	24	224	30	472	63	746
1960	223	30	289	39	396	54	734
1965	211	45	252	54	183	39	466
1970	274	61	286	63	130	29	451
1975	255	58	302	68	113	26	443
1980	241	53	343	76	91	20	454
1985	312	69	383	84	43	9	454
1990	395	88	414	92	13	3	448
1995	414	95	423	97	2	0.5	435
2000	431	99	426	98	1	0.2	435

etc. (so-called ‘on-licenses’) as they were to retailers that sold alcohol for consumption off the premises (so-called ‘off-licenses’). A refusal to grant an on-licence meant that when people wanted an evening out at a restaurant, they crossed the border to a neighbouring municipality, which naturally affected the home businesses. But even more crucially, new hotels and restaurants were being opened in places where they could get a license to trade in alcohol. Both factors meant further job losses and diminishing revenues to the councils concerned. A further point was that if a council had already granted one or more off-licences for beer, the grounds for refusing a licence to restaurants etc. were severely eroded, and vice versa. As the number of licences to shop owners rose, so did the number of licences to hoteliers and restaurateurs. In 1950, 13 per cent of Norway’s local councils had granted on-licenses. By 2000, 98 per cent had done so.

Originally, the standard practice was to licence only the most reputable shop owners and restaurateurs. But as licenses were handed out in more liberal quantities, a refusal was felt to be tantamount to discrim-

ination. The demand for fair treatment meant that it became standard practice to approve licence applications, and refusals became the exception. The result was an ever increasing number of on- and off-licensed premises. From a modest 1 409 on-licensed businesses in 1955, the number grew – especially during the 1980s – to reach 6 355 by 2000, more than a fourfold increase. The fairness principle also meant that more were allowed not only to serve beer – or beer and wines – on the premises, but spirits too. Only 6 per cent of the cafes, restaurants and hotels were licensed to serve spirits in 1955, but by 2000 that figure had grown to 68 per cent. Due to the fact that a number of small, local shops had been forced to close due to the competition from the big supermarkets, the number of off-licensed shops has decreased since 1970. But more and more of the remaining shops have got a licence. While in 1980 only 58 per cent of all grocery stores and supermarkets in the country were licensed to retail beer, by the year 2000 the proportion had swelled to 98 per cent.

While local councils can control physical

accessibility through their licensing powers, it is central government that decides the size of the tax on alcohol, and hence price levels. And until relatively recently, the government-controlled part of alcohol policy – curbing access to alcohol by means of high taxes – remained unchallenged. But this pillar of Norwegian alcohol policy has also begun to show signs of decay. And it is again the increased mobility and the accompanying economic consequences that are causing the cracks to spread. This time, however, rather than local inter-municipal travel creating local economic problems, it is travel across country borders that is having an impact on state finances.

The high price of alcohol in the shops prompts consumers to seek out cheaper sources. It is not surprising that home distilling is a widespread and deeply entrenched cultural enterprise in Norway, as, to a lesser extent, is wine-making and beer brewing. But because this requires equipment and time – and distilling spirits also happens to be illegal – most people leave it alone. The increased mobility, however, creates more opportunities to bring alcohol back to Norway from other countries. The countries in question are primarily Sweden and Finland, both of which share borders with Norway and are within a couple of hours drive for a great many Norwegians. While prices in the three countries used to be pretty similar, Finland and Sweden's membership of the EU has resulted in a change in relative prices over the past few years, making it worthwhile to replenish stocks abroad. And because Norway remains outside the EU, the tax free trade is upheld. Ferry companies operating between Denmark and Norway finance their services mainly through the sale of alcohol

Table 2. Stores and monopoly shops licensed to sell alcohol and establishments licensed to serve alcohol and spirits in Norway 1951–2000

	Establishments licensed to			Of these: serve spirits	
	sell alcohol	serve alcohol n	index	N	%
1951	3495	..	..	..	..
1955	4136	1409	100	88	6
1960	4846	1785	127	191	11
1965	5694	1879	133	253	13
1970	6835	1997	141	320	16
1975	5450	2033	144	431	21
1980	4637	2439	173	592	24
1985	5005	3119	221	863	28
1990	4961	4591	326	1730	38
1995	4524	5315	377	3019	57
2000	4413	6355	451	4311	68

that takes place on board; the price of the actual ticket is symbolic. And in addition there is the alcohol bought in connection with foreign air travel. Estimates indicate that the quantity of spirits people imported in 2002 amounted to nearly half as much (43 per cent) as was sold (legally) in Norway. For wine it was nearly 20 per cent (Nordlund 2003). There has also been a sharp rise in the professional smuggling of spirits in later years. If we add smuggler spirits and the amount illegally distilled around the country, then about half of all the hard liquor drunk in Norway originates outside the legal market.

It goes without saying that moonshining and smuggling, and not least the cross-border trade where people often stock up not only on drinks but other commodities too, the cost to the government amounts to a considerable sum in lost taxes. The government has therefore felt compelled to cut prices, especially on wines and spirits, in an effort to prop up declining domestic sales. The first tax cut was introduced in 1999, halving the

tax on fortified wines. The second came in 2002, reducing tax on spirits by 20 per cent. Both taxes have been cut further since.

Government policy on alcohol has also been affected in other ways. Although local councils have sole authority on granting and revoking licenses, wines and spirits are re-tailed through the state monopoly, and it is the government that decides how many outlets the monopoly shall have in the country as a whole. Even though a local authority might want an outlet established locally, it is the government that has the final say. And until relatively recently, the government have been far from willing to grant the wishes of local authorities. However, rising private imports have put mounting pressure on government to make spirits and wines more physically available. So the number of outlets is rising, from 114 in 1997 to 176 in 2002, an increase of more than 50 per cent over a five year period, as against a 4 per cent increase in the previous five-year period.

These developments have gradually undermined much of the traditional *raison d'être* of Norway's alcohol policy. The point is now rather to avoid further losses accruing to local authorities and central government from diminishing alcohol tax revenues. The changes in licensing practices mean that virtually anyone who applies will be given a license to sell or serve alcohol. The meticulous sifting of the worthy from the unworthy is more or less a thing of the past, with the result that especially restaurant businesses now attract dubious

characters motivated mainly by a desire for a quick but substantial return, and not too bothered about the methods employed.

The increasing numbers of short-lived businesses that declare bankruptcy to evade paying taxes – along with other forms of economic criminality such as illegitimate work, accounts fraud and money laundering – have brought about further changes to the alcohol laws. In 1997 a regulation was passed stipulating that licenses could only be granted to owners and others implicated in the business concerned if they had a clean financial record, and that a license would become void if the licensee no longer met the requirements. If the business was sold or run into insolvency, again the licence would be revoked. The police, customs and tax authorities and other official bodies have been instructed to tighten up controls of businesses dealing in alcohol, and report irregularities to the licensing authorities. But the driving force behind these changes is not the old alcohol policy – the point of which was to limit the harm caused by drink by restricting access to it – the aim now is to fight economic crime in the restaurant trade. Norway's original policy aims have been overtaken by economic realities – a need to bring income to the local and central government, and to prevent the loss of income due to crime.

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The role of alcohol in the global and regional burden of disease

Introduction

How large a share of all preventable ill health in the world can be explained by excessive drinking? To what extent does the role of alcohol in ill health vary between different parts of the world? How does alcohol compare with other risk factors in an analysis of global and regional ill health? These are some of the questions addressed by an international group of experts in the WHO project *Global Burden of Disease 2000* (GBD 2000). It might, at first glance, seem a rather unlikely challenge they have taken on, yet upon closer inspection we find that the project has in fact gained meaningful insights into many aspects.

The analysis of alcohol as a global and regional risk factor is just one of a number of components in the GBD project where international groups of researchers have applied similar methods to study the role of alcohol and 25 other risk factors in the disease burden in different parts of the world. This has provided a unique opportunity to rank order and compare the health effects of various risk factors, both global and regional.

The dataset that has been collected on drinking habits and the risks involved from all over the world is truly impressive, as is the statistical analysis presented of these data. There is no doubt that the results will have a major impact in the field of alcohol research, not least in the effort to determine the influence of drinking habits on the occurrence of cardiovascular disease and accidents. In addition, the project has made a groundbreaking effort to determine the role of alcohol use in the occurrence of depression. The project's comparative

perspective adds greatly to its interest value; this applies most particularly to its regional comparisons of the impacts of alcohol on ill health and to the comparisons of alcohol with other risk factors. One would certainly hope to see the message reach the world's political decision-makers because it is clear from the results that in many regions there is every reason to give alcohol policy greater weight and priority.

The purpose of this article is to give an overview of the GBD project insofar as it deals with alcohol as a global and regional risk factor; to describe the methods and approaches applied by the project; to summarise its main results; and to briefly discuss the question of how the results could and should be put to use in the political arena.

For the most part I have relied on studies recently published in *European Addiction Research* and *Addiction* (Rehm et al. 2003a-c; Room et al. 2003), as well as a chapter in a WHO title covering many of the risk factors studied in the GBD project (Rehm et al. 2004). As for more general information on the project and on other risk factors, I have consulted articles published in *Lancet* (Ezzati et al. 2002; Ezzati et al. 2003). In addition, many of the project's more detailed analyses have been published in scientific journals; this applies for instance to its studies of alcohol and cardiovascular diseases (Gmel et al. 2003). Furthermore, the results from studies on alcohol and accidents as well as alcohol and depression will soon be coming out.

Methods and approaches

■ The definition and measurement of disease burden

Traditionally, the burden of a particular disease upon a given population is assessed by looking at the number of deaths from a specific diagnosis in relation to the total number of the population. One obvious problem with this approach is that it considers each death equally serious regardless of whether the person was 25 or 85 at death. Another weakness is that this approach disregards the disease burden that usually affects both the individual and society over a certain period of time before the person dies.

One of the measures that is used for these purposes is Disability Adjusted Life Years or DALYs. This includes an assessment of the number of life years lost to deaths occurring before optimal life expectancy, for instance 80 years among men and 82.5 years among women (these figures are for Japan). In other words, the number of lost life years for a female dying at age 40 in this case is 42.5 years.

This measurement of lost life years is then combined with an assessment of the disability implied by the disease concerned. Disability is defined in terms of how far the disease prevents or inhibits "normal" function. Different diseases obviously affect people's well-being in different ways and to different extents and give rise to different degrees of disability. Based on assessments made by experts, a relatively complex procedure has been used to calculate for each type of disease a disability weight which ranges from 0 (no influence) to 1 (death). In order to determine alcohol-related disability, then, it is neces-

sary first of all to have information on the number of people in the population who suffer from an alcohol-related disease or who have been involved in an alcohol-related accident and then apply the relevant disability weights.

WHO experts have calculated DALYs for a number of diseases in a total of 14 WHO regions, and alcohol researchers have then proceeded to estimate the proportion of these that can be attributed to alcohol.

Although DALYs, at a theoretical level, certainly capture the phenomenon of disease burden more accurately than traditional measures of mortality, there still remain some empirical question marks. On the basis of the literature available it is very difficult to assess the quality of the underlying regional data on disease prevalence and on the other hand the quality of the disability weights applied. It is therefore a strength of the WHO study that the burden of disease is explored both from the point of view of alcohol-related mortality and alcohol-related DALYs.

■ The choice of alcohol-related causes of death and diseases

The choice of diseases included in the assessment of alcohol's global disease burden obviously has important implications. The choice is based on the ninth revision of the international classification of causes of death and diseases (ICD-9): working from this basis, WHO experts have identified some 60 diagnoses of diseases and accidents for which there is consistent and sound scientific evidence of a causal link with alcohol. These diagnoses have been divided into three groups according to the impact of alcohol upon risk levels.

The first category consists of 13 diagnoses where alcohol by definition is the decisive risk factor, such as *alcohol* poisoning and *alcoholic* liver disease. The second category comprises chronic illnesses where research has established that long-term heavy alcohol consumption is a contributing cause, albeit to varying degrees. The inclusion of a chronic disease requires not only that a connection has been shown in numerous studies, but also that specific biological mechanisms are implicated. The third category consists of acute consequences, such as different kinds of accidents, suicide and violence. Generally the requirement for inclusion here is that the decisive risk factor is a single bout of heavy consumption and that chronic abuse is not necessarily a leading risk factor.

■ Counting the proportion of alcohol-related cases for different diagnoses

The next step is to try and establish how large a proportion of different kinds of diseases and accidents are attributable to alcohol both globally and in six WHO regions: Africa, Americas, East Mediterranean, Europe, South-East Asia and Western Pacific. These are in turn divided into 14 sub-regions on the basis of infant and adult mortality. Such classifications are obviously always open to criticism, but by and large it would seem they have a reasonably solid and sound foundation.

For the 13 diseases that are by definition alcohol-related, it is obviously superfluous to assess the proportion of alcohol-related cases; all of them are thought to be attributable to alcohol. For other chronic diseases and accidents an Alcohol Attrib-

utable Fraction (AAF) is calculated: this expresses the proportion of cases that are due to alcohol. An AAF of 0.5, for instance, implies that if there were no alcohol consumption at all, half of the current cases of disease/death should be eliminated.

■ Chronic diseases

The AAF for chronic somatic diseases is primarily dependent on the quantity of alcohol consumed. On this basis one would expect that the proportion of liver diseases caused by alcohol is lower in countries where 1 per cent of the population are heavy consumers as compared to countries where 15 per cent are heavy consumers. It follows that the proportion varies not only between different regions, but also between men and women and different age groups. In most chronic diseases, however, drinking patterns are thought to have a lesser impact on risk levels.

In order to calculate the AAF for a certain disease, we need to know how the risk of getting that disease varies at different consumption levels as compared to abstinence. Such assessments of relative risks have been made for most alcohol-related diseases in studies following up the mortality of cohorts after a baseline investigation of their drinking habits. Since it is only rarely that these studies have used alcohol-related morbidity as an outcome, the GBD project has generally relied on mortality-based AAFs even in the case of diseases that are included in the DALY measure.

AAF determinations have been carried out somewhat differently for different diseases. For the majority of chronic diseases, experts have reviewed the latest research estimating the risks of death at different

Table 1. Classification of daily alcohol consumption for men and women

Drinking levels	Men	Women
Non-drinkers	0	0
Consumption level 1	0<40 g*	0–20g
Consumption level 2	40<60g	20–40g
Consumption level 3	60g+	40g+

*One bottle of wine (75cl) is the equivalent of 70 grammes of alcohol
Source: *Rehm et al. (2003a)*

levels of consumption and then calculated the average relative risks in these studies (pooled meta-analyses). The results have then been compiled for non-drinkers and for three different consumption levels separately for women and men (see Table 1).

If the meta-analysis shows that the number of new cases of acute pancreatitis, for instance, is 2 per 10,000 men at consumption level 3 and 0.5 per 10,000 men who do not drink, this means that the relative risk for men at consumption level 3 is fourfold. In other words: men at this level of consumption have a four times greater risk of developing acute pancreatitis than men who do not drink. This kind of information about risks at different levels of consumption is then applied to data on gender and age distributions of alcohol consumption and abstinence in different countries.

So how does one know how many people in each country can be slotted into different consumption levels? This is based on official statistics on total alcohol consumption as well as estimates of unregistered consumption, which are then divided between different groups according to the results of various questionnaire surveys. Using the relative risks calculated for different levels of consumption, researchers can then determine the proportion of

pancreatitis cases that can be attributed to alcohol in different countries. In a country where a relatively large proportion of the male population are at consumption level 3, the AAF for acute pancreatitis will thus be higher than in a country where that proportion is lower.

■ Cardiovascular diseases and depression

There are two types of chronic disease for which different methods of AAF determination have been used, namely cardiovascular diseases and depression. Recent research has revealed a rather complex association between alcohol and cardiovascular diseases in that moderate and regular consumption appears to lower the risk of disease, whereas heavy drinking bouts seem to increase the risk. As most of the cohort studies available provide only limited documentation on the number of heavy drinking bouts, the research group drew the conclusion that cohort studies should not generally be used in determining the proportion of alcohol-related cases, especially in countries such as Russia where drinking patterns are dominated by heavy consumption and drinking to intoxication.

In order to establish the role and impact of different drinking patterns, the WHO group of alcohol researchers conducted a separate analysis of the associations between drinking and mortality from cardiovascular diseases in 74 selected countries, which were divided into four drinking pattern categories from 1 (favourable) to 4 (damaging). The measure includes the extent of bout drinking, the extent to which alcohol is consumed with meals and in restaurants or at pubs. These estimates have

been obtained partly through experts from the respective countries and partly through questionnaire studies insofar as these have been available.

Using a method combining multilevel analysis with time series analysis, the researchers discovered that an increase in average consumption in countries with the most favourable drinking patterns led to a reduced mortality, whereas mortality increased in countries with the most damaging drinking habits. No statistically significant association was seen for countries in the second or third drinking pattern categories.

For the majority of countries the measure of associations derived from this aggregate analysis was used to determine the AAF for cardiovascular disease – although the effect shown by the calculation was halved to allow for the possibility that the effect of alcohol depended in part on factors that were not controlled for in the analysis. However, in established market economies (Western Europe, North America and Australia) where most of the cohort studies had been done, and which generally were thought to have favourable drinking patterns, the same methods were used as for other chronic diseases, i.e. calculations based on relative risks derived from follow-up studies. One important difference, though, is that the relative risk for cardiovascular diseases was less than 1 for low consumption, i.e. it was assumed that alcohol has a protective effect.

As for depression, the results suggest that not only does alcohol dependence vary statistically with depression, but it is actually a cause of depression. In contrast to other chronic illnesses, however, there are no set risk levels for depression, and therefore researchers have had to rely on associ-

ations identified in questionnaire studies. It is not quite clear from the published material available exactly how these assessments have been made, but the general principle has been to use questionnaire studies from different countries to work out the association between the number of cases where alcohol dependence has preceded depression and their proportion of the total prevalence of alcohol depression in the population. These analyses have shown that the association is positive, i.e. the larger the proportion of people with an alcohol dependence, the larger the proportion of depressed people with an alcohol dependence that precedes the onset of depression. Using a mathematical formula, this association can then be translated into an AAF. The researchers are keen to stress they have been very conservative in their assessments, halving the figures obtained in order to allow for the possibility that other factors may come into play that they have not been able to control for.

■ Acute harm

AAF determinations for acute harm (accidents, violence) are based on the most recent meta-analyses; their results, in turn, come primarily from case-control studies as well as analyses of police statistics. One exception is alcohol-related violence, where the figures are derived from population-level studies. As drinking patterns play a decisive role in this type of harm, they were also included in the final determinations of regional AAFs. An analysis corresponding to that carried out for cardiovascular diseases confirmed what the researchers had expected: the more harmful the drinking pattern, the stronger the association with the risk of accidents at

given levels of change in total alcohol consumption. The effect was significantly stronger for men than for women.

Results

■ Global alcohol-related mortality

The WHO researchers' estimate is that alcohol "caused" 1.8 million deaths in the world in 2000, accounting for 3.2 per cent of all the people who died that year (Table 2). The proportion is around 10 times greater among men (6.2%) than among women (0.6%). Acute alcohol-related deaths through accidents are the single most common cause, accounting for almost half of global alcohol-related mortality; accidents are followed by alcohol-related cancer (20%) and cardiovascular diseases (15%). Other non-contagious diseases, primarily cirrhosis of the liver, account for 13 per cent, while 6 per cent of all "alcohol cases" were attributed to psychiatric disorders such as addiction syndrome, depression and psychoses.

It is worth noting that in their assessment of cardiovascular diseases, the researchers have cleaned the figures to allow for the deaths that they assume have been prevented by favourable drinking habits: the figure they propose is more than 300,000 cases. Alcohol was thus accountable for almost 600,000 cardiovascular deaths, which is more than the figure for accidents.

■ Global alcohol-related disease burden

If the number of person-years lost to death as well as disability caused by alcohol are included in the figures, the contribution of alcohol to the global burden of disease increases from 3.2 to 4 per cent (see Table 3). The increase is particularly noticeable among women, where the proportion is

Table 2. Global mortality burden (thousands of deaths) attributable to alcohol by major disease and accident categories in 2000

Diseases and accidents	Women	Men	Total	Per cent of alcohol-related mortality burden (%)
Foetal damage	1	2	3	0
Cancer	86	269	355	20
Neuropsychiatric disorders (e.g. depression, alcohol dependence)	19	91	111	6
Cardiovascular diseases	-124	392	268	15
Other non-contagious diseases (e.g. cirrhosis of the liver)	49	193	242	13
Unintentional accidents (e.g. traffic accidents, poisonings)	92	484	577	32
Intentional accidents (e.g. suicide, murder)	42	206	248	14
Alcohol-related mortality (all)	166	1,638	1,804	100
All deaths	26,629	29,232	55,861	
% of all death cases	0.6	5.6	3.2	

Source: Rehm et al. (2003b)

more than doubled from 0.6 per cent to 1.3 per cent, while the figure for men shows a more moderate increase from 5.6 per cent to 6.5 per cent. The biggest difference between mortality and morbidity was found for neuropsychiatric diagnoses (e.g. depression and alcohol dependence), which rarely occur as direct causes of death but which often are quite common in the population and which often have a significant adverse effect on quality of life. Neuropsychiatric disorders account for as much as 38 per cent of the alcohol-related burden of diseases as compared with just 6 per cent of alcohol-related deaths, and they generate the same kind of burden of diseases as alcohol-related accidents.

■ Regional differences

There are marked geographical differences in the contribution of alcohol to mortality and the disease burden (see Table 4). The greatest negative impact on both morbidity and mortality can be seen in Europe C

(e.g. Russia and the Baltic countries), where almost one in five deaths among men are alcohol-related. Other regions with major problems are Europe B (e.g. Poland), Americas B (e.g. Mexico) and Americas D (e.g. Bolivia). Not surprisingly, the adverse health effects of alcohol are least pronounced in East Mediterranean Muslim countries, where the proportion of female alcohol-related mortality and morbidity is as low as 0.1 per cent.

For women in Europe A, Americas A and Western Pacific A, it was found that alcohol saves more lives than it causes deaths, whereas for men alcohol did not lower mortality in any region. When morbidity is also taken into account, there is no region where alcohol reduces the burden of disease either for men or for women, even when the protective effect of alcohol is taken into consideration. This implies that the adverse effects of alcohol on mortality and morbidity clearly outweigh its beneficial health effects all over the world.

Table 3. Global burden of disease (DALYs in thousands) attributable to alcohol by major disease and accident categories in 2000

Diseases and accidents	Women	Men	Total	Per cent of alcohol-related mortality burden (%)
Foetal damage	55	68	123	0
Cancer	1,021	3,180	4,201	7
Neuropsychiatric disorders (e.g. depression, alcohol dependence)	3,814	18,090	21,904	38
Cardiovascular diseases	-428	4,411	3,983	7
Other non-contagious diseases (e.g. cirrhosis of the liver)	860	3,695	4,555	8
Unintentional accidents (e.g. traffic accidents, poisonings)	2,487	1,4008	1,6495	28
Intentional accidents (e.g. suicide, murder)	1,117	5,945	7,062	12
Total alcohol-related burden of disease (DALYs)	8,926	49,397	58,323	100
All DALYs	693,911	761,562	145,5473	
% of all death cases	1.3	6.5	4.0	

Source: Rehm et al. (2003b)

Table 4. Alcohol-related mortality and disease burden (per cent of total) for men and women in different WHO regions in 2000

WHO region ¹	Per cent of total mortality		Per cent of total morbidity	
	Men	Women	Men	Women
Africa D	2.4	0.7	2.0	0.6
Africa E	4.0	1.0	3.5	0.8
Americas A	2.0	-1.6	11.9	3.2
Americas B	14.2	3.5	17.3	4.1
Americas D	7.6	2.5	8.6	2.2
East Mediterranean B	1.5	0.3	1.3	0.2
East Mediterranean D	0.5	0.1	0.6	0.1
Europe A	3.2	-4.1	11.1	1.6
Europe B	9.7	2.7	10.2	2.5
Europe C	18.0	5.1	21.5	6.5
Southeast Asia B	4.1	0.9	5.3	1.0
Southeast Asia D	2.3	0.4	2.8	0.4
Western Pacific A	3.7	-5.4	8.1	0.6
Western Pacific B	8.5	1.3	9.1	1.8
World	5.6	0.6	6.5	1.3

¹ Letters represent different mortality levels: A= low adult and infant mortalityE= very high adult and infant mortality.

Source: Babor et al. (2003), Rehm et al. (2003b)

Table 5. Burden of disease attributable to 12 selected leading risk factors by level of development (% of total DALYs)

High mortality ¹	%	Developing countries Low mortality ²	%	Developed countries ³	%
Underweight	14.9	Alcohol	6.2	Tobacco	12.2
Unsafe sex	10.2	High blood pressure	5.0	High blood pressure	10.9
Water and sanitary conditions	5.5	Tobacco	4.0	Alcohol	9.2
Indoor smoke from solid fuels	3.6	Underweight	3.1	High cholesterol	7.6
Zinc deficiency	3.2	High BMI	2.7	High BMI	7.4
Iron deficiency	3.1	High cholesterol	2.1	Low fruit and veg intake	3.9
Vitamin A deficiency	3.0	Low fruit and vegetable intake	1.9	Physical inactivity	3.3
High blood pressure	2.5	Indoor smoke from solid fuels	1.9	Drugs	1.8
Tobacco	2.0	Iron deficiency	1.8	Unsafe sex	0.8
High cholesterol	1.9	Water and sanitary conditions	1.8	Iron deficiency	0.7
Alcohol	1.6	Unsafe sex	1.4	Lead poisoning	0.6
Low fruit and vegetable intake	1.3	Lead poisoning	1.4	Sexual abuse of children	0.6

1.= E.g. Bolivia, Egypt, India, Nigeria

2.= E.g. China, Iran, Indonesia, Mexico

3.= E.g. Japan, Russia, USA

Source: WHO (2002)

■ The global burden of disease and its causes in a comparative perspective

Among the 26 risk factors included in the study, alcohol ranked fifth, accounting for four per cent of the global burden of disease (WHO 2002). This is almost as much as the figure for smoking (4.1%) and high blood pressure (4.4%), but less than those for malnourishment (9.5%) and unsafe sex (6.3%). On the other hand, alcohol has a much greater detrimental effect on world health than such factors as high BMI, physical inactivity and high cholesterol levels.

Alcohol's role as a major risk factor in different parts of the world is clearly demonstrated in Table 5, which rank orders 12 selected leading risk factors in three regions with different mortality profiles and patterns of economic development. Alcohol has the most adverse effects on public

health in developing countries with low mortality, whereas it is a less significant factor in the poorest parts of the world such as Africa, where total mortality is high. By contrast the burden of disease caused by alcohol is high in industrial countries, including Eastern Europe, where 9.2 per cent of the disease burden is thought to be attributable to alcohol. This means that alcohol is the third most damaging public health factor in these regions – only tobacco and high blood pressure are higher up on the list of leading risk factors.

Discussion

There is, of course, a wide understanding in large parts of the world today that alcohol consumption increases the risk of many health-related problems. On the other hand the thesis regarding the positive

health effects of alcohol has also been gaining significant ground, which may well work against the view of alcohol as a source of ill health. It is therefore important that in its estimates of the burden of disease, the GBD project has also allowed for the positive health effects of low and moderate alcohol consumption. One of the project's greatest merits is that it has managed to establish that in virtually all societies around the world, alcohol continues to cause much more ill health than it contributes to preventing ill health.

The prominent role that alcohol appears to play in the global and regional burden of disease as compared with other risk factors, lends strong support to the view that drinking is a serious social problem indeed. As alcohol represents the third most serious risk factor of ill health in the Western world, that certainly should give cause to some sober debate and deliberation on the EU's currently very passive stance on alcohol policy, for instance. With the ongoing process of EU enlargement, the already extensive burden of disease looks set to expand even further within this region.

In other parts of the world, these results can be taken to shed useful light on an area that hitherto has remained largely unexplored. Hopefully they will also encourage political decision-makers to take steps aimed at reducing the detrimental effects of alcohol. In certain developing countries, especially those with low infant and adult mortality, alcohol emerged as the risk factor with the most damaging effects on public health. It is worth noting in this context that acute harm constitutes such a major disease burden all over the world, and not least in developing countries, that there should be good prospects for a rapid improvement in the current situation. It is of course rather too early to say anything definite about the impacts that the results will have on the political arena, but it is quite clear that this is an issue that deserves to be closely monitored over the next few years.

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Conflicting interests

Commercial interests are gaining a stronger foothold in the international alcohol policy field. This is one of the reasons behind the recent erosion of the restrictive Nordic alcohol policy. This issue of *Nordic Studies on Alcohol and Drugs* contains four articles analyzing and discussing, how the conflicting interests between the public health position and the industry are expressed today.

One problematic aspect of the present situation is the imbalance of power between private interests and public concerns. Today, two of the strongest supranational institutions, the EU and WTO, clearly favour commercial interests and trade priorities over concerns for public health and well-being. The decision making rules in these institutions aim at liberalizing trade and protecting private investors from unfavourable changes in the economic environment. Ellen Gould presents the present position of the alcohol question in the General Agreement on Trade in Services (GATS), negotiated within the WTO. Changes of commitments in this agreement require consent of all WTO members. This means that a decision in one country to give up a restrictive alcohol policy measure will be almost impossible to reverse, even if it is vital for the well-being of the population in that country.

New negotiations within GATS aim at further restricting national regulations within the service field "to ensure they impose the least possible burden on commercial interests." This is supported by the European Community representatives. Gould warns that advertising restrictions and the alcohol monopoly systems operating in some countries may be threatened by these principles. The emerging process emas-

culates national decisions which might serve as public health counterweights to commercial interests. However complicated they may seem, we need to understand these mechanisms in order preserve effective public health structures – and if we want to change the framework of international alcohol policy co-operation.

Can the alcohol field learn something from the tobacco people? As Harry Lando states in his article, in 2003 the WHO enacted the Framework Convention on Tobacco Control. This unique treaty presents a number of effective measures, such as advertising restrictions, price and tax measures, and surveillance, to combat the use of tobacco. The measures are largely based on research evidence. Even if Lando depicts a situation with an outrageous imbalance between the economic resources spent by the tobacco industry to promote cigarette smoking and the money spent on research and advocacy for tobacco control, his optimism is encouraging. Systematic mapping of and networking between tobacco researchers and tobacco control advocates, efficient use of modern technology to disseminate new scientific knowledge, international co-operation and special support to researchers and advocates in less resourced countries have produced results. It is our belief that these models could be developed more systematically within the alcohol area as well. The European alcohol policy meeting in Warsaw in June 2004, “Bridging the Gap”, was one step in this direction.

The general public and the policy-makers are finding it increasingly difficult to discern who is who in the alcohol policy arena. The blurred boundaries between different actors and a lack of openness

about financial and institutional ties makes it difficult to form effective public health policy alliances. The industry is today for instance funding social aspects organisation in 13 European countries. These organisations aim to “promote sensible drinking, to help reducing alcohol misuse, to foster a balanced understanding of alcohol issues” (quoted from the Amsterdam Group’s brochure “The Social Aspects organisations throughout Europe”) – messages that are quite close to the public health NGOs. NGOs and the State in many countries are also involved in co-operate efforts with the private sector, without a clear division of labour.

Anders Ulstein who works for Actis, a Norwegian Policy Network on Alcohol and Drugs (a “child” of the Norwegian temperance movement) sets out to discuss general principles that would clarify whose interests actually lay behind different organisations and what should be the rules of conduct for the public health NGOs in their communication with the industry. The first principle, Ulstein suggests, should be to acknowledge that “the alcohol industry is a stakeholder, not a public health partner”. Openness about industry funding and sponsorship of NGOs is thus a reasonable demand. Public access to and government or international organisation involvement in policy discussions between the industry and NGOs is another. Transparency is essential for an informed debate to take place.

Today, defenders of the common good and the public health will also have to learn the difficult art of critical analysis. There is a growing stream of policy-relevant information that includes reports on public welfare issues published by institu-

tions with private economic interests. Thomas Babor and Ziming Xuan evaluate two international surveys on alcohol policy, one by the social aspect organisation ICAP, the other by WHO. They demonstrate that the findings and conclusions of these two surveys differ substantially from each other. The report of the industry-related organisation gives lower estimates of numerous alcohol policy measures in the world. Further, the ICAP report contains biased interpretations of the results of its survey, supporting the prevalent priorities of the industry, such as there emphasis on education as a policy measure. The conclu-

sion of this analysis is that if reports such as these are presented for policy guidance as empirical research contributions, then quality assurance measures, such as scientific peer review, should be required by the informed public.

We hope that these examples of conflicting interests have showed not only that the policy analysis situation is capable of being monitored and understood, but also that there are measures that could and should be taken to defend the public health interests in a world increasingly being driven by private commercial priorities.

ELLEN GOULD

Negotiating under the influence

The WTO and corporate interests

Introduction

In an era when increasing exports has become virtually synonymous with advancing the public good, governments have given corporations pride of place in determining their bargaining position at the WTO. Corporations are now able to win at the international level many of the policy debates they have lost in the domestic arena. WTO experts repeatedly emphasize that the organization is reaching into areas never before conceived of as trade-related. The notion of what constitutes an unacceptable trade barrier is being stretched to cover much more than tariffs and now encroaches on domestic regulatory authority.

As part of the current efforts to expand the WTO, corporate lobbyists are pressing to have new WTO rules that would require regulators treat service suppliers in a “less onerous way” (White & Case Law Firm 2002). The “disciplining” of domestic regulation is only one of the potential means by which alcohol policy could be weakened. However, as the WTO’s mandate is extended far beyond anything ever dealt with by a trade body, the overriding influence of corporations on the organization appears increasingly illegitimate.

The alcohol lobby – there from the start

The WTO from its very beginning has had a significant impact on alcohol policies. In 1995, the first year of the WTO’s existence, the European Communities launched what would become a string of disputes to get taxes in other countries lowered for European alcohol exports. When WTO panels ruled these taxes violated trade agreements, the Scotch Whisky in-

dustry celebrated, pointing out they were “the only industry to have achieved a hat trick of successful WTO cases” (The Scotch Whisky Association 2001).

While the alcohol industry saw the rulings as proof that the WTO worked, the countries that lost these cases voiced a different perspective. After its WTO loss, Chile cut taxes on whisky imports from 70 to 27 per cent. Chile argued that if developing countries had known WTO rules would mean they could not maintain high taxes on luxury imports, they might never have joined the organization. Chile also pointed out that the EC analysis of how alcohol should be priced “seems to have been drawn more from the Scotch Whisky Association’s crusade to equalize alcohol taxes in the EC Member States than from a correct analysis of Article III:2 [of the GATT]” (WTO 1999).

The October 2003 edition of the UK government’s trade periodical, “Overseas Trade”, underlines the close relationship between the alcohol lobby and those who develop trade policy:

“Government support is critical in the battle against trade barriers. The Scotch Whisky Association works closely with the UK Government at all levels and greatly values regular dialogue on developments and strategy”.

The WTO victories for the alcohol industry to date have been based on a principle common to most trade agreements - by not discriminating in their treatment of domestic and foreign products, governments can lower prices and increase the availability of goods for consumers. This is a questionable goal when applied to alcohol products, but it is at least recognizable as trade-related. The current services negoti-

ations are focussed on restricting government authority in areas only tangentially related to trade, such as policies related to government monopolies and regulation.

The new frontier – liberalizing services

The multilateral trade negotiations that stand to have the most impact on domestic alcohol policy are the ones directed to expanding the WTO services agreement – the General Agreement on Trade in Services (GATS). These talks are multi-faceted and involve WTO negotiators in a number of negotiating subgroups. While trade officials deny that the negotiations threaten domestic regulatory authority, one GATS subgroup is working on exactly that, and is entitled unambiguously “The Working Party on Domestic Regulation”.

The direct involvement of industry representatives in formulating the GATS negotiating positions of WTO Members is commonplace. A WTO director publicly credited “the enormous pressure” generated by the dominant US services corporations for the very fact that the GATS even exists (Hartridge 1997). These corporations formed the US Coalition of Service Industries back in 1982 to get services placed on the international trade agenda. In 1998, the former EC Trade Commissioner initiated the creation of a corporate lobby group – the European Services Forum – to parallel the US Services Coalition. Robert Madelin, a director of DG Trade, wrote the head of the ESF in a December 17, 1999 letter to say that the Commission “would like to encourage all European services industries to continue cooperating actively with us to develop the solid and detailed

common negotiating position that we wish to present in Geneva at the appropriate time next year". Madelin had previously told industry executives that the Commission would consider the ESF's input in the GATS negotiations on a par with that of the EU's member states: "We are going to rely on it [the ESF] just as heavily as on member state direct advice in trying to formulate our objectives" (Wesselius 2002).

The retail lobby and the GATS negotiations

EuroCommerce and other major retail associations are members of the ESF. The advantage for the retail industry in becoming involved in the GATS negotiations is that it can make gains on two critical fronts at the same time:

- Externally, by getting their governments to make a GATS bargaining "request" of other countries that they liberalize their distribution policies.
- Internally, by getting their governments to make a GATS bargaining "offer" that would either lock in or advance domestic liberalization.

Internally, in terms of achieving change within the context of the European Union, EuroCommerce is lobbying the EC to change its GATS offer on distribution services to liberalize European alcohol policies. EuroCommerce, which represents the retail and wholesale sector in Europe, is recommending among other things that the remaining EC limitations on alcohol distribution "be abolished" (Kamphöner 2003). If implemented, this recommendation would mean Sweden, Finland, Ireland and Austria would have to completely open up the retailing of alcohol to competition and foreign investment. No govern-

ment retail monopolies could be maintained. And all EU members would have to allow unrestricted cross-border sales, such as through the Internet.

Achieving permanent deregulation through the GATS

Government alcohol control policies are constantly criticized by industry groups who advocate self-policing and consumer education as alternatives to government regulation and monopolies over alcohol distribution. These groups are often successful in rolling back alcohol control measures. The particular significance of getting alcohol liberalization through the GATS, though, is that this is supposed to be a one-way street. Because commitments once made cannot be changed without the consent of all WTO members, a domestic decision such as privatizing a government monopoly becomes virtually irreversible if it is entrenched as a GATS commitment. For example, in its 1994 GATS commitments, Norway reserved the right to maintain alcohol monopolies at both the wholesale and retail levels. But in its June 2003 offer, Norway only maintains its retail exception, making permanent the liberalization that has taken place in the wholesale sector.

The intent of locking liberalization decisions through the GATS is supposed to be to attract private investors. As the WTO guide to the GATS explains: "By guaranteeing that investment and trading conditions will not be changed against their interests, a commitment in the GATS provides the security which investors need". However, guarantees that liberalization policies will never be changed effectively removes are-

as of policy permanently from the realm of democratic decision-making.

The EC's GATS negotiating position on alcohol

In terms of advancing the external interests of industry, the European Commission is making very aggressive negotiating requests that other countries liberalize alcohol and tobacco distribution. These requests were supposed to be kept secret and were not circulated by DG Trade to other directorates within the Commission. They ask that countries make unlimited commitments in the distribution sector if the sector has not yet been committed, with exclusions only for arms and ammunition.

For countries that have already partially committed distribution services, the EC is specifically asking for alcohol and tobacco to be covered. For example, the leaked document "GATS 2000 REQUEST FROM THE EC AND ITS MEMBER STATES (HEREINAFTER EC) TO CANADA" notes that Canada has not committed to liberalizing the distribution of "liquor, wine and beer". The EC request is that Canada "Take full commitments, i.e. schedule 'none' [no limitations]".¹ If Canada agrees to the EC request, Canadian regulations limiting alcohol sales would be vulnerable to a WTO challenge. As well, several provinces would have to eliminate their alcohol retail monopolies. As DG Trade officials have pointed out, the maintenance of monopolies is fundamentally in conflict with GATS market access commitments.

DG Trade prepared its GATS negotiating position in a series of back and forth exchanges with industry groups in 1999 and 2000. Various drafts of the EC distribution request were circulated on a confidential

basis to industry advisers. The second draft, sent to industry for comment in September 2000, stated that the EC should get the limitations for exempt products narrowed so that only arms, ammunition, and explosives would be excluded. The distribution services paper the EC submitted to the WTO in December 2000 says that the EC does not believe there is "any justification for restrictions" in GATS commitments on the distribution of products such as beverages and tobacco. Opposition to "restrictions on the distribution of some goods" was reiterated by representatives from Ahold, Carrefour, EuroCommerce, the European Retail Round Table and other industry representatives at a meeting hosted by DG Trade on 10 December 2001.

While the EC negotiating requests do not have to match what it is willing to offer, the EC undercuts the basis for maintaining its own alcohol-related limitations when it presses other countries to eliminate them. This is especially true when the EC argues in a WTO position paper that there is no justification for alcohol and tobacco exceptions to liberalization of distribution services. Global health considerations, as well as the cultural inappropriateness of asking countries such as Pakistan not to treat alcohol as a sensitive product, make the EC bargaining position seem ill-considered.

GATS disputes – a record of losses for governmental regulatory authority

In his June 2003 presentation to the European Commission's Working Group on Alcohol and Health, Nicholas Bernier of DG Trade said that "the EU would continue making a significant effort to promote

trade liberalisation of distribution services". Bernier stated that he saw no incompatibility between this effort and regulation of alcohol in the public interest because: "The GATS has effective mechanisms to promote trade liberalization and respect domestic regulation".

It is hard to know what Bernier was referring to in terms of the mechanisms in the GATS that he believes respect domestic regulation. Whatever mechanisms there might be, the record of GATS disputes to date would indicate they do not seem very effective.

The definition of government measures that can be found in violation of the GATS includes: "a law, regulation, rule, procedure, decision, administrative action, or any other form" (GATS Article XXVIII, "Definitions"). The European Communities lost a WTO case on the basis that its regulations over the importation, sale and distribution of bananas were found to be a violation of the GATS, as these regulations favoured imports from former colonies (WTO 1997)

The US has recently lost a GATS challenge to its regulations that prohibit gambling on the Internet. In the GATS case that Mexico lost over its telecommunications regulations, the panel explained that while the GATS may allow governments to retain regulatory autonomy, this does not mean they can regulate in a way that violates their GATS commitments: "International commitments made under the GATS 'for the purpose of preventing suppliers ... from engaging in or continuing anti-competitive practices' are, however, designed to limit the regulatory powers of WTO Members" (WTO 2004a).

The GATS does have exceptions that

governments can use to try to defend their regulations. But in the dozens of cases where governments have invoked similar clauses in other WTO agreements, they have failed in all but one instance to prove to the satisfaction of a panel that their regulation met the difficult criteria required to qualify for the exception.

The extreme difficulty in being able to use these exception clauses was recently highlighted in the US gambling case. U.S. Trade Representative Robert Zoellick, expressing concern over the implications of the decision, criticized the panel for not allowing the US to defend its Internet gambling ban on the basis of the GATS exception for laws that protect public morals. Zoellick stated: "If this isn't an exception that that should meet, I don't know what is" (Reuters 2004). Therefore, the odds would not seem good for this exception to save restrictions on alcohol distribution based on cultural traditions, such as the ones that underpin alcohol policy in Nordic countries.

The Asbestos case is often cited as proof that WTO panels will allow regulations to be defended on the basis of health objectives. In this case, Canada challenged a French ban on the use of asbestos. It is important to note that this is the only successful example of the use of a WTO exceptions clause, and involved circumstances when the defending state could argue it was regulating to prevent catastrophic rates of death. But a critical aspect of what the WTO Appellate Body said in ruling on the case was that a regulation that violates trade commitments and severely restricts trade is justifiable *if* the "value pursued is both vital and important in the highest degree" (WTO 2001). Having WTO dispute

lawyers act as the ultimate arbiters of the importance a country's regulatory values would seem to be a serious infringement on governmental regulatory authority.

Proposed GATS restrictions on domestic regulations

The most significant impact the GATS could have on alcohol regulation could result from the new GATS restrictions on domestic regulation that are being negotiated. The EC and Japan are the principle advocates of these new GATS restrictions, which would require that all licensing requirements, qualifications, and standards be "no more burdensome than necessary to ensure the quality of the service". This has nothing to do with the traditional bans in trade agreements on discriminatory treatment. The proposed GATS restrictions on domestic regulation would require WTO member states to revise their regulations on services to ensure they imposed the least possible burden on commercial interests, even when these regulations in no way discriminate against foreign companies.

In a March 2004 presentation for a conference on the GATS and domestic regulation, World Bank analyst Aaditya Mattoo explained the significance of the proposed new GATS provisions in light of existing obligations:

"National treatment (Article XVII) is a powerful discipline. It captures all forms of discrimination. Any measure that modi-

fies conditions of competition to the detriment of foreign services and service suppliers would be considered inconsistent with national treatment, regardless of whether it extends formally different or formally identical treatment".

An example of what could already be challenged as a GATS national treatment violation are restrictions on advertising. Even if both domestic and foreign companies were subjected to the same restrictions, the impact of the restrictions could be found to have a discriminatory impact on foreign companies because they need advertising to break into the market. This would be considered an example of a de facto national treatment violation. It is these far reaching implications of existing GATS rules that Mattoo says should be considered before negotiators proceed to write even more rules about how governments can regulate.

With the new grounds to challenge domestic regulation that the EC is seeking to insert into the GATS, restrictive licensing of liquor outlets or stringent alcohol advertising standards could be challenged as "more burdensome than necessary". The new GATS rules the EC is proposing could hand the alcohol industry a permanent victory in their age-old battles against government regulation.

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NOTE

- 1 The leaked EC requests are available at <http://www.polarisinstitute.org/gats/main.html>

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Strategies to reduce the global burden of tobacco

I have been a smoking researcher for over 30 years. The vast majority of my work has been devoted to developing more effective cessation interventions and working to disseminate those interventions. I am trained as a psychologist and I spent the first 16 years of my career in a psychology department. In 1988 I was recruited to the School of Public Health at the University of Minnesota. My interests had been moving in the direction of public health for some years, and this change in academic departments helped to reinforce this shift. Upon moving to public health, I quickly encountered the concept of “disease vector” and became familiar with the classic example of the Broadstreet pump in London in the 19th century as the cause of a cholera epidemic (Benenson 2003, 367–373). I learned that the tobacco industry is a key disease vector for smoking and is, indeed, the Broadstreet pump of the 20th and 21st centuries. Late in my career, I have come to dedicate myself to collaborative efforts to reduce the global burden of tobacco.

A global emergency

The death toll caused by tobacco is almost unimaginably large and this may be a key part of our problem in communicating this message – the numbers are so large as to become virtually incomprehensible. Current figures indicate that tobacco kills almost five million people worldwide annually. Half of these people live in developing countries. If present

The opinions expressed in this commentary are my own and do not reflect the positions of the Society for Research on Nicotine and Tobacco or any other organization.

trends continue, the annual death toll will reach ten million by 2030. Seventy percent of these deaths will be in poor and middle-income countries (MacKay & Erikssen 2002; Peto & Lopez 2001; World Health Organization). This is clearly a global emergency and one that requires a coordinated international response.

I have learned that piecemeal and isolated approaches to the problem have, at best, limited impact. Thus, although tobacco cessation holds the most immediate promise for reducing the death toll (Peto et al. 1996), cessation approaches by themselves are not the answer. Neither is prevention, which would take far longer to affect the death toll. Furthermore, prevention is extraordinarily difficult in contexts where smoking is normative among adults and there are pervasive pro-tobacco messages. Needed are comprehensive approaches that combine what we know about prevention, cessation, and public health policy.

The framework convention on tobacco control

The recently enacted Framework Convention on Tobacco Control (FCTC) offers a useful starting point (Framework Convention Alliance 2003). This is the first ever attempt of the World Health Organization to use its treaty authority. The FCTC is a reality because of the irrefutable case against smoking. The FCTC addresses a broad spectrum of measures that, in combination, could reduce the prevalence of smoking and other tobacco use. Key provisions include restrictions on advertising and promotion, labeling and prominent health warnings, price and tax measures, public education and awareness initia-

tives, and research and surveillance.

Research played an important role in the adoption of the FCTC, although the final document reflected a mixture of science and politics (Warner Manuscript under review). Both science and politics are now necessary to support implementation of the FCTC and to reduce the global death toll. Research that is country specific is critically important. Relevant topics include epidemiology, potential local impact of policy changes, health effects of environmental tobacco smoke (these may be different in countries with different sources of exposure, such as in China where the impact of other environmental pollutants appears to be substantial), local effects of taxation, effective means of risk communication, and developing and delivering effective low-cost treatment.

Tobacco control versus the multinational tobacco industry: David versus Goliath?

One of the most discouraging aspects of the current situation is the dramatic imbalance of resources between the multinational tobacco industry and those available to advocates of global tobacco reduction. In 2001, in the United States alone, the tobacco industry spent \$11.2 billion on advertising and promotion (Federal Trade Commission 2003). At approximately the same time, an initiative of the Fogarty International Center of the US National Institutes of Health funded 14 grants to support partnerships between primarily US tobacco scientists and researchers in developing countries (Fogarty International Center 2002). This initiative, by far the largest research program targeted at tobacco in de-

veloping countries, is budgeted at approximately \$3.8 million US per year. Simple arithmetic calculations indicate that the entire annual budget of the Fogarty tobacco initiative could support tobacco industry advertising and promotion in the US alone for approximately three hours!

Additional challenges facing tobacco control advocates are the tactics and influence of the multinational tobacco companies. These companies have been able to buy influence in much of the world. Tobacco industry documents reveal consistent patterns of deception (Glantz et al. 1996; Muggli & Hurt & Blanke 2003). Thus, for example, the industry has paid scientists to argue against the importance of environmental tobacco smoke (Muggli & Hurt & Blanke 2003). It has lobbied effectively against legislation that could protect the public, including clean indoor legislation, restrictions on advertising and promotion, and increases in excise taxes (Glantz et al. 1996; Glantz & Balbach 2000; Muggli et al. 2001).

A far more effective coalition of tobacco control stakeholders is needed against this highly motivated and exceedingly well-funded adversary, including researchers, practitioners, advocates, representatives of NGOs, and governmental organizations. We have made some progress, but much more needs to be done. All too often, researchers and advocates fail to see our common interests. Research has made a critical difference, not only in the anticipated adoption of the FCTC, but also in widespread awareness of health harms and reductions in both prevalence and exposure in a number of countries, primarily in the developed world.

Advocates have had considerable im-

pact in raising public awareness about the harm of tobacco and the tactics of the industry. Advocates and researchers can and should play mutually beneficial roles and be resources for each other. Advocates can effectively use research findings to advance the case for effective tobacco control policies. Researchers can greatly benefit from the ability of advocates to lobby for additional funding and increased priority for tobacco control initiatives, including research.

Organizations that address global tobacco control

Although more resources are desperately needed, much can be accomplished with existing resources and networks. My colleagues and I have drafted a paper that describes the current landscape in global tobacco control research (Lando et al. Manuscript under review). We see electronic methods of communication as holding great promise for facilitating linkages and exchange of information, even in poor countries. GLOBALink has done an outstanding job of linking researchers and advocates internationally and of disseminating information on tobacco control (<http://www.globalink.org>). With a membership of 4000+ tobacco control advocates, GLOBALink is a recognized catalyst for dialogue and collective action.

The Global Tobacco Research Network (GTRN) at the Johns Hopkins University Bloomberg School of Public Health is another outstanding resource. GTRN is intended to facilitate coordinated global efforts for tobacco control across a wide range of scientific and technical disciplines, and to help overcome barriers, including a lack of research and data-gather-

ing infrastructure in many countries. GTRN will rely heavily upon web-based resources and communication (Stillman et al. Manuscript under review).

Lando et al. (Manuscript under review) also describe other organizations with interests in global tobacco control research. A number of these organizations emphasize specific regions. The World Health Organization continues to play a major role both through the Framework Convention and its Tobacco Free Initiative at its headquarters and at regional offices (World Health Organization). Foundations and other organizations such as the Open Society Institute, the Swedish International Development Cooperation Agency, and the Department of International Development have supported tobacco control research initiatives. The International Tobacco Evidence Network (ITEN) has been effective in linking economists, epidemiologists, social and other tobacco control experts to provide relevant research on tobacco control issues at the country, regional, and broader international levels. The World Bank has supported tobacco control research in low- and middle-income countries. Emphasis has been on the economic impact of tobacco. Research on International Tobacco Control (RITC) has taken the lead in developing tobacco control research strategies and global partnerships. RITC has played a central role in bringing together potential funders of global tobacco control research. RITC and its partners view tobacco as a threat to equitable and sustainable development in low- and middle-income countries.

Additional organizations, including the US National Institutes of Health (through the Fogarty International Center and sever-

al institutes), the Office on Smoking and Health in the US Centers for Disease Control, and the American Cancer Society have had substantial involvement in supporting tobacco control research and other initiatives, including training of researchers and advocates, and data collection, including surveillance. The Campaign for Tobacco-Free Kids supports global initiatives and has effectively linked researchers and advocates (<http://www.tobaccofreekids.org>). The Society for Research on Nicotine and Tobacco has increased its emphasis on global tobacco research, including initiatives to increase its global membership and reach (<http://www.srnt.org>).

RITC has convened meetings of stakeholder organizations. GTRN will serve a valuable networking function. Last spring, the Society for Research on Nicotine and Tobacco worked closely with the Campaign for Tobacco-Free Kids to draft and solicit support for a concept statement to the Bill and Melinda Gates Foundation identifying tobacco control research as a grand challenge in medical research for developing countries. Although we were not successful in convincing the Gates Foundation to support this initiative, more than 40 organizations in 26 countries signed on to the concept statement. In addition to Tobacco-Free Kids, GLOBALink played a significant role in circulating the statement and gathering endorsements. This type of collaborative effort could be replicated in other contexts.

Potential role of the society for research on nicotine and tobacco (SRNT)

I have worked for the past several years within SRNT to increase our global em-

phasis. SRNT is the only major scientific society devoted exclusively to nicotine and tobacco research. We now have almost 1,000 members. Although our membership is still overwhelmingly from high-income countries, we have made strong efforts to recruit members from low- and middle-income countries as well. We recently awarded free annual membership to 24 scientists from low- and middle-income countries around the world. We continue to have a long distance to go in making our Society more truly global, however. It will be important to partner with other organizations and initiatives, such as the Fogarty grantees, to expand capacity and to attract additional scientists in developing countries.

During my term as president of SRNT, I took the lead in organizing a pre-conference immediately prior to our annual meeting on global initiatives in tobacco research. This pre-conference attracted over 200 registrants and addressed topics including the role of research in global tobacco control; global perspectives: where do things stand now?; global nicotine research and tobacco control for the 21st century; SRNT as a facilitator and broker for research; and call for action: funding. This pre-conference was followed by an interactive workshop during the SRNT meeting on future directions for international research. One key recommendation that came from the workshop was to facilitate opportunities for investigators from developing countries to publish in indexed journals. SRNT cosponsored a one-day workshop at the 12th World Conference on Tobacco OR Health in Helsinki in 2003 on grant writing for researchers from low- and middle-income countries. There were

over 150 attendees at this workshop. The 2005 annual SRNT meeting will be held outside of North America for the first time – in Prague. This venue should attract scientists from countries including those in Eastern Europe that have very high tobacco use, and that have had minimal representation at prior SRNT conferences.

SRNT may have a particularly important role to play in helping to develop training and mentorship programs in coordination with other organizations (Kassel & Ross Manuscript under review). Our mission is to stimulate the generation of new knowledge concerning nicotine in all of its manifestations from molecular to societal. However, there will be difficult challenges in developing training and mentorship. Resources are extremely limited, and effective mentoring can demand considerable time and effort. If such effort is not compensated, this will constitute a substantial barrier. Furthermore, training and mentorship go in both directions — primarily western researchers will have a great deal to learn from researchers in developing countries, especially about local issues and culture. I certainly am finding our own Fogarty project (focused on tobacco cessation in India and Indonesia) to be a learning experience, and I am humbled by my current lack of knowledge about cultural issues pertaining to tobacco in our intervention sites.

SRNT can also play a leadership role in working with other organizations and initiatives to advance science, to lobby for additional resources, and to communicate more effectively about the need for tobacco control research and tobacco reduction initiatives. We can work to increase and improve communication and coordina-

tion between organizations and stakeholders. Global conferences, most notably including the World Conferences on Tobacco OR Health, provide excellent opportunities for networking and for advancing tobacco science, as do regional conferences such as the Asia/Pacific Conferences on Tobacco OR Health. These conferences also provide venues for workshops and training.

Future needs and directions

We must attract committed individuals to the global fight for tobacco control, including additional scientists, practitioners, and advocates. Committed volunteers can make a considerable difference, and many organizations in tobacco control rely heavily upon volunteer efforts. The challenges can seem overwhelming, but even modest initiatives have the potential of saving literally millions of lives. And yet, despite the growing tobacco epidemic, several key organizations actually are reducing or eliminating their financial commitment to global tobacco reduction. It has been difficult to secure new commitments. This is tragic. To maximize impact, additional resources, both human and financial, are essential.

The magnitude of the epidemic is huge, but much can be accomplished. Organizations not currently involved in tobacco reduction efforts should be recruited. Initiatives should be undertaken to increase communication and to pool resources in pursuit of common objectives. Rich countries should be called upon to support tobacco control initiatives in poorer regions. The larger burden of tobacco as a challenge to sustainable development should be more widely recognized. We must not delay our efforts, however, while we lobby for additional resources. Every day, almost 15,000 people around the world die from tobacco-related diseases and these numbers are increasing. Researchers must play a key role in tobacco control initiatives and must be prepared to work in close collaboration with tobacco control advocates. The time is right with the adoption of the FCTC. Together, we can make a critical difference in reducing the global tobacco burden.

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THOMAS F. BABOR | ZIMING XUAN

Alcohol policy research and the grey literature

A Tale of Two Surveys

It was the best of times, it was the worst of times, it was the age of wisdom, it was the age of foolishness, it was the epoch of belief, it was the epoch of incredulity...

Charles Dickens,
A Tale of Two Cities

Introduction

In some respects, Dickens' characterization of the situation in London and Paris leading up to the French Revolution has analogies to our own times, at least as they relate to the uses and abuses of statistical information. The questionnaire survey has become the method of choice for gathering information for a wide variety of social and scientific purposes, including alcohol policy. By alcohol policy we mean government measures designed to protect public health by controlling the supply of or demand for alcoholic beverages.

This commentary is a tale of two international surveys of alcohol policy that were both conducted in the year 2002. One was sponsored by an international public health agency, the World Health Organization (WHO 2004), the other by a "social aspect organization", the International Center for Alcohol Policies (ICAP 2003), which is funded by the alcohol industry. Both studies

ABSTRACT

T. F. Babor & Z. Xuan:
Alcohol policy research
and the grey literature

This commentary is a tale of two international surveys dealing with alcohol policy. One was conducted by an international public health agency, the World Health Organization, the other by a "social aspect organization," the International Center for Alcohol Policies, which is funded by the alcohol industry. Although the two studies share a similar survey methodology and common policy aims, the findings and conclusions are very different. Prevalence estimates for a variety of alcohol policies were significantly lower in the ICAP survey, suggesting possible sampling bias or poor survey design. We found the WHO report appropriately cautious in the conclusions drawn, with no instances where the interpretation did not conform reasonably well to the data reported. In contrast, the ICAP survey was faulted in the areas of transparency of the data analyses, the accuracy of the statistical reporting and

interpretation of the data. In particular, the ICAP report claims that public education on alcohol was identified by 70% of respondents in "emerging" market countries, when this item was endorsed by only 38% of the sample. If there is any lesson to be learned from this "tale of two surveys," it is that users of the grey literature need to discriminate between frivolous survey research and more serious attempts to provide accurate and useful information.

■ **KEY WORDS**

alcohol, alcohol policy, survey research, grey literature, partnerships

were designed to collect information about alcohol policies in order to improve the ability of governments and health authorities to prevent and manage alcohol-related problems. Both studies, either implicitly or explicitly, are concerned with alcohol policy in developing countries, in part because these countries are likely to be particularly vulnerable to the negative effects of increasing alcohol consumption. Although the two studies share a similar methodology and are directed at common policy aims, the findings and conclusions are very different. In this paper we examine the nature of the differences and consider the implications for alcohol policy and collaboration between the scientific community and industry-sponsored social aspect organizations.

Both studies collected survey data from national Health Ministers or their representatives throughout the world, and both published their results in semi-official reports that have been described by journal editors as the "grey literature". This literature is considered "grey" (instead of black or white) because of its ambiguous status in relation to the popular press and the scientific journals. In the policy area, a large amount of literature is produced in the form of semi-published reports, conference abstracts, and booklets published by organizations (Auger 1998). Because this literature is not typically submitted to the traditional peer review process, its scientific value and, in the case of empirical research, its methodological quality, are considered to be variable. In this commentary, we compare two such examples of survey research published in the grey literature.

Aims

The ICAP study was published as a periodic report in February, 2003 under the title: "Alcohol policy through partnership: Is the glass half-empty or half-full?"

The stated purpose of the survey was to identify priority areas for policy development throughout the world. The report explains that the "lessons learned from this survey will serve as a benchmark for future policy questionnaires and for the development of policy approaches tailored to the needs of different cultures, populations and drinking practices" (p. 1). According to one of the study's authors, "the survey was not intended to be a rigorous scientific study, but rather an attempt to track perspectives on various issues relating to al-

cohol policy development around the world" (Marjana Martinic, Personal Communication 2004).

The second study, (World Health Organization 2004), is entitled: "Global Status Report: Alcohol Policy". The stated purpose of the study is to "inform WHO Member States of the status of existing alcohol policies and to provide them with a baseline for monitoring the situation" (p. 1). A second aim is to serve as "an advocacy tool for identifying existing gaps and raising awareness about the need for alcohol policies"(p. 1).

Methods

■ Instruments

The ICAP survey contained nine questions, which asked about the current focus of government policy in each country, priorities with regard to implementing alcohol policies, the types of alcohol policies currently in effect, government and other "sectors" involved in the development of alcohol policies, and the role of the alcoholic beverage industry in policy development. Five of the nine questions were followed by checklists with fixed response categories. The study was conducted using a mail survey printed only in English. Respondents, whose anonymity was assured, were allowed to respond by mail, fax, or through the ICAP website, where the questionnaire was also posted. After explaining that ICAP is a "not-for-profit organization funded by major international producers of beverage alcohol", the cover letter sent to respondents explained that ICAP's mission is to "encourage dialogue and pursue partnerships involving the public health and scientific communities, the beverage alcohol industry, and other

parties with a legitimate interest in alcohol policy".

The WHO survey contained 20 questions focusing on the country's definition of an alcoholic beverage, age restrictions on alcohol consumption (specific for beer, wine and spirits), restrictions on availability (including state control on production and sale and the types of licenses required for sale); drink driving legislation (including the maximum legal blood alcohol concentration (BAC); frequency of roadside breath testing); restrictions on alcohol consumption in public domains; the extent to which alcohol advertising is permitted and regulated in different media by beverage type; and requirements for health warnings on containers and in advertising. In addition to English, the questionnaire was translated into French, Russian and Spanish. Response formats varied, but most questions asked for specific "yes/no" answers or for detailed information about alcohol policies. The questionnaire was developed by a group of experts and based on the experiences of the WHO Regional Office for Europe in collecting information on alcohol policies in 1995 and 1999 (World Health Organization 1999). Prior to the finalization of the WHO survey, copies of the draft instrument were sent to at least one key informant in each WHO region to test the feasibility of the questions and to obtain recommendations for improvement. All respondents were identified by name in an appendix to the report.

■ Sampling

The ICAP survey was sent to "Health Ministers, Directors General of Health Services and key policy professionals in national governments, quasi-governmental bodies

and other national entities responsible for developing and implementing alcohol policy throughout the world" (p. 1). The report does not explain how many surveys were mailed out but subsequent inquiries (M. Martinic, Personal Communication 2004) indicated that it was sent to 114 countries around the world. Countries in which alcohol consumption is prohibited were excluded. Official responses were obtained from 48 respondents representing the same number of nation states. The response rate is therefore 42%. The overall global population coverage, computed by the present authors from population estimates of the countries surveyed, is estimated to be 22% of the world's population.

The WHO survey was sent out either to the official WHO Representatives in the countries (usually in the Ministries of Health) or "to other contact people working in the field of alcohol" (p. 7). In total, the WHO questionnaire was sent to representatives in 175 countries. Replies were received from 118 respondents for a response rate of 67%. The overall global coverage was estimated by the report's authors to be 86% of the world's population.

Findings

■ ICAP survey

The findings of the ICAP survey are presented under four headings: issues and challenges, priorities, existing policies, sectors involved in alcohol policy, partnerships with the alcohol industry, and where industry partnerships are desirable.

When asked to prioritize challenges regarding alcohol policy, 81% of the respondents identified underage drinking as the most pressing issue facing their respective countries. The other commonly cited

challenges were: public education on alcohol (cited by 73% of respondents), prevention and treatment (65%), drinking and driving (65%), regulation and law enforcement (63%). 50% of respondents in "mature" markets identified binge drinking as a pressing policy issue, while only 6% of those from emerging market economies cited it.

Regarding priorities, increased education about alcohol was found to be "the most common global priority for future policy implementation". It was identified as a priority by 85% of all respondents, by 90% of the African respondents and by 82% of the Latin American respondents. Areas considered to have the lowest priority were taxation, management/staffing and regulatory reform.

Regarding existing policies, drinking-driving legislation (81%), regulations on licensing of outlets (75%), minimum alcohol purchase age (63%), and those pertaining to advertising and promotion (52%) were cited most frequently by the total sample of respondents. Further analysis showed that Latin American respondents were the least likely to report drink-driving legislation (50%). Restrictions on advertising were identified by 33% of countries within the E.U., and by 82% of non-E.U. countries.

Regarding the issue of partnerships with the alcoholic beverage industry, 50% of the respondents answered yes to the question: "Do you view the beverage alcohol industry as an effective partner in developing alcohol policies in your country?"

Among the respondents answering in the affirmative (N = 24), 92% cited education as the main priority in implementing alcohol policies.

Regarding existing partnerships with industry, the report states that currently “the beverage alcohol industry is a partner in 44 percent of mature markets, but only 25 percent of emerging markets” (p. 8). With in Europe, for instance, the industry was cited as a “partner” by 71% of respondents from Western Europe, and only by 17% in Eastern Europe. Among emerging markets, public education on alcohol was the most prominent area for partnership, identified by 70% of respondents.

The findings of the ICAP report are interpreted by the report’s authors to support the following conclusions:

- Key issues in alcohol policy differ among regions of the world and among mature and emerging economics.
- Underage drinking is the main issue of global concern in alcohol policy and alcohol education is seen as the key priority to addressing such concerns.
- Ample common ground exists for future partnerships with the beverage alcohol industry, notably for educational efforts.
- Effective industry partnerships exist around the world.

■ WHO survey

The main findings of the WHO survey are organized under six areas of alcohol policy. The first pertains to the definition of an alcoholic beverage in different countries according to the minimum amount of absolute alcohol. The definitions ranged from 0.1 to 12.0% alcohol by volume, with a mean of 1.95%.

The second area covered by the WHO survey is restrictions on the availability of alcoholic beverages. More than 70% of the responding countries require a license for the off-premise retail sale of at least one

type of alcoholic beverage, whereas 15% have a state monopoly on the sale of beer, wine or spirits. In the remaining countries (12%) there are no specific restrictions on the sale of alcoholic beverages. The report notes that age limits for buying alcoholic beverages varied from 15 to 21 years. A large majority of the responding countries have age requirements for the sale of beer, mostly 17/18 years. Having an age limit of 16 years or younger is almost exclusively a European phenomenon.

Drink driving legislation was the third area covered by the WHO survey. Most of the respondents reported a defined, legal BAC limit for driving a car. In about 40% of the countries, the legal level is around 0.5 per mille. Countries without a BAC limit were found mainly in South-east Asia and Western Pacific regions, and Africa.

The fourth policy area covers price and taxation. About 90% of the responding countries indicated the existence of general sales tax or Value Added Tax, ranging from 3% to 40% as a general sales tax. The average tax rate was 16.6%. Europe had a slightly higher average (19.2%) than other regions of the world. Using the GDP per capita as a standardizing measure, the findings indicate that alcoholic beverages are clearly less expensive in developed countries.

Advertising and sponsorship is the fifth area. Alcohol advertising was found to exist in almost all the countries (92%). Some 23% to 31% of the responding countries, depending on the media and the beverage, have partial restrictions on advertising. About 15% of the countries rely on voluntary agreements. Advertising on television and radio is more restricted than for print media and billboards. Beer advertising is

less controlled than that for wine. Spirits have the greatest controls. Few countries restrict alcohol industry sponsorship of sport or youth events; only 24% have statutory controls.

Alcohol consumption in public places is the final area considered. In general, alcohol consumption in public settings is in most countries strictly controlled with around 50% having total or partial bans.

The WHO report concludes with the following points:

- There is tremendous variation among countries in national level alcohol policies and only a small number have comprehensive policies.
- A clear gap exists between research and action.
- The most effective mix of policies for a given country might include a) a measurable definition of an alcoholic beverage, b) some government control over retail sale, c) restrictions on days and hours of sale, d) culturally appropriate age limits, e) a relatively low blood alcohol concentration limit for drinking and driving, f) alcohol taxation, g) controls on advertising and sponsorship, and h) strong restrictions on drinking in public places.

Limitations

No caveats or limitations are provided to the readers of the ICAP survey. In contrast, the WHO report explicitly lists five main limitations of the study. The first is data coverage both geographically and across relevant policy areas. Not all countries initially identified in the sampling frame were reached and not all countries that were reached responded. Due to the space limitations of the survey, important alco-

hol policies could not be included, such as alcohol education, community intervention projects, and server training. The second limitation is the cross-sectional nature of the survey, which did not allow policy monitoring over time. A third caveat is regional differences within federal states. Countries with large variations in alcohol policies among their own states should ideally have been treated separately. Another problem is high reliance on key informants. Although basic validation of internal cohesion was conducted, the policy and enforcement data were not checked against the alcohol legislation in the countries.

Evaluation and discussion

In recent years alcohol policy research has grown in volume and sophistication on an international level (Room et al. 2002; Babor et al. 2003; Babor 2002). This literature is often consulted when questions arise about the policy differences among countries, and the extent to which these differences are associated with per capita alcohol consumption, excessive drinking patterns, and population rates of alcohol-related problems. International surveys of alcohol policies therefore serve several important functions. They can provide useful information to policymakers about the acceptability and implementation of different policies, and they are a useful source of information for policy researchers interested in cross-national comparative studies. To the extent that some of this research is published in the "grey literature", it is legitimate to ask whether it meets acceptable methodological standards.

The main purpose of this article is not

only to compare two reports from the grey literature, but also to evaluate them in terms of their methodologies and conclusions. Both studies represent empirical research, and as such, their conclusions depend on three key features: the validity of the measurement instruments, the representativeness of the samples, and the organization, analysis and presentation of the data.

■ Validity of measurement

The validity of a measurement instrument can be affected by the instructions given to respondents about the purpose of the survey, the way the questions are worded, and the response categories and format. Instructions to respondents may have influenced the quality of the data collected in both surveys. The ICAP cover letter did not inform respondents that they were reporting data that would be used to represent their country as a whole. It is possible that these anonymous respondents may have been more careful in checking factual information and reporting their own individual opinions if they knew that the data would be used to represent their countries. In the WHO survey, respondents were clearly told that they were key informants for their countries, and their names were listed at the end of the report. They were asked to carefully check all information a second time to make sure that it was being presented accurately in a published WHO document. In this case, respondents were in effect being asked to publicly certify the accuracy of the data.

The validity of responses can also be affected by question wording and response formats. The design of the two questionnaire surveys is a critical methodological

feature which could affect the validity of the data. The ICAP survey contained 3 questions using a List format (check all that apply in the list), one question using a categorical format (e.g., yes/no), and 3 open-ended questions. According to Sudman and Bradburn (1982, 168), open-ended, ranking, and list formats are among the least valid methods of collecting survey data. In questions where respondents are asked to check "all that apply", it is difficult to interpret what the absence of a check mark means.

Other design features that may have affected the response accuracy are language and regional differences within countries. The ICAP survey was presented only in English, which may have affected not only the response rate in countries where English is not the first language, but also the respondent's ability to understand the questions. This may have been less of a problem with the WHO survey, which was translated into three of the official languages of the United Nations. The validity of responses may also have been affected by the complexity of alcohol policies in countries with large regional differences, making it difficult to answer yes or no to a particular question.

In summary, neither survey reported supporting evidence of the reliability and validity of the data collection procedure, although the WHO report did point out possible limitations (particularly the inability to check responses against published laws and regulations) and the investigators took precautions to motivate respondents to respond accurately. The ICAP survey design, in particular, contains numerous limitations that may have affected the validity of the responses.

■ Representativeness and generalizability

Surveys are typically conducted with the intent of generalizing the results to the population of interest (Girden 2001). In the two studies reviewed in this article, the surveys were designed to describe alcohol policies throughout the world, and to compare policies among regions and countries at different levels of socioeconomic development. For example, using phrases like “the most common global priority” and “the most commonly named (policies) globally”, the ICAP report gives a clear impression that the responses represent a summary of the global situation. The ICAP authors also refer to “respondent countries” throughout the report, implying that the questionnaire respondents were speaking for their respective nation states.

Because many of the key informants failed to respond, the samples included in both studies may not generalize to the entire population of nations worldwide or within regions. To what extent are these surveys capable of generalizing results to the world, to different socio-economic systems, and world regions? The ICAP survey was sent to respondents in 114 countries, and received a 42% response rate. The WHO report was sent to 175 countries, with a 67% response rate. The ICAP report does not explain its sampling frame, which we define as the population that has a chance to be selected. WHO considered its sampling frame as all UN member states ($N = 191$), but sent out surveys to a lower number ($N=175$) because the investigators could not locate informants in some countries. If the total of UN member states is considered to be a relatively complete world listing of nation states, then the two

surveys' response rates should be reported as 25% for ICAP and 62% for the WHO. Both the WHO report and ICAP (M. Martinic, Personal Communication 2004) mention the difficulty of surveying countries where alcohol prohibition is in effect, but WHO only excluded a small number of countries for this reason. Taking into account both the coverage of countries and world population coverage (22% ICAP, 86% WHO), we conclude that both surveys may have resulted in biased samples, which may make generalizations difficult at a global level. Perhaps as a consequence, the WHO report is more cautious in its generalizations and reports individual country data for virtually all of its descriptive statistics.

■ Organization, analysis and presentation of the data

An important issue in the reporting of survey results is the organization, analysis and presentation of the data. Ideally, the data should be organized in a logical way, the statistical or descriptive analyses should be transparent and the inferences should be consistent with the data. In addition, readers should be forewarned about the limitations of the methodology. Using these criteria, we evaluated the two surveys in two ways. First, we present a direct comparison of reported prevalences of five alcohol policies that were the subject of both surveys. Second, we evaluated the transparency of the data analyses, the accuracy of the statistical reporting and interpretation of the data.

Although the two surveys were not directly comparable in most areas of inquiry because they addressed somewhat different questions, there was one important

Table 1. Comparison of ICAP and WHO surveys in terms of reported prevalence of five alcohol policies listed as potential response options in both questionnaires.

Policy	Global %		Regions									
			L. America %		Africa %		W. Europe %		E. Europe %		Asia Pacific %	
	ICAP	WHO	ICAP	WHO	ICAP	WHO	ICAP	WHO	ICAP	WHO	ICAP	WHO
Number of countries	(48)	(118)	(12)	(23)	(10)	(26)	(7)	(20)	(6)	(23)	(6)	(19)
Minimum purchase age	63%	82%	67%	100%	60%	64%	72%	100%	50%	87%	83%	74%
Licensing of sales	75%	73%	58%	88%	80%	82%	100%	65%	83%	52%	83%	80%
Drinking and driving	81%	93%	50%	96%	70%	84%	100%	100%	100%	96%	100%	89%
Regulations on advertising	52%	60%	42%	70%	20%	43%	72%	70%	83%	74%	50%	65%
Health warning labels	25%	33%	42%	56%	20%	27%	14%	10%	17%	30%	0%	33%

area of overlap. Both surveys made similar inquiries about the current existence of five alcohol policies, and computed global and regional summary statistics. These data can be compared to determine whether there are systematic differences between the two surveys at the global and regional levels, as well as variations within policy areas and regions. Table 1 shows the percentages of respondents to each survey who indicated that a given policy was in effect in their country. At the global level of analysis, ICAP provides lower estimates on four of the five policies, with the largest difference being 19% for minimum alcohol purchase age policies. Even greater percentage differences are apparent within the Latin American region, with the smallest discrepancies occurring in the African region. To evaluate systematic differences, we compared the 25 pairs of percentages across all five policy areas and all five regions using the Paired Samples t-test. The results indicated a significant difference ($t = 2.13$, $p < .05$) with the WHO survey yielding prevalence estimates that

were on average 8.76 percentage points above ICAP's. Although we will not venture to suggest which survey was more accurate in estimating alcohol policies, we do note that the surveys differed in their questionnaire design and sample representativeness. The ICAP survey used a checklist of 8 policy options, asking respondents to check as many as applied to their country. The WHO survey asked multiple and detailed questions about each policy. In general, the more detailed and specific the questioning procedure, the more accurate the response will be (Sudman & Bradburn 1982). The differences could also have been the result of sample bias, with some types of alcohol policies being more or less prevalent in the countries that happened to be selected by each survey. Finally, it is important to note that the ICAP results for most regions are based on extremely low denominators for the calculation of percentages (e.g., 7 for Western Europe, 6 for Eastern Europe, 6 for Asia-Pacific).

A related issue is the caveats provided to

readers of the respective reports. The ICAP report contains no mention of methodological limitations and no caveats regarding the quality of the data or the interpretation of the findings. In contrast, the WHO report has a separate section on methodological limitations and in some parts of the text makes cautionary statements.

Another way to compare the two reports is in terms of three quality indicators: the transparency of the data analyses, the accuracy of the statistical reporting and interpretation of the findings. We found the WHO report “transparent” to the extent that almost all summary data could be verified by comparison with individual country level data, and that the aggregation and analysis procedures were clearly specified. As indicated below, we did not find the same degree of transparency with the ICAP data.

Regarding accuracy of the statistical reporting, we could detect no errors in the reporting of the WHO data, and found it easy to conduct spot checks to verify summary statistics. In contrast, we found one major example of inappropriate data analysis in the ICAP report that resulted in a misleading interpretation of the findings. In Figure 9 of the ICAP report, percentages of respondents are reported for emerging and mature market countries in terms of “common issues for partnership”. The text states that “respondents identified many common areas for partnership” between the public health community and the beverage alcohol industry, but the report fails to note that the sample used in these calculations included only respondents who answered yes to the previous question, indicating that they viewed “the beverage alcohol industry as an effective partner in de-

veloping alcohol policies” in their countries. In effect, the percentages reported in Figure 9 leave out all 24 respondents who answered that the beverage alcohol industry is not an effective partner, thereby biasing the results in the direction of considerably higher levels of cooperation with industry. Recalculations of percentage distributions, shown in Figure 1, based on the full number of respondents who indicated their views about cooperation with industry (N=48), alters the percentages considerably. For each “common issue” of potential cooperation between industry and public health, the first two bars show the actual percentages for emerging and mature market countries, respectively, based on the correct denominators (32 and 16, respectively), and the next two bars show the ICAP percentages, based on the incorrect denominators (17 and 7). Instead of 9 out of 17 emerging market respondents answering that they believe prevention and treatment are common issues for working with the alcohol industry (i.e., 53%), the actual number of affirmative responses should have been 9 out of 32 (28%). In other words, most of the respondents (72%) failed to endorse this issue as an area for cooperation. Similarly, the ICAP report claims that “public education on alcohol was the most prominent area for partnership, identified by 70 percent of respondents” (p. 10). If the excluded negative responders are included in the denominator, only 38% of emerging market respondents endorsed this item, with the remaining 62% indicating either they do not believe partnerships with industry are effective, or, at least in this area, they do not want to work with industry.

Because these negative responders were

Figure 1. Percentages of respondents answering affirmatively to nine “common issues” of potential cooperation between industry and the public health community. For each issue, the first two bars show the actual percentages for emerging and mature market countries, respectively, based on the correct denominators, and the next two bars show the ICAP percentages, based on the incorrect denominators.

excluded from the denominator in the ICAP calculations, the percentages on the “common issues” appear to be almost twice what the raw data indicate. In summary, by presenting percentages as if they represented the entire sample of respondents, rather than only those who believed that industry could be an “effective partner”, the report leads to a misleading interpretation of the survey data.

■ Interpretation of questions and responses

We found the WHO report appropriately cautious in the conclusions drawn, with no instances where the interpretation did not conform reasonably well with the data reported. This was not true of the ICAP report, where we found numerous examples of misleading statements and misinterpretation of the data reported. For example, as reported above, those respondents who believed the beverage alcohol industry

represents an effective partner in developing policy (Q. 5) were asked to identify areas which “the public health community and the beverage alcohol community in your country can best work together on”. (Q. 6). In the text of the report, this question is interpreted as meaning “areas in which cooperation might be possible or desirable” (p. 9), and the statistics cited imply that there was majority endorsement of partnership arrangements in both emerging and mature market countries. As noted above, the opposite was the case.

In other parts of the report, question wording saying one thing is interpreted in the text as meaning something different. In particular, the interpretive figure titles and section headings were not consistent with the data presented or the questions asked. For example, if respondents indicated that the alcohol industry was one of many “sectors” involved in developing alcohol policy in that country (“Which sectors are ac-

tively involved in the development of alcohol policies in your country?”), the responses were interpreted to mean that “existing partnerships” had been established in that country. According to this logic, it is possible that partnerships exist between public health officials and alcohol lobbyists, the media and religious leaders, which are some of the other response alternatives endorsed by respondents. Another example is the portrayal of responses to a question about “common issues” that industry and public health can work on together as indicating areas “where industry partnerships are desirable” (p. 9). Respondents may have found that under-age drinking, an issue listed in the response checklist, was a common issue to work on without believing that an industry partnership was “desirable”.

Conclusions

Although we have titled this article “A Tale of Two Surveys”, it might also be described as a tale of two cities. Just as Dickens’ classic novel unfolded in the power centers of London and Paris, our tale tells a story of latter-day power centers of Geneva and Washington. Alcohol policy is an international issue that involves the conflicting priorities of the alcoholic beverage industry and the public health community. Reliable information is important for policy development because policymakers need to know what policies exist, where they are implemented, and how successful they are perceived to be.

To the extent that reports like these enter into the “grey literature” and are cited and used by policymakers in the same way as research reports and review articles published in peer reviewed journals, it is im-

portant to subject them to rigorous scrutiny to make sure that their data are accurate and the conclusions are consistent with the data. Survey research can be particularly misleading if conventional methodological precautions are ignored (see, for example, Girden 2001; Huff & Geishuff 1954; Cohn 1989) and the peer review process is not used for quality control. In this comparison we found that the grey literature on alcohol policy may vary significantly in methodological quality and informational value. The ICAP report, in particular, seems to present conclusions that are inconsistent with its own data or unwarranted because of faulty survey methodology. The conclusions are also inconsistent with the considerable body of policy research that has been published in recent years (e.g. Room et al. 2002; Babor et al. 2003). In particular, we note that ICAP’s assertion that “ample grounds exist for future partnerships with the beverage alcohol industry, notably for educational efforts” (p. 12) is based on a faulty presentation of the data that actually shows that 50% of the respondents believed the alcohol industry was not “an effective partner in developing alcohol policies”, with only 29% of the 48 respondents endorsing public education as a common issue to work together with industry.

Both of the reports indicate that the current results will be used as a basis for comparison with future survey data collected by means of similar methods. In the case of the ICAP survey, we have identified significant methodological and inferential flaws in the current report that would preclude meaningful comparisons with data collected in the future. In addition, any future policy surveys should employ verification

techniques, at least on a partial sample of countries, to check survey responses against legal statutes and other documented regulations that indicate the presence or absence of a given policy. Finally, even though neither survey was required to undergo prior ethical and scientific review, such review is warranted when the findings will be presented at scientific meetings and busy health authorities are being asked to devote valuable time to the completion of a questionnaire survey. If there is any lesson to be learned from this "tale of two surveys", it is that users of the grey literature need to discriminate between

frivolous survey research and more serious attempts to provide accurate and useful information.

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Lunch with the industry?

The director of The Amsterdam Group, the European front organisation for the drinks industry, last year sent me an email inviting me for lunch “to get a better understanding of your organization and your work and views”. I politely declined. There is no such thing as a free lunch.

The alcohol industry is in pursuit of partnerships. They not only appear as ‘the other team’ in the alcohol policy field; an industry stakeholder which non-governmental organisations (NGOs) and governmental organisations may or may not play ball with. They are now donning the team colours of public health NGOs and claiming they share our objectives.

In this situation, NGOs need a clear set of guidelines, a consensus or some basic rules on how to relate to the industry, and not least we need a discussion amongst not-for-profit NGOs on the implications and pitfalls of industry cooperation. It’s time for “a public health warning” (Eurocare 2002).

No public health partner

Dialogue is the credo of a pluralist society. At European level, dialogue is the *modus operandi*, whether you are networking between NGOs or searching out compromises in the EU multi layer policy processes. In the social and health arena, the state is overburdened, existing measures often deemed inadequate, and “effective approaches are politically impossible” as Robin Room describes the alcohol policy impasse (Room 2000). To resist dialogue and partnership with the industry as this article advocates may seem not only politically incor-

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rect, but a losing battle.

An advocate must always be prepared to compromise. That is the nature of progress in politics. Every step forward is small and half way. However, in the process of small steps and compromises, public health NGOs must take great care to preserve the legitimacy of the organisation, its values, and not undermine the essential and long term objectives.

Both Eurocare and European Public Health Alliance (EPHA)¹ believe that the industry is not a public health partner, but a stakeholder. The EU has a similar approach. In a Council resolution from 1986, the Commission is requested "to weigh carefully the interest involvement in the production, distribution and promotion of alcoholic beverages and public health interest and to conduct a balanced policy" (Resolution 86/c184/92).

The European Parliament approved in 2001 a report on alcohol and young people – with 445 Members of the European Parliament in favour and 63 against – that pictured the industry as a part of the problem, not a part of the solution: "The manufacturers of alcoholic beverages have realised that adolescents constitute a new market. Such exploitation must be prevented... More binding European rules on advertising directed at young people for alcoholic beverages are necessary ... these measures [should] also seek to reduce the supply of alcohol" (The European Parliament Stihler report 2000).

Finally, the WHO Ministerial Conference in 2001 declared that "public health policies concerning alcohol need to be formulated by public health interests without interference from commercial interests" (WHO 2001a).

In one of Eurocare's first reports, "Counterbalancing the Drinks Industry", it stated that "it is necessary to recognise that there is potentially an intrinsic conflict of interest between policies designed to promote health and social well-being and policies designed to promote the free trade, sale and consumption of products such as alcohol and tobacco" (Eurocare 1995). It follows from this that no Eurocare member will receive any funding from the drinks industry, and that any cooperation remains difficult.

At one instance, in 2002, Eurocare accepted an invitation to meet the Amsterdam Group (TAG) after agreeing on the agenda and after assurances that the minutes will be subject to approval and that the meeting will take place in the public domain. The meeting was an exchange of views. Eurocare stated at that meeting that at present "there is no common ground between us". (Eurocare minutes from Annual General Meeting 2002). It was especially mentioned that in spite of the industry's extensive alcohol policy initiatives, and guidelines on marketing, the industry is marketing alcohol aggressively.

TAG also asked for a meeting with EPHA, and got it. Tamsin Rose, the secretary general explains: "EPHA will talk to the drinks industry because we have clear messages to give them but we'll not acknowledge them as public health partners because their goal is to sell more of their own products. We are also very careful not to lend our name to their causes. If 'a stakeholder dialogue' is not properly defined, misinterpretations that NGOs endorse industry initiatives are easily made" (e-mail from Tamsin Rose 28.5.2004). When TAG asked again this year for a follow up meeting

EPHA declined since there did not seem to be more to talk about. A request for a second meeting with Eurocare was also turned down.

Eurocare emphasises that it is “prepared and does sit down with the industry when government or intergovernmental bodies organise meetings to discuss alcohol policy. However, there is little of worthwhile value to be gained by bilateral dialogue between Eurocare and the alcohol industry” (Eurocare’s annual report 2002/2003, para 9). This position is communicated to the Commission.

This is a pragmatic strategy based on a rigid *modus operandi*. Pragmatic since Eurocare, as a European-wide alliance will remain sensitive to the cultural and social variations in Europe, pragmatic when supporting a “balanced alcohol policy which allows those who gain pleasure from drinking the freedom to do so whilst minimising social, health and economic harm” (Eurocare 1995, Para 14,5), and pragmatic in pursuing a piecemeal approach in the advancement of policies, but rigid in observing our distance to the industry and acting on empirical data.

Boundaries blurred: Lessons from Big Pharma

The various producers, be it of tobacco, alcohol, food or pharmaceuticals all have aspects that are peculiar to them. But some of the same scepticism should be employed when they approach an NGO and lessons can be learned from experiences of other potentially addictive and harmful substances concerning NGOs integrity and the wider strategic picture.

Numerous patient groups are funded by the pharmaceutical industry. The EFA (Eu-

ropean Federation of Allergy and Airways Diseases Patients’ Associations) congress in Oslo 24th June 2004 is sponsored by GlaxoSmithKline, Pfizer and Novartis. EFAs statutes states that EFA shall be a “strong and critical partner for the European Union”, but there is no word of whether it should be a critical partner to the industry. (EFA’s Mission). The NGO Alzheimer Europe is sponsored by Pfizer; The European Federation of Psoriasis Associations (Europso) is sponsored by Biogen; The European Aids Treatment Group is sponsored by GlaxoSmithKline, Pfizer and more; The European Multiple Sclerosis Platform is sponsored by the biotech firm Serono etc.

A number of European and national patients groups went along with the industry and experts to form the European Platform for Patients’ Organisation, Science and Industry (EPPOSI) in what they describe as a “unique multi-stakeholder approach”. The platform’s aims are to promote research, and not least to “promote dialogue about the acceptability, the limitations and ethical issues surrounding new innovative technologies used in human health care, including gene and cell-based therapies...” (EPPOSI Info).

These are NGO events and organisations sponsored by the industry. Another category, perhaps as controversial, is industry conferences ‘sponsored’ by NGOs. By doing this the NGOs may be seen to lend them political, moral and popular support, something the industry need. In effect, who’s sponsoring who, may be difficult to discern.

When the European Federation of Pharmaceutical Industries and Associations (EFPIA) in 1999 organised the conference “Getting better: Developing mechanisms

to ensure the best benefit for patients from medical progress” it was in cooperation with six patients’ organisations within the framework of EPPOSI. The conference was sponsored by Bayer, Boehringer Ingelheim, Bristol-Myers Squibb, Aventis, Merck Sharp & Dohme, Novartis, Pfizer, Schering. Present at the conference were several representatives from the European Commission, Member States governments and the European Parliament.

No one can blame patients for essentially trying to recover their health, but how far should the cohabitation with the industry go; and how can it be done in a manner that serves the integrity and objectives of the NGO? “Calls from a pharmaceutical company for government adoption and reimbursement of their drugs may be seen as partisan. Sponsoring an NGO to make the same appeal can be much more effective, and cheaper,” write two experts from the NGO community in Brussels (Rose & Wilson 2003).

One topical issue is tobacco cessation drugs. The pharmaceutical industry cooperates with some anti-tobacco NGOs in this area. Apparently they seem to have a common cause, but there is a danger that this may lead to excessive medicalisation and, not to forget, it may undermine the societal strategies for preventive tobacco control.

The industry knows the value of displaying their brand name on the right web sites and conference boards. NGOs should be equally concerned about their brand name. The public’s trust in NGOs is remarkably high, and well ahead of governments and business (Rose & Wilson 2003). That is one reason why the industry would like to be associated with NGOs, and this is why NGOs should be extremely cautious.

Blurred borders: Lessons from Big Tobacco

It is well known that the tobacco industry for several decades attempted to influence the WHO tobacco control efforts. One way of doing this was to fund and gain a foothold within NGOs and in particular within scientific groups in order to “manipulate political and scientific debate concerning tobacco and health” (WHO 2001b). The above mentioned independent study from 2000 mentions in particular one organisation, the International Life Sciences Institute (ILSI), that enjoys NGO status with the WHO.

Influencing the scientific and political discourse seems to have been one of the tobacco industry’s main lobbying strategies. In the words of the Tobacco Advisory Council, set up by the industry: “The close links which have been forged over many years with the Government, Members of Parliament, scientific contacts, the medical establishment, academic and professional circles, the trade unions, and others (including the media) should be assiduously preserved and extended. Through them, the industry is in a position to discuss and influence, often without publicity, most of the issues in which tobacco is involved” (The Tobacco Advisory Council 1978).

From tobacco to alcohol

It is perhaps not surprising to discover that the alcohol industry too has funded an ILSI project on alcohol. It was ILSI, that in the words of Griffith Edwards, the editor of *Addiction*, “insults the integrity of science,” by submitting their book *Health Issues Related to Alcohol Consumption*, published in 1999, to the journal for review without declaring that it had been

funded by the alcohol industry. Edwards and Susan Savva (the review editor of *Addiction*), established that “it is evident that The Amsterdam Group commissioned its production and used the lead chapter within a report which the Group employed for lobbying purposes. ... the public was offered a book which derived from a project commissioned by the drinks industry, which had the drinks industry in a position to influence the choice of authors and possibly other aspects of the editorial process, and with the drinks industry involvement in the project entirely undeclared in the published volume” (Edwards & Savva 2001).

Today, the three most prominent Social Aspects Organisations (SAO), which are non-governmental organisations for the drinks industry, are the International Centre of Alcohol Policy (ICAP) which works at the global level, The Amsterdam Group (TAG) in Europe and the Portman Group in the UK. SAOs exist in most countries in Europe. TAG is in their own words “an alliance of Europe’s leading producers of beers, wines and spirits who work together *as well as with governments and other interested groups* to address social problems related to the excessive or inappropriate consumption of alcoholic beverages” (my italics) (The Amsterdam Group). Literally, they see themselves as playing on the team of public health NGOs: “SAOs have the same goal as NGOs (non-governmental organisations) and Public Health Authorities, i.e. to combat alcohol abuse and misuse (e.g. fight against alcohol consumption by minors, pregnant women, drivers)” (The Amsterdam Group 2003).

This sentence from TAG exemplifies what might happen in this process. While

declaring they have the same goal as public health authorities, the SAOs immediately start redefining them by narrowing the agenda to abuse and special groups.

The industry lists 360 “social responsibility initiatives” from 34 countries worldwide that are undertaken by SAOs, brewers or other alcohol industry associations or in part funded by them (Witheridge 2003; The Brewers of Europe 2002). The majority are in Europe, most are in the category of “campaigns and educational material on responsible and moderate drinking” and some are in partnership with other NGOs. Examples of such partners are: Sécurité Routière (a French road safety organisation), the Union of Students of Ireland, The Bergen Clinics (a Norwegian regional treatment and research centre), the Spanish Consumers and Users Confederation, The Danish Road Safety Council.

At the conference: “Working for Responsible Consumption” organised by the Brewers of Europe 18th April 2002 in Brussels one speaker, Mark E. Van Rijn from Heineken explained that the motive behind the drinks industry initiatives for the “minimisation of anti-social behaviour” was improving the industry’s reputation. He presented a chart showing the alcohol industry at the bottom of a social responsibility rating in the eyes of the public. Only the tobacco industry had a worse rating.

Long term trends of consumption have been moving downward or stagnated for some time, while the regulatory environment in Europe is getting tougher (World drink trends 2004; Norström et al. 2000). The EU itself has taken a new interest in alcohol policies, in particular from 2001²,

after the arrival of alcopops in the mid nineties caused resentment among politicians and the public that triggered new policy initiatives both nationally and on EU level. Responding to this, the industry is in a hurry to improve their legitimacy and credibility. And this is where public health NGOs come in.

In 2002, after the EU embarked upon two significant alcohol policy trajectories in 2001 that are potentially damaging to the industry, the industry established a Stakeholder Dialogue. This started with a request for “interviews with key stakeholders” in “a Stakeholder Dialogue process” (notice the capital letters). They wanted our opinion about the alcohol industry and its products. A couple of dozen NGOs and a few government agencies and officials in Europe accepted. TAG then organised “an interactive stakeholder workshop” on 16 & 17 October 2003.

A second round of interviews is presently being conducted (winter/spring 2004). Finally, some participants are invited to sit in a European “review panel” which task is to review commercial communications in pre-screening and as a complaint committee, all a part of the industry newly established programme of self-regulation.

In 2003, The Amsterdam Group produced a video called “Industry partnership to promote Responsible drinking”. It shows “the range of activities in Europe to inform consumers and to educate young people in order to encourage moderate and responsible consumption. You will realize that the majority of these activities are planned and implemented in partnership with bodies and/or organisations from the public sector. We hope that this video will encourage new partnerships and will help

to maintain existing ones”, the Director of TAG, Mr Helmut Wagner writes in a cover letter to the video (21. January 2003).

Booklets, video, reports and minutes from partnerships and the Stakeholder Dialogue are presented to policy makers as tokens of the industry’s public health credentials. A ‘dialogue’ that started out as an industry invitation to be questioned by NGOs might end with NGOs serving in an industry programme, and consequently being a part of industry PR and their strategic agenda. What will be the impact on policy makers and the public opinion if this show of partnership becomes sufficiently impressive? And; how will partnership in projects, participation in conferences and regular dialogues influence the NGOs own agenda and perspectives?

Power politics

From the position of being a ‘partner’ in alcohol policy and by its growing partnership with not-for-profit NGOs, the industry increases its leverage over politicians and public authorities. One example is how an alcohol industry executive in the United Kingdom in a meeting with a government minister recently “slammed” the government for wanting to start up a new public project on alcohol prevention outside the industry partnership. If the government starts to fund new projects on their own, this might “mean” the industry would reduce their funding of the Portman Group and potentially “destabilise” it (The *Publican*, 22.4.2004)³. Such an attitude indicates that the industry must feel very confident. The prevention programmes of the Portman Group and its partnership with NGOs like the National Union of Students might

have added to this confidence.

The Portman Group lobbies the government as well as being supported by them. One example is the Portman Group's designated driver programme which is supported by the Ministry of Transport and other public authorities. A House of Lords committee report in 2002 criticises the government for taking advice from the Portman Group and not experts and NGOs on lowering the BAC level from 80mg to 50mg. "We note that the department's position coincides with that of the alcohol industry but is opposed by local authorities, the police, the British Medical Association, the Automobile Association, the Royal Society for the Prevention of Accidents, the Transport Research Laboratory, and the Parliamentary Advisory Council for Transport Safety," the report concludes (Alcohol Alert 2002).

A comparable situation developed in Sweden during the late nineties. Following the general economic recession, resources for government alcohol prevention campaigns dried out. The temperance movement stayed out, but several government agencies and some NGOs took part in a grand coalition primarily between the alcohol industry, hospitality sector and the Ministry of Social Affairs, called the "Independent Cooperation on Alcohol" (Oberoende Alkoholsamarbete) (Tigerstedt & Karlsson 2003).

The aim was to compensate for the erosion of alcohol policy instruments caused by the Europeanization of alcohol policies, by embarking on a long term information programme. The industry put 15 mill kronor (EUR 1.65 million) on the table annually (1998-2000). However, most resources were spent on combating illegal alcohol. Consequently, as researcher Håkan Leif-

man notes, illegal alcohol became the top alcohol policy issue – even in the government (Leifman et al. 2003). The Alcohol Bill in 1999 outlined steps to increase access to alcoholic beverages in order to combat the illegal sale of alcoholic beverages. The minister of Social Affairs explained in 1999, at the height of the campaign against smuggling, that "regarding alcohol policy, society's most important task is to combat black market liquor" (my translation) (Tryggvesson & Olsson 2002, 35). In effect, these industry funded campaigns shifted focus away from how legal alcohol can be managed in order to reduce harm, to a debate on how to combat smuggling, in effect preparing the ground for attacks on alcohol control policies like excise duties and personal import quotas.

While the industry in Sweden influenced the alcohol policy discourse through its heavily funded information projects against illegal alcohol, the industry lobbied the EU Commission in Brussels for a termination of the Swedish personal import restrictions.⁴ The Swedish government was in a tight spot. Not only were they under pressure from two sides to reduce taxes and accept the abolishment of import quotas, but, apart from the temperance alliance, a number of influential alcohol policy actors were involved in a large scale domestic cooperation project with the industry. These groups consisted of NGOs and different government agencies and bodies. One cannot rule out that the close cooperation with the industry during those crucial years played a role in the government's decision to give in to the Commission's demands on removing the quotas.

The question that should be raised is then to what extent public health stake-

holders and experts and NGOs unintentionally became hostages in this process by endorsing the shift of agenda, by lending credibility to the industry and reducing the leeway and space for an independent voice from stakeholders and NGOs that could have swayed the government to resist?

An important lesson to draw from this and other examples mentioned here is that seemingly harmless local cooperation projects should be judged not only on their merits but as possible parts of larger European industry strategies. In 2000, the Swedish parliament finally terminated OAS and the cooperation with the industry on the grounds that the government cannot be an equal partner with vested interests in public health policy.

Another current example of how the industry tries to influence the European alcohol policy agenda by its cooperation with alcohol experts and NGOs is a conference in Poland of the International Coalition on Alcohol and Harm Reduction this autumn. The manager of this 'coalition' is a Dutch private consultancy (Quest for Quality), and the conference is organized by the philanthropist Polish Batory Foundation. One sponsor is the Soros Foundation. However, the Amsterdam Group and the International Center for Alcohol Policy are both co-sponsors and members of the programme committee. Registration is free and there are scholarships on offer. One aim of the conference is "a shift of attention from 'reduction of alcohol consumption per se' to 'reduction of alcohol related harm'" (The Amsterdam Group).

When it is a matter of justice

'Dialogue' omits one important aspect of our relationship with the industry: the

question of liability. The question is not only how to prevent future harm; it is also about responsibility for the harm done, now and in the future. It is possible that we have only seen the beginning of such court cases against the alcohol industry in Europe, in particular regarding marketing and damages. An industry-NGO partnership might make it more difficult for NGOs to support the legal claims and concerns of its members or from a member of the public.

Partnership with the industry on issues of drinking patterns, responsible consumption, parents responsibility etc. might undermine the societal responsibility for alcohol control, it might exonerate the industry for its marketing and promotions, it might endorse approaches towards alcohol control that are overall less effective, and it may create extenuating circumstances.

This is not a hypothetical question. GlaxoSmithKline PLC is accused in June 2004 by the New York Attorney General of failing to publish unfavourable data about a certain antidepressant for kids. Glaxo sponsors a number of NGOs. One of the projects they fund is "partnership for children"⁵ where Mental Health Europe and the International Association for Suicide Prevention are partners. If things get serious, with which side of the court room will these groups like to be associated? Or will they simply be silent?

Conclusion

The examples above illustrate the dire straits not-for-profit NGOs may find themselves in when sailing industry waters. One additional aspect is the fact that these industries are heavily centralised and glo-

balised, while NGOs at national and local level logically are not. The industry's strategies are international, NGOs are predominantly specialised and fragmented. National and local NGOs and public authorities should therefore, when approached by the industry, ensure they review all potential benefits and dangers, and not least place the industry 'invitation for lunch' in its larger context of trends in the market, alcohol policy developments and industry strategies.

In the case of public health NGOs and alcohol policies, what is at stake is the danger of undermining both the effective policies and the organisations integrity. We are presently at an important stage in the development of efficient alcohol policies both at national and European level. As mentioned above, the industry is under pressure. There is in effect a race going on at European level and nationally about who will shape the future alcohol policy. This is unfortunate, but NGOs cannot allow themselves not to take this wider picture into consideration.

Finally, public health NGOs have an important role in *counterbalancing* the industry and monitoring their activities. If not, who will?

Future safeguards

There exists already an unwritten general consensus on 'transparency' in the not-for-profit NGO community at European level. If you receive funds, you declare it. It is time for this to be defined, elaborated and put down on paper, where not-for-profit NGOs should be invited to sign up to it.

Consensus on public health NGOs and the alcohol industry

The alcohol industry is a stakeholder, not a public health partner. Alcohol industry funding of NGOs and their activities shall be made public; and the industry should be invited to disclose all their funding of NGOs.

1. Discussions and negotiations with the drinks industry on alcohol policy shall only take place under the auspices of government or international organisations like the EU or WHO.
2. If a public health NGO chooses to cooperate or meet with the alcohol industry, it should ensure full authority over:
 - a. the agenda and minutes
 - b. the content and publications
 - c. the participation of other partners
 - d. the administration of the activities
 And make sure:
 - e. you promote effective environmental alcohol policies within the context of the cooperation
 - f. you request assurances from the industry that this cooperation, although transparent, is not used for PR purposes for the industry in their PR material or in their communications with policy makers.
 - g. the industry is not in a position to influence the policy making and shaping of your organisation.
 - h. you inform your partners, financiers and members about all aspects of the cooperation or dialogue with the industry.
 - i. you take the opportunity to raise issues of concern with the industry like the marketing of alcohol.
 - j. that your work, comments and knowledge that is shared within the

context of the cooperation cannot be used to increase the industry market share, improve its competitiveness and marketing skills.

3. Meetings and communications with the industry and records thereof shall be placed in the public domain
4. Don't attend conferences or events in a

manner that might be seen as endorsing something you don't.

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NOTES

- 1 Eurocare, Advocacy for the Prevention of Alcohol Related Harm in Europe is an alliance of voluntary and non-governmental organisations representing a diversity of views and cultural attitudes; and concerned with the impact of the European Union on alcohol policy in Member States. See www.eurocare.org. EPHA has more than 90 NGOs and not-for-profit organisations as members, "working in support of health in Europe". See www.ephha.org
- 2 2005 is also a deadline for two EU Commission proposals on alcohol policy, one on marketing and one on an alcohol strategy for Europe. Both take the cue from mandates from the EU Council of Ministers in 2001 (Council Conclusion 2001/C 175/01, and Council Recommendation 2001/458/EC) This was the year when EU Health Commissioner David Byrne in a speech at the WHO Ministerial Conference on Alcohol and Young People in Stockholm said: "So industry, if you are listening, the ball is now in your court". If there is no reduction in alcohol related harm in Europe and if there is no improvement in the way alcohol is marketed towards young people in particular, the Commission may want to legislate.
- 3 "Steve Cahillane, head of Interbrew UK,

has slammed government plans to set up a fund for projects tackling alcohol related harm". In a meeting with Home Office minister Hazel Blears Interbrew said that "there were already industry-funded initiatives such as The Portman Group, which promote responsible drinking and he believes the creation of a new fund would mean "less industry funds and would destabilise The Portman Group"".

- 4 See CEPS Annual report 1999, page 49: "A position paper, setting out why the European Union spirits industry believes that the restrictions [of the personal import of duty-paid alcoholic beverages to Sweden] are incompatible with, and have caused damage to the Single Market, was therefore submitted to the Director General of Directorate General for Taxation and Customs Union in September... the CEPS paper sets out that they have penalised consumers, distorted trade and consumption statistics, protected Scandinavian tax regimes and resulted in considerable increases in illegal activity. The European Union spirits industry believes that the restrictions should therefore be removed immediately."
- 5 Available at www.partnershipforchildren.org.uk/

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New winds sweeping the clinics and the streets

The Nordic countries often portray themselves as generous welfare states with advanced universal social benefit systems which encompass not only social and welfare matters but also education, labor and gender policies etc. The emphasis on equality between genders and social strata has had a high standing. At the same time the Nordic drug policy has by and large been known as restrictive, although complemented with other preventive measures and treatment. The most popular drug, alcohol, has a long temperance history. Alcohol has been controlled by limiting the availability and by price policy but also by laborious social responses – lay temperance boards which could issue warnings to drunken fellow citizens, professional social workers trying to come to terms with alcohol abusing clients' problems or needs; sobering up stations, a variety of half way houses and treatments of various kinds in open and closed institutions most often under the social welfare sector. During the last decades we have seen more of the less pervasive short term therapies but also skid row shelters, where the worst off alcoholics have been "hidden". The Nordic alcohol policy has for different reasons been relaxed but the policy when it comes to illegal drugs has so far been upheld. Seen from the outside, like Tim Boekhout van Solinge did (1997), it seemed that the restrictiveness in drug policy had its foundation and part explanation in the attitude towards alcohol. Denmark with the least influence of temperance was the most drug liberal in the Nordic family and it also had the most widely spread substitution treatment of opiate addiction from the 1960:s on. The other Nordic countries either did not have any opiate problems – like Fin-

land and Iceland – or they strictly regulated the terms of substitution treatment like in Sweden.

However, come the 1990s and most of this changed (Konvonen et al. 2001). The temperance cause was lost and alcohol policy liberalized. The welfare state changed into a less generous one. New drugs in new large amounts came in: for Finland it was opiates in the late 1990s, and for Norway and Sweden heroin in larger amounts than before. New generations of users were recruited – schoolchildren and well to do students, but also after some time those of the younger generation who did not have such good life opportunities in the first place – the school drop-outs, the criminal and the marginalized. In the face of HIV and hepatitis problems and the threat of a permanently “lost” generation, the demands for both more treatment and harm reduction were articulated. Increasingly, treatment – and very often under a medical rubric – was not looked upon in a general welfare perspective or from a drug policy perspective anymore, but from a more individualized point of view, in which the rules of good medical practice and evidence-based medicine should apply. Hence, substitution treatment in general came to the forefront. In Norway the changes were probably the most dramatic from an almost complete no to substitution treatment in the early 1990s to a yes to a nationwide offer of this kind of treatment from 1997 on.

The succeeding reviews all reflect present day activities and thinking on substitution treatment in the Nordic countries, with the exception of Iceland. They deal with how a “new” substance, for some a new magic cure, the use of buprenorphine,

has been received and implemented in practice in this northern corner of the world. It seems 1999 was a magic year – when buprenorphine was accepted as a medicine to be used in substitution treatment for drug abusers both in Denmark and Sweden. This same year the Norwegian minister responsible for such matters learned, during her visit to France, that such a drug had been successfully used there on a large scale. Before that, buprenorphine had been available in the form of either Temgesic or Subutex only on a trial basis and in restricted medical practice in most of these countries. In Denmark, which has long favored substitution treatment, buprenorphine seems routinely to have been incorporated in the offer given to drug abusers, within the context of other psycho-social treatment and under the supervision of the county councils (amter). In Finland the early history of unauthorized prescription of this substance (see Hakkarainen 2003) definitely speeded the way for the use of buprenorphine in organized detoxification and substitution treatment in general, but its role in actual illegal use is more difficult to assess. It remains a fact though that many Finnish drug abusers start their drug abusing career with buprenorphine, bought in the streets and outside the clinics at the same time as the experiences with using the drug in the clinics are promising. In the two remaining countries research has played a role. Sweden with its restricted model of methadone maintenance curiously enough initially did not regulate the prescription of Subutex (buprenorphine) in medical practice at all, but a controlled study of the effects of these treatments paved the way for a more organized implementation. And Norway

seems to be the promised land of best practices, where the large scale implementation of new treatment and harm reduction policies is followed and evaluated through a variety of more or less controlled trials.

These accounts give a flavor of the early stages of buprenorphine history in the North. It remains to be seen what role the experiences will play in future Nordic re-

sponses to drug problems, where in some countries, like Finland and Sweden, the majority of the abusers prefer other illegal drugs (amphetamines) than opioid, but still would like to receive some assistance.

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Buprenorphine treatment in Denmark

Introduction

The limits for the treatment of substance abusers can be found in a number of laws that concern the health and social authorities (see Act No. 435 of 14 June 1995 concerning changes to the Hospital Sector Act, as well as Act No. 944 of 16 October 2000 concerning social services (Serviceloven) and Act No. 267 of 12 April 2000 on legal rights and administration in the social sector (Retsikkerhedsloven). while medical treatment with euphoriant substances is regulated through § 5 in The Medical Practice Act (Lov om udøvelse af lægegerning, LBK No. 272 as of 19 April 2001), which was most recently revised in 2001. According to this paragraph the Health Board decides what is meant by dependency creating substances. The Health Board distributes at regular intervals circulars that define more closely the regulations for how dependency creating substances are to be prescribed in general somatic and psychiatric practice, as well as in special circumstances such as substitution treatment.

Numerous controlled studies of substance abusers in methadone treatment have demonstrated lesser mortality and use of heroin than among untreated substance abusers, but effects on criminality have not been conclusively proven (Mattick et al. 2003 a). Controlled studies have shown similar results for buprenorphine and methadone, but a higher drop-out rate for buprenorphine treatment (Mattick et al. 2003 b). The purpose of substitution treatment is to not only stabilise the substance abuser medically, but also socially and psychologically. It is therefore recommended in Denmark that medicinal treatment not stand alone, but is accompanied by psychosocial treatment that deals with the substance abuser's psychological and social issues.

The first marketing approval for a treatment substance in Denmark was granted in 1979 for the product Temgesic, which

is used for the treatment of pain. Buprenorphine in the form of Subutex was released for substitution treatment in Denmark as of 14 May 1999. In Denmark it is the county that has responsibility for overall treatment. The county has likewise an obligation to see to it that an overall treatment plan is established as quickly as possibly, and combined with a municipal treatment since the municipality provides social services and further arrangements in connection with possible halfway-house treatment and aftercare.

The prescription of dependency creating medicines for the treatment of substance abusers can apart from short-term detoxification treatments only be carried out by doctors in county facilities and the probation services. These special prescription rights apply to methadone and buprenorphine. The prescription rights can be delegated to other physicians such as GPs and doctors at private treatment facilities. In order for a substitution treatment to begin it should be relevant in terms of a social treatment plan and meet the following criteria 1):

- There should be proof of opioid dependence (F 11.2) as defined in WHO ICD-10.
- The substance abuser should want treatment. Treatment should be voluntary with considerable weight being attached to the wishes of the client.
- Other relevant treatment alternatives should have been considered.
- Pregnant substance abusers who wish to complete their pregnancies should be offered substitution treatment in the event that detoxification is unrealistic.

Buprenorphine is today recommended as a first choice medication for new, primarily opiate dependent substance abusers. The substance is recommended due to its

low toxicity, for not suppressing breathing and for its fewer side effects.

The consumption of buprenorphine in Denmark in general

The Danish Medicines Agency publishes yearly medicinal statistics (The Danish Medicines Agency, 2003). For this article we have looked at the consumption of buprenorphine in the age bracket between 20 and 50 years. The rationale for choosing this group is that persons outside this group are rarely seen in substitution treatment with buprenorphine, as younger abusers are frequently offered drugfree treatment, while older substance abusers can more often be expected to be found in methadone treatment. Moreover, only consumption in the primary health sector is included since consumption in the hospital sector only to a small extent can be presumed to be substitution treatment.

The consumption of buprenorphine in this age group has undergone a development in which the number of persons in treatment has dropped during recent years (from 4,438 to 3,590 in 2001), while the number of daily doses has risen (from 407,933 to 621,708 in 2001). This seems to indicate that buprenorphine is used to a higher degree in long-term treatment, as it means that more daily doses are used per person.

Treatment with and abuse of buprenorphine among treatment-seeking abusers in Copenhagen Municipality

The internal monitoring system of Copenhagen Municipality oversees the continual registration of entries for treatment due to illegal substance abuse in the municipality.

The municipality contains between one third and one half of all the substance abusers in Denmark, although it only contains one sixth of the country's inhabitants.

Every year around 1 500 treatment episodes are registered in the SFS (Status og Forskningsystemet), wherein the substance abusers state which intoxicants they are seeking treatment for. Citizens can disclose up to 16 different intoxicants, whereof only one primary substance and a maximum of two secondary substances are registered.

Since 2001, Copenhagen Municipality has monitored the share of clients that are given substitution treatment in conjunction with registration. On a yearly basis around 1500 persons are registered for substitution treatment. Of the registered clients around 5–6 per cent are admitted for buprenorphine treatment while 50–60 per cent are admitted for substitution treatment with methadone. During this period substitution treatment has constituted a falling share of all treated users, while the share of those in substitution treatment who are offered buprenorphine consists of approximately ten per cent of all the registered persons in substitution treatment. The pattern is the same for new registrations and re-registrations.

Buprenorphine emerges for the first time as an illegal substance in 2000, when two citizens seek treatment due to buprenorphine as the primary substance. At no point in time has the number of applications in which clients desire treatment by stating buprenorphine as their first or second substance risen over one percent. In this sense, buprenorphine does not play a major role as an intoxicant among treatment seeking substance abusers in Copenhagen Municipality. Observations from the

drug scene and treatment facilities indicate that buprenorphine is purchased illegally by persons who wish to detoxify and free themselves from opiate abuse without contacts with the treatment system.

Moreover, there are reports of a small number of persons who abuse buprenorphine by snorting it. These are primarily persons who are allegedly clean from substances but wish to evade urine control, in connection with, for instance, cases involving the custody of children. The reason these people choose to abuse buprenorphine is that Copenhagen Municipality's laboratory for the analysis of urine samples is still unable to control for buprenorphine. However, the number of such persons is presumably quite low.

Conclusion

All in all, buprenorphine seems to be a substance that is used increasingly in the treatment of opioid abuse and is not widely resold in Denmark. The highest societal cost is the well-documented rise in drop-outs from treatment. This means that this type of medicine can only be used on unstable substance abusers to a limited degree. One can also note the high price of the medicine. Anecdotal reports about the abuse of buprenorphine should lead to more being done to monitor buprenorphine through urine controls in cases where it is expected that the abuser is clean, ie., not in substitution treatment.

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NOTE

- 1) Lov om udøvelse af lægegering (The Medical Practice Act), LBK No. 272 as of 19 April 2001:

§ 5 f. The prescription of euphoriant substances as a part of substance abuse treatment should be carried out by physicians within the municipal/county medical facilities or hospitals of the capital. However, individual prescriptions can be carried out by other physicians in connection with short-term abstinence treatment

Section. 2. Prescription rights as mentioned in section 1 can subject to negotiation be delegated to a GP (general practitioner) or practising specialist.

Section. 3. The Health Board determines more specific regulations for prescription and to that purpose associated distribution and control, as well as deciding whether the right, to give distribution and control measures shall

be decentralised.

Section. 4. This regulation does not apply to treatment in the institutions of the probation services. The Ministry of Justice decides in consultation with the Health Board the rules as regards co-operation between the physicians of the probation services and the physicians mentioned in section 1.

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Buprenorphine more common as a problem drug in Finland

According to information obtained from the Finnish Drug Treatment Information System (Partanen & Virtanen 2001; 2002; 2003)¹, abuse of buprenorphine has become more common among drug users seeking treatment. There was a clear change within the opiate group, although the relative proportions of the main intoxicant groups have remained at the same level in 2000–2002 (Figure 1). In 2000, heroin was clearly more common than buprenorphine as the primary opiate leading to the seeking of treatment, but in 2002 the situation had reversed.

Mixed substance abuse is common in Finland, and also among those who use opiates. Those who sought treatment primarily due to heroin used as secondary drugs (2. or 3. substance) in 2002 especially amphetamine (52%), cannabis (43%), and buprenorphine (34%). However, those who sought treatment due to buprenorphine mentioned as their second or third problem substance most frequently benzodiazepines (41%), cannabis (41%) or amphetamine (39%), but more rarely heroin (21%).

Of those who sought treatment due to buprenorphine, 82–85% had experience of injecting within the preceding month, while the proportion among the heroin users ranged from 49–74%.

Those who sought drug treatments primarily due to heroin were older (mean age 29.4 years) than those who sought drug treatment due to buprenorphine (mean age 25.4 years). The mean age of all the drug clients in the substance treatment services was 26.2 years.

Source: Partanen A. (2003) *The National Drug Information System 2000–2002: Buprenorphine more common as a problem substance*. *Tiimi* 6/2003, p. 7–10.

Figure 1. Primary problem substance of those entering treatment in 2000–2002 (%)

The proportion of those who have received opiate substitution treatment has risen during the last three years. One in four of those who sought treatment for heroin and one in ten of those who sought treatment for buprenorphine received opiate treatment.

Problem use of buprenorphine already in the 80s

Buprenorphine is not a new substance that only emerged in Finland among drug users in the 2000s. Signs of its problem use have been observed earlier. In a survey carried out among the clients of the detoxification unit at the Helsinki University Hospital in 1987–1991 (Meretniemi, no date), it was shown that the main substance of abuse was amphetamine at 31% of the clients, the mixed use of alcohol and drugs at 19%,

buprenorphine at 11%, cannabis at 10 per cent and heroin at 9%.

In the material now under scrutiny, the experiments of the 1980s are evident in the background for those seeking substance treatment primarily due to buprenorphine, although the experiments only became more widespread after the latter half of the 1990s (Figure 2).

The decrease of heroin use and the increase of buprenorphine in the 2000s have also become evident in the statistics on drug offences. The clear drop in heroin use started in 2001, when the supply stopped almost completely due to the reduction of heroin production in Afghanistan. Meanwhile, buprenorphine has already surfaced among seized narcotics since the latter half of the 1990s, but has according to the National Bureau of Investigation (Keskus-

Source: Partanen A. (2003) *The National Drug Information System 2000-2002: Buprenorphine more common as a problem substance*. *Tiimi* 6/2003, p. 7-10.

Figure 2. The relative share of those who began the use of buprenorphine and entered treatment due to drug abuse in 2002 in the age groups 15-19 years, 20-24 years, 25-29 years and 30-34 years according to the primary substance that led to the seeking of treatment.

rikospoliisin tiedote 2003) become more common in street trading due to the reduced availability of heroin.

The medicinal treatment of opiate dependents

Great hopes have been placed on the use of buprenorphine in the treatment of heroin users. The medical treatment results have been encouraging and hardly any risk of dependency or deaths due to overdoses are expected with its use. Buprenorphine has nonetheless falteringly become part of the medical treatment in Finland of opiate dependents. Due to a certain doctor who gained publicity in Finland by prescribing buprenorphine to a large number of patients, buprenorphine was labelled a non-manageable, self-medicating substance or even intoxicant. Buprenorphine has also become problematic since it is to a significant degree injected in Finnish drug culture, and therefore subject to the risk of communicable diseases.

The current medical treatment of opiate dependents has been seen to represent a

strict and restrictive substitution treatment model (Virtanen 2004) in which admittance to treatment has been subject to strict criteria and the realisation of medical treatment is carefully monitored (Decree 289/2002 issued by the Ministry of Social Affairs and Health). Both methadone and buprenorphine are used in substitution treatment. Criteria for treatment are among others a proven opioid dependence and previously failed detoxification attempts involving other treatments. Those receiving treatment for opioid dependence usually collect their doses daily from the treatment unit. Medical care and psychosocial rehabilitation are also an integral part of the treatment.

There have been positive experiences of buprenorphine in opiate treatment in Finland (Baas & Seppänen-Leiman 2002). Special state subsidies were granted to municipalities in 2002 and 2003 to increase among other things opiate substitution treatment and the development of treatment services for drug addicts with severe problems. In 2001, approximately 200

persons received medical treatment for opiate dependency; in August 2002, the number of persons in care was 400 and at an equivalent period in 2003, the number of persons in opiate substitution treatment was estimated to be 500 (Virtanen 2004; Villikka 2003). According to Schering Plough (2004) there were about 600 persons in opiate substitution treatment in Finland in the end of 2003 of whom 428 were in buprenorphine substitution treatment. However, the need for opiate treatment has still been estimated to be considerably higher than the supply, something that has resulted in the formation of treatment queues in some localities. One may have to wait to gain admittance to buprenorphine treatment especially in the metropolitan area (Villikka 2003).

Discussion

The use of buprenorphine as part of the problem use of substances has emerged as a topic in public debate in Finland after 2000 when the street use of buprenorphine has increased. The ascendance of buprenorphine into public consciousness has also been sped up by the development of the medical treatment of opiate dependents. The negative tinge attached to buprenorphine in the media has been caused by the medical care practices of the above-mentioned physician, which the supervising authorities have been forced to deal with accordingly.

From a medical point of view, buprenorphine is a effective drug in the treatment of opiate dependents, but has simultaneously proven to be a deepening problem among abusers and especially so among young ones. This has also been observed in treatment services, where there has been criti-

cism directed towards opiate treatment, as it has been demonstrated that those who seek treatment may continue its use on the street. The importance of non-medical treatment for persons hooked on drugs has also been brought to attention.

From the perspective of the treatment of problem users it is however important that the availability of medical treatment for opiate dependents is increased further in Finland despite the increasingly common street use of buprenorphine in Finland. The demand for opiate substitution treatment is greater than the current supply of this form of treatment. In Finland, opiate substitution treatment is very supervised, which in itself binds resources. This also restricts the supply of treatment. There is lively discussion in Finland about criteria for treatment and how treatment should be carried out.

Alongside the development of the treatment of opiate dependents, attempts have also been made to prevent the supply and spread of buprenorphine in the illegal street market. Finnish opiate abusers used to go on trips especially to France to get buprenorphine, which has had a liberal prescription practice. The Decree on the personal import of pharmaceuticals to Finland (1088/2002), which came into force at the beginning of 2003 and was based on the Schengen Agreement, stopped import from France (Hermanson 2003). However, the import of buprenorphine has also continued after this, although the source country has changed to Estonia.

Comparison of material from the National Drug Treatment Information System for 2000–2002 gives some indication that the use of buprenorphine may be starting at a younger age than previously. This

might reflect that buprenorphine has particularly aroused the interest of younger users and that it might become the first opiate used for some.

Typical in the substance abuse of buprenorphine is injection and its use as part of a mixture of various substances. A clear risk of overdosing is associated with the mixed use of buprenorphine, benzodiazepines and alcohol (Kintz 2001). Findings associated with buprenorphine cases involving deaths have also been observed in Finland, while overdoses associated with heroin have conversely decreased as the availability of heroin has dropped (Vuori 2003).

It is important that the extent of buprenorphine abuse and its various patterns of use and related user culture are monitored closely. Although the use of buprenorphine has presumably partly replaced heroin use among opiate users, this situation might change as the supply of heroin changes. There are also some indications that buprenorphine may have become the first opiate used among young

problem drug users. This may be creating a new type of substance abuse group, whose treatment will set new challenges for treatment service professionals. It would be especially important now to clarify to what extent buprenorphine has become an established product in the range of the drug trade, and to what extent those waiting in treatment queues use street buprenorphine as an alternative to legitimate medical treatment. It would also be valuable to establish how well medicinal buprenorphine treatment alongside improvements in the life situation of users reduces the side use and injection of buprenorphine and benzodiazepines.

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NOTE

- 1 Anonymous statistical information on clients who have sought treatment for substance abuse at treatment services, as well as their use of services, social background, substance use and risk behaviour is collected in the National Drug Information System.

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From methadone to medicine-assisted rehabilitation

The Norwegian Storting decided in 1997 that medicine-assisted rehabilitation was to be a countrywide treatment offered to opiate abusers that met a given set of criteria. The then Ministry of Health and Social Affairs had prepared provisional national guidelines for those who were entitled to such a treatment so that the treatment proceeded under the auspices of the programmes sanctioned by the Ministry (Rundskriv I-25/98). In comparison with other countries, admittance criteria were and still are strict (>25 years of age, long-term opiate abuse, other treatment measures undertaken).

Initially, substitution treatment was one-sidedly tied to methadone (methadone-assisted rehabilitation). However, several doctors prescribed buprenorphine (Temgesic) and codeine to drug users outside sanctioned programmes. The Norwegian Board of Health pursued the matter legally in order to stem non-regulated prescribing, but did not succeed in its endeavour.

Buprenorphine in from the cold

Alongside the problems the authorities had with trying to assume control over doctors who carried out non-regulated prescriptions of buprenorphine to substance abusers, a discussion arose over whether Subutex was as suitable as methadone in substitution treatment. The then Minister of Social affairs travelled to Paris in the spring of 1999 to study the French experiences with Subutex. On her return, the Minister of Social affairs made it clear that she wanted to allow the use

of substitution treatment also in Norway. Subutex was approved as a medicine in medicine-assisted rehabilitation as of 1 January 2000.

Buprenorphine equated with methadone

The guidelines for substitution treatment therefore no longer became specifically tied to methadone, but to medicine as a link in medicine-assisted rehabilitation of narcotics abuse. One thereby went from the use of the term methadone-assisted rehabilitation to medicine-assisted rehabilitation. It is up to the prescribing doctor whether opiate abusers approved for medicine-assisted rehabilitation shall be treated with methadone or buprenorphine. There are therefore an increasing number of patients in ordinary medicine-assisted rehabilitation that are treated with buprenorphine (Subutex) alongside the specific trial projects which we wish to illuminate. Of the 2,431 patients that were included in the medicine-assisted rehabilitation at the outset of 2003, twenty per cent or 484 were prescribed buprenorphine.

It is, however, still a precondition for all substitution treatment, regardless of whether methadone or buprenorphine is used, that it should happen within the framework of programmes approved for such treatment. The prescription guidelines have been changed so that doctors are no longer allowed to order and chemists no longer allowed to deliver medicine for substitution treatment of heroin abusers within procedures not approved by the Ministry of Health (Rundskriv IK-15/2000). Against the background of increased interest in the use of Subutex in medicine-assisted rehabilitation in Nor-

way, a review of research literature about the use of buprenorphine has been implemented (Bachs et al. 2001).

Sobuxone (buprenorphine with a naloxone core) has been introduced in individual regional centres. The medicine is exempt from approval requirements in Norway.

Special Subutex projects

■ The Subutex project in Kristiansand

During the period of 1999-2001, a study of 50 patients (38 men and 12 women) was carried out in Kristiansand. These patients alternately received high-dose Subutex for six months and high-dose methadone for six months (Espregen & Kristensen 2002). The goal was to ascertain which medicine provided the greatest benefit and patient satisfaction. After the patients were approved for medicine-assisted rehabilitation, they were randomised to either Subutex (16 mg) or methadone (flexible dose, on average 106 mg) in an open controlled study. After 26 weeks in substitution treatment with either Subutex or methadone, the initial treatment was gradually decreased and replaced with the other medication in order to complete an additional treatment period of 26 weeks.

After a completed treatment with each of the two medications, the patient could choose with which medication he or she wished to continue the substitution treatment. At the end of the project, seven of the 50 patients continued their treatment with Subutex, 41 with methadone, while one of the patients was dead and one was waiting to be admitted to a new treatment. It was concluded that both methadone and Subutex are safe medications within the framework of medicine-assisted rehabilitation

such as it is set up in Norway. It is said, however, that high-dose methadone appears to be the most well-suited medication and the most suited one for older, heavily opiate dependent patients, although Subutex is a good alternative in cases of therapeutic failure and side effects from methadone treatments.

A cost-benefit analysis of maintenance treatment was also carried out, wherein methadone was compared with Subutex over a period of a year after treatment began (Andresen & Jentoft 2002). The analysis showed that when taking as a starting point the number of persons that discontinued the treatment and the retention rate with the 50 patients receiving methadone and Subutex respectively, the societal gains were far greater with methadone than with Subutex.

■ The Subutex project in Oslo

Against the background of the long waiting list to gain admittance to medicine-assisted rehabilitation a time-limited trial project was initiated with Subutex but without simultaneous psychosocial follow-up care as it is set up within the framework of ordinary medicine-assisted rehabilitation. The purpose of the project was to see whether daily use of Subutex without control and with the use of other substances and no psychosocial support reduces the problems of heroin abusers on the waiting list to gain admittance to ordinary medicine-assisted rehabilitation.

Two studies were carried out during the course of the project. One of these was a randomised, double blind study lasting 12 weeks and comprising 106 patients (70 men and 36 women) where 55 patients received Subutex (16 mg) and 51 patients re-

ceived a placebo (Krook et al. 2002). The results showed that those who were in the Subutex group on average remained 42 days in the project compared with 14 days in the placebo group. Sixteen of the patients in the Subutex group participated in the whole project period while none did in the placebo group. The Subutex group reported a greater reduction in the use of opioids and other intoxicants than the placebo group. The Subutex group also reported improvements in their life situation. None of the patients participating died during the trial period.

In the other study everyone received an individually adjusted dose of Subutex for almost a year before admittance to ordinary medicine-assisted rehabilitation. All those who were included in the first study received an invitation to participate. In this study, which began with 96 patients, 38 completed the project and were directly admitted to ordinary medicine-assisted rehabilitation, while the rest were admitted gradually thereafter.

It was concluded that heroin abusers waiting to gain admittance to medicine-assisted rehabilitation would reap substantial benefits from buprenorphine (Subutex) as a temporary intervention. Those who received Subutex reported minor use of narcotics and an increased subjective feeling of well-being. It is said, however, that high-dose buprenorphine treatment is not enough to keep patients in treatment over a longer period without psychosocial support.

■ The Subutex project in Helseregion Vest

In 1999, a local-based buprenorphine-assisted project was initiated under the guid-

ance of the methadone clinic at the Bergen Clinics Foundation in Helseregion Vest for clients on the waiting list to gain admittance to medicine-assisted rehabilitation. The goal was to extend a time-limited offer under the direction of the local health and social services for clients that met the criteria for methadone-assisted rehabilitation. Those who participated in the project would receive an offer of ordinary methadone treatment. After Subutex was placed on an equal footing with methadone during the trial period, this was changed so that patients could choose if they wanted to continue with the Subutex, switch over to methadone or complete the treatment within a year. During the course of the project 59 patients were admitted (43 men and 16 women) whereof 43 completed the project (Haga et al. 2002). Most of these received a daily dose of 16 mgs. It was reported that the project appeared to be effective with regard to reducing the waiting time for treatment. The project showed positive effects for many of the patients, although so-called side use was still an occasional problem for many. The methadone clinic at the Bergen Clinics Foundation prefer Subutex in searching for the right dosages in the first phase. After having a decentralised prescription of Subutex, this has now been reined in due to problems with leakage. Now all the patients at the methadone clinic are administered Subutex initially.

■ Subutex in abstinence-oriented treatment

Not all heroin users are suited for maintenance treatment such as it is organised in Norway. They may be too young, have too "short careers as substance abusers", or not

have completed a non-medicinal treatment regime yet. In addition, not all heroin users want a maintenance treatment that in practice might last their entire lives.

The University of Oslo has a research project that comprises 75 patients (Kornør & Waal 2003). The criteria for inclusion are as follows: opioid dependence in accordance with the ICD-10 criteria, ≥ 22 years of age, a clear motivation as regards time-limited substitution treatment with freedom from opiates as the goal. Subutex is administered for nine months with three months adjusting to the right dosages and stabilising treatments, three months of treatment as a basis for problem-solving psychosocial interventions and three months of detoxification/slow withdrawal. Forty-nine patients have completed the treatment plan, 10 have discontinued the treatment, while 13 continued the treatment with the buprenorphine and three have died. Of the 49 who completed the treatment plan, 11 have since then re-continued the buprenorphine treatment. Twenty-four of the 75 have in other words switched over to the long-term maintenance treatment. There are no conclusions available yet, as the study is still underway.

Non-regulated prescribing – abuse of buprenorphine (Subutex)

When it comes to quota prescriptions there is continued non-regulated prescribing of Temgesic (low dose buprenorphine) and Dolcontin (morphine sulphate) to narcotics abusers in Norway. The extent of this is not known, however.

So far we have scant knowledge in Norway as to the extent of buprenorphine substances in user milieus, whether it be leak-

age from patients in approved treatment regimes or Subutex/Temgesic imported illegally. However, there have been some seizures of buprenorphine; in 2002, there was a seizure of 50,000 Temgesic tablets for instance.

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Subutex treatment in Sweden – an initial description

Historical overview

Methadone treatment of persons afflicted with intravenous opiate abuse was already initiated in Sweden in 1966 at the research clinic in Ulleråker Hospital at Uppsala by Professor Lars-Magnus Gunne. Since the beginning of the 1990s, it has also occurred at the university clinics of Stockholm, Lund and Malmö. The methadone programmes have always worked according to the strict criteria set by Dole & Nyswander (1965). The National Board of Health and Welfare has set limits for the maximum number of persons that can simultaneously be in treatment and for several years the maximum was 800 patients, although it changed to 1,200 patients as of 1 January 2004. On 31 January 2001, there were 749 opiate abusers on methadone, whereof 343 were in Stockholm. The number of heavy drug users in Sweden (i.e. those who have injected sometime during the past 12 months or used narcotics daily or practically daily during the past four weeks) has risen from 15,000 in 1979 to 19,000 in 1992 and 26,000 in 1998 (Olsson & Adamsson Wahren & Byqvist 2001). The share of those with opiates as the primary substance of abuse amounted to 15 per cent in 1979, 28 per cent in 1992, while 47 per cent used opiates in 1998. This amounts to 2,250 heavy abusers with opiates as the primary substance in 1979 and 7,300 in 1998, i.e. almost a triple increase. The treatment limits set by the National Board of Health and Welfare have led to only 10 per cent of heavy abusers receiving methadone treatment in spite of good results from such treatment. (Dole & Nyswander 1965; Stenbacka & Romelsjö 1997).

In Sweden, Subutex (buprenorphine) was introduced as a medicine for the substitution treatment of opiate dependence in autumn 1999. The text in FASS, a book for Swedish physicians with description of all pharmaceutical drugs and their use, states that it should be prescribed in combination with medicinal, psychological, and social treatment. A Swedish survey found methadone and buprenorphine to have comparable effects (SBU 2001).

The sales of Subutex at pharmacies have risen from the equivalent of 486 grams in 2000 to 3,131 grams in 2002. An average dose of 16 mgs means that around 540 patients entered treatment in 2002. Due to discontinued treatments etc., the actual number was perhaps 25–50 per cent higher, i.e. on the same level as the number of persons in methadone treatment. Whereas methadone treatment has been continually subjected to strict regulations, guidelines for the comparable buprenorphine treatment are completely lacking. A study by Heilig and assistants was of importance as regards the rapid development in the field. Forty patients were randomised for treatment with either buprenorphine or a placebo with additional psychological and social treatment in both groups. During the follow up a year on, 15 patients remained in the buprenorphine group while none of the placebo group remained in treatment. Repeated ASI-interviews in the buprenorphine group showed a marked improvement (Kakko et al. 2003). The study does not evaluate whether bio-psychosocial treatment entails advantages exceeding those of Subutex treatment. When the current study was planned, there was no information about Subutex treatment in Sweden. A questionnaire comprising 30 ques-

tions was carried out in May 2003 in 12 of 14 known clinics with Subutex treatment..

Characteristic features of Swedish Subutex treatment

The majority of clinics started their activity in 2000. Most of the registered patients accounted for in this description are from the four units in the Stockholm area (The St Erik and Huddinge reception at the Stockholm Addiction Center, the Maria Addiction Center and the Narva Clinic) and the reception at Ulleråker Hospital. Each of these clinics held a total of 80 or more at some time registered patients. The share of males was predominant. The most common admission criterion was at least a year of documented, intravenous opiate abuse, while some units accepted heroin users who smoked the substance. Most of the patients had experiences with Subutex, which they had bought before treatment, but few had been treated with methadone. The ways in which the patients sought treatment varied. All of the patients at the Stockholm Addiction Center, for instance, came from local outpatient clinics, perhaps after a referral from the social services. All the patients at one metropolitan reception came on their own, while 90 per cent were referred by the social services at another reception. A waiting period is to be expected in most places. The average Subutex dose is somewhere around 16 mgs per day. All the clinics except one stated that Subutex treatment was integrated with psychosocial treatment. As a rule, this seems to be adjusted according to the individual. The possibility of taking Subutex for treatment at home occurred at most of the clinics, but as a rule after a period without so-called side use. All of the clinics

mentioned that side use was common. Urine controls are carried out initially daily up to two times a week, but are gradually phased out after a period of treatment. Criteria for exclusion vary. At one clinic, patients are discharged upon the first instance of side use, while another reception cites "mixed use" and "insufficient motivation" as reasons for discharging a patient. All the clinics state that they have an ongoing co-operation with the social services as well as other agencies. As with methadone, retention is important in treatment. In most of the units between 40 and 70 per cent of the patients remained in treatment after 12 months.

Discussion

As is evident there are both similarities and differences between the Subutex treatments at the various units. There are similarities in admission criteria such as at least 1–2 years of documented opiate dependence, several years of opiate abuse, a large majority of the patients having tried Subutex before they received Subutex treatment, few patients with experiences of methadone treatment, quite frequent urine controls, and the possibility of "take-away" treatment. The average Subutex dose shows limited variation among the clinics. Each clinic cites cooperation with other authorities, although there is probably substantial variation. All the units except one mention that psychosocial treatment as a rule occurs on an individual basis in line with the recommendations set for methadone treatment in, for instance, Ward & Mattick & Hall (1998). Retention is

of central importance for successful treatment (negligible or no side use, an improved social and psychosocial situation) and is around 40–80 per cent, which is a decent figure.

Tangible differences exist as regards criteria for exclusion. There are also significant differences between units as to how patients enter treatment, which probably reflects differences in organisation. Since we lack more detailed information about patients and have far too little information about treatment content and the application of exclusion criteria, a comparative evaluation of programmes and treatment cannot be carried out. Now in the spring of 2004, a study on patient information, treatment content and the effects of the newly introduced guidelines is being planned. We know that sales of Subutex have increased, as have the number of treatment units and patients. In May 2004 new common guidelines for substitution treatment with methadone and buprenorphine were issued from the national Board of Health and Welfare. These have a two-year requirement of documented opiate dependence (previously four years for methadone, and often one year for buprenorphine). Thus, the two worlds of methadone treatment in Sweden have been merged.. How, this will affect treatment and patient characteristics is to be studied further on.

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Re-analysis of important Nordic studies

Robin Room (ed.)

The Effects of Nordic Alcohol Policies – What happens to drinking and harm when alcohol controls change? NAD publication 42, 2002, 180 p.

Alcohol policy as a part of public health policy has been an important aspect of the Nordic welfare states with emphasis on prevention or in modern terminology – health promotion. However, it has become increasingly difficult to defend this important aspect of the welfare policy with an ever-increasing market economy and globalisation. It took many centuries to learn about the harmful effects of alcohol. It was only in 1849 that a Swedish psychiatrist, Magnus Huss, introduced the disease concept “chronic alcoholism” and during the latter half of the 19th century that the temperance movement gained a foothold in the Nordic countries. Following these developments stringent alcohol control systems were introduced during the first quarter of the 20th century. Soon thereafter various interest groups started their campaigns to have the controls relaxed and they have to date succeeded in reducing the control quite considerably.

But unlearning is much faster than learning. Therefore, this review and re-analysis of studies carried out in the Nordic countries during the last 50 years or so is timely, and considers the impact of alcohol policies on alcohol consumption and the harm caused by drinking. Many of these important studies have only been previously published in a Nordic language.

In the introductory chapter the background and developments of alcohol controls are reviewed briefly as well as the development of Nordic social research on alco-

hol since 1950. The reader is reminded of the fact that alcohol policies were seen as part of the welfare state, and that evidence-based knowledge was seen as a necessary element in social planning. It is noteworthy that the authors use the past tense when writing this, which conveys the message to the reader that today these factors may sometimes be overlooked. Per capita consumption still remains an important indicator for the general alcohol policy, but it is important to understand the differential effects of policies on different segments of the population.

The evidence from 50 years of Nordic studies on changes in alcohol consumption related to policy changes, mostly in the way of decreasing control, is reviewed in the second chapter. Apart from the repeal of the prohibition in Finland, Iceland, and Norway which occurred before the period which this review covers, the most drastic effects followed the abolition of the rationing book (*motboken*) in Sweden in 1955 and the introduction of medium strength beer in grocery stores in Finland in 1969, along with a great increase in the number of other alcohol outlets. This resulted in a large increase in per capita consumption as well as a large increase in alcohol related harm. A general common sense observation was confirmed by this review, i.e. liberalisation of alcohol policy has the greatest effect on those whose behaviour was most restricted, as well as on the heavy drinkers who will drink even more. The evaluations from experience in the past should help policy makers, as well as the general public, to understand what kind of effects can be expected of future alcohol policies.

The next seven chapters that are based on an analysis of data from all Nordic countries further illustrate the last mentioned main point and help to foster understanding of the differential effects of alcohol policies on various segments of the population.

Two chapters are based on a re-analysis of data from Finnish panel surveys in 1968 and 1969 that studied who started to drink more and changes in the characteristics of drink-

ing occasions. These studies demonstrated that changes in consumption will be roughly proportionate to the original level of drinking in a group (chapter 3) and that increased availability of alcoholic beverages resulted not only in a quantitative but also in a qualitative change (chapter 4).

In chapter 5, an analysis of repeated survey data and a time series analysis of alcohol sales are used to study the effect of legalising medium-strength beer in Iceland in 1989. The main changes in consumption patterns occurred in the first year when beer was introduced and remained to a large extent three years later. The per capita sales increased in the first year as expected, but decreased temporarily again during the severe economic recession, only to re-attain the 1989 level in 1999.

The impact on alcohol-related hospitalisations of the repeal of medium-strength beer in grocery stores in Sweden in 1977 (chapter 6) and of the 1982 wine and liquor strike in Norway (chapter 7) are studied by time series analysis. The results showed a definite decrease in per capita consumption in Sweden and a reduction in alcohol-related hospitalisations in both studies.

The effect of an experiment of extended alcohol serving-hours in Reykjavik is the subject of chapter 8. The general experience was negative, except that the nightshift was easier on the police as previous street gathering after closing time was spread more evenly over the night!

In chapter 9 it is shown by survey data that political measures can be a useful tool to reduce the alcohol consumption of young people. In 1998 an age limit of 15 years for buying alcoholic beverages was enforced in Denmark with the aim of sending parents the message that children and alcohol do not belong together.

In the concluding chapter attention is drawn to the Nordic experience that big changes in physical or financial availability (i.a. alcohol prices) can have large effects. However, the magnitude of the effect may depend on other circumstances at the time,

such as general economic circumstances. Further, policy changes affect different demographic and other groups in a differential way, although drinkers tend to be affected proportional to their existing drinking level.

Under the increasing pressure from the alcohol industries it is necessary to bear in mind the important concluding message of this book that: "From a policy perspective, it is the effects on drinking problem rates which really matter." The Nordic policy impact studies support arguments for a general alcohol policy rather than more narrowly targeted policies.

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Solid report urges action

Thor Norström (ed.)

Alcohol in Postwar Europe. ECAS I. Consumption, drinking patterns, consequences and policy responses in 15 European countries. Folkhälsainstitutet, 2002.

Håkan Leifman & Esa Österberg & Mats Ramstedt (eds.)

Alcohol in Postwar Europe. ECAS II. A discussion of indicators on alcohol consumption and alcohol-related harm. Folkhälsainstitutet, 2002.

During her term as Swedish minister for health and social affairs, EU Commissioner Margot Wallström took the initiative for a comparative study on alcohol consumption, alcohol policy, and alcohol-related harm in the EU member states. The EU Commission jumped at the idea and the result became the substantial project called the European Comparative Alcohol Study (ECAS). It comprises the current member states in the EU (except Luxembourg) as well as Norway,

i.e. fifteen countries in all (referred to as “the ECAS countries” in the report).

The European Commission, the Swedish public health institute and ministry for health and social affairs, as well as the Finnish research institute Stakes are mentioned as financiers of the project. Eleven researchers from Finland, Norway, and Sweden have been involved in the research group, which also included a contact person from each country under scrutiny. Thor Norström from Stockholm University has served as project leader while Jussi Simpura from Stakes served as assistant project leader.

The work has been carried out on a broad basis and has produced a number of scientific articles along the way (31 of which are mentioned in the supplement to the final report). If my calculations are correct, the project also comprises five books, in which the two final reports with the title “Alcohol in Postwar Europe” (ECAS I and II) are covered.

The reports build on new research to a large extent, although previous work has of course also been used, which becomes apparent in the extensive list of references. As the title states, the ambition has been to cover almost the entire postwar era (1950–1995). Although there are gaps in a few series of figures, and data and definitions vary between countries, it nonetheless provides a very good foundation for the discussion on the role of alcohol in Europe, which is still in its infancy.

The external researchers invited to comment on the project, and whose views have been reproduced in the final chapter, talk of a milestone and a kind of “landmark in the alcohol field”. This is not just boasting. Above all, it means that we stand on firmer ground than previously as regards the central questions about alcohol consumption and related harm that are at the forefront of the alcohol policy debate.

Neither does this mean that we now “know everything” about alcohol. On the contrary, a valuable feature in the final reports is precisely that the researchers point at the need for further knowledge and better

foundations for comparative studies that not only include the current “ECAS countries” but also the countries that recently became new members in the EU.

The ECAS reports do, however, together with for instance the two international research overviews “Alcohol Policy and the Public Good” (Edwards et al. 1994) and “Alcohol: No Ordinary Commodity” (Babor et al. 2003) mean that we now know more than enough about the harmful effects of alcohol and the instruments of alcohol policy to be able to state what needs to be done, on a local, national level and at a European level in order to prevent harm. No European politician or civil servant in a position of trust can shirk their responsibility by citing that they did not know how serious the problem was or which measures should be taken.

The work within the project has been divided so that the Finnish research group has mapped alcohol policy in the examined countries and studied drinking patterns and their significance. In Finland, an analysis of the significance of economic factors for alcohol consumption has also been carried out. The Norwegian and Swedish researchers have treated questions concerning the development of consumption and alcohol-related harm over time in the various countries.

The connection between consumption and harm can be illuminated through modern time-series analysis. It shows that increased alcohol consumption entails increased harmful effects in all the examined countries. Unfortunately, this link is particularly pronounced in the Nordic countries. The researchers’ assumption that this can partly be explained by drinking patterns- i.e. that we in the Nordic countries tend to devote ourselves more towards drinking to the point of intoxication- seems reasonable, although there is a need for a firmer foundation here in order to make reliable statements.

In summary, the results mean that the dream still held dear by many – above all by those who are commercially involved in the alcohol sector, but also a few politicians –

that alcohol consumption can increase without a rise in attendant harm must be characterised as just that, a dream without foundation in reality. That which will perhaps prove to be the most important result of the study is also accounted for in this section: on the population level, increased alcohol consumption does not lead to decreased mortality in cardio-vascular diseases and neither does it lead to a decrease in general mortality. Even the cherished idea of a couple of glasses of wine a day as a health drink will therefore for the present have to be regarded as a dream.

The econometric relationship between income, prices, and consumption is recorded in a separate publication by Kalervo Leppänen et.al. Together with the mentioned time-series analysis they constitute a strong support for the so-called total consumption model, i.e. that alcohol-related harm can be limited with general means, such as alcohol taxation.

This certainly does not mean that total consumption is the only interesting indicator of alcohol problems. The distribution of consumption among individuals is of course just as important, and so too the way in which the individual consumes, i.e. that which can be summed up as a drinking pattern or drinking culture. It can be seen as one of the virtues of the ECAS project that a serious attempt has been made to study these aspects. Unfortunately, one is forced to note that access to data and the quality of them makes it difficult to draw reliable conclusions. The most important conclusion is that one needs to build, on a European level, a database of recurring studies of drinking patterns and individually experienced problems. This is not easy, as one is partly looking for comparability between countries. Partly one must also, when posing questions, formulate them so that one takes into account that differences in views on alcoholic beverages mean that the same term is interpreted differently in different countries.

The study of the drinking habits of youths in the so-called ESPAD project, which now comprises some 30 countries, points at difficulties that are both methodological and ad-

ministrative. It also shows that it is possible, however, and that much valuable information can be extracted from such studies.

In summary, it must be emphasised that the ECAS research group has accomplished quite a feat. The conclusions ("policy implications") that the group draw in the final chapter are well founded and modestly formulated. This does not mean that they are uncontroversial on the European alcohol policy scene. Nevertheless, they lend strong support to those who want the EU to take alcohol issues more seriously and that trade policy arguments should not always be given precedence over public health arguments. It was perhaps this that Margot Wallström hoped for when she proposed a comparative European study.

ECAS is also a report that calls for action on two levels. On the one hand, the conclusions about the connection between alcohol policy, consumption and related harm that exist in the report should be included in the basis for the work on the alcohol policy strategy decided by the EU Council of Ministers in spring 2001, which until now has been put on the backburner. On the other hand, the work of filling in the knowledge gaps that the report points at should be started immediately, as well as the formulation of common indicators for alcohol consumption and related harm that is developed further in the ECAS II report. For a Swede it feels perhaps even more urgent to have a follow-up, as the report here discussed ends in 1995. After that, our alcohol consumption has risen more than 30 per cent instead of dropping 25 per cent, which was the goal of the policy that the Swedish parliament adopted in the middle of the 80s.

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Everything about alcohol policy in Europe

Thomas Karlsson & Esa Österberg (eds.)

Alcohol Policies in EU Member States and Norway. A Collection of Country Reports. Helsinki: Stakes 2002, 470 pp.

The sociological aspect of alcohol research holds a special interest for those who determine or influence alcohol policy. Important premises for policy choices are descriptions of the extent of harm, theory formation on connections between consumption patterns and harm, studies on conditions that influence the extent of harm, and explanatory models for the causes of these contexts. The knowledge base of decision-makers is often insufficient. It is also important to ensure popular support for measures that affect people. The “precautionary” principle does not apply here since the most effective measures are often less than popular. On the contrary, the decision-maker makes great demands on reliable statements for systematically obtained information that leads to policy changes. After all, this is part of the nature of politics. This

does not mean that this is irrational, since politics should weigh different societal considerations. In this kind of evaluation, knowledge of policies in other places becomes an important premise for decision-making. This applies in relation to other municipalities as well as other countries.

In “Alcohol Policies in EU Member States and Norway”, edited by Esa Österberg and Thomas Karlsson we have now received a comprehensive account of alcohol policy in the current EU area. The book constitutes part of the EU-financed “European Comparative Alcohol Study”, ECAS.

The project has as a goal to analyse similarities, differences, drinking patterns, and alcohol consumption, as well as the collation of comparable data about the extent of alcohol-related harm.

There is no doubt that the book wishes to satisfy a long sought after need for accessible documentation about the situation in other countries. As such it can become a very useful contribution in the dissemination of information to decision-makers.

The most practical aspects for practitioners are the articles about the individual countries. These are in a positive sense of the word encyclopedic. The articles are built on a joint model that also includes some useful information about the history of the country, its population, and economy. Thus, one examines the situation according to subject matter and a systematic structure ranging from a description of production and the market to political measures, and finally something about the treatment sector.

Emphasis has been placed on an informative layout and a useful index, which makes it easy to leaf through to what one is looking for in the book.

The book contains two important chapters that do not conform to the model of the individual country reports, i.e., the article about alcohol policy on an EU level and the final summary report in which all the 16 countries are compared.

In this way, the book satisfies two needs in a way that actually strengthens the book. On

the one hand it is a contribution to theory formation about alcohol policy in the EU countries and the EU system and on the other it has easily accessible factual information about the individual countries. This information can often be useful in the political decision process, although it is seldom afforded room in theoretical articles.

Although not a book to be read from cover to cover, it is nonetheless strongly recommended that one set aside enough time for the country reports. They provide a range of facts that are not always easy to get hold of, while also showing the many political distinctions between national factions, which we usually perceive of as having the same policy. There are many pearls to be found for those looking for good pedagogic examples.

To give an account of the alcohol policy in 16 countries in a way that allows for comparison is not without its problems. ECAS established national contacts in the research milieu of all the countries. The editors opted for the country reports being written locally after a standard model. It became apparent that a significant number of the countries contented themselves with collating data for the articles so that Österberg and Karlsson not only conceived a general model but also put together the articles. The danger with this is that the author is not sufficiently familiar with the material. The advantage, however, is that the individual articles become more comparable. If one wants to repeat the project one should surely choose a model that employs the same group of authors for all the country descriptions.

The coverage of preventive programmes influencing attitude is not particularly systematic. Despite great political will to invest in this area, these are measures that lie outside the focus of sociological alcohol research, other than as examples of what one can choose instead of effective measures. The descriptions become incidental and perhaps to a higher degree than in other parts of the account subject to the values of the national contact. It is in any case a debatable conclusion, when for instance the

promille campaign Bob in Belgium is described as a success.

The sections on substance abuse treatment are left hanging in the air. Here it does not seem as if there are any clear indications as to what is supposed to be described. Self-help organisations, for example, are described in some of the articles, but left out in others. This reflects well the situation the treatment sector finds itself in vis-à-vis the alcohol policy field in general.

One has made the right choice in collating information according to country and not political region, even more so because the summary in the final chapter provides a good comparison within each political region. If one wishes to understand the politics of a country, one should collate the most characteristic elements. One of the issues examined in the ECAS programme are changes in drinking habits and patterns between countries. The book raises some questions about this, but does not provide answers other than that habits and patterns seem to change more slowly than the level of consumption. A professional challenge in the future is to establish better teamwork between the professional and methodological sphere in order to illuminate this fact. Here analyses of quantitative studies are probably not sufficient in order to gain insight. Perspectives of a socio-anthropological and cultural variety would also strengthen the country descriptions. For me, the reading of Troels Lund's *Daglig liv i Norden i det 16. århundre* (Daily Northern life in the 17th century) is an inspiring source as regards the understanding of our alcohol traditions. However, it is a hundred years since that came out.

I mention this also because the attempt to group the countries according to political strength jars intuitively. I just cannot seem to get it to add up. It is not so much the calculations themselves, but whether they hit their mark. I would have liked to see it supplemented with a socio-cultural study for instance.

Another important question which in any

case should be afforded room in a new edition is the relationship between the four freedoms of the EU and the development in spheres where one wishes to achieve good sector-political results by regulating the market in one form or another. The issue is raised in the book in general ways. However, neither political development through legal decisions in the European Court of Justice or the discussion concerning the place of public health in the new EU Treaty is sketched.

I got off to a bang as a user of the book, as the day after I received the book, I received a call from the English radio channel Fivealive who were going to broadcast live from Oslo the following morning. This was the same day that a new alcohol report was published in England and they wanted to use the alcohol issue as a call-in theme in their morning broadcast from Oslo.

The chapter on the United Kingdom was duly read, and was an excellent aid when it came to commenting on Norwegian conditions to an English audience.

Esa Österberg and Thomas Karlsson have realised a pioneering work, which is also highly readable. However, it is first and foremost an extremely useful and easy to use aid which should find in its place on the bookshelf of all those who work with alcohol policy issues in research, administration and politics. Congratulations to the authors.

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A German gold mine of information

Bühringer, G. & Augustin, R. & Bergmann, E. & Bloomfield, K. & Funk, W. & Junge B. & Kraus, L. & Merfert-Diete, C. & Rumpf, H.J. & Simon, E. & Töppich, J. (2002)

Alcohol Consumption and Alcohol-Related problems in Germany. Hogrefe & Huber Publishers, Göttingen. 2002. 205 p.

Eleven German alcohol researchers joined forces in 2002 to publish a volume entitled *Alcohol Consumption and Alcohol-Related Problems in Germany*. The project was funded by the German Ministry of Health. It is a meticulous piece of work and therefore not perhaps a very easy and fluent reading experience, but for anyone interested in the German alcohol scene this detailed account of alcohol consumption, drinking patterns and alcohol-related harm is real gold mine of information.

Running to just over 200 pages, the volume is divided into six chapters: background and aims, production and consumption statistics, alcohol consumers and alcohol consumption by consumer groups, alcohol-related problems, recommendations for sensible drinking, and summary and discussion. The authors set themselves the goal of producing as accurate a quantitative description of alcohol consumption and alcohol-related problems in Germany as possible. It is also observed in the background chapter that debate and discussion on alcohol consumption and alcohol-related harm has increased in Germany over the past few years. This, it is suggested, is attributable in part to the publication in 1994 of *Alcohol Policy and the Public Good* by Griffith Edwards and colleagues, which was also translated into German in 1997.

Varying estimates

As well as addressing some fundamental issues about the measurement of phenomena related to alcohol consumption and alcohol-

related problems, the book has some very practical goals. One example is provided by the chapter on alcohol consumption statistics, which sets out to recount the figures for alcohol consumption in Germany. At first glance this might seem a relatively simple undertaking, and indeed in principle it involves just two relatively straightforward steps. The first step is to establish how many litres of different types of alcoholic beverage are sold in Germany; the second step is to establish the average alcohol content of these beverages. In practice, however, the task of compiling alcohol consumption statistics is quite a complex business, and as the authors of this volume demonstrate, there were in 1997 still some ten or so different, more or less authoritative lists and estimates of alcohol consumption in Germany. Per capita total consumption of alcohol, according to these different sources, ranged from 9.5 litres to 11.8 litres.

Working closely with the alcohol industry and trade, the authors have done some hard counting and arrived at the figure of 10.8 litres: this is now the official statistic for German alcohol consumption in 1997. The alcohol contents established in this process for different beverages will also be used in future calculations, unless continuous monitoring shows they have changed. An agreement signed by the parties concerned regarding procedures for the future revision of average alcohol contents is attached as Appendix 1 to the book. Another outcome of this project is that the figures for total alcohol consumption in Germany in 1997 have been revised upwards in the statistics maintained by Dutch alcohol producers (and consequently in the Stakes statistical yearbook) from 9.5 litres to 10.8 litres.

It is a good measure of the accuracy and comparability of international alcohol statistics that the Dutch sources had regarded the old German figure of 9.5 litres as worthy of three stars, an indication of high reliability: clearly, in this light, there is a need for similar re-assessments of the reliability of existing statistics on overall alcohol con-

sumption in many other countries as well. One minor shortcoming in this German effort is that the authors have not produced or at least not presented any estimate of the amount of unrecorded alcohol consumption, even though they are well aware of its existence.

Young moderation

The most important contribution of the chapter on drinking patterns is its review of earlier studies on German drinking habits at national, state and local level. The approach adopted by the authors in this analysis is to classify consumers on the basis of their daily alcohol consumption. This yields the result that some 85 per cent of the German population are below the low-risk consumption level (which for men is 30–40 and for women 20 grammes of alcohol per week). From a Finnish point of view, however, the most interesting result is that in the age group 18–24, 15 per cent of women and 11 per cent of men have never drunk alcohol. In the age bracket 30–59 years, the corresponding figure is around 6 per cent; for men around 4 and for women around 8 per cent. The authors' interpretation is rather simplistic in that they observe that lifelong abstinence naturally decreases with advancing age. This is no doubt true, but surely it would be useful at least to ask why abstinence should still clearly decrease after age 25. Another possible approach to analysing the statistics presented would be to study the population by age cohorts. It is entirely possible that younger age groups are more moderate drinkers than older age groups, which might also explain why total alcohol consumption has decreased in Germany from 1980 to 1997 by some 16 per cent.

Harmful effects

The volume devotes more than 70 pages to alcohol-related problems, so there is plenty of material in the book for readers interested in this aspect of the German alcohol scene. The figures include an assessment of the direct and indirect costs caused by alcohol in

1995. Without going into this in greater detail, it might be noted that according to the working group's calculations for 1995 alcohol was responsible for some 31,000 deaths in men and just over 11,000 deaths in women in Germany. In addition to these 42,000 annual deaths, it is estimated that some 4 million Germans suffer from acute alcohol problems. The German population numbers just over 80 million, so it can be estimated that each year there are some 50 alcohol-related deaths per 100,000 population.

The quantitative recommendations offered in the volume for sensible drinking clearly show how risk levels have been revised downwards and how the criteria for these recommendations have changed over the past four decades. In the early 1970s, the risk level for liver cirrhosis was a ten-year history of daily alcohol consumption exceeding 120 grammes or 160–200 grammes a day. By the end of the same decade, the recommended limits for alcohol consumption were 60–80 grammes or 80–100 grammes, and for young adults 40–50 grammes. In the 1980s the limits continued to drop, and by the 1990s the recommendations were that men should not drink more than 30 grammes and women no more than 20 grammes of alcohol a day.

In each chapter the working group behind this volume has also presented its future recommendations. Therefore it might be appropriate to conclude this review with a general recommendation as well: It would be an excellent idea if other European countries followed the German example and undertook a national effort to carry out a basic survey of alcohol consumption, drinking patterns, alcohol-related harm and alcohol policy.

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Impressive evidence-base for alcohol policy

Thomas Babor (ed.)

Alcohol – No Ordinary Commodity. Oxford Medical Publications. Oxford University Press. 2003. 290 pp.

Minimum legal purchase age, a government monopoly of retail sales, restrictions on opening hours, restrictions on density of outlets, random breath testing, lowered BAC limits in the traffic, the suspension of drivers' licences for drunk driving, graduated licensing for inexperienced drivers, as well as brief intervention in health-care; all these measures are part of the top ten in effective alcohol policy measures that are recommended in a new authoritative overview.

The alcohol issue is a hot topic in the political debate. This is particularly true in countries where newly developing international trade agreements pose serious threats to the public health. The problem is that neither the EU nor the large international trade organisations such as the WTO consider the socio-political effects of consumption of various commodities. This becomes most apparent in the Third World, where the tobacco and alcohol industry now constitute a very serious threat to public health. A one-sided market-oriented thinking is also dominant in the EU bureaucracy, and has among other things forced radical changes to alcohol policy in the Nordic countries.

It is in this context that an international group of alcohol researchers led by Thomas Babor and sponsored by the WHO is making an important contribution with their book *Alcohol: No Ordinary Commodity*. The book can be seen as a sequel to the 1994 book *Alcohol Policy and the Public Good* with Griffith Edwards as editor and largely the same group of authors. The central message in the new book can be deduced from its title; alcohol cannot be viewed as an ordinary commodity. The market economy thinking that

has prevailed during the post-war era has completely dominated all international trade agreements and presumed that free trade and growth always brings about increased prosperity. However, this does not apply to alcohol. Alcohol differs from the majority of other commodities in that the marginal benefits of alcohol are negative. This is to say that an increase of alcohol consumption leads to more harm than good. There are, therefore, good reasons for the regulation of the alcohol market.

Alcohol – No Ordinary Commodity is built on a considerably broader research base than its predecessor. The amount of studies in this field has increased exponentially during the past decade. The foundation for the alcohol policy conclusions is therefore markedly stronger, even though the conclusions are the same in all essentials. The book consists of two parts: an epidemiological and an alcohol policy section. The epidemiological chapters describe on the one hand trends in consumption and drinking patterns and on the other links to various health consequences. This comprises the foundation for the alcohol policy section that contains both national alcohol policy strategies and alcohol policies at the community level. Here we have a presentation of a comprehensive international socio-medical and sociological research, where a number of methods used to prevent alcohol-related harm have been examined.

An important part of the epidemiological evidence is found in the work *The Global Burden of Disease* carried out by the WHO, and reported in *The World Health Report 2002*. Within the framework of this project, comprehensive studies on the epidemiology of alcohol have also been carried out, which in turn has supplied the field with new and important knowledge for alcohol policy. Globally, two trends emerge in the consumption of alcohol. In most regions of the world there was a peak in alcohol consumption around 1980, after which consumption dropped. This applied to most of Europe, Africa, Australia, as well as North, South and Central

America. However, in some regions there have been sharp increases, principally in Eastern and Northern Europe and in South-east Asia, which mainly reflect the deregulation of alcohol policy and increased purchasing power respectively.

Interesting new data based on worldwide studies is presented regarding drinking patterns and alcohol addiction. Even though this data is reasonable enough in broad terms, some of the details seem doubtful. Questions regarding the reliability and representativeness of data collected from certain regions need to be posed. One problem in particular is the WHO's classification of regions, which lumps together completely disparate alcohol cultures in summary values for both consumption and problems. Hindu dominated India with a population larger than that of the EU and with equally large regional differences within the country has been combined with among others Bangladesh, which has a Muslim majority. Various provinces in India have ever since independence introduced and alternately repealed total prohibition, rationing, alcohol taxation, and other alcohol policy instruments of control. For this to happen there must have been causes and effects, which are lost in this compilation. It is also questionable to combine the Nordic countries with Southern and Western Europe in a joint index as regards the harm of drinking patterns. This EU region receives here a very favourable index value, while the former Eastern European countries receive a very unfavourable index value. However, this comment is in no way a criticism of the underlying idea of evaluating the harm of drinking patterns. On the contrary, it is one of the book's most important contributions. It has become increasingly apparent that the tendency to drink to intoxication plays the most important role in the majority of alcohol-related problems, rather than the consumption of alcohol per se.

Here we can establish that Europe has a north-south gradient as regards intensive consumption (> 6 drinks during the same

drinking session, > 5 for women). In Northern Europe 2–3 times more drinking sessions lead to intensive consumption than in Southern Europe. At the same time, it is also clear that in absolute figures, intensive consumption occurs just as often or even more often in Southern Europe as the total number of drinking sessions is markedly higher. Therefore, the Italian has on average eighteen intensive consumption sessions per year compared to the Swede's eight and Finn's thirteen.

These findings are of major significance for the following chapter on health effects. In this chapter, the reports from the last few years concerning the positive health effects of moderate drinking are viewed from a new perspective. Firstly, the negative effects of alcohol outweigh the positive, even if one includes the protective effect of alcohol for above all cardiovascular diseases, but also for diabetes. Secondly, even for cardiovascular diseases a negative net effect of alcohol can be discerned on a global level. Thirdly, no protective effects of alcohol can be discerned on an aggregate level; when alcohol consumption in the European nations rises, the total mortality level increases as does the mortality in the majority of the diagnosis groups. No effect can be discerned for cardiovascular diseases here. It is largely drinking patterns that explain these health effects.

In this sense, the Nordic drinking pattern is a specific problem. It is this drinking pattern that explains why increased alcohol consumption leads to considerably more negative health effects than a similar increase in the southern European countries. This distinction has hitherto been lacking when some commentators, mostly cardiologists, have publicly advocated moderate drinking. Given the drinking patterns of Nordic inhabitants, the studies in recent years indicate that increased drinking will probably also lead to an increase in cardiovascular diseases. This is what happened in Russia after Gorbachev's period of alcohol restrictions.

The following section of the book about alcohol policy and preventive measures does not contain any really new findings. The research of the past few years mainly confirms the results from previous studies accounted for in *Alcohol Policy and the Public Good*. However, the examination carried out is exemplary, well structured and well substantiated. An excellent element is the table that is presented towards the end of the book where different preventive strategies are graded. Here the effectiveness, the scientific basis, the cross-cultural experiences and the costs of implementing 32 different methods for the restriction or prevention of alcohol problems are evaluated. The lack of effectiveness of school-based alcohol education is also incontrovertibly clarified here.

The conclusion of all this is clear. The best effect is gained from general, national alcohol policy measures that restrict the economic and physical availability of alcohol. There are, however, a number of effective alternatives for those societies where it is not possible to carry out such a general policy. Largely these policies are also about availability and control: drinking-driving countermeasures, the control of alcohol serving in restaurants, and local measures to enforce age limits for alcohol consumption. The only informational initiative that has an effect on drinking behaviour is individual counselling for high-consumers within the health care system. However, major difficulties have been reported in many countries as regards the application of this strategy.

The moulding of public opinion is, however, necessary in order to gain the support of the populace for these strategies. For this, a *community mobilization* strategy of the traditional socio-medical type is recommended. In this type of strategy, *media advocacy*, or in other words a specific strategy for working with the media, can play an important role. A number of more traditional methods are otherwise quickly snubbed, above all school-based programmes and mass media campaigns, but also university programmes, warning labels, and alcohol-free leisure al-

ternatives. To this, one can add that a lack of research results is not the same as an absence of effect. Consequently, there is a new generation of school-based programmes on their way that has not yet been researched on a larger scale. These include initiatives to improve the psychosocial climate in schools, which mainly reduces the marginalisation of especially vulnerable children, and indirectly also reduces a number of risk behaviours including alcohol consumption.

Certain areas are lacking in the book. These are mainly to do with parents/family. Here effectiveness is proven fairly conclusively. Partly this comprises initiatives for unruly/vulnerable, small children and their families, and partly parental programmes based on literature on risk and protective factors. The latter can be directed towards both high-risk families and ordinary families. An important spin-off of these programmes is that they constitute a link to the local community and can be included in a strategy for local mobilisation. Moreover, the effect of integrating mass communications initiatives with local public health work is not discussed.

What is also lacking is a discussion on how drinking to intoxication can be affected. This stands out as a major flaw as so many of the disadvantages of alcohol can be attributed to intoxication.

Alcohol: No Ordinary Commodity is despite some minor and unavoidable flaws a very impressive work. The book can be heartily recommended to both decision-makers and professionals in the field of alcohol. The book delineates sharply the discrepancy that prevails between theory and praxis in this field. In practice, preventive measures are still governed by an approach based on the individual and treatment. However, from a public health perspective efforts based on the individual only yield limited effects that are furthermore short-lived, as the underlying societal system that produces the alcohol problems is not affected. Furthermore there is a one-sided focus on initiatives directed towards the youth. On the other

hand, the initiatives that research has proven to be most effective are often conspicuously absent. This is largely because local decision-makers often lack a research-based foundation for their prioritisations in this area. To that end, this book can fulfil an important service.

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Policy relevant social science

Thomas Babor (ed.)

Alcohol – No Ordinary Commodity. Oxford University Press. 2003. 290 p.

What could be more exciting than to review a book that declares to be a continuation of a work that started my research career under Kettil Bruun, “Alcohol Policies in Public Health Perspective” (1975). At the time, I was asked to collect and analyse statistics on world trends in alcohol production, international trade and consumption. That study resulted in my dissertation a few years later. The present volume offers a welcome opportunity to observe what has happened in policy relevant alcohol research in thirty years.

Babor et al. justifiably include in their work’s self-made genealogy, a second book, “*Alcohol and the Public Good*” under Griffith Edwards (1994). All three volumes have been sponsored by the WHO and co-authored by many researchers from several countries. They all focus on rates of alcohol-related problems in whole populations, mostly national, and they all summarise research evidence on the effectiveness of a selection of policy instruments. And they do

not hesitate to make clear and strongly formulated recommendations to policy makers and concerned citizens.

The main argument of the original purple book seems to have required little revision in the light of research since it was first formulated. The distribution of alcohol consumption is skewed so that the higher the average consumption, the higher the number of consumers exceeding a risk threshold however defined, and the higher the consumption level of those who are above it. If the average consumption can be influenced by policy measures, then the likelihood of risks and prevalence of harmful consequences are also affected. The major refinements to the 1975 formulation concerned first the exact mathematical form of the distribution. Then the so-called "prevention paradox" shifted attention from the heaviest consumers to the observation that some consequences may have risk functions such that the low or moderate consumers generate most harm among the population. For example alcohol-related accidents and injuries occur more often among the great majority of people who are not heavy consumers. The other important case is the j-shaped risk curve for coronary heart disease, meaning that alcohol has cardio-protective effects at low consumption levels.

These questions were adequately handled by research already summarised in the 1994 book. From the policy point of view, they were rather minor refinements – total consumption still remains the key target variable. "Less is better" nearly always at the population level.

After 1994 the most interesting new research findings concern the effects of drinking patterns and high risk situations on consequences both for individuals and for populations. These are described and discussed in the present volume but the authors do not change their conclusion: the total consumption remains the key indicator of the severity of alcohol problems in any population. Another new perspective is the use of summary measures such as the global health burden. Alcohol is the fifth most detrimental risk factor in the whole world, measured as Disa-

bility Adjusted Life Years (DALY) index developed by the WHO. In the developed world alcohol accounts for 9.2% of the whole burden of disease, third after tobacco and blood pressure. In emerging economies such as China and East-Central Europe, alcohol is the leading cause of lost life years. Such composite measures can, of course, be criticised for being merely calculations based on informed guesses about the causal role attributable to each risk factor, but in any case they do tell the sad story in concrete and comparable language.

In the basic message, then, no change in thirty years. Still the emphasis in each of the three books is different. Three words appear in the titles of them all: alcohol, public and policy, but the respective positions of these words are different. Bruun et al. presented the total consumption model as a public *health* alternative to the then prevalent control system that selectively picked "alcoholics" as the targets of control mainly for *social* reasons. The "*public good*" in Edwards et al. already is much more explicitly contrasted with the private good of the alcohol industries. As I read it, the *public policy* in the title of Babor et al. is a contrast to *privatised policy*. First, it signals a protest against the ongoing tendency in national and international policy-making to promote private interests at the expense of public health and social concerns. Secondly, it insists that policies be formed openly on the basis of solid evidence, not of ideology without proper public consideration of the consequences.

The shift is understandable given the context. It was no secret in 1975 that the total consumption approach implies state regulation of the market – although it did not in any way *stem* from ideological premises to this effect. That was the time when alcohol policy first began to be seen as a left-right political issue in the Nordic countries, but the purple book itself could hardly be read as a socialist manifesto against free trade. There was no need: the Nordic, Canadian and many US monopolies were steadily in place, and Alko partly financed the study.

Today, state alcohol monopolies have been privatised or have lost their public health edge. Babor et al. openly stress the continuing need for state regulation – and do this against a mega-trend towards completely free global markets.

The political emphasis aside, the recommendations have stayed as stable as the doctrine that underlies them. (1) Tax-regulated price policies, availability controls, limits on days and hours of sale, age limits, anti-drink driving policies, mandatory good serving practices and rule enforcement work. Also treatment services and early intervention practices have proven to be effective tools also in population-based prevention. (2) Education, information, community work without regulatory changes, partnerships and indirect methods such as social skills training are for the most part a waste of time. As the authors of the present volume say, something must be wrong as the first category of policies is so unpopular, and the second so favoured by policy makers. This is a very serious question at a time when many areas of the world are undergoing trade deregulations, including the Nordic countries and East-Central Europe, where alcohol is already a serious health burden. One cannot but conclude that it is irresponsible and harmful to waste money and time on education, “community-based prevention work”, networking and partnerships, while proven effective regulations such as taxation are being relaxed.

The present volume suggests two new avenues for future summaries of this type. Relevant new knowledge can be expected from neurobiological and genetic research on the mechanisms of intoxication and addiction. We may at some point have reason to go back to Jellinek-style typologies of alcoholism if mechanisms of different kinds of addiction will be identified. Genetic risk screening may be helpful in individual counselling, but even this will probably not change the basic factor of exposure, i.e. the total consumption and availability of alcohol.

The other avenue could already have been discussed more systematically in the light of existing research. Babor et al. do not explic-

itly evaluate the possibility of harm-reduction aimed at drinking patterns. This could be a policy option if indeed drinking pattern is an independent risk factor. Policies that have so far been justified in this way have been compromised because they are *also* conducted according to higher total consumption. The recent 40 percent tax and price reduction of vodka in Finland will be an interesting case for epidemiologists, since this time increased volume is accompanied by an increased proportion of alcohol consumed as strong drinks and – presumably – less healthy drinking patterns.

Babor's volume provides a methodological example on what policy relevant social science should do much more consciously than presently. We should be sensitive to variable cultural and social contexts but not be mis-carried by them. Many research results *can* be generalised, not within one study but across a large number of studies in different sites and situations, given that the singular studies are reasonably designed and reported. In contrast, “prevention projects” that have no specific and measurable goals and no identifiable input variables either, are of no use from the research point of view. For policy making and persuasive purposes it may be justified to stress, as Babor et al. do, that the research basis is there, and even strong. From a scientific point of view, there is much to add to this basis especially on the efficacy of policy measures targeted at (a) social harm, (b) high-risk situations such as late night drinking, and (c) drinking patterns. Although the causal mechanisms from alcohol to harms might be impossible to detect in these cases, policy effects can be proven with adequate quasi-experimental designs. And that is what matters.

With its summary boxes, tables and user's guide this is a very recommendable book, not only to policy makers but also to those responsible for setting research priorities in the field.

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Drug users in the cold countries

Espen Houborg Pedersen & Christoffer Tigerstedt (eds.)

Regulating Drugs – between Users, the Police and Social Workers. NAD publication No. 43. Helsinki 2003, 117p.

Like the title tells, there are three main characters in this book: the police, the social worker and the drug user. The book, with its eight articles, is about drug policy in practice, not so much about legislation or formal strategies. Relying mainly on interviews and observations, the authors depict how the police, social workers and the users 'do their being' in everyday life contexts and what do they think of each other. The result is a picture of drug policy as "essentially a play – sometimes battle-like, sometimes harmonious – *between* these actors" as the editors put it in their introduction. Although the book is a joint Nordic product with articles from four countries (Denmark, Sweden, Finland and Norway) comparisons are largely left for the reader to make (there is, however, one page in the introduction discussing developments in each country).

Howard S. Becker, wrote in 1967 that when studying deviance, it is not about whether the researcher should take sides but about *whose side are we on*. The tone in most of the articles is critical, but words are cautiously put, that is, sides are not clearly taken. Maybe, in the climate of Nordic drug policies, this is wise despite what Mr. Becker said.

The book is divided into three parts. The first section deals with the drug users in Denmark. Although named "The users' view", this section does not present their views – it is about the concept of user participation (*brugerinddragelse*) in the Danish social policy. Vibeke Asmussen first depicts how the concept has entered social legislation and then conducts a Foucauldian analysis on the actual techniques of user participation in social services. The user is being

governed through the new ideas of empowerment and partnership, through the construction of self-governing and self-observing clients for social services. In the second article, Esben Houborg Pedersen continues on the same track. He focuses on how outreach work among users tries to make them visible, knowledgeable and governable by giving them a "voice" as active citizens.

The second section of the book deals with street-level policing in Denmark, Finland and Norway. Aarne Kinnunen has followed police raids to so-called "drug flats" (were illicit drugs are sold and/or used) in the Helsinki area and provides a detailed picture of a project during which selected neighbourhoods were put under intensified police control to address the population's safety needs and to develop a cooperation network with other authorities.

In her article, Evy Frantzen relies on Zygmunt Baumann's rejection of homogenous urban space because it "makes people hostile, reserved and greedy, and causes them to withdraw into their fortress homes" – Baumann prefers living together in a fellowship based on negotiation. Needless to say, fellowship and negotiation between the police and the drug users do not take place in Copenhagen "prohibition zones" where the users are not allowed to loiter, whether using drugs or not.

The study by Regine Grytnes also draws a picture of this hide-and-seek game between the police and the users in two other Danish cities (Randers and Odense). Maintenance of order in this way, cleaning up the streets from unaesthetic sight of drug users, blurs the distinction between illegal acts and illegal persons. (It should be noted, by the way, that this is not only a human rights problem of the "strict" Nordic drug policies, but that similar arbitrariness take place in "liberal" contexts, e.g., in Amsterdam there are prohibition zones.) The users who are routinely being swept from the streets lack rights as citizens, and are totally something else than partners in equal negotiations about urban space.

In the last article of this section, Elisabeth Myhre Lie takes the reader to Norway, to see how the mobile police squads encounter the drug users in Oslo. Based on observations and interviews of the police officers, she describes how they are trying to cope with the ambivalences of their daily work with the users.

The third part of the book is about the interaction and social dynamics between social workers, the police and drug users. Sakari Andersen analyses the discourses of the Finnish police and social workers in Helsinki and Turku, and Monika Skinjar their colleagues in Malmö and Stockholm. What is striking in these analyses, is that the two authorities talk more or less in unison, i.e. have very similar lines of argument. Shouldn't there be differences in approaches?

Eventually in the last article by Charlotta Fondén and Malin Leiknes, the users (Swedish) are allowed to talk for themselves. Like Skinjar, the users themselves find the police and social workers to be more or less the same in their role as fighters for the drug-free society. Some voluntary organisations seem to provide the users with a haven from the battlefields of the drug war.

Now let the users talk?

The book is a valuable opening within Nordic drug research. Despite some repetition between articles and stiff English in places, it is a nice piece of critical research on the control and construction of deviance. But after this opening, what next?

Should we hear some more of that "users' voice"? In this regard the book promised more than it gave: only the last article is based on user interviews, in others he/she is present only in professionals' talks and researchers' interpretations. Now that there are user organisations emerging in all of the countries – also in Finland, now after the book has been published – more research and other discussion on their role, claims and strategies, as well as on the reception of them by the authorities, would be very wel-

come. The first two articles by Asmussen and Pedersen set the direction for this type of research.

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Important book on mutual help

Keith Humphreys

Circles of recovery: Self-help organizations for addictions. Cambridge: Cambridge University Press, 2004, 238 p.

This important and useful book is in four parts. The first chapter discusses the definition, scope and origin of mutual-help groups. The second chapter is an overview of an international selection of addiction-related mutual-help organizations. The third and fourth chapters present studies of how mutual-help group involvement affects members, and the fifth chapter discusses the interaction between mutual help and professional treatment systems.

Humphreys rightly points out that, taken literally, "self-help" is a misnomer for what happens in mutual-help groups but opts for speaking interchangeably of "self-help" and "mutualhelp".

It is an asset that Humphreys knows the literature on mutual help in other fields besides addiction. The review of what mutual-help organizations are and what they are not is both innovative and accurate. It is without any doubt the best discussion of this complex phenomenon I have seen anywhere, and the distinction between universal and optional features is as helpful and elegant as it is simple.

The discussion of the generic factors behind the development of the mutual-help movement is refreshingly down-to-earth, and Humphreys presents a good critique of the fanciful but vague and non-substantive explanations presented in the literature.

Most of the research on alcohol-related mutual help has been carried out in North America, and the great majority of studies have dealt with 12-step movements. It is an important accomplishment that Humphreys presents useful descriptions of 19 organizations representing three continents and a wide variety of philosophies and organizational structures, including the Polish Abstainer Clubs, the Swedish Links, the Japanese Danshukai as well as Vie Libre and Croix Bleue. The book also covers North American alternatives to 12-step movements such as Moderation Management, Rational Recovery, SMART Recovery, and Women for Sobriety.

It is useful to distinguish between genuine mutual-help groups with peer leadership and groups led by professionals or voluntary outsiders. Professionals have played an important supportive role in many mutual-help organizations, but peer leadership is a defining criteria of mutual-help groups. Humphreys points out that several organizations described in the literature as mutual help turned out to be controlled by professionals who did not personally have the problem addressed by the group.

Some organizations have blended professional and peer leadership, such as the Clubs for Treated Alcoholics in the Adriatic countries. SMART Recovery is another borderline case. It was not started by people with a drinking or drug problem but by professionals who wanted an alternative to AA. The group leader is a volunteer but does not need to have a substance problem. The voluntary coordinator has access to a professional advisor between meetings.

It is also important to distinguish between mutual help and professional treatment inspired by mutual-help programs, for example, the Twelve Steps of AA. This distinction

is often forgotten in studies of the effects of mutual help. For example, a recent Norwegian review of meta-analytic studies of various treatment alternatives (Norges offentlige utredninger 2003) does not distinguish between spontaneous AA attendance, professional treatment applying the 12-step program or mandatory meeting attendance in prisons. In a similar fashion, the only available meta-analysis of AA studies (Kownacki & Shadish 1999) presents a distorted picture of both the content of the treatments and the characteristics of the populations studied.

Humphreys aims at presenting an evidence-based discussion of mutual help. "Evidence-based treatment" is a good catchword, but health professionals have a tendency to define "evidence" too narrowly and in terms of randomized clinical trials. Fortunately, Humphreys is well aware of the fact that mutual-help movements cannot be adequately studied with a treatment outcome protocol. Self-selection is an important and necessary component of becoming a member, and no truly randomized studies of mutual-help membership are possible. This does not mean, however, that the effects of mutual help cannot be evaluated.

First of all, actions taken by the public health and social control systems with respect to mutual-help movements can and should be evaluated. If medical practitioners advise their patients to attend mutual-help meetings, controlled trials can be designed to evaluate this advice. If courts use mandatory attendance to mutual-help meetings as an alternative to other penalties, this sentencing practice can and should be evaluated.

Secondly, other research designs provide information on how mutual help affects members. Surveying the literature as a whole, Humphreys shows that the effects of mutual-help involvement include reduced alcohol and drug use, diminished depression and anxiety, improved social functioning, changes in self-perception, and an increased number of close friends.

Evaluation studies are useful in selling the idea of mutual help to treatment professionals, but we also need to understand how mutual-help groups and organizations work. It is interesting to ask "what happens to people joining mutual-help groups" as an open question and for its own sake. An evaluation perspective does not necessarily set limits to the questions asked but may do so in practice. We should ask our questions about membership in mutual-help groups in a similar fashion as we would study the effects of joining a church or a political party. We thus need descriptive and qualitative studies of what happens at mutual-help meetings, how members interact in between meetings and how groups and the mother organizations are kept going and viable.

One key task is to describe and to evaluate various professional practices in relation to mutual-help groups. On this topic, Humphreys makes sensible use of both his good judgement and his impressive command of the empirical literature.

Individual healthcare professionals have made great contributions to mutual help, but full collaboration requires pervasive changes in the attitudes of professionals and better knowledge about the nature of mutual help. Surveys of health professionals in Australia, Germany and the United States show that only a very small proportion of clinical staff express blanket negative attitudes toward mutual-help organizations, yet only a minority have any significant interaction with them.

The effectiveness of widow peer-helping programs has been clearly established in multiple randomized clinical trials using both no treatment as a control condition and in comparison to much more expensive professional treatment. Nevertheless, professionals in Quebec totally discredited the local mutual-help network despite never having had any contact with it (Lavoie 1983).

One study (Toro et al. 1988) compared the social environment and social norms in two types of groups operated by GROW – a mutual-help organization of individuals with se-

rious psychiatric disorders. One set of groups was led by GROW members and the other set was led by professionals. GROW participants in peer-led groups rated the groups higher in cohesion, expressiveness, and self-discovery than did participants in the professionally-led groups. Outside observers rated participants in peer-led groups as talking more, providing more information and agreeing more often than did participants in professionally led groups.

Very few studies exist of the referral practices of professionals. One interesting randomized study (Sisson & Mallams 1981) shows that meeting attendance was much more likely if the clinician made an in-session phone call to a 12-step group member who talked to the patient and agreed to accompany him/her to a meeting than if the clinician just gave the patient a list of meeting locations and suggested attendance. The problem with the more effective referral practice of course is that the clinician cannot remain neutral with respect to alternative groups and their ideologies. Having personal contact with a group member also increased the client's likelihood of attending mutual-help groups for serious psychiatric disorders (Powell et al. 2000).

Members of mutual-help groups should not be used as some kind of junior social workers. In one recent study, AA/NA members were asked to call by phone recently discharged inpatients and to rate their "self-efficacy for self-help group attendance" using psychological scales (Caison 1997). Inpatients in the experimental condition were no more likely to attend AA/NA meetings than controls that had no callers assigned to them. This was because experienced AA/NA members were, for good reasons, reluctant to apply foreign concepts and language.

Humphreys presents many good recommendations towards better interaction between professional treatment and mutual help. For example, professionals should not think of mutual-help groups only as "after-care". Information of mutual-help groups and encouragement to attend should be

available at all levels of health-services. Inventories of local mutual-help groups should be available all over the system. Treatment units should not only offer meeting space but actively invite mutual-help groups to demonstrate their potential value to residents. Information about mutual help and visits to mutual-help groups should be included in the training and practice of treatment professionals.

Many countries carry out national surveys of the utilization of formal and informal health care for different disorders. Such efforts often ignore mutual-help organizations as a source of help. Questions about mutual-help groups should be included in inventories of help-seeking options.

Read this book.

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Drug use as a social indicator of well-being? Reflections on the conference “Globalization, youth cultures and drugs”

The Nordic Council for Alcohol and Drug Research (NAD) hosted on 26–28 April a conference on globalization, youth cultures and drugs. The conference was held in Kalmar, an idyllic small town in the south of Sweden where time seemed very much to stand still. Lined by quaint old wooden houses, the streets in the evenings were quite empty, and at the cemetery near the well-preserved old castle there was a stern notice which said “No jogging”. It was to this oasis that we descended from all around Scandinavia as well as Estonia, Lithuania and Australia, to discuss the consequences of globalisation and the new face of drugs and drug use.

The conference opened with an interesting presentation on technoculture by visiting speaker Sam Inkinen from Finland. He traced the beginnings of the phenomenon to Detroit in the mid-1980s when three DJs: Juan Atkins, Derrick May and Kevin Saunderson began to use the word “techno” to describe their style of house-oriented music. Apparently the inspiration came from techno-visionary Alvin Toffler, who in the 1970s had predicted that modern society was headed for a “future shock” as major structural upheavals in both the technological and social domains would cause widespread anxiety, depression and disorientation (Toffler 1972; Wikipedia 2004). In hardly no time at all, techno music sprang from a utopian, marginal phenomenon into a com-

mercial, mainstream phenomenon – which surely, Inkinen said, is one of the distinctive characteristics of globalisation. Is there anything today, he continued, that is not mainstream, or that does not rapidly become mainstream?

This, to me, was one of the main questions of the conference. Another question raised by many of the researchers was this: What is the rationale that explains the new kind of (illegal) drug use that was often described as controlled and recreational use associated with various subcultures?

During his presentation, Inkinen was asked by Finnish researcher Pekka Hakkara-inen what he thought was the difference between the hippie culture of the 1960s and 1970s and modern-day technoculture. The answer, which was later elaborated upon, was that in contrast to hippie culture, technoculture neither is nor seeks (any longer) to be an alternative to mainstream culture. On the contrary, technoculture is marked by a deep faith in technology and a pursuit of success in both private life and the world of work, and it also views success in very conventional terms. Some speakers described the youth cultures where illegal drugs are used as alternative, but comments by other participants called these descriptions into question and problematized the concept of alternative. The Norwegian anthropologist Per Kristian Hilden went the farthest in stating that “the mainstream has been culturalized, most items today are opposite items; the most counterculture phenomenon would be to say that you are mainstream.”

Two associations spring to mind for me from this and other descriptions of youth cultures at the conference. The first is a writing contest organised in Sweden in 1999 on the theme of blasphemy.

While writing an essay for this contest my friend Henrik Bruun asked me “What constitutes an act of blasphemy in present-day society?” At the time we agreed that the animal activists might be described as modern blasphemers who are fighting for a good cause. Later as I reflected on the question,

however, I was not completely content with the answer. What is blasphemy today? Maybe still, an act of violence that infringes upon life or the individual's most inviolable rights, such as manslaughter, but to describe such an action as alternative certainly doesn't seem right. At the same time Per Kristian Hilden's statement that "the most counterculture phenomenon would be to say that you are mainstream" must be seen as one designed to amuse. What remains then is a life like Michael K's in J.M. Coetzee's "The story of Michael K"¹: a life outside of society in such a thoroughgoing sense that one doesn't pay any taxes, doesn't work in society or consume any of its goods or services, and doesn't accept any help from its institutions. This is so because our society today swallows all opposition and is based upon constant self-scrutiny and self-criticism. All activity in society, both support for and criticism of prevailing norms and structures, serves to uphold society, because it uses the criticism for self-improvement and development. And we at Kalmar are contributing to this self-same process. "Why," Maja Skrowny from Denmark asked me during one of our many coffee breaks, "why do you think that so much money is being invested now in research on various subcultures and drugs?"; and the only conceivable answer seems to be that it is for the purpose of maintaining control, to learn about and to absorb the unknown, to transform the threat into a usable fuel. We are like experts and workers in an enormous nuclear power plant: our knowledge and comprehension is helping to regulate the control rods and to safely generate useful energy.

The other association that sprang to my mind from the descriptions of different youth cultures and drug use within those cultures was the book by L.W. Sumners on "Welfare, Happiness and Ethics"². Here, Sumners describes and discusses three main theories of welfare: hedonism, preferentialism (the maximal satisfaction of preferences and desires) and perfectionism (maximal [individual] perfection). All these -isms

seems to be overly simplistic in their common vantage-point of maximisation of this or that, but the interesting thing is that the values and underlying ideologies of the youth cultures described and analysed at the conference are highly congruous with these theories.

Airi-Alina Allaste, Sam Inkinen and Philip Lalander all described hedonistic values as typical of the youth cultures where drugs are relatively prominent, and Johanne Korsdal Sørensen talked about the pursuit of transgression beyond the ordinary emotional level by giving in to music and dance.

Per Kristian Hilden described in preferentialistic terms the values of what he called a new cultural climate among drug users: a pursuit of personal goals, ambitions, potentials and desires. Merete Mellum, in turn, talked about the accumulation of experiences as symbolic capital, while Kati Rantala talked about extreme experiences.

Rantala, Hilden and Allaste also talked about values that can be subsumed to perfectionism: self-improvement, focus on bodily fitness, mental growth, beauty and health, and success.

A main character for all these values is that they are opposite to the ascetic values of Christianity that have been attacked by many of the great thinkers of our time, including Sigmund Freud, Friedrich Nietzsche and Ludwig Feuerbach. Furthermore, all these values are in consonance with the values prevailing in mainstream culture today, even though they are perhaps somewhat more pronounced in the youth cultures.

This implies that the reasons for illegal drug use must ultimately be searched for not only in youth cultures, but in prevailing society and in the global systems that permeate and influence society. In line with this Philip Lalander also said that he would like to see Kirsten Verkooijen take a broader perspective in her ongoing study, so that it won't become just a critique of youth cultures but also of present-day society. He stressed the importance of a socio-critical

perspective and during our discussions at one of Kalmar's pubs promised this perspective to be included in his forthcoming book – which we are all very much looking forward to.

Within this broader position, Per Kristian Hilden's question as to why we tend to concentrate on illegal rather than legal drug use, also seems both relevant and important. We may ask why the prescription of legal so-called happiness pills has sharply increased in recent years, but we may also ask what this trend indicates.

Illegal drugs and legal psychopharmaceuticals

Over the past decade or so, happiness studies have virtually grown into an academic discipline. While objective instruments such as GDP and the UNDP Human Development Index³ have met with increasing criticism and proven to be ambiguous and imperfect measures of welfare, happiness studies have continued to gain ground and more and more international studies on subjective well-being have been done to compare the self-rated happiness of people in different countries. Interestingly, the results of these studies have shown that people in western industrial countries do not on average seem to be any happier than people in developing countries⁴ (Hoffman 1997, 46–47). Likewise, studies covering the period from 1946 to 1990 in the United States, Japan and France have shown no overall increase in happiness, and one recent study by David Myer covering the period from 1957–2002 shows a slight decrease in the percentage of very happy people in the United States (Diener & Suh 1997, 200–213; Bond 2003, 43). When these results are compared against the sharp increase in the use of different types of psychopharmaceuticals in western countries, the picture is gloomier still. Individual happiness is an important value in our culture that we are keen to foster. Bookshops and libraries are full of self-help books and magazine articles on how we can advance our well-being, and doctors are prescribing more

and more drugs to people who feel they are out of form, yet the happiness indices show we are none happier than people from poorer countries. Self-rated happiness is obviously not a totally objective indicator of how happy people really are, but it seems at least as easy to imagine possible confounding factors favouring the results of the industrialized countries as finding possible disfavoured factors.

What, then, does the increased use of legal psychopharmaceuticals indicate; and is the simultaneous increase in the use of illegal drugs (see Figure 1) partly indicative of the same thing? Oriental wisdom has various personal strategies that can help people achieve internal satisfaction at times of unsatisfactory external circumstances. Are the increasing prescription of legal drugs and thus perhaps also increased drug use indicators that should be taken into account in studies of subjective well-being? Is it possible that increased levels of illegal and legal drug consumption are, in some aspects, indicative of a too inhumane society? Is it possible that certain youth cultures are indicative of the same thing? Many of the originators of techno have begun to see techno as an expression of future shock (see page 190) and post-industrial angst (Wikipedia 2004).

What about the other theories of welfare, those of preferentialism and perfectionism? I have seen no empirical studies on how well societies are doing against their yardsticks, but it is a safe guesstimate that western countries would come out quite well in such comparisons – probably people in other countries cannot satisfy as many preferences and desires as we can, and almost surely people in poor countries cannot on average be as successful (as defined by our measures) and in good physical trim. There is, though, another side to this coin. We pursue happiness and turn to medicine if we're not happy, we satisfy most of our desires; but are these really our own desires, or have they possibly been created for us by the markets. We pursue perfection, but how do we achieve that goal: by cosmetic surgery, sili-

Sources: National Agency for medicines, Finland 2002, 292; EMCDDA 2003, 34 & 62

Figure 1. Percentage increase in the consumption of anti-depressants and in indicators of the consumption of drugs in Finland during the reform of welfare policy over the past decade.

con and steroids? The questions we need to ask are: Is this all just one big hoax; is our society high on drugs as well as on mass produced and prefabricated stimuli and alternatives; is ours a life of collective self-deception, does the exploitation of nature and environmental degradation go on without even giving our generation something essentially good in exchange?⁵

But are these hypotheses right? Are we using illegal and legal drugs as an alternative avenue to pleasure and satisfaction when we cannot find them in the sober society? Or are we instead trying to find more experiences of pleasure and greater enjoyment at all levels and with all conceivable means at the same time? Are the drug trips alternatives, or are they just one kind of trips among many others, or additions, complements to overall experiences? The question still remains: What are the ultimate reasons for drug use in youth cultures and how much weight do these reasons carry in relation to one another? In an abstract of Johanna Svensson's paper that she unfortunately never presented, the Swedish youths she interviewed said that the most important thing is to have several interests and goals in life and not to turn to drugs in response to a sense of emptiness in life.

The journey home

On the train back home, I lean back and enjoy the beautiful Swedish countryside that flicks by. How wonderful it must be to live out in the country, I think to myself, but how awkward if your living is an academic job. As the train pulls in to Stockholm, I see grey concrete buildings all around. I see someone who for some reason has become trapped on a narrow green triangle at the intersection of three busy roads. And I think: Why are all the buildings in these intellectual concentrations – (major) cities – so aesthetically repulsive, they weren't like that in ancient Greece. I descend from the train into a wall of faces I don't know. In Kalmar I was somebody, in Kalmar I knew many of the people who were there and we were a group, but here I am no one, and I believe I understand one of the interesting details in the presentation of Kirsten Verkooijen's.

Verkooijen had asked young people in Denmark whether they would agree if a friend described them as a member of the following groups: sporty, pop, hip-hopper/skater, bodybuilder, quiet, technofreak, computer nerd, religious, and hippie. Interestingly, quite a lot said they would agree with one, but no more than one of the statements (38.3 per cent). To view oneself as a member

of a specific group is perhaps a strategy for overcoming the sense of loneliness that may come in a society of pronounced individualism at the same time as the individual is surrounded by crowds of unknown people. This is not the case in all cultures; there are not metropolises everywhere and the languages of Cree, Innu, Ojibwa and Micmac do not even have a word for "I". If in any of these languages you want to express the idea that "I can see you", you have to say something like "you are seen by me". But how long will these languages that reflect such a different outlook on life be allowed to survive? The process of globalisation is leading to the loss of languages at the rate of two per week (Nordin 2004, 10).

David Moore from Australia began his presentation by explaining that there are both those who take a pessimistic view on

globalisation thinking it will lead to increased cultural homogeneity, and those who are more optimistic and who believe it will induce greater heterogeneity. In that case I am both an optimist and a pessimist: I am a pessimist from a global point of view in that I feel there is nothing we can do to halt the irreversible process of global degradation in terms of cultural and biological heterogeneity; but I am an optimist from a local point of view in that I believe heterogeneity can continue to grow and proliferate regionally. Through its contacts with other cultures that still retain their original distinctiveness, our society can benefit from an historically unique cultural enrichment that I hope we will look after, and preserve as far as possible for future generations.

Translation: David Kivinen

Johan Sandelin

NOTES

- 1 Coetzee; J.M. (2003): Historien om Michael K. [The story of Michael K] Stockholm: Brombergs Bokförlag
- 2 Sumner, L.W. (1996) Welfare, Happiness and Ethics. Oxford: Clarendon Press
- 3 The United Nations Development Programme UNDP has since 1990 published a Human Development Report which includes a Human Development Index (HDI). The HDI index consists of three factors or indicators: real GDP per capita; life expectancy at birth; and a factor that describes education, based two-thirds on literacy and one-third on attendance of lower education, upper secondary education, polytechnics and universities.
- 4 This was the conclusion of David Myers and Ed Diener in their study on subjective well-being and happiness in different countries (see Hoffman 1997). All in all the researchers reviewed one thousand studies from different coun-

tries, comprising 1.1 million people.

- 5 This pessimistic assumption is supported by certain objective indicators of welfare. In the rich countries of the world the number of suicides committed per 100,000 population is higher than in the poorer parts of the world (Diener 1995, 125). The same applies to the prevalence of depression and schizophrenia (Murray & Lopez 1996, 602-608).

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- ing Quality of life: Economic, Social and Subjective indicators. Social Indicators Research 40: 189-216
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Nordic alcohol statistics 1993–2003

With this contribution, the Swedish National Institute for Public Health (NIPH) presents a general overview of registered alcohol consumption in the Nordic countries. With the help of the Finnish National Research and Development Centre for Welfare and Health (STAKES) NIPH has collected statistical data on alcohol sales, retail outlets, licensed premises, death caused by alcohol and cases of drunken driving. We present figures for Denmark, Finland, Norway, Sweden, Greenland, the Faeroes and Iceland. The diagrams include figures for 1993–2003 while the tables only include figures for 1998–2003.

Unregistered consumption is not included in our figures. Unregistered consumption includes legal and illegal domestic brewing and distilling, smuggling, substitutes and alcohol imported in connection with travels abroad. Unregistered consumption in Norway, Sweden and Finland is estimated to be between 15–30 per cent of registered consumption. There has been an increase in the amount of tourist-imported alcohol in all of the Nordic countries. Considerable pressure has been exercised to lower alcohol duties to reduce private import from cheaper EU countries. In the autumn of 2003 Denmark decreased their alcohol taxes considerably and in 2004 Finland made a similar decision.

Registered alcohol consumption in the Nordic countries

■ Alcohol consumption

The Nordic countries prepare statistics over registered annual consumption – or annual alcohol sales figures. Even if unregistered

consumption is not included in our figures, the registered annual consumption figures give an impression of trends in alcohol consumption over time.

As the sales figures show, registered alcohol consumption varies between the Nordic countries. Greenland has the highest figure by 12.30 litres pure alcohol per inhabitant 15 years and older in 2002 while Norway has the lowest by 5.89.

The figures also show that changes have occurred over time with regard to overall consumption. Consumption was fairly stable in Denmark and in Greenland in the period 1993–2002 while an increase was apparent in Finland, Iceland, Sweden and Norway. Iceland had the biggest increase. Consumption rose from 4.45 litres of pure alcohol (1993) to 6.52 (2003).

■ Sales of different types of alcohol

There has been a considerable increase in sales of spirits in Denmark, a clear increase in Finland, some in Norway from 1993 to 2003 and, somewhat later, from 1998 to 2003, in Sweden, measured in terms of litres per head of population aged 15 and older. In 2002 Norway had the lowest consumption level of spirits, 2.83 litres per head of population aged 15 and older. In Finland, who had the greatest consumption of spirits, the consumption was more than twice as much for the same period. In 2003 the consumption was 6.61 litres in Finland.

Wine consumption, which once represented only a small fraction of Nordic alcohol preferences, has risen sharply for some time. Between 1993 and 2003 the biggest increases were in Finland, Sweden and Iceland. Finland has increased its consumption of wine from 10.26 registered litres to 25.55; Sweden from 15.54 litres to 25.00; and Iceland from 6.31 litres to 15.37 litres. Throughout the whole period the country with the highest wine consumption has been Denmark, where, in 2003, consumption reached 37.61 litres per head of population aged 15 and older. The reader should note that the figures for wine consumption in-

clude cider. In Finland, from the year 1995 shops and kiosks dealing in groceries were authorised to sell cider (with alcohol contents of 4.7 per cent or less). In Finland nowadays cider makes up for half of what is registered as wine consumption.

The figures reveal that people in the Nordic countries are beer aficionados first and foremost. Greenland tops the list with a consumption of 213.58 litres per head of population aged 15 years and older (2000). Denmark comes next, while Swedes drink the least beer. Beer drinking in Denmark has fallen from 145.06 litres (1993) to 115.90 (2003). The same applies to Finland with a fall from 104.55 litres in 1993 to 94.84 in 2003 and in Sweden with a fall from 62.79 litres in 1993 to 61.30 in 2003. The greatest rise is in Iceland, where between 1993 and 2003, consumption rose from 29.58 to 67.09 litres per head of population aged 15 and older.

The sale of alcohol in the Nordic countries

In Finland and Norway spirits, wine and strong beer are sold through government run retail outlets. In Sweden and Iceland medium strength beer is also sold across the counter in such outlets. In Denmark and Greenland there are no restrictions, and alcoholic beverages can be sold by anyone running a commercial business. Table 3 shows that the number of government outlets for spirits and wine in the Nordic countries has risen.

Alcohol and economy

In all Nordic countries, except Finland, the real price of alcohol went down at the end of the period (Table 4). In Finland this happened in 2004.

Money spent on alcohol by consumers has risen between 1998 and 2003 throughout the Nordic countries (Table 5). However, only in Finland and in Iceland its share of household consumption increased. State revenues from alcohol, as a percentage of total state revenues, decreased in all those countries where figures are available.

Alcohol related damages

All of the Nordic countries have initiated different types of measures to separate drinking from driving. Denmark, Finland and Iceland have a prescribed blood-alcohol limit of 0.5 ‰, Sweden and Norway 0.2 ‰. Table 6 shows an increase of cases of drunken driving, from a relatively low level, in Sweden. In Denmark and Finland there has been a slight increase while in Iceland and Norway the number of cases of driving under the influence of alcohol has decreased.

Figures on deaths caused by alcohol related diseases include the incidence of deaths due to liver damage, alcohol poisoning, alcohol-related psychoses, alcohol dependence etc. (Table 7). Since 1996, classification and coding has been based on the ICD-10 edition of the World Health organisation's international classification of diseases.

Denmark had the highest number of deaths caused by cirrhosis of the liver, but Finland is not far behind. The Finnish number of deaths from alcohol poisoning, 338 persons in 2002, is remarkably high compared to the other countries. Looking at all alcohol-related deaths per 100,000 inhabitants 15 years or older, Finland and Denmark have much higher numbers than the other Nordic countries.

Figure 1. Litres of pure alcohol per inhabitant aged 15 years and over

Figure 2. Litres of spirits per inhabitant aged 15 years and over

Figure 3. Litres of wines per inhabitant aged 15 years and over

Figure 4. Litres of beer per inhabitant aged 15 years and over

Table 1. Annual sales of alcohol 1,000 liters, 1998–2003

Spirits		Wine	of which		Long drinks ¹⁾	Beer	of wich		
			Fortified wine	Table wine			Strong beer	Medium beer	
Denmark									
1998	15,206	154,211				556,704			
1999	14,559	158,841				542,013			
2000	14,642	165,033				532,154			
2001	15,600	167,999				515,777			
2002	20,083	162,726				508,389			
2003	25,442	164,393				506,533			
Finland									
1998	26,267	77,499	4,511	72,988	23,298	398,909	31,374	367,535	
1999	26,535	90,195	4,372	85,823	20,651	400,485	31,519	368,966	
2000	26,111	97,267	4,359	92,908	18,405	393,194	29,354	363,840	
2001	27,551	104,378	4,698	99,680	18,047	404,193	28,896	375,297	
2002	28,187	108,759	4,314	104,445	24,049	410,449	28,625	381,824	
2003	28,433	109,869	4,391	105,477	26,111	407,780	26,641	381,139	
Norway									
1997	9,578	40,778			2,851	237,125	1,527	225,683	
1998	..	..				..	..	..	
1999	9,491	44,855			4,252	230,456	1,146	220,370	
2000	9,578	48,762			5,295	232,676	1,302	223,267	
2001	9,132	48,579			5,556	229,730	1,166	221,456	
2002	10,234	54,953			5,884	236,391	1,373	228,305	
Sweden									
1998	24,050	129,729	3,102	126,627		436,065	194,065	242,000	
1999	24,676	140,107	2,694	137,410		458,395	218,395	240,000	
2000	24,948	144,225	2,619	141,606		439,061	224,061	215,000	
2001	26,676	157,087	2,566	154,521		437,001	239,001	198,000	
2002	27,439	174,954	2,468	172,755		446,693	257,393	189,300	
2003	23,284	184,446	5,493	178,953		448,499	265,348	183,151	
Iceland									
1998	968	1,982	386	1,596		10,965	10,965		
1999	975	2,257	418	1,839		12,206	12,206		
2000	978	2,517	486	2,031		13,048	13,048		
2001	961	2,827	547	2,280		13,685	13,685		
2002	909	3,159	656	2,502		14,566	14,566		
2003	805	3,436	693	2,743		14,996	14,996		
Faroe Islands									
1997	231	185	13	172		879	471	408	
1998	235	199	14	185		914	465	449	
Greenland									
1998	175	625	28	598		8,701	206	7,105	
1999	167	684		653		8,610	222	7,047	
2000	168	672				8,887			
2001	159	715				7,807			
2002	168	789				7,415			
1) Norway: Fruit drink, includes alcopops.									

1) Norway: Fruit drink, includes alcopops.

Table 2. Annual sales of alcohol per inhabitant, 1998–2003

	Litres per inhabitant aged 15 years and over				Litres of pure alcohol per inhabitant aged 15 years and over					Litres of pure alcohol per inhabitant
	Spirits	Wines	Long drinks ¹⁾	Beer	Spirits	Wines	Long drinks ¹⁾	Beer	Total	Total
Denmark										
1998	3.50	35.51		128.19	1.37	4.24		6.03	11.64	9.54
1999	3.35	36.55		124.72	1.37	4.36		5.87	11.60	9.49
2000	3.37	37.95		122.37	1.41	4.53		5.76	11.69	9.54
2001	3.58	38.58		118.44	1.39	4.60		5.57	11.56	9.41
2002	4.60	37.30		116.52	1.42	4.43		5.48	11.34	9.22
2003	5.82	37.61		115.90	1.60	4.47		5.48	11.55	9.38
Finland										
1998	6.28	18.52	5.57	95.30	2.30	1.58	0.33	4.38	8.60	7.00
1999	6.14	21.30	4.89	94.49	2.23	1.75	0.29	4.34	8.62	7.05
2000	6.15	22.92	4.34	92.63	2.22	1.85	0.26	4.27	8.59	7.04
2001	6.46	24.48	4.23	94.81	2.32	2.01	0.25	4.37	8.95	7.34
2002	6.59	25.42	5.62	95.92	2.37	2.11	0.34	4.43	9.24	7.60
2003	6.61	25.55	6.07	94.84	2.38	2.19	0.36	4.37	9.31	7.67
Norway										
1997	2.71	10.75	0.81	67.19	1.01	1.28	0.04	2.95	5.28	4.26
1998	..	..	..	..	..	..	..	..	..	4.20
1999	2.66	12.59	1.19	64.68	1.05	1.49	0.06	2.84	5.45	4.36
2000	2.67	13.61	1.48	64.92	1.05	1.62	0.07	2.93	5.66	4.53
2001	2.54	13.49	1.54	63.80	1.00	1.60	0.07	2.82	5.49	4.39
2002	2.83	15.19	1.63	65.34	1.12	1.81	0.07	2.89	5.89	4.71
Sweden										
1998	3.30	18.00		60.60	1.30	2.00		2.50	5.80	4.70
1999	3.40	19.40		63.60	1.30	2.10		2.70	6.10	5.00
2000	3.40	20.00		60.80	1.30	2.20		2.70	6.20	5.00
2001	3.70	21.70		59.90	1.40	2.40		2.70	6.50	5.30
2002	3.80	24.10		61.30	1.40	2.80		2.70	6.90	5.70
2003	3.80	25.00		61.30	1.30	2.90		2.80	7.00	5.70
Iceland										
1998	4.63	9.47		52.38	1.74	1.18		2.64	5.56	4.25
1999	4.59	10.63		57.48	1.76	1.25		2.89	5.91	4.53
2000	4.54	11.67		60.51	1.73	1.38		3.03	6.14	4.71
2001	4.39	12.90		62.47	1.68	1.52		3.12	6.32	4.86
2002	4.11	14.27		65.81	1.58	1.67		3.29	6.53	5.02
2003	3.60	15.37		67.09	1.39	1.79		3.35	6.52	5.04
Faroe Islands										
1997	6.90	5.50		60.90	2.68	0.66		3.25	6.60	..
1998	6.90	5.90		61.30	2.69	0.70		3.24	6.60	..
Greenland										
1997	4.01	15.87		204.93	1.61	1.89		9.31	12.80	9.28
1998	4.30	15.37		213.86	1.72	1.83		9.76	13.30	9.63
1999	4.10	16.76		210.95	1.64	1.99		9.61	13.25	9.64
2000	4.07	17.00		213.58	1.63	2.02		9.73	13.38	9.70
2001	..	..		..	..	..		..	12.50	9.30
2002	..	..		..	..	..		..	12.30	9.10

1) Norway: Fruit drink, includes alcopops.

Table 3. Number of establishments licensed to sell alcohol

	Number of retail outlets			Number of licensed outlets				
	All alcoholic beverages ¹⁾	Only beer ²⁾	Total	All alcoholic beverages ¹⁾	Only wines and beer	Only beer ²⁾	Others ³⁾	Total
Denmark								
1998				10,946				10,946
1999				11,192				11,192
2000				11,027				11,027
2001				11,139				11,139
2002				11,395				11,395
Finland								
1998	259	7,784	8,043	4,165	315	4,832		9,312
1999	268	7,630	7,898	4,439	309	4,393		9,141
2000	275	7,348	7,623	4,640	264	4,050		8,954
2001	284	7,199	7,483	4,861	244	3,903		9,008
2002	299	6,996	7,295	5,011	230	3,780		9,021
2003	314	6,886	7,200	5,086	212	3,435		8,733
Norway								
1998	120	4,448	4,568	3,613	2,304	144		6,061
1999	130	4,411	4,541	3,925	2,213	114		6,252
2000	141	4,413	4,554	4,311	1,939	104		6,355
2001	156	4,430	4,586	4,653	1,808	86		6,629
2002	176	4,336	4,512	4,908	1,776	98		6,871
Sweden								
1998	397			7,077	1,615	74	2,167	10,933
1999	403			7,371	1,447	46	2,185	11,049
2000	411			7,945	1,367	42	2,196	11,550
2001	416			8,090	1,269	42	2,150	11,551
2002	419			8,502	1,240	49	2,168	11,959
2003	420			8,707	1,180	49	2,146	12,082
Iceland								
1998	26	0	26					467
1999	32	0	32					505
2000	35	0	35					547
2001	39	0	39					564
2002	40	0	40					..
2003	42	0	42					..
Faroe Islands								
1997	6	9	15	26	4			
1998	6	9	15	26	4			
1) Norway: Spirits and wines. From 1.3.1993 spirits, wines and strong beer Sweden: Spirits, wines and strong beer 2) Finland and Norway: Medium beer 3) Sweden: All alcoholic beverages or only wines and beer or only beer								

Table 4. Real price indices for alcoholic beverages

	Real price indices for:				
	Spirits ¹⁾	Wines	Long drinks	Beer ²⁾	Total ³⁾
Denmark					
År 2000=100					
2000	100.0	100.0		100.0	100.0
2001	101.1	101.6		98.8	100.2
2002	101.6	102.4		96.0	99.0
2003	95.2	102.4		95.7	98.0
Finland					
År 1980=100					
1998	104	112	115	113	116
1999	104	112	116	114	117
2000	102	111	115	115	117
2001	101	108	116	116	116
2002	100	108	119	119	117
2003	100	109	121	120	118
Norway					
År 1998=100					
1998	100	100		100	100
1999	97	101		100	100
2000	97	99		102	100
2001	96	98		101	99
2002	85	94		99	95
Sweden					
År 1995=100					
1998	109	102		84	98
1999	111	103		82	98
2000	117	104		80	99
2001	114	100		78	96
2002	108	92		77	91
Iceland					
År 1980=100					
1998	92	130		73	102
1999	91	130		72	101
2000	87	125		71	98
2001	84	123		70	95
2002	84	121		69	94
2003	90	113		67	96
1) Denmark: Spirits and wine					
2) Iceland: Basis year for beer: 1989=100, Sweden strong beer					
3) Sweden: Spirits, wine and strong beer					

Table 5. Consumer expenditure on alcohol and state revenues from alcohol in the currency of each country (millions), 1998-2003

Consumer expenditure on alcohol						Alcohol expenditure as a % of household consumption	State revenue from alcohol as a % of:		
Spirits ¹⁾	Wines	Long drinks	Beer ²⁾	Total ³⁾	consumer expenditure on alcohol		total State revenue	direct and indirect taxes	
Denmark									
1998	6,914			6,393	13,307	2.3	28.47	1.14	1.15
1999	6,994			6,385	13,379	2.3	28.99	1.04	1.05
2000	7,331			6,461	13,792	2.3	..	1.11	1.12
2001	7,698			6,240	13,937	2.3	..	1.05	1.06
2002	7,967			6,020	13,987	2.2	..	1.03	1.04
Finland									
1998	1,003	634	120	1,492	3,249	5.6	55.7	5.6	6.8
1999	992	702	112	1,596	3,401	5.7	55.1	5.3	6.7
2000	1,010	769	105	1,621	3,506	5.7	53.7	4.8	5.8
2001	1,069	841	107	1,730	3,746	6.0	52.5	5.5	6.3
2002	1,099	892	149	1,824	3,965	6.2	51.8	5.5	6.6
2003	1,112	917	177	1,847	4,053				
Norway									
1997	4,191	5,132		11,011	20,334	4.1	55.0	1.9	2.3
1998	4,364	5,804		11,112	21,280	4.1	55.6	..	..
1999	4,218	6,366		10,964	21,548	3.9	58.8	..	..
2000	4,235	6,934		11,237	22,406	3.9	57.6	..	..
2001	4,011	6,881		10,979	21,871	3.5	57.5	..	..
2002	3,978	7,538		12,291	23,808	3.6	53.3	..	..
Sweden									
1998	8,550	9,994		7,526	26,070	..			
1999	9,201	11,145		8,561	28,907	3.4			
2000	10,109	11,989		8,993	31,091	3.3			
2001	10,308	12,635		9,436	32,379	3.1			
2002	10,379	13,238		10,045	33,662	3.1			
Iceland									
1998					10,117	3.2	78.5	4.4	4.9
1999					11,392	3.2	62.9	3.2	3.9
2000					12,342	3.3	60.9	3.3	3.7
2001					13,683	3.5	53.6	3.1	3.5
2002					14,701	3.7	47.5	2.7	3.2
2003					15,046	3.5	..	..	..
Faroe Islands									
1997	66	15		22	103				
1998	69	17		23	109				
1) Denmark: wine and spirits									
2) Sweden: From 1995 only strong beer (>3,5 vol%).									
3) Sweden : Spirits, wines and from 1995 only strong beer (>3,5 vol%).									

Table 6. Cases of drunken driving in the Nordik countries, 1998–2002

	Number of cases of driving under the influence of alcohol ¹⁾			Cases of driving under the influence of alcohol involving accidents with injuries of people ²⁾		Number of cases taken in custody for drunkenness	
	Total	Per 1,000 motor-vehicles	Per 1,000 inhabitants aged 15 years and over	Cases involving alcohol	Percentage of road accidents	Total ²⁾	Total in the capital ³⁾
Denmark							
1998	13,761	6.4	3.2	1,126	15.2	6,164	949
1999	14,372	6.6	3.3	1,202	15.9	4,899	615
2000	15,335	6.9	3.5	1,272	18.1	4,334	492
2001	15,502	6.9	3.6	1,140	17.1	2,970	280
2002	14,969	6.6	3.4	1,230	18.0	3,512	250
Finland							
1998	21,850	9.1	5.2	1,018	14.7	90,755	17,403
1999	21,940	8.8	5.2	994	14.2	94,134	16,847
2000	22,783	8.9	5.4	971	14.6	96,944	15,645
2001	22,722	8.7	5.3	942	14.6	95,913	15,832
2002	23,033	8.7	5.4	920	14.8	96,023	15,859
Norway							
1997	4,274	1.7	1.2			2,418	425
1998	4,416	..	1.2			2,270	361
1999	4,525	..	1.3			2,514	528
2000	3,901		.. 1.1			2,864	502
2001	4,821	..	1.3			3,094	641
2002	4,162	..	1.1			3001	669
Sweden							
1996	15,023		2.1	737	3.3	57,880	5,900
1997	13,551		1.9	753	..	61,324	..
1998	12,127		1.7	781	..	66,401	..
1999	13,941		1.7	791	..	52,131	..
2000	17,403		2.3	855	..	47,646	..
2001	18,030		2.5	974	..	45,323	..
2002	19,583		2.7	..	..	44,163	..
Iceland							
1998	2,111	13.2	10.1	44	4.4	..	..
1999	1,975	11.5	9.3	58	4.9	1,576	1,382
2000	2,482	13.8	11.5	55	5.5	2,117	1,806
2001	2,081	11.5	9.5	45	5.2	1,829	1,535
2002	1,859	10.1	8.4	43	4.1	1,529	1,186
2003	..	..	..	..	..	1,595	1,326
Faroe Islands							
1997	170			16			
1998	149			14			
Greenland							
1997	149	40.9	3.8			1,429	
1998	170	43.9	4.2			1,490	

1) Denmark and Sweden: Cases examined by the courts. Finland and Iceland: Cases registered by the police. Norway: Number of sanctions

2) Norway: Number of sanctions

3) Denmark: The capital district includes Copenhagen, Frederiksberg and Gentofte

Table 7. Number of deaths from alcohol-related illnesses

Alcohol psychosis and alcohol dependence ICD-10 F10 ICD-9 (291, 303)		Cirrhosis of the liver K70,K73-74 (571)	of wich Alcoholic liver disease K70 (571.0- 571.3)	Alcoholic poisoning X45 (980)	Total	Number per 100,000 inhabitants aged 15 and over
Denmark						
1992	265	738	473	56	1,059	24.6
1993	326	724	467	53	1,103	25.7
1994	237	872	586	48	1,157	26.9
1995	226	873	691	38	1,137	26.4
Finland						
1998	315	649	553	382	1346	32.2
1999	335	620	511	380	1335	31.7
2000	294	672	562	390	1356	31.9
2001	256	710	617	401	1367	32.1
2002	228	786	682	338	1352	31.7
Norway						
1998	176	189	189	20	408	11.5
1999	199	172	172	11	413	11.6
2000	189	185	185	11	401	11.2
2001	205	149	149	9	378	10.5
Sweden						
1995	308	589		122	1,019	14.2
1996	284	501		139	924	12.9
1997	411	442		65	918	12.8
1998	430	542		72	1044	14.5
1999	405	531		63	999	13.7
2000	374	512		81	967	13.4
Iceland						
1998	1	5	3	3	9	4.3
1999	7	8	5	.	15	7.1
2000	3	3	2	.	6	2.8
2001	3	3	3	1	7	3.2
Greenland						
1995	6	1	-	2	9	22.3
1996	1	-	-	2	3	7.4
1997	3	2	2	-	5	12.3
1998	1	3	3	-	4	9.8