

Medicalising Prohibition

Harm Reduction in Finnish and
International Drug Policy

161

Tuukka Tammi



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FOREWORD

This study about competing perspectives in drug policy can also be read as a crime story. The story has two protagonists who can, depending on the reader, both be regarded as the sympathetic character, the do-gooder, and the other one as anti-hero, the one accused of the crime that has been committed. The main scene of the narrative is Finland and the story has a twist at the end.

This jolly metaphor is to say that drug policy's in-built heavy moral load makes it simultaneously fascinating and boring as a research theme. On the fascinating end, it is rewarding to work on a subject that appeals so widely to professional and public sentiments. But on the boring end of things, drug policy is addicted to binary talk: soft versus hard, treatment versus punishment, fun versus misery, liberal versus conservative, 'doing good' versus 'doing justice'. I am afraid that I am not totally guiltless of maintaining this bipolarity myself either.

Along the way to dissertation, I have discussed it with numerous people and benefited from more comments than I can possibly acknowledge here. Being painfully aware of the fact that there will be people forgotten from the following list, I will still try.

I thank my two impeccable supervisors, Pekka Sulkunen, to whom I pay especial tribute for not letting his students take the easy way out, and Pekka Hakkarainen, whose expertise on drug research is unequalled in Finland. I am deeply grateful also to Matti Piispa, my third mentor.

I was honoured to have two highly competent scholars, Juha Partanen and Olavi Kaukonen, as the pre-examiners of the study.

I would like to thank all those who have commented and discussed my manuscripts in seminars and other meetings. Of particular importance as intellectual communities have been "the intervention group" at the Sociology department, the monthly drug research seminar, "Huumeseuja", at STAKES, and the seminars by the Finnish Youth Research Network. It is imperative to thank at least the following by name: Tommi Hoikkala, Toivo Hurme, Heini Kainulainen, Mirja Määttä, Riikka Perälä, Kati Rantala, Mikko Salasuo, Pauliina Seppälä and Christoffer Tigerstedt.

I have had three important opportunities to extricate myself from a simple-mindedness towards drug politics that threatens someone who has lived all his life in the European periphery. In 2003 I spent three months as a visiting researcher in Amsterdam (the Centre for Drug Research at the University of Amsterdam), in 2004, two months at the ISS institute in Bern, and in 2006, one month in the New York Department of Sociology at Queens College. In addition to meeting interesting people and seeing things happen, I was especially lucky to be hosted by three wise men: professors Peter Cohen, Harald Klingemann and Harry G. Levine.

Among international experts who I want to thank for their time are Tim Boekhout van Solinge and Robin Room.

I would like to thank the Academy of Finland, Emil Aaltonen Foundation, Jenny and Antti Wihuri Foundation, the Finnish Foundation for Alcohol Studies and the Scandinavian Research Council for Criminology for grants enabling me to write this dissertation. Other institutional thanks go to the Drug and Alcohol Research group at STAKES, the Youth Research Network, the Department of Sociology and NAD.

I want to extend my gratitude to my interviewees and other informants, and to the people at the A-Clinic Foundation who introduced me to this field in the first place. A word of professional thanks goes also to my mother, Mailis Taskinen.

And I thank Pauliina once more – for she is not to be thanked only for being an energetic commentator but also for other, more important reasons.

Helsinki and Koh Lanta in March 2007,

Tuukka Tammi

ABSTRACT

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The increase in drug use and related harms in the late 1990s in Finland has come to be referred to as the second drug wave. In addition to using criminal justice as a basis of drug policy, new kinds of drug regulation were introduced. Some of the new regulation strategies were referred to as "harm reduction". The most widely known practices of harm reduction include needle and syringe exchange programmes for intravenous drug users and medicinal substitution and maintenance treatment programmes for opiate users.

The purpose of the study is to examine the change of drug policy in Finland and particularly the political struggle surrounding harm reduction in the context of this change. The aim is, first, to analyse the content of harm reduction policy and the dynamics of its emergence and, second, to assess to what extent harm reduction undermines or threatens traditional drug policy.

The concept of harm reduction is typically associated with a drug policy strategy that employs the public health approach and where the principal focus of regulation is on drug-related health harms and risks. On the other hand, harm reduction policy has also been given other interpretations, relating, in particular, to human rights and social equality. In Finland, harm reduction can also be seen to have its roots in criminal policy.

The general conclusion of the study is that rather than posing a threat to a prohibitionist drug policy, harm reduction has come to form part of it. The implementation of harm reduction by setting up health counselling centres for drug users – with the main focus on needle exchange – and by extending substitution treatment has implied the creation of specialised services based on medical expertise and an increasing involvement of the medical profession in addressing drug problems. At the same time the criminal justice control of drug use has been intensified. Accordingly, harm reduction has not entailed a shift to a more liberal drug policy nor has it undermined the traditional policy with its emphasis on total drug prohibition. Instead, harm reduction in combination with a prohibitionist penal policy constitutes a new dual-track drug policy paradigm.

The study draws on the constructionist tradition of research on social problems and movements, where the analysis centres on claims made about social problems, claim-makers, ways of making claims and related social mobilisation. The research material mainly consists of administrative documents and interviews with key stakeholders.

The doctoral study consists of five original articles and a summary article. The first article gives an overview of the strained process of change of drug policy and policy trends around the turn of the millennium. The second article focuses on the concept of harm reduction and the international organisations and groupings involved in defining it. The third article describes the process that in 1996–1997 led to the creation of the first Finnish national drug policy strategy by reconciling mutually contradictory views of addressing the drug problem, at the same as the way was paved for harm reduction measures. The fourth article seeks to explain the relatively rapid diffusion of needle exchange programmes after 1996. The fifth article assesses substitution treatment as a harm reduction measure from the viewpoint of the associations of opioid users and their family members.

Keywords: drug policy, harm reduction, Finland

SUMMARY IN FINNISH

Tuukka Tammi. Medicalising prohibition. Harm reduction in Finnish and international drug policy [Medikalisoituvu kieltolaki. Haittojen vähentäminen Suomessa ja kansainvälisessä huumausainepolitiikassa]. Stakes, Research Report 161. Helsinki 2007. ISBN 978-951-33-1179-7

Huumeiden käytön ja tähän liittyvien haittojen lisääntyessä 1990-luvun jälkipuoliskolla alettiin Suomessa puhua toisesta huumeaallostasta. Rikosoikeudellisiin keinoihin pohjautuneen huumausainepolitiikan rinnalle tuotiin uusia tapoja säännellä huumeekysymystä. Osaa uusista sääntelystrategioista kutsuttiin ”haittojen vähentämiseksi” (engl. harm reduction). Tunnetuimpia haittojen vähentämisen käytännön sovellutuksia ovat neulojen ja ruiskujen vaihto-ohjelmat suonensisäisesti huumeita käyttäville ja lääkkeelliset korvaus- ja ylläpitohoito-ohjelmat opiaattien käyttäjille.

Tutkimuksen aiheena on huumausainepolitiikan muutos Suomessa sekä erityisesti haittojen vähentämistä koskenut poliittinen kamppailu tämän muutoksen osana. Tavoitteena on ensinnäkin eritellä haittojen vähentämispolitiikan sisältöä ja sen ilmaantumisen dynamiikkaa ja toiseksi arvioida, missä määrin tämä heikentää tai uhkaa perinteisen huumeepolitiikan asemaa.

Haittojen vähentämisen käsite liitetään tyypillisesti kansanterveysnäkökulmaiseen huumeepoliittiseen strategiaan, jossa sääntelyn ensisijaisena kohteena ovat huumeisiin liittyvät terveyshaitat ja -riskit. Haittojen vähentämisen poliittikalle on toisaalta annettu myös muita, erityisesti ihmisoikeuksiin ja sosiaaliseen tasa-arvoon kytkeytyviä tulkintoja. Suomessa haittojen vähentämisellä on myös kriminaalipoliittiset juuret.

Tutkimuksen yleinen johtopäätös on, että haittojen vähentäminen ei ole luonut uhkaa huumeiden kieltolakipolitiikalle, vaan on asettunut sen osaksi. Huumeiden käyttäjien terveysneuvontapisteinä – joiden keskeisin osa neulojen vaihtotointiminta on – ja laajentuneena korvaushoitona toteutettu haittojen vähentäminen on merkinnyt erikoistuneiden, lääketieteeseen pohjautuvien palveluiden syntyä ja lääkärökunnan lisääntynyttä panosta huumeongelmien hoitamisessa. Samanaikaisesti huumeiden käytön rikosoikeudellinen kontrolli on tehostunut. Haittojen vähentäminen ei siten ole merkinnyt siirtymää liberaalimpaan huumeepolitiikkaan, eikä se ole heikentänyt perinteistä huumeiden totaalkieltoon perustuvaa politiikkaa. Haittojen vähentäminen yhdistyneenä rankaisevaan kieltolakipolitiikkaan muodostaa uudenlaisen kahden raiteen huumeepoliittisen paradigman.

Tutkimus nojautuu sosiaalisten ongelmien ja liikkeiden konstruktionistiseen tutkimusperinteeseen, jossa analyysin kohteena ovat sosiaalisia ongelmia koskevat vaatimukset, niiden esittäjät ja vaatimusten esittämistavat sekä näihin kytkeytyvä yhteiskunnallinen mobilisaatio. Keskeisimpinä tutkimusaineistoina ovat hallinnolliset asiakirjat ja avainhenkilöiden haastattelut.

Väitöskirjatutkimus koostuu viidestä alkuperäisartikkelista ja yhteenvetoartikkelista. Ensimmäisen artikkelissa luodaan yleiskuva huumausainepolitiikan jännitteisestä muutoksesta ja muutossuunnista vuosituhannen vaihteen molemmin puolin. Toisessa artikkelissa keskitytään haittojen vähentämisen käsitteeseen ja sitä määrittäviin kansainvälisiin järjestöihin ja ryhmittymiin. Kolmas artikkeli kuvaa prosessia, jonka tuloksena vuosina 1996–1997 luotiin ensimmäinen kansallinen huumausainestrategia sovittamalla yhteen keskenään jännitteisiä näkemyksiä huumeongelman hoitamisesta ja samalla avattiin tietä haittojen vähentämiseen tähtääville toimille. Neljäs artikkeli tarjoaa selityksen neulojenvaihto-ohjelmien verran nopealle leviämislle vuodesta 1996 alkaen. Viidennessä artikkelissa arvioidaan korvaushoitona toteutettua haittojen vähentämistä opioidien käyttäjien ja heidän läheistensä järjestöjen näkökulmasta.

Avainsanat: huumausainepolitiikka, haittojen vähentäminen, Suomi

SUMMARY IN SWEDISH

Tuukka Tammi. Medicalising prohibition. Harm reduction in Finnish and international drug policy [Medikaliserande förbudslag. Skadereduktion i Finland och i den internationella narkotikapolitiken]. Stakes, Research Report 161. Helsingfors 2007. ISBN 978-951-33-1179-7

Då narkotikabruket och de därmed förknippade skadeverkningarna ökade mot slutet av 1990-talet började man i Finland tala om en andra narkotikavåg. Vid sidan om den narkotikapolitik som baserat sig på straffrättsliga metoder började man lyfta fram nya sätt att reglera narkotikafrågan. En del av de nya strategierna gick under namnet "skadereduktion" (på engelska harm reduction). De mest kända praktiska tillämpningarna för att minska skadeverkningarna är nål- och sprutbytesprogrammen för injektionsmissbrukare och läkemedelsprogrammen för substitutions- och underhållsbehandling av opiatbrukare.

Ämnet för undersökningen är förändringen i den finska narkotikapolitiken samt i synnerhet den politiska kampen kring skadereduktion som en del av denna förändring. Målet är för det första att specificera innehållet i skadereduktionspolitiken och dynamiken i dess uppkomst samt för det andra att bedöma i vilken mån skadereduktion försvagar eller hotar den traditionella narkotikapolitikens ställning.

Begreppet skadereduktion förknippas vanligen med en folkhälsobaserad narkotikapolitisk strategi, där regleringen primärt avser hälsorelaterade skador och risker med anknytning till narkotika. Politiken för att minska skadeverkningarna har å andra sidan också getts andra tolkningar, som gällt i synnerhet mänskliga rättigheter och social jämlikhet. I Finland har skadereduktion också kriminalpolitiska rötter.

Den allmänna konklusionen av undersökningen är att skadereduktion inte har skapat ett hot mot förbudspolitikerna på narkotikaområdet, utan blivit en del av den. Skadereduktion, som genomförts i form av hälsorådgivningsstationer för narkotikabrukare – där verksamheten huvudsakligen utgörs av byte av använda sprutor – och utvidgad substitutionsbehandling, har lett dels till att det uppstått specialiserade medicinska tjänster och dels till att läkarkårens insats ökat i behandlingen av narkotikarelaterade problem. Samtidigt har den straffrättsliga kontrollen av narkotikabruket intensifierats. Skadereduktion har således inte inneburit en förskjutning mot en mer liberal narkotikapolitik och den har inte heller urholkat den traditionella politik som grundar sig på totalförbud mot narkotika. Skadereduktion i kombination med en bestaffande förbudspolitik bildar ett nytt slags dubbelspårigt narkotikapolitiskt paradigm.

Undersökningen baserar sig på den konstruktionistiska forskningstradition som studerar sociala problem och rörelser. Analysobjekten i denna tradition utgörs av de krav som ställs för att lösa de sociala problemen ifråga, av själva kravställarna, av hur kraven framställs och av den sociala mobilisering som sker för att genomdriva dessa krav. Det viktigaste undersökningsmaterialet består av administrativa dokument och intervjuer med nyckelpersoner.

Doktorsavhandlingen består av fem originalartiklar och en sammanfattande artikel. I den första artikeln skapas en allmän bild av den spänningsladdade förändringen i narkotikapolitiken samt av förändringstendenserna före och efter millennieskiftet. Den andra artikeln fokuserar på begreppet skadereduktion och de internationella organisationer och grupperingar som bidrar till att definiera begreppet. Den tredje artikeln beskriver den process som åren 1996–1997 resulterade i den första nationella narkotikastrategin genom att samordna olika inbördes spänningsladdade synsätt på hanteringen av narkotikaproblemet. Samtidigt öppnades vägen för skadereducerande åtgärder. Den fjärde artikeln erbjuder en förklaring till den förhållandevis snabba spridningen av sprututbytesprogrammen sedan år 1996. I den femte artikeln bedöms skadereduktion i form av substitutionsbehandling ur opiatbrukar- och anhörigorganisationernas synvinkel.

Nyckelord: narkotikapolitik, skadereduktion, Finland

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- V Tammi, T. (2006). Who is the expert? Patient groups and Finnish substitution treatment policy. In: Asmussen, V., Anker, J., Tops, D. & Kouvonen, P. (Eds.): *Drug Users and Spaces for Legitimate Action*. Helsinki: NAD publications Nr 49, pp. 23–35.

“The INCB calls on Governments which intend to include “harm reduction” measures into their demand reduction strategy, to carefully analyse the overall impact of such measures. These may sometimes be positive for an individual or for a local community while having far-reaching negative consequences at the national and international levels.”

– Press Release No.4, 3 March 2004, The International Narcotics Control Board (INCB).

1 INTRODUCTION

Drug policy¹ is an exceptional field in international politics: the consensus among the international community on the need for drug prohibition and related heavy control systems is remarkable. Drugs are perceived to pose a threat, not just to health and well being, but also to the stability of nations and the structure of societies around the world (Carstairs 2005). The growth and globalisation of the drug control regime, i.e., world-wide drug prohibition, has led to dichotomous attitudes and to categorical rejection of alternative models for drug regulation.

The subject of this study is a drug policy approach called *harm reduction*. The approach has been subject to repeated confrontations in international, national and local drug policy-making since its emergence in the 1980s (see, e.g., Bewley-Taylor 2004). Harm reduction, in the context of drug policy, holds a variety of meanings and working methods, but it has been especially disputed politically due to its presumed aim of “shifting drug policies from the criminalised and punitive end to the more decriminalised and openly regulated end of the drug policy continuum” (Levine 2002).

What is common to methods under the rubric of harm reduction is also what makes it a politically delicate issue: all of the measures aim to reduce certain harms related to drug use without eliminating drug use as such. In addition to this feature, i.e., tolerating drug use to some extent, another claim of the harm reduction school of thought has been to activate, involve and “empower” drug users as legitimate actors to prevent and reduce the drug-related harm they experience; drug users are perceived as individuals capable of reasoning.

Predominantly, the harm reduction approach consists of two measures: exchange of clean needles and opiate substitution treatment programmes targeted at injecting and/or opiate users. Also some other methods, such as establishing safe-injection sites for drug users and educational prevention programmes, belong to the harm reduction tool box but to date, they have remained relatively marginal in practice. The concept of harm reduction arose in drug policy in the mid-1980s, when especially the growing recognition of the fact that sharing needles and syringes could lead to HIV infections among drug users had led to the establishment of programmes through which social and health workers, peers and other activists distributed clean injection sets as well as condoms, safer use and safer sex information to drug users to prevent the spread of HIV. In 1990, the First International Conference on the Reduction of Drug Related Harm was held in Liverpool, UK, a city where one of the first harm reduction programmes operated.

¹ “Drug policy” here refers to the international, national and local systems whereby the production, traffic, sale, use and possession of certain psychoactive substances are controlled and regulated. Primarily, however, this study is focused on drug policy from the viewpoint of societal reactions to use and users of these substances called illicit drugs.

Around the event and that time, the approach became named the harm reduction movement, and several organisations and networks were established to promote it. (see, e.g., Erickson et al. 1997; Riley et al. 1999; Tammi 2004.)

Before the 1980s and the introduction of needle exchange schemes, substitution and maintenance treatment² programmes for opiate addicts had been periodically available in the UK and USA since the 19th century; the USA had been home to major methadone programmes since the 1960s (Berridge 1993; Conrad & Schneider 1992; Riley et al. 1999). These treatments are typically regarded as part of the harm reduction movement. It is a matter of approach whether substitution treatment is seen as the root of the harm reduction approach, or whether it was originally a somewhat unrelated trajectory that was later subsumed and “monopolised” as part of the harm reduction movement.

My own interest in the harm reduction approach was aroused at the end of the 1990s, when as a recent graduate I had begun to work for a Finnish drug treatment agency introducing needle exchange and substitution treatment to Finnish drug policy. The context and background of the launch was a national drug policy crisis. This crisis and related policy reformation process took off when the level of drug use and related harms increased during the mid-90s. The harm reduction approach was put forward as a partial solution to increased drug-related harms and threats. However, for some time it seemed that harm reduction was the *source* of the crisis: needle exchange and substitution treatment became fiercely debated also in the Finnish political and professional fora. In short, the critics of harm reduction were afraid that it would destroy the very foundations of the strictly prohibitionist drug policy in Finland. The opponents argued that harm reduction practices would hinder the enforcement of prohibitive drug laws, lessen their deterrent effect, and normalise drug use by sending “the wrong message” to young people.

The debate on harm reduction in Finland was stormy, but surprisingly short-lived: in fact both the needle exchange programmes and substitution treatment became quickly and easily established. The version of the harm reduction approach that was adopted in Finland was strongly public health-based, which means – among other things – that the harm reduction approach did not include general demands to liberalise drug user control. In fact, the reverse happened: parallel to the adoption of needle exchange programmes and substitution treatments, criminal control of drug use and possession has become stricter, not looser (Kainulainen 2006).

This study describes the adoption of harm reduction practices which have set the scene for a new kind of *dual-track policy* in which both medical harm reduction and penal control of drug users are well-established, expansive parts of the official

2 In Finland the definitional difference between substitution and maintenance treatment is that substitution treatment includes more “ambitious” goals, such as eventual abstinence, whereas maintenance treatment aims “only” to reduce the most serious harms (see Working group... 2001, 43). However, in what follows, I will not draw a distinction between the two, but use the term substitution treatment to refer to both forms.

drug policy. Furthermore, Finland is not a deviant case in this sense: similar dual-track development has taken place in other countries where harm reduction practices have been adopted. Based on these notions, in this summary article I develop an argument that – despite the occasional strong confrontations between harm reductionist and prohibitionist approaches in political contexts – in practice the harm reduction approach constitutes an agreement and integrates well with the drug prohibition regime. As Harry G. Levine (2002) puts it, harm reduction is a movement *within* prohibition.

1.1 SUBJECT OF THE STUDY

The drug policy crisis and related conflicts between the drug policy stakeholders was the source of my motivation to start studying the harm reduction school of thought: I wanted to pin down the nature and dynamic of this seemingly controversial approach, and further, to determine if the prohibitionist drug policies really are threatened by harm reduction. To be able to answer these basic questions, I have subdivided them and conducted case studies on how harm reduction became conceptualised and adopted in Finland on different levels of drug policy.

To lay the necessary groundwork and contextualise the case studies, I have described the general evolution of drug policy in Finland (Tammi 2002) and analysed the history and ideological self-understanding of the international harm reduction movement (Tammi 2004) as part of the thesis. The first case study (Tammi 2005a), focuses on the use and interpretations of the term harm reduction in formal drug policy-making, *considering the contents and background of harm reduction discourse in the national drug strategy*. In the second case study (Tammi 2005b), I analyse the practical and political processes through which the “harm reduction flagship”, the needle exchange programmes, was diffused in Finland so as to eventually become a pivotal part of drug policy, and ask *how and why needle exchange programmes have succeeded and become established in Finland*. In the third case study (Tammi 2006), I consider whether the adoption of harm reduction caused changes in drug users’ political positions in the field of drug policy, that is, *if harm reduction’s promise of drug user empowerment held up in Finland*.

On the basis of the articles listed above, in this summary article I aim to present a more general narrative of the harm reduction adoption Finland. In that vein, I will further address three themes: the nature of the claims-making of the harm reduction movement; the processes whereby harm reduction has become adopted into national drug policies; and the consequences of harm reduction adoption in Finland. Accordingly, the article is composed as follows. Firstly, in chapter 2, after scrutinising the harm reduction proponents’ claims-making that sympathise with harm reduction for being an emancipating movement away from prohibitionist drug policy’s institutional exercise of power, moralisation and unjust practices, I

introduce some more critical interpretations of harm reduction ideals, according to which harm reduction is rather about a transition from an external-physical to internal-mental form of drug user control. In chapter 3, I move in the direction of *Realpolitik* by first reviewing earlier studies on the adoption of the harm reduction approach in some other national drug policies, and then discussing them with the results of my case studies from Finland.

1.2 DESIGN AND DATA

The research subject, harm reduction policy approach and its formation, is part of contemporary society. To explain the general context and rationales of contemporary events within a policy field, I have chosen particular cases from different levels of policy-making and practice, and analysed them to answer more general questions about the nature and process of harm reduction adoption in Finland. The idea in conducting case studies is to shed light on a wider phenomenon by illuminating its central parts (Yin 1994). In other words, to explain change we need to describe those unique and critical events that constitute that change. Describing the parts aims to explain the whole by triangulating data from multiple sources and settings (ibid., 13).

Hence, my case analyses on Finnish drug policy are focused on certain episodes of struggle from different arenas where the prevailing drug policy practice became reformed or contested. From the viewpoint of validity, the choice of cases can be critically evaluated and questioned, whether it is pre-eminently these cases that reflect the re-formations of drug policy rationales, or establish a chain of evidence for that (cf. ibid., 32–38). My choice of the three cases is based on ‘levelling’ rationale: one of them deals primarily with the formal, national policy-making level (Tammi 2005a), whereas the two others focus on the levels of national and local implementation and harm reduction practices (Tammi 2005b & 2006).

TABLE 1. Levels and data of case studies

Case study	Level of analysis	Main data
Discipline or contain? The struggle over the concept of harm reduction in the 1997 Drug Policy Committee in Finland. (article 3)	<i>National</i> policy-making.	Records of the Drug Policy Committee, interviews with seven Committee members.
Diffusion of public health views on drug policy: The case of needle-exchange in Finland. (article 4)	Spread of harm reduction practice <i>from abroad to and in Finland</i> .	Administrative & project documents, nine interviews with professionals around needle-exchange launch.
Who is the expert? Patient groups and Finnish substitution treatment policy. (article 5)	<i>Local</i> patients groups in <i>national</i> treatment system.	Documents by the patient groups, a group interview, e-mail exchange with the group members.

TABLE 2. Levels and data of contextualising articles

Case study	Level of analysis	Main data
Onko Suomen huume-politiikka muuttunut? (Has the drug policy in Finland changed?) (article 1)	Description of <i>national</i> policy field.	Policy documents, statistics.
Harm reduction school of thought: three fractions. (article 2)	History and claims-making of the <i>international</i> harm reduction movement.	Publications and other material produced by harm reduction groups, participation to a harm reduction conference as well as discussions and interviews with "activists".

The data for the articles of the thesis consist of official documents, working papers and other written material (articles, letters, web sites, petitions, etc.) produced by different actors in the drug policy field. Both thematically structured interviews as well as more informal discussion with drug policy stake-holders and research literature were used. Newspaper articles and records of parliamentary debates on drug policy were complementary data. The data used are documented in more detail in each article.

In addition to the case study strategy, the study draws on the social constructionist tradition of studying social problems. Simply put, it means that the researcher aims at recognising and describing conflicting *claims* about the nature of a social problem, *actors* making these claims (claims-makers) and the *processes* along which claims are being made and opposed (Spector & Kitsuse 1977). The

approach has its background in the major paradigmatic change that took place in the field during the 1970s and 80s. At the time, increasing critique towards positivist and functionalist paradigms, that had aimed at defining social problems in an objectivist manner, gave birth to a new approach that was labelled as the “constructionist study of social problems”, “social problems as claims-making”, or later simply as “sociology of social problems”. The approach viewed social problems, not as objectivist expert definitions, but as “social constructions which are created and maintained through individuals’ and groups’ expressions of claims about social reality and the subsequent responses of others” (Miller & Holstein 1989, 2).

Even though there are also “objective” social problems with links to concrete social, mental and material conditions, the constructionist approach has a limited interest in these conditions. Rather, it focuses on the collective representations and shared understandings of the problems and putative conditions behind them.³ Still, a mere description of claims-making about the nature of and solution to a given social problem is not enough: what is said needs to be linked to what is actually done. This stance is often termed a contextual constructionist view. In this study, contextualisation means that the overall claims-making repertoire of the international harm reduction school of thought is viewed at from the point of harm reduction realisation in Finland. As it is shown in the articles of the thesis, the claims by the international harm reduction movement would give room for a variety of different practical, structural and political applications, but what happened in Finland was in many ways a narrow and socio-culturally specific translation of harm reduction rationale into the local drug policy reality.

In addition to the social problems approach I have, in places, exploited the perspective of *social movements* in making sense of harm reduction activism. The social movement research tradition is close to the social problems approach, but is also sensitised to different perceptions, and thus leads to somewhat different conceptions of the research target (Bash 1995, 83). In this study, the social movement perspective is used to underline the fact that harm reduction, at least internationally, is also an organised movement that consists of particular groups of people with relatively persistent and insistent agendas. Harm reduction advocates also perceive themselves as a movement and strive for a collectively shared movement identity. Especially the drug users in harm reduction activism have been able to

3 As such, the approach has been sometimes criticised as overly relativistic, but it should be borne in mind that there are good reasons to for a researcher to limit his/her interest of knowledge: to describe the claims-makers’ theories and how these are used in practical activities, i.e. how the social reality is being conceptualised and manipulated, the researcher should not allow himself a special status as arbiter of truth. Needless to say, this does not mean I would not have drug policy biases. Studying drug control is inescapably an intervention to societal discussion around drug problems, and reflecting upon the background and setting of my own research, it easy to see the stimulus for research questions came, at least partly, from specific moral, salvation and government entrepreneurs, like Armand Mauss (1991, 190–192) has named the stakeholders of the drug policy field. Studying “harm reduction” as a policy option might be in the interests of those drug policy entrepreneurs who want to promote harm reduction-related treatment and prevention programmes (“salvation entrepreneurship”) and professional interests and careers (“government entrepreneurship”), as well as corresponding normative positions (“moral entrepreneurship”) on drug use and problems.

make good use of their new movement identities in deconstructing the restrictive social category of “drug user”. Still, I do not treat harm reduction as the domain of one particular special interest group – because it is not – but rather as a collective “cognitive territory, a new conceptual space that is filled by a dynamic interaction between different groups and organisations” (Eyerman & Jamison 1991, 55).

2 HARM REDUCTION CLAIMS-MAKING

2.1 RATIONAL PRAGMATISM AND DRUG USER EMANCIPATION

To understand the strong political disputes around harm reduction, we should see it as a reform movement which needs to justify itself by proving that its approach is better than the earlier prevalent praxis. This is achieved by means of various strong juxtapositions. Further, the international harm reduction movement has produced a number of programmatic texts, in which its principles, objectives and methods are contrasted with prevalent drug policy. When we read the founding texts⁴ of the movement it is fairly easy to see how the movement's self-image is constructed against the 'enemy' of punitive prohibition.⁵

In these contentious political formulations harm reduction becomes manifested as a rational and emancipating policy approach. There are at least three distinguishing emphases in harm reduction claims-making: 1) *pragmatism* of actions, and closely related to this, commitment to 2) *amoral approach*, and furthermore, trust in 3) *drug users'* rational and active *agency* as well as responsible *partnership* in harm reduction work.⁶

The first, pragmatist principle of harm reduction implies that we have to aim at an optimal regulation of drug harms in all situations by the best possible methods. In addition to value-freedom, pragmatism also means the requirement of evidence-based interventions. Scientific and empirical knowledge is the basis for actions. Erickson et al. (1997, 9) formulate this in an anthology on harm reduction:

“Harm reduction programs are not dogmatic and coercive structures. Rather, they are designed on the basis of accurate, scientific knowledge about drugs and drug use”.

The second distinguishing element, amoral approach to drug use, rises from pragmatism: risks and harmful effects of drug use are what constitute the problem, drug use as such – if there are no observable harms – is irrelevant to a pragmatist.

⁴ Anthologies by O'Hare et al. (1992), based on the First International Conference on the Reduction of Drug-Related Harm in Liverpool in 1990; Heather et al. (1993), based on the Melbourne conference in 1992; and Erickson et al. (1997), based on the Toronto conference in 1994. It should be stressed, however, that there is no consensus or generally accepted definition of the term 'harm reduction', but rather, there is continuous discussion on it. Additional and more recent discussion than presented in these texts can be found, for example, on the home page of the International Harm Reduction Association (www.ihra.net) and especially in the section "Discussion papers".

⁵ I want to emphasise that the following overtly simplified interpretations on harm reduction rationales concern purely the movement's claims-making, or rhetoric, not what harm reduction is in everyday practice; that is a different question.

⁶ For others' characterizations of harm reduction principles, see, e.g. Newcombe (1992) or Riley et al. (1999).

For this, Stephen Mugford (1993, 21) in his article on the ‘moral stance’ of harm reduction has given the following formulation:

“Drug use is viewed as neither right nor wrong in itself. Rather, drug use is evaluated in terms of harm to others and, to some extent, harm suffered by users. The latter is regrettable, but acceptable if it arises from ‘informed choice.’”

Thirdly, harm reductionists claim to view drug users as rational, active and responsible agents of and partners in harm reduction. This “empowerment” imposes new responsibilities on the user towards society. According to Erickson et al. (1997, 8–9):

“The user is regarded as an active rather than a passive entity, capable of making choices about his/her own life, taking responsibility for these choices, and playing an important role in prevention, treatment and the recovery process. (...) as well as a consideration of drug users’ own responsibilities as members of communities.”

All in all, the harm reduction movement constructs drug use and the view on users in roughly this way: drug use is a normal action that inevitably occurs in modern society, and therefore the users should be treated fairly as sovereign citizens and their possible problems should be tackled pragmatically and on the basis of scientific knowledge.

The resistant relation of harm reduction to punitive prohibition – such as the advocates of harm reduction define it – can be further illustrated by breaking it into conceptual opposites:

TABLE 3. Harm reduction vs. punitive prohibition⁷

Harm reduction	><	Punitive prohibition
<i>individualism</i> individual is free also to act to his/her own disadvantage	><	<i>collectivism</i> public good is always primary vis-à-vis to the individual
<i>inclusion</i> drug user is a normal member of a community	><	<i>exclusion</i> drug user is a deviant special case
<i>pragmatism</i> drug policy should be based on knowledge and situation-specific considerations	><	<i>dogmatism</i> drug policy should be based on value goals that justify the means despite costs
<i>emancipation</i> control of drug users should be alleviated	><	<i>paternalism</i> drug users should be punished for and/or cured of drug use

⁷ This table draws on Tammi & Hurme (2006).

In this ideal-typical view, harm reduction is based, first, on a classic liberal-individualistic way of thinking according to which the action of an informed and sovereign person to his/her own disadvantage is acceptable as far as it does not harm others. In the collectivistic thinking of punitive drug policy, by contrast, the norms set by the community are primary in relation to individual liberty. It is a question of defining boundaries between what is right and what is wrong, i.e., whether the community has the right to define what the good life is or if justice between sovereign individuals is taken as the point of departure for the definition. Secondly, the school for harm reduction aims to integrate drug users as full members of their community, not to exclude them as criminals or sick, deviant persons. Thirdly, harm reduction manifests itself as pragmatic action, in which absolute goals (such as a drug-free society) are discarded and a more relative hierarchy of goals is primarily based on research data and experiences, not on dogmatic values. Finally, it is also an emancipating movement to liberate users, which aims at eliminating unreasonable suffering caused by control.

Put this way, harm reduction's claims-making—with its claims on individualism, inclusion, pragmatism and emancipation—resonates extremely well with the moral sensibilities of our contemporary societies: ever fewer people would oppose these as general principles, unlike those of collectivism, exclusion, dogmatism and paternalism. But can harm reduction keep its promise?

2.2 NEW MEDICAL-INTERNALISED CONTROL TECHNIQUE

In many fields of lifestyle and pleasure regulation (e.g. alcohol, sexual or nutrition policies) in contemporary Western society, public policies have changed their mission from promotion of the good life to prevention of detrimental consequences. In the course of modernisation, privatisation, individualisation and decentralisation, and the erosion of homogeneous cultures, many pleasures have become de-politicised, but simultaneously they have become subjects of increasing internal control. Although the state is still expected to worry about the risks and costs of lifestyle choices to the 'other', it can no longer determine what is good for the 'self'. This leads to increasing allocation of responsibility for behaviour to individuals (see also Sulkunen 2001). Also harm reduction's claims for normalisation of drug user citizenship can be viewed to belong to this tendency in public lifestyle policies.

Recently, several critical analyses of harm reduction as part of the so-called new public health paradigm have appeared (see, e.g., Miller 2001; Moore 2004; Bourgois 2000; O'Malley 1999; Zibbell 2004). In these governmentality (or poststructural or neo-Foucauldian) critiques, harm reduction is seen as part of the neo-liberal project through which the state seeks to shift its responsibility to protect the public's health from the state to members of the public themselves, and

which justifies its interventions in the name of objective, "disinterested" science. In the new public health rationale "individuals are expected to take increasingly responsibility for the care of their bodies and to limit their potential to harm to others" (Petersen & Lupton 1996, ix). This all has been found disturbing as the new public health also means "increased potential for experts to intervene in private lives and for established rights to be undermined" (ibid., x). The new public health's "governance from the distance" strategy has been contrasted to pre-modern societies in which power operated through repression, violence, direct coercion or blatant control, whereas in modern societies it is the expert knowledge and the notion of risk and its management has become a key technology of social control (ibid., xii; Moore 2004).

The harm reduction approach is a combination of traditional public health work, i.e., concrete prevention of illness and health risks, and extensive health promotion in accordance with the new public health policy. The latter means a policy in which drug users are "empowered" by a holistic approach. The aim is to develop their individual, communal and political resources so that they will become empowered "health citizens". Thus, users can also be obliged by the rights given to them to assume responsibility for their own health. In this sense harm reduction can be regarded as "surveillance medicine", to put it in Foucauldian terms (see, e.g., Armstrong 1995) in which an individual is not only entitled, but also obliged to take responsibility for his/her own health, to be an "active patient" (Miller 2001). It is a question of a shift from external control to internal control by a rational individual.⁸

While repressive drug policy resembles old-fashioned social hygienic public health work in which drug users are to be punished and cured (to secure a viable nation)⁹, harm reduction constitutes more indirect monitoring and regulation steered by more comprehensive and detailed research on risk factors. In the planning of measures, harm reduction is based on epidemiology, case studies and evidence-based medicine. With increased knowledge of various sub-cultures, user groups, drugs and uses, the picture of drug users is also diversified. When the drug issue thus becomes more scientific and more and more detailed information on it is produced, it also becomes expert-driven and is seemingly depoliticised. Grazyna Zajdow (2005) argues, however, that it is this very emphasis on expert knowledge

8 Harm reduction also blurs the distinction between individual and population level strategies; interventions that are labelled as harm reduction are often argued to work on both levels. On one end harm reduction is surveillance medicine to individual drug users, and on the other end it is a public health operation that aims to protect the general public and improve the health and well-being of the injecting drug user populations. This is in line with the interpretation of harm reduction as part of a new public health project. As Christoffer Tigerstedt (1999, 226) notes, the "control methods that have emerged within the new public health movement are often directed at *both* population groups *and* individuals and are exercised by (public) agencies as well as individuals".

9 Not only punished, but also cured because in Western countries at least the drug addict has belonged simultaneously to both penal and psychiatric discourse; rather than someone who has merely broken the law and must be punished, the addict is also understood to be sick with an addiction that needs to be cured.

and the imposition of new subjectivities on drug users which institutes new diffuse and less visible forms of surveillance, monitoring and social control.

Zajdow (2005, 196) also argues that not wishing to deal with norms because of the movement's pragmatic doctrine, harm reduction denies their existence altogether. However, this "naiveté" in denying moralities becomes more understandable if we consider the harm reduction in its original political context. As Helen Keane (2003) has noted, harm reduction's commitment to an amoral approach to drug use is to be seen as a powerful rhetorical intervention in the highly moralised landscape of drug debate rather than something that could be achieved in practice. Taking strong normative stands by questioning the whole idea of prohibition would also lead nowhere in drug policy debates. Instead, by "neutrally" defining *harms* and their *reduction*¹⁰ as their focus, the harm reduction practitioners have been able to operate and grow as a semi-professional movement. The pioneers of harm reduction were faced with the undeniable fact that hundreds of thousands of injecting drug users would die of AIDS, and carved out new political space *between* legalisation and prohibition by stepping above the policy debate (Reinarman 2004, 239).

Furthermore, in the search for transitions from direct coercion to new "hidden" control techniques, the neo-Foucauldian critique of harm reduction may leave untouched¹¹ those concrete alleviations that the subjects of control can experience with regards to their societal roles and everyday lives. From the viewpoint of the drug user who is governed it does matter whether the form of control is physical, economic, direct and coercive, or if it is persuasive *governmental* control that has a hold "only" on our identities, not so much the bodies or money.

2.3 DIFFERENT VERSIONS OF HARM REDUCTION

In the article *Harm reduction school of thought: three fractions* (Tammi 2004) I have argued that, rather than one, the international harm-reduction movement is a policy community of three epistemic fractions that are in dialogue with each other and thus are constantly redefining the meaning of harm reduction. By categorising different ideological self-understandings of the harm reduction school of thought in the context of international drug policy making and advocacy, I conclude, that the diverse conceptualisations of harm reduction are to be understood as interpretive frameworks that are functionally different to different actors and their social and professional positions. From this viewpoint of actor-based footings, three epistemic fractions of harm reduction with different emphases are recognised: professional new public health, a mutual-help and identity of drug users, and a globally-oriented justice fraction. In the realities of international, national and local drug policies,

10 Harm reduction as a policy label is very advantageous – 'who, in their right mind, could oppose the notion of reducing harm?' as Ethan Nadelmann (1993, 37) has put it.

11 Not all though: see, e.g., Moore & Fraser 2006.

the latter two rights-oriented approaches have remained marginal, whereas the first, with a professional new public health focus, has been successful in reforming drug treatment and prevention policies so as to make them increasingly public-health oriented.

However, the political controversies around harm reduction emerge from the interplay between the rights-oriented and public health oriented versions. Following Neil Hunt (2004, see also Reinarmann 2004; Burris 2004), harm reduction can be further dichotomised: to a ‘weak rights’ version which prioritises public health, and in which human rights mean mainly patients’ and clients’ rights for proper treatment and prevention, and to another, ‘strong rights’ version that additionally recognises a basic right to use drugs. Needless to say, the latter is the politically explosive version out of the two. Like Hunt, Toivo Hurme (2004, 21–22) has seen two overlapping perspectives embedded in harm reduction discourses: the public health perspective and human rights perspective. These two perspectives represent two different understandings of the individual that appear simultaneously in the Western welfare state (Dean 1999, 82, see *ibid.*): the human rights perspective associated with the free citizenship of the individual, and the public health perspective associated with the Christian idea of shepherding individuals through “social integration” to guarantee the health and well-being of the general population. Public health oriented harm reduction wants to free drug-using individuals, but also to have them internalise a means of control, rationality, low-risk methods of use and the regulation of consumption, as well as to adopt the ideals of responsibility and inclusion.

In this view, the most important means of promoting public health and other public interests is to allow drug users to be free and responsible citizens who are themselves able to control their actions in the right direction from the point of view of the public interest. If a drug user does not fulfil these expectations and does not “consent to being informed”, harm reduction may, despite its liberal and value-relativistic emphases, also function as a discriminatory control technique.

As mentioned, the strong rights version of harm reduction – in which drug use would be normalised – would be potentially more empowering for drug users, but at the same time politically more difficult, if not impossible to realise in practice. This is due to the many different drug-related scares collectively shared, and one specific element behind is Western culture’s strict adherence to the *concept of addiction* which is the opposite of the modern idea of free will (see, e.g., Levine 1978; Ferentzy 2002). Any liberalisation from external controls is possible only when the action in question is in accordance with modernity’s meta-narrative consisting of autonomous will, authentic pleasure and a productive lifelong quest for meaning. In the collective perception, drug use represents all that is against modern selfhood, that is, drug use makes a human being less than rational, the pleasure he seeks is inauthentic, and distracts him from his quest for meaning by making him less productive (Fitzgerald 1999; see also Moore & Fraser 2006). This

makes the drug user a non-citizen who is incapable of self-control and thus cannot be freed; drug use is condemned because it is seen to threaten individual freedom. We know very little about drugs, but what we do know is that they are dangerous because they are horribly addictive.

Hence, prohibition in drug policy is about protecting the public, as free individuals, from unfreedom, the addiction. Free, autonomous will is a modern imperative. Both the subject and object of control is free will: free will is used to protect free will by controlling it. Consequently, eschewing the subject of (disease model of) addiction is the political soft spot of the strong rights version of harm reduction; its advocates should be able to either argue that addiction is a minor issue, or that addiction related to illicit drugs is no different from those socially more acceptable forms of addiction related to licit drugs, alcohol and tobacco.

3 HARM REDUCTION ADOPTION

In a classic social constructionist view, drug policies change – if they change – in cycles (see, e.g., Blumer 1971). The prevailing established policy practice is bureaucratised, non-reflective and assumed, as long as a crisis and related mobilisations emerge. The crisis can take different forms, but what is relevant is that the stakeholders in the field have a sense of crisis and feel external pressures to resolve it, and then these senses and pressures become articulated in claims, demands and responses.

In the change cycle there are different phases. At the beginning, some actors may deny the very existence of the crisis, but then as others build new evidence for it, new definitions about the threats as well as about the system's (or the policy's) ability to respond are continuously produced. New actors with new demands might have tried to enter the policy field previously, but without a crisis situation this may have been difficult, and their demands may have remained marginal. When the crisis emerges, however, political opportunities open for new ideas and their proponents. On the basis of new initiatives – if the crisis has not yet dissipated – new strategies and action plans are then drafted, and more and new resources are allocated to them. Simultaneously, the new problem construction and related responses are affirmed through research and other evidence-building. In what follows, I describe the changes that have taken place towards harm reduction adoption in certain national drug policies, and the different factors that explain that change.

3.1 EARLIER ADOPTIONS OF HARM REDUCTION IN NATIONAL DRUG POLICIES

In accordance with the constructionist cycle metaphor, many studies on national-level drug policy formation conclude that drug policy shifts towards harm reduction adoption have been due to triggering events – crises – and related changes in public, political and expert opinions.¹² The relative political ease or difficulty in adopting harm reduction measures has had to do with specific societal and cultural backgrounds, and professionals' roles and positions in the policy field (see Berridge 1996). An increase in the level of drug-related harms has first opened political spaces, and provided the harm reduction advocates with opportunities to influence agenda-setting and policy practices.

¹² Countries that were early adopters of harm reduction policies include especially the UK, The Netherlands, Australia, New Zealand, Canada, and Switzerland.

Practically in all national contexts where harm reduction measures have been approved, the trigger has been the HIV crisis and related public fears. As a result, the relative importance of the medical profession in the policy field has grown as it has been generally agreed that there is a threat of HIV that can be combated mainly by public health means. For example, Gerry Stimson (1990, 124; see also Berridge 1993) notes how HIV simplified the debate around drugs in the UK. In contrast to the political situation before the advent of HIV, the UK drugs field has since been marked by a lack of conflict and criticism about aims, objectives and strategies: “(N)ow we see the emergence of what I will call the public health paradigm. Rather than seeing drug use as a metaphorical disease, there is now a real medical problem associated with injecting drugs. All can agree that this is a major public health problem (– –)”.

The UK has a long history of medical harm-reduction policies. The independence of the medical professional to deal with drug problems was already established in 1926 when the Rolleston report reasserted the disease model of addiction (against the punitive law enforcement policy model) and the doctor’s freedom to prescribe maintenance doses of opiates as a form of treatment. This medical professional independence was eroded to some extent in the beginning of the 1970s when new social-psychological professions came into the drug treatment field with social learning models, often based on abstinence as the aim of treatment. But then again, in the 1980s, HIV served to revive medical- and harm-reduction- oriented arguments in drug treatment and more generally in drug policy (MacGregor & Smith 1998; Berridge 1993, 62–63).

Although HIV is a powerful drug policy change agent, it is not sufficient *per se* to ensure harm reduction practices will be adopted. Switzerland’s drug policy shifted to harm reduction in the beginning of the 1990s (see, e.g. Klingemann 1998). As in almost all switches to a harm reduction approach, the threat of HIV (as well as the internationally notorious open drug scenes in Switzerland) was the necessary prerequisite for re-evaluating the drug policy agenda. But as Daniel Kübler (2001) shows in his study about this process, the change also needed its active human agents: the Aids epidemic led to the formation and persistence of an *advocacy coalition* for harm reduction (consisting of health professionals who were supported by social workers and left-wing and liberal politicians and journalists) which then successfully lobbied for harm reduction, changed the terms of the drug policy debate and eventually overthrew the hegemonic “abstinence coalition”.

The evolution of the harm reduction policy in France illustrates how the drug policy struggle can take place as a paradigm change within one profession, that is, between individual-focused curative, and population-focused preventive (or palliative), medicine. France remained somewhat “anti-harm reductionist” until the mid-1990s when the country “made a U-turn at full speed” (Boekhout van Solinge 2004, 91). This U-turn especially concerned the opiate substitution policy: whereas in 1993 there were officially only 52 patients in substitution treatment, in

2002 the number of patients was 90 000, which now makes France the European leader in drug-substitution (ibid. 92). The context of the sudden policy-change was a wide-spread HIV epidemic among injecting drug users: in the early 1990s approximately 30 % of users were infected (ibid., 88). The treatment paradigm before the crisis was deeply “psychoanalysed” from the 1970s and 80s on; in that paradigm there was no room for drug-substitution treatment or harm reduction. Due to the HIV crisis, however, by the mid-90s new players came into the field: harm reduction advocates, such as Médecins du Monde, general practitioners and other representatives of the public health school of thought, eventually succeeded in changing the professional paradigm. The policy change was thus made more between generations and schools of thought within medical profession, than between the medical and penal professions. (Boekhout van Solinge 2004; Bergeron & Kopp 2002.)

Furthermore, in some countries it is not only the professional groups that have been at the hub of policy-making networks. For example, in Sweden popular movements (parents’ organisations, ex-users’ organisations, etc.) have been very active and influential, and with the support of professionals (especially social workers and the police) the civic groups have succeeded in getting the government to adopt the goal of a drug-free society – as well as in repeatedly and successfully fighting off harm-reduction initiatives (see, e.g., Boekhout van Solinge 1997, 28–32).

Also national societal traditions, ideologies and relative policies where drug policy is situated (the criminal policy traditions, social and health policy traditions, and a country’s cultural history with regard to different substances) have had an effect on harm reduction adoption or non-adoption: The case of easy adoption of harm reduction in The Netherlands can be partly explained by societal traditions (e.g., Wever 1996; Cohen 1997; Tops 2001; DeKort 1996). It has been claimed, for instance, that in The Netherlands a harm reduction policy was adopted early because of their public policy traditions. Harm reduction was the principal aim of drug policy before the concept was even introduced in the international drug policy context (Wever 1996, 62). The cultural-political background of Dutch “pragmatic and normalising” drug policy is claimed to be in the non-punitive criminal policy approach of the 1960s, reflected strongly in the reports of two founding drug policy commissions (Baan & Hulsman commissions) at the end of the 1960s and early 1970s, as well as in the 1976 Opium Act. In practice this non-punitive approach shows in balancing the responsibilities of drug control so as to leave the drug users to be taken care of by social and medical professionals.

While in The Netherlands the adoption was quick because of public policy tradition, in France the development was delayed for the same reason.¹³ France is

¹³ On the other hand, after the delay the change was extremely quick as was described above. A potential explanation for this speed relates to the centralised model of administration in France: when something changes in a centralised system, the change can be rapid and comprehensive. The same applies to Finland.

one of the key countries behind international drug controls and has traditionally been in favour of strict drug controls. In his study about French drug policy, Boekhout van Solinge (2004, 92–103) explains the late adoption of harm reduction practices in France, as partly due to the political tradition of a strong state and the related conception of state-citizenship. He argues that in France, citizens are expected to sacrifice their personal interests for the common good and that laws have a role as beacons of society, giving direction to citizens: breaking laws is like defying the state. Accordingly, any liberalisations of a punitive drug policy have been hard to realise, and when it has been suggested, the French politicians have frequently rejected that by simply reminding citizens of the importance of the law (“*rappel à la loi*”) (Ehrenberg 1995, see *ibid.*, 97).

Similar explanations have been given for Sweden which is one of the rare Western European countries where harm reduction initiatives have been repeatedly rejected.¹⁴ The goal of ‘drug-free society’ makes adoption of harm reduction programs very difficult in Sweden as harm reduction is often considered too liberal or simply about drug legalisation in disguise. The Swedes’ highly restrictive attitudes towards drugs and related drug policy have been explained by a variety of cultural and political background factors (e.g., Tham 1995; Tops 2001, Boekhout van Solinge 1997). Henrik Tham (1995) has developed a general political-cultural explanation according to which drugs in Sweden have become perceived as an attack on cherished “Swedish” values, and that the struggle against drugs has been broadened into a more general national project for the defense of “Sweden”. Boekhout van Solinge (2004, 165) argues that it is also Sweden’s long history with a restrictive alcohol policy, based on a so-called ‘total consumption model’ (which aims to limit the total harm by limiting the total consumption to a minimum), which partly makes a restrictive drug policy a logical option.

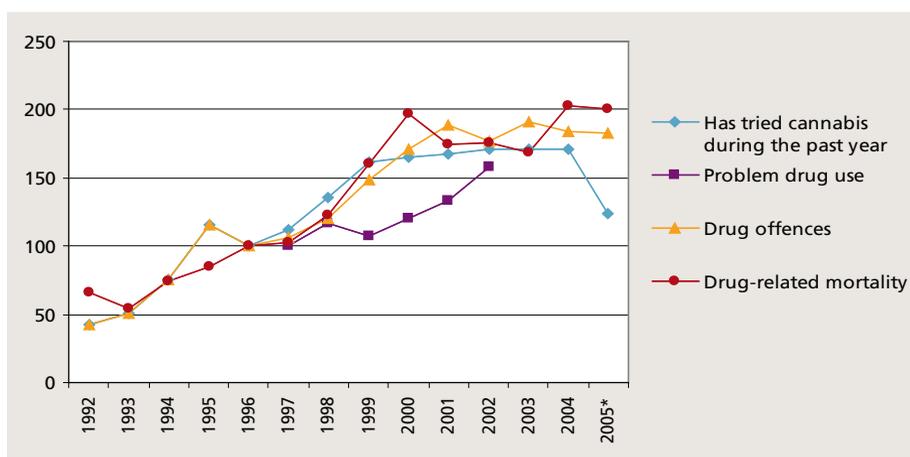
3.2 ADOPTION OF HARM REDUCTION IN FINLAND

The constructionist cycle metaphor applies also to the changes in the Finnish drug policy on both sides of the millennium. Before the mid-90s, public policy on drugs and drug use in Finland was one of the strictest in Europe and based mainly on criminal control: the small number of drug users that existed was mainly regarded as the domain of the police, prosecutors and courts. The treatment and care system was non-specialised, i.e., mostly focused on alcohol abusers’ care. It was

14 It should be noted, however, that the first methadone programme in Europe was in Uppsala, Sweden. There are currently also substitution treatment programmes as well as two relatively small needle exchange points (in two hospitals in Lund and Malmö). The participation criteria for substitution treatment are relatively strict. Furthermore, these services are never called “harm reduction” in Sweden due to the term’s sensitive political connotations. Thus the Swedes’ “problem” with the harm reduction approach is at least partly discursive, not always practical (Boekhout van Solinge 1997, 127–129; 2004, 147). Only recently, has new legislation on needle exchange been passed.

an autonomous and non-reflexive field of public policy in which no contests or exogenous actors could interfere.¹⁵

After the mid-90s the drug situation underwent a considerable shift. The use of cannabis doubled and also the so-called party drugs (such as MDMA, GHB, amphetamines) became increasingly popular among urban youth cultures (see, e.g., Salasuo & Seppälä 2004). From the viewpoint of harm reduction, however, it is more important to note that new opiate-using subcultures were formed in the major cities.¹⁶ As a consequence, the number of serious drug-related harms (deaths, virus diseases, poisonings) rose to a totally different level than before. Some of these trends are shown in Figure 1 below. (Rönkä & Salonen 2006; see also Hakkarainen & Metso 2003; Partanen et al. 2004; about the emergence of local problem use cultures see Hakkarainen 2002; Perälä 2002.)



*) preliminary data

FIGURE 1. Trends in drug use and drug-related harms (1996 = 100)¹⁷

15 And due to the non-crisis few attempts were made; few examples from the early nineties include public or professional discussions on opiate substitution treatment and on alleviations in drug user sanctioning. Both of these initiatives were rejected (see Hakkarainen & Tigerstedt 2005; Kainulainen 2002).

16 Amphetamines have been and still are the main "hard drug" of choice in Finland (see Partanen et al. 2004).

17 This index figure is based the following data sources: Alcohol and Drug Studies, STAKES; Partanen et al. (2004); National Bureau of Investigation; Hospital patient discharge register, STAKES; Department of Forensic Medicine, University of Helsinki. I thank Ms. Sanna Rönkä (from the Finnish National Focal Point of the EMCDDA) for tailoring the figure for me. Compared to the original figure (Rönkä & Salonen 2006, 3), this version is simplified and has a longer time-span.

The kinds of “alarming” information on the changes in the Finnish drug situation resulted in a drug policy crisis. The previous confidence of having the few drug problems under fairly good control turned to collective anxiety and generated a professional and political mobilisation process through which the nature of drug problems and societal responses to them were re-evaluated. The changing situation opened a space for policy change. From a constructionist viewpoint, the crisis was about competing problem constructions between different interest groups and professions in the field.

In the article *Onko Suomen huume politiikka muuttunut?* (Has the drug policy in Finland changed?, Tammi 2002), I lay background for the policy reformation process; it is a general mapping of the drug policy situation from the mid-90s until 2001. It sheds light on the public debate on drugs and drug policy in those years, as well as describes the formal and practical changes that took place in drug policy. I conclude, that in the course of the drug policy field’s mobilisation, the previously more consistent policy field became polarised so that there were two strong tracks in drug policy, one focused on the management of drug-related public health risks, and the other on the criminal controls of drug use, dealing and trafficking. The relationship between the two tracks first appeared as fragile, but soon became firmly established and institutionalised. To guarantee that the consensus achieved in the process of creating joint strategies and action plans would prevail, different institutional structures were established, most importantly the national drug policy coordination group which consists of drug policy administrators from five key ministries as well as from other expert institutions in the drugs field.

In the article, I also presented data on the increase of both harm reduction measures and criminal control measures targeted at drug users between 1996 and 2000; Table 4 below illustrates how the activities on both tracks have continued to develop up to 2005.

TABLE 4. Progression of the two-track drug policy in Finland

Year	Track 1: Criminal control	Track 2: Harm reduction
1995	Police Act (402/95) permits wiretapping, telecommunications and technical surveillance.	3–5 people in substitution treatment.
1996		
1997	Drug Strategy 1997 reinforces restrictive drug policy line, including total ban on experimentation and use of drugs. Number of companies that subjected their staff to drug testing: 103.	Drug Strategy 1997 supports harm reduction measures. Substitution treatment programmes (STP) launched. Needle exchange programme (NEP) starts in Helsinki.
1998		
1999		Consensus statement by Medical Society Duodecim and Academy of Finland takes a stand for substitution treatment and needle exchange.
2000	Drug strategy of the police emphasises street-level policing of drug use and dealing. Number of companies that subjected their staff to drug testing: 464.	NEPs in 12 cities (4.800 clients, 564.500 injection sets exchanged). STPs extended (Decree 607/2000) 200 people in STPs.
2001	Amendment of the Penal Code defines drug use as a category of crime in itself, a "drug-use offence". Police act (21/01; later 525/05) permits new unconventional detection methods, such as undercover activities and pseudo purchase (e.g. of drugs).	
2002	3.103 people fined for drug use by the police. ¹	NEPs in 22 cities (9.300 clients, 1.1 million injection sets exchanged). STPs extended (Decree 289/2002)
2003	4.151 people fined for drug use by the police (an increase of 33.8 %).	Decree on the amendment to the Communicable Disease Act (1383/2003) puts the cities and municipalities under obligation to arrange needle-exchanges when needed.
2004	4.420 people fined for drug use by the police (an increase of 6.5 %). The Act on the Protection of Privacy in Working Life (759/2004) incorporates provisions related to drug testing, e.g. on the employers' right to process in certain situations information on job applicants' and employees' drug use.	600–700 people in STPs.
2005		NEPs in 30 cities (11.800 clients, 1.9 million injection sets exchanged). 900–1.000 people in STPs.

¹ In addition to fines by the police, fines are also issued by the courts for drug use, e.g., 3.468 times in 2004 (Kainulainen 2006, 78, 104). These fines are often connected to sanctions for other crimes.

In articles 3, 4 and 5 (Tammi 2005a, 2005b & 2006) I explore the version of harm reduction that was adopted in Finland. The article *Discipline or contain? The struggle over the concept of harm reduction in the 1997 Drug Policy Committee in Finland* is a case study that revisits the 1997 Drug Policy Committee in Finland and the struggles that were fought within that committee over the definition of drug issues: the two main rival camps were the police authorities that advocated a drug-free society and insisted on policies of strict control and, on the other hand, the social welfare, health and criminal policy alliance that was in favour of the harm reduction approach. The article describes the argumentation of different administrative and professional groups and their positions on harm reduction and the goals of a drug-free society. The committee produced the first national drug strategy. The end result was a compromise between two different logics, which since paved the way for the harm reduction measures, but also stricter penal controls on drug users. I also conclude that the general objective of harm reduction in the drug strategy was not primarily based on public health concerns: in Finland the ideological roots of the concept can be traced back to the tradition of a rational and humane criminal policy that was first adopted in the 1960s and 1970s. According to this tradition, criminal and social policy should be primarily aimed at minimising overall social harm and at protecting the minorities that were the targets of control. In this sense the arguments for harm reduction in the Committee included the human rights approach – but not in form of recognising the right to use drugs, i.e. the strong-rights version of harm reduction, but rather as critical attitude towards excessive use of law enforcement and criminal justice dealing with drug users.

Thus, in spite of needle exchange and substitution treatment initiatives in the 1997 drug strategy, there was not yet a strong public health orientation. In the fourth article, *Diffusion of public health views on drug policy: The case of needle-exchange in Finland*, I further analyse the process whereby public health orientation was put forward in the drug policy, in the form of needle exchange programmes. The rapid spread of needle exchange programmes was made possible by several factors: the general crisis atmosphere due to increasing drug use, successful formation of a multi-professional advocacy network for needle exchange, and most importantly, the HIV outbreak in the late 1990s. The harm reduction advocates also managed to articulate a “politically correct” and thus adoptable *translation* of the harm reduction rationale which fit prohibitionist drug policy; in resonance with the newly established dual-track model in drug policy, the core of this translation was that harm reduction measures, such as needle exchange and substitution treatment, were not opposed to a restrictive policy but supported it. In their argumentation, the harm reduction advocates did not rely only on public health research evidence, but utilised a set of arguments related to costs, public safety and ethics. Also the objective of engaging drug users in treatment through needle exchange programmes was emphasised from the outset.

In the course of the international harm reduction movement's evolution, a new kind of discourse that stressed the importance of drug users' active involvement in arranging services has emerged. In many countries that have adopted harm reduction practices, drug user groups have been active in advocating and developing these services, and have also more generally promoted the users' rights as patients, clients and citizens. The fifth article, *Who is the expert? Patient groups and Finnish substitution treatment policy* (Tammi 2006), is a case study on the limits of user orientation in Finnish drug policy. In the article, the activities and political action spaces of two small patient groups advocating the rights of substitution-treatment patients are investigated. The main conclusion is, in the perception of the patients in substitution treatment at the turn of the millennium, that there was not an equal negotiation between the professionals and their clients. Needless to say, in the context of pharmacotherapy this cannot be otherwise as it is grounded in medical expertise; the main actors in substitution treatment are medical doctors with their monopoly to practise medicine, i.e., to prescribe therapeutic drugs to users. In needle-exchange services the interaction between the workers and clients is more informal and negotiable by nature, there is more room for manoeuvre, and different forms of peer-work are in many ways built in to the daily practice of the needle exchange units (for more about the everyday management of needle exchange in Finland, see Perälä 2007; Jokinen 2005).¹⁸

3.3 MEDICALISING PROHIBITION AS A CONSEQUENCE

The classic antagonism in drug policy, and accordingly in many analyses on the subject¹⁹ is the conflict between penal and medical forms of control. The case studies of this thesis have also focused on this conflict, and as one conclusion, the result from the drug policy crisis in Finland was a new policy paradigm that can be characterised as a dual-track drug policy in which public health oriented harm reduction measures became adopted, but not at the expense of penal control.

My earlier conclusion (Tammi 2002, see also Hakkarainen & Tigerstedt 2004) from the new situation was that drug policy in Finland would be unstable and that the conflict between the two tracks could easily escalate again. Seen from a few years' distance, however, this seems not to be the case. Instead, after a somewhat stormy debate around the turn of the century, the adaptive and non-adaptive responses have peacefully aligned with each other. The dual-track model has become the new paradigm in Finnish drug policy: both harm reduction and criminal control approaches are now well-established and wide spread.

¹⁸ At the time of my study, however, there were no client-user groups involved in needle exchange. Recently one (called "Lumme ry") has been established in Helsinki, and the local needle exchange programme has helped to establish the group.

¹⁹ See, e.g., Alfred Lindesmith's classic study *The addict and the law* (1965).

Similar developments onto dual tracks in drug policies have taken place elsewhere. For example in Denmark, while harm reduction initiatives have gained wider acceptance in policy formulations and in practice, control measures have also been tightened (Anker 2006, 40). In France, the policy towards drug users has remained punitive despite the fact that, during the past 10 years, the French have also quickly become the leading European country in the provision of substitution treatment (Boekhout van Solinge 2004, 101–103). In the UK, where medical harm-reduction policy has a long history, the penal and medical forms of control have become closely intertwined with each other (Berridge 1993, 63). Medical and penal controls do not exclude each other.

The relative power positions of the penal and medical professions, their claims-making and practical activities are important aspects to explore when analysing harm reduction adoption, but this may be too simplistic an approach. In the struggles around harm reduction initiatives, there are also other, more “hidden”, clashes of views and related conflicts between other professions and *within* professions. Two important tensions with regard to harm reduction are between different forms of medical control, namely between individual curative and population-focused, public health approaches, and between psycho-social work and the medical profession. (Berridge 1993, 61.)

Henri Bergeron (2005) claims that the contemporary European historical trajectory is one of gradual medicalisation of the definitions of and responses to drug-related problems. Kettil Bruun (1971; see also Takala & Lehto 1992) once described the Finnish approach to drug and alcohol problems as “non-medical”, but his characterisation is no longer a valid description of the Finnish treatment system for drug users because in the course of harm reduction adoption, a parallel (to alcohol treatment) and more medical and specialised treatment system has been established in Finland.²⁰ The new drug treatment units pay special attention to opiate users’ medical and medicinal treatment, and the focus is on diagnoses and on practices of evidence-based medicine. The units are often directed by medical doctors and also the personnel are predominantly medically trained (Murto 2002; Harju-Koskelin 2007; see also Weckroth 2006). This is a new approach in the Finnish treatment system which has had a strong social work orientation since the 1970s.²¹ Also in needle exchange programmes the justification as well as the funding are public health sourced, and respectively, the majority of workers are medical nurses and work is health-related²² (Jokinen 2005; Partanen et al. 2006).

20 Institutionally, this development is in line with the tendency towards so-called “new public management”: specialised drug treatment services are increasingly being produced by non-governmental organisations and sold to the cities (Kaukonen 2002).

21 See Kinnunen & Lehto (1994); in the article, they also recognise the incipient emergence of the differentiating and medicalising drug treatment system.

22 At some health counselling points (as needle exchange programmes are called in Finland; see Tammi 2005b) also social work related functions, such as serving as day centres for users or guidance-givers on general health and welfare services, are seen increasingly important (Perälä 2007).

In the aftermath of the drug policy crisis all actors in the drug policy field received additional resources (Tammi 2002; Hakkarainen & Tigerstedt 2004; Kaukonen 2005). However, if we had to name a “relative loser” of the formative years during which the dual-track paradigm emerged in Finland, it would be the previously dominant socio-psychological approach in treatment. The drug policy in Finland now represents a more medicalised and de-socialised version of prohibition.

The fact that harm reduction has a medicalising effect on drug treatment and policy becomes almost self-explanatory if we ask what harm reduction is historically about – the medical profession trying to cope with its self-created problems. Despite the efforts of a widening harm reduction agenda to cover all kinds of drug-related settings, such as “recreational” drug use (see, e.g., Kilfoyle & Bellis et al. 1997) and primary drug prevention (see, e.g. Rosenbaum 2007), the only well-established harm reduction measures are still about two things: opiate use and the intravenous use of drugs. Although the medical use of opiates dates back all the way to at least about 1500 BC,²³ the mass production of opiates as medicines as well as the hypodermic syringes are medical innovations of the recent nineteenth century. Opium was the wonder drug of the 19th and 20th centuries, and especially a new morphine derivate called heroin²⁴ became very popular after its introduction in 1898 (Conrad & Schneider 1992, 120–121). The syringe has become such an important medical tool that it is nearly synonymous with the practising physician. But in addition to relief and remedy from these great medical inventions, also the most serious drug-related harm is caused by them. Viewed in this way, the harm reduction measures are about providing drug users with more manageable medical tools (substituting synthetic opiates and clean equipment for injecting) for dealing with their misuse of medical tools.

23 Based on the Ebers papyrus reference to an opium remedy “to prevent the excessive crying of children” (Ray 1978, 300; ref. Conrad & Schneider 1992, 111).

24 Heroin was named after its “heroic” properties and marketed as a non-addicting substitute for morphine or codeine (Conrad & Schneider 1992, 120–121).

4 CONCLUSION

Harm reduction is a convenient political compromise that does not threaten the foundations of prohibitionist drug control policies, but still addresses some of the harms that are beyond the punitive prohibitionist regime. In the self-definition of the harm reduction movement one central doctrine is pragmatism; ideally, what works (to reduce harms) is what should be done. This pragmatist attitude is true also of drug policy. If we draw an axis of the drug policy debate, on one end there would be prohibition and drug legalisation on the other. Harm reduction is a consensual model between these two extremes; when both prohibitionists and legalisers tend to be uncompromising and dogmatic, harm reductionists are politically compromising and pragmatic, even evasive. Harry G. Levine (2003, 149) puts this felicitously: “Harm reduction’s message to drug users is: ‘we are not asking you to give up drug use; we just ask you to do some things (like use clean syringes) to reduce the harmfulness of drug use (including the spread of AIDS) to you and the people close to you.’ In precisely the same way, harm reduction’s message to governments is: ‘we are not asking you to give up drug prohibition; we just ask you to do some things (like make clean syringes and methadone available) to reduce the harmfulness of drug prohibition’”. Neither in Finland nor in many other countries has the introduction of harm reduction policy meant liberalisations of the external control of drug use. Thus, instead of one, there are now two overlapping forms of control exerted on drug users: the external punitive control and the internalising form of medical control based on the risk management approach.

Following David Garland (2001; Hakkarainen & Tigerstedt 2004), this dual-track strategy can be put in more criminological terms: Garland calls this a new criminological predicament. He argues that when the crime rate (here the rate of perceived drug problems) reaches a certain level, it becomes saturated and becomes a “normalised” social problem to which the responses can then be *adaptive* by nature – like harm reduction strategies. Parallel to the adaptive ones, however, there still remain the *non-adaptive* responses to the same problem. This is why it is a predicament. Non-adaptive, repressive responses are needed to justify the image of the state as an efficient and competent actor who does not give up on the problem. The problem can be normalised but it still exists. Harm reduction is not distant, but an adaptable rationale for the drug prohibition system since it is able to deal with increasing drug-related harms which prohibition and its criminal control apparatuses cannot tackle. This double strategy of prohibiting drug use, but at the same time tolerating it to some extent to reduce harms is convenient as it does not contradict our collective perception of drug use, problems and related nuisances. (Garland 2001, see Hakkarainen & Tigerstedt 2004, 182.)

Nevertheless, there is also a promise of liberalisation in harm reduction. In claiming to make drug users responsible and empower them, i.e., improve their chances of taking part in the decision-making concerning themselves harm reduction is part of constituting a civil rights movement for drug users. Harm reduction offers the users a common identity through which it is possible to become mobilised and act together. The ideals of the harm reduction movement—such as pragmatism, amorality and user empowerment—open for drug users a new kind of opportunity as citizens. Even if this citizenship is actualised narrowly through their roles as patients or clients in medically-based harm reduction services, this strengthens the drug users' identities as members of legitimate categories in modern society. In this sense also the medical harm reduction movement can also be considered a civil rights movement for drug users, and transition to a prohibition environment with a harm reduction accompaniment can be emancipating also to drug users.

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Onko Suomen huume politiikka muuttunut?

Tuukka Tammi

Suomalaisen huumausainekysymyksen kehitys vuosisadan alusta 1990-luvulle voidaan pelkistää kolmeksi vaiheeksi sen mukaan, millaiseksi ilmiöksi huumeongelma on kunakin aikana ensisijaisesti määritelty (Hakkarainen 1992; 1999a; 1999b). Huumausainekysymyksen ensimmäisessä vaiheessa vuosisadan alusta 60-luvulle saakka huumausaineiden käyttö ja siihen liittyvät vähäiset ongelmat nähtiin lähinnä lääketieteellisenä ilmiönä, jotka normaalien terveyspalveluiden ja lääkevalvonnan katsottiin voivan hoitaa. Poliisilla ei ollut kovinkaan keskeistä roolia ilmiön sääntelyssä. Huume kysymyksen toinen määrittelyvaihe alkoi 1960-luvun loppupuolella, kun nuorten huumeiden käyttö lisääntyi nopeasti ja huumeet nousivat julkiseksi ja poliittiseksi keskustelunaiheeksi. Vilkkaan keskustelun ja vuonna 1972 voimaan astuneen huumausainelain myötä huume kysymyksen yhteiskunnallisen sääntelyn painopiste siirtyi terveydenhuollosta rikosoikeudellisen kontrollin piiriin: syntyi repressiivinen kokonaiskieltopolitiikka, jossa huumausaineiden myynnin, salakuljetuksen ja välittämisen lisäksi myös niiden käyttö ja hallussapito tuli rangaistavaksi. Samalla päävastuu ilmiön hallinnasta siirtyi lääkäreiltä poliisi- ja oikeusviranomaisille. Tässä huumeongelman toisessa määrittelyvaiheessa huumausainekysymys nähtiin ennen kaikkea nuoriso-ongelmana (Hakkarainen 1999a, 292–293).

Rikosoikeudellisen näkökulman keskeinen asema Suomen huumausainepolitiikassa on säilynyt ensimmäisestä huumeaallostaa nykypäivään. Huume kysymyksen kolmanteen määrittelyvaiheeseen siirryttiin 1990-luvun alussa, kun ilmiön rikosoikeudellinen määrittely muuttui laadullisesti. Pekka Hakkaraisen mukaan (1999a, 295–296; 1999b, 17–21) tämä muutos ilmeni erityi-

sesti vuoden 1994 huumausaineita koskevassa lakiuudistuksessa, jossa huumausainekysymystä ei käsitelty enää järjestyksenpitoon liittyvänä nuorison ongelmana, vaan sen sijaan korostettiin huumausainerikollisuuden yhteyttä järjestäytyneeseen rikollisuuteen. Uudistuksen myötä huumausainerikollisuuden merkitys koko kriminaalipolitiikan kentällä kasvoi. Lisäksi, vaikka lakiuudistuksessa pyrittiin erityisesti vahvistamaan järjestäytyneen huumerikollisuuden vastaista toimintaa, siinä saattoi myös nähdä ensimmäisiä merkkejä niin kutsutusta haittojen vähentämisen ajatuksesta (*harm reduction*), sillä lakiin kirjattiin säännös rikosoikeudellisista toimenpiteistä luopumisesta tapauksissa, joissa huumausainerikoksen tekijä sitoutuu hoitoon tai joissa kyseessä on vähäinen teko (esimerkiksi huumeiden käyttö yksityistiloissa). (Vrt. Kainulainen 2000.)

	Ongelman määrittely	Huumepolitiikan painopiste
1900–	Lääketieteellinen ongelma	Terveystieteellinen (lääkärit, reseptit, lääkeluettelot ja hoito)
1960/1970–	Nuoriso-ongelma	Rikosoikeudellinen kontrolli (poliisi, rikoslaki, rangaistus, ennaltaehkäisy)
1990-luku	Järjestäytyneen rikollisuuden riippuvuus ja ongelmakäyttö Kansanterveyden ongelma	Rikoskontrolli, hoito ja haittojen vähentäminen (rahanpesun kriminalisointi, omaisuuden konfiskointi, uudet tutkintakeinot, rangaistuksen korvaaminen hoidolla, hoidon kehittäminen, neuvojen vaihto)

Lähde: Hakkarainen 1999b, 21.

Kuvio 1. Huumeongelman ja huumeepolitiikan määrittely Suomessa.

Pian edellä mainitun lakiuudistuksen jälkeen alettiin puhua Suomen toisesta huumeaallostasta, kun sekä huumeiden kokeilu- että ongelmakäyttö lisääntyivät nopeasti (ks. esim. Partanen & Metso 1999; Partanen ym. 1999). Huumeongelman kasvaessa kasvoi myös sitä koskevien toimenpide-ehdotusten ja ratkaisumallien kirjo. Kun Suomen virallista huumausainestrategiaa luotiin toisen huumeaallon alussa vuosina 1996–1998, kävi ilmi, että edes valtionhallinnon sisällä ei oltu yksimielisiä keskeisistä toimenpidelinjauksista. Strategiatyössä mukana olleilla huumeepolitiikan asiantuntijoilla oli keskenään hyvinkin erilaisia näkemyksiä siitä, miten kasvaneeseen ongelmaan tulisi ensisijaisesti puuttua (ks. esim. Soikkeli 1998; 1999).

Tarkastelenkin tässä artikkelissa Suomen huume politiikkaa kenttänä, jolla eri toimijat ajavat omia ratkaisumallejaan ja toteuttavat lähtökohdiltaan hyvin erilaisia, jopa ristiriitaisia toimia. Kuvaan nykyisen, entistä fragmentoituneemman huume politiikkamme muotoutumista viime vuosien virallisten strategioiden sekä käytännön toimien valossa. Kiinnitän erityistä huomiota ”perinteisen” rajoittavan huume politiikan ja uuden haittojen vähentämisen politiikan rajankäyntiin. Artikkelin lopuksi pohdin, millainen kokonaiskuva strategioiden ja toimien perusteella muodostuu ja miten huume politiikkamme saattaa lähitulevaisuudessa kehittyä.

Mitä huume politiikka on?

Osmo Kontulan (1998, 181) määritelmän mukaan huume politiikka tarkoittaa ”tavoitteellisia yhteisöllisiä tai yhteiskunnallisia ohjelmia ja toimia, joiden tarkoitus on vaikuttaa yksilöiden huumeidenkäyttöön ja sen aiheuttamiin seurausilmiöihin”. Hän jakaa huume politiikan kolmeen tasoon:

1. huume poliittinen retoriikka
2. formaali politiikka ja
3. politiikan soveltaminen.

Näin ollen huume politiikan muutosta pohdittaessa olisi kysyttävä, miten ovat muuttuneet a) virallinen julkilausuttu valtiollinen huume politiikka eli formaali politiikka (mm. lainsäädäntö, yleiset julkilausumat ja periaatepäätökset, eri hallinnonalojen ja kuntien strategiat ja toimintaohjelmat), b) käytännön ehkäisy-, hoito- ja kontrollitoiminta eli politiikan käytäntöön soveltaminen (mm. eri toimenpiteiden painotukset ja priorisointi, uudet toimenpiteet) sekä c) julkinen keskustelu ja puhettavat eli huume politiikan retoriikka (mm. puheenaiheet, käsitteet, ”retoriset taistelut” ja argumentointi).

Tässä artikkelissa keskityn formaaliin huume politiikkaan ja politiikan käytännön soveltamiseen. Ennen kuin ryhdyn tarkastelemaan suomalaista huume politiikkaa, on syytä yleisesti kuvata erilaisia huume poliittisia malleja eli näkemyksiä huume ongelmista ja niiden hallintakeinoista. Kuviossa 2 on esitetty seitsemän huume politiikan ideaalityyppiä (Waal 2000, 20; soveltaen TT ja Kinnunen, 2001a).

Sota huumeita vastaan	Taistelu huumeita vastaan on aina etusijalla. Huumeiden käyttäjien ja huumeongelmaisten tarpeet on alistettu taistelun vaatimuksille ja voidaan tarvittaessa sivuuttaa. Lopullinen tavoite on voitto vihollisvoimista (huumeet, huumekauppiat ja -tuottajat).
Huumeista vapaa yhteiskunta	Yhteinen hyvä on etusijalla. Huumeet ovat uhka yhteiskunnalle ja heikoille huumeisiin lankeaville yksilöille, joita suojellaan. Lopullinen tavoite on yhteiskunta, jossa huumeita on hyvin vaikea saada eivätkä ne kiinnosta ihmisten enemmistöä.
Rajoittava huume politiikka	Korostaa rajoittavaa huume politiikkaa ja rikosoikeudellisia keinoja, joilla pyritään vähentämään huumeiden kokonaiskulutusta ja sitä kautta ongelmakäyttäjien määrää. Käytön ehkäisy katsotaan kustannustehokkaaksi ja siksi ensisijaiseksi keinoksi, kun taas hoito on kallista ja vaikeaa.
Sosiaali- ja terveys poliittinen painotus	Huumeiden käytön ehkäisy on etusijalla, mutta myös käytön riskien vähentäminen hyväksytään. Rikosoikeudelliset keinot hyväksytään tarjonnan pienentämiseksi ja uusien käyttäjien rekrytoitumisen vähentämiseksi. Tavoitteena on sekä käytön että riskien vähentäminen.
Haittojen vähentäminen	Huumeista aiheutuvien haittojen vähentäminen monin eri tavoin on etusijalla, ja perimmäisenä tavoitteena on mahdollisimman vähäiset haitat. Huumeiden käyttöä pidetään ongelmana, mutta myös ilmiönä, joka väistämättä esiintyy jälkimoderneissa yhteiskunnissa: käytön ehkäisy nähdään epärealistisena tavoitteena. Korostaa huumeiden käytön dekriminointia ja käyttäjän oikeuksia ja intressejä.
Laillistaminen	Huumeiden käyttö ei ole rangaistavaa, sillä juuri kriminalisointi aiheuttaa suurimmat ongelmat. Huumeiden jakelu tulee järjestää valtiollisten monopolien, apteekkien, lisensoitujen kauppojen tms. kautta, jolloin siihen ei liity rikollisuutta.
Liberalismi ja kuluttajanäkökulma	Yksilön oikeudet ja edut ovat etusijalla. Huumeiden käyttäjät ovat kuluttajia ja huumeita tulee olla saatavilla kuten muitakin tuotteita. Kuluttajansuoja edellyttää laadunvalvontaa ja tuotteiden laatua koskevan puolueettoman tiedon jakamista. Kilpailu takaa tuotteiden tyydyttävän hinta-laatusuhteen.

Kuvio 2. Huume politiikat jatkumona ääripäiden välillä.

Käytännössä lähes kaikkien länsimaiden huume politiikat sijoittuvat yhteen tai useampaan jatkumon keskikategorioista. Suomen huumeaine politiikka on viimeiset 30 vuotta perustunut rajoittavaan kokonaiskieltopolitiikkaan. Rajoittavan, repressiivisen huumeaine politiikan peruspilari on huumeaineiden ja niiden käytön kokonaiskielto – kaupan ja salakuljetuksen lisäksi myös huumeiden käyttämisen tulee olla laitonta ja rangaistavaa. Kokonaiskieltopolitiikka perustuu ajatukseen, että käytön laittomuus vähentää huumeiden kokeilua ja käyttöä sekä myös ylläpitää huumeiden vastaisia asenteita. Poliisin strategian mukaan käyttäjien valvonta vahvistaa huumeaine lain säädännön yleisestävää vaikutusta (*Poliisin...*, 1998, 207). Huumeiden kontrollin ja repression tarvetta on perusteltu myös moraalilla, terveydellisillä ja yleiseen järjestykseen liittyvillä seikoilla (Kontula 1998, 182).

Haittojen vähentämisen politiikkaa pidetään usein rajoittavan huume politiikan vaihtoehtona. Huumeiden käytöstä ja sen valvonnasta aiheutuvien haittojen vähentämiseen pyrkivä huume työ on kansainvälisesti yleinen lähestymistapa, mutta Suomessa melko uusi. Haittojen vähentäminen on pragmaattinen lähestymistapa, jossa ensisijaista on huumeiden käytön yksilölle, yhteisöille ja yhteiskunnalle aiheuttamien haittojen pitäminen mahdollisimman vähäisinä. Tähän pyritään muun muassa huumeiden vähäriskisimpiä käyttötapoja edistämällä ja käytettyjen aineiden turvallisuutta säätelemällä. Tunnetuimpia haittojen vähentämisen käytännön sovelluksia ovat huumeiden käyttäjien terveysneuvonta puhtaiden neulojen ja ruiskujen vaihtopisteiden sekä huumeriippuvaisten lääkkeelliset korvaus- ja ylläpito hoidot. (Saarto 1999; Weiker ym. 1999; Erickson ym. 1997.)

Formaalin huumeaine politiikan muotoilu vuosituhatosen taitteessa

Suomen nykyiset huume strategiat ja toimenpidelinjaukset luotiin muutama vuosi sitten 1990-luvun lopussa. Sosiaali- ja terveysministeriö asetti Suomen toisen huumeaallon noustessa vuonna 1996 toimikunnan, jonka tehtävänä oli laatia ehdotus kansalliseksi huumeaine ohjelmaksi. Ylijohtaja K. J. Långin johdolla kokoontunut poikkihallinnollinen työryhmä jätti mietintönsä (*Huumeaine strategia* 1997) vuoden 1997 keuhällä. Esityksen

pohjalta valtioneuvosto teki vuoden 1998 lopulla periaatepäätöksen huumausainepolitiikasta (*Valtioneuvoston...* 1999). Periaatepäätökseen liittyvän toimenpideohjelman toteutusta tehostettiin 32,5 miljoonan markan lisäpanostuksella vuonna 2000. Lisäksi viime vuosina on tuotettu useita alakohdattaisia huumeepoliittisia asiakirjoja. Näistä kannattaa mainita vuonna 2000 valmistuneet Nuorten huumeidenkäytön ehkäisytoimikunnan mietintö (*Nuorten...* 2000) ja Poliisin huumausainestrategia (*Poliisin...* 2000) sekä vuonna 2001 valmistuneet Huumausaineiden ongelmakäyttäjien hoitoa kehittäneen työryhmän (*Huumausaineiden...* 2001) ja Opioidiriippuvaisten lääkehoitoa selvittäneen työryhmän (*Opioidiriippuvaisten...* 2001) mietinnöt. Huumausainekysymyksiä käsitellään myös neljän eri ministeriön (sosiaali- ja terveysministeriö, sisäasiainministeriö, opetusministeriö ja oikeusministeriö) omissa tavoite- ja toimintaohjelmissa.

Suomen huumausainepolitiikka on pitkään levännyt kahden jalan, huumeiden kokonaiskiellon ja yleisen hyvinvointipolitiikan, varassa. On luotettu siihen, että huumeiden käyttöä ja haittoja kyetään parhaiten sääntelemään toteuttamalla kokonaiskieltopolitiikkaa ja edistämällä väestön yleistä hyvinvointia ja hyviä elinolosuhteita. Politiikan peruslinjana on rajoittava huumausainepolitiikka, jota ei ole katsottu tarpeelliseksi muuttaa uusimmissakaan strategioissa. Suomen huumeepolitiikan tavoitteenasettelu on kuitenkin pikemminkin suhteellista kuin absoluuttista – toisin kuin vaikkapa Ruotsissa, missä tavoitteeksi on asetettu huumeeton yhteiskunta. Suomessa rajoittava linja katsotaan perustelluksi nimenomaan ”nykyisessä tilanteessa” (*Huumausainestrategia* 1997, 56) eikä huumeepoliittisia linjauksia ole siten lyöty lopullisesti lukkoon. Suomen formaalia huumeepolitiikkaa voi siksi pitää jopa reflektiivisenä: huume-strategioissa annetaan ymmärtää, että huumeitilanteen kehitystä tarkkaillaan aktiivisesti ja politiikan keinot sovitetaan uudelleen kulloiseenkin tilanteeseen sopiviksi.

Valittua peruslinjaa eli kokonaiskieltopolitiikkaa ja hyvinvointipolitiikkaa alettiin kuitenkin viimeistään vuoden 1997 huumausainestrategiassa tukevoittaa kolmannella jalalla: huumehaittojen vähentämiseen tähtävällä toiminnalla. Huumausainepoliittinen toimikunta esitti seuraavaa (*Huumausainestrategia* 1997, 58–59): ”Huumeiden käytöstä johtuvat epidemiat torjutaan [...] Tämä on välttämätöntä vaikka käyttö jatkuisikin. Tällaisia toimia voivat olla esimerkiksi tartuntojen leviämistä ehkäisevä neuvonta, seksuaali-

valistus sekä huumeiden käyttövälineiden vaihtaminen steriileihin. Kansanterveyden turvaamiseksi on huumeiden käyttöön liittyvien tartuntatautien ehkäisemiseksi tehtävä kaikki voitava.” Ilmaisu ”vaikka käyttö jatkuisikin” voidaan nähdä särönä rajoittavassa linjassa, jonka peruselementti on huumeiden käytön rangaistavuus. Toimikunta käsitelikin mietinnössään argumentteja, joilla käyttövälineiden vaihtamista oli vastustettu: sitä että tällainen toiminta voidaan nähdä vastakkaisena käytön kriminalisoinnin tavoitteiden kanssa ja että tällainen toiminta voisi lisätä huumeiden käyttöä. Jälkimmäistä pelkoa pidetään mietinnössä aiheettomana, mutta käyttövälineiden vaihtamisen ja kriminalisoinnin tavoitteiden välinen ristiriita jäi auki (vrt. Soikkeli 2000).

Seuraava huumeepoliitikamme perusdokumentti, valtioneuvoston periaatepäätös huumausainepoliitikasta julkistettiin vuonna 1998. Periaatepäätöksessä yhdeksi tavoitteeksi määriteltiin ”niiden kustannusten ja haittojen minimoiminen, joita huumausaineiden käytöstä sekä siitä aiheutuvista yhteiskunnan toimista syntyy”. Tavoitteella pyritään edistämään haittojen vähentämistoimia, ja haitat määritellään siinä vieläpä laajasti, sillä tavoitteessa viitataan huumeiden käytöstä aiheutuvien haittojen lisäksi myös ”yhteiskunnan toimista aiheutuviin haittoihin” eli niihin terveydellisiin, sosiaalisiin ja taloudellisiin haittoihin, joita huumeiden kontrollointi aiheuttaa. Haittojen vähentämistoimille luotiin periaatepäätöksessä pohjaa myös luettelemalla ne lainkohdat, joka paitsi oikeuttavat haittojen vähentämiseen osana huumetyötä myös suorastaan edellyttävät sitä viranomaisilta (*Valtioneuvoston...* 1998, ks. myös Soikkeli 2000 ja Virtanen 2001, 17–19). Periaatepäätöksessä vahvistettiin niin ikään huumausainepoliittisen toimikunnan ehdotus puhtaiden neulojen ja ruiskujen vaihtamisesta käyttäjille. Vaikka vaihtotoiminta – yksi haittojen vähentämispoliitiikan peruselementeistä – näin vahvistettiin Suomen virallisen huumeepoliitiikan osaksi, uuden lähestymistavan ottaminen politiikkamme tavoitteisiin ei tapahtunut ilman vastustusta. Huumausainepoliittisista peruslinjoista oli keskusteltu intensiivisesti: valtioneuvoston periaatepäätöstä valmisteltaessa sisäasiainministeriö oli vaatinut irtisanoutumista haittojen vähentämisestä ja huumeettoman yhteiskunnan asettamista suomalaisen huumeepoliitiikan virallistavoitteeksi. Jäätyään yksin se kuitenkin mukautui ehdotukseen, jonka valtioneuvosto myös yksimielisesti hyväksyi. (Soikkeli 1999.)

Valtioneuvoston periaatepäätöksessä Suomen huumausainepoliitiikan ta-

voitteeksi määriteltiin huumausaineiden levittämisen ja käytön ehkäiseminen. Tavoitteeseen pyritään ”huumausaineiden kokonaiskieltoon perustuvaa huumausainekontrollia tehostamalla, huumausaineiden kokeilua ja käyttöä ennalta ehkäisevillä toimilla sekä järjestämällä riittävästi hoitomahdollisuuksia ja helpottamalla hoitoon hakeutumista”. Lisäksi esitetään, että ”huumausaineista sekä niiden aiheuttamista ehkäisy-, hoito- ja kontrollitoimenpiteistä koituvia yksilöllisiä, sosiaalisia ja taloudellisia haittoja pyritään pitämään mahdollisimman vähäisinä”. (*Valtioneuvoston...* 1999). Näin huumeiden kokonaiskielto ja sen valvonta sekä melko laajasti määritelty haittojen vähentäminen mainitaan rinnakkain huumausainepolitiikkamme perustavoitteissa: suomalainen huumausainepolitiikka pyrkii siten samanaikaisesti sekä kontrolloimaan laittomien huumeiden käyttöä kokonaan ja tehostusti että pitämään huumeiden käytöstä ja tämän sääntelystä kaikille osapuolille aiheutuvia haittoja minimaalisina.

Periaatepäätöksen jälkeiset työryhmämietinnöt ja säädökset ovat edelleen vahvistaneet haittojen vähentämisen roolia. Tartuntatautien torjunnan lisäksi niissä on kiinnitetty huomiota muun muassa haittoja vähentävän valistuksen mahdollisuuksiin, jotta käyttäjiä voitaisiin neuvoa kaikkein pahimpien riskien välttämiseen sen mukaan, mitkä heidän käyttötapsansa ja käyttämänsä aineet ovat (*Nuorten huumeiden käytön...* 2000, 68–69). Myös käyttäjäkontrollia on ehdotettu kehitettävän siten, että siitä koituisi mahdollisimman vähän haittoja (mt., 87). Huumeongelmaisten hoitoa koskevissa strategioissa on niin ikään siirrytty asteittain kohti haittojen vähentämissuuntausta ja erityisesti opiaattiriippuvaisten hoidon painopistettä ollaan nopein askelin viemässä kohti haittojen vähentämisajattelun mukaista lääkkeellistä korvaus- ja ylläpitohoitoa (ks. *Huumausaineiden ongelmakäyttäjien...* 2001, *Opioidiriippuvaisten...* 2001, *Sosiaali- ja terveysministeriön...* 2000).

Toisaalta samalla kun sosiaali- ja terveysviranomaisia kehoitetaan huumeepoliittisissa asiakirjoissa haittojen vähentämistoimilleen, on myös kasvatettu lainvalvontaviranomaisten roolia ja valtuuksia sekä vakavan huumausainerikollisuuden että niin kutsutun käyttäjärikollisuuden (käyttö ja hallussapito) tehostettussa valvonnassa. K. J. Långin toimikunnan suosituksissa (*Huumausainestrategia* 1997, 59) korostettiin huumeiden käytön valvonnan tehostamista seuraavasti: ”Huumausaineiden käytön ja leviämisen ehkäisy edellyttää, ettei julkista huumeakauppaa ja käyttöä päästetä syntymään [...] Huumeiden le-

vittämisen ja käytön ehkäisy edellyttää tehokasta katutason valvontaa.” Pyrkimys toistuu poliisin omassa huumestrategiassa (*Poliisin huumeainestrategia...* 2000), jonka mukaan ”paikallispoliisi huolehtii katutason kattavasta ja tehokkaasta järjestämisestä huumeaineiden kaupan, käytön ja huumeekulttuurien leviämisen estämiseksi”. Niin ikään valtioneuvoston periaatepäätöksessä vuonna 1998 esitettiin, että kokonaiskiellon valvontaa tehostetaan.

Vuoden 1994 huumeaineekontrollia koskevassa rikoslainuudistuksessa rahanpesu ja huumeaineerikollisuuden edistäminen otettiin kriminalisointiin piiriin. Poliisilain muutoksista päätettiin keväällä 2001. Siinä poliisille annettiin oikeus toteuttaa niin kutsuttuja epäsovinnaisia rikosten torjunta- ja tutkintamenetelmiä, mitä perusteltiin huumeutorjunnalla ja uusilla huume-kaupan uhkakuvilla. (*Hallituksen...* 1999). Uusittu laki antoi poliisille valtuudet muun muassa huumeaineiden valeostoihin, peitetoimintaan (soluttautuminen rikollisjärjestöihin), teletunnistetietojen keruuseen ja muuhun tehostettuun tekniseen tarkkailuun. Hallituksen esityksen mukaan valeostojen tavoitteena on vaikuttaa markkinoilla olevien huumeaineiden määrään saamalla pois markkinoilta mahdollisimman paljon huumeaineita. Käyttäjäkontrollia pyrittiin kiristämään oikeusministeriön vuonna 2001 tekemällä esityksellä rikoslain 50. luvun 7. pykälän muuttamiseksi siten, että huumeiden käyttäjän syyttämättä jättämisen mahdollisuus muissa kuin hoitohakeutumistapauksissa poistettaisiin laista. Sosiaali- ja terveysministeriö ja Stakes kuitenkin arvostelivat esitystä voimakkaasti (*Stakesin lausunto...* 2000) ja lopulta syyttämättä jättämisen mahdollisuus säilyi laissa (katso tästä ja muusta huumeidenkäyttäjän kriminaalipoliittista asemaa koskevasta keskustelusta Heini Kainulaisen artikkeli tässä kirjassa).

Kun tarkastellaan yhtäältä kontrolliviranomaisten ja toisaalta sosiaali- ja terveysturvaviranomaisten hallinnonalojen omia huumeepoliittisia strategioita ja ohjelmia, nähdään, että molemmat sektorit ovat järjestelmällisesti pyrkineet laajentamaan ja vahvistamaan ”omien tavoitteidensa” asemaa huumeaine-politiikan kentällä: valvontaviranomaiset ovat vahvistaneet huumeiden käytön valvontaa ja sosiaali- ja terveysturvaviranomaiset huumehaittojen vähentämistä osana huumeongelmien ennaltaehkäisyä ja hoitoa. Molemmilla hallinnonaloilla on viime vuosina tuotettu ahkerasti alakohtaisia strategioita ja mietintöjä, lakialoitteita ja asetuksia sekä käytäntöjä, jotka ovat lisänneet viranomaisten keinovalikoimaa ja valtuuksia. Sekä valvontaviranomaisten

mahdollisuudet huumevalvontaan että sosiaali- ja terveysviranomaisten mahdollisuudet huumehaittojen vähentämiseen ovat formaalissa huume-politiikassa parantuneet. Entä sitten käytännössä?

Käytännön huume poliittiset toimet: haittojen vähentämistä ja valvonnan tehostumista

Huumausainestrategiassa esitetyt huumeiden käyttövälineiden vaihto-ohjelmat (niin kutsutut terveysneuvontapisteet) suonensisäisesti huumeita käyttäville käynnistyivät ja laajenivat Etelä-Suomessa nopeasti 1990-luvun loppuvuosina. Vuoteen 2001 mennessä suurimpiin kaupunkeihin oli perustettu kaikkiaan yhdeksän palvelupistettä. Haittojen vähentämistä niin ikään edustava opiaattiriippuvaisten ylläpito- ja korvaushoito on sekin laajentunut askeleittain, joskin hitaammin kuin käyttövälineiden vaihto.

Taulukko 1. Arviot asiakkaiden lukumääristä ruiskujenvaihto-ohjelmissa sekä korvaus- ja ylläpito-hoidossa 1996 ja 2000.

Asiakkaita	1996	2000
Ruiskujen vaihto-ohjelmissa	0	4 800/32 900*
Korvaus- tai ylläpito-hoidossa	0–10	n. 200

* Asiakkaita/käyntejä. Lähde: Partanen 2001.

Ruiskujen vaihtotoiminnan nopean laajenemisen mahdollistivat pääkaupunkiseudun huumeidenkäyttäjien rajut hepatiitti- ja hiv-epidemioiden (ks. esim. Virtanen 2001, 40), joiden torjunta vaati nopeaa toimintaa. Ensimmäisen terveysneuvontapisteen Vinkin toiminta ei käynnistynyt kuitenkaan aivan ongelmitta, vaan mediakirjoittelusta alkunsa saaneen keskustelun vuoksi sen aloitus viivästyi syksystä 1996 kevääseen 1997. Palvelun käytännön järjestämisestä vastanneen järjestön, A-klinikkasäätiön, johto vieraili sisäministerin, oikeusministerin ja sosiaali- ja terveysministerin luona selvittämässä toiminnan tavoitteita ja periaatteita. (Mäkelä 2001.) Muun muassa poliisiviranomaiset ovat toistuvasti esittäneet kriittisiä näkemyksiä neulojen ja ruiskujen vaihtotoiminnasta sen alusta alkaen. Kritiikin kärki on kohdistunut siihen, kuinka käyttövälineitä vaihdettaessa ikään kuin hyväksytään huumei-

den käyttö, joka on rikollista toimintaa (ks. esim. Leppänen 1999). Ajoittain kiivainakin käyneistä linjakeskusteluista huolimatta neuojen ja ruiskujen vaihtopisteet ovat kuitenkin nopeasti vakiintuneet osaksi huume politiikan käytäntöjä. Myös opiaattiriippuvaisten lääkkeellinen ylläpito- ja korvaushoito on ollut kiistanalainen kysymys läpi 1990-luvun ja saanut runsaasti julkisuutta erään helsinkiläisen yksityislääkärin hoitotoiminnasta nousseen kohun vuoksi (ks. esim. *Helsingin Sanomat* 12.1.1999; 1990-luvun alun keskustelusta ks. Hakkarainen & Hoikkala 1992). Ylläpito- ja korvaushoitojen laajaa ja nopeaa käyttöönottoa ovat arvostelleet toisaalta myös päihdehuollon ammattilaiset ja tutkijat (Mäkelä & Poikolainen 2001; katso myös Lasse Murron artikkeli tässä kirjassa).

Huumevalistuksen sisällön kehityksestä ei ole kattavaa tietoa, mutta joi-tain esimerkkejä haittojen vähentämiseen tähtäävistä valistushankkeista on. Esimerkiksi vuonna 2001 alkanut Terveiden edistämisen keskuksen valta-kunnallinen huume kampanja on osittain suunnattu haittojen vähentämiseen. Lisäksi ainakin A-klinikkasäätiö ja Kansanterveyslaitos ovat julkaisseet käyttäjille suunnattuja esitteitä vähäriskisemmistä käyttötavoista ja ensi-avusta vaaratilanteissa. Valtaosa valistusaineistoista tähtää kuitenkin edel-leen vain huume kokeilujen ehkäisemiseen ja huumeiden vastaisten asentei-den vahvistamiseen.

Haittojen vähentämisen näin rantautuessa Suomeen ei rajoittava huume-politiikka suinkaan ole löyhentynyt vaan pikemminkin kiristynyt entises-tään. Huumeusainekontrollia on tehostettu muun muassa lisäämällä poliisin ja tullin voimavaroja, teknisiä apuvälineitä ja koulutusta. Katuvalvonta on siirtynyt entistä useammin järjestyspoliisin vastuulle, kun huume poliisi on joutunut sitomaan suuren määrän resursseistaan törkeän huumerikollisuu-den torjuntaan (Kinnunen, Perälä & Telkkä 2001; katso myös Arne Kinnu-sen artikkeli tässä kirjassa). Taulukon 2 osoittama ”käyttäjärिकosten” (käyt-tö, hallussapito, osto) suuri määrä viittaa siihen, että valvontaa kohdennetaan yhä voimakkaasti myös käyttäjäportaaseen, ei vain ammattimaiseen rikolli-suuteen. Aiemmin mainittuja uusitun poliisilain suomina valtuuksia huumeusaineiden valeostoihin, peitetoimintaan ja muuhun rikollisten tehotark-kailuun ei ole toistaiseksi otettu käyttöön muutamaa valeostotapausta lu-kuun ottamatta (Sisäasiainministeriön... 2002). Tyypillisin huumeusaineri-kos Suomessa on kannabiksen tai amfetamiinin hallussapito tai käyttö, ja

tyypillisin seuraamus huumausainerikoksesta on sakkorangaistus. Vuonna 2000 huumausainerikos päärikoksenaan tuomituista 71 prosenttia tuomittiin sakkoihin. Toisaalta myös huumausainerikos päärikoksenaan rangaistustaan suorittavien vankien osuus kaikista vangeista on miltei viisinkertaistunut 1990-luvun alun tilanteesta: kun vuonna 1991 ”huumevankien” osuus oli 2,9 prosenttia, vuonna 2000 se oli jo 15,5 prosenttia. (Kinnunen 2001b). Huumekontrolli onkin kiristymässä kaikilla rintamilla, niin huumeiden käyttäjien kuin myynti- ja välitysrikollisuudenkin valvonta.

Taulukko 2. Eri tekemuotojen lukumääriä keskusrikospoliisin tilastoimassa huumausainerikollisuudessa vuosina 1996 ja 2000.

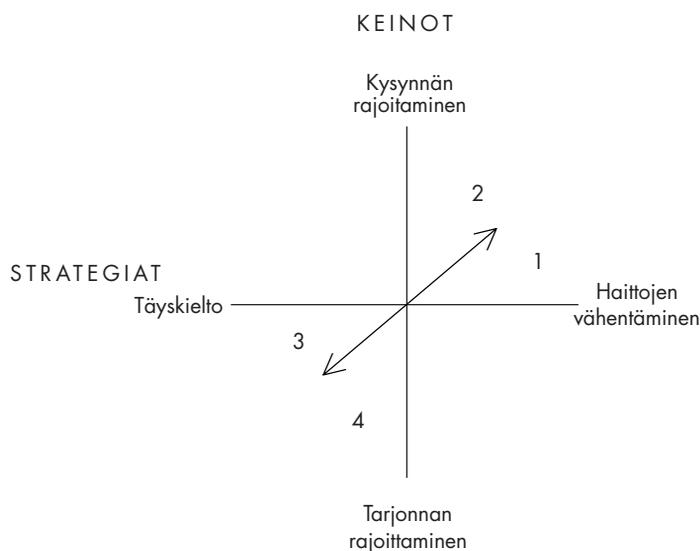
	1996	2000
Käyttö	2558	5541
Hallussapito	4165	7098
Osto	661	938
Myynti, levitys, välitys	605	1662
Maahantuonti	204	313
Viljely	273	483

Lähde: Kinnunen 2001b.

Fragmentoituvaa huume politiikkaa

Suomalainen huumausainepolitiikka näyttää siis kehittyvän samanaikaisesti eri suuntiin. Samalla kun repressiivinen, rajoittava huume politiikka on säilynyt ja vahvistunut, sen rinnalle on kehkeytynyt haittojen vähentämiseen pyrkivän politiikan osa-alue. Suuntia pidetään usein toisilleen vastakkaisina tai ainakin lähtökohdiltaan ristiriitaisina. (vrt. Kontula 1998; Erickson ym. 1997.) Lähestymistapojen keskeisin näkökulmaero liittyy huumeiden käyttäjän asemaan: siihen, määritelläänkö huumeiden käyttäjä rikolliseksi, jota tulee rangaista, vaiko riskikäyttäytyjäksi, jota tulee tukea monin eri tavoin huolimatta siitä, jatkaako tämä huumeiden käyttöä vai ei. Tällä hetkellä suomalainen yhteiskunta pyrkii samanaikaisesti sekä saamaan kiinni ja rankaisemaan huumeiden käyttäjiä että vähentämään käytöstä koituvia haittoja puuttumalla ensisijaisesti vain huumeiden käyttötappoihin ja vasta toissijaisesti itse käyttöön, toisin sanoen rikolliseksi määritelyyn toimintaan.

Kuvio 3 esittää huume politiikan perusulottuvuuksia: vastakkaisia ulottuvuuksia ovat yhtäältä kysynnän vähentäminen ja tarjonnan rajoittaminen sekä toisaalta täyskieltopolitiikka ja haittojen vähentäminen. Tässä kuviossa Suomen huumeaine politiikka lienee perinteisesti sijoittunut keskipisteestä katsoen jonkin verran alavasemmalle: huumeiden käyttöä on pyritty ensisijaisesti ehkäisemään laittomien huumeaineiden tarjontaa rajoittamalla, mutta on myös pyritty vähentämään kysyntää valistuksella, hoidolla ja hyvinvointipolitiikalla sekä viestittämällä kansalaisille huumeaineiden täyskiellosta käytön kriminalisoinnilla ja toteuttamalla tämän valvontaa myös käytännössä. Suomessa valtiovalta ole myöskään asettanut virallista huumeettoman yhteiskunnan tavoitetta toisin kuin Ruotsissa. Kohti kuvion oikeaa laitaa Suomen huume politiikka on liikkunut vasta aivan viime vuosina.



- 1 = ruiskujen vaihtotoiminta
- 2 = ylläpito- ja korvaushoito
- 3 = käyttäjien rikoskontrolli
- 4 = huumeiden myynnin, levityksen, välityksen ja maahantuonnin kontrolli

Kuvio 3. Huumeaine politiikan ulottuvuudet (Sarvanti 1997) ja joidenkin toimenpiteiden suhteellinen sijainti.

Sijainniksemme nelikentässä voi toki ehdottaa muitakin kohtia. Voidaan esimerkiksi esittää, että sosiaalityön perinteestä nouseva päihdehuoltojärjestelmämme on jo pidempään edustanut haittojen vähentämisen lähestymistapaa. Jos näin on, sijoittuu huume politiikkamme jonkin verran oikeammalle. Tai jos korostetaan käyttäjäkontrollin niin kutsuttua yleisestävää vaikutusta ja nähdään se yksinomaan kysynnän vähentämisenä, on sijaintimme vaakaviivan yläpuolella. Sijoittuipa Suomi nelikentässä mihin tahansa, huomionarvoista on, kuinka uudessa huume tilanteessamme keskiarvoisesta sijainnista liikutaan eri hallinnaloilla eri suuntiin. Käynnissä on huume työn tehostamisprosessi sekä kaikenlaisen huume kontrollin kiristämiseksi että haittojen vähentämiseksi.

Klaus Mäkelä on pannut merkille oikeusministeriön lainvalmisteluosaston julkaisussa olleen huume aine lain säädännön valmistelua koskeneen huomautuksen, joka kuului seuraavasti: ”Hallituksen esitykset saattavat olla pikemminkin yksittäisen ministeriön esityksiä, jolloin eri ministeriöiden välisten näkemyserojen sovittelu jää eduskunnan tehtäväksi” (*Yhteiskuntapolitiikka* 5/2000). Mäkelä piti tätä paitsi valtioteoreettisesti ennenkuulumattomana, myös merkinä valtiokoneiston sisäisestä hajaannuksesta huume kysymyksissä. Tällainen fragmentoitumisprosessi näyttää todellakin olevan käynnissä; se on käynnissä niin formaalissa kuin käytännön huume politiikassa.

Koska Suomessa ei ole vahvaa huume poliittista koordinaattoria, kuten Iossa-Britanniassa tai Yhdysvalloissa, keskeiset kysymykset ratkaistaan eri ministeriöiden ja hallinnalojen välisissä neuvotteluissa – tai jätetään ratkaisematta. Suomen huume aine politiikan kokonaiskuva muuttuu pienin vedoin sitä mukaa kuin eri hallinnonalat saavat näkemyksiään läpi valtioneuvostossa ja eduskunnassa. Formaalia valtiollista huume aine politiikkaa muotoiltaessa avainasemassa on eri ministeriöiden välinen köyden veto. Yksi tapa tarkastella huume aine politiikan muutosta ja muodostumista on seurata, miten eri hallinnalojen väliset voimasuhteet ja roolit muuttuvat. Tämä ilmenee esimerkiksi siinä, painotetaanko kontrollia vai hoitoa ja ehkäisyä. Nykyisellään kaksi keskeisintä huume politiikan toimijaa ovat sosiaali- ja terveysministeriön ja sisäasiainministeriön hallinnonalat: merkittävän valtakunnantason huume poliittinen keskustelu käydään näiden hallinnalojen välillä. Toistaiseksi huume poliittinen ohjelmatyö on pyrkinyt ja pystynyt poliittiseen konsensukseen. Hallinnonalat ovat kyenneet myös to-

teuttamaan politiikkojaan ilman suurempia yhteentörmäyksiä. Haittojen vähentäminen ja kokonaiskieltopolitiikka ovat kuitenkin lähtökohdiltaan ristiriitaisia lähestymistapoja. Jännitteisen perusasetelman vuoksi Suomen huumepoliittinen vene on kiikkerä. Se etenee ristiaallokossa, jossa vähänkin voimakas aalto saattaa lyödä yli laidan. (Vrt. Hakkarainen & Tigerstedt 2002.)

Kolme skenaariota huume politiikan kehityksestä

Kuinka pitkälle vahvojen kriminaali-, terveys- ja sosiaalipoliittisten intressien sitten on mahdollista elää ja toimia rinnakkain huumeainepolitiikassa? Mitä voi seurata siitä, jos huume politiikan fragmentoituminen jatkuu? Luonnostelen lopuksi kolme karkeaa skenaariota Suomen huumeainepolitiikan kehityksestä. Ensimmäisen skenaarion mukaan repressiivinen peruslinja säilyy huume politiikan peruslinjana eikä merkittäviä muutoksia tapahdu; toisessa skenaariossa huume politiikan fragmentoituminen jatkuu ja syntyy entistä selvemmin rinnakkaisia politiikkalinjoja, joita ei kuitenkaan nähdä keskenään ristiriitaisina; kolmannessa skenaariossa siirrytään haittojen vähentämispolitiikkaan.

Skenaario 1. Repressio säilyy ja vahvistuu peruslinjauksena. Ensimmäisessä skenaariossa huume politiikka ei juurikaan muutu, vaan repressiivinen peruslinja säilyy ja vahvistaa asemiaan. Laittomien huumeaineidien käyttöön ja hallussapitoon puututaan järjestelmällisesti. Haittojen vähentämistoiminta jää käyttövälineiden vaihdon ja opiaattiriippuvaisten pienimuotoisen lääkehoidon asteelle. Skenaariossa hoidon tarjoaminen syytteen tai tuomion vaihtoehtona ei aktualisoidu käytännössä, vaan sen sijaan keskitytään kehittämään vankiloiden päihdekuntoutusohjelmia, joihin osallistuneiden vankeiden määrä kaksinkertaistui jo vuosina 1996–2000 (Muiluvuori 2001). Päihdehoidon kehittämien vankiloissa mahdollistaa entistä paremmin myös huumeriippuvaisten tuomitsemisen vankeusrangaistuksiin. Skenaariossa myös huumeongelmaisten pakkohoito yleistyy Suomessa kuten Ruotsissa (vrt. Ólafsdóttir 2001, 226). Valistus keskittyy edelleen ensikokeilujen ehkäisyyn ja laillisuuskasvatukseen, jossa poliisilla ja huumeiden vastaisilla yhdistyksillä on keskeinen rooli. Tämän skenaarion toteutumista tukevat kontrolli-

painotteista huume politiikkaa kannattava yleinen mielipide sekä huume tilanteen vakaus tai huumeiden käytön väheneminen.

Tekijä, joka saattaa rajoittaa huume poliittista keskustelua ja edesauttaa repressio-skenaarioiden toteutumista, on nykyisissä strategioissa esitetty yhteisöllisen ja paikallisen toiminnan roolin vahvistaminen huume politiikassamme. On esitetty, että yhteisöllistävää huume strategiaa on omiaan painottamaan kontrollin merkitystä ja yksipuolistamaan huume poliittista keskustelua (Kaukonen 1998, 160). Paikallinen toiminta keskittyy kontrollin vahvistamiseen, ja yhteiskunnallinen ja yhteiskuntapoliittinen keinovalikoima supistuu yksilöiden poikkeavuuden ja lähiyhteisöjen näkyvien ongelmien hallintayrityksiksi. Lisäksi kun huume kysymys yhä enemmän mielletään yhteisöjen ja yksilöiden ongelmaksi, sitä on enää vaikea palauttaa yleiseksi yhteiskuntapoliittiseksi pohdinnaksi, joka mahdollistaisi koko huume politiikan uudelleenarvioinnin. (Kaukonen 1998.)

Skenaario 2. Huume politiikan fragmentoituminen jatkuu ilman yhteentörmäyksiä. Tässä toisessa skenaariossa erilaiset haittojen vähentämistoimet lisääntyvät, mutta ne eivät nouse poliittiseksi linjakysymykseksi. Osaltaan tähän vaikuttaa se, että haittojen vähentäminen jää lähinnä käyttövälineiden vaihtotoiminnan ja opiaattiriippuvaisten lääkehoidon asteelle. Näitä toimia ei nähdä rajoittavan politiikan kanssa ristiriitaisina, vaan ne luetaan pikemminkin terveys politiikan kuin huume aine politiikan alaan kuuluviksi. Lisäksi yleistymisestä huolimatta haittojen vähentäminen jää melko vähäiseksi verrattuna repressiivisiin toimenpiteisiin.

Huume aine kysymyksen määrittely ensisijaisesti ammattirikollisuus-ongelmaksi tukee tällaista politiikan fragmentaatiomallia, kun poliisi mieltää tärkeimmäksi kohteekseen huume aine kaupan ja jättää huumeiden käyttäjät yhä enemmän sosiaali- ja terveysviranomaisten vastuulle. Käytännön toimissa painotetaan edelleen kontrollia, eikä virallinen huume politiikka siksi ole altis muutoksille (katso kontrollin ja hoidon määrällisistä suhteista myös Kaukonen 2000, 86). Myös kontrolli- ja hoitojärjestelmän yhteistoiminta on omiaan edesauttamaan skenaarion toteutumista: huume ainerikoksesta kiinni jäänyt voidaan uusimpien säädösten mukaan jättää syyttämättä tai tuomitsematta, jos hän hakeutuu hoitoon (Kainulainen 2000). Skenaarioiden toteutumista tukee myös vakaana pysyvä huume aine tilanne.

Tässä skenaariossa myöskään valistus ei haasta repressiivistä politiikkalinjaa vaikka päihdekasvatukseen sisällytetään myös neuvontaa turvallisemmista huumeidenkäyttötavoista.

Skenaariota tukee Suomen huume politiikan vahva konsensushakuisuus (Kaukonen 1998, 152; Hakkarainen & Tigerstedt 2002). Suomessa huume politiikkaa tekevät autonomiset toimijat, jotka eivät kovin helposti puutu toisen sektorin tekemisiin vaan kantavat vastuun lähinnä omasta tontistaan. Aktiivinen puuttuminen toisen sektorin toimintatapoihin altistaisi myös oman toiminnan kriittiselle uudelleenarvioinnille. Niinpä vaikka huume politiikkamme onkin edellä kuvatulla tavalla fragmentoitumassa, saattaa sen konsensushenkisenä seurauksena olla sellainen entistä suvaitsevaisempi huume politiikka, jossa rinnakkaiset ja ristiriitaiset politiikkalinjat sietävät toisiaan ennennäkemättömän pitkälle ilman että syntyy julkisia kiistoja ja virallisen huume politiikan hajoamista.

Skenaario 3. Siirrytään haittojen vähentämispolitiikkaan kaikilla sektoreilla. Tässä kolmannessa ja radikaaleimmassa skenaariossa huume politiikan hajanaisuus ja huume tilanteen vaikeutuminen johtavat lopulta poliittisen linjakeskustelun avautumiseen ja haittojen vähentämisen omaksumiseen huumeainepolitiikan keskeisimmäksi tavoitteeksi. Skenaarion toteutumiseen johtavia tekijöitä ovat muun muassa huumeiden käytön ja haittojen sekä tästä koituvien kustannusten kasvun jatkuminen, huumeiden käytön kulttuurinen normalisoituminen ja haittojen vähentämistoiminnan keinovalikoiman aktiivinen monipuolistaminen. Myös EU:n ja sen jäsenmaiden huume poliittinen kehitys kohti haittojen vähentämistä tukee skenaarion toteutumista.

Tässä skenaariossa viranomaiset ja järjestöt käynnistävät vaikeutuneessa tilanteessa yhä enemmän hankkeita, jotka toteuttavat haittojen vähentämispolitiikkaa termin laajassa merkityksessä. Haittojen vähentämistä ei enää mielletä vain pistovälineiden vaihtotoiminnaksi ja ylläpitohoidoksi – joita niitäkin laajennetaan nopeasti – vaan alan toimijat ryhtyvät minimoimaan kaikkia mahdollisia huumeiden käytön haittoja, niin terveydellisiä, sosiaalisia, taloudellisia kuin kokonaisyhteiskunnallisia haittoja. Haittojen vähentämisen periaatteita sovelletaan sekä ehkäisevään päihdetyöhön että kontrolliin. Valistuksessa ensisijaisia ovat sellaiset viestit, joissa lähdetään oletuksesta, että suuri osa nuorista kokeilee huumeita kaikesta huolimatta, ja valis-

tuksella neuvotaan välttämään kaikkein riskialteimpia käyttötapoja. Huumeidenkäyttäjille myös suunnataan monia uudenlaisia palveluja, esimerkiksi huume-tablettien ennakkotestauspisteitä ja valvottuja pistämistiloja, joilla pyritään estämään erilaisten vaaratilanteiden syntyä. Valvontaviranomaiset puolestaan keskittävät resurssinsa ammattimaiseen huumerikollisuuden torjuntaan eivätkä käytännössä enää puutu pelkkään huumeiden käyttöön. Poliisilla on tärkeä rooli huumeongelmaisten ohjaamisessa sosiaali- ja terveydenhuollon palveluihin. Myös keskustelu huumeiden käytön dekriminallisoinnista käynnistyy haittojen vähentämisen nimissä.

Sisältö	Skenaario 1 Repressiivinen huumeepolitiikka	Skenaario 2 Repressiivinen ja haittoja vähentävä huumeepolitiikka rinnakkain	Skenaario 3 Haittoja vähentävä huumeepolitiikka
Huumeepolitiikan kuvaus	<ul style="list-style-type: none"> • Repressiivinen kokonaiskieltopolitiikka säilyy. • Haittojen vähentäminen jää vain käyttövälineiden vaihtotoiminnaksi ja lääkehoidoiksi. • Valistus keskittyy ensikokeilujen ehkäisyyn ja laillisuuskasvatukseen. 	<ul style="list-style-type: none"> • Kokonaiskieltopolitiikka säilyy ja haittojen vähentämistoimet lisääntyvät ja monipuolistuvat, mutta eivät politisoidu. • Kontrollia kohdistetaan entistä enemmän ammatinrikollisuuteen. 	<ul style="list-style-type: none"> • Haittojen vähentämiseen tähtävä poliittikka toteutetaan kaikilla sektoreilla. • Kontrolli kohdistetaan vain ammatinrikollisuuteen. • Valistus keskittyy ensisijaisesti vähäriskisen käytön neuvontaan.
Toteutumiseen johtavia ja sitä tukevia tekijöitä	<ul style="list-style-type: none"> • Huumeepolitiikan paikallistuminen. • Hoidon ja kontrollin integroituminen. • Kontrollin suosio kansalaisten ja poliitikkojen keskuudessa. • Huumeiden käyttö ei lisääny tai se vähenee. 	<ul style="list-style-type: none"> • Poliitiikan konsensushenkisyys. • Terveydenhuollon roolin vahvistuminen huumehoidossa. • Huumeiden käyttö pysyy nykytasolla tai lisääntyy hitaasti. 	<ul style="list-style-type: none"> • Huumeepolitiikan kansainvälinen kehitys. • Terveydenhuollon roolin vahvistuminen huumehoidossa. • Huumeiden käyttö lisääntyy ja normalisoi- tuu; haittojen ja kustannusten kasvu.

Kuvio 4. Huumeepolitiikan kolme skenaariota.

Vaikka tulevaisuuden ennustaminen on vaikeaa, on selvää, että toteutuva skenaario – olipa se sitten jokin tässä hahmotelluista tai jokin aivan muu – riippuu huumeekysymyksen vallitsevasta määrittelytavasta. Kisa parhaiten menestyvästä näkökulmasta on koko ajan käynnissä.

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Has the drug policy in Finland changed?

Tuukka Tammi

Finnish drug policy since the beginning of the 20th century can be divided into three phases based on how the drug problem has been primarily defined (Hakkarainen 1992; 1999a; 1999b). During the first phase—running up until the 1960s—the use of illegal drugs and the minor problems related to it were discussed mainly as medical questions, which could be dealt with via basic health services and medical substance control. The role of law enforcement in controlling the problem was not significant. The second phase began in the late 1960s, when young people's use of illegal drugs increased rapidly and drug use became a public and political discussion topic. Due to the anxious discussion and also the issue of new drug legislation in 1972, governmental control transferred its focus from health care to juridical control; a repressive total-prohibition politics was founded, which included the criminalisation of the sale, import and resale as well as use and possession of drugs. At the same time, the main responsibility of control was transferred from the medical profession to police and legal professions. At this second phase, the drugs phenomenon was understood as primarily a youth problem (Hakkarainen 1999a, 292–293).

The central role of the criminal legislation in drug policy in Finland has maintained from the first drug wave of the 1960s and 1970s until the present. The third phase of drug policy formation began in the beginning of the 1990s, when there was a qualitative change in the criminal justice. According to Pekka Hakkarainen (1999a, 295–296; 1999b, 17–21) the change became apparent particularly in the revision of the drug legislation in 1994. In the revised law, the drug question was no longer discussed as a youth problem and as such a matter mainly related to general public order, but instead drug-related criminality was now linked to organized crime. Along with the reform, the drug policy's significance as part of the overall criminal policy grew. In addition, although the reform was primarily meant to strengthen the forces of law enforcement against organized crime, the first influences of the harm reduction thinking can also be seen, as a statute on waiving criminal sanctions was included in those cases

where the subject commits him/herself to treatment, or when the criminal act is minor (such as the use of illegal drugs in private premises) (see Kainulainen 2000).

	Definition of the problem	The focus of the control policy
1900–	Medical problem	Medical control (doctors, prescriptions, sale bans and treatment)
1960/1970–	Juvenile delinquency	Criminal control policy (police, criminal code, prohibition, criminalisation of drug use)
1990–	Organized crime Addiction and problem use Public health problem	Criminal control policy, treatment and harm reduction (criminalisation of money laundering, confiscation of property, new methods of investigation, replacement of punishment with care, development of treatment, needle exchange)

Source: Hakkarainen 1999b, 21

Figure 1. Social construction of the drug problem and the drug policy in Finland

Soon after the law revision described above, people started to speak of the "second drug wave in Finland", due to increases both in first-time drug use and problem use (see. e.g. Partanen & Metso 1999; Partanen et al. 1999). Parallel with the growth of the drug problem, the related suggestions on models for addressing the problem multiplied and became more varied. When the official strategy on illegal drugs was formulated in the beginning of the second drug wave in 1996–1998, it became apparent that unanimity on the core principles could not be reached even at governmental level. Experts that were involved in creating the strategy held very contradictory conceptions on the main measures that could be used in combating the problem (see, e.g., Soikkeli 1998; 1999).

In this paper I will analyse the Finnish drug policy as a field where various actors are lobbying their own policy models and are implementing acts that are very different and even contradictory in nature. I will depict how the contemporary Finnish drug policy, more fragmented than ever, was formed both in the light of the official strategies and their implementation into practice. Special attention will be paid to the dialogue between the more traditional control policy and the new harm reduction policy. In the end of the paper I will try to draw the pieces together into a more coherent picture of the Finnish drug policy, enabling a discussion of the potential developments in the near future.

What is drug policy?

Osmo Kontula (1998, 181) has defined drug policy as "intentional communal or societal programmes and actions, whose purpose is to have an effect on the

drug use of individuals as well as its consequences". He divides drug policy in three levels:

1. drug policy rhetoric
2. formal policy, and
3. policy implementation.

It follows that discussion on changes to drug policy would need to take account of change in 1) official publicly announced governmental drug policy, i.e. formal policy (e.g. legislation, public announcements and resolutions, as well as the strategies and action programmes of different administrative branches and municipalities), b) practice of prevention, care and control i.e. implementation of drug policy (e.g. areas of focus and prioritisations of different measures, launch of new measures), and 3) public discussion and discourses i.e. the drug policy rhetoric (e.g. topics of speech, concepts, rhetorical conflicts and argumentations).

In this article I will concentrate on formal drug policy and its practical implementation. Before moving into the Finnish drug policy, I will describe on a general level various drug policy models, perceptions of drug problems and their control methods. Figure 2 is a representation of seven ideal types of drug policies (Waal 2000, 20; adapted by TT and Kinnunen, 2001a).

In practice nearly all Western drug policies can be situated in one or more categories. During the past 30 years the Finnish drug policy has based on restrictive prohibitionist stance. The core pillar of this restrictive, repressive drug policy is the total prohibition of illegal substances and their intake, meaning that in addition to trade and import, that drug use should also be criminalised and punished. The total-prohibition approach is based on the idea that the criminal status itself reduces experimentation and use of drugs as well as supports negative attitudes towards drug use. According to the strategy of the police, user control reinforces the deterrent effect of the drug legislation (Poliisin..., 1998, 207). The need for control and repression has also been explained with moral, health and public order related issues (Kontula 1998, 182).

Harm reduction policy is often seen as an alternative to restrictive drug policy. Drug interventions aimed at reducing the harm caused by drug use and drug control represent a common approach internationally while in Finland the approach is rather new. Harm reduction is a pragmatic approach that emphasises the primacy of keeping the harms that drug use causes to individuals, communities and society at as low a level as possible. To this end, efforts are made to promote the less risky ways of using drugs and to increase the safety of the substances used. The best known practices of harm reduction include health counselling provided to drug users and related needle and syringe exchange centres, as well as medicinal substitution and maintenance treatment for drug addicts. (Saarto 1999; Weiker et al. 1999; Erickson et al. 1997.)

War on drugs	The fight against drugs has absolute primacy. The addicts' interests are subordinated to the needs of the fight. The ultimate aim is victory over the enemy forces (drugs, drug dealers, and drug producers).
Drug-free society	The common good has primacy. Drugs are a threat to the society and to the weak who should be protected. The ultimate aim is to create a society where drugs are hard to get and not of interest to the large majority.
Restrictive drug policy	Emphasises restrictive policy and criminal control measures which aim to reduce the total consumption and thereby the problem consumption. Prevention is seen as cost effective and should be prioritised when possible. Treatment is costly and often difficult.
Social and health policy emphasis	Prevention of use has primacy but also risk reduction is accepted. Criminal control measures are accepted to reduce the supply and incidence of new users. The aim is to reduce both use and risks.
Harm reduction	Reduction of drug-related harm has primacy. Drug use is seen as problematic but nevertheless an unavoidable element in modern society. The prevention of use is unrealistic. Emphasises decriminalisation as a tool for reduction and drug users' rights and interests.
Legalisation	Drug use should not be a punishable behaviour because the prohibitive laws are the cause of major problems. Drugs should be supplied in ways that do not presuppose illegal acts such as through public offices or monopolies, prescriptions and pharmacies or registered and controlled, privatised, authorised shops.
Liberalism and consumer orientation	The rights and interests of the individual have primacy. Restrictions are seen as an infringement on the right to consume drugs. As consumers the users have the right to consumer control and quality information. Drugs should be available as other goods through stores with competition securing low prices and quality.

Figure 2. Drug policies as a continuum between extremes

Formal drug policy formulations at the turn of the millennium

The current drug strategies and policy definitions of Finland were drawn up during a few years in the late 1990s. In 1996, when Finland was hit by the second drug wave, the Ministry of Social Affairs and Health set up a committee that was assigned the task of drafting a proposal for a national drug programme. The multi-sectoral working group, led by Director-General K. J. Lång, submitted its report (Huumausainestrategia 1997 "Drug strategy 1997") in spring 1997. Drawing on the report, the Government issued a resolution towards the end of 1998 (Valtioneuvoston...1999). The implementation of the action programme specified in the resolution was promoted by an extra amount of FIM 32.5 million in 2000. In addition, a number of sector-specific drug policy documents have been produced during the last few years. The most important of these documents include the report issued in 2000 by a committee on preventing drug use among young people (Nuorten...2000) and the police's drug strategy from the same year (Poliisin... 2000), as well as the 2001 report of a working group on developing treatment for

drug abusers (Huumausaineiden... 2001) and that of a working group dealing with medicinal treatment for opioid addicts (Opioidiriippuvaisten... 2001). Drug issues are also discussed in the target and action programmes of four different ministries (Ministry of Social Affairs and Health, Ministry of the Interior, Ministry of Education and Ministry of Justice).

Finnish drug policy has long rested on two legs: total prohibition of drugs and general welfare policy. A common belief has been that the best way to regulate drug use and the harm caused by it is to pursue a policy of total prohibition and promote general welfare and good living conditions among the population. The basic strand of this policy is a restrictive drug policy; not even the most recent strategies have considered it necessary to change this. However, the setting of targets in Finnish drug policy has taken place in relative rather than absolute terms – unlike in Sweden, for instance, where a drug-free society has been set as a target. In Finland, the restrictive approach is regarded as justified "in the current situation" in particular (Huumausainestrategia 1997, 56), so the drug policy definitions cannot be regarded as definite. The formal drug policy of Finland can therefore even be regarded as reflective: the drug strategies suggest that the development of the drug situation is being monitored actively and that the political measures taken will be readjusted to the prevailing situation.

However, it was already in the 1997 drug policy strategy if not earlier that efforts were being made to stabilise the chosen basic line, that is, total prohibition and welfare policy, with a third leg: harm reduction measures. The drug policy committee stated as follows (Huumausainestrategia 1997, 58–59): "Epidemics caused by drug use will be combated [...] This is necessary even in the case of continuing use. Necessary measures include counselling with the aim of preventing the spread of infections, as well as sexual education and the exchange of syringes and needles. With a view to safeguarding public health, all necessary action needs to be taken to prevent communicable diseases related to drug use." The expression "even in the case of continuing use" can be seen as a crack in the restrictive policy line, the core component of which was that drug use is punishable. The committee did, in fact, deal in its report with arguments put forward against the exchange of needles and syringes: the notion that this kind of activity can be seen to be in conflict with the objectives of the criminalisation of drug use and that it could increase drug use. The latter fear was seen to be without foundation whereas the conflict between exchange programmes and criminalisation remained open (cf. Soikkeli 2000).

The next basic document of Finnish drug policy, the Government Resolution on drug policy, was published in 1998. One of the targets set in the resolution was "to minimise the costs and harms caused by drug use and related public policy measures." The aim with the target is to promote harm reduction measures, and what is more, harms are given a broad definition: in addition to the harms caused by drug use, the target mentions the harms caused by "public policy measures", that is the health-related, social and economic harms caused by drug control. The Government Resolution also paved the way to harm reduction measures by listing the legal provisions that not only justify harm reduction as part of substance abuse

prevention but also specifically oblige authorities to reduce such harm (Valtioneuvoston... 1998, see also Soikkeli 2000 and Virtanen 2001, 17–19). The resolution also confirmed the proposal of the drug policy committee concerning needle and syringe exchange for drug users. Although the exchange activities – one of the basic elements of harm reduction policy – were thus made part of the official Finnish drug policy, the inclusion of the new approach in the policy targets did not take place without opposition. An intensive discussion had been ongoing on the basic drug policy lines: on drafting the Government Resolution, the Ministry of the Interior had required that harm reduction should be rejected and a drug-free society should be set as the official target of Finnish drug policy. With no support from other stakeholders, however, the Ministry agreed to the proposal, which was unanimously adopted by the Government. (Soikkeli 1999.)

The Government Resolution set the prevention of the spread and use of drugs as the target of Finnish drug policy. To attain the target, "efforts are made to intensify the drug control measures based on total prohibition of drugs, in addition to which preventive action is taken to prevent drug experimentation and use and the availability of treatment is ensured and access to treatment improved". Furthermore, "efforts are made to minimise the individual, social and economic harms caused by drugs and related prevention, treatment and control measures". (Valtioneuvoston... 1999). Total prohibition of drugs and related supervision and fairly broadly defined harm reduction measures are thus mentioned alongside each other in the basic targets of Finnish drug policy: Finnish drug policy thus simultaneously aims both at controlling the use of illegal drugs totally and effectively and minimising the harms caused by drug use and regulation to all those affected.

The working group reports and legal provisions issued after the resolution have further reinforced the role of harm reduction. In addition to communicable diseases, they have paid attention to, for instance, the potential offered by education in harm reduction, with the aim of giving advice to users so as to avoid the worst risks, depending on the ways drugs are used and the substances used. (Nuorten huumeiden käytön... 2000, 68–69). Further, it was suggested that user control should be developed with a view to causing a minimum of harm (op.cit., 87). In the same way, drug treatment strategies have gradually moved towards the harm reduction approach; in particular, the emphasis in treatment provided for opiate addicts has rapidly shifted towards medicinal substitution and maintenance treatment based on harm reduction thinking. (see Huumausaineiden ongelmakäyttäjien... 2001, Opioidiriippuvaisten... 2001, Sosiaali- ja terveystieteiden... 2000).

On the other hand, at the same time as the drug policy documents encourage social welfare and health authorities to apply harm reduction measures, the role and powers of law enforcement authorities have been increased in the intensified control of both severe drug crime and so called user offences (use and possession). The recommendations issued by the committee led by K. J. Lång (Huumausainestrategia 1997, 59) underlined that the control of drug use should be made more effective as follows: "To be able to prevent the use and spread of drugs, it is necessary to prevent the development of public drug trade and use [...] The prevention of

the spread and use of drugs requires effective street-level control.” This aim is also included in the police's own drug strategy (Poliisin huumausainestrategia... 2000), which states that ”the local police is responsible for organising street-level control comprehensively and effectively in order to prevent drug use and trade, as well as the spread of drug cultures”. The 1998 Government Resolution also proposed that the control of total prohibition should be made more effective.

The 1994 reform of the Penal Code concerning drug control criminalised money laundering and the furthering of drug crime. The Police Act was amended in spring 2001. The police was given the right to use so called unconventional crime combating and investigation methods, which was justified by the fight against drugs and the new threats of drug trade. (Hallituksen... 1999). The amended act entitled the police to, for instance, fictitious purchase, covert operations (infiltration), retention of telecommunications data and other intensified technical surveillance. According to the Government Resolution, the purpose of fictitious purchases is to influence the amount of drugs traded in the market by removing drugs from the market as extensively as possible. User control was to be made tighter by the 2001 proposal of the Ministry of Justice, which aimed to amend Section 7 of Chapter 50 of the Penal Code so as to remove from it the possibility of dropping charges in cases concerning drug users except for in the case of the user seeking treatment. However, the Ministry of Social Affairs and Health and the National Research and Development Centre for Welfare and Health (STAKES) strongly criticised the proposal (Stakesin lausunto...2000) and finally the possibility of dropping charges was retained in the Penal Code.

An analysis of the sector-specific drug policy strategies and programmes of law enforcement authorities on the one hand and the social welfare and health authorities on the other shows that both sectors have systematically attempted to enlarge and reinforce the position of ”their own targets” in the drug policy field: law enforcement authorities have aimed at a stronger control of drug use while social welfare and health authorities have emphasised harm reduction as part of substance abuse prevention and drug treatment. In recent years, both sectors have been actively producing sector-specific strategies, reports, legislative proposals, regulations and practices that have widened the range of available instruments and authority powers. The possibilities of both law enforcement authorities and social welfare and health authorities to exercise drug control have improved in the context of the formal drug policy. What about practice then?

Practical drug policy measures: harm reduction and intensified control

The needle and syringe exchange programmes for intravenous drug users (so called health counselling centres), introduced by the drug strategy, were launched and expanded rapidly in Southern Finland in the late 1990s. By 2001, there were already a total of nine counselling centres in the largest cities. The other type of harm reduc-

tion, substitution and maintenance treatment for opiate addicts, has also gradually become more common, though at a slower pace than the exchange programmes.

Table 1. Estimates on the number of clients in needle exchange programmes and substitution treatment in 1996 and 2000.

Clients in	1996	2000
Needle exchange programmes	0	4800/32900*)
Substitution or maintenance treatment	0–10	about 200

*) Clients/visits Source: Partanen 2001.

The severe HIV and hepatitis epidemics among drug users in the Helsinki metropolitan area enabled the rapid expansion of the needle and syringe exchange programmes (see e.g. Virtanen 2001, 40), since combating the epidemics called for rapid action. However, the operation of the first health counselling centre, Vinkki, did not start without problems. Due to a debate that originated in the media, the start-up was delayed from autumn 1996 to spring 1997. The management of the A-Clinic Foundation, an organisation responsible for the practical arrangements for the service, visited the Minister of the Interior, the Minister of Justice and the Minister of Social Affairs and Health in order to clarify the objectives and principles of the service. (Mäkelä 2001.) From the very beginning, police authorities, among others, have repeatedly presented critical views of the needle and syringe exchange programme. The thrust of the criticism has been the notion that exchanging needles and syringes tends to implicitly presents drug use as acceptable rather than illegal (see e.g. Leppänen 1999). Despite the intermittently heated discussion on policy lines, the needle and syringe exchange centres have rapidly established themselves as a part of drug policy practices. Another contradictory issue throughout the 1990s has been the medicinal maintenance and substitution treatment for opiate addicts. The issue has received a great deal of publicity on account of a private doctor practicing in Helsinki, whose treatment practices caused a sensation in the media (see e.g. Helsingin Sanomat 12.1.1999; as for discussion in the early 1990s see Hakkarainen & Hoikkala 1992). The extensive and rapid introduction of maintenance and substitution treatments has also been criticised by professionals and researchers in the field of substance abuse prevention (Mäkelä & Poikolainen 2001; see also the article by Lasse Murto in this book).

No comprehensive data are available on the development of the content of drug education campaigns; however, there are a few examples of information campaigns aimed at harm reduction. In 2001, for example, the Finnish Centre for Health Promotion launched a nationwide drug campaign that was partly directed at harm reduction. In addition, at least the A-Clinic Foundation and the Public Health Institute have published information leaflets targeted at drug users concerning less risky drug consumption and first aid in cases of emergency. A majority of information material, however, is still entirely aimed at preventing drug experimentation and at reinforcing anti-drug attitudes.

With the harm reduction approach gaining a foothold in Finland, the restrictive drug policy has by no means become less restrictive, rather the opposite. The drug control measures have been intensified e.g. by increasing the resources, technical equipment and training of police and customs authorities. Street-level control has increasingly become the responsibility of the patrol police at the same time as a major part of the drug police's resources are bound to combating aggravated drug crime (Kinnunen, Perälä & Telkkä 2001; see also Aarne Kinnunen's article in this book). The high level of "user offences" (use, possession, purchase) shown in Table suggests that control measures are still strongly targeted at users as well, rather than concentrating on professional crime. To date, the new powers provided by the amended Police Act for fictitious purchases, covert operations and other intensified control of criminals have not been exercised with the exception of a few cases of fictitious purchases (Sisäasiainministeriön...2002). The most typical drug offence in Finland is the possession or use of cannabis or amphetamine, the most typical sanction for a drug offence being a fine. In 2000, 71 per cent of those sentenced with a drug crime as their primary offence were fined. On the other hand, prisoners serving their sentence with a drug crime as their primary offence as a proportion of all prisoners is nearly five-fold compared with the situation in the early 1990s: "drug prisoners" accounted for 2.9 per cent in 1991 compared with 15.5 per cent in 2000. (Kinnunen 2001b). Drug control measures have become more stringent in all fronts, including drug users as well as drug selling and trafficking crime.

Table 2. Numbers of drug offences in the statistics of the National Bureau of Investigation

	1996	2000
Use of drugs	2558	5541
Possession	4165	7098
Buying	661	938
Selling, distributing, dealing	605	1662
Trafficking	204	313
Cultivation	273	483

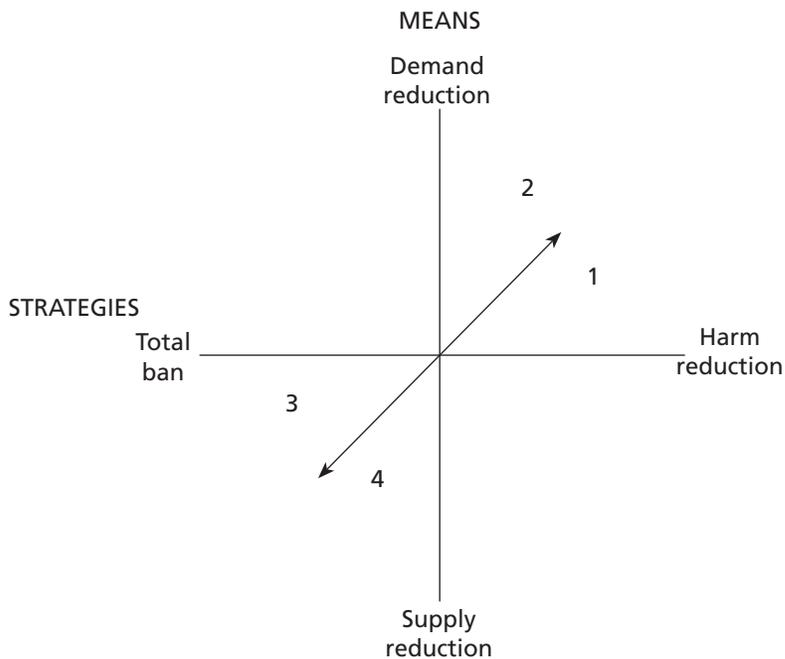
Source: Kinnunen 2001b

A fragmenting drug policy

Finnish drug policy thus seems to be simultaneously developing in different directions. At the same time as repressive, restrictive drug policy has maintained and strengthened its position, a policy line aimed at harm reduction has emerged alongside it. These two policy lines are often regarded as contradictory or at least as being based on conflicting assumptions. (cf. Kontula 1998; Erickson et al. 1997.) The most important difference between these approaches has to do with the position of drug users: whether drug users are defined as criminals to be punished or

as persons engaging in risk behaviour who need to be supported in various ways irrespective of whether they continue to use drugs or not. Finnish society currently both makes efforts to catch and punish drug users and to reduce the harm caused by use by intervening, primarily, in the ways drugs are used and, secondarily, in drug use as such, that is, the action defined as criminal.

Figure 3 shows the basic dimensions of drug policy: The opposing dimensions include those of reducing demand and restricting supply on the one hand, and those of total prohibition policy and harm reduction on the other. In the figure, Finnish drug policy would traditionally seem to have been positioned slightly bottom left from the centre: the principal way of preventing drug use has been to restrict the supply of illegal drugs, but attempts have also been made to reduce demand through education, treatment and welfare policy, as well as by sending a message to citizens about the total prohibition of drugs by criminalising drug use and by implementing drug use control in practice. Unlike in Sweden, central government authorities in Finland have not set the official target of a drug-free society. It is only during the last few years that Finnish drug policy has been moving more towards the right of the figure.



- 1=needle exchange
- 2=substitution and maintenance treatment
- 3=criminal control of drug users
- 4=criminal control of sell, distribution, dealing and trafficking

Figure 3. Dimensions of drug policy (Sarvanti 1997) and the relative position of particular activities

Other ideas of our position in the four-field figure are, of course, also thinkable. For instance, it can be maintained that the Finnish system of delivering services for substance abusers, springing from the tradition of social work, has long represented the harm reduction approach. If this is the case, Finnish drug policy would be positioned somewhat more to the right. Or if the emphasis is on the general deterrence effect of user control and if this deterrence is exclusively considered to be a matter of reducing demand, our position would be above the horizontal line. Whatever Finland's position in the four-field presentation, what is important is how the movement from the mid position in different directions takes place in different administrative sectors in the new drug situation. A process for intensifying drug interventions is ongoing, with the aim of both tightening all kinds of drug control and reducing harms.

Klaus Mäkelä draws attention to a remark on the drafting of drug legislation contained in a publication by the Law Drafting Department of the Ministry of Justice. The remark reads as follows: "Government proposals may rather be proposals by specific ministries whereby the conciliation of differing views between different ministries remains to be done by the Parliament" (Yhteiskuntapolitiikka 5/2000). Mäkelä not only regards this as unprecedented in terms of political theory but also as a sign of the state machinery being internally fragmented in drug questions. This kind of fragmentation process really seems to be under way, both in the formal and practical drug policy.

As Finland, unlike Great Britain or the USA, has no strong drug policy co-ordinator, key questions are settled – or remain unsettled – in negotiations between different ministries and administrative sectors. The overall picture of Finnish drug policy is changing through small strokes in proportion as the different administrative sectors get through their views in Government or the Parliament. The tug of war between different ministries plays a key role in drafting national formal drug policy. One way to look at the change and formulation of drug policy is to examine changes in the power relations and roles of different administrative sectors. For instance, it can be studied whether the emphasis is on control or treatment. At present, the two key drug policy actors are the administrative sectors of the Ministry of Social Affairs and Health and the Ministry of the Interior: the most important nation-level discussions on drug policy take place between these two administrative sectors. So far, the work on the drug policy programme has aimed at reaching and reached political consensus. The administrative sectors have also been able to implement their policies without major collisions. However, harm reduction and total prohibition policies are basically conflicting approaches. Due to this strained background, Finland's drug policy is like a rocky boat caught in a cross-swell where one increased swell may flood the bow (cf. Hakkarainen & Tigerstedt 2002.)

Three scenarios about drug policy development

To what extent can the strong and parallel interests of criminal, health and social policies co-exist? What will be the result of an on-going fragmentation of drug policy? I will map out three rough scenarios on the development of Finnish drug policy. In the first scenario, the repressive policy endures and no significant changes will take place; in the second scenario the drug policy fragmentation continues to develop but the parallel policy lines are not to be perceived as contradictory; in the third scenario, drug policy moves over to harm reduction.

Scenario 1. Repression endures and strengthens. In the first scenario, drug policy does not change much, but the repressive definition of policy endures and strengthens its position. The use and possession of illicit drugs are systematically controlled. Harm reduction is restricted to needle-exchange and small-scale substitution treatment. In the scenario, treatment as an alternative to prosecution or sanction is realised in practice but likewise, the criminal system invests in the development of rehabilitation programmes inside prisons. The number of convicts in these programmes doubled between 1996 and 2000 (Muiluvuori 2001). Development of drug treatment inside the prison system also prepares the way for increasing the sentencing of addicts to imprisonment, while coerced treatment also increases in this scenario, as it has in Sweden (cf. Ólafsdóttir 2001, 226). Drug education continues to focus on the prevention of drug experimentation and legal education, in which the police and anti-drug civil groups have a central role to play. Realisation of this scenario is underpinned by a public opinion that is favourable to criminal control and stability or decrease in the drug situation.

An element that can restrain the drug policy discussions and set the scene for this scenario is the current strategies' emphasis on community and local levels in drug policy. It has been suggested that the community focus is bound to stress the role of control and make the drug policy debate more unisonous (Kaukonen 1998, 160). Local activities are concentrated on strengthening control, and societal and public control methods are limited to dealing with individual deviance and problems visible at the community level. Additionally, when drug problems are increasingly perceived as individual and community problems, it is difficult to bring the discussion back to societal level considerations, which would enable the re-evaluation of the overall drug policy (Kaukonen 1998).

Scenario 2. The fragmentation of drug policy continues without clash of views. In this second scenario different harm reduction measures increase, but they do not become politically controversial issues. This is partly due to the limiting of harm reduction to needle exchange and substitution treatment. These measures are not seen as contradictory to the restrictive policy, but they are rather regarded as health policy and not drug policy issues. Harm reduction measures also remain marginal compared to repression.

Defining drug problems primarily as problems with organised crime supports this kind of fragmentation model, when the police increasingly see drug sales as the most important target for effort and leave the drug users to the responsibility of social and health professionals. In practice the control approach still remains dominant and the formal policy is thus not subject to alteration (for the ratios of drug treatment and criminal control, see Kaukonen 2000, 86). Also the co-operation between drug treatment and criminal control works in favour of this scenario: according to the newest regulations drug users subjected to criminal control can be left without prosecution if he/she is willing to engage in treatment (Kainulainen 2000). Realisation of this scenario is also promoted by a stable drug situation. In the scenario, drug education does not challenge repressive policy, although some elements of safer drug use is included in it.

This scenario is also supported by the strong consensus mentality of the Finnish drug policy (Kaukonen 1998, 152; Hakkarainen & Tigerstedt 2002). In Finland, drug policy is being made by autonomous actors who do not easily intervene in the business of other actors, but rather focus on their own field. Active intervention in other fields would also expose their own activities to critical assessment. Hence, although our drug policy is being fragmented as described, it may well be that the consensus-spirited end result from this is such an ever more tolerant policy model in which the parallel and contradictory policies put up with each other more than ever without public confrontations and dissolution of official drug policy.

Scenario 3. Transition to harm reduction in all fields. In this third and most radical scenario the incoherence of drug policy leads finally to the opening of fundamental policy debate and to the adoption of the harm reduction approach as the main aim of the drug policy. Increase in drug use, harms and costs, as well as the cultural normalisation of drug use and the active widening of harm reduction agenda are among factors that stimulate this development. Likewise, the general development towards a harm reduction approach in the EU and its member states supports the scenario.

In this scenario, in an aggravated situation the authorities and civic groups increasingly implement projects that put harm reduction into practice in the wide sense of the term. Harm reduction is no longer perceived only as needle exchange and substitution treatment—which also expand quickly—but the actors in the field aim at minimising all the possible drug-related harms, to health, to social well-being, to the economy, and to the whole society. Harm reduction principles are applied to both drug education and criminal control. In drug education the messages are based on an assumption that most youngsters experiment with drugs, whether we want that or not, and the advice is given to avoid the riskiest forms of drug use. The drug users are provided with new kinds of services, such as pill testing at clubs and raves as well as drug consumption rooms for injecting drug users, which aim at preventing dangerous situations. Criminal control authorities, for their part, centre their resources on combating professional drug crime, and do not in practice interfere with drug use. The police have an important role in directing drug addicts

to social and health care services. Also public discussion on drug decriminalisation begins in the name of reducing harms.

	Scenario 1 Repressive drug policy	Scenario 2 Parallel repressive and harm reduction policies	Scenario 3 Harm reduction policy
Description of the drug policy	<ul style="list-style-type: none"> * Repressive prohibition remains * Harm reduction is limited to needle exchange and substitution treatment * Drug education focuses on primary prevention and legal education 	<ul style="list-style-type: none"> * Prohibition remains and harm reduction measures increase but do not become politicised. 	<ul style="list-style-type: none"> * All drug policy is set to aim at reducing harms * Criminal control focuses only on organised crime * Drug education focuses on safer use messages
Factors leading to and supporting the policy	<ul style="list-style-type: none"> * Localisation of drug policy * Integration of treatment and control * Popularity of repression among the general public and politicians * Drug use does not increase or decrease. 	<ul style="list-style-type: none"> * Consensus mentality * Strengthening of the role health care in drug treatment * Drug use does not increase or increases slowly. 	<ul style="list-style-type: none"> * International development * Strengthening of the role health care in drug treatment * Drug use increases and becomes normalised; increase in harms and costs.

Table 4. Three scenarios of drug policy

Although predicting the future is difficult, it is evident, that the scenario that will take place – whether it was one of these three or something totally different – depends on the prevailing problem construction of the drug problem. Competition about the most successful approach is currently going on.

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The harm-reduction school of thought: three fractions

BY TUUKKA TAMMI

Despite its relatively long history in the international drug policy field, the meaning of the term harm reduction is still disputed. From a description of the different actor-based footings of the international harm-reduction school of thought, the analysis concludes that the diverse conceptualizations of harm reduction are to be understood as interpretive frameworks that are functionally different according to the different types of actors and their social and professional positions. Three epistemic fractions of harm reduction are recognized: a professional new public health fraction; a mutual-help and identity movement fraction of the drug users; and a globally oriented fraction. It is argued that, rather than one, the international harm-reduction school of thought is a policy community of the three epistemic fractions that are in dialogue with each other and thus are constantly redefining the meaning of harm reduction.

KEY WORDS: *Drug policy, harm reduction, school of thought.*

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Harm reduction is an international school of thought that aims to promote an assemblage of harm-related practices and goals to drug policies. As such, it is often treated as a policy community with a somewhat coherent approach to the drugs issue (Riley et al. 1999; Room 2004). Although on the point of some main principles this may be the case, when we take a closer look at the actors of this epistemic community, examining their claims-making as well as the causal logic they use to orient means to goals and purposes, we will find varying and sometimes competing priorities regarding the harms and subjects facing them. In this article, I develop an argument that the harm-reduction school of thought consists of different fractions, or subgroups, that approach drugs and harms as social problems from clearly distinguished angles. These angles are linked either to the movement members' different professional backgrounds or to their expertise arising from their own experiences. In other words, the article describes the different self-understandings of the harm-reduction school of thought: The focus is not so much on how the harm-reduction activists "go about their business, but on how and why they *define* the business as they do" (Boli & Thomas 1999, 3).

Using a constructionist framework of analysis, different actors and their claims regarding the drug problems are traced from the body of texts produced by or near the harm-reduction advocacy networks—publications and other documents that are more or less programmatic by nature and advocate harm reduction as an advisable drug policy model.¹ All of these publications are internationally produced and distributed. Various harm-reduction magazines, leaflets and web sites, my taking part in the 16th International Conference on the Reduction of Drug Related Harm (held in 2003 in Chiang Mai), and my many discussions with drug policy reform activists have been other important information sources.

Some histories and forums of harm-reduction advocacy

Several international advocacy networks and nongovernmental organizations have been established since the international harm-reduction school of thought emerged out of the AIDS crisis in the mid-1980s. Major arenas for consolidation have been the annual international conferences on harm reduction since 1990 (IHRC; International Conference on the Reduction of Drug-related Harm) and the *International Journal of Drug Policy* (IJDP) since 1989. Both of these forums are facilitated by the International Harm Reduction Association (IHRA), probably the best-known of the international harm-reduction networks, which was originally gathered around the people working at the Mersey Drug Training and Information Centre in the UK.² In Europe the movement has also been evolving around the central European organization European Cities on Drug Policy (ECDP), and its “Frankfurt Resolution” in 1990. Other well-known organizations pushing harm reduction into drug policies are the US-based Drug Policy Alliance³ and the International Harm Reduction Development Program (IHDP), both of which have financial links to investor George Soros’s Open Society Institute (OSI) or to national Soros Foundations in Eastern Europe. In addition to these, a handful of other internationally operating drug policy reform organizations or forums promote harm reduction as part of their agendas—e.g., the Drugs and Democracy program of the Transnational Institute (TNI); the ENCOD (The European NGO Council on Drugs and Development); the Italian Radical Party; and the Transnational Radical Party. All of these forums are, and have been, necessary in the production of an interpretive framework through which drug issues are seen by the harm-reduction school of thought.

There have been several attempts to define the term *harm reduction* by those involved in the movement (see, e.g., Newcombe 1992; Strang 1993; Erickson et al. 1997; Riley et al. 1999; Wodak 1999; Inciardi & Harrison 2000; Riley &

O'Hare 2000). In the first "textbook" on harm reduction (based on the presentations at the first International Conference on Harm Reduction in 1990, Liverpool, UK), Russell Newcombe (1992) defined the concept as follows:

Harm reduction—also called damage limitation, risk reduction, and harm minimization—is a social policy which prioritizes the aim of decreasing the negative effects of drug use. Harm reduction is becoming the major alternative drug policy to abstentionism, which prioritizes the aim of decreasing the prevalence or incidence of drug use. Harm reduction has its main roots in the scientific public health model, with deeper roots in humanitarianism and libertarianism. It therefore contrasts with abstentionism, which is rooted more in the punitive law enforcement model, and in medical and religious paternalism.

However, after years of discussion and mobilization, it has become generally recognized among the harm reductionists that there are many meanings of the term *harm reduction*. These different conceptualizations are discussed also at the web site of the International Harm Reduction Association (IHRA):⁴

There is no generally accepted definition of harm reduction. . . . The term "harm reduction" was originally used in the early 1980s to refer to policies and programmes directed primarily at reducing the adverse health consequences of mood altering drugs. This interpretation is still common. However, these days, the term "harm reduction" is also sometimes used to mean all measures that might reduce drug-related harms, including interventions intended to reduce the supply and demand for drugs. A third and more empirical interpretation is policies and programs which have been demonstrated to actually reduce harm. Some refer to harm reduction only in the context of illegal drugs, while others include all mood-altering drugs (alcohol, tobacco, prescribed and illicit drugs as well as volatile substances). Occasionally, the term "harm reduction" is also used to encompass measures intended to increase the potentially beneficial effects of mood altering drugs.

Although finding a common definition appears to have been difficult, one can decipher some main—more or less commonly shared—features of harm reduction, such as: value neutrality toward drug use (vs. moralistic stance); the drug

user is seen as a normal citizen with full responsibilities and participation rights (vs. seen as a deviant person or as a helpless victim; as a target for coercion); pragmatism and scientism (vs. ideologies and beliefs); human rights and humanistic values (vs. human rights violations in “the war on drugs” and other injustices); public health priority (vs. criminality perspective). In other words, the way that the harm-reduction school of thought strives to frame the drug phenomenon is something like this: Drug use as such is morally neutral and non-deviant behavior, and thus the users should be treated as normal and competent citizens whose health and other problems are to be dealt with pragmatically and scientifically, without violating their human rights and human dignity (cf. Riley et al. 1999).

The harm-reduction school of thought as different fractions

I will now withdraw myself from the attempts to find a *common* ground for harm-reduction activism, reversing field to characterize harm reduction as *different* types of collective action that well up from the *diverse* backgrounds of the actors. As Neil Wieloch puts it, it is the expressions of difference and criticism of dominant systems that serve as the foundation upon which the identities of political communities are built (Wieloch 2002; Taylor & Whittier 1992). In what follows, I describe the harm-reduction school of thought in terms of three different fractions, as (1) the professional (new) public health fraction, (2) the mutual-help and identity fraction, and (3) the global justice fraction.

(1) The professional (new) public health fraction

To date, the professional public health fraction, with its focus on drug treatment and prevention policy reform, has been the most visible and successful trajectory within the harm-reduction school, its ideas having entered the reality of international, national and local drug policies. The history of harm-reducing public health practices⁵ dates back to 19th-century Britain, where the pharmacists and medical doctors argued for the

prescription of opiates to addicts to keep them in a “useful” condition (for a history of harm reduction in Britain, see Berridge 1993; 1999); but if we look at harm reduction as a more programmatic initiative evoking international attention, its birth is located in the mid-1980s, when the first extensive harm-reduction programs took place in Liverpool, Amsterdam, and a few other European cities (cf. Riley & O’Hare 2000). The health-related features of harm reduction were made visible through new kinds of medically oriented care and support services targeted at drug users. Nowadays needle-exchange and substitution treatment programs are central parts of drug policy in many countries; these services aim primarily at protecting the individual’s health as well as the public’s. And as these methods have been taken into use, they have more or less replaced some other, often non-medical, practices. Especially the abstinence paradigm has been attacked as a barrier to new and effective harm-reduction services. The following extract is from an article titled “Changing a dysfunctional nightmare into a working alternative. Harm reduction—why do it?” (Watson 1990), in which the author criticizes the old abstinence paradigm and associated treatments:

Recent events, including the upsurge of HIV infection in people who inject drugs, have commanded a review of policies relating to injecting drug use/users to replace the abstinence focus with a “harm reduction” focus. . . . [A]bstinence is a perfectly respectable way of being. . . . But most importantly, abstinence has no impact on safe drug usage or harm reduction. In fact, abstinence and harm reduction are mutually exclusive. . . . Clients of services are clients because of their lack of resources; any person with a modicum of self-respect, money or support would avoid contact with existing services and thus retain some sense of self-direction. These people become drug free without the “assistance” of counselling or residential “therapeutic” communities. These people, in fact, have no need to show themselves as drug users and identify themselves as powerless.

Professional social movements are collective processes where professionals, their clients and institutions around the phenomenon become vocal contenders of prevailing services and professional practices. Professionals are accompanied by

other interest groups pursuing a position in the field. Since the 1980s, the professionals of the public-health-oriented harm-reduction fraction have been criticizing the unsatisfactory manner in which drug treatment and care have been organized, and, in the name of harm reduction, have offered new solutions to the drugs problem. The evolution of the AIDS epidemic has especially involved new professional groups moving into the drug policy field. The “social work–psychiatric treatment” model, with an abstinence aim, was challenged by the practitioners of the new “survival medicine school,”⁶ who prioritized preventing transmittable diseases and acute health problems instead of drug use per se. This new emerging *revisionist drug policy community* defined itself as having claims to knowledge (science), a value neutrality, and autonomy—the same attributes that characterize professionalism in general (Hoffman 1989, 191). The principal expressive actors in the professional fraction are the public health professionals and the other new semiprofessionals working within the harm-reduction services and related research fields. With “evidence-based” knowledge being the main driving force for professionalism, the production of evidence for harm reduction has followed; hundreds of studies⁷ have aimed at proving the necessity and supremacy of the new practices. Pat O’Hare, the president of the International Harm Reduction Association, ended our interview (in April 2003) by stating unambiguously: “The evidence is there.” There is a natural affinity between harm reduction as a professional reform movement and another buzzword of our times: that of evidence-based medicine, which is also a professional movement.

Public-health-oriented harm-reduction development is also parallel with the so-called *new public health movement*: “Not only do they coincide historically, they coincide conceptually . . . the principles are the same” (Rhodes 2002, 85). The “positive” interpretation of the new public health movement emphasizes the new methods of risk reduction by promoting individual and community action, whereas the critics see the new public health movement as a source of moral regulation

and an example of “surveillance medicine” aimed at recruiting “active patients”—self-observing actors who monitor their own bodies and lifestyles for signs of abnormality and deviation from the role of responsible individual citizen and are urged into compliance by the medicalization of everyday life (cf. Miller 2001; Petersen & Lupton 1996).

(2) The mutual-help and identity movement fraction

In addition to the health professions, the drug users (and their fellow travelers) have been active in advocating harm-reduction policies. When drug users are put in the hub of harm-reduction activism, it manifests itself as a *mutual-help movement*. Mutual help can be both defensive and emancipating, its opponent changing depending on the socio-historical context, with alternatives like charities, state regulation or expert power as a constant challenge (Mäkelä 1998). When the harm-reduction activities are steered by public health professionals, the intellectual interests and resources are more technical and research based, whereas in the case of the mutual-help movements they are *personal*, arising from the “tacit knowledge” of the movement intellectuals’ mundane experiences.

The user organizations have had an important role in demanding and launching new kinds of (harm reducing) services for the users. The best-known example of this kind of initiation process is from Amsterdam, where the first needle-exchange program was started by a users’ organization (“Junkie Union”⁸) in 1984. Since that time, tens or hundreds of other user organizations⁹ have been established all over the world, and many of them have become recognized in their local and national drug policy fields (Klingemann 1999). As Asmussen (2003) has recently noted, however, this phenomenon should also be viewed in the context of the more general growth in the 1970s and 1980s of self-help and consumer organizations related to illness, disability, childlessness, etc. In the decentralizing Western societies, there is a growing discourse on *empowering* clients through *partnerships* between them and the professionals; client participation and relationships based on equality are also positively valued buzzwords of our times

among the health and social work administration—i.e., the professionals (Asmusson 2003). Zibbells (2004) sees user involvement—creating “expert patients” and “responsible consumers”—as both an instrument and an effect of neo-liberal governance of our times.

The drug user organizations often strive for establishing “user-centered” drug services similar to those run by the professional fraction, but health and social concerns are only some of the items on their agenda; promoting the users’ general *rights as citizens* is the ultimate aim and driving force for the mutual-help fraction. The ninth point of the declaration (Mol et al. 1992) by the European interest group of drug users claims that:

The practice of non-discrimination on the grounds of drug use should be applied by all national and international bodies like non-discrimination on the grounds of sex, race, religion, handicaps and sexual, social and political orientation. We call for an end to all daily discrimination against drug users in matters of employment and education, child rearing and housing.

The twofold strategy of social and health services promotion on one hand, and of civil-rights activism on the other, is well depicted in the London-based magazine *Users Voice* (April 2003), which describes a Canadian user organization that had just received a Human Rights Watch prize:

With more than 1000 members and 800 peer volunteers, VANDU [Vancouver Area Network of Drug Users] has since become one of the strongest drug users’ associations in the world. . . . In addition to promoting harm reduction initiatives, better housing and access to care, VANDU has consistently stood up in the face of power and authority to oppose measures that threaten the well-being of their members.

So demanding civil and human rights—equal citizenship—for drug users is high on the user organizations’ agendas. In addition to their mutual-help (or self-help) character, the drug user fraction of the harm-reduction school of thought is to be seen as an *identity movement*—that is, as a means for its members’ positive deconstruction of their suppressed drug

user identity. Participating in consciousness-raising groups and other political activities gives drug users a new interpretation of themselves and the events around them. Identity work is both reflexive and empowering: Users become conscious of their ability to shape their social selves. In this sense the drug user movement can even be seen as a *proto-political movement*, since through the identity work the activism provides its members with general opportunities (that they would otherwise not have) for political participation beyond drug issues—in a manner similar to that of the temperance movement decades ago (see Sulkunen & Warpenius 2000).

We could still distinguish one more type of drug user activism: the *consumer movement*. In consumer movements the rights and interests of the individual have primacy. Restrictions are seen as an infringement on the right to consume whatever does not harm the interests of others (Waal 2000). It is not, however, very clear what the role of harm reduction is in this argument, and how much it remains merely a matter of individual pleasure seeking—but, on the other hand, this is no dilemma for harm reductionism in its position of “value neutrality”: “Advocacy for harm reduction measures is not synonymous with condoning or promoting pleasure seeking, nor opposing it. . . . Both the hedonist and the puritan can apply harm reduction” (Strang 1993).

(3) The global justice fraction

In 2001 there was an instructive debate in the *International Journal of Drug Policy*, initiated by a group of harm-reduction experts (Friedman et al. 2001), who suggested that there is a clear need for alliances between the harm-reduction movement and some other named social movements. The authors argued that the era during which the harm-reduction movement was originally formed was not favorable to speaking for the excluded and the working class, as neo-liberalism was then ideologically triumphant. But in their view, now the *zeitgeist* has changed, and they saw this as an opportunity for the harm-reduction movement to broaden its scope and develop the alliances needed for harm-reduction advocacy:

Mass strikes and other labour struggles, community-based struggles against cutbacks, opposition to the World Trade Organization and other neo-liberal agencies, and other forms of social unrest have increased in many countries. This opens up the possibility of new allies for the harm reduction movement . . . with careful discussion and research about what approaches work to convince other movements to work for and with harm reduction, and which approaches do not.

In the discussion, the authors perceived harm reduction as a social movement and as a voice of the unfortunate and excluded. They also took it more or less for granted that the harm-reduction activism is a part of the frontier against “neo-liberalism.” They saw an intellectual relationship between the harm-reduction movement and so-called new social movements (about the definition of “old” and “new” social movements, see, e.g., Eyerman & Jamison 1991), such as the anti-globalization movement, as well as between harm reduction and some older social movements (like the labor movement, trade-union movements, or the women’s movement). Portraying harm reduction in this manner, as a part of the frontier against neo-liberalism and referring to the increasingly popular anti-globalization movement as its potential partner, has to do with a third epistemic fraction of the harm-reduction school of thought—a “global justice fraction.” This fraction, with a strong global solidarity and human rights emphasis, focuses primarily on the social, developmental and environmental aspects of the global drugs problem. The “enemy number one” is the US-generated war on drugs,¹⁰ which is seen to maintain and worsen drug-related problems not only nationally (in the US), but especially in the developing countries. The activists in the global justice fraction can be characterized as globally oriented scholars and civil-society activists who regard the drug issue as part of the global neo-liberal and imperialist regime.¹¹

As an example of claim-making style in the global justice fraction, the Drugs and Democracy program of the Transnational Institute (TNI) aims at

replacing prohibitive and repressive drug policy with policies and operational directives based on harm reduction, fair trade, development, democracy, human rights and conflict prevention.¹²

Another organization representing this fraction, the ENCOD (the European NGO Council on Drugs and Development), a coalition of nongovernmental organizations, claims that “drug prohibition generates social conflicts, violations of human rights, corruption, ecological destruction and major rural poverty in developing countries” and continues to argue that “it is possible to design a coherent drug policy starting from the principle that, to reduce harm, it is essential to improve the conditions of life of people involved in both ends of the drug chain.”¹³ The repeated argument in the global justice fraction is that there are seriously harmful effects of international drug control on so-called producer countries (i.e., developing countries). With its main emphasis being on human rights¹⁴ and social conditions, this fraction runs parallel with the drug user fraction, but the basic difference is that whereas the user movement is primarily concerned with individual and communal rights, the global justice fraction is more concerned with larger drug-related questions of social marginalization, exclusion, and global inequality. It is no surprise that nowadays special sessions are devoted to drug policy issues at the World Social Forums (WSF), those massive international events that bring together various reform groups targeting changes in various global issues.¹⁵

What is the role of harm reduction in the argument of this fraction then? As depicted above, harm reduction is being offered as an alternative to repressive policies, but to some representatives of this fraction the question is whether it is enough to “just” reduce harms. At the World Social Forum 2003, Dutch drug researcher and drug policy reformer Peter Cohen¹⁶ suggested it is not:

... harm reduction is too limited to meet the political problems that discrimination-based drug policy creates for us. Maybe we have to move to a different philosophical position and say that some of the

harms that are created by our discriminatory drug policies *can no longer be accepted*. . . . The intolerable damage inflicted on third world drug producers [is] merely the side effects of trying to keep illicit drugs out of the United States or the European Union: this damage is simply not acceptable. *We have to develop ideas about harm refusal*. Human rights are of course the philosophical background against which we can judge those harms and I think that is what we should apply. Harm reduction is relevant for certain social conditions and for certain political contexts. . . . In some areas of drug politics we have to move from harm reduction to harm refusal.

The global justice fraction of the harm-reduction school of thought is to be seen in relation to a more general critique of, and action taken against, (US-led) global governance and its adverse effects not only on the field of drug control, but also on many other fields (e.g., on the economy, development, environment, women). Thus, when analyzing harm-reduction activism in the context of international drug control, the changing role of global social movements (GSMs) in international politics could be taken into account; since the 1980s there has been a general change in the functioning of key multilateral international institutions to move beyond their intergovernmental mandates to actively engage actors in civil society. Many multilateral institutions, such as the IMF, the World Bank, and the WTO, have increasingly interacted with global social movements, such as the environmental, labor, and women's movements (O'Brien et al. 2000; Deacon et al. 1997). To date, harm reduction as a term has been controversial in the context of the international drug control system, and there was a strong effort by the US in the mid-1990s to rule out use of the term altogether (Room 2003). It remains to be seen whether global justice-related claims on drug policy will similarly be taken seriously in the future by the international drug control system.

Fractions in the harm-reduction school of thought

FRACTION ATTRIBUTES	1. "Professional fraction"	2. "Mutual-help fraction"	3. "Global justice fraction"
Actors ("movement intellectuals")	"Public health expert" (traditional intellectual)	"Drug user citizen" (organic intellectual)	"New activist" (organic intellectual)
Resources (allies)	Science (medicine, epidemiology, evaluation)	Tacit knowledge (mundane experience)	Ethics (human rights, justice)
Obligation to act	Professional knowledge	Lifestyle, identity politics	Solidarity, global equality
Measures	Evidence-based interventions	User-centered policies & practices	Stopping the US war on drugs; "sustainable development" instead
Goals	Public health	Equal citizenship	New just world order
Opponents	Other (heretical) professionals realizing non-evidence-based policies	Paternalistic authorities	Imperialist, neo-liberal governance (e.g., US, INCB, UNODC)
Organizations (examples)	IHRA	MDHG, VANDU (IHRA)	TNI, ENCOD

Conclusion

I have described three fractions of the harm-reduction school of thought and some of the central aspects of their claim-making. These ideal types are summarized in the accompanying table on the basis of their relative positioning with regard to their actors (“movement intellectuals”),¹⁷ resources, obligations, measures, goals and opponents. Needless to say, in real-life contexts these ideal types overlap, but through this categorization I have aimed to illustrate how the different conceptualizations of and disputes around the term *harm reduction* could be better understood by locating the actors at the center of the analysis. The actor-based focus in different fractions is divergent. Rather than a homogeneous whole, the international harm-reduction school of thought should be seen as a policy community consisting of fractions that are in dialogue with each other and thus constantly redefining the meaning of harm reduction.

Notes

1. E.g., O’Hare et al. (1992; based on the presentations from the First International Harm Reduction Conferences held in 1990 in Liverpool); Heather et al. (1993; based on the International Harm Reduction Conference in 1992); Erickson et al. (1997; based on the presentations from the International Harm Reduction Conferences 1990–96); and the *International Journal of Drug Policy* (1989–2003), published by the International Harm Reduction Association.
2. For a description of the “Mersey model,” see O’Hare (1992, *xiii*).
3. The organization was born in the year 2000, when its predecessors, the Drug Policy Foundation (est. 1987) and the Lindesmith Center (est. 1994), were merged.
4. <http://www.ihra.net/index.php?option=articles&Itemid=3&topid=0&Itemid=3#> (19-1-2004).
5. That is, related to drug use; harm reduction is of course also a more generally relevant term to describe the practices of the medical profession.
6. According to a Swiss doctor, Robert Hämmig (2003), before the Anglo-Saxon domination in German- and Dutch-speaking countries, the term “help for survival” was used instead of “harm reduction.”

7. For an extensive list of such studies, see Hunt, Neil (2003): A review of the evidence base for harm reduction approaches to drug use. Available at: <http://forward-thinking-on-drugs.org/review2.html>.
8. Medische Dienst Heroïne-Gebruikers (MDHG), <http://www.mdhg.nl>.
9. To mention some: Asud in France (<http://www.asud.org/>); Australian Injecting and Illicit Drug Users' League (<http://www.tuf.org.au>); Dutch National Interest Group of Drug Users "LSD" (<http://www.104design.nl/lsd/>); Svenska Brukarforeningen in Sweden (<http://www.brukarforeningen.com>); National Alliance of Methadone Advocates (NAMA) in US (<http://www.methadone.org>); Methadone Alliance in UK (<http://www.methadone.org.uk>).
10. The U.S. war on drugs is more or less the common "enemy" of all harm-reduction fractions, but in the global justice movement it is pronounced.
11. It should be added, though, that in spite of the global focus, the target of actions can well be local. As the well-known slogan says: "Think globally, act locally."
12. www.mi.org/drugs/project/drugs.htm (31-10-2003).
13. From an editorial in *Drugs & Development*, the newsletter of ENCOD. No. 30. November 2001.
14. During my writing of this article, it was repeatedly suggested that I should add a fourth fraction, *human rights*, to the typology. I have deliberately left it out—not because I would not find the question of human rights central in the discussions around harm reduction, but quite the opposite: I did not include a "human rights fraction" in the typology because human rights is a theme that penetrates all of the movement types. Harm-reduction activist Neil Hunt (2002) has recently distinguished two philosophies of harm reduction: a weak human rights version that prioritizes some other goals, such as public health, and a strong version that prioritizes human rights as its main goal. Nevertheless, human rights is embedded in both forms.
15. The WSF is ". . . an open meeting [for] movements of civil society that are opposed to neo-liberalism and to domination of the world by capital and any form of imperialism, and are committed to building a society centred on the human person" (from the WSF Charter of Principles).
16. Presentation at the World Social Forum, Cartagena de Indias, Colombia, June 16–20, 2003.
17. In social movement research, the intellectual movement leaders have been distinguished as either *organic* movement intellectuals, as those who carry out their tasks within a social movement, or *traditional*

movement intellectuals, who are formed within established institutional contexts. It is also emphasized that in the actual knowledge-building processes of social movements, the line of demarcation between the two categories is often very fluid. (Eyerman & Jamison 1991, 94–99; Gramsci 1971).

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Policy Analysis

Discipline or contain?
The struggle over the concept of harm reduction in the 1997
Drug Policy Committee in Finland

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Abstract

Based on archive sources and interviews with the people involved, this case study revisits the 1997 Drug Policy Committee in Finland and the struggles that were fought out within that committee over the definition of drug issues: the two main rival camps were the police authorities that were advocating for a drug-free society and insisting on policies of strict control and, on the other hand, the social welfare, health and criminal policy alliance that was in favour of harm reduction. The committee's efforts produced the first national drug strategy. Applying a social constructionist approach to social problems, the analysis concludes that the general objective of harm reduction, in the drug strategy was based not only on public health concerns: the ideological roots of the concept can be traced back to the tradition of a rational and humane criminal policy that was first adopted in the 1960s and 1970s. According to this tradition, criminal and social policy were primarily aimed at minimising overall social harm and at protecting the minorities that were the targets of control. The article describes the argumentation of different administrative and professional groups and their positions on harm reduction and the goals of a drug-free society. The end results, the aims and measures of the drug strategy, was a compromise between two logics, which has since paved the way to the further elaboration of the policy of harm reduction but also stricter criminal controls on drug users.
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Keywords: Drug policy; Finland; Harm reduction; Public health; Criminal policy

Introduction

This case study describes the social construction of the drug problem in Finland at the end 1990s. In a social constructionist approach, drug policy or any other regulation policy in society is seen to be formulated in a collective process of defining the policy object (social problem) and related means for addressing it (Blumer, 1971). In order for us to understand a policy or regulation, the main actors and their claims of expertise regarding the problem need to be identified.

In their comparison between drug policy formulations in Sweden and Great Britain, Lindberg and Haynes (2000) focus on the influence exerted by societal and professional elites in particular. They conclude that the differences between the drug policies of these countries can largely be attributed to

the hegemonic or marginal position of different professions and other interest groups in drug policy formulation and government. Drawing on the neo-elite theory (Gray, 1994, p. 105; Lindberg & Haynes, 2000), they argue that drug policy elite groups and their networks tend to control drug policy discourses and disregard any analyses of the problem that are unfavourable for them. Elite networks persuade decision makers to look at the problem from a specific perspective and to accept their solution to the problem. According to the neo-elite theory, power is not exerted by a certain coherent group but by a less specified situation-specific network composed of individuals, groups or organisations sharing the same values and aims to a sufficient degree. In what follows, I will analyse drug policy formulation in Finland employing the similar approach as Lindberg and Haynes: as a distributive ('each actor's power depends on other actors' power') and collective ('by joining forces actors can increase their power

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in relation to others') use of power where the different professions and other interest groups strive to increase their power resources and strengthen the position of their own problem construction as a basis for the selection of drug policy goals and means.

The analysis focuses on the work of the 1997 Drug Policy Committee in Finland. This Committee delivered the first ever national strategy on drug policy (Huumausainestrategia, 1997). The work of the Committee was concerned with the reconciliation of the views of different authorities and experts at a time when public concern about and attention paid to the drug issue were rapidly increasing (e.g. see Hakkarainen & Tigerstedt, 2004). From the perspective of a constructionist analysis of power, the debate within the Committee was about the 'ownership' of the drug problems. The outcome, i.e. the national strategy, was a kind of co-ownership arrangement: it gives a voice to all the key actors: law enforcement authorities, social and health authorities, substance abuse care agencies, the medical profession, NGOs, researchers, and so on. But although many voices are heard in the strategy, some voices are louder than others. In what follows, I will describe these voices, i.e. the implicit authors of the drug strategy, and describe the drug-policy rationalities of their position-taking. To do this, I focus on the notion of *harm reduction* as used in the report: what the Committee referred to when speaking about harm reduction, how, why and by whom the drug issue was defined as a matter of harm and harm reduction, and how, why and by whom the use of this notion was opposed.

The data consist of the records of the Drug Policy Committee and interviews with two Committee secretaries and five members and experts of the Committee. The records consist of some 13 folders of Committee proceedings, notes, Committee members' comments on draft reports, expert reports submitted to the Committee, documents distributed, press clippings, correspondence, and opinions requested from various authorities and organisations after the submission of the Committee report. In addition, I have made use of a variety of drug, health and criminal policy documents and discussions on the media to put the harm reduction discourse into context.

Goal: harm reduction

One of the main principles stated by the Drug Policy Committee in its report was that the goal of drug policy should be harm reduction. Accordingly, the goal of drug policy was to prevent drug use and the spread of drugs so as to minimise harm, but the best way to achieve this was seen to be a restrictive, prohibitionist policy:

The goal of drug policy is to prevent drug use and spread of drugs so that the financial, social and personal harms and costs caused by their use and combating them will be as small as possible. (. . .) In the present situation the best way to promote this goal is a restrictive drug policy, including a ban on experimentation and use. (p. 56)

Typically, it is considered that there are two main drug policy approaches: restrictive policy and harm reduction policy. In Finland, these policies have been seen as being contradictory (Kontula, 1998) or at least in conflict with each other (Hakkarainen & Tigerstedt, 2004; Tammi, 2002), although they have occasionally also been regarded as complementary strategies. The report by the 1997 Drug Policy Committee mention them both, one as the goal and the other as the means. The Committee thus ended up regarding these strategies as complementary: restrictive policy (the means) is used to reduce harm (the goal).

I will next describe the process in the course of which this kind of interpretation was arrived at. I also argue that the notion of harm reduction was used at two different levels in the Committee's work. First, it was used to refer to the introduction of certain public health-policy measures to make them an integral part of official drug policy. There was opposition to the introduction of such measures (needle exchange and substitution treatment), but compared with Sweden (see Lindberg & Haynes, 2000), for instance, the opposition was less determined and had less arguments to present. Second, the notion of harm reduction was used in the broader context of the struggle between those who advocated harm reduction policy, i.e. 'the rationalists', and the proponents of a drug-free society, who were against it. In this struggle, the main emphasis was not on the public health-policy goals of harm reduction but on more general differences in societal ethos and public policy thinking.

The functions and composition of the Drug Policy Committee

Until the mid-1990s, illicit drug use and related problems remained marginal in Finland, but towards the end of the decade the situation began to change: drug use and related harms increased quite rapidly (Partanen & Metso, 1999). According to population surveys, the life-time prevalence of drug use (i.e. mainly experimenting with cannabis) doubled between 1992 and 1998 (from 4.6 to 10.2%), and the estimation on the number of 'hard drug users' indicated that only in 2 years—between 1995 and 1997—their number had been increased by 40% in the Helsinki area (Partanen et al., 1999). As a result of informing the public, politicians and authorities about the arrival of this 'drug wave' to Finland, there was increasing public concern about and attention paid to the drug issue. Drugs were debated in public on a daily basis, professions demanded more resources and soon a national committee was set to create a national drug strategy for handling the emerging social problem:

The Parliament requires that the Government should draw up an action programme in 1995 for preventing drug use and the spread of drugs. (Report No. 51/94 of the Parliamentary Social Affairs and Health Committee on the

government report on the development of the drug situation.)

The schedule originally set by the Parliament was not met, however: the Committee was finally set up in February 1996. One reason for the delay was that the views on drug-policy coordination varied from one branch of government to another, i.e. it was not clear whose responsibility the setting up of the Committee was. Preparatory work was done in both the Ministry of the Interior and the Ministry of Social Affairs and Health; the former was not satisfied with the composition and functions of the Committee as outlined by the latter. However, being responsible for crime control, the Ministry of the Interior also made arrangements for the Committee. Following ministerial negotiations, the Committee was finally set up by the Ministry of Social Affairs and Health, after the other ministries had been given an opportunity to influence its composition and functions. The Committee was assigned seven tasks: in addition to the assessment of the drug situation and the current drug policy, the Committee was to suggest ways of reducing drug-related harm and combating drug crime. Social and health impacts were also included in its remit, and so were 'the social costs and other harm caused to society'. This referred not only to the reduction of harm done by drug use but also to the reduction of the economic harm associated with drug control. In addition to the Ministry of Social Affairs and Health, the Ministry of Justice contributed to the inclusion of harm and costs in the remit.

In addition to the Ministry of the Interior (including the National Bureau of Investigation (NBI) that is a major national unit of the Finnish Police) and the Ministry of Social Affairs and Health, the Ministry of Justice had a key role to play in the Committee. K.J. Lång, Head of the Prison Administration Department of the Ministry of Justice, was appointed chair of the Committee, in addition to which there were two other representatives of the Ministry of Justice. These three ministries were the most actively involved in the work of the Committee, regardless of whether broad drug policy lines or specific issues were being dealt with. The other members of the Committee mainly participated in the discussion in their own area of expertise (drug treatment, medicine control, border control, international relations, education and training, youth). The Committee also consulted 11 external experts and 8 associations. Of these associations, three were engaged in substance abuse treatment, and three in substance abuse prevention, while one was a peer support group for substance abusers and one a 'cannabis user interest group', the Finnish Cannabis Association. That the Cannabis Association was consulted was criticised both by some Committee members and in the media. K.J. Lång responded to this criticism by asking whether 'position to the legalisation of drugs should be taken without asking those who advocate such legalisation' and pointing out that he 'would not accept the chairmanship of a committee that would choose not to explore the social reality, that is, meet people who think in a different way.' (*Ilta-Sanomai* (a tabloid), 29 January 1997: 'Lång defending

the Cannabis Association's right of opinion—the Committee heard 'hemp growers')

Researchers also significantly contributed to the work of the Committee. In the same way as its predecessor, the 1969 Drug Policy Committee in Finland, also the 1997 Committee made extensive use of research in its work. It commissioned eight specific studies, which were published later as an annex to the drug strategy. These studies dealt with the scope of the use of illegal drugs and medicines, drug crime, cost of drug-related harm, prevention, treatment systems and different countries' drug policy models. In particular, other European drug policies were discussed to find out whether the emphasis in the measures was on criminal, social or health policy. Further, the studies looked at harm reduction as an emerging international trend (Skorpen & Tigerstedt, 1998) or advocated it as a preferable model (Kontula, 1998). The Committee was keen to hear about policy outcomes in different countries, although it finally agreed with the experts consulted that there was no single best practice model that could be imported from some other country. It was pointed out that there was hardly any connection between the drug policy pursued and the drug situation, and that it was mainly the harms that could be affected. This kind of message was communicated to the Committee by at least two researchers: Osmo Kontula (1998) and Juha Partanen (heard by the Committee on 17 October 1996). The Committee also had at its disposal a research description (Reuband, 1995), where the same kind of conclusions had been arrived at based on an international comparison.

Harm reduction as public health policy

In the international context, harm reduction generally refers to a drug policy reform movement where the emphasis is on public health, principally aimed at preventing infectious diseases and other serious health hazards associated with drug use, instead of abstinence from drugs. This prioritisation of goals has made the movement a political one relative to the drug-policy options that put the emphasis on abstinence and criminal controls on drug users.

The views of the public health oriented harm reduction movement were for the first time visibly brought to the Finnish drug policy agenda in the report of the Drug Policy Committee. Among the methods of harm reduction, the report mentioned needle exchange and substitution treatment. These were presented more as public health imperatives than as drug policy definitions. However, the significance of these public health protection measures for drug policy was recognised, and an open attitude was adopted towards the criticism levelled against them:

Distribution of equipment of use by authorities has been opposed on the grounds that the distribution of equipment of use for activities defined as illegal in legislation can be seen to be contradictory to the goal of criminalising

use. This would contribute to undermining the strict drug-policy line and could result in more lenient attitudes to drugs becoming more prevalent and thus an increased use of drugs. On the other hand, there is no evidence that needle exchange programmes lead to people starting drug use or that they increase use. (. . .) Regardless of these considerations, it is out of question that we could neglect efficient measures to prevent the spread of infectious diseases. (p. 31)

It was the Ministry of Social Affairs and Health and the experts working in drug treatment services as well as in the public health field that raised the issues of needle exchange and substitution treatment within the Committee. The medical profession's position and demands can be seen to have decisively contributed to the relatively positive stance taken towards health policy measures aimed at harm reduction. In addition to the Ministry and the experts consulted, the Finnish Society of Addiction Medicine advocated needle exchange and substitution treatment. In a detailed written statement submitted to the Committee, the Society required urgent steps to be taken to develop medical treatment for opioid addicts and to prevent the spread of infectious diseases through injecting drug use.

The proponents of needle exchange programmes supported their views by referring to worst-case scenarios about viral epidemics and to estimates on the costs of treatment. A doctor who was heard by the Committee asked: 'Who will take the responsibility if there are 500 to 1000 HIV infections next year?' It was told that some 80% of injecting drug users have hepatitis C and that a HIV epidemic would follow the epidemic of hepatitis with a delay of a couple of years: as a consequence, there was an urgent need for measures to combat the HIV epidemic. Further, it was noted that viral epidemics will spread from drug users to the rest of the population, and that there are research results providing evidence that needle exchange programmes have not led to increased drug use.

The public health authorities' rhetoric of necessity with its worst-case scenarios was obviously convincing, as the Committee ended up unanimously recommending that a needle exchange programme should be launched. The police authorities, though, voiced opposition until the very end of the Committee's work, being still suspicious of such measures in the statement of opinion issued by the Ministry of the Interior after the submission of the Committee report (1 July 1997). In particular, the police authorities expressed concern about sending the wrong kind of drug policy signal to the general public:

The senior management of the Finnish Police does not believe that the distribution of equipment of use will help achieve the goals that have been set for this activity. On the other hand, it is not totally appropriate to distribute equipment of use that enables an activity that is punishable by law. Such distribution of equipment may be seen as a

change of strategy, showing understanding towards drug use and thus contributing to its partial acceptance.

Traditionally, drug policy arguments associated with public health have not been very central in Finland. Like in Britain in the 1980s (cf. Berridge, 1993, p. 59), however, such arguments gained importance in Finland, too, with the awareness of hepatitis and HIV epidemics in the late 1990s. Also in Sweden (a neighbouring country), the medical profession launched initiatives in the late 1980s to start needle exchange programmes. However, in Sweden parents' associations and social workers, as well as the police authorities, put up fierce opposition and even recruited ministerial level politicians to campaign against needle exchange. It was claimed that such a new practice would undermine the restrictive policy and increase drug use. In addition, the medical profession was accused of attempting to medicalise the drug issue (Lindberg & Haynes, 2000, p. 10). In Finland, by contrast, there was no unified front, but the police authorities (the Ministry of the Interior and the National Bureau of Investigation) were largely alone in their opposition to needle exchange. The parents' association (document dated 14 November 1996) that was heard by the Committee did not completely reject the new public health policy measures, though it did not give its unreserved approval either:

Any use of harm reduction methods (methadone, syringes) should be experimental and well-founded and meet precise criteria. These methods must not send a signal to the effect that drug use is permitted or that it has become less dangerous.

The statements given by the police authorities and the parents' association both emphasised that the introduction of new harm reduction tools must not send people 'the wrong kind of signal'. Opposition to sending out this kind of permissive signal is a repeated theme in the argumentation of absolutist, restrictive drug policy: the basic function of both the formal policy (criminal code) and the control systems enforcing this policy is to strengthen a climate of opinion that regards drugs as unacceptable.

Within the Finnish drug treatment services, the stances taken on the introduction of harm reduction as a public health measure, particularly as regards substitution treatment, were contradictory in the 1990s (see Hakkarainen & Kuussaari, 1996, pp. 145–147). In the Committee, however, a national cooperative body in the field of drug and alcohol treatment (PÄIVYT) took a positive stance towards needle and syringe exchange programmes and substitution treatment (document dated 28 November 1996). As for the latter, however, a high threshold was called for. A drug treatment expert heard by the Committee expressed his opinion on the usability of the different methods as follows:

The responsibility of health and social work services is to help people having problems and to improve their ability to

cope even when they've done something legally or morally condemnable. Strictly from the treatment perspective, it could even be said in a Jesuit-like manner: all means are acceptable if they help the client or patient. (document dated 14 November 1996).

However, when the Committee suggested in its report that substitution treatment (with methadone) should be extended from only a few to 100–150 patients, the Finnish Society of Addiction Medicine (document dated 25 June 1997) regarded this number as all too low and criticised the Committee for ignoring the public health perspective:

The most serious shortcoming is that the Committee seems to have no such **insight into public health** that research into epidemiology, public health and health behaviour provides. (...) A positive aspect is that the report indirectly recognises the limitations of control policy measures. (*bold type in the original text.* -TT)

This criticism indicates that, in spite of the needle exchange and substitution treatment initiatives, the report did not particularly strongly emphasise the public health arguments. The goal of reducing negative health consequences was put forward clearly, but the scope was defined rather narrowly: the main emphasis was on the prevention of viral epidemics and the drug users' retention in treatment, while the importance of the matter in drug policy definitions in general was not underlined.

Harm reduction as 'rational and humane' public policy

The fact that the Committee report (i.e. the National Drug Strategy) defines the goal of drug policy in terms of harm reduction suggests that the rationality employed is a public policy rationality, i.e. a more general one than that of the harm reduction movement with its public health emphasis. This rationality then came into conflict with the views of the police, and especially the National Bureau of Investigation (document dated 24 June 1997), which totally rejected the report's goal-setting:

Unfortunately, the Committee's definition of the goal of drug policy in its statement is inappropriate in that it refers to the minimisation of the financial, social and personal harms and costs instead of setting a drug-free society as its goal (...) the Finnish Police absolutely reject the drug policy goal as defined by the Committee and considers that it is in conflict with the prevailing drug policy definitions and that it thus will greatly contribute to worsening the drug situation in the future.

During the work of the Committee, the Finnish Police had repeatedly proposed that a drug-free society should be

taken as the overall policy goal. Key tools for achieving this goal would be awareness raising campaigns in law-abidance and drug education, as well as intensified police control and punishments (that is, reinforcing the general and specific deterrence of criminal law interventions). Treatment would be the last option in the order of preference. The Ministry of the Interior also proposed that compulsory treatment should be used more extensively (documents dated 1 July 1997 & 24 June 1997).

The demand for a drug-free society was awkward for the Ministry of Social Affairs and Health, which is the ministry responsible for the treatment system, as it was in the Ministry's interest to promote the use of welfare and health policy tools in the drug policy context. But the demand was even more awkward for the Committee Chair K.J. Lång and the other Committee members and experts representing a 'rational and humane criminal policy'.

The predecessor of the 1997 Drug Policy Committee was an expert committee (called 'the drug committee') that operated in the end of 1960s. In the report (Huumausainekomitean mietintö, 1969, p. 104) of this committee it was stated as follows:

To be realistic, a drug policy should acknowledge that, in an industrialised society, it is unavoidable that there is constantly a great array of substances available that can be used not only for their original purpose but also for becoming intoxicated. The point of departure and the first priority should therefore be the minimisation of harm done by drug abuse, while attempts should also be made to achieve the ultimate goal by using all available means in addition to control.

This implies that drugs are seen as a phenomenon that inevitably forms part of our modern society, underlining the importance of both drug control and harm minimisation. Contrary to what is usually assumed, the notion of harm reduction is not a new element in Finnish drug policy, but has a 30-year history behind it. The formulations of the 1969 drug committee, however, were not influenced by any harm reduction movement of the same kind as the present health-policy oriented one, but by a new public policy thinking, an ethos of the so-called 'rational and humane criminal policy' school of thought (whose name was self-given). Rational and humane criminal policy became the prevailing criminal policy tradition in Finland in the 1960s and 1970s. The movement's most important theoreticians in Finland included Inkeri Anttila and Patrik Törnudd who set as its principal goal the minimisation of harms done by criminality and measures to combat it. Criminal policy was seen to form part of the general welfare policy, the ultimate goal of which was defined to be 'the minimisation of suffering and to ensure its fair distribution', and which was also seen to prevent crime and maintain social cohesion. Correspondingly, a criminal policy serving these goals was aimed at minimising the costs and suffering caused by criminality and crime control and to ensure a

fair distribution of these costs and suffering. This goal setting totally excludes the total elimination of crime, which is regarded as unrealistic. Not even reduction of crime is necessarily viewed as a primary goal: more important is to seek to affect the quality and structure of crime so as to minimise the overall harm (see e.g. Anttila, Heinonen, Koskinen, & Lahti, 1973; Törnudd, 1996).

From the perspective of rational and humane criminal policy, the goal of a drug-free society (that is, a society without drug crimes), advocated by the police authorities in the Drug Policy Committee, is misplaced: it is unrealistic and there are no means of achieving it. When interviewed, one of the Committee members mentioned that this 'demagogic' demand was a tricky question for Committee Chair Lång and some other 'rationalist' members of the Committee. As far as is known, Lång never seriously considered including the goal of a drug-free society in the report. At the first meeting of the Committee, the representative of the Ministry of Justice underlined that the Committee's work should be based on the notion of harm reduction. At the same meeting, Lång suggested that the report should present 'an array of measures of varying severity' rather than a single position. About 1 year after the submission of the report, Lång (1998) commented on the question, saying that 'a policy goal without any means for attaining it will only lead to social conflicts and the criminalisation of large segments of young people, hence eroding respect for the law'. Lång underlined that the 'the sword of public power must be clean', referring to the decline of the respect of the law as a result of over-dimensioned control.

As early as the turn of the 1970s, the proponents of a rational criminal policy were doubtful about the criminalisation of drug use: it was not seen as a matter of rational benefit-risk analyses. Patrik Törnudd, a well-known representative of rational and humane criminal policy school, criticised (1969, p. 199) the 1969 Drug Policy Committee for advocating the criminalisation of drug use:

The position taken by the majority, against the expert opinions, that the liability to punishment of drug use should be retained reflects not only the Committee's general timidity and cautiousness but also a proneness to symbolic thinking, not so uncommon in the context of moral crime. Even if it is admitted that a particular provision is more of a hindrance than a help, one does not have the courage to propose that it should be omitted, as this could be interpreted as a 'concession'. This Cold-War styled argument was frequently heard in past years' debates on the revision of alcohol and sexual crime legislation.

Törnudd's reference to sexuality and alcohol policies at the end of the citation is associated with the fact that both new abortion legislation and new, less stringent alcohol legislation were passed at that time. A drug policy debate that contrasts harm reduction or minimisation (in the Finnish discussion, both terms have been used with no further distinction between

them) and the goal of a drug-free society actually bears a close resemblance to that time's alcohol policy debate, even as far as the terminology is concerned. While the ideological goal of the Nordic temperance movement had been an alcohol-free society up to the 1960s, the more tangible goal of alcohol harm reduction took the place of the earlier goal during the 1960s and 1970s (Warpenius & Sutton, 2000, p. 57). Mäkelä distinguished (1971, p. 222) two distinct trends in the debate: Proponents of a strict alcohol policy claimed that alcohol use as such was harmful and that increased consumption would inevitably increase alcohol-related harm, while advocates of a less stringent policy maintained that alcohol use as such would not necessarily lead to personal or social problems and that the harm done by an excessively strict policy might be greater than the harm done by alcohol drinking.

The opposition to the unrealistic and symbolic goal of a drug-free society also has to do with the principle of minority protection. Like Kettil Bruun and Nils Christie in their book *Den gode fiende* ('The suitable enemy') (1985; see also Christie, 1986), K.J. Lång maintained in the Finnish edition of the book (Christie & Bruun, 1986, p. 247) that it is problematic if public policy planning aimed at advancing the public interest to the benefit of the majority creates at the same time problems to disadvantaged minorities. Ideologically, rational criminal policy is closely related to the criticism of the institutional exercise of power, which is levelled at control systems that stigmatise deviant individuals, that is, the provision of 'forced assistance'. Kettil Bruun, a friend and a kindred spirit of K.J. Lång, was an influential representative of this way of thinking in drug and alcohol policy. As a member of the 1969 Drug Policy Committee, Bruun submitted a dissenting opinion to the report, opposing the criminalisation of drug use, as this, for example, would make a drug user's life more difficult. Sixteen years later, Bruun, in his critique on the plan on drug-free Nordic countries, proposed an alternative harm reduction policy. His arguments for this policy included not only the principle of justice and control policy realism but also stressed the opportunity to have an influence on drug use patterns and related harms (Bruun, 1985).

Tigerstedt (1999) has called Bruun's thinking 'emancipatory liberalism', the core element of which is the ethos of negative freedom: the aim is to emancipate the individual from inequality, discrimination, subordination and other unjust practices. Such concerns about control measures that cause individual-level harms can be described as the human rights perspective of harm reduction (cf. Hunt, 2004; Hurme, 2004).

There is a historical and ideological link between 'rational and humane criminal policy' and modern drug and alcohol treatment system in Finland. As the ethos of rational and humane criminal policy gained ground during the period of rapid change in the 1960s and 1970s, more humane attitudes developed in drug and alcohol treatment system too. The representatives of the new criminal policy (especially Inkeri Anttila) joined forces with modern alcohol and drug treatment to resist total institutions and forced care. These were

to be replaced with support on a voluntary basis, alleviation of suffering, and service-oriented policy.

The formulations of the 1997 Drug Policy Committee's report represent the same ethos, highlighting the socio-ethical principle of treatment, according to which people need to be supported in all possible ways even if they repeatedly 'fail' in treatment or reject it:

Even if the drug user cannot be motivated to seek treatment or the treatment has not been successful, he or she should be given a chance to live a life of dignity. Caring for the physical and psychological well-being is in accordance with the fundamental rights and supports motivation to seek treatment.

In other words, treatment outcomes should not be assessed simply from the perspective of abstinence from drinking or not even reduction in drug use, but the emphasis should be placed on alleviating any kind of suffering associated with the life situation, be it temporarily or permanently.

Who benefited?

The Drug Policy Committee's report states that the goal of drug policy is to prevent drug use and the spread of drugs so as to make the financial harms and costs as small as possible. After the approval of the report, the police still took a clearly negative attitude to this goal setting. The National Bureau for Investigation stated that:

This goal setting requires the smallest possible input from control measures—the costs are to be as small as possible! (...) Now that the problem in the country is still limited and thus still controllable, cost saving is not a sensible option.

The Ministry of the Interior adopted much the same attitude:

To seek to make the harms and costs associated with drugs as small as possible is an objective in itself but it is only one step towards the goal. At this stage there is no reason to try to contain the costs entailed in drug control measures, as such measures will perhaps no longer be successful when the problem aggravates, and the costs will in any case be considerably higher.

These advocates of a drug-free society, that is the National Bureau for Investigation and the Ministry of the Interior, thus portrayed the situation as a turning point representing the last opportunity to avert the impending danger; later on this would no longer be possible, not at least with reasonable costs. The National Bureau for Investigation rejects both the problem (harms and costs) and the proposed remedies (cost containment), whereas the Ministry accepts the problem setting but rejects the proposals for solving the problems: although the

minimisation of costs is an objective in itself, this is not the right time for cost saving. The police authorities underlined that new resources should be allocated for street-level drug control in particular. Their interpretation of the Committee's statement in principle was that it opposed any increases in drug control funds.

The Committee did not propose in its report that more resources should be allocated for drug control measures. Two reasons for this can be mentioned. First, the representative of the Ministry of Finance curtly announced in the very beginning that no extra funding would be available for drug control measures, and as a consequence, the existing resources should be reallocated to agreed priority areas. Second, there was a fear that the drug issue could be politicised. To prevent this, it was viewed as necessary to refrain from any increases in resources and from any centralisation of drug control so as to prevent a single sector from taking over the responsibility for the drug issue.

Lång (1998) pointed out later: 'Both the social and health authorities and the law enforcement authorities are under the misguided perception that these problems can be dealt with by allocating new ear-marked resources. (...) This is why the Drug Policy Committee did not support any proposals for resource increases, but our starting point was that both the treatment and the control system should operate with the existing resources, and if the drug problem was regarded as urgent, they should reallocate their resources accordingly.' Lång believed that constant demands for more resources in a way imply shrugging off the responsibility on the pretext of the belief that an increase in resources will help solve the problems. Lång's views were in line with those of Klaus Mäkelä, a well-known sociologist also heard as an expert by the Committee, who recommended that a cautious attitude should be taken to resource demands from both the treatment and the control authorities. According to Mäkelä, there was the risk that, as has already happened in many countries, there will be a vicious circle where these two authorities appeal to decision makers and citizens in their efforts to increase their resources and remit, as a result of which, in order to reconcile their demands, each side is given something by turns, which, in turn, leads to an overgrowth of both systems that feed each other's growth.

Nevertheless, the division of power between control policy and harm policy, defined by the Drug Policy Committee, has later resulted in a competition for resources and political attention between different branches of government. In the last few years, both the law enforcement authorities and the health authorities have repeatedly succeeded in having their demands met for both new resources and new powers in crime control and drug treatment. The 'rationalist', moderate goal-setting introduced in the drug strategy and the balanced, consensus-minded governing model advocated by it have prevented the politicisation of the drug issue in the sense of politics, whereas it is possible that at the same time they have promoted its politicisation in the sense of policy (i.e. between authorities).

Conclusion

The Drug Policy Committee was typically an administrative and expert workgroup, not a political committee. Criminologist Garland (2001, pp. 111–113) has distinguished between a political and an administrative logic of control policy: the political logic is characterised by its tendency to give priority to (non-adaptive) measures that are impressive and heavy, have public support, and cannot be interpreted as signs of weakness or evasion of social responsibility. The administrative logic, in turn, typically prefers means that are adapted to each specific situation (adaptive measures), and it also seeks to be realistic in its goal-setting. The reference groups of the political logic include the public opinion and politicians that call for law and order, whereas those of the administrative logic include administrators, researchers, experts and various reform organisations (ibid.). In the Drug Policy Committee, the fraction emphasising harm reduction can be seen to represent the administrative, adaptive logic of operation, while the police authorities' goal-setting was more in line with the political, non-adaptive logic. When these two logics of operation were brought together in the Committee, the Committee became a battlefield for the struggle between the different interest groups and experts. This, however, largely passed unnoticed by both the media and politicians.

Two key parties could be distinguished in the intermittently fierce but however consensus-oriented struggle: the police authorities advocating an absolute definition of the social problem and the goal (a drug-free society), and the social, health and judicial authorities supporting a pragmatic and relativist harm reduction policy. Unlike in Sweden, the party that spoke for a drug-free society did not succeed in mobilising allies from other interest groups. On the other hand, neither was the drug policy defined as a harm reduction policy in a strict public health policy sense. The drug policy outlined in the report was a compromise and represented a multi-track approach: it involved crime control and welfare policy, as well as harm reduction as a public health measure. It should be remembered, though, that in Finland it was not the strong position of the medical profession that played a part but it was rather that the elite who were advocating the public policy thinking referred to here as rational and humane had a strong position in the Committee.

Two different rationales behind the notion of harm reduction are often distinguished: a human rights perspective and a public health perspective (see e.g. Hunt, 2004; Hurme, 2004; Tammi, 2004). Drawing on the analysis presented in this article, a third harm reduction perspective can be identified: a public policy perspective that combines the public health and human rights perspectives and is founded on the philosophy of a rational and humane criminal policy. This can be seen as a rationality of social regulation in which the primary focus is on the harms and costs caused to the system.

On the other hand, the drug strategy formulated by the Drug Policy Committee and subsequent drug policy documents (Committee Report on Drug Prevention among Young

People, 2000; Government decision-in-principle on drug policy, 1999; Working Group Report on Developing Medicinal Treatment of Opioid Addicts, 2001; Working Group Report on Developing Drug Treatment, 2001) has provided authoritative backing for harm reduction measures that are relevant from the public health perspective. This has later enabled a relatively rapid expansion of harm reduction programmes in Finland (cf. Hakkarainen & Tigerstedt, 2004; Tammi, 2002 & 2005).

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DIFFUSION OF PUBLIC HEALTH VIEWS ON DRUG POLICY: THE CASE OF NEEDLE EXCHANGE IN FINLAND

TUUKKA TAMMI

Drug policy is a public policy sector which, since the 1960s in most Western countries, has been primarily based on repression. Drug problems have been constructed as problems that fall mainly under the responsibility of crime policy and law enforcement authorities. However, over the past two decades, the emergence of health-related risk awareness and the prevalence of public health views generally, have challenged this traditionally repressive policy approach. Indeed, since the late 1980s and the beginning of 1990s, especially in some Western Europe countries, there has been a tendency for drug policy to move toward a public health framework. Even those European countries that have often been considered ‘strict’ or ‘repressive’ in their drug policies, have slowly taken health views on board, and set them side-by-side within frameworks of criminality.

The body of knowledge and practical activities that strive for identifying and changing risky lifestyles have come to be known as the *new public health movement*. The main aim of this new public health is “to create and implement strategies that position citizens as acting of their own free will and in their own interest to protect their own health” (Petersen and Lupton 1996: 175). In the field of drug policy, parallel with the new public health movement is the *harm reduction* school of thought: “Not only do they coincide historically, they coincide conceptually ... the principles are the same” as Tim Rhodes (2002: 85) has put it. The goal setting of the harm reduction school of thought has been the subject of major controversies for the last 20 years in drug policies all over the world. This is due to its emphasis on harms instead of drug use itself. According to the repressionist thesis, drug use is seen in the first place as morally condemnable, dangerous and thus subject to sanctions. Conversely, within harm reduction ideology, drug use is seen as risky behavior whose carrier (the drug user) should be given the resources (practical and mental) to cope with the risky habit that he/she shares with others – an inherent rationality when it comes to health (Stimson and Donoghue 1996; see also Riley et al. 1999).

With regard to practice, offering injecting drug users clean needles and syringes in exchange for used ones (in order to reduce certain harms related to drug use) is, together with opiate users’ substitution treatments, the most famous and successful



practical application of harm reduction ideas. To date, needle exchange programs (NEPs) have been implemented in all EU countries although there are still very few in Sweden, Greece and Ireland (EMCDDA 2003).

In this article, I examine the case of launching NEPs in Finland between the years 1996–2002. Finland – a country with a repressive drug policy (e.g. Hakkarainen et al. 1996) – was one of the later adopters of NEPs in the EU. Accordingly, this article deals with the *diffusion* of public health views on drug policy and asks: How did the NEPs eventually diffuse to and within Finland, and how can this successful diffusion be explained? Which were the factors that opened the way for the harm reduction framework? To answer these questions, I will describe the process of making claims as to the nature of drug problems, and identify the different actors, situational factors and mechanisms that enabled the emergence of NEPs in Finland. I have reconstructed this process on the basis of nine expert interviews, along with various project plans and other administrative documents, as well as other complementary material such as newspaper articles and records of debates in the Finnish parliament.

On the diffusion of drug policies

In their article *National treatment systems in global comparisons* (1999), Harald and Hans-Dieter Klingemann list factors that are typically regarded as central in studies on drug policy diffusion: “Normally the focus is on a country’s drug scene, its health system and the policy positions of the major political actors. The causes of drug policy development are viewed as emerging within the nation. However, states are not isolated entities. They exist in an international environment of communication and influence. Political elites of different nation-states tend to observe one another’s capacity for problem-solving” (ibid.: 109). Klingemann and Klingemann (1999: 110, 114) distinguish between *hierarchical* diffusion – adoption of innovations from larger, more advanced units by smaller units – and *spatial* diffusion – diffusion along lines of geographical proximity, or alternatively, along major lines of communication. It is argued (ibid.) that the latter plays only a limited role in the adoption of drug treatment policies, whereas the idea of hierarchical diffusion proves to be a useful framework for interpretation.

The relative importance of the drug issue compared with other social problems and the cultural adaptability of the arguments used for new policy models, are also important aspects to be taken into account. Importantly, whatever the source of policy innovation, and whatever the mechanism through which this innovation becomes imported to new surroundings, the actual diffusion needs its makers. That is, it needs people who promote the policy and translate its meanings into the language of the new context. Foreign policies and working models are rarely, if ever, transferred directly from one country to another – they change on their way. Diffusion theorist Everett Rogers defines diffusion as “the process by which an innovation is

communicated through certain channels over time among the members of a social system.” In this somewhat simplistic view, communication, as transport of (new) knowledge, is both a prerequisite and a primary tool for policy diffusion: when the knowledge-transport from the sender to the receiver fails, so too the diffusion process fails. Björn Johnsson (2003) argues, in his study on the diffusion of methadone treatment to Sweden, that it is more important to pay attention to the *processes of translating meanings* on local and national contexts, than to the processes of communication transfer (between countries) *per se*. With the concept of translation (Latour 1986), Johnsson argues that wherever a new working model is brought into new context, the network of actors in this context will shape and interpret (i.e. translate) it so as to make it fit into the new social and cultural surroundings. In other words, every new policy suggested needs to go through the process of ‘semiotic metamorphosis’ and become localized. The translation work is done primarily by change-agent networks, which strive for changes in policies and politics. In this article, the formation of a needle exchange advocacy group in Finland is looked at not so much as an organization but as a *process* of forming arguments and a ‘cognitive praxis’ (Eyerman and Jamison 1991) for policy reform.

In what follows, I will first describe, broadly, the process in which the NEPs were started, debated and established in Finland. I will also pay attention to some of the situational factors that affected the diffusion. Secondly, I will move on to the translation of the NEPs’ rationales into the Finnish drug policy, by examining the argumentation used for and against the NEPs. Then thirdly, I will come up with a summary of the main factors that created the opportunity for the NEPs to be diffused in Finland as they were.

The launch and diffusion of needle exchange programmes in Finland

Until the mid-1990s, both the use of drugs and related problems remained relatively marginal in Finland, compared to most Western European countries. Then the situation began to change: experimenting with and use of illicit drugs became more common. Furthermore, several statistics also indicated that intravenous drug use and related harms, as well as demand for treatment and drug-related crime, was increasing quite rapidly (Partanen and Metso 1999). According to population surveys, the lifetime prevalence of drug use (i.e. mainly experimenting with cannabis) had doubled between 1992 and 1998 (from 4.6 to 10.2 percent), and the estimation of the number of ‘hard drug users’ indicated that in just two years (between 1995 and 1997), their amount had been increased by 40% in the Helsinki area (Partanen et al. 1999). As a result of the public, politicians and authorities being informed of the arrival of this ‘second drug wave’¹ in Finland, public concern and attention to the drug issue boomed. Drugs were debated in public on a daily basis, authorities set up working



groups, professionals demanded more resources, action plans were made, and so forth (see Hakkarainen and Tigerstedt 2004; Tammi 2003).

One of the hot issues in public debate in 1996/7 was the idea of starting a needle exchange program (NEP) in Helsinki. Since the first needle exchange program started in Amsterdam in 1984 and soon after that in Liverpool, as a new public health technique it became a popular ‘import item’ in many countries during the 1980s and 1990s (see Stimson and Donoghue 1996). To Finland, the idea of experimenting with needle exchange came relatively late: planning started at the beginning of 1996 within an outpatient clinic in Eastern Helsinki.

In 1994/5 there had first been a hepatitis A outbreak amongst the intravenous amphetamine users in Helsinki (Leino et al. 1997). This was followed by a rapid rise in hepatitis C and B infections from 1995 onwards. These outbreaks made epidemiologists from the National Public Health Institute increasingly aware of the interplay between drug use and viral infections. They contacted a doctor from the above-mentioned drug treatment clinic with a wish to prepare a project plan for decreasing infection risks amongst the users.²

Most concretely, the idea for needle exchange came from Glasgow, Scotland, where the doctor had visited a methadone treatment conference and was also introduced to the local needle exchange program, too (this program had started to operate already in 1987; for more about the Scottish system, see Greenwood 1992). After the Scots had, in their turn, visited Finland, the medical doctor sent one of his workers – a nurse planning the forthcoming NEP – for a study visit to Glasgow. As a result, the NEP in Helsinki was then modeled on the basis of the NEP in Glasgow.³ However, as the doctor commented in an interview: “we soon became aware that these programs took place in almost all countries.”

According to the first project plans (dated 16.1.1996 and 29.11.1996) the tasks of the first NEP included exchange of clean needles and syringes for used ones, as well as distribution of self-cleaning equipment, condoms and various health advice leaflets. The anonymous user-clients were also provided with free hepatitis B vaccinations as well as HIV and hepatitis tests. It was stressed that the users will have a possibility to confidentially discuss their problems with the staff and be guided to actual treatment places.

The NEP was planned to start in the autumn 1996⁴ but just before the start, the plans were leaked to the media and the program was aborted: its aims, the rationale behind them and its legal status were soon questioned by certain authorities, politicians, the police and some professionals in the drug treatment field. In particular, the Minister of Interior and the Minister of Justice were publicly against the program.

At the beginning there were four organizations behind the NEP: the A-Clinic Foundation, the National Public Health Institute, the health department unit responsible for infectious disease prevention in the City of Helsinki, and the Ministry of Social Affairs and Health. As soon as it became public and debated, representatives from all four organizations defended the trial run of the program publicly. From the diffusion perspective it was important that there was a wide-based institutional network,

including one ministry, involved in the NEP advocacy. During the winter of 1996–97 this group was active in many ways in assuring the critics that the new working model made sense and was a legal and ethical thing to do: A delegation from these organizations visited both the Minister of Justice and the Minister of Interior to explain the rationale behind the NEP; letters on the subject were sent to the local treatment units⁵ as well as to different branches of the City of Helsinki,⁶ who were asked to form their opinion on the matter; three civil servants from the Ministry of Social Affairs and Health wrote a propounding article⁷ on the subject to *Helsingin Sanomat* (the biggest national newspaper); the doctor in charge of the NEP wrote an article on the subject to the newsletter of the drug police;⁸ a multi-institutional expert steering group for the NEP was established, and so forth. Also in a response to a claim that giving needles to the users would be illegal (as “tools for crime”) the Ministry Social Affairs and Health asked the Ministry of Justice to take an official stance on the legal status of needle exchange (which it did and eventually decided the activity as such is *not* against the law).⁹

At the time when the debate was hottest, there were also two drug policy committees working in Finland: a national drug policy commission working on the first national drug strategy and a local committee working on the drug strategy for the City of Helsinki. In both commissions there were people from the organizations behind the NEP trial, either as members or as experts. Both commissions came up with a recommendation to start the project, although only as a trial that needed to be carefully evaluated (cf. Tammi 2003). Eventually, after a half-year’s delay in the spring 1997, the NEP in Helsinki was allowed to start on an experimental basis.

The efforts of individual experts and organizations and their joint network played a decisive role in starting the NEPs. However, it was really the *HIV epidemic* of 1998–2000 that eventually amplified the arguments for NEPs, legitimized the already started trial and made similar programs diffuse throughout the country. Or put it the other way around, the emergence of the epidemic finally resulted in the persistence of the new policy advocacy coalition and led to establishment of the needle exchange programs. In October 1998, the National Public Health Institute (NPHI) published a press release stating that a first local HIV epidemic had occurred during the past summer amongst the intravenous (injecting) drug users (IDUs) in the Helsinki area. Referring to international research evidence, the NPHI insisted that new NEPs should now be rapidly established in all major cities, or else the majority of the IDUs would soon be infected. It also warned that the disease could easily spread to the non drug-using population through sexual relationships.¹⁰ A vast mobilization followed: various ‘emergency meetings’¹¹ were arranged by the Ministry (of Social Affairs and Health); weekly situation reports and codes-of-conduct were given by the NPHI and local health authorities in the field of infectious diseases to the media and health care units; training on needle exchange was also organized in health care districts throughout Finland. Not as yet forced by legislation, the cities were given a strong recommendation to act by the views of central public health authorities. Thus, many new NEPs were soon established.



With regard to diffusion models, during this phase *hierarchical diffusion* took place in Finland. In addition to the centralized ‘information guidance’ by the government bodies (NPHI and the Ministry), table 1 (below) shows how the NEPs first appeared in the largest cities and were then adopted by successively smaller cities. The last two rows of the table also show the exposure, as well as the catalyzing, effect of the HIV epidemic on the diffusion.

TABLE 1. STARTING YEARS OF NEPs & HIV CASES AMONG INJECTING DRUG USERS (IDUs) IN 1997–2003.

Population in the city	City	1997	1998	1999	2000	2001	2002	2003
>100.000	Helsinki	X						
	Tampere		X					
	Vantaa				X			
	Turku				X			
	Espoo					X		
	Oulu					X		
50.000-100.000 inhabitants	Lahti			X				
	Kuopio			X				
	Jyväskylä				X			
	Pori					X		
	Kotka					X		
	Lappeenranta							X
Joensuu							X	
<50.000 inhabitants	Hämeenlinna				X			
	Rauma				X			
	Imatra				X			
	Hyvinkää					X		
	Lohja					X		
	Salo					X		
	Kouvola						X	
	Valkeakoski						X	
New HIV cases among IDUs (Finland)		0	20	86	56	49	26	24
Year		1997	1998	1999	2000	2001	2002	2003

By 2003, NEPs were established in 21 Finnish cities altogether. By the end of 2003, there were also two decisions made that further established the position of NEPs within Finnish drug policy. Firstly, needle exchange activity was enacted to the Decree on Infectious Diseases (Valtioneuvoston... 2003); this decree put the cities and municipalities under obligation to arrange needle exchanges in their regions when needed. The second decision was made by the Prosecutor General who, in his answer to a complaint by an individual police officer who had asked the Prosecutor General to take stance on the (il)legality of needle exchange, determined that exchanging needles is not only legal, but also in accordance with the official drug policy in Finland (Valtakunnansyyttäjäviraston kirje 2003).

Translating needle exchange into the national context

So far, I have described the process by which the NEPs became established in Finland. I have also paid attention to situational factors that affected this: the general increase in drug use, harms and related public concern, the formation of an advocacy network and eventually the HIV epidemic among the injecting drug users. Since the 1960–70s, the drug problem has been primarily constructed as a criminality problem in Finland and the drug policy has been accordingly repressive in its nature, including systematic punishments for use and possession of illicit drugs. When a reformist working method like needle exchange is imported to this kind of a political climate, the aims of and rationalities behind it need to be carefully translated into the language of a local context; its success cannot be sufficiently explained merely by situational factors but also the argumentation for the need of a policy reform needs to be examined. In what follows, I will depict the range of arguments that were used by the advocates. I argue that the way the proponents developed a many-sided set of arguments, a cognitive praxis for the advocacy, was important for the success of NEP diffusion.

As described earlier, the idea and the model for the NEP came from Glasgow. The NEP advocates also presented the ‘Glasgow model’ as a public health success story when the confrontation between the authorities on the topic became public in the media. The Glasgow model was said to be successful, and more effective when compared with some other models, let alone those cities that did not have a NEP. Among opponents, however, this international model sharing was not accepted as a valid basis for such a project. On the contrary, such policy copying was subject to critique; on September 11, 1996, the newspaper *Helsingin Sanomat* wrote:

[The Minister of Justice] is of opinion that a needle exchange service would mean surrendering to the drug problem (...) and he emphasizes that Finland should not take models from those countries that have given up on drugs.¹²



The counter-argument was that models were taken from wrong countries, and they would not apply to Finland. Three weeks later (*Helsingin Sanomat*, Sep 30), a police chief continued in the same newspaper:

Distributing needles can mean that harm-reduction thinking is being snuck into to Finland (...) the drug problem in Finland is so different from the situation in Central Europe that there is no reason to copy policies from other countries (...) but if models are to be sought from other countries, we should take a look at the other Nordic countries where the conditions and drug situations are closer to ours.

This critique above can be read as a recommendation as to how drug policies should diffuse: the police chief is in favor of spatial diffusion along the lines of geographical proximity and along the culturally established communication channels that Finland traditionally has with other Nordic countries. Further in the course of the debate, the opponents had two main arguments against NEPs: the first was that distributing needles sends (young people) the wrong (i.e. permissive) signals about drug use, and second, that distributing needles is in effect distributing tools a for crime. Although the first NEP was allowed to start, these arguments were presented repeatedly until the emergence of the HIV epidemic, which finally challenged the terms of debate in the drug field for Finland. The more talk there was about the costs and threats of the HIV epidemic spreading, the less attention was paid to the talk about ‘sending the wrong signals’ or a ‘drug free society’, upon which the criticism was largely based at the beginning of NEPs’ launch. According to two interviewed law enforcement authorities, the police, who had at first opposed NEPs, started to make a distinction between the actual drug policy and public health matters such as needle exchange. The following extract from the editorial of *Aamulehti* newspaper (August 1999; titled *HIV Infections are a Result of Delays in Authorities’ Actions*) illustrates the emergence of public health and also economic based views in drug policy discourse¹³:

They have had ten years to prepare themselves for the epidemic. However, the authorities have put their resources to debates on the orthodoxy of drug policy and treatment models. The price of this selfish and moralistic hesitation has now become clear: citizens’ health. To those who understand numbers it can be told that the cost to the society of one HIV-patient is about one million Finnish marks, and that a hepatitis infection costs some hundreds of thousands.(...) The disputes about the principles of drug policy need to be forgotten now and our forces united in the fight against the epidemic.

Needle exchange advocates did not only limit their argumentation to empirical public health debates, although those were used too. Economical and ethical arguments, as well as arguments related to public safety, were also used repeatedly. Klaus Mäkelä (1976) has distinguished between three frameworks through which alcohol problems are looked at in modern Western societies: i) public health, ii) public security, iii) productivity/economy. These can be applied to collective perceptions of drug problems, too. Regarding the public health framework, the NEP advocates argued,

referring to (unnamed) international studies, that in addition to preventing virus epidemics and also promoting health in other ways among drug users, needle exchanges also protect the general population from these viruses. This argument combines public health and public safety frameworks. The economical argument was that it is dramatically cheaper to prevent infectious virus diseases beforehand than to treat hepatitis or HIV positive patients. In the public security framework, the argument was that NEPs are the only way to keep virus-polluted needles away from parks and other public spaces. That is, away from the hands of children and the other innocents. Most of these repeatedly used arguments, as well as an explicit ethical argument, are covered in the speech by the Minister of Social Services, the coordinating minister for drug policy in Finland, in 2002 when the law enactment on NEPs was debated in parliament:

The needle exchange program (...) has been a great success, as we have succeeded in just couple of years in reducing the number of HIV and hepatitis infections due to intravenous use. HIV is currently a big threat to the whole population just because prostitution is related to drug use and through this there is a clear channel of HIV first to men and then to their wives. (...) That we've succeeded in reducing HIV infections with this particularly successful syringe exchange program is a great achievement. I would like to ask from the viewpoint of consequence ethics, are those who think that this [*needle exchange –TT*] shouldn't be allowed, ready to accept the cases of death which would follow both for drug users and the rest of the population? I find this a rather peculiar a discussion. (...) There is no evidence whatsoever that syringe exchange programs would increase the selling of drugs (...) It has been studied internationally in different parts of the world. Additionally, as this is about exchange programs, it decreases the number of those needles that are left in children's playgrounds. (Underlinings by TT.)

As regards to the drug policy climate in Finland, it was strategically important to present the idea of NEPs (and harm reduction in general) so as to make it fit with a drug policy that is based on total prohibition and is as such widely supported (Hakkarainen & Metso 2004). In 1999, when the HIV epidemic was still spreading, the Medical Society Duodecim (a medical doctors' association) and the Academy of Finland (the main funding body for academic research) arranged a high-level professional conference on drug treatment (called *the Consensus Conference*). The conference gathered politicians and civil servants as well as drug treatment and health care experts together with an aim to formulate a joint resolution on "evidence-based drug treatment". The conference was a great success for public health and harm reduction approaches and thereby for the needle exchange advocates as well. In the conference's resolution, it was concluded that both needle exchange and substitution treatment are evidence-based methods, and it was therefore recommended that they should be taken much more widely into use. As a translation of harm reduction ideology (e.g. Riley et al. 1999) into the language of Finnish drug policy, the conference came up with a politically important interpretation, according to which:



Harm reduction is not opposed to a restrictive drug policy, but it is about creating contacts [*with problem drug users – TT*] and reducing drug-related health risks and as such, it supports the restriction of drugs.

In some other contexts, the NEPs are arranged so as they only focus on the immediate risks and have deliberately minimized the contact between the professionals and the users in order to maximize participation of potential clients (Stimson and Donoghue 1996). Such an interpretation of harm reduction, which only addresses the immediate harms and disregards the use of drugs *per se*, would not have been strategically wise – if even possible – to use in Finland. One of the official aims of the NEPs from the very beginning was to motivate, direct and engage (i.e. refer) drug users into treatment, which was a politically important emphasis. NEPs were not only about needle exchange: they also had other, more ambitious goals. Unlike some countries, in Finland providing onward referral to treatment was not a condition of the scheme (*ibid.*); yet even so, the ‘bridge to treatment’ aim has been rhetorically and tactically central. For example, it came up clearly in the parliamentary speech of the MP responsible for initiating the enactment of NEPs into law:

This activity today is not, nor can it be in the future, only about the technical exchange of syringes – it is essential that it also includes expert assistance and possibilities to withdraw from drug use.

As a particular national innovation, the NEPs have not officially been called ‘needle exchange programs’ in Finnish at any phase. In the beginning, the first trial in Helsinki was called *the infection risk project*, and after that NEPs were named as *Health Counseling Points* (Terveysneuvontapiste). In addition to *not* referring directly to the most politically delicate part of the activity (i.e. to needle exchange), the name also implies that their activities are more diversified and ambitious than those of only mechanically changing needles; they provide the drug users with more general help and advice.

The main arguments and related frameworks are summarized in table 2 below.

TABLE 2. THE FRAMEWORKS AND RELATED ARGUMENTS OF THE NEPs DEBATE.

Public health framework	* “The model is internationally proven effective in reducing infectious diseases among the drug users” (“evidence-based” [* No evidence on increasing the use of drugs] * “Protects the general public from the HIV epidemic”	* “Increases drug use” (by sending a wrong signal to the young) [* “NEPs as such will increase drug use”]
Public security framework	* “Protects the general public from the HIV epidemic” * “Especially protects children (in the playgrounds)”	--
Economical framework	* “Prevention is much cheaper than treatment (of HIV and Hep C patients)”	--
Ethical framework	* “Protecting people from fatal diseases is morally right”	* “Immoral to give tools for criminal activity”
Drug policy framework	* “Is in harmony with the existing drug policy” (as it helps get users into treatment & provides the users with more general prevention messages)	* “Is in contradiction with the existing drug policy” (as it approves the drug use)

Conclusion

The Ottawa Charter for Health Promotion (The Ottawa Charter for Health <http://www.ldb.org/iuhpe/ottawa.htm>) gives health promotion practitioners the task of “creating public policies that are supportive to health” – in other words, the public policies are to be made ‘health literate’. But how are policies changed to be ‘supportive to health’ or made health literate in practice? The diffusion of needle exchange in Finland serves as a good case study for this kind of policy change.

Social emulation, or ‘model behavior’ is one central mechanism of policy diffusion, and it can take place either hierarchically or spatially between countries (Klingemann and Klingemann 1999: 110). Such model behavior also played a role in ‘importing’ the first NEP to Finland from Scotland. Did this ‘bilateral trade’ follow the lines of hierarchical rather than spatial diffusion? It was maybe a coincidence that the aforementioned doctor happened to visit the NEP in Scotland and created professional contacts for new visits and information exchange, but still as such, it can be seen representing both hierarchical and spatial diffusion. In comparison to Helsinki, Glasgow was a more advanced center and an earlier adopter of a NEP (hierarchical diffusion), but it was more about spatial diffusion based on established



communication channels between experts, not on geographical or cultural proximity.

Regarding the national level, I have described a political process which started as open conflict between public health (together with drug treatment practitioners) and law enforcement authorities, but quite quickly opened the way for the needle exchange programs to diffuse from Helsinki to 20 other Finnish cities, as well as become established by law. I developed two main explanations as to why the NEPs could be successfully launched (i.e. diffused) in Finland between 1996 and 2002. The first explanation for the successful diffusion has to do with the situational factors of the time when NEPs were introduced in Finland: drug use and related harms were rapidly increasing after the mid-1990s. This raised the importance of the drug issue on the political agenda. Public concern and the related something-has-to-be-done atmosphere gave way to diverse drug-based political mobilizations: commissions and working groups were set up, conferences, projects and training organized, and so on. The most important situational factor and a final breakthrough for NEPs was due to the HIV epidemic among drug users in 1998–2000. From the viewpoint of diffusion, the epidemic was ‘perfectly timed’, and the most important actor was non-human: the Human Immuno-deficiency Virus.

The mobilization due to increased drug use and the HIV epidemic created an opportunity for the formation and persistence of an advocacy network whose specific way of translating the idea of harm reduction into the Finnish drug policy context is the second explanation for the successful diffusion. In those ‘translations’, i.e. arguments, they did not rely narrowly on public health research evidence, but utilized also arguments related to costs, public safety and ethics. In the U.S. where in many states establishing NEPs has repeatedly failed, Buchanan et al. (2004: 439–440) have come up with a proposal that the proponents of needle exchange should create new, more morally-driven arguments related to equity (“help the disadvantaged”), security (“protect the innocent – women and children”), efficiency (“save the tax-payers’ money”) and liberty. The explanation and analogous strategy suggested by Buchanan et al. is based on a presupposition that it is the diversity of different arguments that matters in policy change. As such, it can be seen as a discourse-based theory on drug policy diffusion, for it suggests that by using certain types of argument the needle exchange programs would diffuse more easily into the US cities. On the basis of the Finnish case, the kind of versatile combination of arguments used really seemed to be effective: the NEPs were not only diffused throughout Finland but, today, are also supported by the general public (see Hakkarainen and Metso 2004).

Furthermore, the advocates of needle exchange also made two politically important translations of the needle exchange rationale – and of harm reduction ideas more generally – into the language of Finnish drug policy: first, that the harm reduction approach is not in conflict with the prevailing prohibition model, but supplements it; and second, that NEPs not only strive to reduce the immediate harms of drug use but also have an important role in motivating and directing drug users into (abstinence-oriented) treatment. Thus in Finland, unlike in some other contexts, the harm reduction approach was not interpreted as an opposite to the abstinence model and restrictive

drug policy but as complementary and helpful to them .

Regarding the members of the advocacy network it should be noted that this NEP establishment process brought about a new and powerful actor in the drug policy field. It was the first time when the public health profession (i.e. the National Public Health Institute as well as the infectious disease experts at the Ministry of Social Affairs and Health and in the Helsinki City health care system) became heavily involved in the Finnish drug policy-making. Also the particular clinic which started the first NEP, was directed by a medical doctor, whereas other clinics had social workers or other non-medical professionals as their directors (see Holopainen 1992). Thus, the NEP diffusion process, together with the parallel process of expanding substitution treatment (see Hakkarainen and Tigerstedt 2005), can be seen as a process during which the drug policy-making system has been ‘medicalized’ with regard to incorporating a new and influential actor – the public health profession – into the field.

As the last explanation for the NEPs diffusion, it should be noted that despite some initial criticism there was no strong counter-movement to the NEP advocacy network. In other words, one explanation for the NEPs’ success in Finland could be the weak resistance to it. In some other countries, the launch of needle exchange has resulted a strong mobilization against it, e.g., in the US city of Springfield, Massachusetts, a group of residents formed an influential lobbying organization, Citizens Against Needle Exchange, CANE (Buchanan et al. 2004: 429); or in Sweden it was the social work profession together with parent organizations that powerfully resisted the NEPs (Lindberg and Haynes 2000), not to mention the extremist example in St. Petersburg where a needle exchange ambulance (of the Médecins Sans Frontières) was burned in an arson attack. In Finland, it was basically the police together with individual politicians and citizens that resisted the NEPs, and they more or less ‘gave up’ after the emergence of the HIV epidemic.

In his analysis of the Swiss drug policy change in the late 1980s, Daniel Kübler (2001) has described how AIDS made new actors enter the drug policy arena as part of the mobilization of a harm reduction advocacy coalition in Switzerland. The emergence of the HIV epidemic among the Finnish drug users had a similar mobilizing effect. We can even say that a *harm reduction profession* was born in Finland in this process. As NEPs were established in all major cities, dozens of new drug workers were recruited and different expert networks mobilized for them. This professionally, organizationally and geographically heterogeneous group of practitioners from drug treatment, social work and health care – together with their clients and other supporters (e.g. civil servants, researchers and institutions) – is to be viewed as a new “collective identity that is a shared definition produced by several individuals or groups and concerned with the orientations of action” (Melucci 1995: 44). What is new to this identity is the primary orientation to the drug users’ physical health and health literacy *per se*.



Notes

- 1 Researchers Juha Partanen and Leena Metso used this expression in the title of their population survey report in 1999, and it has since been taken into everyday use.
- 2 Project plan, dated 16.1.1996.
- 3 Interview of the doctor in charge of the NEP; also “Travel report from the study trip to Glasgow: 24.9.–31.9.1996”.
- 4 Contract dated 28.2.1996.
- 5 Dated 24.1.1997.
- 6 Dated 17.1.1997.
- 7 Mäki J., Rosenqvist P., Saarinen, M.: “Attempts to be made to curb drug related diseases” (Helsingin Sanomat 25.10.1996).
- 8 Holopainen, A.: “Intravenous drug use related infectious diseases are a new threat” (Piikki 2/1996).
- 9 Memorandum by the Ministry of Justice, dated 31.10.1996.
- 10 Press release, 19.10.1998.
- 11 E.g. Meeting between the Ministry and the State Provincial Offices on “Drug users’ counseling and clean injection equipment” 22.09.1999; Expert meeting “HIV epidemic among iv-users – what should be done?” 27.04.2000.
- 12 Helsingin Sanomat 11.9.1996.
- 13 In 1996–2000 there were altogether 10 editorials on needle-exchange in the four newspapers investigated (*Helsingin Sanomat*, *Aamulehti*, *Iltta-Sanomat*, *Iltalehti*): none of them was critical towards it.

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V

Who is the Expert?

Patient Groups and Finnish Substitution Treatment Policy

Tuukka Tammi

Introduction

Based on their literature review, Hunt and Barker (1999) conclude that the client's experience of drug treatment is the single most uncharted area in drug treatment research. Although substitution treatment (with methadone) is one of the most investigated treatment modalities, research on clients' perceptions and experiences is virtually non-existent: researchers have been more concerned with documenting the use and efficacy of treatment services and less concerned with the clients' perspective on the treatment they receive (Hunt & Barker 1999, 129–131). However, the rare – often ethnographic – studies that have been conducted on the methadone clientele show how clients are not passive recipients, but instead active participants within the world of the clinic, and they may successfully resist the surveillance as well as the new particular identity offered to them as clients or patients (ibid.; Skoll 1992; Fraser 1997).

This article contributes to the limited research on client experiences of substitution treatment. It describes the claims-makings of two Finnish client organisations with regard to substitution treatment. These organisations were born out of dissatisfaction with the slow progress and poor quality of substitution treatment in Finland at the turn of the millennium: they are an association for the support of opiate addicts (Opiiaattiriippuvaisten tuki ry; ORT) and an association for the support of substitution treatment (Korvaushoidon tuki ry; KT). As will be described below, both of these groups started out in response to a sense of being deprived of something as patients.

Until the mid-1990s, both the use of drugs and related problems were still relatively marginal in Finland when compared to most other Western European countries. The situation then began to change: not only experimentation but also intravenous drug use and related harms began sharply to increase, which also drove up the demand for treatment and drug-related crime (Partanen & Metso 1999; Virtanen 2005). This resulted in various mobilisations in the drug policy field: committees and working groups were set up, action plans were drafted, and various professions called for more resources. As a consequence, many concrete

changes followed (for more on these changes, see Tammi 2002, 2005a & 2005b; Hakkarainen & Tigerstedt 2004). One was the dramatic change in substitution treatment policy, which saw the number of clients increase from just a few patients in the mid-1990s to almost 1,000 in 2005.

The rapid changes have been explained not only by reference to the changing drug situation, but also by the forceful campaigning of a medical lobby for substitution treatment. Initially this lobby consisted of just a couple of medical doctors, most notably *Pentti Karvonen*, a private MD whose liberal practice of buprenorphine prescription first gave rise to official warnings, then to his being struck from the medical register, and eventually to a prison sentence for illicit trafficking and distribution of buprenorphine to his clients. At the same time as this drama was unfolding, the lobby for substitution treatment continued to grow and even many official players in the drug treatment policy field became more favourably inclined towards the new practice. Particularly influential in this regard was the advocacy of substitution treatment by *Osmo Soininvaara*, the Green Party Minister of Social Affairs, and *Mikko Salaspuro*, a prominent medical expert (Hakkarainen & Tigerstedt 2005).

While at the beginning of the 1990s expert committees on drug treatment (Report on arranging treatment for addicts in Helsinki 1991; Working group report on developing medicinal treatment of opioid addicts 1993) had still taken a negative stance on substitution treatment, by the end of the decade working groups on drug treatment (Working group report on developing drug treatment 2001; Working group report on developing medicinal treatment of opioid addicts 2001) as well as general drug policy strategies (Drug Strategy 1997 – Report by the Finnish Drug Policy Committee; the 1998 and 2000 Government Decisions-in-Principle) were advocating a widening of substitution treatment. Funding has also been made available to local authorities for the start-up of these treatments.

Needless to say, when we look at the range of actors who took part in this policy-making process, we find that the field was predominantly authority- and expert-driven: the actual target of the policy, *the drug user*, had a very little role in policy-making. This, of course, does not mean to say that users have no views and opinions on how the policies should be developed. In what follows, I give voice to the two user groups mentioned above. My data consist of documents produced by the groups concerned as well as of interviews, discussions and e-mail exchanges with group members. I first provide some background information on the groups' formation, composition and activities, and then move on to their claims-making. I conclude with a general discussion of drug policy and user participation in Finland.

Evolution and Activities of the Patient Groups

The Partisans: Association for the Support of Opiate Addicts (Opiattiriippuvaisten tuki ry; ORT)

ORT worked in 1997–2003 to “increase the availability of treatment for opiate addicts and generally develop the quality of these treatments”. The group lobbied particularly for buprenorphine-based substitution treatment, this being the drug with which the above-mentioned doctor Karvonen had treated his patients. ORT was keen to adopt the so-called “French system”¹: in France buprenorphine has become the main form of substitution therapy, with some 70,000–80,000 (OFDT 2004) people being prescribed it, often by private doctors. In general, ORT wanted to “improve the way that these people who wanted buprenorphine were treated” and “to increase lay people’s knowledge about the fact that drug use is a disease that leads to many other difficulties (such as crime, domestic violence, use of child protection, infectious diseases, etc.) if not treated properly”.

As mentioned, one of the main advocates of substitution treatment in Finland was a private MD who readily prescribed buprenorphine to opiate users in the Helsinki area, until the National Authority for Medicolegal Affairs (TEO) in May 1997 withheld his rights to prescribe these drugs and eventually struck him off the medical register. The formation of ORT was ultimately prompted by this decision. At the time of the decision (according to ORT) the doctor had some 200 patients who were suddenly deprived of their medicine. A group of parents and other people close to these patients approached the relevant authorities and treatment organisations in an attempt to get the treatments re-started. However, they soon noticed that the authorities “didn’t know anything about the prevailing problems and their attitude was very ignorant”.²

When the association was started in 1997 it had a membership of ten. Next year the number increased to around 30, at which level it remained until its dissolution in 2003.

Who were these people? During the first two years the association consisted of drug users’ support persons and other closely related persons, in 1999 and 2000 they had also other “support members”, and from 2001 onwards ORT also reported having among its members “ex-users who are in treatment”.³ So

¹ The term was used e.g. in a letter from the ORT to the Ministry of Social Affairs and Health, dated 17.12.1998. About the French substitution treatment policy, see Bergeron (1999).

² ORT, Report on activities 1997.

³ ORT, Reports on activities 1997–2003.

although the association was open to (ex-)users, ORT was not run by users but rather by their parents or other people close to them; therefore the association could be regarded as a semi-user group.

The group had some success in its efforts to break into the formal field of drug policy-making. For instance, their opinions were consulted by the Ministry of Social Affairs and Health when the regulations on substitution treatment were updated; they testified to an expert working group on substitution treatment; they were invited to deliver a speech at a high-level conference on “evidence-based drug treatment” in 1999⁴; and in 2001 they also received funding from the state gaming monopoly RAY, the main source of NGO funding in the field of social welfare and health, for a two-year project. In other words, ORT achieved recognition as a valid claims-maker in the field.

In spite of this relative success, ORT was closed down in 2003. In the words of the ORT chairperson, this was done “in frustration after banging our heads against the wall in talking about heroin users as worthy human beings, about their rights to treatment, equality with other patient groups and so on”.⁵ However, during its six years of existence the group had actively advocated its cause. It wrote newspaper pieces, sent letters to politicians, submitted petitions to officials responsible for drug treatment, and maintained its own website. To give a few examples, one of the first petitions was submitted in 1997 when the Ministry of Social Affairs and Health had issued its first regulation on substitution treatment (1997:28). ORT submitted a list of demands on how the regulation should be amended. Its demands included a significant increase in the number of substitution treatment places; the allocation of resources and responsibilities to private clinics; a shift in emphasis from inpatient to outpatient treatment; the separation of drug user clients from mental health care patients; the setting up of drug-free units and needle exchange services in prisons; patient involvement in their treatment and medication; and the removal of the three-month ceiling to treatment periods.

One of ORT’s biggest efforts took place in August 1999 when they filed a complaint to the parliamentary Ombudsman together with the ombudsman for clients of substance abuse care, who provides free legal counseling for clients in drug or alcohol treatment.⁶ The Parliamentary Ombudsman is an institution to

⁴ These so-called consensus conferences are arranged by the Finnish Medical Society Duodecim together with the Academy of Finland; the idea is to offer a forum for discussion between medical scientists and decision makers around a given medical problem and treatment alternatives.

⁵ Letter from the chair of the ORT to the author, dated 13.7.2004.

⁶ The ombudsman is a project funded by the RAY, the national gambling monopoly, and it is being run by *A-Kiltojen liitto* (“A-Guilds Union”) which is a wide network of local associations of the clients of “A-clinics”, the outpatient treatments units for substance abusers. In practice, this association focuses purely on people with alcohol problems, but the above-mentioned service has been actively used also by the clients in drug treatment.

whom citizens can file complaints if they suspect that a public authority or official has breached the law or failed to perform their duties.⁷ Briefly put, the content of the complaint was that the cities of Helsinki, Vantaa and Espoo (the latter two are neighbours of Helsinki) had failed to organise buprenorphine-based treatments according to patients' needs, and that this was a contravention of legislation. The decision from the Parliamentary Ombudsman came more than two years later (dated 31 Dec, 2001) and was based on replies from the three cities as well as on three statements by the Ministry of Social Affairs and Health. This process had forced the officials to give an answer to ORT, although the passage of time and changes in substitution treatment policy had already resolved part of the problem by the time that the Ombudsman's decision finally came through. By late 2001 buprenorphine-based treatments were increasingly accepted and offered, but the Ombudsman took the view that at the time of the complaint (1999) ORT had been in the right: demand had exceeded the supply of substitution treatment with buprenorphine. Although the Ombudsman was of the opinion that the patients had a fundamental right to treatment, she took a negative stand on the patients' subjective right to choose what they regarded as the best treatment (i.e. substitution treatment with buprenorphine); according to the decision the patients do have the right to refuse a particular treatment, but not to choose another treatment instead. This stand was a major setback for ORT who from the outset had maintained that they and the patients were the best experts, based on both patient experiences and the latest scientific research from abroad.

Patient Activism from Inside: The Association for the Support of Substitution Treatment (Korvaushoidon tuki ry; KT)

Support for substitution treatment (KT) is a new association that is based on the same kind of underlying idea as the SBF (*Svenska Brukarföreningen*) in Sweden and the DDUU (*Brugerforeningen for Aktive Stofbrugere*) in Denmark. It has been set up by patients themselves around the inadequacies of substitution treatment with the aim of influencing treatment from within, from the client perspective. Although the group is still very small and young (indeed it is not yet clear whether it will survive the early dispute described below), it deserves to be introduced here because it reflects the changes that have taken place both in the drug (treatment) policy field and in user activism: just a few years ago an association like this would not have been possible because both the target of action (the content of substitution treatment) and the actors (patients in substitution treatment) did not exist in Finland. While ORT was still about influencing the system from the outside and calling for the provision of buprenorphine-based substitution treatment, the setting in the case of KT is

⁷ The Parliamentary Ombudsman is based on the Constitution of Finland and pays special attention to the implementation of fundamental and human rights.

different: here the aim is to influence the existing substitution treatment system from within, as patients who have been admitted to treatment. Changes in the policy field have made possible new forms of collective protest.

KT was established in spring 2004 by four clients of a substitution treatment clinic in southern Helsinki⁸. The overall aim of the association is to “improve the quality of treatment and to promote treatment practices that respect drug users as equal and normal human beings”. The initial impetus for the association was the sudden decision to change the founding members’ substitute drug without consulting their opinions as patients, despite the side-effects that the patients reported to the treatment personnel. The drug was changed from Subutex to Suboxone, which is a combination of buprenorphine and naloxone. Naloxone is a drug that has been used to help users who have overdosed as it should block the effects of medicines and drugs like methadone, heroin, and morphine. The idea of combining naloxone with buprenorphine is to stop people from injecting the drug: according to the manufacturer’s website, “The naloxone in Suboxone is likely to precipitate withdrawal symptoms when injected by individuals dependent on heroin, morphine, or other full opiate agonists. Therefore, it is assumed that Suboxone would be less attractive to ‘street addicts’ and less likely to be diverted. Therefore, it is strongly recommended that Suboxone be used whenever unsupervised administration is planned.”⁹ In Finland, too, street-use, i.e. injecting buprenorphine has become quite common and attracted criticism as an undesired effect of the expansion of substitution treatment – this was the official reason for the switch to Suboxone.

KT rejected this official argument for the change of drugs and countered it with its own experience-based information. In a petition to the doctors-in-charge of four substitution clinics, they stated: “We, as patients, feel that we are being used as forced, unpaid laboratory animals. If our situation is compared with some other patient group (e.g. diabetics, epileptics) for whom a new drug is prescribed; if the new drug did not help them, this would hardly mean that instead of going back to the old drug the only option would be to try another new but useless drug or quitting treatment”. The alternative to Suboxone offered by the clinic was methadone, which KT members considered too strong and addictive compared to buprenorphine.

To date, KT’s activities have consisted of writing petitions to experts and officials as well as meeting with their counterparts and others concerned (such as representatives of the pharmaceuticals company that sells both buprenorphine-based drugs). Like ORT, KT invokes the Act on the Status and Rights of Patients

⁸ Touting for new members has been going on since but according the funding members this has been difficult because other patients fear they will be sanctioned if they’ll join the group (Petition, dated 27.4.2004).

⁹ <http://www.suboxone.org/Suboxone/patients/faqs.htm> & <http://www.suboxone.org/Suboxone/phys/faqs.htm>

in support of their demands. At the core of their argument is section 6 of that Act, according to which “The patient has to be cared for in mutual understanding with him/her. If the patient refuses a certain treatment or measure, he/she has to be cared for, as far as possible, in another medically acceptable way in mutual understanding with him/her.” In addition to the adverse side-effects from and ineffectiveness of the new drug, KT reported that, contrary to the thinking of the officials, Subuxone was being sold and injected in the streets just like Subutex.¹⁰ KT members claim that the motive for the change of drugs is ultimately of a political nature and not based on medical knowledge; they report that despite repeated requests for research information on the side-effects of Subuxone, no answers have been given.

Six months later, KT received a reply from the doctor who was in charge of their treatment (letter dated 16 Dec 2004) – a dispassionate response which made no promise of changing back to Subutex. It is noteworthy that this was just two days after Professor of Addiction Medicine *Mikko Salaspuro*, whom KT had approached earlier, had sent the doctor a letter in which he informs his colleague about a relevant piece of research and takes a stand in favour of the patients’ right to receive their former medication: “A recent study from Australia shows that the shift from Subutex to Subuxone with similar doses does not work smoothly and unproblematically. (...) Referring to the study above, permission to change drugs should always be obtained from the patient. Additionally, the patient must have the right to revert to his old medication when side-effects occur”.¹¹ Getting the professor on their side in this struggle was certainly a small victory for KT. Importantly, this episode also created divisions among substitution treatment professionals.

Patients Claim Expertise and Just Treatment

I move on now to characterise some of the most central claims made by ORT and KT about themselves and other actors, and what they see or saw as problems that need to be resolved with drug treatment. I do this by describing how they typify the problem in general and what kind of examples they give of the problem, as well as the new orientation they suggest for resolving the problems (cf. Best 1989).

Generally speaking, both groups aim to challenge and deconstruct the restrictive social category of problem drug user. They want to break the cultural identity of injecting drug user that no doubt is one of the most miserable and narrowest in our societies: users are seen as marginalised and also potentially criminal,

¹⁰ KT, interview & petition, dated 27.4.2004.

¹¹ Quotation from the letter dated 14.12.2004.

although these attributions increasingly display the user's "disease of the will" (Valverde 1998), failure of responsible self-control that they can't help.

Both ORT and KT accept the disease concept of addiction, in fact it is the very starting-point for their self-definition as patients. Since they are patients, they should have the same kind of rights as any other patient group (the act on patients' rights is repeatedly referred to) and they should not be treated differently from other patient groups. The core message is that disease, as a medical problem, is something for which individuals should not be held responsible, but also that despite their disease of addiction they are normal and reliable patients – but now they lack the rights of patients and thus of citizens more generally.

In their petitions and other material, both groups offer illustrative accounts of punishments, humiliations and overly strict rules at clinics. These are presented to exemplify the more general culture of control that pervades practices in treatment, which again conflicts with the medical perspective. The stories draw attention to the use of unskilled staff, attitude problems, an unprepared system, and also the general atmosphere of repression in drug policy. For instance:

Every morning, pills are distributed in a very unpleasant and disgusting way. Instead of natural conversation, the patient is stared at for 15–20 minutes while the Subutex pills melt under the tongue. After this his mouth is checked to make sure that no unmelted pills remain. (ORT, 17 Dec 98)

Therefore, the

negative attitudes of treatment personnel must be changed ... The behaviour towards addicts and their relatives must be humane and show respect ... As it is, it is best described as belittling, sometimes derogatory. (ORT, 3 Oct 97)

It is also emphasised by the groups that patients are individuals who are at different stages of the disease and therefore they should be treated individually:

Patients are individuals, they have different histories of drug use and different life situations. (ORT, 3 Oct 97)

Furthermore, not only are they unique individuals, but they are also *experts* on their disease and life around drug use. This is a world to which no outsider has access. The claim on expertise shows up in demands according to which patients should have a say in deciding on the treatment and medication that suits them best: after all it is the patient who will feel the effects or non-effects of the drug. In addition, they also claim that they have other related expertise (from "the streets"), as in the following excerpt:

The medical director ... argued ... that the health risks and street dealing of Subutex make Subuxone a better choice. This information is incorrect: once Subuxone treatments were started, it was immediately dealt in the streets, and in

contrast to what is claimed, it can be and is used intravenously. (KT, 27 April 2004)

In sum, ORT and KT present themselves as patients suffering from the disease of addiction, which should be treated medically. The problem is that currently this is not the case: the system is presented as an ill-prepared and unskilled machinery of control that fails to respect their patients' rights. Accordingly, the groups demand that they be treated both as individuals and as experts of their disease and life around it.

The solution proposed by ORT and KT can partly be placed under the general heading of *evidence-based medicine*. Moreover, the specific treatment practices are to be imported, particularly from France in the case of ORT. If this were to happen, patients would receive proper treatment for their disease and they could lead a useful life:

In the so-called French system ... the patient can lead a normal social life: travel, work, get an education ... the patient can feel that the main thing is living a life and substitution treatment is a minor point . (ORT, 17 Dec 98)

Thus ideally, being a patient would be a secondary status for them, whereas in the current repressive treatment practice they are primarily and inescapably reduced to the social status of drug abusers with a fatally troubled personal life that needs to be continuously controlled from the outside.

But as the patients claim that their own expertise should be taken into account, there is a strong element of ambivalence related to the relationship between medical expertise and the users' own life-world expertise. This is especially visible when it comes to the debate on preferred treatment: although there has been increased support in the medical camp for substitution treatment, there is an obvious tension between the medical profession and patients about the dividing line between the right to get treatment versus the right to get preferred treatment. For instance, the following statement (from a newspaper interview, HS 4 Oct 1999) by a doctor from a substitution treatment clinic goes to show how scientific and life-world expertise do not necessarily meet each other:

I don't know whether the number [of patients who are given substitution treatment] should be the same as the number of patients who want it. After the expansion it will, however, meet the medical need.

The juxtaposition of medical and life-world expertise raises many sociologically interesting questions, such as: Who claims the right to correct knowledge? What is the relationship between scientific and professional knowledge and "lived" lay knowledge about the effects of the same drug (buprenorphine)? The gap between these two epistemic positions has been a central theme in medical sociology since Talcott Parsons (1951) created his classic concept of sick role, and it has become ever more topical; this due to two trends that have amplified the clients'

or patients' voice in Western social and health care settings. The first of these is the trend towards greater *consumerism*, which is particularly clear in the health care context where patient activism has burgeoned since the 1970s (Halpern 2004). With the growing number of technologies used in health care, rising educational level in patients, the increasing availability of health and drug information and with patients actively seeking for information from different sources, people have increasingly come to feel that they should have more control over decisions affecting their bodies and be able to challenge the physician's authority and modes of practice (cf. Toiviainen et al. 2005). The second trend is the growing discourse on *empowering* clients through *partnerships* between them and the professionals, the desired end-result being active, self-governing and self-observing clients (cf. Asmussen 2003).

In today's reality of drug treatment in Finland, however, it is definitely too early to speak about consumerism or empowerment. Treatments for opiate users still seem to involve a strong element of control and the users' rights to influence treatment basically means the right to refuse treatment. The situation is also complicated by the fact that the drug in question – buprenorphine – is a synthetic opiate that can potentially be abused. In other words, the reluctance on the part of the doctors to accept shared decision-making in the case of substitution treatment is not only a question of patients' rights, but it may also have to do with moral judgements concerning intoxication.

Epilogue: The Future of Drug User Groups?

The two user groups introduced in this article are still rather weak examples of drug user activism. In contrast to the situation in Denmark and the Netherlands, Finland has not yet had any really influential drug user interest groups. Why is this? Are drug users in Finland – of whom 16,000–21,000 are classified as “problem users” (Virtanen 2005) – too oppressed or too satisfied to mobilise themselves collectively in defence of their rights as users, clients, patients and citizens?

Like all social movements, drug user movements are conditioned by national and local factors: by the political norms and culture on a general level, and by the local drug situation and its history more specifically. To answer the question as to why user activism has remained so modest in Finland, we need to think of these preconditions. To put this in more conceptual terms, we need to ask what are the necessary prerequisites for such activism in society more generally; what kind of space for action in society in general and in the drug policy field in particular is needed for stronger drug user lobby groups not only to emerge but to be taken seriously by other actors in the field?

One direction where we could look for better answers is the short history of the current drug situation. As institutional mobilisation and creation of critical mass take time, one candidate for a general answer to the why-not-user-activism question is that the current drug situation, with increased levels of use and related harms, is still new to Finnish society. As described at the beginning of the article, it is only recently that the “first round” of institutional mobilisation and adjustments in drug policy has been accomplished. Presumably we might expect to see an expansion of the policy field, including more contentious users’ voices, in a second round of policy-making (a prerequisite for such a second round is that drug use remains at the same level or increases).

Another, somewhat more specific explanation for the lack of user participation also relates to the short Finnish history of mass drug use. On average drug users in Finland are relatively young compared to many other European countries: in 2002 the mean age of all drug-related clients in outpatient treatment centres¹² in Finland was 25.1 years, whereas in Denmark it was 31.6 years and both in Sweden and in the Netherlands it was 33 years. Presumably, in order to become politically conscious and active, users need to reach a certain age and/or have a long enough “drug user career”, and it also takes time to form the necessary critical mass. So perhaps in Finland user activism will rise somewhat later than in the other Nordic countries?

We should also look at the dynamics of the drug policy field *per se*: to what extent can the modest level of user activism be explained by the field of Finnish drug policy and its established actors? In the social movement literature, the political opportunity structure refers to the “dimensions of the political environment which either encourage or discourage people from using collective action” (Tarrow 1994, 18). Political opportunities are composed of several factors, key among which is the division among policy-making elites. In the case of substitution treatment policy in Finland, there were initially some significant divisions among treatment experts, officials and researchers, but these divisions soon faded and the medical lobby for substitution treatment, drawing on “evidence-based medicine”, came out on top of the battle. What is relevant, from the user influence point of view, is that the professional/medical lobby was strong enough to make the change on its own; the users weren’t their allies, at least publicly. Given the “narcophobic” cultural climate in Finland (Partanen 2002), an alliance between the medical lobby and user-patient groups could in fact have hampered the advocacy of substitution treatment in the late 1990s.

However, once substitution treatment has reached an established position in the drug policy field, user interest groups focusing on patient rights could be growing in importance and establish a position in the field. Finnish treatment experts (see Halonen 2004; Holopainen 2004) have already hoped for an

¹² The number of clients in outpatient care is the only context where somewhat comparable data from different EU-countries is available.

evolution of drug patient unions. Opiate users in substitution treatment may slowly be winning recognition as “normal” patients alongside other patient groups.

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