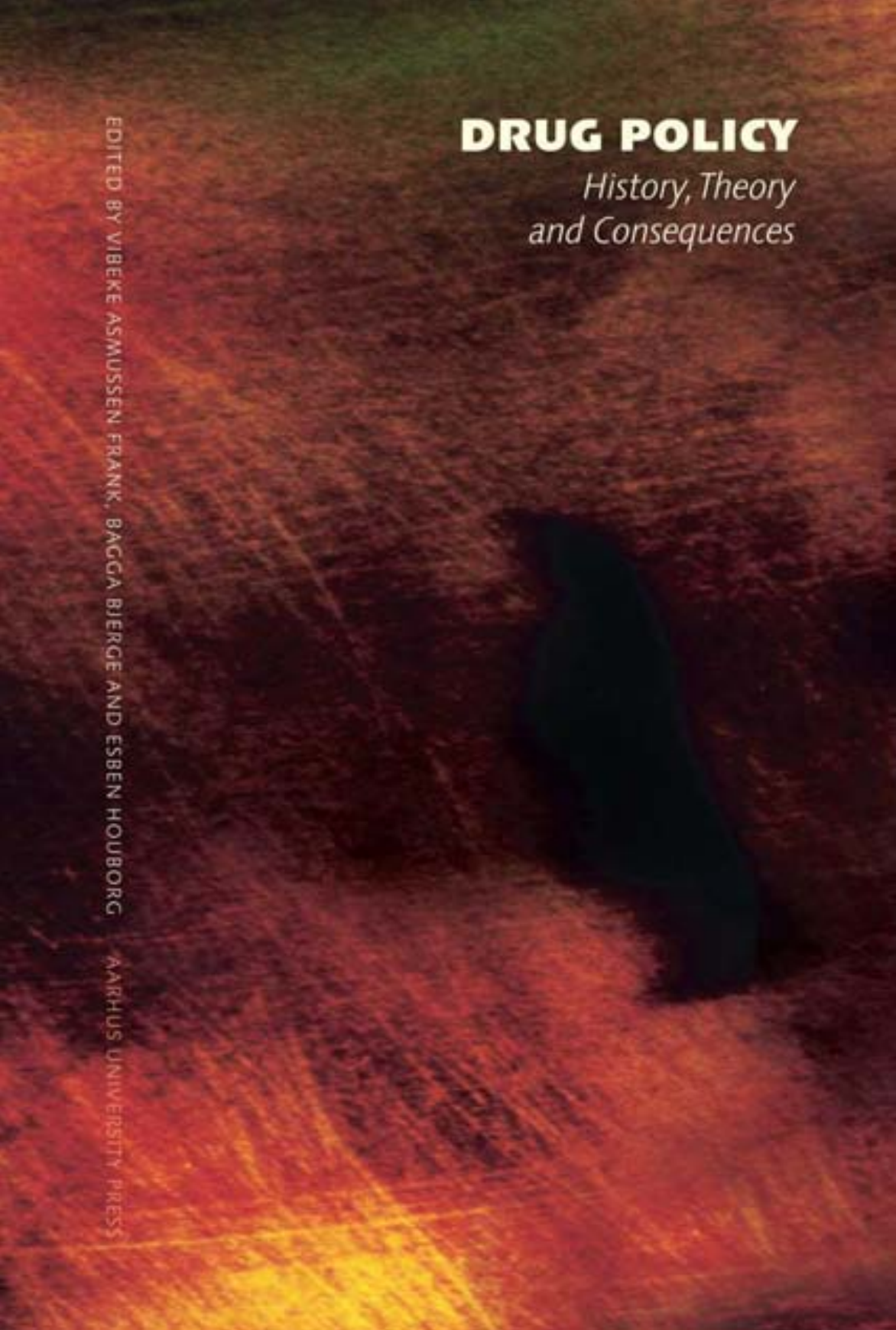
Drug policy: history, theory and consequences ; examples from Denmark and USA

Asmussen Frank, Vibeke (Ed.); Bjerge, Bagga (Ed.); Houborg, Esben (Ed.)


DRUG POLICY
History, Theory
and Consequences
EDITED BY VIBEKE ASMUSSEN FRANK, BAGGA BJERGE AND ESBEN HOUBORG
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DRUG POLICY

– HISTORY, THEORY AND CONSEQUENCES

Examples from Denmark and USA

In memory of Lau Laursen Storgaard
Distinguished Danish drug policy researcher

DRUG POLICY

Edited by
Vibeke Asmussen Frank, Bagga Bjerge & Esben Houborg

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PREFACE

This book is the outcome of the curiosity of several social drug researchers about how drug policies emerge and spread into many and often surprising areas of social life. In their effort to satisfy this curiosity, some of the researchers taking part have set up projects to do research on drug policy or included drug policy as an important topic in their ongoing research. How does international drug policy take local forms? What are the practical and ideological implications when national drug policies change? How should we approach the drug field as social scientists? How can we understand the processes that transform policies into social life? Questions like these have forced the authors to make choices as well as rethinking drug policy as a field of study. The aim of drug policy is usually perceived as the regulation of drugs, comprising drug control, treatment, prevention, and/or harm reduction. The authors show that studying these different elements as interrelated areas instead of separate areas leads to important insights into the drug research field in general.

All the authors but one are (or have been) employed at the Centre for Alcohol and Drug Research, Aarhus University, Denmark, and have a professional background in anthropology, criminology, or sociology. All the empirical examples but one are also from Denmark. The last contribution is from the US. The opportunity to explore differences and compare research between a welfare society like Denmark and the US (which is the world's leading drug policy maker) has been important to all the authors. We should like to thank the Faculty of Social Sciences, Aarhus University, for making it possible to discuss and exchange experiences across the Atlantic by supporting a seminar on drug policy held in Århus in April 2007.

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Finally, we thank all the peer reviewers who willingly took upon them to read and criticize the articles. Their comments and constructive advices have made them all better.

Århus, September 2008
Vibeke Asmussen Frank, Bagga Bjerge & Esben Houborg.

Esben Houborg, Bagga Bjerge & Vibeke Asmussen Frank

INTRODUCTION: DANISH DRUG POLICY – HISTORY, THEORY, AND THE INTERNATIONAL FRAMEWORK

Danish drug policy has seen considerable changes since the turn of the century. These changes have been on two fronts. First, formal government policy has undergone a number of changes which have made Danish drug policy more restrictive – although on the other hand the political focus on treatment which started in the mid-1990s has continued, for instance by making drug treatment a social right and making heroin substitution treatment possible. These developments can, as we will show below, be understood by applying a number of well-known concepts in drug policy analysis. The second front in the development of drug policy in Denmark concerns a veritable proliferation of drug policies. An increasing number of players and institutions such as parents, local communities, educational institutions, sports clubs and private enterprises are now engaged in developing and carrying out drug policies. Sometimes this is a consequence of new governmental strategies on behalf of public authorities. But frequently it is also because drugs and living with drugs are now an immediate concern for many people and institutions. Not only in relation to the dangers of drug use, but also a focus on drug use and drug dealing as a nuisance in local communities. The development of Danish drug policy on these two fronts makes it very relevant to study Danish drug policy today. Without claiming to present a comprehensive account of these various developments, this volume will include contributions that supply some of the first pieces of the increasingly complex puzzle of Danish drug policy today. This will be done under three headings dealing with various levels of drug policy. First, the ways in which drug policies are developed in various institutional settings like prisons and social institutions for homeless people. These studies deal with the way drug policies vary as they are developed and

practised in various institutional conditions, and the way particular conditions (the prison setting, for instance) can place severe constraints on the kind of drug policies that can be implemented. Secondly, we include studies of the way in which drug policies are developed and carried out at local level in two Danish cities, and the effects and consequences of these local drug policies. The third and final section deals with drug policy more on a macro level in terms of the historical development of modern Danish drug policy, with regard to legislation, law enforcement and treatment. It also contains a contribution from the USA, which shows one particular version of how drug policy proliferates into all sorts of different policies and practices. In this introduction we will provide a framework for these various contributions to this volume. We will elaborate on the current state of Danish drug policy on the two fronts mentioned above – the formal drug policy of the Danish government and the proliferation of drug policies beyond the state. It is the opinion of the editors that these developments in Danish drug policy provide a fertile basis for the articulation of new empirical problems and analytical questions in drug policy analysis, some of which will be presented. When discussing the framework and conditions of drug policy it is not possible to ignore the international drug control system, which puts a number of constraints on how problems can be defined and which solutions can be developed both nationally and locally. This introduction will therefore also present this system to readers who are not familiar with it, and discuss the room for variety in drug policy, which this system leaves.

Danish drug policy

Drug policies usually comprise a mix of three or four different ways of regulating drugs. These are: drug control, which encompasses drug legislation and law enforcement; drug treatment for people who have drug problems; drug prevention to stop people from starting to use drugs; and finally harm reduction, which has the goal of minimising the risks and harm of ongoing drug use. Against this background the particular drug policy of a country, region or city can be characterised according to the content of and balance between these different elements of drug policy. The overall drug policy resulting from such a mix is sometimes described according to how it prioritises

use reduction and harm reduction – comparing stopping or minimising use as much as possible against minimising the harmfulness of use (MacCoun, Reuter et al. 1996; MacCoun 1998; MacCoun & Reuter 2001). There is not necessarily a contradiction between these two goals, but there may be. It is all a matter of degree. Too much effort put into stopping or minimising use can lead to higher risks and more harm for people who continue to use drugs (O'Malley & Mugford 1991).

Modern Danish drug policy was born in 1955 with the Act on Euphoriant Drugs (see Jepsen in this volume). This act was in principle a regulatory instrument with an added penal clause, which raised the penalties for violations of the drug legislation to two years from the six-month maximum of the Opium Act, a predecessor to the Law on Euphoriant Drugs that focused on production rather than use. The Act on Euphoriant Drugs made the possession of illegal drugs for personal consumption an offence in Denmark for the first time (Nimb 1961; Jepsen 1966; Kruse, Winsløw et. al. 1989). However, in connection with the promulgation of the act it was stated that the penalisation of possession was not meant to criminalise users, but was only meant to be a short cut to criminalising possession with the intent to deal. During the years 1965-1969 an increasing number of charges were made in connection with possession (primarily of cannabis). Particularly in Copenhagen the numbers rose steeply, although the dominant reaction was a simple caution. Only a few minor dealers were charged, and here the primary reaction involved fines. The rising number of cases was among the reasons for the creation of a separate provision in the penal code in 1969 (§ 191 of the penal code) for particularly serious violations of the Act on Euphoriant Drugs, which raised the maximum penalty to six years. Less serious violations were still dealt with under the Act on Euphoriant Drugs, with its maximum of two years' imprisonment.[1] The Danish Parliament wanted to avoid a 'rub-off effect' of the rise in penalties, and did not want to criminalise the large number of young people experimenting with drugs, particularly cannabis. So an agreement was made between the Parliament and the Ministry of Justice, which told the Attorney General to issue a circular instructing police and prosecutors not to go after simple possession, particularly not young people (for details see Jepsen in this volume). Law enforcement was to be used primarily against drug dealers and drug traffickers, while other means like treatment,

education, social services and prevention were to be used against drug users (Laursen 1995; Storgaard 2000; Laursen & Jepsen 2002). Following this de-penalisation of possession for personal consumption, the number of charges for possession dropped while the number of charges against serious violations rose in the following years. This de-penalisation of possession of drugs for personal consumption has meant that Danish drug policy was considered to be relatively liberal by international standards. Contributing to this image was also a distinction between 'hard' and 'soft' drugs, which was introduced in 1975 in connection with an increase of the maximum penalty for serious drug crimes.

This liberal drug policy ended in 2004 when parliament decided to re-penalise possession of illegal drugs as part of an overall zero-tolerance drug control policy. This, in turn, was embedded in a more general change of the politics of law and order in Denmark. But this move towards more restrictive drug control is only part of the picture. Because at the same time as legal control has been made more restrictive, drug treatment has also been given a high political priority. In the 1990s drug treatment saw an infusion of resources, and political attention with regard to treatment increased from the mid-1990s (Storgaard 2000; Houborg 2006). Since the turn of the century, drug treatment has continued to be an important political issue, owing among other things to a high death rate among people with drug problems in Denmark (Sundhedsstyrelsen 2007), and following this pressure to implement new measures like heroin maintenance treatment. In 2003 it became a social right to receive drug treatment within 14 days of application for treatment (L37/2003). It is therefore no longer possible for the social authorities to turn people applying for drug treatment away for any reason. The present treatment policy continues a policy of having a differentiated treatment system, which provides a variety of different kinds of drug treatment in order to accommodate different kinds of clients and different kinds of drug problems. This policy started in the mid-1980s under the slogan 'differentiated goals', and means that drug treatment should not have abstinence as the only goal, but should be able to reduce the problems and improve the resources of people with drug problems, even if they continue to use drugs (Alkohol- og Narkotikarådet 1984). This has been the basis of a treatment system in which methadone maintenance treatment plays a substantial part, even though it is

drug-free treatment, which receives most political attention. In the 1990s it was also the basis for the establishment of many low-threshold institutions, which provide care and service for drug users. This policy has continued and been expanded since the turn of the century, for instance by setting up low-threshold health services like street-level health clinics, drop-in centres and outreach workers (Pedersen 2003; Grytnes 2004; Siiger 2004). While there has largely been political consensus about Danish treatment policy for drug problems, the same has not been the case for Danish drug control policy. The latter has been (and continues to be) an area of political conflict.

The overall purpose of modern Danish drug policy since it was established in 1955 by the Act on Euphoriant Drugs has been to reduce the use of illegal drugs. But for 35 years Danish drug policy made a distinction between the measures applied to the supply side and the demand side of the illegal drug market respectively. Law enforcement and legal sanctioning were the primary measures against the supply side, while other more 'social' measures were applied to the demand side in order to avoid the criminalisation of drug users. The 2004 re-penalisation of possession for personal use has made law enforcement and legal sanctioning an even more important element of Danish drug policy than it already was. It has been given a much more important role in the regulation of the demand side of the illegal drug market, where (until 2004) other kinds of social control were the primary means of regulation in order to avoid the criminalisation of drug users, as we have already discussed.

Harm reduction

The first real introduction of harm-reduction thinking in Danish drug policy occurred in the mid-1980s, when the principle of working towards 'graduated goals', as mentioned above, was introduced. This was a major policy change from a treatment policy, which had until then made abstinence the primary priority. This policy change towards providing treatment and help, even to people who continued to use drugs, was stressed even further in the following years, when prevention of AIDS became a major concern for Danish drug policy. This shift in thinking about treatment was a major factor behind the development and (for a long time ambivalent) acceptance of methadone

maintenance treatment in Denmark (Houborg 2006). The AIDS problem led to the introduction of syringe exchange programmes in Denmark, albeit with large local differences. From the early 1990s social exclusion became a major concern in Danish social policy, and as a consequence large resources were allocated to develop new measures and services for socially excluded people, among them drug users (Narkotikarådet 1999; Bømler 2000). Accordingly, many low-threshold institutions as mentioned above were established.

Denmark has been more reticent with regard to more controversial harm-reduction measures. The white paper called *The Fight against Drugs* (Regeringen 2003), which articulates current Danish drug policy, argues that new measures in Danish drug policy should always be judged not only by the extent to which they help the people they target, but also according to how they affect the way we live with drugs in Denmark more generally. More specifically, steps should be measured according to how they affect the prohibition of all non-medical and non-scientific use of narcotic drugs, which has been the basis of Danish drug policy since the Act on Euphoriant Drugs in 1955, but underlined by the signing of the United Nations 1961 Single Convention on Narcotic Drugs (see below). This means that even if there is evidence that a measure helps the people it targets, it should only be implemented if it does not violate this basic principle of Danish drug policy, which it might do by 'sending the wrong signal' that drug use is acceptable, for instance. According to *The Fight against Drugs*, evidence about the effects of specific measures should always be subjected to the political discussion about how we want to live with drugs. Ever since the birth of modern Danish drug policy in 1955, the political majority has been in favour of a use-reduction drug policy as the primary goal of Danish drug policy, instead of a drug policy which has harm reduction as its primary goal.

On this basis *The Fight against Drugs* rejected both heroin maintenance treatment and safe-injection facilities, although to some extent this was done on different grounds. Heroin maintenance was largely rejected on pragmatic grounds: it was too expensive, and it was not appropriate to implement a controversial measure as long as the existing measures were not used to the maximum extent. It was acknowledged that heroin treatment might not constitute a formal violation of the conventions, because it would be defined as medical treatment. But it was felt that it would send a mixed signal about

heroin as an illegal drug. This pragmatic rejection of heroin treatment made it relatively easy for the government to change its position when a majority emerged in the Danish Parliament in 2007 in favour of heroin treatment. Thus, on the state budget for 2008 and 2009 roughly EUR 10 million has been allocated to an experiment with heroin treatment. Safe-injection facilities have been rejected on more formal grounds, because they were seen as a direct violation of the prohibition against the non-medical and non-scientific use of illegal drugs. According to *The Fight against Drugs*, safe-injection facilities would violate not only the foundations of Danish drug policy (both formal and ideological), but also the international drug control treaties, which Denmark has signed.

Denmark and the international drug control system

The central concern of Danish drug policy to maintain a prohibition against all non-medical and non-scientific use of narcotic drugs reflects a close adherence to the international drug control system, revealing how much this system means to Danish drug policy – more perhaps for current Danish drug policy than for the drug policy of other countries. Because whereas the Danish government has been reluctant to implement new harm-reduction measures by referring to the international drug control system, other countries like the Netherlands, Germany, Switzerland and Australia have explored the flexibility of the international drug control system to the limit. Once again, political decisions are involved here. In order to understand this, let us now take a short look at the international drug control system and its relevance as a framework for national drug policy.

The international drug control system is based on three United Nations conventions: The 1961 Single Convention on Narcotic Drugs[2], the 1971 Convention on Psychotropic Substances[3], and the 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances.[4] The first two conventions established the basic control system, while the last one is primarily concerned with how control should be enforced and with international cooperation against international drug trafficking (Boister 2001; Bewley-Taylor 2003). The control system is a prohibitionist system, which requires the signatory states to limit the use of a number of substances exclusively

to medical and scientific purposes, and to prohibit all other uses of these drugs. While the 1961 and 1971 conventions only required the nations to apply a criminal policy to the supply side of the illegal drug market, the 1988 convention (article 3 § 2) required the signatories also to make the possession of drugs for personal use a criminal offence under their domestic laws (Krajewski 1999; Bewley-Taylor 2003; Fazey 2003).

The control system consists of a number of lists (or schedules, as they are called) designating varying degrees of control for various drugs according to an evaluation of their addictiveness and potential for abuse (Boister 2001; Bewley-Taylor 2003). Schedule 1 consists of drugs, which are subject to the standard control mechanisms of the conventions, including drugs like heroin, cocaine and cannabis. The control mechanisms for these drugs should include: these drugs should only be produced, traded, used and possessed for medical and scientific purposes and only under licence from the state; journals should be kept for the exchange of these drugs; to pass such drugs on to individuals should require a medical prescription; and a system should be established to limit the amount of these drugs in the country. Schedule 2 contains drugs used for medical purposes, which are seen to have less potential for abuse and therefore require less control than the drugs on schedule 1. Schedule 3 consists of pharmacological products which contain only small amounts of psychoactive substances and therefore require even less control than the drugs on schedule 2. Finally, schedule 4 consists of drugs, which are deemed to be particularly dangerous. These drugs should be included in schedule 1 subject to the control mechanisms of these drugs, but they should also be subject to special control measures, which the signatories deem necessary, e.g. prohibiting any production, possession, exchange and use of these drugs unless scientific purposes are involved. Included on this list are drugs like heroine, cocaine and cannabis (Bewley-Taylor 2003). The World Health Organisation (WHO) is responsible for the medical and scientific assessment of psychoactive substances according to their addictiveness and potential for abuse, and advises the Commission on Narcotic Drugs (CND) (see below) about how drugs should be classified (Bewley-Taylor 2003). The assessment and scheduling of psychoactive drugs by the international drug control system is debated, particularly the fact that drugs like heroin and cannabis are both on the list of particularly dangerous drugs despite

the differences between their addictiveness and psychoactive effects (Zimmer & Morgan 1997; Bewley-Taylor 2003). The reason for this 'political pharmacology' (Asmussen & Jöhncke 2004) is that the basis for scheduling is not only the pharmacological properties of the drugs, but also an assessment of their therapeutic value, as well as a political decision about what is acceptable to society (a question of morality). This means that even if it is not possible to point to particularly dangerous properties of a drug, it can still be put on schedule 4 because it lacks therapeutic value or is politically and morally unacceptable. This is why the debate about the medical use of cannabis is possible (e.g. www.medicalcannabis.com). The international drug control system thus represents a particular medico-political way of thinking about psychoactive substances. This is e.g. reflected in the fact that the Single Convention (article 49) in 1961 stated that any existing quasi-medical and non-medical use of e.g. coca and cannabis should be discontinued within 15 to 25 years.

Given the fundamental prohibitionist character of the conventions, a central question is how much room the conventions leave for countries to develop more liberal drug policies with regard to handling the non-medical use of illicit substances. This issue is central to the discussions about drug policy in Denmark, both with regard to penalisation/de-penalisation of possession of drugs for personal consumption and with regard to the more controversial treatment and harm-reduction measures like heroin maintenance treatment and safe-injection facilities. Two issues in particular are discussed in this connection: first the possibility of not enforcing or 'soft' enforcing drug legislation with regard to possession for personal use; and secondly the possibility of defining addiction as an illness and on this basis prescribe heroin or other drugs for treatment (Fazey 2003).

With regard to the first issue, the UN drug conventions are treaties of indirect applicability, which means that they have to be implemented into national legislation according to the constitutional principles and basic concepts of the legal system of the states concerned (Krajewski 1999; Lenton et al. 2000; Bewley-Taylor 2003). This means that even though the signatory states are required to make the possession of illicit drugs a criminal offence, they have discretion with regard to how serious an offence they want to make it, and with regard to if and how they want to enforce this legislation (Kra-

jewski 1999; Jepsen 2001; Bewley-Taylor 2003; Fazey 2003). For instance, possession for personal consumption can be defined as a petty crime, which only requires a small fine, a warning or no sanction at all. This was at the heart of the Danish de-penalisation of possession of cannabis for personal consumption and the well-known liberal drug policy of the Netherlands. Concerning the second issue the conventions do not define 'medical and scientific purposes', thereby allowing states to prescribe controlled substances for medical treatment including addiction, if this is defined as an illness (Fazey 2003). In the case of the forthcoming Danish use of heroin for maintenance treatment, the only requirement is that the Minister for Health removes heroin from schedule 4. These arguments for flexibility for the signatory states are highly debated, and one of the UN drug control agencies in particular, the International Narcotics Control Board (INCB), does not agree that such 'liberal' measures are possible under the international drug control system.

The UN drug control conventions are administered and supervised by a number of UN bodies and agencies (Albrecht 2001; Boister 2001; Fazey 2003). The most important of these are the United Nations Commission on Narcotic Drugs (CND)[5]; the International Narcotics Control Board (INCB)[6]; and the United Nations Office on Drugs and Crime (UNODC)[7]. The CND is the policy-making body of the international drug control system. It has 53 member states elected by the Economic and Social Council of the United Nations (ECOSOC), and its main task is to analyse and discuss the world drug situation and make proposals on and implement international drug policy. The commission works on the basis of consensus, which makes it difficult to make any major changes of international drug policy, because it only takes one nation to obstruct such new measures.

The INCB is the independent monitoring body for the implementation of the UN drug conventions, and is considered to be the watchdog of the conventions because it monitors whether the parties uphold their obligations according to the conventions. The Board cannot sanction violations of the treaties, but can publish its criticism of countries which it thinks fail to do so. Furthermore, the Board administers the international system for legal trade in narcotic drugs, which involves each nation reporting each year how much of the controlled substances it expects to stock for the next year and what happened to the drugs it has stocked for the past year. The INCB has

13 members, which are elected for a five-year period. Three of the members are medical, pharmacological or pharmaceutical experts elected from a list put forward by the WHO. Ten members are elected from a list nominated by members of the UN. The INCB publishes an annual report, which includes an analysis of the world drug situation with regard to trends in use, production and trafficking, developments and changes in national drug policies, and recommendations about how nations can uphold their obligations to the conventions. Both in its annual report and on other occasions, the INCB issues statements about the drug policy of various countries if this policy goes against the prohibitionist ideology of the UN drug conventions (INCB 2001, 2002, 2003, 2004; Fazey 2003; Bewley-Taylor 2005). The INCB has thus been directly involved in the drug policy debate in various countries, for instance the Swiss debate about heroin maintenance treatment and the Danish debate about safe-injection rooms. In Denmark, during a discussion about establishing public safe-injection facilities in Copenhagen, the government consulted the INCB regarding its opinion about the legality of such a measure before passing legislation to make such a measure possible. Not surprisingly, the INCB stated that such a measure would be against the fundamental prohibition of all non-medical and non-scientific use of controlled substances under the conventions, and hence the issue was dismissed by the government and a majority of the Danish Parliament. This is perhaps the clearest example of the close connections between Danish drug policy and the international drug control system, connections which have grown closer with the changes of Danish drug policy in recent years.

The UNODC is the administrative body of international drug policy. It helps member states to adopt and implement drug control policies, and functions as a secretariat for both the INCB and the CND. The UNODC does analytical work and supervises the international drug situation, publishing The World Drug Report each year. The agency is funded mainly by contributions from the member states, with the USA as the largest contributor. This has led to criticism that because of its financial dependence on the USA the UNODC is biased against harm-reduction measures (Bewley-Taylor 2005). For instance, it has been reported that the UNODC removed references to harm reduction in its printed and electronic statements after the United States threatened to cut back funding of the office if it supported harm reduction

(Bewley-Taylor 2005; Pancevski 2005; Transnational Institute 2005). However, recently UNODC has released a discussion paper on harm reduction (UNODC 2008).

A number of international non-governmental organisations (NGOs) monitor the work of the UN agencies, e.g. by publishing reports commenting on the World Drug Report by the UNODC and on what they see as the biases of this publication towards a prohibitionist line.[8] Such NGOs also attempt to influence the development of international drug policy, particularly when international drug policy is up for discussion in the Commission on Narcotic Drugs or when the United Nations General Assembly discusses future international drug policy – as it did in 1998 and will do again in 2009. At the same time, some NGOs work to retain the status quo. The involvement of these NGOs in international drug policy shows that drug policy is not only a matter of government legislation and the activities of public authorities. In many countries including Denmark, NGOs and society as a whole play an important role in developing and carrying out drug policies, for instance by setting up needle-exchange programmes or low-threshold services for drug users. Sometimes this is done in collaboration with public authorities, and sometimes it is done autonomously. As mentioned earlier in this introduction, not only society as a whole but also the private market seem to have grown increasingly involved in drug policy in recent years. More and more players and institutions seem to be engaged in developing and carrying out drug policies.

New networks of drug policy development and delivery

The white paper *The Fight against Drugs*, which we discussed above as the ideological foundation of current Danish drug policy, acknowledges that the drug problem will not go away. It is a social fact with which we have to live. This does not mean that Danish drug policy, and more particularly its prohibitionist foundation, is seen as a failure. Quite the reverse: Prohibition is seen to have kept the prevalence of illegal drug use in check. Since the 1990s the use of illegal drugs has received much public and political attention. One reason for this has been a significant increase in the prevalence of illegal drug use in Denmark from the mid-1990s to the early years of the new millennium mentioned above, particularly among young people. Another related reason

has been signs of what has been called a new drug culture among young people (Sundhedsstyrelsen 2000; 2004; Københavns Kommune 2006). In this drug culture the use of illegal drugs is seen as a mainstream phenomenon, which is no longer associated with particular subcultures and stigmatisation. According to the reports, such use is regarded as socially acceptable behaviour even among young people who do not use drugs. Following this it is also reported that drug use is no longer a clandestine activity, but something done in the open. Users and non-users are no longer necessarily separated from each other. This all adds up to a description of drug use in these reports as an individual consumption choice. These reports about an increasing prevalence and acceptance of drug use among young people as an ordinary activity have been supplemented by numerous newspaper stories about the ubiquity of drugs, about how drugs are everywhere young people go as an almost natural part of their environment. Together these reports paint a picture of what the international literature has called a 'normalisation' of drugs among young people (Parker 2005), something which seems to have been one of the governing images behind recent Danish drug policy.[9]

This image has been part of the motivation behind the shift towards a zero-tolerance policy on possession, which we have already discussed based on the argument that it is important to send a clear signal of the unacceptability of drug use in the face of changing norms about this activity. But it has also been an important factor behind a project carried out from 2003 to 2007 in which 14 municipalities were to engage a number of different players as stakeholders in the development of local drug policies (Sundhedsstyrelsen 2005; Sundhedsstyrelsen & Muusmann Consulting 2007). The aim of the project was to limit the availability of drugs and the number of young people who use and experiment with drugs. The project was called 'Get the drugs out of town' ('Narkoen ud af Byen' in Danish), and it crossed the boundaries between state, market and civil society by engaging parents, schools, sports clubs, commercial and non-commercial party venues etc., as stakeholders. This project is perhaps the most visible sign of a political strategy which attempts to regulate drugs by governing through the local community and creating networks of players to bridge the gap between public and private, commercial and non-commercial.

Part of the project involved institutions developing their own drug poli-

cies. This is, however, not something that only happens as part of an official government policy. Whether it is because of the image of the normalisation of drug use or not, the question of how to handle drugs seems today to be a matter of immediate concern in a variety of different contexts. And because of these concerns players and institutions, which are not usually thought of in terms of drug policy are now involved in the development of ways of handling drugs. Private enterprises, sports clubs and other groups and societies actively think about and develop ways of handling drug use. There is an emerging market for private drug solutions; parents and other interested parties are taking it upon themselves to conduct drug control; drug users themselves are letting themselves be heard about drug control and drug treatment; and in local communities citizens are organising ways of developing drug solutions or putting pressure on public authorities.

The development of new drug policy networks addresses not only young recreational drug users or employees and other members of 'mainstream' society, but also marginalised hard drug users like those living in the transit areas of our big cities. In some of these areas citizens organise themselves in various ways in order to develop drug solutions or to affect the way in which public authorities and local institutions handle drug problems. In the neighbourhood Vesterbro in Copenhagen two different groups of citizens organised in order to solve the problem of drug use and drug dealing being a nuisance to the local community. One group of citizens saw removing drug users as a solution, the other argued for more harm reduction measures. The former saw the social work done in one of the churches in the parish as the major problem to why hard drug users congregated in the area. With the primary agenda of stopping this social work candidates ran for election to the parish council. They did not, however, succeed. On the other hand, in the same community a network of different players including both public authorities (e.g. for funding) and local citizens has been created in order to develop new drug policies for the community. One of the steps taken is the establishment of an organisation that promotes 'health rooms' – a place where drug users can come to inject their prescribed drugs – as a solution to the local drug problem (Olsen 2008).

Drug policy today is therefore not only a matter of government policy and government institutions, but also something, which is developed and carried

out by networks of players and institutions, which are both public and private. This means that the organisation of how we live with drugs is following trends which can also be found in other policy areas like social policy and crime control (Garland 1996; Loader & Sparks 2002), where private players and public-private partnerships are part of policy development and policy delivery. This suggests that even if it is still relevant to pay close attention to government policy and the activities of government institutions, something could be learned by occasionally shifting our focus from the institutions of government to the activity of governance (Osborne & Geabler 1992) in our analysis of drug policy, i.e. how families are advised to develop their own drug policies in order to be prepared, when its younger members will be confronted with illegal drugs. In the following paragraphs we will present two analytical perspectives which we suggest may be fruitful in the analysis of drug policy if we make the practicalities of how drug problems are defined and solutions developed the centre of our attention, irrespective of who is involved in this work.

Drug policy as governance

Policy is often associated with a deliberate plan of action worked out by public authorities, enterprises or organisations in order to handle a state of affairs, which has become a matter of concern or something, which requires action. Policy can also be associated with individuals who develop particular ways to handle particular situations. For instance, dieting can be thought of as an individual's policy with regard to eating. These ways of considering policy all involve a pre-established player – public authority, enterprise, organisation or individual – developing a plan of action. However, policy can also be thought of as the effect of an association of different players joining forces as stakeholders in the management of some state of affairs because they are concerned about it, or because they are called upon by others to handle it. In this case policy cannot be attributed to a particular player, but has to be seen as an effect of the interaction of a multiplicity of players, who deploy a number of methods, techniques and forms of knowledge in order to control or manage a state of affairs (Hunt & Wickham 1994; Dean 1999). This is, in other words, a conception of policy which is well suited to the analysis

of some of the new drug policies 'beyond the state' (Rose & Miller 1992) which we have described above. To understand policy in terms of governance means to look at *how* policy comes about irrespective of who is involved in developing and carrying out this policy. Policy as the effect of the interaction between a heterogeneity of different players is nothing new. The way we define and handle things like poverty, unemployment, crime or drugs and drug use has often resulted from such associations and interactions (as Jepsen's and Houborgs's contributions to this volume show). However, it has been argued that owing to increasing societal complexity and differentiation non-governmental players are becoming increasingly involved in the management of public issues and problems. According to this perspective, policy is increasingly something, which is developed by networks of players who come from and interact across different sectors of society, blurring the distinctions between states, market and civil society (Kooiman 1999).

To think of policy as a deliberate plan of action involves – as mentioned above – a state of affairs coming to the attention of one or more players as something which requires action. This is often the case when established ways of thinking, talking and acting become problematic because they are confronted with something which they are not immediately able to handle (see Houborg in this volume). But before such a denaturalisation occurs, the policy of handling drug problems, for instance, can be more or less tacitly embodied in the social and material infrastructure of society. This means that policy should not only be analysed as something coming from the outside, but also as something which can be embodied in the behaviour and world views of the players involved as well as in the social organisation of institutions like treatment centres and the various methods and techniques used. When new organisational or administrative structures or new technologies and methods are introduced in a system, the possible field of action (Foucault 1982) of the people who work there is altered (see Bjerge in this volume). If 'empowerment' is one of the dominant ideological elements of public substance-abuse treatment policies, it is likely that both the treatment staff and even the drug users will be affected by it in their everyday lives. Even if public practitioners do not agree with the dominant policy, they still have to relate to it because it is inscribed in daily procedures such as action plans and demands for empowerment-oriented treatment in the organisation. In

short, specific policies determine the scope of their possible actions in the field. Implicitly, this will sustain the social order, which a certain policy tries to set up. In this perspective, when we study drug policy we should not merely see it as a set of rules and regulations, but also as an expression of an underlying rationale and as a wish to govern.

Drug policy as practice

There seems to be a general perception that when a law or regulation is passed it is implemented in the way it was planned and has the effects it was planned to have. For instance, when the Ministry of Social Affairs in Denmark declares a 14-day treatment guarantee for people who wish to be enrolled in a drug treatment programme, one would expect this to happen. This, however, is not necessarily the case in practice (Pedersen & Nielsen 2007). Sociological, anthropological and political science studies of everyday practices in crowded local government offices, public treatment centres and shelters show that laws and regulations are interpreted, manipulated and acted out in various ways (Moore 1978; Lipsky 1980; Winter 2004).[10] To understand a policy, it is therefore necessary to take the context in which it is implemented into account. All sorts of different factors may influence the outcome of a policy; economic constraints, high work pressure, competing moral positions and rationalities. In Lipsky's words:

> I argue that the decisions of street-level bureaucrats, the routines they establish, and the devices they invent to cope with uncertainties and work pressures, effectively *become* the public policy they carry out. I argue that public policy is not best understood as made in legislatures or top-floor suites of high-ranking administrators, because in important ways it is actually made in the crowded offices and daily encounters of street-level workers (Lipsky 1980: xii).

In other words, if one wishes to understand the effects of a policy in practice, one has to investigate actions, interpretations and strategies carried out in these everyday practices. This perspective recognises the actor as relatively autonomous and focuses on situated practices in particular institutional set-

tings in order to explain policy by deploying both institutionalist (Prottas 1978; 1979; Lipsky 1980) and interactionist (Zimmerman 1969; Holstein & Miller 2003) theories. Users and practitioners develop strategies and coping mechanisms and play specific roles to overcome stressful dilemmas, or try to push their personal agendas through by interpreting policies actively. This perspective acknowledges the societal framework of actions and conduct. For instance, a substance-abuse treatment centre is regulated by its position in the public sector, by its economy, by laws regulating social service etc, and by societal notions and norms of conduct. But the focus is on the ways in which actors try to overcome dilemmas between the demands of users and clients on the one hand, and the organisation on the other. Thus, it is through the interactions between the institutional context, employees, users, laws and regulations that policy takes effect in practice.

Contributions of this volume

As mentioned at the beginning of this introduction, the contributions to this volume fall under three headings. The first concerns the development of drug policies in various institutional settings; the second concerns local drug policy; and the third puts Danish drug policy into a historical context and shows the USA as an example of a country in which drug policy has proliferated vastly.

As discussed above, Danish drug policy has seen a number of significant changes in recent years. The changes of formal drug policy in themselves make Danish drug policy an interesting topic of research. The first two contributions analyse the way drug policies vary as they are developed and practised in various institutional conditions. Charlotte Siiger analyses how drugs and drug policies are negotiated among staff in hostels for the homeless. Vibeke Asmussen Frank & Torsten Kolind analyse the balance between drug control and treatment practices in a prison setting. Both studies discuss how drug policies take form in practice. The next two contributions analyse the way in which drug policies are developed and carried out at local level in two Danish cities. The re-penalisation of possession of drugs for personal use and the much harder policy on cannabis might even be said to constitute a natural experiment, which it is very interesting to follow. Kim Møller's contribution

to this volume is one of the first analyses of this experiment. Helle Vibeke Dahl discusses how local control policy in a major city in Denmark influences the everyday lives of drug users, both as clients in methadone clinics and in relation to their use of city space as congregation points. Her contribution also shows that the various elements of drug policy (treatment and nuisance policy) are experienced by drug users as one and the same thing. The third and final section contains four contributions and deals with drug policy more on a macro level in terms of the historical development of modern Danish drug policy, with regard to legislation, law enforcement and treatment. In various ways the contributions by Jørgen Jepsen, Esben Houborg and Eric Jensen show the constitution and development of drug policies at a more structural level. Focusing on control policy Jørgen Jepsen discuss the development of modern Danish drug policy. Esben Houborg analyse how the new youth culture associated with the modern drug problem of the 1960ies became a major challenge for institutions responsible for handling deviance and producing social integration – the child- and youth welfare system, the psychiatric system and the prisons. And he shows how a separate drug treatment system emerged, partly because it was better suited to handle this new youth culture. The contribution by Eric Jensen shows the American version of how drug policy proliferates into all sorts of different policies and practices. These three contributions show that drug policy is affected not only by changes in drug control but also by policy developments occurring outside the traditional realm of drug policy. This is also the focus in Bagga Bjerge's contribution where she analyses the effects of the large-scale structural reform of Danish social policy on local municipal drug policies.

Overall the contributions give insights into various levels of drug policy. It is not, however, the claim of this anthology to give a comprehensive account of Danish drug policy today. But we hope to show a number of significant developments within Danish drug policy and point to a number of problems related to the study of drug policies in general.

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NOTES:

1 These two legal instruments, the Act on Euphoriant Drugs and § 191 of the penal code, are still the backbone of Danish drug control policy.

2 www.incb.org/pdf/e/conv/convention_1961_en.pdf.

3 www.incb.org/pdf/e/conv/convention_1971_en.pdf.

4 www.incb.org/pdf/e/conv/convention_1988_en.pdf.

5 http://www.unodc.org/unodc/en/commissions/CND/index.html.

6 http://www.incb.org/incb/index.html.

7 http://www.unodc.org/.

8 E.g. the International Drug Policy Consortium (http://www.idpc.info/) and the Internatinal Harm Reduction Association (http://www.ihra.net/).

9 Whether this is actually the case is not our concern here, as we are only concerned with the way in which this image underpins drug policy.

10 For an integration of this approach with a governance approach see (Hupe & Hill 2007).

Part I
Drug policy in institutional settings

Charlotte Siiger

CAUGHT IN-BETWEEN: DILEMMA MANAGEMENT AT A HOSTEL FOR THE HOMELESS

Social work is subject to a state of conflict caused by the incompatibility of two overall rationalities: individual client treatment and compassion on the one hand, and mass processing and rule-application on the other (Lipsky 1980: 44-45). These conflicts are mirrored in daily dilemmas when ideals and goals collide with the complex and ambiguous reality of staff-client encounters. Using a Danish hostel for the homeless as an example, this article explores the nature of such dilemmas and the processes involved in trying to solve them.

Roughly speaking, hostels in Denmark can be divided into two categories in terms of drug and alcohol rules: either the use of drugs and alcohol is tacitly accepted in certain areas (e.g. residents' own rooms and outdoors), or it is not accepted on the premises at all[1]. In both cases, hostels are constantly confronted with the issue because the use of alcohol and illicit drugs like cannabis, heroin, cocaine and various kinds of pills is an integral part of homelessness.

In a larger perspective, the difference between rules corresponds to a difference between two competing approaches to drugs: zero tolerance versus harm reduction. Policies of zero tolerance, if interpreted rigidly, maintain that drugs should be prohibited and eradicated through tough-on-crime police actions, and also (something which is important in this context) focus on abstinence when offering drug treatment. In contrast, harm reduction is a pragmatic approach based on the argument that the war on drugs has failed, consequently taking as a starting point that drugs are here to stay. Instead of only one goal of abstinence in treatment, goals should be differentiated and based on individual wishes and realistic assessments. Harm reduction

may or may not lead to abstinence in the long run, but the first priority is to treat the harmful consequences of use. Substitution treatment and free delivery of needles are examples of harm-reduction initiatives (Jepsen 1993; Ege 1997; Narkotikarådet 1999; Asmussen & Dahl 2002; Houborg 2007).

To some degree, this difference in policies is reflected in the rules of hostels: zero tolerance translates into a non-acceptance rule, and harm reduction into an acceptance rule. As a basis for analysis, this article focuses on a hostel that pursues a non-acceptance rule because doing so makes dilemmas engendered by the conflicting rationalities of harm reduction and zero tolerance stand out with specific clarity – there is an obvious paradox in being a provider of services for homeless people who are known to be heavy users, while forbidding them from using drugs at the same time. The paradoxical nature of this rule is also displayed by the fact that forbidding residents to take drugs and drink alcohol, implying a degree of control, collides with a basic idea in social work: that social workers should try to establish a relationship based on confidence with clients. The establishment of such a relationship is considered to be basic if clients are to change or develop in directions that are believed to be better for them.

An equally important aspect of social work is that clients should be treated in a universalistic way – i.e. without discriminating. Despite sincere attempts to live up to this ideal, work is nevertheless, as Michael Lipsky (1980) rightly points out, influenced by worker bias: some clients are preferred to others. Lipsky draws attention to three circumstances in which street-level bureaucrats display biased behaviour: first, some clients simply evoke more sympathy than others; second, some clients are believed to be more worthy of services than others; and, third, some clients are preferred because they respond well to treatment (Lipsky 1980: 108-111).

These biases can also be viewed as elements of a model of social exchange which was developed by Marshall Sahlins (1972). According to this model, social exchange can be categorised in three analytically distinct forms: generalised reciprocity, balanced reciprocity, and negative reciprocity. The difference between the three is in the 'spirit' of exchange, and can be placed on an imagined continuum between two poles with the positive at one end ('people we like'), the negative at the other ('people we do not like'), with balanced reciprocity in the middle ('people we have agreements with, almost

independently of likes and dislikes') (Sahlins 1972: 194-195). Applying Sahlins' model to the categorisation processes of social work, it appears that generalised reciprocity includes clients who evoke sympathy, who are viewed as worthy, and/or who are responding well to treatment. In contrast, clients who are disliked or who do not respond well to treatment are subjected to negative reciprocity. Third, balanced reciprocity includes clients who are considered to be worthy and who respond well to treatment, while issues of likes and dislikes are scaled down.

This article argues that it is not the rule of non-acceptance in itself that causes dilemmas, but the conflicts between several overall rationalities that cannot be united into one unambiguous way of acting. It is at the point of trying to translate these conflicting policies into practice that dilemmas arise. Specific attention is paid to the conflict between rule application and individual client treatment because it seems to permeate all other dilemmas. Furthermore, this article argues that dilemma management in social work has a lot to do with classification processes. Placing relationships and people in categories reduces complexity, thereby engendering more straightforward solutions to problematic situations. Despite its dilemma-ridden nature, everyday life at the hostel nevertheless runs pretty smoothly. This may be partly explained by a pragmatic approach sometimes employed by staff in which they prevent a dilemma arising by not gaining knowledge about offences committed by clients – or by ignoring knowledge they have already obtained.

These arguments are based on an analysis of views and opinions shared by staff when they discuss the consequences of violating the rule of non-acceptance of drug and alcohol. Since meetings among staff constitute the structural frame for the exchange of views and decision-making, these are central objects of analysis. Here certain themes stand out: first, the resident's possible benefits from the services provided by the hostel; second, the worthiness of the resident; and, third, the nature of the relationship between the resident and staff. This analysis has wider relevance for other hostels independently of the nature of their rules, as well as for social work in general.

Analytical frame

This article draws on Michael Lipsky's (1980) classic study of street-level bureaucracy as a main frame of reference. One of Lipsky's important contributions is that he, on the one hand, recognises that practice is influenced by overall rationalities and cultural assumptions in society at large, and, on the other, argues that the actual patterns of actions performed by street-level bureaucrats *are* the policies of an organisation (ibid: 107, 144). Inspired by this approach, policy is here analysed by looking at the way staff react to problematic situations, while at the same time paying attention to the fact that hostels are part of a larger context. For instance, when some clients are favoured at the expense of others even though they should ideally be treated equally, this may be due to limited resources and general ideas of worthiness rather than the likes or dislikes of the social worker concerned (Lipsky 1980: 109). From this perspective it is possible to regard preferential treatment as engendered by organisational constraints and societal values rather than by attributes of human nature.

Along the lines of Lipsky, one common explanation of why street-level bureaucrats diverge from rules is that they feel compassion for an individual resident. In order to explain how staff legitimise the fact that some residents are exempted from the rules while others are not, I supplement Lipsky's analysis with Michel Foucault's (2006) concepts of confession and forgiveness.

To explain how Foucault defines these concepts, a few words about his genealogical strategy of analysis are necessary. He examines the lineage of phenomena and how they have developed and either been transformed or disappeared through history. The genealogical method takes as its starting point a problem or an event in present time, and explores historically how it has become the way it 'is'. Foucault emphasises that the genealogist actively creates a historical problem or event – it is not waiting out there to be discovered independently of its observer. Instead the genealogist selects a point in history at which there seems to be a break in the way power and knowledge interplay; whereby he or she makes a strategic move that gives rise to specific events. In this way, historical events are largely products of the work of the historian rather than being 'true facts' (Foucault 1983b, Villadsen 2003).

Confession is one of the practices that Foucault has examined genealogi-

cally. It can be traced back to at least medieval times, when it became an important ritual to produce truth. Over the years the meaning of confession has been transformed, but as a practice it is still very much alive and has spread widely into most fields of society (Foucault 2006: 65-66), including the field of social work. In this analysis, the practice of confession appears in the way staff try to push residents to tell the so-called truth about their use of drugs and alcohol. According to Foucault's analysis, confession is seen as a way to remove restraints and liberate truth. A characteristic feature of confession, Foucault continues, is that it takes place in a relation of power: one cannot confess without having somebody, at least virtually, to confess to. Relief from mistakes, liberation and forgiveness, is the reward for anyone speaking the truth (Foucault 2006: 69-70). In this respect, the relationship between confessor and forgiver can be termed as one of reciprocity, which points to the relevance of Sahlins' three forms of exchange.

The deployment of Sahlins' model makes it possible to understand how solutions to dilemmas in social work are connected to the way clients are categorised in terms of a reciprocity scale. Roughly speaking, staff at a hostel for the homeless may categorise residents as 'good', 'bad' or 'somewhere in-between'. Note that it is predominantly staff and not clients who determine how the nature of reciprocity should be interpreted. This observation coheres to the asymmetric power relation which is a general condition of relations between a helper and one in need of help. Seen from this perspective, at least, reciprocity of any nature is ultimately never a 'purely' horizontal relation between equal partners. In this context, this is clearly evident in the fact that staff possess the truth and access to salvation, which is, again, conditioned by clients' subordination through confession. The better clients are believed to be, the better their chances of being forgiven for an offence. This point, combined with the fact that staff at the hostel being studied devote some time to discussing drug dealing, makes it pertinent to include Ross Coomber's (2006) study of 'pusher myths' in the analysis. As Coomber explains in his study, drug dealers play the part of ultimate enemies of society, which makes them obvious candidates to enter into a negative form of reciprocity with staff.

Hostels in Denmark

Based on reports from 65 Danish hostels and other services included in the same statistics, 7,291 people (2005 figures) annually live for a short or a long period of time at a hostel. A small number, however, are not homeless in that the statistics cover a slightly broader category (e.g. hostels for battered women). Out of the total from 2005, 56 % are between 30 and 49 years of age; 74 % are men; and 26 % are women (National Social Appeals Board 2006).

The hostels studied are regulated by the Danish Law of Social Services ('Lov om Social Service' in Danish), which stipulates that they are meant for people who have nowhere else to go, and who are experiencing complex social problems. An important element of the work is to prepare residents for a more independent life, possibly with support from outreach workers. The purpose is to create better life conditions and increase the chance of such people being integrated into society. In daily work the idea of integration is reflected in the way staff operate with three categories of integration: occupation, treatment (e.g. for drug and alcohol use or diseases), and housing.

The law also states that the homeless should only stay at hostels on a temporary basis – unlike the law from before 1998, which said nothing about time duration. The shift in 1998 marked an attempt to make efforts more goal-oriented: residents should not only receive care at a hostel; they should also be met with expectations of changing their way of behaving and living. However, the term 'temporary residence' is not a very specific guideline, being open to a variety of interpretations at local levels. Some hostels interpret 'temporary' to mean no more than three months; while others regard it as meaning more than a year. In all cases, staff argue that the time duration depends on an assessment of each individual resident, and on the range of services provided at hostel facilities. Some hostels do not provide many kinds of services because they aim to produce rapid referrals. Others provide a wider range of services, like in-house training, teaching in health-related issues, and art groups. Country Side Hostel, which constitutes the concrete example in this article, belongs to the latter kind. Such hostels distinguish more openly between their clients in terms of inclusion and exclusion: if clients are considered to be possible beneficiaries of hostel services they are allowed to stay; if not, they are soon referred to another facility. In all cases,

'temporary residence' is a condition of work that urges staff to think and act in terms of making residents move on.

The idea is that each resident has a right as well as a responsibility to make his or her own decisions and plans. Staff perform the task of guiding residents in directions that are believed to be realistic and best for them. This is reflected in the way much staff effort revolves around attempts to establish the identity, true will, and potential for change of each individual resident. In this sense social workers are involved in partially unintentional processes of trying to define and shape the way residents express themselves, rather than residents making their own free choices.

While using one hostel as a concrete example; this article is based on ethnographic fieldwork at three Danish hostels for the homeless. The fieldwork took place from March 2006 to December 2006, including short breaks. The fieldwork consisted of participant observation and conversations with various players: superintendents, mid-level managers, other staff members, and residents. Most time was spent with staff, specifically social workers. I use this term to refer to a broad category of staff, most of them formally trained, who have the responsibility of caring for, supporting, educating and planning with and for residents. In addition, I interviewed 57 people: 44 staff members in various positions, 3 superintendents, and 10 residents.

Country Side Hostel

Country Side Hostel has room for just under 40 residents ranging from the age of 18 to 70, with a majority aged between 25 and 45. 85 % are men, and 15 % are women. It employs just over 30 social workers, who cover day, evening and night shifts (Driftsaftale 2005-2006). They are divided into two teams, each covering approximately half of the residents. Within each team, social workers are key workers for a small number of residents. Key workers have the main responsibility for creating confidence, responding to needs, and solving problems together with the residents allocated to them. Each team holds a meeting once a week. But this is only one of many kinds of meeting: a good deal of hostel work is organised *as* meetings as well as *at* meetings.

Compared to other hostels, Country Side Hostel makes use of a relatively extensive control and support strategy. For instance, staff wake up

reluctant residents in the morning to make them attend workshops or other programmes, and, if possible, check if they stay as long as they should. This is based on the idea that residents need stability and structure in order to gain control of an otherwise chaotic life.

If staff find that residents are using too much alcohol or too many drugs, they may demand that they submit to urine tests, an alcohol meter, Antabuse[2] treatment or other kinds of technology to detect and control use. Residents who are determined to stay accept these technologies, but rarely without ambiguity or protest. Staff spend quite a lot of their working day observing which residents are willingly submitting to such tests, and which are refusing to submit (by cheating with a urine test, for instance).

Three reasons are given as to why Country Side Hostel does not accept drugs and alcohol: first, some drugs are illegal and the hostel would therefore be breaking the law if they allowed drugs on the premises; second, some residents need peace and quiet away from the stressful life of drugs; third, if drugs were allowed staff would lose control, and the place would be in a mess. But staff also recognise the paradox of being an agency which provides services for people who are known to be heavy users of drugs and alcohol, while forbidding them to use drugs and alcohol at the same time.

Because of its relatively strict regime, Country Side Hostel is attractive to those among the homeless who want to stop using drugs or alcohol, and who believe their chances of success are higher in an environment of zero tolerance. Residents who do not comply are likely to leave the hostel after a short time.

The rule of non-acceptance is made in agreement with local government policy, and constitutes a specific target group: people who show a will to change. However, it differs from central government policy, which more broadly stipulates that hostels should provide care and shelter for everybody who has severe social problems and nowhere else to go. This gap between policies fortifies the already inherent conflict in social work between rule rigidity (in line with local policy) and compassion (in line with central policy); a gap that is frequently displayed in the form of opposing views and opinions during staff meetings.

The problem of producing evidence

The first challenge in applying the rule of non-acceptance of drugs and alcohol is how to even monitor that such substances are being consumed. This requires careful observation and interpretation of the physical condition and social performance of each resident. Are they able to keep their balance, or do they stumble over a doorstep as a sign of drunkenness? Are they apathetic, perhaps because of cannabis? Do they attend the treatment programmes as they should?

Observations are shared at meetings at which staff decide on the consequences. Here opinions and attitudes are contested and negotiated, and decisions made. This decision-making process can have far-reaching consequences for residents. Not only because they may be expelled from the hostel, but also as a daily concern. For example, a resident explains that he fears being thrown out, because Country Side Hostel provides the right environment for him to get 'clean', and his son has refused to see him as long as he is a 'junkie'.

However, being under the influence of alcohol or drugs is not in itself against the rule, so staff have to determine whether alcohol and drugs are being consumed on the premises or outside. This is reflected in a frequent statement at meetings: "We have to catch residents red-handed before we accuse them of violating the alcohol and drug rule"[3]. To catch somebody red-handed involves, for instance, detecting a lump of cannabis, a beer or a needle during a room search and then making the resident admit his or her offence.

Staff often disagree about the nature of consequences when it has been revealed that a resident has violated the rule. Part of this may be because of differences in personal preferences, but to a larger extent disagreements mirror clashes of fundamentally different rationalities: at one and the same time, staff have to handle zero tolerance versus harm reduction; intervention versus self-determination; confidence versus suspiciousness; mass treatment and rule application versus individual treatment and compassion. On top of the complexity and ambiguity inherent in these conflicting rationalities, social workers, in line with Lipsky's street-level bureaucrats, are subjected to the necessity of quick decision-making and immediate action (1980: 29).

Below, four cases from Country Side Hostel show how staff handle such

situations. Specifically, the cases point out how processes of decision-making in dilemma-ridden situations involve assessments of each individual resident in terms of their worthiness, ability to benefit from hostel services, and relationship to staff.

In the first two cases the dilemmas are similar in that they both revolve around whether residents should be thrown out after they have been caught red-handed violating the rule of non-acceptance of drug and alcohol. In both cases, staff conclude that the residents should be allowed to stay, but the lines of argument are different. The third and fourth case have in common that residents are unwanted, but since they have not been caught red-handed in breaking the non-acceptance rule, staff have to fabricate other arguments to make them move out.

Producing a professional explanation

At a meeting, a staff member reports that Simon, a resident in his early twenties, has been caught smoking cannabis. In principle people like Simon, who repeatedly violate the rule of non-acceptance, should be thrown out, but reality is more blurred. The first reaction is: "Let's take it nice and easy. What we should do is make it clear to Simon that he is not allowed to smoke cannabis on the premises". Another staff member protests indignantly: "How long should Simon be allowed to cheat on us? He does exactly as he pleases; no matter what we say or do. Other residents have been thrown out for smoking cannabis. It's not right that Simon is let off just because he's charming!" A third opinion is expressed in a tone of conciliation: "We shouldn't throw Simon out at the moment because we're waiting for him to be properly examined by a psychologist". The indignant person replies: "We're subordinating ourselves to Simon. We aren't helping him in this way." At this point the social worker who introduced the subject in the first place suggests postponing the decision to a team meeting. This is where the subject rightly belongs. A fifth staff member thinks this is a good idea, but adds: "While we wait for the psychologist's opinion, we shouldn't refrain from taking action. For instance, we could tell Simon that there are certain kinds of behaviour we do not tolerate here." The discussion is brought to a halt for now with the decision that the staff will await the result of the psychologist's examina-

tion. A representative of the management will have a talk with Simon. The staff do not seem very convinced that the talk will make Simon change his behaviour. Rather, the aim is to reconfirm the allocation of roles: the staff are in charge, and the residents are subordinates.

There are at least two dilemmas embedded in this staff communication about Simon. First, there is the dilemma between general rules and individual treatment, reflected in the disagreement about whether the rule of non-acceptance of drugs and alcohol should apply to a young man whose psychological condition has not yet been clarified. According to Foucault, this search for a psychological explanation is an exercise in trying to gain knowledge about the insides of people's minds and revealing their innermost secrets (Foucault 1983a: 214) in accordance with staff attempts to make residents confess the 'truth' about their use of drugs and alcohol. With regard to Simon, staff want to know if he is 'normal' and therefore responsible for his own actions (and consequently unworthy of the hostel's services); or if he is 'sick' and therefore 'innocent' (and consequently worthy of the hostel's services). One aspect of this dilemma is also the two contrasting positions on equality and fairness; as when a social worker with the utterance "other residents have been thrown out for smoking cannabis" implies that rules should be the same for all independently of sympathies or antipathies. The opposite stance is that fairness and equality are achieved when each case is assessed individually.

The second dilemma is wrapped up in a remark from the staff member who says: "We're subordinating ourselves". This remark refers not only to the above-mentioned issue of reconfirming role allocations, but also to a general issue in social work of whether staff can and should trust residents. Trust is crucial to social workers because of the idea that the creation of confidence is important if their attempts to make clients develop or change are to succeed. The rationale is that if staff succeed in convincing residents of their good intentions, then a relationship of friendship-like trust can be established, and the client will be more likely to follow the instructions of staff.

Applying Sahlins' model of reciprocity, the discussion among staff can also be seen as an attempt to categorise their relationship to residents in terms of the 'spirit' of exchange. Generalised reciprocity is exercised when the resident,

metaphorically speaking, is regarded as a friend or family member; somebody staff like, whose mistakes are easily forgiven. However, such a relationship is constantly challenged by the scepticism lurking in the attitude of the staff towards the residents; a scepticism that relates to a general conception of homeless drug users as people who are skilled in trickery and cheating, for which reason it would be naïve to fully trust them. Consequently, social workers cannot develop the generalised reciprocity relationship to its full extent. Rather, they switch between various kinds of reciprocity relationship, trying to strike a balance between creating confidence and not being fooled. In the case of Simon, though, it seems that generalised reciprocity is an appropriate category for the client-staff relationship because the staff decide to forgive Simon – at least for now.

Staff discussions about Simon also expose a hierarchy of arguments, starting off with: "Other residents have been thrown out for smoking cannabis [why not Simon?]". Since this is not enough to convince his colleagues, the person plays a trump: "We aren't helping [Simon] in this way". This remark entails a certain moral reasoning of how best to help clients: it is better that they are met with demands and consistency, whereas it is poor service to let them stay despite a rule violation. Reflecting harm-reduction rationality, the opposite opinion is based on the same argument – but in inverse ratio: clients can be helped more if they are treated with compassion and flexibility, whereas throwing them out constitutes failure. According to Lipsky, it is not surprising that two conflicting opinions are based on this same argument because it is a typical characteristic of street-level bureaucracy that services and procedures, no matter what content they have, are presented as benign (1980: 119).

The final decision is postponed in Simon's case. This is quite a common way to deal with the uncertainty which is part and parcel of any dilemma: let us not rush too much, maybe something will come up that changes the situation. Later it turns out that the psychologist's opinion, as hoped for by some staff members, actually *does* solve the dilemma because she arrives at a diagnosis: Simon is probably suffering from ADHD (Attention Deficit Hyperactivity Disorder). In Foucault's line of thinking, the diagnosis tells the truth to staff about who Simon is, and consequently their dispute is settled all of a sudden: the moral argument that he is a cheat is silenced, and so is

the talk about his use of cannabis. This implies that a professional answer to a problem, due to its perceived unambiguousness, is easier for staff to handle than a moral one.

In Simon's case, the diagnosis opens a field of new explanations for his behaviour and new solutions to problems: staff will start looking for an institution that specialises in treating young people with ADHD. Simon is still in the wrong place, but he is deemed worthy to stay until staff find the right place.

The next case of Martin, another resident, illustrates a different kind of solution to the conflict between individual client treatment and mass processing. In contrast to Simon, Martin is considered to be in the right place because he expresses his problems in ways that fit the models of solutions with which the hostel already operates.

Establishing a relationship of confession and forgiveness

The key worker brings up Martin's breach of the non-acceptance rule at a team meeting: "This morning we held a meeting with Martin about the needle that was found in his room". The finding of the needle is a strong indication that Martin supplements his legally prescribed methadone with illegal, intravenously administered drugs. As expressed by his key worker, Martin had explained that he had not injected himself at the hostel, and that there must be another reason why the needle was in his room. Perhaps it had fallen out of his bag? As the conversation proceeded, the key worker continues, Martin had finally admitted he had smoked cannabis and used cocaine as recently as the previous day, but he maintained that he had stopped injecting drugs.

Compared with the rest of the clientele, Martin, in his early fifties, is regarded as a relatively reasonable person who works hard to get his life on the right track, and who "has resources": he is intelligent, he has previously had a regular job, he has children, and he is in touch with his ex-wife. Still, as evident from his relapse, he is perceived as more fragile than most others and therefore in dire need of help and support.

Against this background, the staff agree relatively harmoniously that Martin lives up to the image of a resident who fits into this institutional

setting – as opposed to Simon, who is considered to be better off at another kind of institution. Martin's case constitutes, with a term from Lipsky, an example of "creaming": faced with more clients than they can attend to in a satisfactory way, street-level bureaucrats are inclined to choose those who are more likely to succeed in terms of institutional criteria (Lipsky 1980: 107). Since hostels for the homeless have to live up to the law saying that residents should preferably move out to a more independent life, it is not surprising that staff make an effort to help Martin, who is regarded as standing a comparatively good chance of doing just that.

Consequently, staff are motivated for fabricating a legitimate reason for letting Martin stay. This turns out to be that he is honest, admits his offence, and declares a willingness to cooperate with staff because such behaviour makes it possible for staff to forgive him. The fact that Martin does not actually admit an offence that corresponds with the 'proof' (a needle) is apparently compensated for by his admission of another offence (the use of cannabis and cocaine). On the whole, it is appreciated that residents are honest, confess their mistakes and cooperate with staff. The establishment of a confession-forgiveness relationship and its inherent confirmation of power relations, as seen in Martin's case, illustrate a widespread way out of dilemmas related to rule violation.

Employing Foucault's analysis of confession, the ideal user, like Martin, is somebody who knows how to play the game of truth and confess his mistakes to the social workers, who play the corresponding role of the authority who is obliged to forgive. The relationship is one of reciprocity to which both parts contribute, and is part of the processes of creating confidence. In this manner, following Sahlins, the relationship between staff and Martin can be characterised as balanced reciprocity: a relationship of give and take between trading partners. Simultaneously, it is important to bear in mind that unlike Sahlins' definition of the 'spirit' in balanced reciprocity, the relationship between staff and residents is never equal because of their asymmetrical power positions: not only have staff far better goods to trade with, they also define the very foundation of negotiations.

The problem with honesty is that when residents admit they use drugs or alcohol on the premises, a new paradox arises: such activities are forbidden. From Martin's case, and others similar to his, it seems that as long as

things are generally moving in the right directions – as staff see it – a single violation can easily be forgiven. Staff also have pragmatic ways of preventing the paradox from arising at all: by not reacting if they accidently overhear a conversation between residents revealing that they are violating the rules, or by not asking questions which could bring a paradox out into the open. For example, I observed a meeting at which a social worker appealed to a resident to be honest, and when he finally complied and admitted that he smoked cannabis, she did not take the case of a possible violation further – refraining from asking if the resident had smoked on the premises or outside. The point is that ignoring petty offences saves resources, and that excessive staff control and sanctions may threaten their professional efforts to create trust with residents. Consequently, I suggest that staff sometimes employ a tacit consent of 'pretending not to know' or 'refraining from asking' in order to make their work function. These forms of actions may play a more important role in coping with the dilemma-ridden nature of work than is immediately apparent. The decisive factor seems to be that as long as staff generally agree that a resident belongs to the target group, it is not worthwhile to engage in labour-intensive processes of discussing consequences.

Both Simon and Martin were caught red-handed breaking the rule of non-acceptance, both of them confessed, and both of them therefore risked being thrown out: even so they were still allowed to stay. The two cases reflect a general way out of dilemmas between rules and individual treatment: to produce legitimate exemptions from rules based on moral or, preferably, professional reasoning. As implied in the two cases, telling a person to leave due to drug or alcohol use is a considerable product of what Lipsky (1980: 13-16) calls discretion among staff about what kind of individual they are dealing with, and his or her potential for making and following plans, combined with the way hostel staff define their services.

Thus, there are several ways of adjusting or overruling rules in the pragmatics of daily life. In the above cases, adjustments were made in order to make it possible for residents to stay at the hostel. But, as will be evident in the case below, the reverse also happens: rules are adjusted with the purpose of getting rid of people.

Adjusting rules to legitimise expulsion

Staff are caught up by the logic that because drugs are forbidden at the hostel they have to look out for drug dealing. In a concrete case, staff suspected that a certain resident, Carl, was selling cannabis. He had already been confronted with their suspicion, but, as expected, he denied it. Calling in the police to search the hostel for drugs was suggested at a meeting, but rejected on the grounds that experience showed that the results of such actions were meagre compared with the effort invested. Lacking a justified reason to force Carl to move out, the staff decided that his key worker should try to persuade him to leave 'voluntarily' on the ostensible grounds that the hostel could not provide the kind of service he needed.

Apparently this did not have the desired effect, but some time after, the problem was solved quite easily because staff found a small amount of drugs in Carl's possession: thanks to the official drug and alcohol rule, staff could now make him leave. It seems that a resident like Carl, who is under strong suspicion of dealing, is not deemed worthy of compassion and forgiveness. Unlike most cases, the rule in this instance worked in a straightforward way as a simple consequence of an offence. The fact that Carl was told to leave for another reason than the 'real' one confirms that it is not the rule itself that causes dilemmas, but the consequences of violating it. That is to say, when staff agree on the consequences, there is no dilemma.

However, the problem persists because another resident, Sam, takes over the drug dealing, and, again, staff cannot catch him red-handed. Drug dealing is becoming a frequent and worrying theme of debate among the staff. As time goes by, staff are able to identify not only one but three named residents who are running the drug traffic at the hostel. Staff feel increasingly under pressure to take action, but they still lack concrete evidence. After lengthy debates, they finally decide that all three suspects will be thrown out on suspicion alone. A participant at the meeting phrases the significance of this decision: "This is a completely new thing. Up to now suspicion has never been enough".

Coomber (2006) writes that drug dealers, in general, are stereotyped as evil, amoral individuals, who unscrupulously go for economic gains (2006: 1). This attitude, permeated as it is in society, may explain why staff at the hostel do not raise the issue of worthiness at all when it comes to drug deal-

ers: it seems to be taken for granted that they are unworthy. Drug dealers are apparently people who nobody feels obliged to defend. In Sahlins' model of reciprocity, staff relations to drug dealers can be termed as negative reciprocity; the reciprocity between 'enemies'.

The fourth and last case resembles the preceding one in that it is about a resident who is unwanted at the hostel. But whereas the analysis up to now has been about dilemmas in relation to storage and consumption of drugs and alcohol *at* the hostel, this case deals with dilemmas arising when resident use substances *outside* the hostel. As a rule, residents who are drunk or under the influence of drugs are told to go to their rooms and stay there until they are sober or the effect of the drugs has worn off. Only if residents do not follow the instructions of staff or if their use is termed problematic will they be told that if they want to stay they must agree to submit to control technologies.

One example is Iris, a woman in her 30s. Soon after she moves into the hostel, staff find out that she is developing a habit of paying visits to the nearby town for drinking sprees, after which she either spends a night or two in town or returns drunk to the hostel. Her excessive drinking is problematic in the eyes of staff because it opposes the idea that residents should work to get their lives on the 'right' track. So the staff demand that she takes Antabuse. This has, however, caught the staff and Iris in a power-game which is allegedly unwanted by both parties but which is nevertheless generally known from treatment with Antabuse (Steffen 2005): the staff find themselves in the role of controllers of whether the client, in this case Iris, is actually swallowing the drug whereas the client tries to cheat for instance by hiding the drug in their mouth only to spit it out later. In addition, the fact that Iris does not use her room for days at a time makes staff query whether she is actually living at the hostel, and whether they should hand over the room to somebody who may need it more. All in all, Iris does not show any seriousness in cooperating with staff.

Blaming the victim

Eventually, Iris is defined as a person who is unwilling, uncooperative, and unable to formulate what she 'really' wants in a consistent way. In these respects, she is all that Martin is not. Her case becomes a recurring subject

at staff meetings, and the staff feel that a decision about what to do with her is becoming increasingly urgent. One day, Iris's key worker opens up the discussion at a meeting with: "As you all know, Iris is drinking". Another participant accepts the challenge by introducing the issue of responsibility: "Are we capable of taking responsibility for Iris?" The problem is that Iris is not motivated to take Antabuse, and even on those occasions where staff actually succeed in making her take it, it does not prevent her from drinking. This situation is highly undesirable, because drinking while taking Antabuse is a health hazard, somebody warns. A third person suggests: "Should we refer Iris to a treatment institution?" Participants doubt if it is worth the effort, because Iris will probably run away anyway. "We can't throw her out onto the streets, can we?" somebody asks, without getting an answer. Then follows the what-is-best-for-the-client-argument, similar to the one discussed in Simon's case: "Maybe Iris will be better off at an institution that can exercise more unconditional care and less strict rules than we have here. At such a place she will be freer to come and go as she pleases".

For the staff none of these suggestions seems to be just right. On the one hand, they cannot let Iris stay unless she changes her behaviour and attitude towards Antabuse, which is obviously considered unlikely, and, on the other hand, there does not seem to be a promising alternative. This dilemma reflects the inconsistency between local policies promoting a target group confined to people who want to stop their problematic drug use, and central policies promoting a broader target group of, in principle, all the homeless. Moreover, the dilemma involves the issue of responsibility of staff: will they be failing if they let Iris stay even though they cannot offer her what she needs? Or, on the other hand, will they be failing if they force her to leave? This resembles the discussion about Simon before he was diagnosed, but it seems easier for the staff to agree that Iris has to move out, and, in my opinion, this is because she has no prospect of getting a diagnosis.

The dilemma of what to do with Iris is solved for now with the decision that she should be offered a place at a treatment institution for alcoholics. If she does not accept, she will be thrown out. In a last-minute remark, though, this is moderated: first, Iris' key worker will have a talk with her. Still, staff think they cannot just throw Iris out without referring her to an alternative agency – for which reason the suggestion to discharge her onto the street will

probably not be taken too seriously, leaving only two possible outcomes: a treatment institution, or another hostel with a more tolerant profile in line with harm reduction.

The staff end up with the solution that has the most intervening character (a treatment institution), even though this is the solution they doubt the most. As in Simon's case, Iris is referred to another institution. It is common practice at hostels for the homeless to refer people elsewhere if they are deemed not to benefit from the services provided, or if they are regarded as being in the wrong kind of institution for any other reason. According to Lipsky, referrals serve the client's interest when their needs have been well identified, and resources are available at the receiving agency (1980: 132). This seems to be the case for Simon, whereas Iris' situation is more blurred, and it appears that in her case, getting rid of a resident who does not fit the institutional setting carries more weight than providing the best help. In extension of this point, the suggestion to refer Iris may be viewed as an attempt to renounce responsibility and the risk of blame it involves. Part of this rationality is also disclosed in the proposal to give Iris a choice. Choice is commonly thought of as an exercise of freedom, but this is hardly the case here since Iris' field of possibilities is very limited: either she submits to a treatment institution or to another hostel, or to the good will of accidental acquaintances to spend the night. So, when staff use arguments regarding residents' 'own responsibility' and 'choice', this may sometimes be seen as an endeavour to escape a problematic situation in a legitimate way, rather than as a sign of respect for residents' self-determination.

Using Sahlins' model, Iris is more 'an enemy' than 'a friend' in that there are not many excuses for her behaviour in an institutional setting influenced by zero tolerance: she is not equipped with either a diagnosis (like Simon) or resources (like Martin). However, she is not as bad as a drug dealer, and actually staff seem to like her. But sympathy alone is not enough to let residents stay – it is more important that they behave in a fairly consistent manner that can convince staff about their honest will to change in directions staff define as 'right'. Martin is able to do this; Iris is not.

But the meeting does not settle the matter of Iris completely, which could be because staff after all feel uneasy about the direction the decision process

is moving in. This is implied by a softening up at the end of the discussion with the remark that Iris will not be thrown out before she has had a conversation with her key worker. In this way, the possibility that Iris could be given another chance still exists. As in many other cases, the dilemma between individual treatment and rule rigidity is only partly and tentatively solved.

Conclusion: A state of in-betweenness

Dilemma management is first and foremost a ubiquitous part of social work, entailing assessing and establishing the identity of the client and the nature of the relationship between social workers and clients. Once this has been more or less settled, it becomes easier for staff to make the 'right' decisions. The processes of discretion and decision-making should not be seen as isolated entities, but as imbued with cultural assumptions of worthiness, responsibility and normality.

Processes of dealing with dilemmas can be placed in a model developed by Sahlins about three different forms of reciprocity. First, there is generalised reciprocity, in which the client is considered to be a friend in the metaphorical sense of the word. A family-like, paternalistic relationship is typical of this form. Dilemmas become easier to handle thanks to the clear role distribution: staff are generous service providers who do not expect much in return from clients, who are, correspondingly, not regarded as being responsible for their own actions. In some situations the client's behaviour is given a professional explanation, which has a dilemma-solving force because it points to solutions in a fairly unambiguous manner.

The second form of exchange, according to Sahlins, is balanced reciprocity, which means that social workers strive to treat clients as equal partners. Clients are regarded as responsible and able to make changes in their lives. From such clients staff expect honesty, cooperation and other forms of compliance in return for their help and support. Such a role distribution provides, according to the rationale of staff, a suitable framework for the creation of the confidence they wish to establish with clients.

In the third type of relationship, staff and client are engaged in negative reciprocity. This means that the client is regarded as a person who cannot and will not change, or who has a bad character. Staff cannot or will not

expect much from such clients because they are looking for a legitimate way to make them move out of the service agency.

Only a few client-staff relationships can be placed unambiguously in one of these exchange categories. In most cases the categories are flexible, and people move in and out of them. The point here is that the categories of exchange can be seen as tools that staff utilise to find out if the needs and problems expressed by a client can be met within the framework of a specific institution, or if the client should move to another place.

Whatever particular form a dilemma takes, it is characterised by being the outcome of pressures from conflicting rationalities and overall policies which cannot be translated into just one 'right' way of acting. In this sense, social work can be recognised and understood as a state of in-betweenness, i.e.: a state that entails unpredictability and uncertainty. As a consequence, decisions are often tentative and open-ended so as to leave room for any alternatives which may arise if things are postponed a little. However, progress cannot be too slow because social workers are expected to make quick decisions and take immediate action.

Staff may also prevent a dilemma from arising at all by refraining from asking for the kind of knowledge that could bring a dilemma out into the open, or by pretending they do not know about a rule violation (even though they do). These pragmatic methods are observed in the form of discreet suggestions and sympathetic understanding among staff rather than as clearly articulated issues. I suggest that not only does this kind of manoeuvring take place at human processing agencies to a larger extent than recognised formally, but that such manoeuvring may also be of crucial importance in ensuring the continuation of organisational life.

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NOTES

1 It is worth noticing that even if hostels pursue an acceptance rule, they still distinguish between *use* and *dealing*, and warn that if they suspect dealing with illicit drugs is taking place on the premises they will report the matter to the police.

2 Antabuse is also known by the name disulfiram. It is a prescription drug for people considered to have a misuse of alcohol and it produces sensitivity to alcohol which results in a highly unpleasant reaction involving flushing, heart beating and difficulty in breathing if someone drinks alcohol after taking the drug. The idea is that people who take Antabuse restrain from drinking to avoid this unpleasantness. Thus, the treatment is supposed to work as a deterrent whereas it does not remove the urge to drink. Antabuse is widely used in Danish alcohol-treatment (Steffen 2005).

3 The quotations in this article are translated and edited from Danish by me. In the editing process, I have adjusted the quotations in order to make them more readable, while at the same time remaining loyal to the actual words spoken. Most of the quotations stem from field notes made during meetings. Although they were written in great detail, they are not to be taken as literal as if they were recorded.

Vibeke Asmussen Frank & Torsten Kolind

DILEMMAS EXPERIENCED IN PRISON-BASED CANNABIS TREATMENT – DRUG POLICY IN DANISH PRISONS

Introduction

During the past ten to fifteen years prison-based drug treatment has become part of national drug policies in many European countries. Today numerous prisons in Europe offer some kind of drug-free treatment, substitution treatment or detoxification to inmates (Duke 2000; 2005; *Prison, Drugs & Society* 2002; McSweeney, Turnbull & Hough 2002; Stöver, Casselman & Hennebel 2006). Due to its relatively brief history, prison-based drug treatment is also a new field of research. There are only a few European studies on the effect of drug treatment in prisons (Egg et al. 2000), on prison-based drug treatment as part of national drug policy (Duke 2003), on the experiences of inmates and counsellors in connection with treatment (Carlin 2005; McIntosh & Saville 2006), or on the conditions of treatment in prisons compared to community-based treatment (Neale & Saville 2004). This article, therefore, breaks new empirical ground by its focus on the experiences of drug-treatment staff in the prison setting, and by its focus on how staff implement policy into practice and thereby rework it.

The study focuses in particular on the experiences of treatment staff with newly established cannabis treatment programmes in four Danish prisons. These programmes are closely linked to a new and more restrictive line in Danish drug policy, and drug treatment in prisons in general is subjected to particular conditions of control and punishment. In order to understand the practices and experiences of counsellors better, these are contextualised by integrating various empirical levels in the analysis including: national drug policy, drug policy in prisons, institutional logic of the prison, and inherent organisational and ideological differences between prisons and treatment institutions.

The four cannabis treatment programmes studied are located in four different Danish prisons: two programmes in maximum-security prisons and two in minimum-security prisons. The data includes both qualitative interviews and written material. All the treatment staff (eight persons) in the four cannabis treatment programmes, three treatment managers, and three treatment advisory officers (known as 'behandlingskonsulenter' in Danish) were interviewed.[1] Written material includes: documents from the treatment programmes, prison statistics, laws, policy documents, and reports from the Prison Service.

The first part of the article discusses three different contexts influencing cannabis treatment. These are: new directions in Danish drug policy and their consequences for the prison system; aspects of policy in practice, including the specific logic of total institutions (Goffman 1961) and counsellors' discretion and manoeuvring (Lipsky 1980) in the prison system; and general dilemmas related to drug treatment in prisons including a brief history of prison-based drug treatment in Denmark. The second part of the article consists of an analysis of counsellors' experiences with prison-based cannabis treatment in Denmark. As will be shown, these experiences are closely linked to the three different contexts outlined above.

Zero tolerance and treatment guarantee

Danish drug policy has undergone significant changes within the past six years, characterised by a shift from a liberal to a more repressive policy. Today there is a dual goal of zero tolerance towards drugs and a concurrent ambition of expanding treatment facilities for drug users, focusing especially on abstinence. The new direction in Danish drug policy was formulated in 2003 in the government's action plan for drug misuse: *The Fight against Drugs* (Regeringen 2003). The changes were inspired by repressive drug policies, including zero tolerance in the US, the war on drugs, and the rationality of the international drug control system. There is no longer any distinction between 'soft' and 'hard' drugs (cannabis versus cocaine, heroin, etc.) or between drug dealer and drug user in Danish drug policy (Asmussen & Moesby-Johansen 2004; Storgaard 2005; Asmussen & Jepsen 2007; Asmussen 2007).

In prisons the policy of zero tolerance has introduced new control elements and disciplinary sanctions. *The Fight against Drugs* (2003), for instance, suggests erecting better fence systems, introducing more sniffer dogs, creating prisons as cashless societies, applying new technological aids (e.g. scanners, detectors, transillumination devices, drug tracking tests), and (importantly) introducing random urine tests. These initiatives have now been implemented in various ways by the Prison Service ('Kriminalforsorgen' in Danish).[2] As a consequence, since July 2005 it has become compulsory for prisons to perform daily random urine tests on inmates. Before 2005 urine tests were only used in cases of well-founded suspicion, on imprisonment, and before and after leave.

On the other hand, the increased availability of drug treatment is reflected in a treatment guarantee implemented in 2004 for drug users in community-based treatment (Pedersen & Nielsen 2007), including inmates using drugs from January 2007, when the *Act on Execution of Sentences* was amended. The treatment guarantee for inmates promises some kind of psychosocial drug treatment (not substitution treatment) within two weeks of applying for treatment. As a result of this guarantee, new treatment programmes have been launched including psychosocial support for methadone clients and treatment for the problematic use of cannabis.

The focus on drug treatment in prisons is in tune with general developments in the EU, demanding increased action in this area and insisting that drug treatment should be integrated into the prisons' general functions. The EU strategy on drugs (2000-2004) required member states: "To intensify their efforts to provide drug-prevention and treatment services and, where appropriate, measures to reduce health-related damages in prisons and on release from prison" (*Drugs in Focus* 7: 1). So it is a political challenge to ensure that a term of imprisonment at the very least does not worsen a drug problem, and greater ambitions are invited when an up-to-date drug treatment is offered. This is also in keeping with a right-based approach, as stated in Principle 9 of the United Nations Basic Principle for the Treatment of Prisoners: "Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation" (Møller et al. 2007).

Policy in practice

One thing, however, is political action plans – another is how such policies are implemented. The theoretical point of departure for our analysis is a focus on policy in practice. Several studies have investigated political decision-making as a practice in itself (Bailey 1969; Shore and Wright 1997; Duke 2003). This article, however, investigates the way in which political decisions are translated, reworked, and resisted when *implemented* in practice (see also the Introduction to this volume).

In recent years Michel Foucault's writings have been in vogue when analysing modern welfare policies. Increasingly, researchers have focused on the implicit governmental principles embedded in both welfare policies and practices (Burchell, Gordon & Miller 1991; Shore & Wright 1997; Cruikshank 1999; Dean 1999; Petersen 2003). Foucault's grand historical tours of the creation of modern subjects (1982; 1991; 1994) are a valuable backcloth for understanding general trends in modern society, but they are also limited. For example: it is probably correct to argue that the practice of drug treatment staff in prisons is imbued with and reproduces a certain governmental principle (individualisation or active citizenship, for instance). But it is also a very general statement to make. It does not capture the many (often contradictory) strategies which characterise such institutional practices as drug treatment. In order to properly investigate dilemmas and experiences related to (in this case) the delivery of substance-abuse treatment in a prison setting, other theories and analytical frameworks must be included.

To understand the individual strategies that treatment staff employ in order to overcome dilemmas and problems related to treatment, it is useful to look at both Lipsky (1980) and Goffman (1961). Lipsky's (1980) study of the interaction between citizens and street-level bureaucrats is sceptical towards the idea that policy implementation is only a top-down process. He focuses on the way in which street-level bureaucrats mediate between laws, rules, budgets and resources on the one hand, and citizens with particular needs and wishes for services on the other. Lipsky hereby clears a space for approaching some of the more mundane logic attached to carrying out welfare policy in practice which is also valid when providing substance abuse treatment in a prison setting. His main concern is street-level bureaucrats – professionals such as teachers, social workers, nurses, treatment staff and prison guards employed

to put political decisions into practice. Street level bureaucrats become the interpreters and mediators of policy documents and statements. For instance, inmates 'meet' a policy of zero tolerance not in written statements but in the way such mediators deliver policy. However, this kind of logic only enters real life when concrete street-level bureaucrats in concrete interactions with citizens "mediate aspects of the constitutional relationship of citizens to the state" (Lipsky 1980: 4). This means that governmental categories only come to life in the actual meeting of street-level bureaucrats and citizens, a process that may easily change or mould such categories.

According to Lipsky, the distinctive quality of street-level bureaucrats lies in their exercise of discretion – in the active and reflective transformation of formal rules and regulations into practice. In fact, as professionals they are actually expected to exercise judgement in their field, as strictly rule-obeying behaviour would be seen as obstructive. The special thing about street-level bureaucrats is that they work with humans in complex situations that cannot be reduced to programmatic formats. Instead, flexibility and individual considerations are expected. Such informal considerations often contradict the official policies of an institution, but are also basic to its survival. For instance, a drug treatment programme in a prison might target heroin-addicted inmates, but in order to utilise prison capacity effectively, inmates with other addictions (cannabis, cocaine, etc.) are also enrolled in the same treatment programme. In fact, Lipsky maintains, the discretion of the street-level bureaucrats is so much part of the profession that strategies of resistance can be observed when this discretion is felt to be threatened. Staff may work to rule, work slowly, or work against new working procedures.

In our study, Lipsky's plea to explore policy in practice through the mediating work of street-level bureaucrats will be placed in an analytical framework constituting some of the innate working principles of the prison. This context is important as a framework for analysis, since it contains particular characteristics that create distinct dilemmas and conditions. Prisons are a specific kind of welfare institution which Goffman (1961) called "total institutions", imbued with some general characteristics: they strive to uphold a clear distinction between the staff and the inmates, and they rationalise the supervision of people *en bloc*. In order to accomplish these two functions, a whole ideology is erected and various practices and precautions are created.

For instance, the ideas that punishment is justly deserved, that the prisoners would escape if they had the chance, and that the prison should not offend the public's sense of justice by being too lenient and offering too many privileges to prisoners. The staff should have a strict focus on discipline and order, maintain a general suspicion of the prisoners' motives, avoid personal involvement with the inmates, support the economic, physical, emotional and personal deprivations inflicted by the institution, and so on (Goffman 1961). Western prisons, however, also entail a more liberal ambition of re-socialisation and rehabilitation (Mathiesen 1988). As a result, they have contained the dilemma between punishment and rehabilitation for a long time. In fact, this dilemma can be seen as innate in the very basis of the prison institution trying to combine two contradictory aims: on the one hand deterrence, retribution, defending the community against criminals and punishment; on the other hand reformation, rehabilitation and education (Garland 1991; Foucault 1991). Introducing drug treatment in prisons constructs new problems rooted in the same old dilemma, as we will discuss in the following.

Dilemmas of drug treatment in prisons

In Denmark the first response to increased drug use in prisons was the implementation of a so-called 'attenuation ideology', dispersing drug users throughout the prisons in the hope of minimising the influence of drug users on the prison environment (see also Houborg in this volume). This policy started in the late 1960s and was dominant throughout the 1980s. Only in 1996 was drug treatment in Danish prisons initiated when a trial involving drug-free treatment was set up and drug-free wings created.[3] After a positive evaluation of the drug-free treatment trial, government money was earmarked in 2003 to set up six additional drug-free treatment programmes, mainly for heroin users but also for users of stimulants. At the same time pre-treatment programmes were set up in jails to motivate inmates to begin a drug treatment programme on commencement of their sentence. Today prison-based drug-free treatment is a permanent part of drug policy in Denmark. At the moment drug-free treatment is offered in nine prisons.[4] The treatment is carried out by private and/or public treatment institutions, and not by the

Prison Service. However, it is the Prison Service that authorises drug treatment institutions to perform treatment in prisons as well as monitoring the quality and outcome of these treatment programmes. Drug treatment institutions are therefore independent within the prison system. The treatment staff are employed by the treatment service in question, not by the Prison Service – unlike health-care workers, social workers, teachers and others.

Researchers have pointed to the dilemmas that arise when two different organisations and work cultures meet in drug-free treatment units (Neale & Saville 2004; Carlin 2005; McIntosh & Saville 2006). The Prison Service is organised in a top-down, hierarchical organisational structure. The focus is on surveillance, punishment and control techniques; the relationship between inmates and prison staff is based on mistrust, and they often have little contact with each other. This resembles Goffman's (1961) characteristic of total institutions outlined above. And it differs markedly from treatment institutions, which perceive themselves as egalitarian, self-managerial, and based on a consensus meeting structure. The treatment culture is also often dominated by ideas of confidence in client/therapist relationships, dialogue, and therapy and self-development. So it is not surprising that drug treatment staff are sometimes seen as an alien community in the prison setting, being both too lenient and too different, creating tensions or even conflicts between prison staff and treatment staff. Such conflicts and dilemmas have been recorded both nationally (Asmussen, Kolind & Nielsen 2006; Dahl & Pedersen 2006; Storgaard 1998) and internationally (*Drugs in Focus* 2003; Prendergast & Wexler 2004; McIntosh & Saville 2006). McIntosh & Saville (2006), for instance, maintain that treatment will always be secondary to the very fact that inmates are serving a sentence, and therefore that prison control and punitive functions will always prevail; the relationship between inmates and prison staff is often negative or even hostile; and the relationship between inmates and treatment staff is caught between the two functions of the prison (control and rehabilitation). A general conclusion in these studies is that the prison setting tends to counteract many of the normal intentions and work procedures of community-based drug treatment programmes (Kothari, Marsden & Strang 2002; Carlin 2005; Stöver, Casselman & Hennebel 2006). In line with these studies, we will discuss the role of treatment staff and how they act in the conditions to which prison-based drug treatment is subjected.

Methadone maintenance treatment in prisons lives a silent life in Denmark and in many European countries (Stöver et al. 2006). Although methadone was brought into the prison system back in the 1980s, no unified or clearly stated medical regime exists. Prison doctors interpret national guidelines regarding methadone dispensing differently, so accessibility to methadone treatment varies from one prison to the next. And, as mentioned above, the treatment guarantee does not include methadone maintenance. Until January 2007 no psychosocial support was offered as part of methadone maintenance/detoxification treatment in prisons. However, this has changed with the 2007 treatment guarantee. But unlike the drug-free treatment modalities described above, inmates in methadone treatment do not serve time in separate units.[5]

There are no general comparative studies in Europe of the organisation and implementation of drug treatment, and no outcome evaluation on drug treatment services in Denmark has been conducted. However, European research shows that drug-free treatment as well as substitution treatment in prisons has a positive effect (Egg et al. 2000; *Prison, Drugs & Society* 2002; Smith, Gates & Foxcroft 2006), both when it comes to recidivism and the reduction of drug use. This is important, but it is not our focus here. Instead, we focus on the conditions of drug treatment in prisons, the experiences of the treatment staff, and on the unintentional consequences that the zero tolerance policy produces. We find this relevant, as it seems reasonable to suggest that dilemmas and problems attached to prison-based drug treatment influence the treatment outcome.

The setting

Approximately 50 % of all Danish inmates are estimated to have a drug problem (Kramp et al. 2003), which resembles European figures (Griffiths et al. 2003). Urine screenings in Denmark in 2006 on a random day showed that 10 % tested positive for cannabis and 3 % for harder drugs (heroin, cocaine, etc.), although the statistically variance was +/-3 percentage points. On average 6 % of Danish inmates tested positive in random mandatory urine tests (*Evaluation of the intensified urine control* 2006). In other words, inmates who use drugs are also active drug users in the prison setting. Furthermore, studies

show (Duke 2003; Kolind 1995) that many inmates use cannabis in prisons or jails as a way to handle the psychological stress caused by imprisonment, including boredom, sleeplessness, emotional deprivation, etc. The statistics also show that drug problems in prisons are much larger and more serious than in the community as a whole, as imprisoned drug users are burdened with higher incidences of mental and cognitive problems than people in community-based treatment (Kothari et al. 2002:417, McIntosh & Saville 2006). Finally, the mortality rate among Danish drug users released from prison is significantly higher than drug users in community-based treatment (Christensen, Hammerby & Bird 2006).

The cannabis treatment programmes in this study are based on various treatment methods, and differ in terms of how intensive they are. For instance, one programme runs for five hours five days a week, while another consists of individual therapy for one to two hours once a week. All programmes are organised as out-patient programmes, they have from six to twelve inmates enrolled at a time, and mostly they run for six to eight weeks. Two programmes offer individual counselling to inmates as a form of aftercare. There are 1-1½ full-time treatment staff employed in each cannabis project. If they participate in the programmes, inmates fulfil the work obligation demanded by the prison. The treatment programmes have few enrolment criteria: cannabis must be the primary problematic drug use, though the problematic use of other drugs is 'accepted' (heroin users are referred to separate programmes); inmates must be able to communicate in Danish (insufficient language skills are therefore an exclusion criterion); inmates must be motivated; and finally, abstinence is not compulsory although the reduction of drug use is. Though this last criterion runs counter to the zero-tolerance policy in prisons, it has been accepted by the Prison Service.

Experiences of counsellors with prison-based cannabis treatment

In this section the discretion of treatment staff – using Lipsky's (1980) concept – in certain situations is analysed and discussed. Firstly, we explore the way in which random urine tests influence cannabis treatment programmes in various ways. Secondly, we analyse the way in which treatment goals are redirected owing to the particular situation in which treatment is performed:

the prison setting. And lastly, we analyse and discuss the nature of the cooperation between prison guards and treatment staff.

Mandatory random urine tests: adversary or assistant to cannabis treatment?

Random mandatory urine tests were, as noted above, introduced in the Prison Service in 2004 as part of the new control techniques implemented with the policy of zero tolerance. In 2003, 13,000 inmates were tested owing to well-founded suspicion, on imprisonment, or before and after leave. In comparison, 40,000 tests were taken in 2005, 70 % of these being the new random mandatory urine tests. 27,600 of these tests were taken in the thirteen Danish prisons (5 maximum security prisons and 8 low security prisons with a total capacity of approx. 3,100 inmates). The disciplinary sanctions following a positive urine test are: fines, punitive cell, withdrawal of rights to go on leave, or restrictions on social participation. Since 2004, the number of disciplinary sanctions within the Prison System has increased by 38 %, an increase that is due in all probability to the new politics of zero tolerance (Kriminalforsorgen 2006).[6]

So random urine tests were well implemented when the cannabis treatment programmes were introduced in January 2007. They are part of the basis for practising cannabis treatment in prisons. In general, the treatment staff are not in favour of this control aspect. They see it as counterproductive to treatment, fearing, for instance, that disciplinary sanctions following a positive urine test may undermine their attempts to establish trusting relationships with clients. For instance, one counsellor reported that her loyalty had been tested because she was regarded as an object of suspicion owing to the random urine test:

> You are sometimes tested out. I have clients who have lied about using drugs. They then admit that they use drugs the next time we meet to find out whether they would be given a urine test when they got back to their wing. Or they tell me about cannabis or other drugs in some of the wings. They leak something to see if I will betray them.

Counsellors explicitly tell their clients that as treatment staff they have nothing to do with the urine tests and the disciplinary sanctions. Instead, their aim is to motivate through trusting dialogues with the inmates, as stated by this counsellor:

> We are not strong supporters of urine tests. If inmates relapse, we would rather intervene and work with the problem.

On the other hand, ambivalence exists among treatment staff regarding the use of random urine tests. Some counsellors, for instance, experienced that the urine test was a highly motivating factor for inmates to start treatment. They pragmatically note that they would not have as many clients in their programme if there were no urine tests:

> The random urine tests are definitely a motivational factor. I am not totally sure, but at least 80-90 per cent of our clients begin treatment simply to ensure that their urine tests will be negative so they can keep their right to go on leave.

As a consequence of the disciplinary sanctions following a positive urine test, many inmates have their leave suspended. By starting treatment, inmates try to abstain from drug use and thereby regain their right to go on leave. However, this motivational factor is mainly found in inmates who are eligible for leave[7], or those who have obligations on the outside (children and spouses, for instance). And this is mainly the case in low-security prisons, where inmates are serving a shorter sentence and are therefore eligible for leave more quickly. Furthermore, counsellors doubted the sincerity of the motivation arising from the new disciplinary sanctions following a positive urine test, as explained by this prison nurse:

> The only reason to stay off cannabis is to be able to go on leave. The clients simply have to stay off in order to get their leave. So, sadly enough, the primary reason is not to stay off cannabis.

Finally, counsellors reported that it was primarily the less affected drug users who could switch this motivation on and off:

> We have actually experienced, after we got the zero-tolerance policy and the random urine tests, that inmates use cannabis just for fun – Saturday evening, or only in their spare time. The ones who are not drug addicts, they are the ones who are able to stay off cannabis.

Counsellors know that urine tests motivate inmates to start treatment, and this has led them to involve themselves more directly in the way the prison sanctions positive tests:

> If one of the inmates enrolled in our cannabis programme is caught with a positive urine test, we get to know immediately. Normally there are certain consequences, such as the withdrawal of leave for 30 days. But if I can vouch for him, reporting that he has participated in the treatment programme, has been active and shown motivation to get off cannabis, then he might get his leave earlier.

Such involvement contradicts the way treatment staff distance themselves and their programme from urine tests in general with a view to creating a trusting relationship with the inmates, as shown above. But instead of seeing this as an inconsistency, we analyse it as part of the way in which counsellors exercise discretion, i.e. the active and reflective transforming of formal rules and regulations into practice. Counsellors perform their treatment in dissimilar frameworks and distinct situations, and act in different ways when it comes to random urine tests, for instance.

However, the fact that urine tests motivate some inmates to discontinue their drug use does not mean that they necessarily abstain from drug use in either the short or the long run. Treatment staff find that some inmates start using cannabis again shortly before their sentence expires, in the period when they are not eligible for leave anyway. Even if they have a positive urine test, this will not have any effect on their leave or their term of imprisonment.[8]

> It is my experience that the random urine tests help motivate people with a one-year sentence, for instance. But people with 60-day sentences or less might prefer to say: "It's only two weekends I can't go on leave. So I don't care." They don't really want to bother with treatment.

In other words, inmates with short sentences or with a short time remaining before their sentence expires are not particularly motivated to quit cannabis altogether. It should also be emphasised that treatment staff also find that inmates who are unable to terminate their problematic drug use, and who do not start treatment for various reasons, are continually exposed to disciplinary sanctions as a consequence of their drug use. And as a result they often isolate themselves and become resigned, as a counsellor in one of the high-security prisons reported: "We have an inmate here who has not been on leave for almost two years due to positive urine tests for cannabis use". So according to treatment staff, it is only one particular group of inmates that profit from and start cannabis treatment programmes.

Redirecting the goals of prison-based cannabis treatment

Drug treatment tends in general to take second place in relation to the focus of prisons on security and discipline, as discussed above. In the following we explore the way in which treatment staff adapt their treatment to such institutional conditions. Three examples of the way in which the prison setting redirects drug treatment are chosen: first, how treatment staff rethink the goal of treatment when confronted with the prison system and the inmate culture; second, how goals are redirected due to cooperation with prison guards; and third, the treatment staff's widening acceptance of inmates' motivation for starting treatment.

Cannabis treatment in prisons – pros and cons

In some ways treatment staff see drug treatment in prisons as an ideal treatment situation, partly because the setting is highly structured. Although participation in the programmes is voluntary, enrolled inmates are obliged to participate in the same way as they would be obliged to work when serving

a sentence. So clients attend treatment regularly – even considerably more than clients in community-based treatment. As one counsellor reported:

> It is an advantage to do treatment in prison. I can always get hold of my clients. If they get bad-tempered and walk out on the treatment, I can pay them a visit the next day and say: 'How are you today?' and start by saying: 'Hey, should we continue or what?'

The prison setting sets a particular framework that is valued positively by counsellors in some respects. On the other hand, treatment staff also feel that the prison setting counteracts the treatment goals. The counsellor quoted above who saw some advantages in prison-based drug treatment also had this important reservation:

> I don't really see any advantage in having treatment in here. Inmates are locked up in an environment where cannabis is being smoked right in front of them. They can't go anywhere if they want to get away from the cannabis.

Comparing the pros and cons, treatment staff mostly highlight the drawbacks of the prison as a backcloth for providing drug treatment. They report that drug use is part of prison life, and that after treatment sessions inmates return to the prison environment, where cannabis is easily obtainable, and that inmates have to adjust themselves to an inmate culture which is both impersonal, threatening, strongly hierarchical, and mentally unstimulating, entailing norms and values which are not valid in the treatment sessions. Even though such predicaments can be compared to some extent to the struggle in community-based treatment to get drug users out of detrimental social environments, prison life does not hold any alternatives. Even in drug-free wings the same inmate culture exists and the strongly hierarchical and control-oriented relationships between staff and inmates prevail. Such circumstances led one counsellor to say that when confronted with an antagonistic attitude by inmates he does not necessarily perceive this as personal or targeted at the treatment programme. Instead, he interpreted it as part of the inmates' general way of reacting within the prison. This reaction is fully in line with

the structurally determined antagonism within prisons between officers and inmates as analysed by Goffman (1961).

Drug treatment: alleviating the negative consequences of imprisonment

Treatment staff find that many of their clients – especially those with long sentences – are heavily troubled by their imprisonment. For instance, they stress clients' fear of a violent environment, impersonal and depriving social relationships, relationships with antagonistic prison guards, and loss of contact to close relatives. So in order to carry out cannabis treatment they see it as necessary to work primarily with the distress of being in prison. In fact, this takes up a great part of the treatment staff's work: alleviating the negative influence of imprisonment. In the following quotation a counsellor is reflecting on doing therapy inside prison:

> I: What's it like doing cognitive therapy in prisons?
> C: Well, the environment is rather restricting. People react to the system they are subjected to. And I understand that! But if inmates want to avoid being nagged all the time or avoid sanctions for disobeying rules, and if they don't want to be sent to the punitive cell all the time, they have to be a bit wiser about their own situation.
> I: So is treatment in prisons also about learning to relate to the prison environment?
> C: Yes, they have to learn, because the prison environment takes up so much space. I am sure that some of the inmates I meet in here who are really distressed by the prison system would be different outside this system.

Not only the prison system but also the inmate culture is seen as detrimental to drug treatment. One counsellor reported that he explicitly worked with this aspect, but knew that this work only had a limited effect:

> I try to construct a separate space in the treatment where the pecking order between inmates is suspended. Everybody's aim in treatment is the same: to come off cannabis. If anyone is president of this or that, well it has no value in treatment. And this is accepted by the clients. But when they leave

> the treatment they have to put on the mask again, and accept the pecking order of prison life once again.

Another counsellor was simply somewhat reluctant to inspire the inmates to be too trusting and open. He feared that emotional vulnerability shown by clients in a group session, for instance, could be turned against them afterwards and make it difficult for them to manage the hierarchical inmate culture.

> They simply have to be able to cope with the hierarchical environment they are living in. So every time we escort them back from the treatment session we make sure we can leave them, that they are OK. They have to be closed; they need time to build up the façade. You have to take care not to take too much from them, not to make them too vulnerable.

The prison setting influences the treatment staff's treatment aims, thereby changing the aim of the treatment guarantee as formulated in official policy. Treating the problematic use of cannabis becomes secondary to alleviating the negative aspects of being in prison. In this way treatment in prisons resembles new trends in community treatment, where it has become more legitimate to downplay the treatment of problematic drug use and focus on other aspects of the drug user's life (financial aspects, housing, physical health, work situation etc.) in order to help clients to stabilise (Vanderplasschen 2004, Asmussen & Kolind 2005). The difference, however, is that the prison environment is seen as detrimental – an environment that offers no alternative.

Cooperation between prison guards and treatment staff

The relationship between prison guards and treatment staff is often tense and conflict ridden, considering the contrasting values and objectives of drug treatment and the prison system. The challenge for the counsellors is to navigate in this field of ambiguity.

In general, treatment staff are very pragmatic and accept that when carrying out treatment in prisons they have to subject themselves and their drug treatment programmes to a larger system based on punishment and security. They accept that compared to community-based treatment, drug treatment

in prisons is restricted and limited in several ways, as Neale & Saville (2003) have also reported from the UK. All treatment programmes have established official routes of cooperation with the prison management. However, as we saw above with urine tests, treatment staff also sometimes see themselves as mediators between inmates and the prison system. For instance, they spend a lot of time establishing and maintaining informal contact with the prison staff. Some treatment staff have deliberately allied themselves with and befriended people in the prison system who are sympathetic towards the treatment projects and willing to help. A counsellor reflects on his mediating position:

> We work as a kind of buffer, no doubt. One inmate really needed to call his girlfriend, but was refused permission. I mediated and argued that it was essential for him. Another example was in a case of forcible removal of a child. The inmate really needed information about his child, and he was given permission because I intervened. So this is also the situation. We are sometimes like advocates on their behalf, at least in some matters. … But it is also a balancing act, as we have a partner: the prison.

This counsellor takes it upon himself to help bend rules for inmates. He believes that it helps the inmate's treatment process, as frustration, emotional imbalance and distress due to the inability to participate in family life outside prison are some of the primary reasons for taking drugs.

Treatment staff also know that in their daily lives inmates are solely in contact with prison guards and other inmates, and they know about the limitations this puts on the treatment programme. For instance, one counsellor reflecting on this predicament explained that the use of cognitive behavioural therapy aiming to help drug users find more adequate ways of behaviour is strictly limited by the incarcerated lives they lead, since they only have the treatment staff to practise their newly obtained skills with. Their relations with both prison guards and other inmates are few, impersonal, or strictly hierarchical; in sum not useful for trying out new behavioural patterns as suggested by therapy.

Treatment staff also have to take into consideration the prison guards' often negative attitudes towards drug users and drug treatment. Prison guards

often have limited knowledge about drug use and treatment programmes, and their work functions are essentially different from the tasks of the drug treatment programmes. The negative attitudes of guards towards inmates who use drugs may also be connected with the marginalised and stigmatised position that drug users in general have in prisons (see also Owen 1988). For instance, treatment staff report that the prison guards tell them that they are too naive if they believe that treatment matters, too soft on drug users, and that they take them too seriously.

> C1: Some prison guards are really grudging. They meet drug treatment with a lot of scepticism.
> I: What is this scepticism about?
> C1: 'Do you really think it's of any use?' If an inmate in our project delivers a positive urine test, the attitude is like: 'Ha, ha! There you see, he is not motivated at all'.
> C2: In some wings the prison guards were really dissatisfied if inmates were caught with a positive urine test but not thrown out of the treatment project. They think clients had to be thrown out; that it would be more motivating.

The relationship between prison guards and treatment staff is important, as treatment staff are dependent on prison staff in many situations – for instance in assisting in practical matters regarding the inmate, taking an inmate to therapy, informing them if a treatment session is cancelled, etc. Counsellors are also heavily dependent on the guards' informal contributions to or acceptance of drug treatment. For instance, do prison guards allow an inmate in treatment with serious abstinence to leave the cell door ajar? Are they lenient towards inmates who are irritable because they are in a special phase of treatment? Do they treat drug users with the same respect as other inmates? Relationships between prison guards and treatment staff can be filled with tension, which led one treatment manager employed by one prison to perceive his job as being that of an intermediary or translator between the treatment staff and the prison guards. In sum, the prison guards' attitudes are important in relation to the treatment process, the inmates' compliance, and the general acceptance of the counsellors' work.

Even though the prison setting counteracts the treatment goals, as reported in other studies (Kothari et al. 2002), the treatment staff pragmatically navigate in this field of ambiguity and adjust to rather than resisting the counterproductive conditions of the prison. We argue that such situation-based pragmatism instead of upfront resistance may be related to the general element of discretion as a characteristic of street-level bureaucracy (Lipsky 1980).

Why are clients motivated for treatment?

In general, motivation is regarded as very important by treatment institutions and treatment staff in explaining why clients start or leave treatment – either voluntarily or when they are expelled. In this sense, motivation becomes a black box explaining both the successes and failures of treatment (e.g. Asmussen & Kolind 2005). In relation to the cannabis treatment programmes, motivation in inmates is also deemed to be necessary in order for them to start treatment. Such motivation varies a great deal, but as argued above the main motivating factor for inmates is to ensure that they have negative urine tests and thereby uphold privileges (especially leave). Furthermore, as treatment staff report, motivation to seek treatment is primarily found in inmates who are close to their release.

It is well documented that people who seek drug treatment have a variety of different motives, some being rather pragmatic and not necessarily involving abstinence, for instance (Koester, Anderson & Hoffer 1999; Kolind 2007). In prisons, we argue, such pragmatism is pushed even more to the forefront, primarily as a consequence of the special treatment setting in a "total institution" and the zero-tolerance policy towards drugs. Consequently, not only are clients' motivations for seeking treatment diverse, but the treatment staff also willingly accept almost any motive a client may have for seeking treatment. As a counsellor optimistically states:

> It doesn't matter what reason an inmate has for applying for treatment. When an inmate has started, we will motivate him properly.

For the treatment staff, the very act of seeking treatment is a token of client motivation. Among the variety of reasons for starting treatment, counsellors

report the following: clients feel treated more respectfully in treatment programmes than in the prison system; treatment represents a pleasant change to the dull life of prison; clients hope to get an easier stay in the prison; clients want to use the treatment setting to create networks for dealing in cannabis; and some seek treatment because they want to stop/reduce their cannabis use (often in order to ensure that they are eligible for leave). In general, the treatment staff accept these motivating factors, naturally apart from the idea of using treatment as a network for dealing in cannabis. Another reason for the counsellors' non-insistence on strong motivation is that the treatment programmes need clients in order to run. Even though none of the treatment programmes had any difficulties attracting clients, counsellors know that their efforts will be judged partly on the number of enrolled clients.

Motivation, then, is a precondition for starting treatment; but it is also a black box containing a variety of meanings depending on the individual client and the treatment programme in question.

Conclusion

This article has focused on a new field for studying policy in practice: prison-based drug treatment. Our analysis has focused on counsellors' experiences with prison-based cannabis treatment in the context of national drug policies, drug policy in prisons, prisons as special institutions, and inherent organisational and ideological differences between prisons and treatment institutions. The aim has been to demonstrate how these aspects frame and influence counsellors' practices in concrete situations.

We have argued that the political focus on zero tolerance and the subsequent disciplinary reactions in relation to prison-based drug treatment amplify some of the dilemmas already existing in the prison setting, mainly the tension between rehabilitation and punishment. Relying on Goffman (1961) and Lipsky (1980), we showed that the act of discretion among treatment staff was highly determined by the general structural framework of the prison, based on supervising a prison population *en bloc* and having the primary objective of order and discipline. In other words, the pragmatism embedded in the work of treatment staff is situated and determined by the institutional setting. As a consequence, treatment practice in prison-based

cannabis treatment is redirected and takes on a life of its own irrespective of both the official political intentions behind the treatment guarantee and the usual goals of community-based drug treatment. We have indicated four important aspects of this institutionally determined pragmatism/discretion:

First, we have shown how counsellors are situated in a field of tension when it comes to the massive introduction of urine tests. On the one hand these tests may motivate inmates to seek treatment; but on the other such motivation is seen as not particularly sincere. Furthermore, positive urine tests and the subsequent disciplinary sanctions may undermine the building of a trusting relation between counsellors and clients in important ways. Secondly, we have argued that when providing cannabis treatment counsellors have to work primarily with the psychological stress caused by imprisonment: rather than providing drug treatment, counsellors alleviate the damage caused by incarceration. Thirdly, the counsellors' relationship with the prison guards is important with regard to treatment. Counsellors report that guards are often uncooperative and sceptical towards the treatment programmes, and may even actively work against them. Finally, as in community-based treatment, motivation is the key for clients in starting treatment. In prisons, however, the organisational framework produces additional and rather pragmatic motives for treatment. The zero-tolerance policy and the random urine tests with subsequent sanctions for positive tests are the main motivating factors for starting treatment in all four programmes.

Finally, it is worth underlining that the treatment staff's necessary pragmatism (which Lipsky (1980) called discretion) when working in a highly disciplinary setting or 'total institution' is very diverse and situated. The ease with which official policy documents can initiate new initiatives, such as drug treatment and a treatment guarantee in prisons, is counterbalanced by the complexity of practice. The consequence of the redirections of the goals of prison-based drug treatment as analysed above should give rise to critical re-examination and reconsideration of the official goals of drug treatment in prisons.

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NOTES

1 Treatment advisory officers are employed by the Prison Service in order to supervise all treatment activity in the prison.

2 The Prison Service is responsible for implementing new laws and regulations in the prison system. They operate with a four year contract with the government. In the contract for the years 1999 – 2003 no focus was placed on drugs. In the contract for 2004 – 2007 a particular

focus was placed on "zero-tolerance towards drugs in prisons and jails". The aim being to "crack down" on drugs in prisons, as the contract underlines (www.kriminalforsorgen.dk); a direct result of the new drug policy.

3 In the drug free units inmates sign a contract with the prison to abstain from using drugs. The prison then offers better facilities, education, etc. for these inmates. In 2005 there were about 55 places in these wings (www.kriminalforsorgen.dk), (Lodahl & Pedersen 2007).

4 The drug-free treatment programmes are high threshold services with demand on clients for abstinence during the course of treatment. Treatment methods differ from programme to programme including 12 steps, therapeutic community, and social-pedagogical methods. Inmates participating in a drug-free treatment programme are placed in separate units, cut off from the rest of the prison. Here counsellors work full time. The programmes are voluntary, however inmates are referred to treatment by a prison counsellor and might be transferred to another prison in order to get treatment (Asmussen, Kolind & Nielsen 2006, Dahl & Pedersen 2006, Storgaard 1998).

5 Prescriptive medicine is judicially under the Ministry of Health and The National Board of Health. It is their responsibility to organise and supervise methadone and other substitution medicine prescription. However, the responsibility for the psychosocial treatment of drug users is under the Ministry of Social Affairs. Inmates can be in methadone treatment when serving time in two ways. First, if inmates are already in methadone treatment upon arrest and if the community treatment service agrees to enrol the client upon release, they can uphold their prescriptive medicine in prison. Secondly, the prison doctor can prescribe methadone treatment to drug using inmates. This however, is mostly used not as maintenance, but as a three weeks detoxification. No statistics about how many inmates are in methadone treatment exists, but unpublished data from the Prison Service show that around 320 inmates are in methadone maintenance treatment covering all 13 Danish prisons.

6 The prison systems data show a general decrease in positive urine tests from 17 % in June 2005 to 12 % in June 2006. This drop is primarily related to a decrease within jails and in test that are positive for cannabis, meaning that the more severe affected drug users (both of cannabis and other drugs) continue their problematic drug use (*The intensified urine control* 2006).

7 Legibility is authorised by the individual prison authority, and has to do with the length of the sentence, the conduct of the inmate, risk of escape, and so on.

8 In this study we have not heard about change in drug use as a consequence of implementation of mandatory random urine tests, as for example Dean (2005) suggests.

Part II
Drug policy at local levels

Helle Vibeke Dahl

OPEN DRUG SCENES: DANISH DRUG POLICY REFLECTED THROUGH INTERNATIONAL DRUG PROHIBITION AND LOCAL INTERVENTIONS[1]

Introduction

Over the course of the twentieth century the structures and organisations established in support of international drug policy have proliferated in number as well as in complexity. The major conventions and treaties behind this development, elaborated with the explicit aim of repressing all non-medical or non-scientific production, distribution, possession and consumption of drugs, provide the foundation for the existence of a worldwide system of drug prohibition supervised by the United Nations (Nadelman 1990; Hartnoll 1998; Levine 2003).[2] In the real world, however, national drug policies are neither uniform nor static but represent a rather variegated spectrum with marked differences in underlying philosophies, formulated goals, legislation and interventions; and as suggested by Reinarman & Levine (1997) the varieties of drug prohibition can be seen as a long continuum, extending from the most criminalised and punitive to the most decriminalised and regulated forms. Drug policy operates at three distinct levels: the international, the national and the local; but as stated by Wodak (2006), in the end 'all drug politics is local'.

In this chapter attention is paid to the local level – the level at which local politicians chart the course of public interventions and settle expenditure, where street-level bureaucrats (e.g. the police and professional practitioners engaged in the drug treatment field) translate policies into practice (Lipsky 1980). 'Drug policy live' will therefore always be an expression of peculiarity, as it is enacted in response to uncountable unique sets of conditions and constraints of a particular local community; thus local drug policy can be

seen as a prism through which international and national resolutions are reflected and enacted (Hartnoll 1998; Hunt & Barker 1999).

The subject of local drug policy will be approached with a focus on drug scenes as sites of public intervention and control, and in more detail by exploring the local drug scene landscape in a Danish urban setting that has been subject to regulation and intervention for almost forty years. The main objective is to describe and analyse the way in which local citizens – in this instance poly-drug and methadone users – perceive, adjust to and react to interventions based on law enforcement, medical substitution treatment and harm reduction services.[3]

Intervention deals with people shaped by their time and place, as pointed out by Agar, who argues with specific reference to the drug field: "… becoming an addict and becoming an ex-addict follow different trajectories in different places at different times. The endorphins are the same, but the biographies and histories and languages are different. What makes it happen and makes it stop are *local* more than *chemical*." (Agar 2006:248, italics original).

As an anthropologist and a dedicated fieldworker, Agar has persistently called attention to the fact that to understand, explain and effectively intervene in aspects regarding problematic drug use it is crucial to know how and why something goes seriously wrong for so many in some social clusters and not in others. In his view, this requires an intimate and first-hand knowledge of the drug-using world: "Its basic premise is, if you're interested in some corner of the world, you climb inside it and spend time with its inhabitants. Another premise is, you look for connections, among the pieces of that world and between that world and the rest of the city, the country, the planet." (ibid.: 18). In line with Agar, I will argue that to understand drug policy, its effects and impact, it must be investigated in its local setting with an eye to everyday practices and interactions between local authorities, street-level practitioners and drug users.

In the major part of the drug research literature, the voices and perceptions of drug users are generally neglected or completely excluded, and in studies on drug and control policy they are almost totally absent as active and reflexive subjects (Hunt & Barker 1999, Dahl 2004). However, qualitative research and in particular ethnographically based studies aiming to

understand the nexus of meaning and context (Agar 1997; 2006) proceed on the assumption that the life stories, subjective experiences and points of view of drug users are relevant and valuable sources, both for research which addresses the micro-setting of drug use and intervention, and research which addresses the macro-setting of policy and social and economic structures and their impact on individual and group drug behaviour and practices (Grund 1993; Waterston 1993; Bourgois 1995; Bourgois et al. 1997). Neglecting or excluding the perspectives of drug users has been considered a manifestation of the social order and an expression of how dominant perspectives overrule the perspectives and experiences of the subjects of intervention instead of appreciating them as sources of information for policymakers to develop more pragmatic and efficient strategies and interventions in deference to the needs of users (Bourgois 2002; Asmussen & Jöhncke 2004; Agar 2006).

With the priority placed on repression and criminalisation of illicit drugs in preference to public health, Danish drug policy operates within a prohibitionist framework. These priorities are reflected at ground level, but display variegated local strategies and manifestations, as two recent Danish studies on the policing of drugs and drug scenes in Odense (Grytnes 2003) and Copenhagen (Frantzsen 2005) have demonstrated.

This study adds yet another element to the knowledge of Danish drug policy at local level. It focuses on how local solutions to local problems on the one hand are performed in accordance with international drug control policy, and on the other have recourse to solutions and practices conflicting with the ideals of international prohibitionist and abstinence ideology. In this sense, the changing and uneasy balance of local control and social and public health interventions provided by the discretion of street-level bureaucrats (Lipsky 1980) mirrors the 'ambivalent balance between repression and welfare' embedded in national Danish drug policy.[4]

The street-level perspective of this chapter is primarily informed by drug and methadone users' experiences with and perceptions of drug control and intervention strategies. The chapter is structured around cases depicting drug scenes in various inner-city locations customarily frequented by drug and methadone users with a focus on the 'open drug scenes'. Combined, these empirical cases are aimed at providing insight into what constitute the main settings and activity spheres in the lives of socially marginalised drug and

methadone users who spend some or almost all of their time 'on the streets' and in low-threshold facilities. These cases will serve as a background for looking into how 'local drug policy in action', defined as attempts to regulate, prevent and suppress illegal drugs and drug use, has developed historically and how it tends to reflect conflicting interests between different players and authoritative bodies at local, national and international level.

Methods and data

The analysis of local drug scenes in Aarhus as a case of local drug policy is based on an ethnographic field study on the everyday life of methadone and poly-drug users in four Danish cities. For the present purpose I mainly rely on data from Aarhus, the second largest city in Denmark with a population of 300,000, which was the main site for the most intensive part of a year-long piece of ethnographic fieldwork followed by regular contact revisits.

The role of ethnography has been described as an attempt to 'record how individuals perceive, construct, and interact within their social and economic environment' (James 1977:188), and to allow for a holistic, flexible and explorative approach to the field. The collection of data involved observations, participation, and informal interaction with drug and methadone users in various settings: in and around treatment centres and methadone clinics, low-threshold facilities, the open drug scenes of the streets, and in private homes. Life-story interviews were carried out with 15 male and 10 female long-term methadone users, two of them former users. The only criterion for the formal interviews was the wish to participate. The age of the interviewees ranged from 21 to 55, but like the majority of my informants most were in their thirties or forties.[5] In addition to the taped and transcribed interviews, shorter conversations with key informants were taped when the opportunity arose and subject to informed consent. The bulk of the data, however, has been produced on the basis of observations, conversations and informal interaction with users and recorded as field notes (Sanjek 1990; Emerson et al. 1995). Another set of textual data has been procured from external sources in the form of newspaper articles, various official documents, reports and literature providing information on local initiatives, and incidents regarding drug issues have been included as field data. The latter material, covering the

period 1969-2007, has served the dual purpose of validating information about past events and developments provided by interviewees and informants met during fieldwork on the one hand, and of supplying information about local debates, political initiatives, public interventions and responses to open drug scenes on the other. Newspaper articles have been found through the Local Historical Archive of Aarhus's collection of articles on drug issues (1969-1987) and through Infomedia.[6] These searches, resulting in around one hundred articles and references, have been confined mainly to two locally based daily papers: Århus Stiftstidende (ÅS) and Jyllands-Posten, including the local section JP Aarhus (JP).[7] The articles have provided an overview of events and patterns regarding the local situation, and of whom and what are the local main players and claim-makers in the field. For the present purpose they have especially served to focus the framework of the chronology and date events with the users' narratives, providing their perspectives on and understandings of the course of events and interventions.

Setting the drug scene – in terms and in public space

All over Europe in cities of a certain size there are usually one or more locations where groups of drug users get together, typically in the centre of the city and in the vicinity of popular spaces such as railway stations and main shopping streets. According to Bless et al. (1995), there is no generally accepted definition of the term 'open drug scene', because the location and size of such scenes as well as the types of drugs and users involved vary significantly. In consequence, the concept can at best be said to refer to "all situations where citizens are publicly confronted with drug use and drug dealing" (ibid: 129). Yet, three distinct types of drug scenes have been identified: *concentrated open scenes* described as large permanent concentrations of drug users at a focal point; *dispersed open scenes* consisting of small concentrations of drug users at various places and individual scenes, often mobile; and *hidden scenes*, where drug activity is limited to residential premises of users and dealers or to public places where evidence of drug use activity consists of discarded needles and other sorts of litter (ibid.).

In European metropolitan contexts, concentrated urban drug scenes began to develop in the late 1970s and early 1980s, some of them including hun-

dreds and even thousands of drug users. This was the case in Zurich, where throughout the 1980s hundreds of drug users and ultimately 2,000-3,000 disorderly and unhealthy illicit drug users congregated daily at Plaztspits Park until 1992, when the police dispersed them to other parts of the city (Grob 1993; Klingemann 1996; Falcato et al. 2001). However, the drug scene problem of Zurich, which was mainly defined in terms of public and social nuisance, was curtailed when the repressive control strategies were eventually replaced by a harm reduction-based approach upheld by broad-spectrum treatment and care services (Waal 2004).

Open concentrated drug scenes, characterised by activities of undisguised drug and injection use, dealing, soliciting and petty crime on a 24-hour basis in combination with intense policing and surveillance to repress the phenomenon can still be observed in European cities (Kemmesies 1999; Waal 2004), among these Oslo and Copenhagen (Frantzsen 2001; 2005).

Compared to the open drug scenes in Western urban and inner-city sites described in the literature, the problems exposed in the pockets of the dispersed drug scene landscape of Aarhus certainly appear more restrained and modest in terms of the number of users, drug-taking behaviour and the scale of drug dealing. Nevertheless, complaints of social nuisance from the neighbouring surroundings and local citizens seem comparable to reactions elsewhere (Fischer et. al 2004).

Although alcohol has become the main substance of consumption on the drug scenes of Aarhus within the past ten years, the majority of those gathering at particular sites in public space regularly use illicit drugs, so the term 'drug scene' is maintained in this study. However, neither among themselves nor to others will the users talk about drug scenes. The traditional inner-city meeting places are commonly called by their official local names, e.g. name of the street, square, park, but with one exception. When referring to 'busskuret' [the bus shelter], users know exactly which shelter they are talking about: the one close to the methadone clinic. At present there are two main scenes and six smaller ones, all sharing the characteristics of being relatively permanent but dispersed with small concentrations of drug users. The first case deals with the current major open drug scene of Aarhus.

Alfred and "Chestnut Corner"[8]

Drawing on data from one of the main drug scenes of Aarhus, the purpose of this first case is to introduce the main elements in the local drug scene phenomenon, including the complex of regulatory drug policy mechanisms enacted to keep illicit drug activities and the users under control.

The drug scene in question is located on a corner facing a busy thoroughfare with central city bus stops in a mixed residential and shopping area. Sheltered by several old chestnut trees and a recently established public lavatory, the users hang out in small groups. Depending on the weather and the time of the month, 30-60 users will attend this site on a daily basis, some going to and fro several times a day. Roughly speaking[9], at least 200 persons come by more or less infrequently. Usually there will be around 5-10 users congregated, and only rarely will more than 20 be present at the same time. Over time the scene represents a flow of various people coming, staying, leaving and returning.

The groups of users compose a mixed clientele as regards age, drug consumption patterns, criminal activity and associations with the public treatment system. The vast majority are male, aged 30-55 and enrolled in methadone maintenance treatment. Women and younger drug users, and non-drug users only drinking beer, constitute a minority. Most users (though not all) attending the drug scene suffer obviously from various kinds of ill health. Many complain that their drug use has caused both physical and psychological health problems; others relate their deteriorating health to the stress and hazards of their former or current street life comprising violence and contaminated drugs in addition to risky injection habits. They may blame themselves for bad behaviour and weak character, but they may also blame 'society' or 'the system' for its intolerant and condemnatory attitude to their drug use – thereby turning them into 'second-rate citizens'.

> From morning till early evening drug and methadone users come by Chestnut Corner looking for company, exchanging news, drinking beer, or selling or buying drugs. Some stop shortly, others hang out for hours. Small-scale dealing takes place, mainly of pills and hashish, and usually discreetly. When dealing in heroin and cocaine, typically in small quantities of pre-packed 'user bags', the people involved will usually leave the site and

go to more secluded areas nearby such as backyards and basement passages. Alternatively, they may do business between the parked cars behind the site.

Alfred, a man in his late forties and a former 'heavy drug user', is usually the first one to arrive in the morning, and at the moment he is the only person hanging out all day at this particular site. For more than fifteen years he had a daily use of opiates or 'whatever he could get his hands on'. These days he only drinks and smokes some hashish. His mistrust of the system in general and the methadone system in particular, which in his experience was both inflexible and humiliating, made him quit 'the hard drugs' on his own around four years ago. After quitting he isolated himself, but becoming more and more depressed and weary by his self-imposed solitude, he returned to Chestnut Corner. Spending his days here has become a routine which Alfred compares to that of 'the common, working people'. He says that it gives his life structure and meaning. Having spent a total of three years in prison, he now takes his precautions: no possession and dealing of any kind of illegal drugs, and no interference if or when violent episodes break out. Alfred has a high status among the regular visitors owing to his knowledge about what is going on in the environment, his willingness to share information and communicate contacts, and his persistence in abstaining from 'hard drugs' – although many are still convinced that it is only a matter of time before he resumes drug taking.

Over the years, neighbouring shopkeepers and residents have often made complaints about the disorderly and at times loud groups congregating at Chestnut Corner. Following a report the police will demand that the people present leave the site, and will follow up for a short or longer period of time with more intense patrolling and frequent busts. According to the users, Alfred included, nowadays the police are more lenient than in former times: "Taught by experience," as Alfred states: "They know that we will just occupy another corner if we're chased away from here. They've learned that we will always return." Nonetheless, Alfred detests the police. Every time a police car passes by he spits on the ground and turns away mumbling words of disgust. When police officers arrive at Chestnut Corner for a chat with users or for examinations and personal searches, he is visibly angered. When spoken to by the police, he is a man of few words.

At certain times and on certain days during the week, the street team (a nurse and one or two social workers) comes by, talking to the users, providing simple social counselling and health services, and distributing syringe sets. Alfred appreciates their services. A former street team worker helped him to find his present apartment and to apply for an early retirement pension. In several instances, the street nurse has taken care of and advised him about concrete health-related problems. Despite this he has often expressed his doubts as to whether the street team's assurances of anonymity and professional secrecy are to be trusted. Thus, his suspicions were raised when first a police officer came by looking for an elderly user by the name of Jens Jensen and then the street team nurse asked for the same man later the same day. The nurse had a hard time convincing Alfred that this was a pure coincidence, and that she herself had a prearranged appointment with Jens. Alfred nevertheless accused her of breaking the confidentiality rule 'by using the man's full name', and insistently impressed on her 'never ever to discuss his person or his matters with anybody from 'the system''.

Competing control strategies and responses to drug use and users

This snapshot depiction of a local drug scene contains the fundamental aspects of the drug scene phenomenon and local drug policy practice. In addition, it suggests that local drug policy interventions can also be read in the life stories of individual drug users. These aspects will now be discussed briefly.

Like other open drug scenes, Chestnut Corner contains the basic elements of a site at which users meet and socialise and where drugs are sold on the one hand, and a site causing nuisance and public reaction on the other. Open drug scenes and the exposure of illicit drug-related activities have increasingly become a matter of public concern, debate and analysis at national and international levels with a view to what the appropriate responses should be (Waal 2004). The reactions of different societies and local communities show considerable variation in their reflection of different societal attitudes and levels of tolerance in relation to drug users, drug use and associated behaviours ranging from 'restrictive' to 'liberal' responses (ibid.). No matter whether the responses are based on predominantly restrictive or liberal

humanistic measures, they contain a dual consideration regarding the well-being of the public on the one hand and the individual drug users on the other. The restrictive approach tends to be influenced by the perception of drug use as an epidemic against which repressive measures must be taken to prevent the spread of what is regarded as a disease (ibid.). Police actions and law enforcement against drug scenes will therefore primarily be performed to protect the public. In opposition to the representation of drug users as contagious and diseased with deviant behaviours to be repressed and/or punished, the liberal and humanistic approach takes the view that the drug user is a victim of alienation and stigmatisation in a repressive society (ibid.). In turn, prohibition and oppressive measures are blamed for causing the sufferings and illnesses of the drug users (Nadelman 1990; Szazs 1998). According to this "non-prohibitionist" position, the only meaningful response to prevent and repress the social nuisance of drug scenes is to promote public health interventions based on harm reduction.[10]

As described above, Chestnut Corner attracts both prohibitionist and anti-prohibitionist oriented interventions. When congregating at this open drug scene, users are under supervision by and targets of the dual and in fact contradictory strategies of policing and harm reduction. This paradox occasionally becomes particularly evident when police officers in civilian clothing search users on suspicion of drug possession or dealing, while at the same time the uniformed street team turns up to provide users with injection equipment.

Alfred and other users primarily visit Chestnut Corner and other open drug scenes in search of company – not only to consume, buy or sell drugs (even though both use and minor dealing does occur). In the users' perceptions, the drug scenes are social scenes which they frequent to avoid boredom, loneliness and social isolation. With regard to the question of why they congregate in an open public space, two interrelated reasons stand out. The first refers to lifestyle and the relative autonomy of street life – for instance when users explain that social life in open drug scenes adds variety to meeting privately or at indoor low-threshold facilities. Despite the risk of interference from the police, the drug scenes are widely regarded as 'free spaces' exempted from the trammels of rules and control to which users are subjected in regular treatment settings and to a lesser extent at drop-in

centres. The second reason can be seen as an expression of defiance or resistance against the experience of marginalisation. In general, the users are well aware that their presence provokes public annoyance and is only tolerated as long as they keep a low profile. Actually, it can be argued that although the local drug scenes of Aarhus are located in popular places, users actually always stand back and allow other people to pass by at a distance. The users' insistence on their right to be present 'at the centre of things' is expressed using arguments such as: "Even though I'm a drug addict/methadone user, I can stand wherever I like" or "We're outsiders and a thorn in the flesh of society, but we're still citizens and taxpayers", thereby claiming their right to congregate freely like everybody else.

Alfred, the main character in the particular case of Chestnut Corner, is truly exceptional compared with most of the users frequenting open drug scenes, for three specific reasons: (1) he gave up opiates after many years of intravenous use, (2) he did so on his own without any formal treatment, and (3) in spite of his abstinence from 'hard drugs' he spends his days in the drug environment, socialising with active drug users. In other respects his life and drug history differ little from that of most other seriously afflicted drug users: an agitated childhood and adolescence spent at various children's homes, foster families and youth reformatories; little schooling; no education and a criminal record. From the age of 17 he was left to his own devices, and for many years to come he moved in and out of rented rooms, shared apartments, prisons for short-term sentences, and shelters. All his life, he says, he has been surrounded and controlled by social workers, police and prison guards; all his life he has been pushed around.

According to my informants, the experience of surveillance and control, of being pushed around, driven away, chased, expelled, subjected to quarantine and refused admittance to specific locations and areas is a fundamental part of illicit drug use and street life. In recent years uniformed security guards privately hired by the city association of shopkeepers bar certain users from entering stores, supermarkets and shopping centres on a daily basis, and make them 'clear off'.[11] Now and then, police officers may turn up or start more intensive policing in order to make people leave their habitual congregation sites. Both charitable and public care facilities and drug treatment centres may also require users to leave for a certain period of time (or for good in

case of violations of institutional rules), and popular low-threshold facilities have been closed down or reorganised – leaving some or all users with no other alternative but the streets.

The strategies of policing, stressing and dispersing users from outdoor street scenes are just one aspect of local drug policy in action. Another is the workings of the socially based interventions and the expansion of public drug treatment developed since 1970, the existence and services of which can be linked to the visible presence of drug users in the streets and inner-city meeting places. These two intervention strategies will be described in the following pages.

Evolution of the local drug scene – police enforcement and user responses

Since the emergence of 'the youth drug problem' in the late 1960s, the municipal authorities of Aarhus have responded actively to the presence of drugs, dealers and users in public (Mark 1973).

The 1960s were a decade of change and transformation throughout the western world. As a university city, the influence of the youth revolt and the radical break-ups in values and traditions was soon evident in Aarhus. However, like everywhere else the seemingly unified groups of young people congregating around music and experimental drug use were composed of various subgroups. In his book on early drug use in Aarhus, Mark (1973) distinguishes between five groups, including the *provos* representing political activism and the *hippies* representing a pacifistic, collective and alternative lifestyle. In these two groups drug use was experimental and usually controlled, mainly involving substances such as cannabis, hashish, LSD, and (more rarely) amphetamines. A third group consisted of the *rockers* and *mods,* representing a hostile and aggressive attitude especially towards the hippies. Their educational level was in general low, but their level of criminal activity was high. The drug use in this group primarily involved amphetamines, sometimes morphia, and very rarely hallucinogens; but within the core group alcohol and Coca Cola were the preferred drugs. The fourth category was a group of adolescents without any established group culture whom Mark termed the *social losers*. In his description they represented 'a proletariat of restless opportunists', children of the child welfare authorities, environmen-

tally damaged and with a high percentage of psychological damage. Unlike the fifth group of *socially adjusted* young people still in elementary school or in further education or training, whose drug use was restricted to hashish and isolated experiments with LSD and amphetamines at weekends, Mark claims that the indiscriminate use and administration of drugs by these 'social losers' or 'socially maladjusted youngsters' was linked from the outset to release problems and chaotic abuse. In the early period they mixed with the tolerant hippies, a circumstance that made Mark characterise them as 'plastic hippies' (ibid.).

Although they never used that term themselves, several of my older informants who were once part of this emergent drug scene have reported that initially they regarded themselves as hippies. During a taped conversation with Eva and her husband Otto (who is four years older than her), they talked about how they had dressed up in colourful shirts, skirts and sheepskin coats; how drugs were shared generously; about the acceptance and tolerance they experienced; and about the feeling of belonging which had been part of the 'hippie scene'. Provoked by Eva's nostalgia, Otto eventually interrupted her, claiming that in spite of everything 'they' had always been different and regarded as different:

> We were another sort of people, and they knew it. They also knew I was always good for providing a little something for a smoke. And they would start discussing the quality and the differences between 'red Lebanon', 'black Nepali' and 'standard Moroccan', or how LSD could help change people and the world for the better. I just wanted to get stoned and have a good time (...).
>
> The acid trips drove me completely 'star crazy', but the morphine, oh ... that was my drug; and it scared them. They turned away; it was 'junkie stuff'. They didn't want us to be around because we shot the stuff. (...)
>
> Remember Eva, down in 'the house', when we had this bottle with pink morphine that Olsen and Prip had cracked from some pharmacy! That was the time when we still shared everything; you could just use what you wanted. Uhh ... I can still see that bottle in my mind's eye, one litre or so ... That's also when I got hooked for real. (Otto, methadone user, 55 years old.)[12]

As a young teenager Steen had also joined 'the hippies' in the Town Hall Park, and recalls his first experience of police intervention as an attempt "to smash up the peace, love and understanding". After a life on drugs, the last fifteen years almost continuously in methadone maintenance, he says he has calmed down and prefers the drop-in shelters when in need of company, although he may occasionally pay a visit to one of the open street scenes. Looking back, summarising the main locations and events regarding the inner-city drug scenes, he matter-of-factly states: "We've always been pushed around! We've always been chased! They throw us off one site and we start frequenting one of the others. Then after some time we usually return. It has been going on for years, you get used to it." (Steen, methadone user, 50 years old.)

To Steen and other 'addict survivors' (Courtwright et al.1989) of his generation as well as to younger users, the police are the main force behind the 'pushing and dispersing strategies' practised for more than three decades. In a broader framework, the users' experiences clearly reflect the repressive trend in Danish drug policy and the high priority given to law enforcement. On the other hand, they also illustrate the limited success of these repression efforts. Over time the problem of drug users loitering on inner-city sites has certainly been physically displaced and in some instances permanently removed, but groups of users have always been visible in the public space. However, the street drug scene has undergone changes over time. One major change can actually be seen as a consequence of the police efforts, another as a consequence of the increased availability of methadone treatment and low-threshold drop-in centres.

The 'pushing around' strategy: 'purification attempts' and dispersal of the street scenes

The closure of the early drug scene and later of the social experiment involving the user-run house resulted in young drug users (increasingly experimenting with various illegal morphine preparations and engaging in criminality to support their use) trying to keep out of sight of the police and the social authorities (Mark 1973). During the last period of the existence of 'the house', hashish disappeared for a time from the market in Aarhus, and within that same period intravenous drug use increased drastically (ibid.)[13] Several infor-

mants and interviewees have confirmed that 'the drought' meant a change in their drug use.

In the early 1970s new types of drugs were introduced, among them 'Paki pills', the name given to morphine tablets imported from Pakistan. Heroin did not appear on the market in earnest until the mid-1970s. Throughout the 1970s small, mobile groups of drug users mostly stayed in public parks and condemned houses, and heroin became their preferred drug of consumption (although anything would be used if heroin was not available). As predicted by Mark (1973), the 'social losers' had turned into a social and criminal problem which the police and social street workers found it hard to tackle.[14]

In the 1980s two open drug scenes grew up. Until the late 1990s these two consumption and market scenes were segregated, with different drugs being sold in different locations. Hashish was sold in Mølleparken, a park in front of the main municipal library; and heroin, amphetamine and prescription medicines were mainly sold on Bispetorv by the Cathedral (Spannow 1997). Both sites were subjected to police surveillance and frequent busts, but attempts to suppress them had only short-term effects (ibid.). According to 1994/1995 data, outdoor drug dealing was estimated to represent only 10 % of the illegal market, with 90 % being provided from private addresses and social networks (Kaa & Bowmann 1997).

In 1990 the Municipality of Aarhus introduced a 'city-cleaning' campaign (ÅS 1991).[15] During the 1990s 'alcohol-free, non-drinking zones' were established, eventually comprising the area from the main railway station through the pedestrian precinct till Bispetorv, the central 'meeting and market place' at which up to 50 or 60 drug users would congregate at what was called 'Spytbakken' [the Spittoon].[16] In this process the users were pushed around and away. But as in Vesterbro in Copenhagen, where prohibition zones were introduced and breaches led to fines (Frantzsen 2005), other corners and places just outside the 'prohibition zones' were subsequently occupied.

Over the years several initiatives were taken to find more permanent solutions to the drug scene problems in Aarhus, and some of the most controversial of these will be presented here. The first attempt dates back to 1991, when local politicians agreed to put a stop to the drug scene activities going on around Spytbakken on Bispetorv, and as an alternative proposed and finally established a fenced-in outdoor area near the Town Hall, soon

to be known as 'Abeburet' [the Monkey Cage] (ÅS 1991a). Users' protests and assurances that the site would not be visited voluntarily were ignored. Eventually, complaints from the leader of a nearby music school and parents of children attending the school had an effect. The project was cancelled and the wire fence removed (ÅS 1991b).

Once again in the mid-1990s politicians and shopkeepers tried to establish an alternative to 'Spytbakken'. This time an on-site hut staffed with social workers and mainly aimed at attracting young users was placed (to the dismay of the neighbourhood) on Vesterbro Torv near the centre of the city. After a few months and several anonymous threats of violence to make the users disappear, the on-site hut was burned down by unknown perpetrators (ÅS 1996; 1996a; Nielsen 1997). It was never re-erected.

In connection with the annual Aarhus Festival Week in 1997, the police tried out a new method which caught the attention of the national tabloids. An article reported that "Ten of the most visible injection addicts in Aarhus" had been preventively arrested on the first festival day and only released after the weekend with a restriction imposed on them by the police to stay away from Spytbakken for the rest of the festival week. The police officer on duty explained the intervention in this way: "Usually we are able to disperse the drug addicts throughout the city, but during Festival Week, they congregate wherever they can make themselves most visible. So we have arrested them, using a so-called flexible clause to stop them from causing annoyance" (EB 1997).

In 1999 discontent among shopkeepers and residents in the city centre escalated. The local authorities announced their plans for a "permanent solution" by constructing two open sheds with sanitary facilities, one for alcoholics and one for drug users, on an empty plot of land to be planted up with willows in the harbour area (JP 1999). The plan, instantly known as the 'Needle Park' among locals, was introduced partly as a solution to the physical "removal of the drug and drinking problem" from the city space, and partly as "a harm-reduction initiative" with reference to the access to running water and boxes for safe needle disposal.

From the announcement of the plans in July 1999 until the Needle Park was officially opened in April 2001, there was a great deal of debate in favour of and against "exporting the drug users to a remote harbour area". Basically,

the police supported the idea and agreed not to seek out and stress the users in the same way as in the streets; on the other hand, they said that the Needle Park represented a true dilemma in relation to their law enforcement role in connection with illegal drugs (JP 2001). Street workers and other street-level bureaucrats in daily touch with users objected to the plan. The users themselves were never officially asked, but claimed that they had no intentions of using the place. In a letter to the authorities, the local user organisation protested by referring to the fact that "like other so-called groups of outcasts we prefer to congregate near to the throbbing pulse of the city." (St.R.I.S 2000).

During the debate two aspects were underlined. Firstly, the fatal costs of heroin injection use were highlighted by the overdose deaths of six individuals in the month of August, which brought the number of drug-related deaths in 2000 up to ten (JP 2000).[17] Secondly, a significant aspect of "the drug and public nuisance problem" was highlighted. Shopkeepers and resident neighbours' complaints about increased violence, drug dealing and consumption in the open area around a low-threshold drop-in centre in the inner city drew attention to the role of public drug treatment. In short, the focus was turned to the availability, organisation and quality of the services provided by the local drug treatment centre, revealing problems and malfunctions in several areas, e.g. lack of coherence and cooperation between medical and social drug treatment; serious problems in the working environment of the municipal social drug treatment centre; a substantial staff turnover rate; and not least long waiting lists for treatment (ÅS 2000; 2000a, 2000b; 2000c). In response to the criticism, the Social Welfare Committee demanded that the drug treatment sector should establish order and optimise social treatment and health-care initiatives (ÅS 2000d; 2000e). In the course of 2000-2001 the waiting lists were eventually brought down, and with a less restrictive attitude to prescribing methadone maintenance a significant number of the drug users who had been creating problems in the streets started treatment and the situation calmed down. Not least the opening of a municipal low-threshold drop-in centre and a pilot project for the worst affected methadone users based on harm-reduction principles (Asmussen et al. 2003) helped to thin out the groups of users hanging out in the streets.

The establishment of the Needle Park was not a viable solution removing

groups of users from the inner-city street scene. As predicted by the target group, the place has neither been seen nor used as an attractive alternative. Some may go there occasionally, but in general the site is visited reluctantly if ever. The distance from the city and the isolated location, combined with the risk of being robbed or visited by the police deter users from using the place the way the authorities intended.

Changes in the illegal market and consumption patterns

By about 2000 the police had finally succeeded in turning Mølleparken and Spytbakken into such stressful and unattractive meeting places that they were abandoned for good. In consequence, the inner-city outdoor sale of hashish and 'hard drugs' (which had formerly been segregated) merged with a proliferation of indoor hashish clubs creating new challenges for the police and local residents around town. (Asmussen & Moesby 2004).

However, basically the nature of the local drug street scenes in Aarhus has not changed much over the last three to four decades. They are still primarily social scenes for marginalised and socially excluded citizens seeking company among equals who accept drug taking as a social activity. On the other hand, this is exactly what has put these scenes under constant pressure. What has changed is the type of drugs taken and circulated, and the consumption patterns. Since the late 1990s injecting in public has become an increasingly rare practice, while consumption of alcohol in the form of strong beer has increased immensely, especially among users on methadone, whose number has increased considerably since the mid-1990s.[18]

In general, alcohol use on the drug scenes now plays a prominent role. Most of the users included in my material rarely or never drink alcohol when they are in active drug use, which is explained with reference to various factors. The most frequently mentioned grounds are the following: alcohol "boosts the effect of methadone" (intoxication purpose); it relieves withdrawal symptoms, e.g. from inadequate methadone dosing (self medication); and some of the quite plain reasons given are that alcohol is a legal and a social drug (cultural conventions) and serves to fill in time ('empty time'/boredom). During one interview Benny, whose alcohol use was creating problems, touched on several of these explanations as this excerpt illustrates:

Before I never drank; heroin and alcohol don't go well together, and besides I was busy chasing (…)

In the beginning methadone was good, I got enough to get a small high then after a while it ebbed. And believe me or not, but for a long time I was very motivated to stick to methadone alone. However you can't help hearing and seeing what is going on around on the [methadone] clinic, and I was getting restless or … nothing really happened, I didn't know what to do with all this leisure, the days felt so long. (…)

Some say that hot coffee along with methadone will make it work stronger … and 'benzos' too, but I've never been a 'pill-nodder'. Strong beer works too (…).

I started to hang out at the clinic, and somebody goes off to buy beer and later we may decide to go to 'The Fountain' or 'Chestnut Corner' or down to the drop-in centre (…) These days I always take a couple of beers with me, and I've usually drunk a couple or more before I pick up my methadone. I'm not drunk; it just makes me feel at ease, it takes the tip off my tensions (…)

But you saw how I freaked out the other day when she [clinic staff] asked me to blow [breathalyse]. And I know very well that I'm on a downward path, but interfering with our use of alcohol to dispense methadone … I mean; that's not up to them to decide what I drink, I've started treatment for my drug problem. (Benny, 42 years old.)

Quantitative effect studies have also shown changes in users' drug consumption patterns after being maintained on methadone (Pedersen 2001). In addition, it has been documented that problematic alcohol use is significantly higher among the most stressed and elderly methadone users than among younger and 'active' drug users (Asmussen et al. 2003). However, field observations suggest that alcohol consumption in general has been under-reported in questionnaire-based investigations among both male and female users. The local street-team nurse also reports that alcohol use had increased significantly among methadone users. She is worried that the use of more frequent breathalyser tests in the methadone clinic, something which was introduced as a medical precaution and which may result in the refusal to dispense methadone if the alcohol concentration units exceed 1‰, has

caused several people with an alcohol problem to drop out of methadone treatment and consequently develop more destructive consumption patterns and chaotic behaviour in public.

Recurring patterns – the never-ending story?

From a street-level perspective the open drug scenes of today (year 2007) display similar traits and patterns as in the preceding decades, but due to the greater availability of methadone maintenance and low-threshold facilities the number of users frequenting the traditional drug scenes has decreased since the 1990s. Visible groups of users, however, still provoke public reaction and nuisance complaints, indicating that the repressive strategies, the treatment and harm-reduction services combined have not been able to cleanse the streets of drugs. Actually things seem to recur over and again, which became absurdly obvious during the early spring – something which will now be illustrated with a final 'up-to-date case' of the drug scene in Aarhus:

The local media reported over the months of February and March 2007 that drug users and alcoholics congregating at certain sites in the city centre were causing public nuisance (JP 2007). Commenting on the situation, the leader of the special police stated: "As usual strong action is taken when things get too serious", adding that law enforcement was a short-sighted strategy: "They [the users] are a part of society and what we do is just push them around." (ibid.)

The politician responsible for the social sector was more confident. Finding the present situation unacceptable, he promised to ensure that the 'drug abusers' were removed from the inner city and that the alcohol ban already in force would be extended to include all squares, street corners and places where the 'problem groups' congregated (ibid.) Finally he assured the public that steps would be taken to find these people an isolated location outside the city centre. "One natural option", he suggested, could be "the harbour area" [sic!] (ibid.)

Not a single word about the Needle Park which had already been established in the harbour area, but which had been unable to attract the target group; nothing about the years of unsuccessful attempts to remove users from the streets; and no reference to the recent financial cutbacks in municipal

budgets. Prior to the structural reform and takeover of new fields of responsibility to be implemented from January 2007[19], and in connection with a considerable budget deficit, the Aarhus City Council had made a number of cutbacks which had also affected the field of social welfare, including drug treatment and rehabilitation projects (Aarhus Kommune 2006). Services targeted at socially vulnerable and marginalised groups were not excluded from the budget reductions. Included in the retrenchment programme was the drop-in centre established by the municipality as an intended "alternative for users staying at inner-city sites and squares". A note attached to the proposal, which was politically accepted and which meant a reduction in staff and opening hours, stated that: "The consequences will be less acquaintance with and contact with drug abusers, and also fewer opportunities to motivate them to attend activities and treatment. In addition, more visible drug abusers in the street scene must be expected" (ibid.) Against this background it should not have come as a surprise that the reductions in drop-in centre facilities, which were perceived by the most marginalised poly-drug and methadone users as the most tolerant and popular service on offer, made some of them return to the open drug scenes.

Local drug scenes and policy practices in the perspective of international drug policy. Picking up the threads

The phenomenon of open drug scenes defined in terms of the relations between illegal drug use, related crime and public nuisance is known all over Europe, but responses to the scenes have varied nationally and locally. This chapter has focused explicitly on the prime strategies employed to repress and regulate the evolving, developing and contemporary scenes in a local Danish urban setting over a period of almost forty years. Based on the particular case of Aarhus, this chapter has illustrated the way in which the phenomenon has occurred constantly at popular corners and sites in the inner city despite constant efforts to eliminate it.

As mentioned in the introduction, drug prohibition constitutes the foundation and framework of international drug policy, something which has obliged Denmark and other member states to follow the overall goal of combating certain drugs by criminalising them. In a brief summary, Danish

drug policy of today is presented in the action plan *The Fight against Drugs* as "a persistent and balanced effort that involves prevention, diversified and coordinated treatment services and undiminished control efforts" (Regeringen 2003).

Over the years, the varying course of Danish drug policy seems to have tended more towards promoting disciplining, punitive measures and abstinence interventions than towards public health and social services, and the attempts to intervene against illegal drugs and their distributors have increasingly been directed towards the users (Laursen & Jepsen 2002; Frantzsen 2005). According to the users, the prime motive for congregating in public is (and has always been) socially conditioned, although 'drugs will always be around when drug users meet', as the saying goes. From this perspective the need for social gathering has conquered the risks of being confronted and harassed by the police. However, as stated by the users and as drug seizures performed by the local police have demonstrated, the open drug scenes in Aarhus have never been major markets for drug dealing. The policing of the local drug scenes may therefore be aimed less at drug control and more at controlling the users in order to prevent any public nuisance.

One major consequence of international and national drug prohibition at local community level is that certain individuals and groups of citizens have been criminalised, socially stigmatised and marginalised. Made into 'outsiders' by criminal law and moralising judgements, most users refrain or are prevented from maintaining stable income-generating strategies (Bourgois et al.1997), something which may eventually force them to become "beggars and thieves" (Fleisher 1995) to finance their drug use, and to restrict themselves to social networks of equals.

Although the drug scenes appear on the surface to be static sites for illegal and deviant behaviour, when seen through a time lens they are scenes of change, reflecting the surrounding society's political and interventionist approaches to drugs and drug use. By providing a historical outline of the Aarhus city authorities' attempts to tackle 'the drug scene problem' over the period 1968/69 until 2007, it has been demonstrated that one overall strategy has been enforcement and restrictive repression to deter or drive users to seek treatment. In response to the failure to repress the problem for good, strategies and efforts to establish permanent solutions have been based

on the recipe of 'more of the same' – in other words more control in the attempt to deter, disperse and deport the users from the inner-city street drug scenes. However, at best 'the problem' has only been pushed around, and with a phrase borrowed from Agar (2006): it keeps appearing in inner-city "intoxicated corners" populated with groups of drug and methadone users.

The users' non-conformity in terms of socialising, their exposure of intoxicated behaviour and hustling activities in the public space, have made them the visible targets for control, law enforcement and dispelling as well as various kinds of health and behavioural disciplining interventions. Seen from a street-level perspective, police interventions against open drug scenes appear predominant, but as already indicated Danish drug policy aims to maintain a balance by offering and providing access to public drug treatment. With specific references to 'heavy drug abusers', it is emphasised that harm-reduction strategies should be an integrated element of drug policy (Regeringen 2003). However, in the international context of drug policy harm reduction is a contested and controversial issue; in fact, even the term 'harm reduction' has only been reluctantly accepted (if at all) by central United Nation bodies, e.g. UNDCP and several national governments, among them the USA (Hartnoll 1998; Levine 2003). In the light of international conventions and treaties and the Danish government's declaration of 'an uncompromising fight against drugs', it is admitted that the acceptance of harm reduction may appear paradoxical, but nonetheless both pragmatic and reasonable when targeting 'the most vulnerable drug abusers' (Regeringen 2003). Basically, however, harm-reduction strategies such as the organised supply of clean syringes and not least the establishment of the 'Needle Park' in Aarhus conflict with current international drug prohibition principles, a dilemma that the local police were aware of when agreeing to address users and drug taking more pragmatically and leniently when frequenting this specific site.

In spite of the priority attached to drug-free treatment, since the mid-1990s methadone maintenance has been the predominant form of public drug treatment provided to opiate-dependent users in Denmark. In relation to international drug policy, this development represents yet another controversial issue because the replacement of an illicit drug with an equally addictive substance runs contrary to the ideal of abstinence. Thorough documentation

and scientifically based evidence of the effectiveness of methadone maintenance in terms of significant reduction in use of heroin, in intravenous use and criminal activities as well as in the rate of drug-induced deaths (Dole et al. 1968; Ball & Ross 1991; Barnett et al. 2001), has not made the decision-making bodies of the international drug policy organisation depart from the principle of abstinence, and neither has the fact that methadone maintenance is becoming increasingly accepted as a legitimate medical practice around the world, although not universally (Hartnoll 1998; Levine 2003). With the status of substitution treatment, methadone maintenance has come to represent a rather unique treatment modality compared to other medically based interventions of the public health sector. Although there are great variations in local practices, one dominant characteristic of the methadone regimes is the extensive range of strategies employed to control the dispensed drug as well as the users (Dahl forthcoming).

In Denmark methadone maintenance is still contested among professionals, and users also regard it ambiguously. From the users' perspective methadone maintenance represents freedom (from chasing drugs), security (the daily maintenance dose) and decriminalisation (a legally prescribed drug); but at the same time it brings new forms of dependency (of another drug and of the treatment system), and also new and intimate forms of control (strict supervision and tests of bodily fluids and breath) (Dahl 2005; 2007).

While methadone maintenance has had an impact on the situation on the drug scenes in Aarhus, staffed drop-in centres and activity projects based on harm-reduction principles seem to have been the most effective intervention in relation to attracting users from the drug scenes. According to the users, a tolerant atmosphere and staff make them frequent the drug scenes less, a point that was clearly illustrated when the opening hours and staff were recently reduced in one popular low-threshold facility. For the more marginalised users, access to methadone maintenance alone has not been a means to keep them away from the drug scenes. On the contrary, many will say. It can in fact be argued that in the past ten years methadone has prepared the ground for a few new drug scenes: the largest and liveliest as regards dealing, soliciting and hustling is located at the methadone clinic, where users will often hang out before and after swallowing and collecting their methadone rations (Dahl 2007). In addition, methadone has influenced and changed the

drug consumption patterns in the older drug scenes. Despite the fact that 'intoxicated corners' is still an appropriate term to describe the social life in the open scenes, the drugs consumed are becoming increasingly legal – at least as long as strong beer and tobacco remain legal drugs. For as we have learned from the history of drugs and drug control, the categorisation of drugs into legal and illegal has more to do with who is using than with the drug being used (Gossop 2000; Agar 2006; Reinarman 2007).

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NOTES

1 This article is based on research supported by the National Research Council of Social Science and the Centre for Alcohol and Drug Research, University of Aarhus.

2 The major treaties behind the international system of drug control policy can be downloaded from www.unodc.org/unodc/en/treaties/index.html. See also Houborg, Bjerge & Asmussen Frank in this publication.

3 'User' will be defined in this context as a category comprising users of illegal drugs, in most instances characterised by poly-drug use of both legal and illegal substances – as well as users of public social and medical drug treatment services.

4 *See* Laursen & Jepsen 2002, and Jepsen in this publication.

5 In the course of the study qualitative interviews have been performed with 50 methadone users (6 of them ex-users) and 10 health staff attached to methadone clinics in the four cities. All textual field material has been coded in the data program NVivo 2.0.

6 Infomedia is a digital database containing full-text articles from Danish newspapers back to around 1990.

7 Articles on drug criminality and legal cases that make up the greater part of newspaper coverage were not included in the searches.

8 The case is constructed on the basis of field notes from the year 2004. Individuals are made anonymous throughout the chapter, but while the local names of the drug scenes are retained in the following descriptions, they are changed in this specific case. Nonetheless, local citizens will be able to identify the location.

9 This estimate is based on the assessments of users and street workers and my own observations and field notes. In the fieldwork period, approximately 350 people were in methadone treatment.

10 The term 'non-prohibitionist' refers to any aspects of policy other than those concerned with banning drugs and drug use. It covers a wider spectrum of policy positions, among these various forms of legislation covering all or particular drugs through decriminalisation or reduction of penalties for drug use; demand-reduction approaches based on prevention, treatment and rehabilitation; and the overlapping range of harm-reduction interventions such as methadone maintenance and syringe exchange (Hartnoll 1998).

11 Users caught by security guards shoplifting will be stopped if they later try to enter not only the shop in question but also other shops and supermarkets. Simple suspicion or appearance and behaviour associated with drug users have also been used to alert security guards and forbid users access to shops and malls.

12 As a solution to the groups of young people crowding in the Town Hall Park and later demonstrating for the right to have a place of their own, the municipality agreed to support a social experiment and allowed the young people to run a condemned building with four flats in the inner city themselves. The driving force consisted of ideologically and politically active individuals, but 'the house' soon attracted various groups of socially marginalised people, among them older homeless people, heavy drug users, alcoholics, young school drop-outs and curious visitors. With the gas not working and the electricity unreliable during a very cold winter, 'the activists' finally gave up and the escalating drug use among those remaining led to the house being closed by the authorities and later demolished (Mark 1973).

13 The number of drug users known to the authorities in Aarhus increased from 50 in 1968 to 450 in 1972 (Mark 1973).

14 In 1980 the local drug treatment centre had contact with 100 users (40 of these women) who had started intravenous opiate use in the 1960s. After a period of stagnation between

1974 and 1979, there was a 50 % increase in new injection users in 1977-1979, and in the first half of 1980 100 new users were registered (ÅS 1980).

15 Initially the initiative was not explicitly aimed at drug users, but was mainly a response to the increased public nuisance caused by large groups of young people drinking at a specific location on the main pedestrian street during spring and summer (ÅS 1991a).

16 Spytbakken is the local name of a small site on Bispetorv situated above an underground complex of public lavatories.

17 In 1999 drug-related deaths dropped to 2 from 8 in 1998, 19 in 1997, and 10-12 the previous years (ibid.).

18 The changes in the open drug market and consumption patterns have been demonstrated in Kaa et al.'s studies on the illegal drug market in Aarhus, based on all drug seizures by the police in the years 1992/93 (1997) and again 2002/03 (2006), which documents a decline in the number of inner-city outdoor drug confiscations – in the latter period amounting to 17 %. Cannabis is still the most frequently confiscated drug, and since 1992/93 there has been a significant increase in confiscations of cocaine, which in 2004/05 overtook confiscations of heroin (Kaa 2006). Moreover, chemical analyses of the confiscated drugs in Aarhus show that the purity of cocaine, amphetamine and heroin base has decreased considerably since 1992/93.

19 *See* Bjerge in this publication.

Kim Møller

REGULATING CANNABIS MARKETS IN COPENHAGEN

Since 2001 there has been a series of significant changes in the legal regulation of cannabis in Copenhagen, Denmark. The changes have encompassed stricter laws and a series of zero tolerance police programs enacting these laws. Together these changes constitute a paradigmatic shift in Danish cannabis policy. This article describes and analyses the results and effects so far.

First a brief historical excursion to introduce the traditional Danish cannabis control policy. Denmark initially criminalized drugs, beyond opium and derivates, in 1953 with the introduction of the Law Against Euphoria-Inducing Substances, which regulates lesser drug infractions to this day. In 1969 the law was reformed in order to implement the United Nations Single Convention of 1961, but a parliamentary majority insisted on adding exceptions to the regulation of cannabis. These exceptions were formalised in a series of State Attorney Circulars issued between 1969 and 1971[1] that contain prioritised provisions for the police enforcement of drugs. Two important distinctions were made, separating cannabis and hard drugs as well as users/retail-dealing and larger scale distribution. The distinctions were meant to separate drug markets and reduce the harm to users arising out of the black-market conditions that affect distribution, consumption and control.

Until 2001 the circulars have formed the basis for Danish cannabis control policy (Storgaard 2000). In brief, this traditional Danish policy can be described as a passive criminalization[2] with an unspoken toleration of individual possession of up to ten grams of cannabis (Rigsadvokaten 2006). The conflicts of interests surrounding this policy revolve around the grey area in defining the line between tolerated individual demand and non-tolerable supply that connects retail- and wholesale markets.

This article first introduces a model that describes the characteristics of the different types of retail cannabis markets present in Copenhagen. Next the recent changes in the law against euphoria-inducing substances and its enforcement are described as having "reversed" (Asmussen 2007: 14) the traditional policy. The new cannabis control paradigm focuses on use- and prevalence reduction by applying a zero-tolerance approach to the enforcement of the law. It is the ambition of the new policy to shrink the retail-market, thereby reducing use and thus reducing aggregate harm as well. The article concludes by comparing the politically set objectives with the current status of the cannabis retail-market in Copenhagen.

Cannabis Markets in Copenhagen

Historically the cannabis market in Copenhagen has been largely synonymous with an area known as Christiania. In 2003, police estimated that about two-thirds of the total retail-sale of cannabis in Copenhagen took place in Christiania, but other types of cannabis selling locations have coexisted; particularly so-called hash-clubs have been in public focus. The cannabis market as a whole is assumed to be highly responsive to changes in policy and law enforcement intensity. The dynamics and balance between various types of markets is assumed to influence the social costs of illicit distribution as much as total market activity, and it is a lot easier to analyse in the short run (MacCoun et al 2003: 76). To analyse these changes in market structure a model of retail market types is introduced, based on two qualitative characteristics. The purpose is to project the reactions of the various markets to law enforcement efforts and to describe the consequences of the changes in market structure.

Taxonomy of Market Types

Two dimensions of characteristics are assumed to influence how a particular retail-market type functions and responds to enforcement: Accessibility and community. In the model they are represented as two ends of what is in reality continuums. When combined they form a simple matrix of four market types represented in Copenhagen.

Accessibility

Accessibility describes how easily cannabis users can get in contact with dealers. The model presents two types of retail market types along this continuum: those that are person-specific and those that are place-specific (Harocopos & Hough 2005: 1). Access to person-specific markets is based on social networks and individual contacts. Uninitiated individuals will in theory be denied access. The advantage of keeping the dealing person-specific is to avoid attention from law enforcement. The disadvantage is the restrictions this has on the size of the customer base. Place-specific markets on the other hand are accessible to anyone who knows the informal social codes involved in acquiring illicit drugs. In various degrees place-specific markets are "open" to the public, but can be more or less geographically hidden and flagrant in their operations.

Community

The term community is meant to describe the circumstances surrounding the market. Do the surroundings, more or less grudgingly, accept the presence of the drug market or it is an unwelcome feature that the residents are openly hostile to (Steinberg et al 1992)? The community dimension has local markets at the one end of the continuum and public markets at the other end. Drug markets with local support are obviously a rare phenomenon due to the associated problems of disorder. Where they do exist the sellers will most likely be residents of the area, which entails a degree of acceptance, stability and most importantly informal social control. Thus local markets are characterised by fewer conflicts and relative stability, which separate them from public markets. Stability involves established territorial boundaries for dealers and a more efficient distribution due to "learning by doing" effects (Rasmussen & Benson 1994: 88). Public markets are the most common. Dealers will use public areas like parks, train stations, or schools to peddle their wares. There will be issues of public disorder, directly and indirectly. The lack of clear territorial boundaries leads to instability and promote dealer/customer mistrust and potentially conflicts between rival drug dealers.

Matrix of Market Types

The matrix is formed on the basis of these dimensions of characteristics. Below there is a description of the analytical implications for the currently dominant retail-market types in Copenhagen: Christiania and the hash-clubs.

		Accessibility	
		Place-specific	**Person-specific**
Community	**Local**	Christiania	Other (*)
	Public	Hash-clubs	Street

(*) "Other" retail-market types encompass private sale, typically from apartments.

What is Christiania?

Christiania is a 34 hectares area of Copenhagen that was squatted in 1971. Cannabis dealing in Copenhagen has historically been inextricably tangled together with this so-called Free Town of Christiania. At the time it consisted of abandoned army barracks, today it houses somewhere around 900 inhabitants and is the second biggest tourist attraction in Denmark. A Supreme Court ruling of 1976 called for the immediate eviction of the squatters, but the ruling newer came to fruition as the Danish parliament passed a special law that allowed the area to exist as a "social experiment" (Krarup 1977: 3). In 1980 Nils Christie described Christiania as an "alternative to Denmark", almost a "caricature", populated by two types of people, the middleclass activists and the poor, together "the lumpenproletariat" (Christie 1980). The issue of drug use and selling in the area has been a recurring theme for Christiania as well as surrounding Copenhagen and it's one million citizens. In Christie's (1980) article the main theme was the so-called "junk blockade" which signalled the end of hard drugs in the area and Christiania's official acceptance of the cannabis market. The rest of Danish society hasn't been as unanimous in its acceptance of cannabis dealing and the consequences of formulating such a sharp soft-drugs/hard-drugs distinction. In fact the public's attitude towards Christiania's autonomy in these matters has historically been divided along political lines (Jæger et al 1993) where the left wing supports

the social experimentation and what it entails and the right wing parties call for more police control. The Law of Christiania[3] from 1989 addressed this dividing issue, the recurring problem of flagrant cannabis dealing on Pusher Street in Christiania. To the proponents of the law Pusher Street stood in the way of the ambition of "normalisation", which refers to adherence to building codes and instatement of regular police patrolling. Anyone interested in Orwellian terminology will appreciate that this is a difficult process to combine with social experimentation.

Unfortunately for the social experimentation the cannabis market was drawing quite a bit of negative attention from police and politicians. In the early nineties Pusher Street's turnover was estimated[4] at 40 million euros annually (Jæger et al 1993: 84). This made Christiania: "The constant cause of anxiety in Nordic cannabis policy" (Jepsen 1995: 4). Christiania's alleged role as a distribution point between continental Europe and the Scandinavian markets has been a constant source of outspoken resentment from our Nordic neighbours (Storgaard 1996). By 1992 the Copenhagen Police had become so frustrated with Pusher Street that they took it upon themselves to implement a crackdown. This crackdown never received any financing or political back up, and in 1994 a new minister of justice Erling Olsen instructed police to be more reserved towards small-time dealers in Christiania. This instruction made police feel betrayed by their boss and they responded by withdrawing from Christiania altogether (Jepsen 1995: 4). The cannabis market resumed at full capacity the moment the police left the area (Memorandum on Christiania, R 12) which prompted an evaluation of the crackdown in the magazine Danish Police as: "the biggest waste of resources in recent years" (Andersen 2005: 15)[5].

Essentially this conflict between the minister of justice and the police exemplify the dilemmas of the traditional Danish cannabis policy. How is the Christiania market to be interpreted in relation to the State Attorney Circulars of 1969-'71? Was the cannabis market in Christiania to be perceived as consisting of a series of small time dealers or an organised unit? An Attorney General's reminder circular of 1994[6] described the situation in accordance with the minister of justice, as: "enforcement in minor drug cases", whereas the police consistently describe the Christiania market as: "organized crime controlled by criminal groupings … involving threats, extortion and violence etc." (Københavns Politis Virksomhedsberetning 2005: 77)

Pusher Street – A combination of place-specific and local market characteristics

Pusher Street epitomized a local market. First off all, to be a dealer you had to be a resident of the area (Pedersen 2006). This geographical anchoring includes many advantages that can be summed as stability and "criminal capital". Criminal capital is an "intangible social capital" (Kleiman 1989: 127) that is the basis for co-operation between participants in a credit based black-market economy with no access to society's regular system of legal sanctioning. It revolves around "established trust" which basically refers to non-cooperation with authorities (BRÅ 2007: 50). This trust reduces "the curse of credit based economy"[7] because of informal social controls. Aside from the cost advantages these social controls made it possible to establish and enforce internal codes of conduct that banned other drugs than cannabis, and allegedly also the sale of cannabis to minors less than fifteen years (Pedersen 2006).

The most unique feature of Pusher Street is the community support surrounding the market[8]. This support is exemplified by the 12 "big confrontations" that have taken place in Christiania between 2004 and 2006. There have been 114 injured police officers (Andersen 2006) and 29 people have lodged formal complaints against the police with the State Attorney, alleging unjustified arrests and unnecessary use of force (Scharling 2004: 7). In 2005 the police estimated the daily turnover in Pusher Street at 20 kilos with an estimated value of about 85 million euros annually (Københavns Politi Virksomhedsberetning 2005: 81). Police estimates of this kind are generally seen as inherently exaggerated (BRÅ 2005) and criticisable in that none of the calculations used to form the estimates are published.

What are Hash-clubs?

In the mid 1980's a new phenomenon in retail cannabis dealing in Copenhagen started to emerge in the so-called hash-clubs. These "clubs" were locales either strictly for dealing cannabis or fashioned after the Dutch Coffeshops, providing a social space as well. Typically they were little more than scantily furnished basement locations, but ethnographic research described them as having functions parallel to regular youth centres (Asmussen og

Moesby-Johansen 2004). The Copenhagen City Council acknowledged this function as well and recommended further funding for youth centres when the closing of the hash-clubs was planned (Law Proposal L 234 supplement 1 Høringsoversigt). By the 1990's the hash-clubs had become very popular. Despite their relatively discreet locales they became quite visible due to their numbers. In 2000 around 146 were operating in Copenhagen, according to police estimates (Parliamentary Question no. S 3974 2007).

Hash-clubs – Place specific and Public

In the public discussion on hash-clubs two lines of arguments dominated. The first argument focused on the problems of public disorder outside of the clubs due to influx of customers. This nuisance to the residents in the vicinity of the clubs became the central argument for their closing.

The main problem with hash-clubs was their easy accessibility. Interestingly the worries concerning what was happening inside the clubs rarely focused directly on the selling or consumption of cannabis. Rather they were presented in the press as gateways into a world of organized crime. For example, a common line of argument against the clubs focused on the presence of one-armed bandits that could lead to young people establishing gambling debts. All in all the hash-clubs were publicly discussed as little more than criminal sanctuaries and breeding grounds for the next generation of organized criminals. This view was colourfully presented by Troels Ørting Jørgensen, leader of the National Police's Investigative Centre: "The hash-clubs are criminal mini cells. This is where the gangsters of tomorrow are trained in money laundering and handling of weapons. But I can understand how they feel tempted when they can see cousin Mohammed driving a cool car, bought with drug money" (Politiken 2005, my translation).

Traditionally police are influential claim makers in Danish drug policy (Storgaard 2000) and the hash-club's lack of legitimating circumstances, i.e. social experimentation and local support, made them a powerful symbol of the integration of organized crime and the cannabis market that was a central concern leading up the change of policy.

Change of Policy 2003

In 2003 the government published an Action plan named The Fight Against Drugs that spells out a list of normative intentions and changing priorities in the drug control policy contained in four specific goals. In 2004 a law popularly known as Stricter Effort Against Drugs[9] was passed, thus formalising the intentions of the plan.

Paradigmatic Shift from Harm reduction to Use Reduction

At the fundamental level there can be said to two perspectives on cannabis policy (Kleiman interview on PBS Frontline winter '97-'98). The first is that cannabis is the least harmful of the illicit drugs and that there are harm reducing advantages of regulating it separately from other types of drugs. This is akin to the traditional Danish policy. The other view is that cannabis is the one drug that adolescents are most likely to use and relatively high proportions become long-time users. In this perspective, making it harder for new users to get in contact with cannabis should be a high priority (Rikskriminalpolisen 2007). These views can reasonably be presented as separate drug policy paradigms under the headings of harm reduction and use reduction (Caulkins & Reuter 1997: 5). Use reduction as an overarching paradigm can be further divided into prevalence reduction, quantity and expenditure reduction: *Prevalence reduction* focuses on the number of people who consume a drug within a certain period of time or who define themselves as drug users. The term for first time use would be incidence. *Quantity reduction* is focused on the weight consumed, number of use sessions or number of hours of intoxication and *Expenditures reduction* the amount users spend on drugs and, hence, the amount drug sellers receive (Caulkins & Reuter 1997: 3). The intentions put forth in the Actionplan are focused on prevalence reduction and more specifically incidence reduction as priority is given to reducing the number of new users.

Stricter Effort Against Drugs 2004

This law contains two significant changes specifically aimed at deterring participants in retail cannabis markets. First it raises the overall level of penalization for selling of drugs in specific locations with about a third of the

existing maximum penalties. Secondly it up-penalizes possession of cannabis for personal use, from a discriminatory warning[10] to an obligatory fine of initially about 75 euros. In early 2007 a new bill[11] was introduced that suggested quadrupling that level of fines for possession.

Together these changes served two objectives. They were meant to make it easier for police to punish small-time dealers that would previously claim possession for personal use and they could deter buyers in certain areas by rigorous law enforcement. Unfortunately police records do not distinguish between fines issued for selling cannabis and fines issued for possession so it is not possible to evaluate how this aspect of the law has been implemented. It would be interesting to known the balance between fines issued for buying and selling of cannabis.

The general principle applied by enforcing stricter prohibition is to make drug possession and selling more risky and, in turn, socially unacceptable. This method of reinforcing a moral stigma to certain actions can be described as a general deterrent effect of the penal laws (Erickson & Fischer 1997). General deterrent effects have never been plausibly established and this form of drug policy is criticised as being judgemental and divisive. It tends to make the users rather than their actions the problem (Böllinger 1994; 1997).

Hash-Club Laws 2001

Even before this change in the overall direction of Danish drug policy, legislation was passed through parliament that was a step in the direction of zero-tolerance towards the retail-market.

Initially police had attempted to close the hash-clubs by issuing tickets according to the Law on Euphoria-Inducing Substances, but with little to no success. Either the sellers ignored the fines or a new seller immediately replaced them. Also the landlords found out that they couldn't readily evict these tenants. Eviction is a civil law matter, which gives tenants a lot of protection, even in cases of systematic infringement of the law. In practice this made it impossible for the police to put an end to the hash-club phenomenon (Jacobsen 2002).

Around 2000 the Police turned to politicians with their frustrations and two new laws were passed that directly addressed the issue of closing the hash-

clubs A ban on visitors to designated places[12], referred to as the Hash-club law, and Termination of tenancy pursuant to ban on visitors to designated places[13]. Together these laws formed the basis for the police crackdown on the hash-clubs. The point of departure is that the neighbours have to contact police regarding: "activities fit to involve inconvenience or insecurity". Afterwards police can administratively issue a warning. If this warning is not respected a three month ban on visitors is imposed. Breach of this ban will result in a fine of around 800 euros for the person responsible for using the premises, and half of that for any visitors. The law uses the principle of "absolute accumulation", that is to say, the fines increase steadily with each warning and can ultimately result in a prison sentence (Rønn 2006).

The basic idea behind the law was to make the premises instead of the seller the object of criminalization. This turned out to be an effective tool for the police. The problem with traditional drug law enforcement in the case of hash-clubs is that there is no shortage of risk-willing sellers in such high-demand lucrative markets (BRÅ 2005). Also, arresting sellers doesn't actually target the persons responsible for the illegal activities. In principle the organisers of the hash-clubs could easily be living outside the country and have no daily business on the premises (Rønn 2006). By targeting the physical location at least the activities can be effectively disrupted.

With the new laws in place police implemented a crackdown on hash-clubs. Between 2001 and 2005 1307 searches were carried out, resulting in 5685 persons charged according to the Hash-club law. Also 38 "illegal weapons", which could be guns as well as knives, were confiscated. No hard drugs were found during this crackdown. Of a 135 existing hash-clubs registered by police in 2005, only seven remained at the end of the year, and these were predominantly on new locations (Københavns Politis Virksomhedsberetning 2005: 74-76).

Journalists critical of the police's story took it upon themselves to see if they could find hash-clubs in Copenhagen that the police didn't know about. They found 20 (Politiken March 16. 2005). Also, critics of the law pointed out that it's basic premise, administratively issued sanctions, constituted a violation of the Constitutional right of assembly. The criterion of infringement being the assessment of "activities fit to involve inconvenience or insecurity" was criticised as being too broad and inaccurate (Law Proposal L

234 bilag 1 Høringsoversigt). The ministry of Justice turned this criticism down by pointing out that systematic criminal activity is not protected by the constitution (Law Proposal L 234 bilag 24 Cirkulære). After the closing of the biggest hash-club in Copenhagen, "The Gold Nugget", with an estimated annual turnover of 1.5 million euros, an ensuing trial approved the procedure as congruent with all applicable laws (Rønn 2006).

Renewed Focus on Christiania 2002

With the problem of hash-clubs out of the way, or at least temporarily out of sight, focus was once again put on Christiania's cannabis market. By 2002 politicians had finally lost trust in the ability of the Christiania inhabitants to put an end to cannabis selling. A new parliamentary decision[14] called for a stricter adherence to the Christiania law of 1989.

Seeing as how a large police force was in Copenhagen late 2002, on occasion of Denmark's EU-presidency, a new crackdown was attempted in Christiania. The strategy called for a variety of police measures. Firstly demonstrating a police presence in the area, secondly finding and confiscating stocks of cannabis, and thirdly targeting buyers by controlling vehicles in Christiania's immediate vicinity during cannabis "rush hours". As with the attempt, ten years previously, the police experienced only temporary and limited effects on the market. The market would be up and working at full capacity only hours after the police retreated, which is a typical problem when enforcing retail markets (Harocopos & Hough 2005: 24). What was necessary was: "very significant police resources, probably through a longer period" (Parliamentary Decision V 37). This is not to say that the efforts were wasted. The crackdown signalled a new phase of police focus on Christiania's market demonstrated by the willingness to spend many man-hours on disrupting the market. This element of communicating an enforcement threat has value of its own, as deterrence is a "perceptual phenomenon" (Nagin 1998: 5). In other words, to maintain a deterrent effect of the law, it is better for police to enforce the law sporadically, than not at all.

Crackdown on Pusher Street 2004

Two years later the Stricter Effort Against Drugs law paved the way for a new and more ambitious crackdown. The crackdown was named Phase-1,

signalling the beginning of a long-term effort, and was carried out by "several hundreds" specially trained police officers in full riot gear (Københavns Politis Virksomhedsberetning 2005: 79). March 16, 2004, became a "historical date" in Danish drug policy (Asmussen 2007: 20).

On the first day, 37 makeshift stalls were torn down. 60 dealers and their helpers were arrested, 20 of which were accused of being members of an organised lookout corps "CET" (Christiania's Intelligence Service) (Cour & Hansen 2004). 33 people were convicted and received prison sentences averaging 15 months (Københavns Politis Virksomhedsberetning 2005: 79-81). The judicial proceedings were long due to the number of people charged. Eight months after their initial arrest 36 people were still in custody. Danish law regulating pre-trial detention states that periods over three months are to be avoided and must be reported to the State Attorneys. After the trials the State Attorney issued a formal statement directed at police and prosecution to impress on them to uphold the three-month respite (Rigadvokaten 2005).

The following year police tried to enforce a zero-tolerance zone in Christiania with a heavy police presence. 4834 fines were issued and 471 kilos of cannabis was confiscated in 2005. By comparison, the police had issued 173 fines and confiscated 626 kilos, the year before (Københavns Politis Virksomhedsberetning 2005: 64), illustrating a marked shift in tactics. The new focus was to disrupt the bottom rungs of the distribution ladder.

Currently the strategy is to have a police presence in the area to enforce a zero tolerance zone and maintain public order and peace. As of this writing, late 2007, Copenhagen Police have yet to publish figures for their efforts in Christiania for 2006.

Market Reactions to Changed Enforcement

Following the closing of the hash-clubs and the Phase-1 operation in Christiania the cannabis retail-market in Copenhagen underwent a period of restructuring. In keyword form this restructuring chronologically involved replacement, and displacement, and was fuelled by a series of violent altercations. These developments will be described and analysed according to assumptions of the "economic logic of drug markets" when confronted with increased enforcement and penalty action (Kleiman 1997: 8). Have the ef-

fects of the enforcement effort been in concordance with the ambitions of the use reduction paradigm as understood by the four goals put forth in the Actionplan of 2003?

Goal: Vindication of the Law. Effect: Replacement

The first stated goal of the new drug policy was to end Christiania's mockery of society. This is another way of saying, vindicate the law, and punish the drug dealers. The trials against the drug dealers from Christiania and their lookouts demonstrated this vindictive aspect. First of all the sentences were quite severe by Danish standards. Secondly a lot of prison time was served in pre-trial custody. Thirdly it was made a point that the organized – conspiratorial – nature of the lookout corps was an aggravating circumstance. Fourthly the severity of the violations was underpinned by the police's use of agent provocateurs, surveillance, wiretapping and so forth in the investigative process. Finally the willingness to spend this amount of resources certainly sent a signal about the authorities' capacity and willingness to end cannabis dealing and punish the perpetrators. In this sense the law was vindicated retributively. This reduction of Pusher Streets market by incapacitation only lasted briefly. Another set of risk willing dealers immediately undertook the available positions. In economic terms this phenomenon can be described as the Problem of Replacement (Kleiman 1997: 8). This is a widely occurring phenomenon in retail drug markets. As long as demand persists, arresting drug dealers primarily has the effect of opening a market position for a new dealer.

On a general level a Swedish analysis of drug market participants concluded that a shift in risk willingness had taken place in recent years. The next generation of drug dealers appear to be more risk willing as well as content with earning less money (BRÅ 2007). This is bad news regarding the prospects of enforcing a zero tolerance approach to retail markets. Also this risk willingness has little to do with the level of possible penalties. It is well established that deterrence is primarily a function of the chance of getting caught (Becker 1968; Kilmer 2002), hence the comment on the lack of effects from general deterrence in itself.

The current status is that the cannabis market in Pusher Street is functioning again. It is reduced in flagrancy, scope and profitability, but cannabis

dealing occurs around the clock. While police seem to agree that their efforts are – by and large – wasted, politicians are divided along the same lines as prior to the crackdown. The ones that believed the crackdown would be a good idea insist that it has been a success to some extent and the ones that were against the crackdown emphasize the extensive and complicated nature of police patrolling in the area (JP 2007).

Goal: Putting an End to Drug Tourism. Effect: Displacement

As mentioned drug tourism has been a problem for the Scandinavian countries as long as Christiania has existed (Storgaard 1996). In a report from 2007 Swedish police asses that this drug tourism from Sweden has "almost ceased". The flipside is that cannabis distribution in southern Sweden has increased at the same time. The cannabis on the market in southern Sweden is still smuggled from Denmark, but in larger quantities meant for distribution, whereas previously smuggling was primarily for personal use (Rikskriminalpolisen 2007: 20, 42). Displacement is the most frequent drug market response to increased enforcement in one area. Aside from the geographic dispersion, displacement also entails adaptation in the dealing methods (Harocopos 2005), as illustrated in the matrix of market types. The adaptation has involved a move towards more person-specific market types, and has included the introduction of new, at least not previously widespread, forms of selling. Social workers and police in the greater Copenhagen area, report of cannabis being currently sold through connections made over the Internet as well as from taxis and in the vicinity of schools, sometimes with the assistance of minors (Larsen 2006). The application of new dealing methods that involve and target minors is an example of how the structure of the market is more relevant to its social harm than it's absolute size.

Not much is known about the current state of hash-clubs in Copenhagen. In a newspaper article Last Winter of the Cannabis Dealers (Bernsen 2006) the journalist interviewed public street-level cannabis dealers in Copenhagen. Their sentiment was that there is plenty of hash-clubs operating, but the locations have become less visible. Typically dealers will use the space immediately out front of former hash-clubs or use scouts ("runners") on the location to inform customers of a new place of transaction (Københavns Politi Virksomhedsberetning 2005). This is a move towards a public and person-

specific type of dealing. The hostility of the surrounding community leads to lack of stability, which makes business transactions run less smoothly. Combined with less protection from law enforcement and tougher competition for customers and turf, operating in public markets is the least profitable of the market types described by the matrix.

Goal: Sending Signals About Drug Dealing. Effect: The Drugs and Violence Nexus

The intention of the new policy is to send the signal that dealing drugs is not easy money; it is risky business. Who are the recipients of this signal? The basic theoretical assumption in criminal law is that penalty levels and law enforcement carries specialized and general deterrent effects. Specialized deterrence is addressed at potential drug dealers and general deterrence is addressed at the greater public. The special deterrent effects are identical to the problem of replacement, described above. For the marginal economic benefits of cannabis dealing to be lower than expected punishment two circumstances apply: the level of punishment and the chance of getting caught. Neither of which is easy to enforce, as demonstrated below. By themselves stricter penalties have no effect on supply. For drug laws to have special deterrent effect a massive and sustained enforcement effort is required (Caulkins & Reuter 2007).

Initially after the Phase-1 crackdown police reported that dealers "laugh off" the issued fines (Andersen 2005: 15). The profitability of the Pusher Street market circumvented the issued fines, i.e. the level of punishment. This problem with deterring retail drug dealers is typical for street level drug law enforcement. The result is often times that the signals inherent in the law are in reality only picked up by society at large. This is not only inefficient it is problematic. The inefficiency inadvertently reduces the respect for the law in general, for public officials as well as criminals and would-be offenders (Erickson & Fischer 1997). Increasing the risk of getting caught by enforcing prohibition will reduce the size of the targeted market, but can at the same time have side effects that are counter-productive. In the case of the market restructuring following the crackdown on Pusher Street incidents of violence were a severe example of this. That violence occurs in relation to drugs is a function of four conditions surrounding drug-dealing enterprises (Mac-

Coun et al 2003). First of all the young age of market participants (Larsen 2006), secondly the monetary value of the drugs, thirdly the threat of law enforcement and finally as a side effect of the drugs themselves. The type of violence associated with cannabis retail-markets is caused by the value of the drug market and an indirect effect of increased police enforcement. Paul Goldstein (1985: 496-7) termed this violence "systemic": "Violence associated with the marketing of illicit drugs, such as turf battles, contracting disputes and so on (...) intrinsic to involvement with any illicit substance. Systemic violence refers to the traditionally aggressive patterns of interaction within the system of drug distribution and use."

The cannabis market in Copenhagen has not been known for associated systemic violence; at least, it is hitherto unheard of for it to spillover and endanger the general public. This changed dramatically during the market restructuring after the Phase-1 crackdown. As early as 2003, police warned politicians and the public that a struggle between, very roughly speaking, two groups of actors over the cannabis market in Copenhagen was impending (Københavns Politi Virksomhedsberetning 2005). In 2005, two registered shooting episodes using automatic weapons took place on two consecutive days in Christiania. One person was killed and five bystanders were injured by machine gun fire. Shortly afterwards a teenager trying to sell cannabis in Christiania died after being brutally beaten. In other parts of Copenhagen there have been at least six episodes involving automatic weapons in the first year and a half following the crackdown. The police have stated these were struggles for turf and shares in the cannabis market, which is consistent with the theory that enforcement in one geographical area leads to violence in other areas (Rasmussen & Benson 1994). All in all at least four persons have been killed and more than a dozen wounded from automatic weapons in struggles over access to turf for cannabis dealing. The data used for this count is simply a collection of newspaper interviews with police following shootouts from the period following March 16 until the end of 2006[15]. The articles have all been gathered from the same newspaper, Politiken, to avoid repetition. It's not possible to give a more accurate picture of this systemic violence since the only source is the police and they haven't published a complete assessment of the unintended consequences of the restructuring. There is nothing invidious about this secrecy, on the contrary. In the sense

that "criminal violence feeds on itself" (Kleiman 1989: 113) it is a good idea to downplay this violence, also known as the "visible hand" (Reuter 1983: 130) of the black market economy, thereby reducing its power (BRÅ 2007).

Goal: Making it Harder for New Users to Buy Cannabis.
Effect: Restructuring

As mentioned, prevalence reduction or specifically incidence reduction has been a central reason for the crackdowns. In theory this has been achieved by forcing the market structure towards more person-specific cannabis-dealing methods. Put another way, the change in market structure can be described in a traditional economic framework. The market structure before Phase-1 could be described as an oligopoly, i.e. dominated by relatively few sellers (Ritter 2006), whereas now it resembles a state of freer competition. The most centralized and flagrant market in Christiania has been replaced by a series of less centralized, less profitable and less visible retail-dealing locations and methods.

The upsides to this restructuring follow from the lessened visibility of the dealing operations. Lessened visibility makes it harder for inexperienced users to inadvertently come in contact with the market. The downside follow from the further marginalisation of heavy users, through problems of "returning to society" (Böllinger 1997: 228) for the ones caught, fined and registered for their buying of cannabis. On a general level American research has shown that there are no significant effects in making drugs harder to find for minors by increasing street-level enforcement efforts (Caulkins and Reuter 1998). The problem with the person-specific street level markets is that they are easily moved around geographically and thus very hard to eliminate through law enforcement efforts. It would require a long-term consistent effort to make the retail-market markedly more inaccessible. This result opens for an important discussion this article hasn't touched upon: patterns in initiation processes. International studies (Wilkins et al 2005, Williams 2004) show that initiation happens primarily among peers, and not through street-level markets. The ones that use the retail-market have sufficient knowledge to circumvent temporary disruptions. Fighting drug initiation through control measures is not very effective and has direct counter-productive results. The obtained results are indirect. Scaring off potential new users by marginalizing

and stigmatising the heavy users. This prevalence reduction tactic thus has no beneficial effects on either the quantity consumed, nor the expenditures. The end result is once again primarily that of signal value.

Conclusion

The four goals of the new policy are somewhat incompatible; at least under the forms in which the police crackdowns in Copenhagen took place. This incompatibility is best understood in terms of the three different types of use reduction. Prevalence reduction, understood as incidence reduction, was identified as a priority since it focuses on the number of people that use a drug. This goal was in theory initially achieved since the crackdowns forced the retail-market to move towards more person-specific and public forms of selling. The problems for users associated with learning about these new locations will in theory reduce the number of users as demonstrated by the halt to drug tourism from southern Sweden. Some of this positive effect has been offset by the market's adaptation through application of new dealing methods described above, but it's much to early to estimate the extent of this adaptation.

This theoretical reduction in prevalence and incidence can't reasonably be thought to have reduced the total quantity consumed though, since heavy users are responsible for the majority of total consumption (Wilkins 2005). In keeping with the various forms of use reduction there hasn't been a quantity reduction following the crackdowns. The incapacitation of the dealers in Christiania ended their particular mockery of society, but others have taken their place. It is not unusual for drug markets to respond to enforcement in ways that are unintended and maybe even decidedly perverse. A typical drug market reaction to making dealing riskier is attracting more sellers (Caulkins & MacCoun 2003). The theory applied in the article points out that this increase in numbers of dealers will have reduced individual earnings, but also reduced the chance of getting caught. The reduced individual earnings for dealers cannot be seen as an expenditure reduction. There is as much money in dealing cannabis as there ever was, but it is spread out among more people.

Overall the primary effect of the crackdowns on these retail-markets has

been the closing of the market structure towards person-specific markets. In the longer run reduced accessibility have some counterproductive implications. Inaccessibility is good for deterring drug tourism and new users, but the black market problems associated with retail-markets are actually exacerbated by it. In closed markets there are no informal controls keeping hard drugs separate from cannabis and essentially very little prospect for future police enforcement. Seen in this way the crackdowns have contributed positively to two of the policy goals, but at the same time worsened two other aspects of the problem. These negative aspects of a closed market are what motivated policy officials to distinguish between cannabis and hard drugs in the original Danish harm reduction policy. The harms to users arising from black market conditions have historically been a concern to policy makers, but these problems are in their nature hidden. This means that the policy goals of sending signals about drug dealing and ending the mockery from Christiania and other black market participants will, on the surface, seem to have been achieved to some degree while in actuality they have worsened. The problems associated with retail cannabis dealing may appear to have been reduced in scope, but are essentially just hidden from public scrutiny. These clandestine dealing operations have more severe consequences to users as well as society as a whole. The incidents of systemic violence illustrate the unscrupulous nature of drug dealing in a harshly competitive environment that has become even more competitive due to the crackdowns effect in reducing Christiania's oligopoly.

The developments presented in this article illustrate that the reversal of policy has resulted primarily in the reactive punishment of drug dealers and lessened visibility of the market. The forward pointing achievement is primarily achieved by the further stigmatisation of cannabis users through criminal labelling, a signal value that's important to the politicians but has no positive effects on the cannabis problem as such. Unfortunately in the current climate of Danish drug policy this trade-off may very well be presented as a positive political achievement, paraphrasing the developments of course.

Is this the same as saying that cracking down on hash-clubs and Pusher Street was an altogether bad policy? Of course not, there were many valid political reasons for doing so. The main reason was that the grey area between tolerated and obviously illegal dealing around Copenhagen had drifted

towards the illegal, because of the scope and visibility of the problem and further fuelled by an increasing tendency of punitive action in Danish criminal justice policy. With that being said it should be mentioned that targeting the most widely used illicit drug would usually require thorough planning, explicit standards for evaluation, long term financing, and most importantly collaboration between preventive, control, and treatment measures. All of which are efforts not applied in the crackdowns since 2001.

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NOTES

1 No.144 of July 15. 1969, September 15. 1969, August 16. 1971 and November 30. 1972.

2 A note on terminology. In international comparison "depenalized" is relatively widely used, though not as often as "decriminalized" which is strictly speaking an incorrect term. Criminalization is dichotomous: either/or (Kilmer 2002).
Other descriptions of the Danish policy include Vagn Greve (1986): "de facto legalization" and Mark Kleiman (2007): "Benign neglect", at the ISSDP conference with a tip-of-the-hat to Erickson and Fischer's (1997): "malign neglect" description of Canada's failed attempts at reforming policy.

3 Law no. 399 of June 7. 1989. The law primarily addressed issues concerning building codes but also included provisions on illegal bars, tax evasion and payment for electricity and water.

4 This and other estimates of market value are to be used very carefully. They are police estimates and are never published with any kind of explanation as to how they were arrived at. First of all it's extremely difficult to pinpoint this value (Wilkins et al 2005) and secondly the police have an inherent interest in exaggerating the figures (BRÅ 2007). They are used in the article because they are the only available figures and they can be compared in order to describe a direction in the development.

5 "Danish Police" is the monthly magazine for the Union of Danish Police.

6 Enforcement of minor drug cases – referring to a Statement on police intervention against drug crime, issued by the National Chief of Police on June 8, 1994.

7 Lars Korsell from Swedish Counsel on Crime Prevention, Brå, quoted from Sweden Against Drugs Conference in Örebro March 2007.

8 This support is by no means unanimous. Plenty of the original residents of the area see the cannabis market as leading to a "Gangster-reign" in conflict with the "social experiment" ideals (Pedersen 2006: 59).

9 Law no. 445 of June 9 2004.

10 A warning is formally a criminal sanction (Greve 2004).

11 Law Proposal L 201 of March 28. 2007.

12 Law no. 471 of 7. June 2001, Asmussen (2007) translation p.17.

13 Law no. 447 of 7. June 2001.

14 V37 of April 9. 2002.

15 May 6. 2005: "Struggle for Power in the hash-clubs", June 1. 2006: "The Grown-Up Criminals", June 4. 2006: "The Nice Victim", November 23. 2006: "Police: Shootings are about Hash".

Part III

History, causes, and consequences of drug policy

Jørgen Jepsen

DANISH DRUG CONTROL POLICY 1945-2007

Introduktion

Denmark has a long tradition for solving social problems via social welfare measures and treatment rather than through law enforcement. However, ever since the modern drug problem emerged in the mid-1960s this ideology has been challenged by the fact that the unauthorised use and possession of certain drugs has been defined as an offence in Denmark since 1955. Hence modern Danish drug policy can be characterised to a large extent as "an ambivalent balance between repression and welfare", as the author of this article and co-author Lau Laursen phrased it in an analysis of Danish drug policy in 2002 (Laursen & Jepsen 2002). This article revisits this issue by presenting a historical account of Danish drug policy since 1945 with particular emphasis on drug legislation and the role of law enforcement. The article will consider the way in which Danish drug policy and particularly drug control have been shaped by official and unofficial influences on a political level, through the state apparatus, and by the influence of interest groups and professionals.

It is the contention of this article that the definition of the drug problem and public perceptions of drug users have played an important part in shaping drug policy, and that these definitions and perceptions have varied over the years resulting in a changing emphasis on drug control and other more social kinds of regulation. It will be suggested that in the public perception and depictions of drug users two main images have been advanced: Users as 'problem carriers' and as 'problem creators'. As *problem carriers* drug users are perceived as people carrying the burdens of the drug problem, who deserve to have their problems alleviated by treatment and other interventions. As *problem creators* drug users are perceived as people contributing to the creation

and maintenance of the drug problem, primarily as dealers, smugglers and criminals involved in the drug field and in acquisitive crime, or as people creating a public nuisance. Another figure has also been important in policy discussions, namely what has been referred to as 'the background figure' (*'bagmanden'* in Danish). This figure is a non-addicted, well protected and discreet financier of drug smuggling and distribution. Over the years the importance of this person, who had a significant influence in shaping official policy and penal law in the sixties and seventies (as evidenced by parliamentary and political debates), has gradually waned and interest has focused on lower-level drug dealers as 'seducers of the young' instead.

The central questions posed in the article are: How have the shifts in the perception of the drug problem and of the balance and content of Danish drug policy come about? What have been the important turning points and critical incidents? Who have been the important players in shaping Danish drug policy, and what part has been played by the state and other parties? The state is clearly not a monolithic entity, but which relevant structures and institutions within the state apparatus are discernible in the process? What have been their different agendas and interests?

The historical account presented here is based on various sources: laws and preparatory material, government white papers, committee reports, statements by various areas of government and other kinds of official documents, as well as previous research and publications in the area. In addition, the experience of the author as a researcher in the field and while serving as a consultant to NGOs and a few politicians, including membership of the research group of the Council on Alcohol and Narcotics and later membership of the Narcotics Council (1995-2001)[1], has provided background information and a platform for observation of policy making.

When investigating Danish drug policy in a historical perspective, there are three important elements which have to be taken into account in particular: the legislative process, government white papers, and advisory bodies. Table 1 presents a summary of Danish drug legislation since 1945, as well as the most important documents and advisory bodies.

Advisory boards to the government and its relevant ministries have been created in reaction to a perceived need for coordination and expert advice, for the procurement of information and research, and for more long-term

deliberations. These boards have involved various kinds of experts, including researchers, medical specialists, psychiatrists, treatment staff, policemen, etc. A number of reports on the drug situation in Denmark have been published over the years, complete with recommendations for reactions to the drug problem. However, most of these reports have dealt with aspects of drug policy that do not include control. In principle these advisory boards[2] were independent of ministries and government bodies. So even though their reports have laid the basis for describing the drug problems and proposing action, they have not themselves been part of government policy. All the same, the advisory boards and their recommendations have had an important influence on policy and have shaped the systems of reaction, treatment and control.

Government white papers have had a more direct impact on Danish drug policy. They have been prepared by one or more ministries acting in conjunction, and can be seen as platforms for the preparation and implementation of legislation and regulation, as well as expressing the government's view on how to interpret existing drug legislation and rules. For instance, the Committee Report in 1953 was commissioned by the Ministry of the Interior and formed the basis of ensuing legislation; and the latest official government policy statement, *The Fight against Drugs* (2003), has been the basis of the fundamental change in policy which has been carried out since then.

When investigating Danish drug policy it is also important to note that international influences have played and still play an important part. Not only formally – Denmark has signed the various UN drug control conventions, making Danish drug policy subject to the conditions of these conventions with the flexibility for developing national drug policies they allow (as discussed in chapter 1 of this volume). But also more informally – the Nordic Council and the Nordic Council of Ministers in particular have been venues at which other Nordic countries with a tradition for more repressive drug policies than Denmark have put pressure on Danish politicians to follow their example, e.g. by closing down the open cannabis market in Christiania or by raising penalties (Laursen 1996a; 1996b; Jepsen 2000). The opposite has also been the case, since Danish politicians have sometimes used international drug policy to strengthen their arguments in the national debate about Danish drug policy. This happened when the Danish government asked the INCB

about the legality of implementing safe injection facilities. This element in the formation of Danish drug policy will also be included in the following account.

A chronology of drug policy development in Denmark

Let us look chronologically at five major phases in the development of Danish drug control policy and the forces behind this development.[3] In order to depict the drug problem in these different historical periods I will describe the drugs mostly dominant on the drug scene as well as in the public debate in each period; the characteristics of drug users (how they vary in numbers, to what lifestyle or subculture drug use is related); and how the patterns of drug use are important in shaping public reactions.

1945-1965: The origin of Danish drug legislation

The present Danish drug legislation was founded in 1955 with the Act on Euphoriant Drugs, and this act is still the basis of Danish drug policy. Following the international treaties, it classifies drugs in four lists, based upon their perceived risks and their application in medical and scientific practice. List 1 contains the drugs which are totally forbidden (except with specific authorisation), while the other lists contain drugs which are more or less allowed for medical or scientific purposes or are subject to various regulatory systems. List 1 includes heroin and cannabis along with opium and opium derivatives etc. The National Board of Health is authorised to add new drugs to these lists in accordance with recommendations from the WHO or other relevant international organisations – or based upon its own judgement.

Section 3 of the Act on Euphoriant Drugs has a penal clause under which up to two years of imprisonment can be imposed for the commission of certain illegal acts in relation to the drugs on the lists. It is punishable to import, export, sell or buy, distribute, manufacture, prepare or possess prohibited or regulated drugs in violation of the regulations in the various categories. The act did not criminalise drug use itself, and in accordance with the recommendations of the committee report in 1953 possession was only penalised as a means of easing the burden of proof in cases against illegal sellers and others.[4] It was not seen as desirable to punish simple drug users or possession

for own use. The Act on Euphoriant Drugs took the place of the previous Opium Act (no. 53 of 6/3 1936), which carried a maximum penalty of six months for the illegal handling of opium and its derivatives. The Opium Act was based upon the opium conventions of 1912, 1925 and 1931, which Denmark had ratified. Denmark did not ratify the fourth opium convention of 1936, as it was considered unnecessary at the time and desirable to await the result of the preparation of what became the Single Convention in 1961 (see the Introduction to this volume). When the Single Convention came into force, the Act on Euphoriant Drugs fulfilled the requirements of the convention, except for the total prohibition of heroin and cannabis, which was introduced by an administrative ordinance (cirkulære) by the National Board of Health in 1963.

The Act on Euphoriant Drugs was based upon a Committee Report (Indenrigsministeriet 1953) commissioned in 1950 by the Ministry of the Interior. The ministry wanted the committee to analyse the extent and forms of the drug problems in Denmark at the time, and to make recommendations for a better regulatory system for the control of prescriptions by doctors and quasi-medical personnel (dentists, veterinarians etc.). The background was that during the late 1940s a number of cases of over-prescription of morphine and amphetamines gave rise to concern over lax practices and abuse of morphine among doctors and other medical personnel. A growing black market in morphine and methadone (under the trade name *Butalgin*) in the harbour areas of Copenhagen also gave rise to concern. Neither heroin nor cannabis was involved, although some over-prescription of cough medicines containing heroin had occurred. It was also noted that the total national consumption of morphine and tranquillisers in Denmark was among the highest in the world. It is noteworthy that cannabis was not seen to any notable extent among abusers until the 1960s, and heroin not until the 1970s.

On the basis of a study of a National Board of Health registry of prescriptions, the Committee Report of 1953 estimated that there were a total of 1,000-1,500 problematic drug users ('eufomaner' in Danish) in the country. Most of the problem was located in Copenhagen. The report located two rather distinct groups of addicts. One was a group of better-off morphine abusers, either among medical personnel or upper-class patients of general practitioners. For this group the committee report recommended stricter

control of prescriptions and warnings to general practitioners who were not sufficiently careful. In the previous years some GPs had had their licence revoked, and a few had received court sentences for unprofessional prescriptions. A group of 227 people – 118 of them women – fell into this category. The other group was a more shady set of hedonistic, so-called bohemians in the harbour areas of Copenhagen. The Copenhagen 'health police' (or vice squad) located a group of some 300 people, many of them known for theft, prostitution and disorderly conduct. They obtained their drugs by stealing from pharmacies, or by forging and stealing prescriptions from general practitioners, or by giving false information about their identity and illnesses. Some of the drugs they obtained in this way found their way into a growing illicit market.

The committee report made a number of recommendations, most of which were subsequently implemented. Some of them concerned stricter regulation of prescriptions, and the report presented a draft set of instructions to doctors and other medical personnel. In addition, a legal provision was proposed to penalise the obtaining of prescriptions by fraudulent information on personal identity. One important part of the recommendations was the passing of the separate Act on Euphoriant Drugs, raising the penalties from the six months of the Opium Act to a maximum of two years. The report stated that it had not appeared necessary so far to hand out sentences of more than the six months available, but if more professional smuggling and trafficking became evident in Denmark it would be desirable to have provisions with a higher maximum.

While the better-off morphine users were handled by the medical system, the lower-class group was the object of the vice squad, which had a tradition for handing out fines and probation sentences to female and male prostitutes, acting in a rather paternalistic way towards their street and bar clientele. Although this type of 'social policing' was resented by the clientele, the sanctioning system was rather lenient. Street patrolling in the vice district was a favoured mode of operation. Only a few more or less professional dealers were imprisoned. So the control system was rather lenient, and the health police were geared towards a traditional lower-class clientele when a totally new pattern of drug use and drug distribution emerged with the new youth cultures of the late 1960s.

1965-1975: Origin of the modern drug problem in Denmark – escalation of drug control

Starting in the mid-sixties a new youth culture gained headway in Denmark along with different drug patterns. In particular the use of cannabis spread in adolescent groups, and the health authorities were concerned with the risk of a major drug problem. A number of studies on the prevalence and spread of drug use among schoolchildren and adolescents were undertaken, either by government committees or by sociology researchers.[5]

Once again in this period the drug situation was characterised by two different groups, which overlapped to some extent in the early years. On the one hand the 'recreational' users of cannabis and LSD associated with the new youth culture, and on the other hand a gradually developing subculture of hard drug users[6]. The *problem creators* were seen by some (e.g. Behrendt 1971a; 1971b) as the youth culture as such, but with some individuals standing out as pushers of the new drugs and the associated subculture. The police talked vehemently about 'user-dealers' and their contribution to upholding the market (Nissen 1973; 1978). But increasingly a distinction between 'background figures' as problem creators and young, rather innocent drug users as problem carriers emerged.

A number of different players were involved in the discussions and the definition of the new drug problem. One important player was the Contact Council on Adolescent Drug Abuse[7] created by the government in 1969 to study the problem and to put forward recommendations about how to handle it. Another prominent player was the police, who from 1967 took a more active role in defining the problem and pushing for solutions in terms of stricter legislation and law enforcement. In addition to this, a number of non-government players began to influence policy, including professionals (e.g. the Doctors' Union), the Association on Mental Health, charitable organisations, churches and laymen, including parents of drug users and a pressure group called the National Association against Hash and Narcotics Abuse (Landsforeningen til bekæmpelse af hash og narkotikamisbrug in Danish).

As a policy response to the problem, in 1969 the Danish parliament passed a new section of the Penal Code (PC § 191), which introduced a superstructure to the Act on Euphoriant Drugs in the form of a supplementary

maximum penalty of up to six years for the most serious offences (the former maximum had been two years). In the political debate leading up to this tightening of the drug legislation a 'tough' and a 'soft' line were in conflict with each other, both in relation to penalisation, law enforcement and control, and in relation to treatment. In parliament a tough group demanded higher penalties – to some extent inspired by Sweden and Norway via the Nordic Council (see Laursen 1996a; 1996b) – in order to deter professional trafficking and in particular distribution to the young generation. On the other hand, a softer group voiced their worries that the new law would criminalise young drug users unnecessarily and lump cannabis together with much more dangerous drugs and in general raise the level of penalties in all drug cases[8]. The outcome of this debate was a compromise, of which the first part was the introduction of a new section 191 in the Penal Code, reading as follows:

> "Any person who, in contravention of the legislation on euphoriant drugs, supplies such drugs to a considerable number of people in return for a large payment or in any other particularly aggravating circumstances, shall be liable to imprisonment for any term not exceeding six years. Similar punishment shall apply to any person who, in contravention of the legislation on euphoriant drugs, imports, exports, buys, distributes, receives, produces, manufactures or possesses such drugs with the intention to supply them as mentioned in subsection (1) above".

The other part of the compromise was the issuing of a circular by the Attorney General (no. 144 of 15/7 1969, supplemented in 1971), which instructed police and prosecutors to be lenient towards young cannabis users by sanctioning first-time appearances for possession for own use with a (police or court) warning only[9]. The key section of the circular says:

> "There will normally not be occasion for starting investigation in order to impose penal responsibility for possession (buying or acquisition) when the suspicion only concerns own consumption of euphoriant drugs. Accordingly, restraint should be exerted before starting investigations on one's own initiative, e.g. at schools, even if the police suspect that abuse of euphoriant drugs is occurring"

This was in effect a de-penalisation of possession of cannabis for own use, which remained in effect until 2004 when the circular was repealed, although even in the late 1970s some political parties had already criticised the circular.

In 1974-75 a new parliamentary and public debate ensued around a proposal to raise the penalty for serious drug offences of a professional nature – again stimulated by pressure from politicians from Norway and Sweden, where maximum penalties had been raised to ten years' imprisonment (see Laursen 1996a; 1996b). Another reason was that some serious drug cases had begun to reach 'the ceiling' of six years, and that even more serious cases could be on the way. Once again a 'soft' group of politicians expressed their worries about the risk of a general rise in drug penalties (a 'rub-off effect'), and in particular the risk of criminalising young cannabis users. The result was a new compromise in the form of a provision which provided harder penalties for professional drug dealing, particularly in large quantities, but which also introduced a distinction between hard and soft drugs. This was done by adding a second subsection to sect. 191, subs.1, reading:

> "If the supply relates to a considerable quantity of a particularly dangerous or harmful drug or if the transfer of such a drug has otherwise been of a particularly dangerous character, the penalty may be increased to imprisonment for any term not exceeding ten years".

The insertion of this distinction was supplemented by remarks that cannabis in particular should not be seen as a 'particularly dangerous or harmful drug' in spite of the fact that it was on the list of most serious drugs. The stated intention was not to raise the general level of drug penalties, and in particular not to increase the persecution of young novices in the drug field. Central to this political response to the new drug problem was the image of 'the background figure' as a problem creator and the young drug user as a seducible problem carrier.

The distinction between hard and soft drugs also led to changes in the police system which followed demands for harder reactions to a growing illegal market based increasingly on smuggling and professional distribution of the drugs. A change of the market, which also happened partly as a consequence

of police clamp down on the somewhat collectivistic distribution of cannabis, which occurred during the late sixties and early seventies[10], set the scene for more professional players.

In 1968 the first drug squad was established in Copenhagen in the form of a separate Section A in the central Copenhagen police headquarters. This was the first unit in Denmark to undertake the investigation and prosecution of major cases of illegal trafficking in drugs (although initially it also had responsibility for murder cases). A police attorney, Volmer Nissen, was put in charge of the new section. Nissen also became an ideological spokesperson for the penal approach to drug problems (Nissen 1973). This was the beginning of the development of a resourceful law enforcement apparatus, which developed over the years[11]. In Copenhagen Police Section N (originally section A) grew from 46 to 72 men from 1975 to 1982. In addition a central unit within the national police force allocated a number of police specialists to assist the local police constabularies around the country (Laursen 2000: 107).

The vice squad was now left primarily to undertake street patrolling and contact young people in public places, warning them against the dangers of drugs in much the same way as they had once handled prostitutes and young males in danger of 'slipping into vice'. But later in 1968 this task was also delegated to the ordinary 'order police', who took over some of the personnel and some of the techniques of the health police (Ibid: 73). This resulted in the creation of a special patrol called 'Uropatruljen' (the Unrest Patrol), which was also entrusted with "observing and reporting on the movements of extremist groups". The Unrest Patrol had 20 people in 1970, 35 in 1975 and 49 in 1981 (Ibid: 107).

At the same time the crime-prevention section of the Copenhagen police, which ran a number of police youth clubs in Copenhagen, with a policeman in each to work alongside professional youth workers, made one of these clubs an experimental unit for preventive work with young people in danger of turning to drugs (PUK-Amager). This club also gradually developed a drug treatment system – to the dismay of their more traditional police colleagues.

1975-1990: Problem development and build-up of treatment and control systems

During the late 1970s and the 1980s the drug problem started to resemble other social problems to an increasing extent. There was an increase in hard drug and intravenous use in the 1980s, accompanied by HIV and Hepatitis C. In 1990 9 % of 282 new HIV cases were related to intravenous drug use, and 90 % of new cases of Hepatitis C were connected to intravenous drug users, while 80 % of all drug users were infected with Hepatitis C. Heroin became more prominent and the cannabis culture attracted less attention, except in police interventions in Christiania (see Møller this volume for an introduction to Christiania). A group of marginalised hard drug injecting addicts dominated the picture in Copenhagen, but the drug problem also spread to the rest of the country. During the years 1974-80 there was a sharp increase in drug-related deaths (from 80 to 165). After a period of stagnation and even a reduction between 1984 and 1989, this figure again rose steeply from 1990 up to an all-time high of around 275 in the years 1994-1996 (Laursen 2000: 108-119 and 135). This development gave rise to increased police activity and some build-up of the treatment system, not least in major provincial towns. In the same period and particularly as a response to the HIV epidemic, methadone maintenance treatment and needle distribution were gradually accepted, although resistance to methadone treatment lasted up until the late 1990s in many parts of the social treatment system[12]. Concern regarding these developments led to a further increase in the police force, also in the provincial towns. Police cooperation with the other Nordic countries (including the stationing of contact officers in the Nordic countries and joint liaison officers in Asian countries) and on a European level (Interpol, later the Schengen system) was also established and expanded.

In 1986 changes in *the Code of Criminal Procedure* were made as a result of demands by police, prosecutors and politicians for more effective intervention measures against the growing drug problems. This provided for increased police powers – wire-tapping, searches and seizures – and for the legitimation of the use of *agents provocateurs* (although initially with the proviso that only police officers could be used). A law was passed by a left-wing initiative prohibiting the use of anonymous witnesses (repealed after the turn of the

century). Accordingly, the growth of law enforcement during the late 1980s was carried forward by increased "control optimism among politicians and other players" (Laursen & Jepsen 2002: 27). This also led to political backing for increased street action by the police, and to intensified efforts to curb illegal trafficking. International police cooperation using wiretapping and agents led to some spectacular seizures of drugs.

However, from the beginning of the 1990s control optimism was superseded by growing criticism of the concomitant 'control damage' such as an increase in drug-related deaths and the spread of HIV and other infectious diseases among drug users. Another point of criticism was that the intensified law enforcement efforts did not remove the drug problem or its visible problem carriers, the miserable injectors visible in the streets of Copenhagen.

Denmark's signing and ratification of the 1988 Vienna Convention on law enforcement in drug cases did not lead to any significant changes in Danish legislation and practice, and Denmark expressed some reservation towards the war rhetoric emanating from the escalating War on Drugs of the Reagan era. Thus in the preparation of the 1988 Convention, the Danish representative stated:

> "To create a drug-free world is unrealistic. Thus the aim must be to reduce the costs (for society as well as for groups of citizens and single individuals), which drugs imply. The balance among the elements of general drug policy must be framed in such a way that the drug users are not inflicted with more damage through the apparatus of control and penalisation than through the drugs themselves. The goal of treatment of drug users is to reduce the harmful consequences of drug abuse as far as possible, and drug abstention is not necessarily a condition for treatment, and not at all the criterion for a successful treatment"

This statement was in clear ideological opposition to the 'Drug-Free North' philosophy advanced by the other Nordic countries.

1990-2001: Criticism of law enforcement – new government initiatives

The drug situation during this period was characterised by an increasingly complex drug use pattern. Amphetamines became more prominent in the

drug environment and gained rather wide use. Cocaine was first found in 'jet-set' circles, but as supplies increased and prices went down in spite of mounting seizures, cocaine became much more widespread. The same happened with 'designer drugs' like ecstasy, which became a widespread 'party drug' at raves and other manifestations of youth culture. A modest number of drug-related deaths under the influence of false ecstasy pills gave rise to alarming media attention and demands for action. Cannabis spread as well, and retained its position as the most commonly used illegal drug.

During this period the definition of problem carriers and problem creators was repeatedly discussed in the media and among policy-makers. On the one hand, the miserable addicts in the streets of Copenhagen and Aarhus were seen as problem carriers to be treated leniently; but on the other hand local inhabitants and the police saw them as problem creators and a public nuisance who should be removed or perhaps referred to treatment. Once again the drug scene was characterised by a dichotomy: on the one hand recreational cannabis and party drug users, and on the other miserable heroin and poly-drug users.

A separate cannabis culture and the open cannabis market continued to exist and expand in Christiania. During the 1990s the police carried out repeated and often violent raids against the pushers, but were met with stones and attacks from the locals (for details see Jepsen 1996; Asmussen 2007; 2008; Møller this volume).

The public image of the drug problems and drug policy was greatly influenced by a TV documentary called "The Road to Hell" in 1994, which vividly depicted the misery of the addicts in the streets and called for other solutions than the current reliance on repressive measures. The Minister for Justice even went as far as to state publicly: "The fight against drugs has been lost" and declared some sympathy for Christiania and its moves towards (semi-) legalisation of cannabis. Alternatives to strict prohibition which would move Danish drug policy in a more liberal direction were proposed by politicians, professionals (including a high-ranking prosecutor and a high court judge H. H. Brydensholt), and a number of collective players such as social-worker unions. The Danish Doctors' Union also criticised the official policy (Lægeforeningen 1994: 671). The control system was seen as too dominating, taking too many scarce resources away from other forms of

intervention and producing 'control damage' which was out of proportion to the alleged gains. This statement recommended increased emphasis upon harm-reduction measures and a lowering of the penalties in drug cases. In relation to government drug policy, these instances of criticism did not have any visible effect, however. It was the claims made by law enforcement bodies and adherents of repressive policies that continued to determine actual policy.

With regard to *government policy and legislation* this period saw a number of changes[13], several of which were directly or indirectly related to law enforcement measures taken in Copenhagen, starting in the early 1990s. In Copenhagen intensified law enforcement efforts started at the end of the 1980s when the police took action against the visible drug scene that had developed not only in Christiania, but also in the 'vice area' near the Central Railway Station, where a number of tourist hotels and local merchants demanded tougher police action to clean up the streets. As the pressure mounted, influenced by the media, the Copenhagen police developed 'Drug Strategy 90' ('Narko-strategi 90' in Danish) to curb the dealing, disperse the market and control crimes committed in the neighbourhood. The police used warnings and expulsion orders (followed by fines in case of violations) against users and dealers and created no-go zones for drug users. A special police vehicle called 'the Blue Bus', designed to check the streets of Vesterbro in Copenhagen for drug users, turned up in the streets and immediately started to arrest injectors and dealers alike. The Blue Bus was the hallmark of this escalation of police methods.

In 1994 the Attorney General issued an instruction reminding the police of the circular of 1969 that directed them to concentrate on professional trafficking instead of users. There had been a dramatic increase in minor police cases for possession, while the number of serious cases under the penal code had gone down. This had led to criticism of the police for going after users and small-time dealers instead of 'background figures' (Alkohol- og Narkotikarådet 1990). In the same year the National Chief of Police (Rigspolitichefen 1994; Laursen 2000: 165) confirmed the obligation to go after 'background figures', but also said that street-level policing was necessary to uphold law and order for local citizens. He also stressed the common argument for arresting the low-down street addicts that the police needed their cooperation

to go after people higher up the drug-dealing hierarchy – an assumption that his own statistics seemed to disprove.

The number of cases under the Act on Euphoriant Drugs rose from 11,000 in 1988 to 18,000 in 1993, mainly due to the street activities during 'Police Action Vesterbro' ('Politiaktion Vesterbro' in Danish), while the number of cases under Penal Code section 191 dropped from 1,450 in 1988 to 750 in 1996. At the same time, however, the number of drug-related deaths rose sharply and critics attributed this in part to the 'stress tactics' of the police.

In 1994 the government also put out a white paper on drug policy, partly in response to mounting criticism of its drug policy, which was stimulated by the sharp increase in drug-related deaths from the early 1990s and mounting pressure for reform inspired by the experiments in Switzerland with heroin prescription and safe injection rooms. The Ministry of Health and the National Board of Health were the primary formulators, but with contributions from the Ministry of Justice and the Ministry of Social Welfare. For those who had hoped for a re-evaluation of drug control policy the white paper was a disappointment – it confirmed the status quo and legitimated the policy of prohibition and maximum repression. One of the legislative outcomes was an addition to the Penal Code section 76a providing for confiscation of funds obtained within a five-year period for which a drug suspect could not account. Such confiscation might even take place from the property of the suspect's spouse. Another consequence of the white paper was the establishment in 1995 of an experimental programme for 'treatment instead of prison', based upon the use of conditional sentences (probation with conditions). This project ran for a number of years, and was finally expanded to cover the whole country.[14]

In addition, and more importantly, one result of the white paper was the development of a more differentiated treatment system with considerably more resources. At the same time a reorganisation of methadone treatment was set in motion, which took the responsibility out of the hands of general practitioners and set up public clinics with adjacent social welfare facilities[15]. In time this led to the constitution of methadone treatment as a normal treatment modality.

In 1996 another clampdown took place in Copenhagen against a group of pushers who were circumventing the current interpretation of the Act on

Euphoriant Drugs by carrying only small quantities of drugs at any one time, thereby avoiding heavy sentences even after repeated raids. A tabloid paper had been informed by the police that a raid would take place, and was present at the raid and at the arraignment of the arrestees in court. This incident was instrumental in launching serious criticism of the existing legislation in unison with the police, as only a few of the 42 arrestees could be detained – the sentences expected were too low.

As a consequence of the debate following this criticism, the Act on Euphoriant Drugs was amended (by Act no. 1054 of 11 December 1996) to provide higher penalties for repeated dealing in small quantities. In popular terms this was called 'the Pusher Act'. The debate also led to a change in the Act on Aliens (Act no. 1052 of 13 December 1996), making it easier to deport foreigners sentenced for (repeated or serious) drug dealing. This legislation was called 'Lex Gambia', based on the nationality of the most obvious street dealers[16]. For the second time in this period we see an alliance between a (local) group of citizens, the police and the media, resulting in more repressive legislation. Frantzsen has said the following about this manoeuvre:

> "This was not a politically well-founded law. It was a law written after pressure from a campaign-like cooperation between a strong and sensation-seeking press corps and strong police patrol with a high degree of esprit de corps and long experience in war against marginalised groups" (Frantzsen 2006; 67).

The public debate which followed the new law enforcement offensive was mostly about insufficient treatment services for drug dependents. The municipalities were criticised for not supplying sufficient resources and not being receptive to treatment demands and the poor results of police offensives.

2001-2007: Denmark joins the war on drugs

In 2003 the National Board of Health carried out a capture-recapture study in order to estimate the number of problematic drug users in Denmark (Sundhedsstyrelsen 2004), estimating that the number had risen from 20,500 people in 1996 to 25,500 people in 2001. In 2004 13,500 people were registered in treatment. Of young people aged 18-24 registered in treatment in

2003, 46 % had cannabis (hashish), 15.3 % heroin and 12.7 % amphetamines as their preferred drug (Sundhedsstyrelsen 2005; 2006a; 2006b). Even before these figures were available, developments were considered alarming.

In the preceding period the image of problem creators and problem carriers had been relatively consistent with the distinction established in the late 1960s, although as we have seen 'street addicts' were increasingly also treated as a 'public nuisance' problem. But after the turn of the century the image of the drug users started to change from one of victims needing protection or at least lenient reactions to one of rational players and illegitimate hedonists who needed to be deterred. In other words, from problem carriers to problem creators who were maintaining the illegal drug market.

This period saw a number of significant and in some cases even paradigmatic changes in Danish drug policy. In 2001 legislation[17] was passed in order to provide the police with tools to deal with the so-called 'hash clubs' which had emerged in Copenhagen and major provincial towns.[18] In addition to housing users of hashish and providing shelters for dealing, neighbours maintained that the clubs were also havens for crime and offenders, including fencers. The legislation authorised the police to close the premises and prevent visitors from entering if illegal drugs were found. However, in spite of these attempts to close down these clubs the media continue to find new hash clubs in Copenhagen (see also Møller in this volume).

A major change in Danish drug policy occurred in 2003 when the government presented a white paper called *The Fight against Drugs* (Regeringen 2003), whose most significant element was the introduction of a zero-tolerance policy echoing the American war on drugs. The major goal of this policy was to put an end to the 'soft' approach to possession for own use which had been in place – but also contested – since the Attorney General's circular of 1969. Following the action plan the government changed the Act on Euphoriant Drugs so it would no longer be possible for police to use cautioning for minor violations of the Act on Euphoriant Drugs, particularly possession for own use. This meant that the Attorney General's circular of 1969 had effectively been repealed. According to the Attorney General (Rigsadvokaten Informerer 2004/35), the change of the Act on Euphoriant Drugs meant that possession of small quantities for own use would now be met with fines. The only exception would be cases where this would not be 'adequate' for special

reasons or "*when social considerations make it advisable to use cautioning, if the use of a drug is judged to be a manifestation of a strong dependence*"[19].

The latter "social clause" is the last remnant of the humanitarian concerns behind the original 1969 circular, which was now rescinded (sect. 2.2 in the Attorney General's information). Furthermore, a change was introduced in the Act on Euphoriant Drugs which raised penalties for distribution of drugs, in particular hard drugs, in restaurants, discotheques and other places where children and young people congregate (techno parties etc.). An instruction from the Attorney General states that any distribution in such places, including cannabis, shall normally be dealt with by a prison sentence, also when a young user passes a small amount of cannabis to a friend in a discotheque.

In June 2007 a new set of higher fines was introduced in connection with a bill with a very modest text but an extended set of motives, stating a new set of directions on fines.[20] With these moves the war on drugs and zero-tolerance policies have taken over from the former, more lenient way of handling drug users.

This new line in Danish drug policy was promoted by the Minister for Justice, who stressed before parliament that the aim was to effect "a dramatic change of attitudes" ("et holdningsskred" in Danish) in the population by "sending the right signals" about zero tolerance (Asmussen & Jepsen 2007). Part of this new drug policy has also been to deal a final blow to the open cannabis market in Christiania. The new line in Danish drug policy reflected a general trend towards zero tolerance in Danish policy.

Another general trend has been the use of longer prison sentences for serious drug violations. Based on a recommendation from the Permanent Penal Code Commission (Straffelovraadet 2002) the maximum penalties in Penal Code section 191, subs. 1 and 2, were raised in 2004[21] to ten and 16 years respectively (from six and ten years – with the possibility of an increase by one half, i.e. a total of up to 24 years in certain aggravated cases under PC sect. 88). Once again the argument was that some of the most serious drug crimes were "hitting the ceiling" and therefore that wider latitudes were needed "to allow for greater differentiation of sentences". There was little critical reasoning regarding the general relevance of increasing penalties in the deliberations of the Commission. It was reiterated, however, that it was

not intended that the rise should 'rub off' on the current penalty level at the lower end of the scale.

The new drug policy articulated in *The Fight against Drugs* not only contained repressive measures. It also provided for increased resources for treatment and legislative 'treatment guarantees' (treatment offered within 14 days of first contact with treatment clinics)[22], which was extended in 2006 to drug users in prison[23]. Further provisions and recommendations concerned treatment for young cannabis users and other expansions of the treatment system. But with regard to the more controversial harm reduction proposals for safe injection rooms and heroin trials, the recommendations remained completely within traditional, conservative lines[24]. The 2004 reform also introduced stricter controls in prison, including random urine testing, revocation of furloughs in case of drug traces in a test, and higher penalties for drug violations committed in prison, including both disciplinary measures and penal sanctions on the same level as those applying to violations outside prison.

In the autumn of 2007 it can be concluded that legislation and law enforcement have moved in a more repressive direction. The most visible part of the cannabis market has disappeared from Christiania, but it does function in other parts of Copenhagen. And there is no indication that the visible misery of the heavy intravenous drug users in central Copenhagen, including Maria Church Square on Vesterbro, has diminished. The total consumption of illegal drugs in Denmark has gone up, and the number of known hard-core addicts is at an all-time high. The drug use pattern is complex, and all types of drugs flow through the market in spite of spectacular seizures of attempted imports. Prices have been going down, not least for cocaine, which is gaining some foothold as a primary drug among the young. A growing number of 'recreational' users have evidently not been deterred even by the increased penalties or law enforcement. Consequently, the criminalisation of the young goes on while efforts to catch the traffickers are not convincingly successful. Nevertheless, support for the hard line seems to prevail.

Reactions to failure seem to be asymmetrical. In the control field failure results in 'more of the same'; while in the treatment field failure in appropriate conditions may lead to a revision of cherished positions (i.e. on methadone) and experimentation with new forms. The major exception is harm-reduction

measures such as safe injection rooms, to which the Ministry of Health has maintained sturdy resistance.

Summary and conclusions

The drug problem in Denmark has seen both continuity and change. Before the mid-1960s the drug problem was primarily associated with abusers of prescription medicine from the middle classes and small deviant and marginalised groups. But from the mid-1960s onwards a new kind of drug use associated with the new youth culture emerged which soon split into recreational/ideological drug use on the one hand and problematic drug use on the other, the latter appearing to be just another symptom of social and personal deprivation. Even if the ideological aspects soon disappeared, there has been a continuity of recreational drug use in Denmark – with cannabis use being particularly prevalent.

In the 1990s a new drug culture associated with the new designer drugs emerged among young people. The population of problem drug users has gradually grown older, but at the same time there has been a continual recruitment of new problem drug users. As for the governing images of drug users, they were first primarily seen as problem carriers, while pushers and 'background figures' on the supply side of the illegal drug market were seen as problem creators. Even if these images were challenged, e.g. by the image of the user-dealer, it was not until recently that a general change in the governing image of drug users resulted in them being seen primarily as problem creators because of their contribution to the maintenance of the illegal drug market.

Danish drug policy and drug legislation has also been characterised by continuity and change. The Act on Euphoriant Drugs originally aimed at another kind of drug problem than the problem that emerged in the mid-1960s. The new provisions in the penal code of 1969, which added a superstructure to the Act, were an attempt to take action against the new drug problem. Parliament agreed to compromise between stricter penal provisions and de-penalisation of users of soft drugs by means of an instruction from the Attorney General. The aim was to go after the supply side of the illegal drug market. This compromise was underlined in 1975, when an increase

of the maximum penalty for serious drug offences was accompanied by a distinction between 'soft' and 'hard' drugs. However, the compromise has also been the topic of a continual discussion between 'hawks' and 'doves' in Danish drug policy, and has also been partly undermined by police practice during certain periods. However, it was not until 2003 that the compromise was broken and a new zero-tolerance policy was enacted.

Over the years more and more legal provisions have been passed in order to increase legal control of the drug problem. The maximum penalties for violation of the drug laws have gradually been raised. Several times pressure from Norway and Sweden has played a part in this. In addition, the 'Pusher Act', the changes in the Act on Aliens in 1996, and the 'Hash Club Act' in 2001 have all been passed in an attempt to control the illegal drug market.

Law enforcement has been transferred from the 'health police', who were benevolent advisors in the streets, to special units starting with the 'unrest patrol' and to special investigative police units with more and more sophisticated means at their disposal. This has been followed by changes in procedural law to increase police powers. We have seen a gradual introduction of measures which were regarded as unthinkable in the early constitution of Danish drug policy after 1969: *agents provocateurs*, registration, wire-tapping, use of extended remand in isolation, use of anonymous witnesses etc. The latest development has been for policing of the drug problem to run parallel to the development of anti-terror legislation and practices, subsumed under provisions on organised crime.

In general *the courts* have followed the political signals with regard to both legislation and administrative regulations, including the policies of prosecution, for instance by consistently raising penalties in drug cases along with the changes in penal legislation. The criticism from defence lawyers that the demands made with regard to evidence are lower in drug cases (see Rothenborg 1979, for instance) has been swept aside and the courts have used remand in isolation with little restraint, until international criticism from the European Committee on the Prevention of Torture and the UN Commission against Torture (CAT) led to a more restrictive policy. There has been increasing readiness on the part of courts to follow the demands of law enforcement (remand decisions, higher penalties, and acceptance of undercover activities).

If one looks for continuity in Danish drug policy, it is evident that the move towards more repressive methods, extension of control and law enforcement and higher penalties has been rather constant, evidencing only occasional setbacks when the 'doves' have managed to halt developments for some time or even to set limits to police methods. But in spite of the fact that a growing number of prison cells are occupied by drug offenders, the development in drug supplies, drug dealing and drug problems has continued. Although there has been stagnation in drug-related deaths during some periods, the increase seems to continue when the availability of drugs rises along with falling prices.

When one looks at the players and influences in Danish drug policy, it is evident that the police have played an important part in setting the agenda, thereby influencing legislation and official policies. Laursen (1996b) has documented (as has Hakkarainen 1996 in Finland) that the police have been a prominent player in media presentations of drug problems and suggestions for their solution.

On a number of occasions, *the police* have interacted with *the media* (in particular the tabloid press) to put pressure on politicians and administrators to adopt more restrictive policies. Pressure of this kind contributed a great deal to the Act on Compulsory Treatment[25] of 1992 and the 'Pusher Act'/'Lex Gambia' of 1996.

The ministries with primary responsibility in the drug field have been the Ministry of Health and the Ministry of the Interior, the Ministry of Justice and the Ministry of Social Welfare. Since the early days of the modern drug problem the Ministry of Health and the National Board of Health have had the initiative and the steering function in relation to the work of advisory boards, as well as proposing legislation and policies. For instance, the Ministry of Health and the National Board of Health have played an important part in putting off a Danish heroin trial and preventing the setting up of drug injection rooms.

Since 2002 the Ministry of Justice has played an important role in charting the repressive course, promoting the tightening of laws and demanding 'signal legislation' to shape public attitudes towards drug use and drug users. While the Ministry of Health has had responsibility for the treatment of drug users within the medical sector (e.g. in relation to methadone) and for drug

prevention, particularly with regard to campaigns and information, the Ministry of Social Welfare has been responsible for social treatment. Generally speaking the Ministry of Social Welfare has played a secondary role in Danish drug policy. Only the Council on Narcotics was placed under the Ministry of Social Welfare, but here too representatives of the Ministry of Health and the National Board of Health along with representatives of the police and the Ministry of Justice have had the upper hand. As a result, control issues were discussed only very cursorily in the council, and the Ministry of Justice and Ministry of Health representatives blocked proposals for injection rooms and heroin experiments even though most of the other members of the Council were in favour.

To conclude, it has often been said that Danish drug policy rested upon the three pillars of prevention, treatment and control. In recent years harm reduction has been grudgingly accepted as a possible fourth pillar, almost at the same level as the traditional three pillars. It has been suggested that harm reduction should be integrated in all the other three pillars, including the pillar of control. From a realistic perspective, however, the development so far has demonstrated that control is the dominant ideology and practice, infusing and dominating all other aspects of policy.

TABLE 1: SUMMARY OF LEGISLATION, ADVISORY BODIES AND IMPORTANT WHITE PAPERS, REPORTS ETC.

Year	*Legislation etc.*	Advisory boards etc.	White papers, reports etc.
1950		Committee on abuse of euphoriant drugs	
1953			Report from 1950 committee
1955	Act on Euphoriant Drugs		

1968		National Board of Health working group	Report from National Board of Health working group
1969	Act no. 276/1969 introducing § 191 in the penal code	Contact Committee concerning Adolescent Drug Abuse (until 1971)	Report 1 from the Contact Committee
1970			Report 2 from the Contact Committee
1971			Report 3 from the Contact Committee
1975	Act no. 268/1975 changes in § 191 introducing maximum penalty of ten years and distinction between soft and hard drugs		
1982	Act no. 161 New Penal Code § 191a and change in AED	Council on Alcohol and Narcotics ("CAN") (until 1990)	Committee report 1023 (Ministry of Justice) on wiretapping, agents etc.)
1984			Ministry of Social Welfare white paper on various aspects of the drug problem CAN: "Meeting man where he stands"
1985	Act no 164: Change in Code of Procedure (wiretapping etc. and use of agents		

1986	Code of procedure: Prohibition of the use of anonymous witnesses		
1992	Act no. 349: On involuntary retention of addicts in treatment		
1994			Government white paper: "Fighting Drug Abuse – elements and main problems"
1995		Council on Narcotics (until 2001)	
1996	Act no. 1052: Changes in the Act on Aliens ('Lex Gambia') Act no. 1054: Changes in § 3 sec. 2 of AED ('Pusher Act')		
1997	Act no. 426: Change in penal code. Confiscation of funds, reversed burden of proof		
2001	Act no. 426: Prohibition of visitors in designated premises ('Hash Club Act')		
2002		Council for Socially Marginalised People	Penal Code Commission (on penalties)

2003	Change of law on social service: Treatment guarantee for drug addicts		Government White Paper: "The Fight against Drugs"
2004	Act no. 218: Changes in penal code and code of procedure Act no. 445: Act on changes in AED		
2007	Bill on change of AED		

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NOTES

1 An advisory board to the government.

2 Indenrigsministeriets udvalg (Committee on abuse of euphoriant drugs, 1950-53), Kontaktudvalget vedr. Ungdomsnarkomanien (Contact Council on Adolescent Drug Abuse, 1969-1971), Alkohol- og Narkotikarådet (Council on Alcohol and Narcotics, 1982-1990), Narkotikarådet (Council on Narcotics, 1995-2001).

3 These periods are not quite the same as those used by Laursen (2000), whose study starts in 1965 and ends in 1995.

4 This mode of legislation has been criticised by Brydensholt (1971) and others.

5 For a number of these studies see (Ulff-Møller 1971; Winsløw 1972; Holstein et al. 1972b).

6 For a description of the emergence of the second group and the distinction between the two groups see (Hindsbo, Madsen et al. 1971).

7 Kontaktudvalget vedrørende Ungdomsnarkomanien, see Houborg (2006) and Houborg in this volume.

8 See Anderson et al. 1971 and others.

9 It was negotiated by the Ministry of Justice, represented by section head H.H. Brydensholt (Brydensholt, 1971 p. 80).

10 For an account of this system of distribution see (Hindsbo, Madsen et. al 1971).

11 As an example of the methods used, which soon found their way into Danish drug control, Nissen started to use *agents provocateurs* even in the early 1970s (Nissen, 1978), a practice which was accepted by the courts but not legitimised by Parliament until 1986.

12 For an account of the ambivalent role played by methadone in Danish drug treatment see Houborg 2006, Jöhncke 1997.

13 In 1992 parliament passed legislation on the involuntary retention of addicts in treatment (Act no. 349 of 14 May 1992), although this was ultimately watered down so much that it has not been used to date.

14 Even though the initial results were not very convincing (Storgaard 1999). See also Asmussen Frank & Kolind this volume.

15 For many years general practitioners had been prescribing methadone to drug addicts without cooperation with the social treatment system, which on its part was very hostile towards the use of methadone (see Houborg 2006).

16 For a comprehensive account of the police actions in Copenhagen and the change of legislation in the 1990s, see Frantzsen, 2006.

17 Act no. 218 "on prohibition against visitors in designated places".

18 See Asmussen & Moesby-Johansen (2004). This legislation was given a more strict interpretation in 2005 because it was not sufficient for its purpose – to close down hash clubs.

19 This cryptic statement has been subject to a long discussion regarding its interpretation.

20 The bill was not turned into law until the end of the legislative session of 2007.

21 Act no. 218 of 31 March 2004.

22 Lov om ændring af Lov om Social Service, 2003 (Act on Changes in the Social Service Act).

23 Act no. 23 of 12 December 2006, revising sect. 45a of the Act on Execution of Sentences (straffuldbyrdelsesloven).

24 However, in 2007 a 'health room' has been accepted where the injection of prescribed drugs is permitted.

25 This act made a kind of voluntary compulsory treatment possible, because it made it possible for the social authorities and drug users to make a contract which allowed the authorities to keep users in treatment. If a drug user turned down an offer to make such an agreement, it would have no consequences with regard to receiving other kinds of treatment. The legislation has had no practical consequences for drug treatment in Denmark.

Esben Houborg

YOUTH, DRUGS AND THE WELFARE STATE – CONSTRUCTING THE DANISH DRUG TREATMENT SYSTEM 1965-1972

This article is about the simultaneous construction of 'youth addiction' ['ungdomsnarkomani' in Danish] as a social problem and of a specialised treatment apparatus to handle it, something which took place from the mid-1960s to the early 1970s. It is the story about how this new problem emerged and how Danish society learned to live with it. A story about going from a state of perplexity regarding how to define the problem and what to do with it, to the institutionalisation of a particular definition of the problem and of a particular treatment model. This co-construction of 'youth addiction' as a particular kind of social problem and of a special apparatus to handle it is a major event in Danish drug policy. Firstly because it ended the medical dominance of drug treatment, which had lasted since drug abuse was first discovered in the late 19th century. And secondly because it ultimately defined the way in which Danish society would live with 'drug abuse'[1] for more than 25 years to come.

The development from perplexity to institutionalisation was a process, which involved many different actors and institutions. Some of the most significant actors and institutions in this process is the focus of this article. They are first of all the institutions, which were given or took upon themselves the task of dealing with the new problem (the psychiatric system, the prison system and the child and youth care system). The difficulties these institutions experienced were central to the constitution of youth addiction as a special problem requiring a special treatment system. Other important institutions were the ones, which, in face of the difficulties experienced by the established health, welfare and penal system, took it upon themselves to develop new ways of handling drug problems and social problems among

young people. Thirdly, experts engaged in scientific and political struggles about how to define and explain drug abuse play an important part in the constitution and institutionalisation of particular ways of thinking and talking about drug abuse. Finally, the media also played an important role in the constitution of the modern Danish drug problem. However, I will only deal with the media provisionally in the first part of the article, where I discuss the relationship between the new youth culture and the new drug culture.

Taking my inspiration from Michel Foucault's archaeology of knowledge (1972; 1986), I will present an account of the construction of the epistemological, institutional, methodological and cultural space within which 'drug abuse' or 'youth addiction' came to exist as a particular kind of social problem. A space which even today largely defines how we think, talk and act with regard to drug problems. I see the prison system, the psychiatric system, the child and youth care system, the media, the field of expert discourse about the new drug problem and the new treatment institutions as important 'surfaces of emergence' (Foucault 1972) of the modern drug problem in Denmark. Such 'surfaces of emergence' are places and situations where ways of thinking, talking and acting which are normally taken for granted are challenged by something which resists and objects, and which requires new modes of thought, discourse and action. Blackman describes such 'surfaces of emergence' in the following way:

> [S]urfaces of emergence, which can be thought of as spaces where certain problematisations of social existence are specified and cast into the governmental arena to be managed and regulated. [...] These 'surfaces of emergence' could be the family, on the streets, within practices such as the school, penal institutions, work and other sites where conduct and experience present themselves as disturbing presences posing problems of management and regulation." (Blackman 1994: 497).

Drawing on both Foucault's archaeology and science and technology studies (Pickering 1995; Stengers 1997; Latour 2004), I will regard the constitution of the space within which drug abuse was institutionalised as a particular kind of problem as the product of a process of resistance and accommodation. I will show how young people with drug problems resisted the existing ways

of defining and acting upon social problems, which in many ways resembled it: medicine abuse, juvenile delinquency and social maladjustment. There was something in the problems, the behaviour and the attitude of the young drug users, which escaped the usual ways of thinking, talking and acting with regard to these other social problems. They were an epistemological challenge, because they resisted received ways of understanding, explaining and categorising social problems. They were a methodological challenge, because they didn't respond or responded badly to the existing methods and measures of the institutions. But the young drug users were also a cultural challenge, because they carried with them ideas and values, which to some extent resisted the normative assumptions and ideals about social integration, social subjectivity and social citizenship upon which the work of the established welfare and penal institutions was based. Perhaps the young drug users could be seen as the first real encounter these institutions had with ideas, values and modes of conduct such as anti-authoritarianism and self-realisation which they would have deal with on a much larger scale in the years to come.

Drugs and the new youth culture

Because of the importance of the cultural challenge, which the young drug users posed for the welfare-penal complex at the time, I will include a short presentation of the association between the new youth culture and the new drug culture of the 1960s. From the early 1960s a new youth culture emerged which was the most visible sign of a number of social and cultural changes occurring during the 'the long sixties' from the late 1950s to the early 1970s (Marwick 1998)[2]. Part of this new youth culture articulated a critique of central values and institutions of Danish society and western societies generally something, which would become increasingly common in the years to come. Established society was experienced as undermining individual autonomy, as alienating, and as making self-development and self-realisation difficult. An ethnographic study of a group of drug users in 1970 described their experience of this in the following way:

> They did not feel that family life, school, apprenticeship or the workplace was their life. They sensed that they were placed in organised isolation,

> suppressive roles, [a] senseless race and an emotionally cold environment. They felt hung up on things which in the future would give them a grown-up existence that they found empty, dishonest and lacking in experiences. (Wad 1971: 214).

Or, as one young man explained in a newspaper interview in 1965:

> The grown-ups have twisted ideas about life. They think that they are the only ones who are right. They will not admit that they are bored terribly sometimes, and that they would like to do something more exciting than getting up every day go to work and then going home to watch television. We are not bored. We discuss music, religion and politics, and we learn a lot from that. We enjoy a freedom, which our parents have never known, because they always have to think about what is nice and what is not nice. We don't. (EB 1965b).

This, of course, was merely a radical expression of a more common feeling – that the experiences of the older generations were of little or no use to young people growing up in a society under rapid transformation (Grünbaum 1988; Marwick 1998). For some the consequence of this discontent with what mainstream society had to offer was to 'drop out' of education, jobs, family etc., and start to experiment with new ways of life. While it was clear that a mainstream existence was rejected, it was less clear what should replace it. But some of the general ideas involved were: 'living for the moment' instead of accepting the deferred gratification associated with an ordinary working life; spontaneity; a laid-back attitude; an orientation towards inner experiences and emotions; experimental curiosity; and creativity (Christie 1968; Hindsbo et al. 1971). This 'longhaired lifestyle', as Christie (1968) called it, involved a general orientation towards exploring new territories – mental, emotional, social and geographical – in the hope that some new and 'truer' existence would be achieved. Travelling, creative activities, contemplation, social experiments, and (last but not least) drugs were means of exploring such new territories. In particular, drugs believed capable of expanding the consciousness (cannabis and LSD in particular) were popular. Thus, as Christie points out, different drugs were associated with different ways of life:

> Alcohol and barbiturates are intimately connected with the life-pattern of large categories of the consumer society. The connection between consciousness expanding substances and the longhaired lifestyle among the anti-consumers is an even bigger possibility. (Christie 1968: 24).

Whereas the drugs of mainstream society were perceived as sedating, the drugs of the new youth culture were seen as ways to gain new insights – as 'doors of perception' – and hence as liberating[3]. In many newspaper articles from 1965 and 1966[4] in which young drug users were given an opportunity to talk about their lives, drugs were given precisely that role. One young man reported in an interview that he used marihuana to gain new insights and experiences, while dissociating himself from a mainstream existence:

> For me it was a wish to provoke my life – some new experiences. If you are pro-smoking [cannabis] with the wish that something should happen, if you are willing to seek into yourself, a psychic change happens which is observable in everyone who smokes. You withdraw partly from life and in a way become an observer. [...] For me, the drug has become a way into a place inside of me, where I see coherence. I guess we are all looking for some kind of self, some coherence between our private person and existence – most of the books by the big writers are about this quest. (EB 1965a).

The new drugs and patterns of drug use became a matter of public concern in 1965, when many newspaper articles were written about it. But according to Winsløw (1984) it was not until 1966 that a connection was made between the new drugs and the new youth culture:

> The connection between especially cannabis-smoking and protest movements in the summer of 1966 turned 'drugs' from being something totally incomprehensible, and (if not harmless) for the majority of the population something which was of no concern, into an open threat to central values like diligence, discipline, striving for material wealth and respect for the institutions of the state and its representatives. (Winsløw 1984: 39f).

Many alarming newspaper articles were written about the issue, and it soon became apparent that some young people found it difficult to handle both 'the longhaired lifestyle' and drugs. The problems started to appear in families, schools, workplaces, youth clubs and institutions like prisons, psychiatric hospitals and reform schools for socially maladjusted children and young people. But the problems proved difficult to handle, because the new youth culture was just as challenging as the drug problems themselves. The institutions were confronted with problems, behaviour and attitudes which did not fit immediately into the usual ways of thinking, talking and acting. And the attempts made to deal with these challenges played an important part in the construction of youth dependence as a separate phenomenon and as a social problem.

Drug abuse: a new symptom of well-known problems?

From 1965 onwards young people with drug problems started to appear in various institutions in numbers which made these institutions take special notice of them. In the prison system, the psychiatric system and the system for child and youth care efforts were made to get to know more about this new kind of prisoner, patient and client. Several of these investigations showed a development in which drug problems increasingly correlated with various personal and social problems. Within a few years of their emergence, drug problems among young people were defined as a new and particularly complicated symptom of well-known problems of social and personal deprivation requiring special intervention.

The prison system

In 1965 a doctor at the prison hospital in Copenhagen started a study to gain information about young drug users who had come to his attention because they were different from the other prisoners (Jersild et al. 1968). He designed a set of questionnaires to gain information about their social and personal background and about the nature of their drug use[5], and found that these drug users differed considerably from the rest of the prison population. Most of the prison population came from the lower social strata, and many of them had a disadvantaged social and personal background with a poor

upbringing and a poor educational and occupational record. In contrast to this, the drug users came primarily from middle-class families and had a much better educational and occupational record, even though the data did suggest a 'drop-out' lifestyle among some of them (Jersild et al. 1968; Manniche & Wolf 1969; Andersen 1970). These prison studies were continued in the following years, partly in collaboration with the Department of Sociology at the University of Copenhagen (Andersen 1970; Voss & Ziirsen 1971). The conclusion was that drug users increasingly came to resemble the rest of the prison population with regard to their personal and social background. It was also apparent that the nature of drug consumption developed from the use of primarily cannabis and to a smaller extent LSD to poly-drug use, including opiates. It was concluded:

> If we combine this knowledge [about drug use] with our knowledge about the increased number of people with little school education, a bad family background and little education, it is obvious that the group, which is already severely socially disadvantaged, has had its conditions made even worse because of drug abuse. (Voss & Ziirsen 1971: 111).

The psychiatric system

'Medicine abuse' was a medical and particularly a psychiatric condition. It was therefore natural for some psychiatrists to investigate the matter when young people started to appear in the psychiatric system in increasing numbers from 1965 onwards. Two reviews of some of the first cases from 1965 and 1966, which were both concerned with the correlation between drug problems and psychopathology, were published. The first review (Bøttcher 1967) related drug abuse to personality disorders and found that in all the cases examined the patients had 'character insufficiencies'[6] even before they started to use drugs. But at the same time it was acknowledged that much drug abuse among young people would probably not constitute a psychiatric problem, as it would just be a sign of adolescent rebellion against the authorities[7]. The other review (Jørgensen 1967) investigated the relationship between cannabis use and psychosis, and found no evidence of such a link if the person was not disposed for psychosis already. This means that in both reviews part of the new drug problem was related to psychopathology, and

was hence defined as a psychiatric problem. But at the same time it was acknowledged that part of the new drug problem could not be attributed to such problems, and hence could not be said to be a natural part of the psychiatric system's sphere of activity.

In 1968 the National Board of Health was asked to assess the new drug problem, and one of the things it did was to carry out a census to find out how many hospital patients were diagnosed with 'medicine abuse', and how many of them were young people (Sundhedsstyrelsen 1968: 88)8. By asking a few questions about the patients (age, gender, material status, occupation, place of residence) and the nature of their drug consumption (drugs, mode of use, frequency, duration), the census made it possible to distinguish between different kinds of drug problems and drug users. In this way a new kind of drug abuser – 'the young drug abuser' – was made visible. This category constituted about one-third of the patients, and was characterised by the use of marihuana and to some extent opiates, whereas the older patients primarily used tranquillisers and to some extent opiates.

In order to gain more knowledge about the young drug abusers who had been made visible by the census, the Committee on Adolescent Drug Abuse commissioned an investigation of all patients committed to hospital with drug abuse in 1969 (Haastrup 1970)9. A comprehensive anamnesis was performed on each patient in order to elucidate possible connections between the personal and social background and the nature of his or her current drug problem. In this way this study bore a close resemblance to the prison studies mentioned above. The study showed that the majority of the patients committed with drug problems in 1969 had a problematic personal and social background. It also showed a correlation between other social problems and drug abuse: the more severe the background, the more serious was the drug problem. The study distinguished between three categories of drug abusers. 'Classic abusers', who were committed to hospital for abuse of prescription medicine (the same as 'medicine abusers'); 'psychedelic abusers', who used cannabis and LSD as part of a 'longhaired lifestyle'; and 'poly-drug abusers', for whom drugs were just one element in a career of marginalisation and deviance. More than two-thirds of the patients were placed in the last category. This study and the prison study contributed to the dominant image of the new drug phenomenon: most of

the people who developed drug problems already had social and personal problems as well.

The child and youth care system

The child and youth care system did not conduct studies like the prison and psychiatric studies. But in 1969 the Directorate for Child and Youth Care asked a number of institutions to give an account of their experiences of the new phenomenon. Parts of these accounts appeared in various journal articles and official documents (Jørgensen 1969; Perch 1969; Kontaktudvalget 1969; 1970). By reviewing the cases involving clients who used drugs, the principal of one institution came to a conclusion very similar to that of the prison studies and the psychiatric study: drug problems were a symptom of maladjustment caused by social and personal deprivation. He was of the opinion that drug-using clients would probably have been institutionalised anyway – even if they had not been drug users.

> Drug abuse is hardly the main problem for these boys, or expressed in another way: even if no drugs were available these boys would, as the description indicates, have been the ones who would be institutionalised anyway. (Jørgensen 1969: 5).

These young people were not described as hippie and provo 'revolutionaries' or 'innovators', but as 'retreatists' who had given up trying to adapt to normal society.

> [...] the result has been what stands out: young people with problematic experiences and a consequential lack of self-confidence, an attitude of resignation towards problems and demands which present themselves: 'I can't manage it, so I might just as well not try'. Or to put it in the language of the pupils: 'I can't be bothered.' (Ibid: 4).

The new youth culture with its tolerance offered these young people a new and 'easy' way to avoid commitments at home, school, work etc.

> For the past couple of years these boys have had the chance to associate themselves with a group, namely the hash, drug, provo and hippie environment around Nikolai Square and Montmartre in Copenhagen and places like that in the provinces. Whatever one can say about these environments, one has to admit [...] that the group is very tolerant and only makes demands that even our pupils can live up to. (Ibid: 5).

This image was confirmed by other professionals who gained contact with young drug abusers (See e.g. Kiørboe 1967; Jepsen 1969; Glumer 1970; Berntsen 1971). Thus, the drug problem started to emerge as primarily a 'social' problem in the double sense of being a result of social deprivation and as a socially acquired behaviour. Medical explanations, including explanations in terms of psychopathology, were no longer sufficient. At the centre of the way in which the drug problems were described was the biography (the deviant career) of the individual. This was noticed by Finn Jørgensen, who voiced (Jørgensen 1969) an epistemological critique of this precise fact.

> The study of the present drug abuse among young people has started with clinical observations of the patients, who came into contact with the doctor at hospitals, social institutions, prisons and the like. [...] Such a method is individualistic, as you only deal with isolated single cases, and therefore important aspects of the drug abuse are neglected. (Jørgensen 1969: 374).

According to Jørgensen, the focus on the individual drug users made the descriptions disregard the important sociological and social psychological aspects of the new drug phenomenon10.

Acute measures: Attempting to accommodate the drug problem in the existing institutions

Along with the efforts to classify the problem, the institutions also had to find ways to handle it. This is where the real challenge and need for accommodation appeared. The initial response to the challenge was for all three institutions – prisons, psychiatry and child and youth care – to try to 'integrate' young drug users into the existing populations and as far as possible to

use the existing methods and technologies. This strategy failed for them all, but in different ways and for different reasons, and naturally the interesting thing is what they did as a consequence of this.

The prison service

When the Directorate for the Prison Service was asked by the Committee on Adolescent Drug Abuse to account for its immediate response to the new drug problem in 1968, it made it clear that it did not consider prisons to be the right place to conduct drug treatment. The Directorate suggested that only drug abusers whose delinquency was due very little to drugs should be put in (youth) prisons:

> [...] people for whom drug abuse is only a random part of an anti-social pattern, and for whom the crime pattern is heterogeneous, ... and ... young drug abusers who have no criminal record and where it is assessed that the drug abuse is not too severe, especially because they are not deeply involved in the drug sub-culture. (Kriminalforsorgen 1968: 5).

People with more serious drug problems were to receive treatment instead of imprisonment, for instance after a suspended sentence. The number of drug abusers placed in prison should represent no more than one-fifth of the total prison population. Furthermore, with the exception of a special ward for drug abusers with hepatitis, they should be placed among other prisoners in the hope that these prisoners would have a positive influence on the drug abusers. This policy of mixing prisoners with drug problems with other prisoners was called the 'dilution policy' (Kontaktudvalget 1969: 225; Sylvestersen 1970: 3; Kriminalforsorgen 1971: 3). Even without major new measures, the Prison Service did expect that handling the drug problem would require extra resources. The hope was that these 'acute' measures would accommodate the problem. They failed to do so. In November 1971 the prisons receiving the largest number of drug users had a proportion of drug abusers which in some cases far exceeded one-fifth of the total population (Vestre Prison in Copenhagen: 25 %; Nyborg Youth Prison: 65 %; Søbysøgård Youth Prison: 75 %) (Kriminalforsorgen 1971: 1).

The psychiatric system

The immediate response of the psychiatric system to young drug abusers was to place them among other patients. Until the 1960s the psychiatric system had been used to provide treatment for 'medicine abuse', involving individuals who primarily had an unauthorised consumption of prescription medicine. This condition was seen as a symptom of mental and/or emotional problems, and it was treated by withdrawal from the drugs involved and psychiatric treatment of the problems causing the abuse of medicine. In contrast to this, as I have already shown, it soon became clear that the drug problems of the young drug users were of a social and psychosocial nature, and did not necessarily involve a bona fide mental illness. Whereas the 'mixing' strategy in the prison system was made difficult because there were too many young drug users who were too entrenched in a drug-using lifestyle, the problem for the psychiatric institutions was that the drug abusers were too young and that they constituted a sub-culture. The drug abusers were younger than most of the other patients, and this led to tensions and conflicts in the wards even when efforts were made to make the environment attractive to young patients.

> Most of them think the wards are old-fashioned and inappropriately organised. They don't like them and are critical about being placed with much older psychiatric patients. They are bored most of the time on the wards, and they miss adequate activities and entertainment, the chance to play their special music. (Jørgensen in Pedersen 1981: 24).

At one hospital such problems led to the placement of young drug users in special wards, but still among other categories of patients. But even without the generation problem, it was a problem that the young drug users belonged to a sub-culture, which they brought with them into the hospitals. This sub-culture – like any sub-culture within a total institution (Goffman 1967) – represented a threat to the normative system, the hierarchy and the social roles, not least the 'patient role' and the patient-doctor relationship upon which the system rested (Goffman 1967; Jørgensen & Ulff-Møller 1972).

> First of all a number of difficulties are associated with treatment of drug abusers in the hospital. They stand apart from the other patients and the staff both with regard to clothes and behaviour and because they constitute a sub-culture with all the conflicts that follow from this. (Groth 1970: 222).

The child and youth care system

By 1968 it was estimated that 10 % of the clients at reform schools[11] in the child and youth care system were drug users (Nielsen 1970); although about one-fifth of the clients at some schools were drug users (Perch 1969). These clients turned out to be different from the other clients, and caused a number of problems. One of these problems was that they were a source of 'infection' because they took drugs with them into the institutions, where other clients might pick up the habit. This led to discussions about establishing special closed institutions for drug users (Jørgensen 1969; Perch 1969; Nielsen 1970). But in 1968 the three reform schools, which had the largest number of drug users presented their experiences of the new clients, and one of these schools stated:

> Experience has shown that in the treatment work it has been necessary to try to let the young people talk about their sometimes very well-defined motives for choosing an anti-social existence, and the best results have been reached by using arguments instead of prohibition and restrictions. (Sundhedsstyrelsen 1968: 169).

In the end one closed unit which had been established before the emergence of the new drug problem was used for a while (Nielsen 1970). But in order to handle the problem four reform schools were given the special task of providing drug treatment, one of the aims being to keep drugs and drug users out of the other schools. This did not happen, and in 1969 it was recognised that a large proportion of the clients at reform schools had tried or were using marihuana, and the four schools were given the task of providing treatment for the most severe cases (Kontaktudvalget 1970). The problems involved in integrating young drug users into reform schools cannot be dissociated from the more fundamental institutional challenge which the young drug

users posed not only for the reform schools, but also for the prison system and the psychiatric system.

An ideological and cultural challenge

The young drug abusers did not just represent a new social problem with the epistemological, methodological and institutional challenges this entailed. They also represented a new kind of client who would have been a challenge to the institutions, which were first given the task of taking care of them, even without the drug problem. It was not just that the young drug abusers resisted the established categories and treatment methods. They also resisted what could be called (using Michel Foucault's concept) the 'modes of subjectification', which these categories and methods represented. In other words, the young clients could not or would not subject themselves to the conditions required of them in order to be regarded as competent members of Danish society. They were not in line with the normative assumptions upon which the institutions based their work. So these young clients were opposed not only to the means of treatment, but also its ends in the form of particular ideas about social integration and social subjectivity. In a statement, which appears in several texts about the child and youth care system, this problem was made explicit.

> The traditional clientele with which the institutions of the child care system works can be characterised as by and large accepting societal norms and values, even if they use illicit means to realise these, and the pedagogical work and the vocational and other measures of the institutions are adjusted to the problems of this clientele. However, many of the young drug abusers reject many of society's recognised values and norms, and they therefore have problems adapting to the norms and demands of the institutions. (Indenrigsministeren 1969: 27; Kontaktudvalget 1969, app. 4: 4; Nielsen 1970: 234).

The institutions – particularly the child and youth care institutions and (youth) prisons – were designed to accommodate young people who, with the proper re-socialisation and vocational training, would 'grow out' of their

anti-social behaviour and adapt to a normal, responsible adult life (Jørgensen 1969). But the young drug users carried with them values and norms which constituted them as a different kind of client who did not long for the kind of mainstream life which lay ahead, and which the everyday running of the institutions tried to simulate.

> Furthermore, there are significant aspects of what Christie has called 'long-haired lifestyle' in the attitudes of these young people. Without romanticising, one could claim that they largely represent a relaxed attitude towards conventions. (Nielsen 1970: 225).

And this of course caused serious problems for the institutions and threatened to undermine the treatment of other clients. For instance, the incentives, which made the traditional clients of the reform schools and youth prisons participate in and benefit from pedagogical activities and vocational training.

> Our present reward system does not provide any motivation for activity for these boys. They are not capable of thinking and making plans for the future in such a way that the work they do on Monday is related in their minds to the pay they get on Saturday, or even capable of relating this salary to the cigarettes they want next Monday (Jørgensen 1969: 7).

Similar problems of resistance to established ways of making good social subjects out of clients were experienced in the psychiatric system – to the delight of some, who saw the young drug users as a healthy challenge to a conservative institution.

> By their presence in the psychiatric wards and by their criticism, the young drug abusers have revealed and pointed out certain deficiencies of the psychiatric wards, just as they have revealed deficiencies of other institutions and in the cooperation between institutions. (Jørgensen 1970, in Petersen 1981: 25).

As an example of the way in which both the means and the ends of the psychiatric system were questioned, I will quote from an ethnography of drug sub-cultures from 1971 in which a girl talks about her encounter with a psychiatrist.

> I wanted to break that shell which is around me or which is inside me. All the phoniness I had built up, because someone forced me to do things in some way. I wanted to get rid of it and just be myself. And when she [the psychiatrist] said to me – and this is very funny – 'When we get people in here at the hospital, we try to get them to build that shell.' I asked: 'Why do you do that?' 'Because people have to do it, otherwise they can't cope.' Then I said: 'Then I don't think we have any more to talk about, because I don't believe in that.' (Hindsbo 1971: 82).

It is not so much the psychiatric institution in itself, which the girl is opposed to as the mode of subjectification which the psychiatrist presents for her. The girl wanted to develop a new more 'true' self, and in her opinion what the psychiatrist had to offer was 'false consciousness'.[12]The big challenge to the institutions was the young drug abusers' recalcitrance regarding the ways in which the institutions made individuals into social subjects. What the institutions had to offer was models for social citizenship, which had been developed under the 'classic' welfare state and which placed the emphasis on 'normalisation' – something which had very little attraction for the young drug users. Until the mid-1990s, the prison system's way of handling the problem was not to provide drug treatment.[13] For the psychiatric system this meant that it withdrew to an auxiliary role in drug treatment, providing detoxification and treatment of dual diagnosis patients something, which it even today finds difficult to handle. For the child and youth care institutions the challenge was a major blow to their legitimacy, because the way in which the drug problem had been constructed had made them central in the handling of it. In an article in 1970, presenting the current status regarding the handling of the drug problem in the child and youth care system, it was concluded that a state of pedagogical crisis prevailed.

> Without exaggeration one can state that the institutions of the child and youth care system are in a state of pedagogical crisis. A large part of the clientele of maladjusted 14-18-year-olds which it previously treated successfully are now suddenly completely unaffected by ordinary pedagogics, and their behaviour puts staff into a situation in which the system falls short. (Nielsen 1970: 236).

Setting up a specialised drug treatment system

The inability of the established institutions to meet the challenge of the new drug problem in a satisfactory manner led the Directorate for Child and Youth Care to fund a treatment experiment designed by Karen Berntsen, the manager of the Youth Clinic14, and the psychiatrist Finn Jørgensen (Perch 1969). The experiment started in March 196915 and was planned to last for three years. The aim of the experiment was to establish a new treatment institution called 'the Day and Night Centre' under the Youth Clinic, with a view to developing a new way to treat drug abuse. This experiment is significant because it constituted a setting in which young people with drug problems were institutionalised and handled as a particular kind of problem. It is also significant because the treatment model, which was developed, became a central reference for the way to think, talk and act towards drug abuse in Denmark for many years to come. The treatment programme was based essentially on sociological and social psychological theories of deviant careers, particularly Howard Becker's career theory (Becker 1963). This means that drug abuse was seen as a learned behaviour, which is associated with marginalisation from conventional groups and integration into sub-cultural groups where drug use is a central activity. The deviant career was conceived as a step-by-step process in which the individual gradually changes his or her attitude towards drugs and develops a deviant identity as a consequence of his or her interaction with the surroundings (e.g. Berntsen 1968; Berntsen 1971; Jørgensen 1971; Ulff-Møller & Jørgensen 1972).

> We assume that in order for an individual to go from one step in drug consumption to another a change of attitude with regard to drug use has

> to take place, and this change takes place in his or her social context. [...] (Ulff-Møller & Jørgensen 1971: 431).

The aim of social treatment was basically to reverse the deviant/drug career. Step-by-step drug users would dissociate themselves from the sub-culture and the identity associated with it, and develop an identity and acquire competences, which would make it possible to cope in more conventional surroundings – without drugs (Berntsen 1969; Andersson 1971). Technologically the major inspiration was the experiments with therapeutic communities which were going on in the USA, and which the manager of the Youth Clinic went to study (e.g. the experiment in New York, which later became Phoenix House). Treatment in the therapeutic community is based on interaction (role-play) between clients and staff, and between the clients themselves. As a result different roles are defined and tried out until the client is ready to leave the community (De Leon 1985; Kløvedal 1970; Andersson 1971). True to the sociological basis of the treatment model, it was important to avoid the 'medicalisation' of the drug problem and the associated 'sick role', which had been a part of the psychiatric treatment of 'medicine abuse'. This would undermine the social construction of the motivation to stop using drugs upon which the treatment model rested, because the sick role would take away the responsibility of drug users for changing themselves. For the same reason treatment was voluntary.

> Our work therefore has to concentrate on liberating the clients from this sickness mentality. As a consequence of this we have to give the treatment an environment, which makes it possible to choose. (Kløvedal 1970: 212).

However, the major difference between this new treatment model and the existing social treatment was the way in which the cultural and institutional challenge of the young drug users was handled. The programme was based on the view that major social changes were taking place in Danish society (changes of which the new youth culture was just one sign), and that the younger generations could therefore not be expected to share the norms, values and ideals of the older generations (Berntsen 1971: 17). The purpose of

treatment was therefore not normalisation and integration into mainstream society, which had been the aim of 'traditional' re-socialisation. Instead, the aim of treatment was to make possible the difficult task of developing one's own identity and existence without using drugs, in order to make one able to find ones own place in society.

> So in my opinion we cannot see it as our job to 'lead' this group of young people further than the point at which they are strong enough to decide for themselves if they want to live according to the patterns of established society or order their lives according to the (incidentally) vague norms of 'the youth culture'. (Ibid: 12).

Neutrality towards the norms and values of the new youth culture, and in some cases even help to realise an alternative lifestyle – without drugs – was central to handling the ideological and cultural challenge, which the young drug users represented. This is probably the reason why the treatment experiment attracted people who associated themselves with the new youth culture as treatment staff (Pedersen 1981; Winsløw 1984)16.

A scientific and political struggle about how to define the problem

The new social treatment paradigm did not go unchallenged, particularly its theoretical foundation and its cultural and ideological implications. The major alternative was based on an epidemic model of drug abuse. This was not just an epistemological struggle, but also a political struggle about which kind of drug policy paradigm Denmark should adopt. And in line with my previous account, it was a struggle about how to meet the challenges of the social and cultural changes which the new youth culture represented. Should the youth culture be accommodated in any way, or should it be rejected?

The epidemic discourse was inspired by an addiction theory presented by the Swedish doctor Nils Bejerot. Bejerot (1971) distinguished between drug abuse and addiction. Both were drug use with negative consequences; but whereas drug abuse was still regulated by the will of the user, drug addiction was not. Addiction was defined by loss of control of drug use, which Bejerot attributed to 'an artificial urge' to seek the pleasure from drugs which came

with continued drug use over a period of time. Attempts to 'cure' drug addicts by means of re-socialisation and the provision of social services would be a mistake because they would not remove the urge, even if they improved the welfare of the drug user. The only possible treatment was long-term psychiatric treatment. This theory makes two important assumptions: 1) Drugs are inherently addictive – after a period of time drug use will shortcut the pleasure-pain mechanism and lead to an uncontrollable urge to take drugs. 2) The availability of drugs is the crucial factor – availability leads to use even among people who are not marginalised and deviant[17]. Everyone is exposed to the danger of developing addiction. But it is not just the availability of drugs in itself, which is the problem. The problem is also that drug users are carriers of 'the infection'. Bejerot developed the much debated concept of 'contact infection' or 'psychosocial infection' (Bejerot 1978, 51) to account for this. Closely resembling the theory of 'psychic infection', drug users are presented as active – even manipulative – people who get others (who are presented as passive and open to manipulation) to use drugs[18]. Critics found this element of the theory to be obsolete and bad science, because it did not rest upon a realistic description of social interaction, and because it did not recognise that attitude and motivation are central to the social process of learning how to use drugs (Andersson et al. 1971; Jørgensen 1971; Løchen 1971).

Proponents of the epidemic model suggested that traditional measures to stop the spread of infectious diseases should be adopted to remove the drug problem. This basically meant finding and removing the infection itself (drugs); and tracking down and isolating carriers of the infection (drug users, or at least dangerous hardcore users) (Bejerot 1968). In this way a group of doctors put forward a list of measures to contain and stop the drug epidemic among young Danes (Behrendt et al. 1971). These measures included preventing drugs from entering the country and being distributed within the country by means of improved border control; deporting foreign drug dealers and drug addicts; confiscating the passports of Danish dealers and addicts; and improving the control of legal supplies of drugs. Other measures aimed to track down and in some cases isolate drug users, for instance by registering known drug abusers, making it an obligation to seek treatment, and making involuntary treatment possible for individuals without the willpower to stop

using drugs. The attorney general's circular of 15.7.1969, which de-penalised possession for own use, was to be revoked because it made it impossible to stop drug use and hence helped to make an environment for drug use possible. Furthermore, the minimum sentence for drug crimes should be raised (see Jepsen in this volume). It was also necessary to regulate the media and the conduct of professionals working with children and young people to make sure that 'agitation' for drug use did not take place. In the same vein, cultural projects and experiments, which accommodated the new youth culture should be stopped because they produced an environment in which drug use was accepted.

The proposals met heavy resistance from proponents of the sociological treatment paradigm. Among them were members of 'the drug seminar', many of whom had played a key role in developing the alternative treatment system (Andersson et al. 1971). They raised the scientific criticism of the epidemic model, which I have already mentioned, but they also criticised the political implications of the proposals for being conservative. Should drug use and drug users – and the cultural and social changes they represented – be seen as a product and part of Danish society itself? Or should they be seen as something foreign, which should be eliminated?

The debate was covered extensively in the media, but the Chairman of the Advisory Committee to the Government on the drug problem did not support the proposals. He found that the proposals only dealt with the symptoms of the problems, and by means of repressive measures at that. Instead he supported the social treatment paradigm, which described the problem as a symptom of social deprivation:

> Even though we do not know enough about the causes of the youth drug problem, it is becoming more and more clear that this is not a disease with a well-defined and certain cause, but rather a mode of reaction to a long line of different influences which, probably, have something fundamentally to do with the conditions, for better or worse, under which we live today – that is an expression of a social problem. If you accept this point of view, it is also clear that it concerns matters, to which not only doctors can show the solutions. This knowledge does not seem to appear from the letter from the nine doctors, and they are guilty of the mistake of thinking

that a series of social problems can be solved primarily by repressive measures … (Politiken 1971).

Conclusion

When young people with drug problems started to appear in Denmark, a number of acute measures were taken in order to accommodate this new phenomenon. Institutions, which were responsible for taking care of similar problems (medicine abuse, juvenile delinquency and social maladjustment), were also given responsibility for doing something about the new drug problems. But even though the drug problem resembled these other social problems in many ways, it was still different in so many ways that the institutions found it difficult to handle. The new drug problem was difficult to fit into the existing theoretical and administrative categories; the existing means and methods were not adequate; and the young drug abusers were a general disturbance to the normal running of the institutions. Some of this disturbance had to do with the drugs, but a good deal did not. It was caused by the fact that the young drug abusers represented not only a new kind of social problem but also a new kind of social client. A client, who resisted the models for subjectification and social integration, which the established institutions and their methods represented. The efforts to accommodate these different epistemological, methodological, institutional and cultural challenges, which the young drug abusers represented were not all very successful. They did not put an end to the perplexity, which the new drug problem caused. The experiences of the established institutions alongside an epistemological and political struggle among drug experts lead to the establishment of a social explanation of drug abuse as a symptom of social and personal deprivation and social maladjustment. In this way drug problems were redefined to a large extent from being a medical problem to being a social problem. It was social experimentation with new treatment methods and ideologies outside the established institutions (but based on public funding), which led to the development of a new model for subjectification and integration of young people with drug problems, a model which could accommodate the challenges. It was able to accommodate the methodological and ideological challenges of the young drug abusers in such a way that Danish society would be able

to live with the problem. And this is what happened. For more than 25 years this apparatus existed as the way to understand and handle drug problems.

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NOTES

1 This is the term most commonly used in Danish drug discourse, although in recent years other terms have emerged because the terms 'drug abuse' and 'drug abusers' are perceived as being stigmatising. In this article, which presents a historical analysis, these terms will be used because they are the terms, which appear in the documents, which are the basis of the analysis.

2 Economic changes, demographic changes, changes within institutions such as the family, educational system and work etc.

3 Articulating here the two major "drug narratives" of western society: Drugs as causing one to lose oneself, and drugs as a means to find one's true self (Valverde 2002). See Hindsbo, Madsen & et al. (1971) for more about how young drug users thought about and used drugs.

4 I have only reviewed four newspapers from May to September in 1965 and 1966, as I was following Winsløw's (1984) account. There is clearly a need for a more thorough media study of the drug debate from the early to the late 1960s in Denmark.

5 One interesting feature of these questionnaires is that they attempted to link drug use with the new youth culture, for instance by asking if the prisoners had "long hair" before they started to use drugs, and if they had learned to use drugs at "intellectual gatherings" (Jersild, Manniche, et al. 1968); Andersen 1970).

6 Known today as "personality disorders".

7 This study applied Ausubel's (1958; Nimb 1961), which distinguishes between "primary", "symptomatic" and "reactive" euphomania. The first two categories are symptoms of personality disorders, while the last is a symptom of adolescent rebellion against authorities.

8 On one day in October 1968 the number of people committed to hospital and diagnosed with drug problems was counted. In subsequent years more censuses were carried out, adding prisons as well as child and youth care institutions to the institutions at which the number of drug users was counted, and the nature of their use was described (see the second report from the advisory committee on the drug problem for the results of these censuses (Kontaktudvalget 1970).

9 This study also developed into a longitudinal investigation (Haastrup 1973).

10 The same critique was later voiced by Winsløw (1991).

11 Institutions to which children and young people who had problems with maladjustment were sent for re-socialising treatment and vocational training.

12 One of the striking things about the only ethnographies of the drug culture in the 1960s in Hindsbo, Madsen, et al. (1971) is the account of the problems associated with developing an alternative identity to a square identity, something, which the young drug users experienced.

13 For the dilemmas of drug treatment in a prison setting, see Asmussen & Kolind in this volume.

14 The Youth Clinic started in 1960 as an experiment in ambulant treatment of juvenile delinquents after ideas developed at the institution for the criminally insane at Herstedvester. Later the clinic became an advisory and treatment centre for young people run by the Danish Society for Mental Hygiene.

15 This specific proposal was the first articulation of a treatment model which was presented in various settings with slight modifications. It was presented by Finn Jørgensen in the second report from the Advisory Committee on the Drug Problem in 1970 (Kontaktudvalget 1970)

and in a proposal for a treatment system under the Municipality of Copenhagen which was also presented in 1970 Københavns Kommune, 1970).

16 In the early 1970s there was a "professionalisation" of this drug treatment, which led to major conflicts within the system and which has been bemoaned subsequently by commentators (Pedersen 1981; Winsløw1984).

17 Both assumptions were supported by referring to addicted medical professionals, who were not socially disadvantaged and deviant except for their drug-using behaviour, but who had still proved difficult to 'cure'. Furthermore, the large proportion of people with additional problems among medical professionals suggested that it was primarily the availability of drugs which was the important factor.

18 In the theory of "psychic infection", people with a strong personality can persuade other people with a weaker personality to take over a particular worldview or display symptoms of a mental illness ("folie a deux").

Bagga Bjerge

THE RE-ORGANISATION OF DRUG TREATMENT IN DENMARK – A WELFARE REFORM AS POLICY

Since its inception in the 1960s, the Danish drug treatment field has been under pressure with regard to its institutional framework. Initially, drug treatment was the responsibility of the public health services – in other words, the psychiatric system and the public hospitals dealt with the issue. This changed in the 1970s as drug treatment largely became reframed as a social instead of a medical problem – now placed under the municipalities and primarily within the social care services. Institutionally, this had a number of consequences. Drug treatment was still split between medical treatment and social treatment. On the one hand, GPs had the professional responsibility for handling methadone. On the other, different departments within the social services were responsible for different aspects of drug treatment. The drug treatment field was characterised by its lack of a coherent service for clients with drug-related problems. By placing drug treatment under another institutional setting (the counties) in 1996, the public system tried to solve the fragmentation to which drug treatment had been exposed. Thus, specialised drug treatment centres were born.

The Danish drug treatment field is now under transformation once again – this time due to a reform of the entire public sector (the so-called 'structural reform'). In this article I analyse the way in which this reform has transformed the organisation of drug treatment, because the Danish counties have now ceased to exist and the municipalities have been given responsibility for the field. Furthermore, I analyse the way in which the reform has changed the field in an ideological sense. A more market-oriented rationale has been enhanced by the reform, which has an effect on the way drug treatment is perceived and the framework in which drug policy is carried out on a daily

basis. I analyse this in relation to the concept of New Public Management (NPM) and other overall developments in the public sector.

The reform process is analysed by applying a policy perspective. This underscores the way in which the reform has consequences for the way public drug treatment is constituted and handled in practice. Traditionally, policies are seen as government tools for top-down regulation purposes, but I wish to elaborate this perspective. On the one hand, policies can be analysed by studying various representations, e.g. political speeches, new legislation and written documents. On the other, policies only seem to have an effect when they are interpreted and experienced by people working in the public sector (Lipsky 1980). In other words, a policy becomes powerful through its ongoing application in social life, in this case through the way it is managed and interpreted by bureaucrats. In this sense, local bureaucrats are mediators between local institutions, national initiatives and policies of modernisation (Britain & Cohen 1980). It is therefore crucial to investigate policy-making at different levels based on different empirical data in order to understand how the structural reform affects both local drug treatment and the way drug issues are articulated in Denmark. Following Shore & Wright (1997), policies can be seen as the form, method or tactic through which the internal order of society is regulated.

Applying this theoretical perspective, I analyse three levels of understanding the drug treatment field as policy in relation to the reform: (A) By analysing the reform documents as policy, I will argue that a specific vision of the public sector is articulated. This vision highlights ideas like choice, decentralisation, competition, economy and efficiency, arguing that the public sector should be close to the citizens. Roughly speaking, before the reform drug treatment was a public, universal service, whereas now it is supposed to be a competitive product which is dependent on market mechanisms to secure the budget of drug treatment centres. These new dimensions of drug treatment also alter the function of managers in a more entrepreneurial direction, and drug users in the system are perceived differently.

Nevertheless, the intentions of new policies should not be mistaken for what is going on in practice. This leads me to my second level of analysis (B): via interviews with bureaucrats involved in the drug field, I analyse the way in which the intentions of the reform clash with their everyday experiences

and the conditions under which they provide drug treatment. The reform contains ambiguities in relation to practice, because drug treatment centres are not able to act in a sufficiently market-oriented manner as intended. As public organisations, drug treatment centres have specific legal obligations – for instance they are required to provide services for drug users, which are very costly. In addition, drug users do not necessarily want drug treatment to be too local or 'close' to the citizen. This contrasts with the arguments of official reform policy. The same phenomenon is evident with regard to the local bureaucrats, who are not in favour of exchanging information between different departments in order to enhance efficiency. Again, a discrepancy between lived experiences and overall policies is underlined by the implementation of the structural reform.

Finally, at a third level (C) I analyse the way in which bureaucrats in the drug treatment field try to handle the challenges and take advantage of ambiguities caused by the reform process. The reform policy claims to have generated space for entrepreneurial bureaucrats. However, these possibilities are limited by the structural reform and its neo-liberal perspective in the sense that manoeuvring has to take place within the overall framework.

These three levels of analysis lead me to the two main arguments of the article. First, that the structural reform unites and enhances ideological and organisational tendencies already present within the drug treatment field in the direction of an even more neo-liberal position. And second, even though social policies are important in understanding the way drug issues are handled in the public sector, coincidence and the interpretations and actions of individual players are important for the outcome of the structural reform in practice.

Setting

The Danish drug treatment system contains both drug-free and substitution treatment. The approaches to treatment vary from cognitive and systemic approaches, psychotherapy and acupuncture to ideas drawing on Minnesota treatment. The staff are mainly social workers, social pedagogues and psychologists. They concentrate on the social issues surrounding the lives of drug users, e.g. family, networks, crime, housing and financial issues; and on psychological issues such as changing the self-image and self-perception of

drug users (what they can or cannot do, etc.) Doctors and nurses who handle medical and physical issues are also involved in the system, as well as a variety of administrative staff and managers from a variety of backgrounds.

In 1996 public drug treatment centres were placed under the counties, except for a few large, delegated municipalities and private institutions. The latter provide most of the residential treatment in Denmark. When the counties were responsible for providing drug treatment, a situation which applied until recently, they were financed directly through the Danish tax system. Even though drug users had the legal right to go to another county for treatment, this right was hardly ever exercised. In other words, the counties were always sure of both the finances and the clientele for their drug treatment centres. Many drug treatment centres also handled alcohol treatment, but alcohol and drug treatment were run separately in practice. Prevention services both in relation to drugs and alcohol were also part of the organisation. Following the structural reform the whole public sector has been transformed, including the organisation of the social service system and drug treatment. In other words, responsibilities, financing and so on have been entirely reorganised.

The counties ceased to exist at the end of 2006 due to the structural reform, and instead five regional units have been established to take over some of the former obligations of the counties. At the same time, new and larger municipalities have been given the task of providing a larger share of public services than previously:

Before 2007	After 2007
13 Counties	5 Regions
271 Municipalities	98 Municipalities

It was decided to give responsibility for drug treatment to the municipalities. This means that the municipalities are bound by law to provide this service without necessarily having prior experience of it. The plan is that the municipalities should choose where they want to buy services for providing drug treatment; the choices range from buying the services from regional drug treatment centres, to establishing their own drug treatment centres, to buying services from other municipalities or private players. Most of the

large municipalities have decided to have their own drug treatment centres. Most of the small municipalities have decided to buy services from the larger ones. The new regions only provide services for a very few municipalities. To sum up, the field tends to be much more diverse than before.

Empirical data and method

The data on which this article is based stems from two different kinds of resource. On the one hand, it is taken from political reform documents such as 'Agreement on the structural reform' [Aftale om strukturreformen] and 'Report on the structural commission, Main Report' [Strukturkommissionens betænkning, Hovedbetænkning] (Indenrigs- & Sundhedsministeriet 2004a; 2004b). This kind of data is mainly used in relation to understanding the overall (A) level of transformations taking place and challenges in the drug treatment field. On the other hand, the data is based on an ethnographic study within the drug field. From August 2005 to February 2007 27 semi-structured interviews were conducted. My informants were mainly people involved in the actual planning and negotiation of the reform process, such as bureaucrats in the counties, managers, co-managers at drug treatment centres and members of working groups. Furthermore, long-term employees with knowledge of organisational history, developments and the drug field in general were interviewed. In addition, observations at meetings, workshops and national and local seminars concerning the structural reform and the drug treatment field were conducted. My main focus was on two drug treatment centres situated in different counties during the reform process – Bakkegården and Mølleengen. The structural reform meant that Mølleengen was transferred to a larger municipality, while Bakkegården was split up with some employees moving to a larger municipality and others continuing to work at the drug treatment centre, which was transferred to the regional level instead. Furthermore, two additional drug treatment centres in Øby and Knaptrup were part my investigation. My focus was on how and why people act, relate to and interpret the process of reform. In other words, to find patterns of how new things were given meaning and context in relation to experience, work practices, professional networks etc. This kind of data is mainly used with a view to understanding what happens when overall policies

meet the everyday practice of the drug treatment field, and when policies are interpreted and used by bureaucrats (B, C).

Ideological and organisational tendency in the public sector

There has been a tendency to focus on empowering the individual and de-bureaucratising the system for the past ten years, for instance by creating user councils and trying to make users responsible for their own treatment (Perrow 1986 [1972]; Thomsen 1997; Andersen et al. 2000; Bjerge 2005a). The idea is to 'humanise' public bureaucracy by giving a voice to users, who are now called 'users' instead of 'clients' partly because of this trend. Users are now expected to be responsible and self-managing. This perspective is rooted in the movements of the 1960s and the wish for freedom, grassroots efforts and the demands of local democracy:

> By the 1960s, community was already being invoked by sociologists as a possible antidote to the loneliness and isolation of the individual generated by 'mass society'. This idea of community as lost authenticity and common belonging was initially deployed in the social field as part of the language of critique and opposition directed against remote bureaucracy (Rose 1996: 332).

This is how the ideological critique of mass society and remote bureaucracy was articulated in the 1960s and 1970s. This perspective gradually became more and more influential in debates concerning the public sector. Or as Ole Thyssen puts it: *"It is the classic objection to the welfare state that on the one hand it prevents the man from falling, but on the other it blocks his desire to walk"* (Bruus-Jensen 1995: 7). In the 1980s, social workers and politicians began to use the concept of 'user' instead of 'client' to signal respect for people using public services. In the 1990s, the opposition between users on the one hand and bureaucracy and red tape on the other was underlined by discussions of the wishes, demands and qualifications of individual users by social workers with a view to providing the best possible services. These tendencies were codified in a series of laws in the 1990s: 'Act on Social Services' [Lov om Social Service], 'Act on Legal Protection and Administration of Social

Matters' [Lov om retssikkerhed], and 'Act on Active Social Policy' [Lov om aktiv socialpolitik].

The public sector has also been under constant pressure to reorganise and become more efficient. Since 1983 there have been attempts to modernise the Danish public sector via decentralisation, outsourcing, focus on targets and goals etc. These attempts were initiated by the Liberal/Conservative governments of the 1980s, and were followed by the Social Democrat-led governments of the 1990s. For instance, the Social Democrat government was even more eager to sell or prepare the sale of public enterprises than the Liberals and Conservatives (Sølvhøj 2004: 4). These tendencies were visible in most other European countries, for instance in the form of 'the Third Way' as an alternative to traditional Labour policy in the UK (Giddens 2000; Whitfield 2001). In spite of Labour traditions, Prime Minister Tony Blair also spoke in favour of reforming the public sector with a view to focusing on the free market and the entrepreneurial individual.

In order to accomplish new ideas of a 'good' and 'efficient' social system, techniques from the private sector such as goals, targets and measurements have been implemented in the public sector (Rose 1996). These initiatives can be understood as parts of a New Public Management (NPM)-oriented strategy (Hood 1991; Dunleavy & Hood 1994; Pollitt 2000; Crouch 2004). The NPM rationale is based on ideas about competition, empowerment, focus on outcome, missions, customers, prevention, decentralisation and market mechanisms (du Gay 2001: 63). The vision is to modernise and rationalise the public sector according to principles taken from the private sector. For example, plans of action (a private-sector technique) are now compulsory in social services such as drug treatment: counsellors and drug users have to write plans for the progress of the treatment process and its inherent goals. To follow up, meetings are held regularly in order to evaluate goal attainment. Such techniques are based on experiences from the private sector, and resemble performance reviews or appraisal interviews in private organisations. What is seen in many new initiatives in the public sector is thus a market-oriented logic. The rationale is that if more responsibility and liberty are given to the individual user of public services, it will be easier to adjust public spending because less money will be needed to ensure the best possible treatment for the individual. Ideally, treatment will be fine-tuned according

to the needs and wishes of the individual. Furthermore, if this is done in all public areas, it should be easier to rationalise the sector in general.

Although these strategies were challenged during the 1980s, the NPM strategy gained more ground in the 1990s and, as we will see later, the structural reform seems to re-enforce and institutionalise these long-term tendencies. The increased focus on the choice and influence of individual users due to NPM and communitarism has produced a new perception of people receiving public services. They are supposedly more responsible, active and self-managing than before (Bjerge 2005a). The development of choice and influence on the one hand and personal responsibility on the other has been conceptualised and understood as a 'neo-liberal' or 'advanced liberal' turn in social services (Dean 1999; Rose 1999). The vision is that societal transformations should take place in the individual and the local community. This means that the public system should draw back regarding its control of and boundaries for local and individual initiatives. Attempts to involve the local community or charity work more in solving social problems are made by focusing more on the role of shelters in drug treatment (Socialministeriet 2006).

In this perspective, citizens are perceived as 'free' as long as they lead their lives according to the official visions of what a 'good' and 'normal' life involves. In this regard, freedom is closely related to notions of responsibility, self-management and self-regulation (Barry et al. 2001: 8). The kind of freedom and flexibility intended by these visions is not an anarchist version such as the freedom to choose not to work or not to be flexible and self-managing. It is a form of regulated freedom, where citizens of the welfare state learn how to make the 'right' choices and use their flexibility in the 'right' direction. The rationale governing these principles is presented as 'freedom', liberty and progress in contrast to disciplined subjects and backward red-tape practices (Foucault 1982; Rose 1999).

The structural reform as a codifier of the NPM rationale

As argued above, the structural reform of the public sector blends present and previous ideological and organisational tendencies. In June 2004 the Danish government and its parliamentary supporter (the Danish People's Party)

decided to reform and modernise the public sector. The claim was that the public sector was too old-fashioned, ineffective and unresponsive in relation to future demographic changes and the present demands of its users. The structural reform was to be seen not only as an organisational and structural reform, but also as a way of rethinking and de-politicising the social system. The idea was to make the sector more decentralised and *"open and attentive, simple and effective"*, as Prime Minister Anders Fogh Rasmussen has put it (Indenrigs- & Sundhedsministeriet 2004d: 11). In other words, the public sector should be more focused on the needs and wishes of its users, making access to these services easier, and it should develop such services by competing on market terms. This is perceived as progressive, both in regard to the quality of the system and in regard to the financial costs of the services.

In a policy perspective, policies codify the social norms and values present in society. At first glance, the concepts used in the reform documents seem neutral and open to interpretation. Policies often seem natural because the language used is commonsensical and the ideas are presented as if they contain the only progressive (or reasonable) way forward (Newman 2001: 46). However, on closer inspection, the concepts reveal that a specific rationale is at stake. Words like 'choice', 'decentralisation', 'close to the citizen', 'efficiency', 'evidence', 'economy' and 'competition' are repeated constantly – whereas words like 'solidarity' or 'distribution of resources' which were previously used in discussions of welfare state services are not mentioned at all. In this sense, the structural reform resonates with the tendencies and developments of an NPM rationale. Words like 'solidarity' and 'redistribution' do not 'fit in' so to speak, because they have connotations to a classical socialist rationale – which present-day Social Democrats, Liberals and Conservatives do not favour.

In 'Report of the structucal Comission' there is a cluster of words which are presented in a positive sense *'openness'*, *'listening to the citizen'*, *'simple'*, *'effective'*, *'value for money'*, *'choice'*, *'close to the citizen'*, *'de-central solutions*, *'local needs'* and *'empowerment'* (Indenrigs- & Sundhedsministeriet 2004a: 11-2). The language used in 'Agreement on the structural reform' is similar. The document speaks of *'future-orientation'*, *'decentralisation'*, *'activation of citizens'*, *'local democracy'*, *'goals, targets and demands of results prior to management in detail'* and *'liberty to prioritise and plan services'* (Indenrigs- & Sundhedsministeriet

2004d: 5, 7, 9-10, 13-4, 37). By analysing the coupling of keywords, a rationale can be identified that resembles the NPM rationale regarding the emphasis on users, competition, empowerment, decentralisation, results and vision rather than rules (du Gay 2000; 2001; 2005). The involvement and activation of citizens (empowerment), goals (visions), liberty in the services rather than administration focusing on details (rules), citizens who are free to choose (users), and decentralisation are central in the documents of the reform in Denmark. These NPM tendencies are not only supported but also accentuated by the structural reform. In this sense the rationale resonates with a neo-liberal vision of a self-managing user in a flexible and non-bureaucratic system.

The commodification of social services is also accentuated by the structural reform. One example is competition and the possibility of public organisations earning money. The exact words are not used directly in the reform documents, but in 'Agreement on the structural reform' elements of efficiency and the use of resources are underlined. For instance, an evaluation institute is established. The task of this institute is to *'systematically follow the handling of de-central public tasks and public compatible results'*, and also to *'promote efficiency and better the use of resources'*, so that thanks to the decisions of the politicians citizens will receive *'the best possible value of public services paid by taxpayer's money'* (Indenrigs- & Sundhedsministeriet 2004d: 26-7). In other words, the public sector has to be measurable and comparable so that citizens receive the best value for money. At the same time, reform documents underline that the reform process should not involve extra public expenditure – in other words, more efficiency and better services for the same expenditure as before (ibid: 29). The visions of commodification transform the public system in a more market-like direction, with the efforts of employees being described, documented and compared.

In the process of de-politicising the public sector, the demands made on its bureaucrats are gradually changing. A more entrepreneurial role is now being proposed for public bureaucrats. For instance, the reform documents encourage the regions to act in a more entrepreneurial manner in relation to new municipal tasks (Indenrigs- & Sundhedsministeriet 2004d: 8-9). If regional organisations have specific competences in a field, they should work with the municipalities as 'entrepreneurs'. This is new, because prior to the structural

reform the county budgets were financially guaranteed via their legal responsibility for different services, e.g. drug treatment. This has been changed by the structural reform so that the regions are now mainly financed via contracts with the municipalities. The visions of the public sector presented in the structural reform state that a more open market for regional organisations should encourage these organisations to sell their competences. In this sense, the structural reform argues against a more traditional perspective on public services, in which these were not 'commodities' for sale. On the one hand, the changing role of bureaucrats and organisational conditions lead to more flexibility in fields of activities. In other words, the individual bureaucrat in public organisations may offer services in new fields and thereby extend his or her activities. On the other hand, he or she is subject to the demands of the market, where the choices of consumers (e.g. municipalities) are crucial. The reform documents do not discuss how this change is to be made possible in practice, or the fact that public organisations have obligations which are not imposed on private organisations. In this sense, alternative discussions are kept off the agenda.

The overall agenda at stake concerns the general development of visions of the welfare state. The public sector should learn from the private sector's way of managing, organising, competing and rationalising to improve and simplify its routines. As a result, users of the public system should be treated more as consumers who choose and influence the services they receive. In other words, the structural reform frames and affects actions in the drug treatment field. Even though the structural reform argues in favour of a system that is close to the user and more empowerment, these ideas do not imply that users are self-determining in all regards, e.g. concerning their dose of methadone or the opening hours of their local drug treatment centre. These problems are experienced as crucial and as some of the most central for the drug users, but it is merely visions of users formulating action-plans and deciding excursions at drug treatment centres which are central in the reform rationale. In this sense, the structural reform argues for the already existing tendencies to avoid 'clientalisation' and treat users of the system as self-managing individuals. However, the structural reform does not discuss the fact that people in drug treatment often find it difficult to choose or act responsibly and in an empowered manner (Bjerge 2005a).

Following Shore and Wright (1997), the keywords of reform documents can be viewed as mobilising metaphors:

> Their mobilising effect lies in their capacity to connect with, and appropriate, the positive meanings and legitimacy derived from other key symbols of government such as 'nation', 'country', 'democracy', 'public interest' and 'the rule of law'. Thus 'individual' became part of a cluster including 'freedom', 'market', 'enterprise' and 'family' and previous associations with 'society', 'public' and 'collective' were diminished (1997: 21).

Shore and Wright's analysis stems from reform documents in the UK, where reforms underlining the market, competition and the individual have been more radical. However, the same way of using some keywords rather than others is evident in the Danish context. The concept of mobilising metaphors is interesting in relation to the reform, because applying this concept makes it possible to focus on the way that keywords form positive associations with a cluster of other keywords. In the 1980s, 'the individual' (Shore & Wright 1997) was pushed on the political agenda, which in retrospect laid the foundations for neo-liberalism. This did not happen overnight of course, but evolved slowly over time, and thus a new perception of the citizen (the individual) became associated with other key ideas during that period like 'the market' or 'freedom'. Slowly but surely a new way of understanding and conceptualising the welfare state became naturalised. Keywords do not mobilise in themselves. First they need to become widely accepted by the general public. Only when people begin to act and think in relation to a new worldview has its mobilising effect been fulfilled. In such a process, keywords such as 'society', 'public' or 'collective' which were previously associated with positive connotations of the welfare state are not voiced – instead, they are kept out of the debate. Through the ongoing exclusion of links and associations to some concepts and the neutralisation of others, this analysis highlights how a policy document implicitly silences previous visions of the public sector, as was seen in the structural reform. In other words, by using a policy perspective it is possible to elaborate on both the intentions (e.g. establishing a new agenda and silencing previous ones), and as we will see in the following sections the effects (e.g. stress, confusion, conflict during the early years) of a policy.

Drug treatment in a twilight zone – a field of ambiguities due to the structural reform

Moving the analytical gaze from political documents to the everyday practices of the players involved, there often seems to be a mismatch between the intention of a reform policy and the actual possibilities, interpretations and practices in a local context. The drug treatment field is no exception in relation to the structural reform. In order to understand what happens in practice due to the structural reform, I will now change the level of analysis from an overall analysis (A) to an analysis of lived experiences in the drug field (B).

In practice, many of the overall ideas behind the structural reform have been implemented. The main change in the drug field is that drug treatment centres now compete under more market-like conditions. In contrast to previous practices, they now have to sell their services to municipalities who may or may not wish to buy drug treatment at the drug treatment centres. This has resulted in what may best be described as 'branding tours', or tours during which drug treatment centres try to sell their services and competences. On these tours, managers have meetings with potential buyers (representatives of the municipalities). During these meetings the drug treatment centres have to 'sell' their services in the best possible way. Not only has this influenced the way of conceptualising public drug treatment as a sort of commodity, it has also altered the tasks of managers. In other words, bureaucrats suddenly have to act as entrepreneurial merchants. In effect, these transformations point towards an increasingly neo-liberal public sector in Denmark.

However, when one moves from an overall analysis of policies and agendas towards practice, ambiguities, practical limitations and dilemmas but also possibilities occur in the apparent coherence of the structural reform. I will now analyse some of the unintended consequences and processes occurring during the implementation of the structural reform in bureaucratic practice. If one takes a closer look at the reform initiatives, they contain several ambiguities which blur the actual directions, goals and rationales of policies when it comes to 'translating' them into practice. I will elaborate on two of these ambiguities:

Commodification versus jurisdiction

Public organisations do not operate with the same possibilities or responsibilities as private organisations. For instance, regional drug treatment centres like Bakkegården are legally obliged to provide services that municipalities do not necessarily want or cannot buy anywhere else. Drug treatment centres have some specific obligations in relation to their jurisdiction, which means that regional drug treatment centres cannot pick and choose between services like private organisations or organisations run by a municipality. This means that under the structural reform municipalities are free to decide to provide services for the least complicated drug users, for instance young drug users of cannabis in short-term treatment. A municipality may also decide that the region should provide services for older drug users in methadone treatment suffering from a variety of other social problems like unemployment and psychological problems, something which is much more costly. Unlike the municipalities, the regions are under a legal obligation to provide drug treatment if the municipalities are not interested in doing so. In this sense, the conditions for regional drug treatment centres resemble those of public hospitals in Denmark. Such hospitals are bound by law to provide services for patients with complicated diseases like pancreatic cancer that occupy a great deal of time and a great number of resources as well as having a very bad recovery prognosis. In other words, they have to provide services related to not very 'profitable' diseases. By contrast private hospitals are often more efficient and cheaper to run, because they can choose only to provide services for less complicated tasks like hip or knee operations and uncomplicated types of cancer with a good recovery prognosis.

Thus, in relation to future drug treatment the increased focus on market orientation and competition in the drug treatment field confuses the managers of the regional drug treatment centres with regard to how to manage such centres. The manager of Bakkegården, Teddy, explains his frustrations as follows:

> Public services will always cost more, because we have to do more administration than private organisations … drug treatment centres in the future region are bound by law to provide services to municipalities who will buy some or all of their services. We meet up with them once a year, and then

> they tell us what they want to buy from us … We are not free flexible players on the market, because we are bound by the agreement with the municipalities. If they suddenly come up with 25 more alcoholics than agreed, we can't help them. Then the municipalities have to use private providers of the services they need. (Interview, Teddy).

The quote above highlights one important ambiguity with regard to the structural reform and the new conditions for managing drug treatment centres. The field tends to be caught up in what could be called a 'twilight zone' between the public and the private sector, in a double bind which demands that public services compete on market conditions while simultaneously restricting their chance of acting on the basis of these conditions owing to legal issues (Crouch 2004). On the one hand, public drug treatment is supposed to be oriented towards the market. On the other, this is problematic in practice because public organisations have different legal obligations and are less flexible in their organisational structure. To ensure the proper management of public resources and services, bureaucrats are legally bound to check and document things (public spending, treatment costs, cleaning, renting facilities, user housing, pension systems etc.) twice, which is very costly. In other words, red tape is deeply rooted in public administration (du Gay 2000; 2001; 2005). This will not be changed overnight by a policy like the structural reform, since this does not imply that public drug treatment centres should become fully private players on the market. I do not wish to speak in favour of either a more private-oriented drug treatment sector or the opposite. Instead, my aim is to analyse the mismatch between official policy, the intentions of changing the public sector, and the actual possibilities and limitations created by legislation in practice.

Furthermore, the NPM vision of being able to measure, calculate and thereby predict social services contradicts the actual experiences in the drug treatment field. According to Teddy, a higher level of flexibility in the annual agreements between municipalities and drug treatment centres is required, because practice does not always correspond to calculations. In other words, the number of people who need drug treatment may vary a lot within a year due to a variety of reasons which are impossible to predict. Finally, in order to be able to 'sell' treatment, it has to be commodified in the sense that all

services should be measurable – for instance, how much does a specific service cost, what does it include, how effective is it etc. By creating new ways of measuring, comparing and controlling social services for the purpose of 'sale', new sets of bureaucratic procedures to carry this out are created as well. In this sense, commercialising the public sector and minimising the traditional bureaucracy may in practice merely result in other types of bureaucracy instead of actually rejecting bureaucracy altogether.

For the sake of the drug user?

The second ambiguity concerns the intention of getting closer to the users. This is related to demands for more transparency in the public sector. However, these demands do not always correspond to the wishes of the users. Being a drug user, an alcoholic or both may have a stigmatising effect on some people, and therefore they are not necessarily interested in attending treatment in their local community (for example by picking up methadone in a small municipality) because they wish to remain anonymous. Hans, a therapist at Bakkegården, puts it this way:

> Everybody talks about being close to the user, but nobody asks the drug users if they want this … The drug users don't want to go to a small municipal office … some of them are married, work and have families, and aren't interested in everybody else in a small municipality knowing about their situation. (Interview, Hans).

In other words, being close to the user can mean exposure of the user – and most drug users are against being more exposed than they are already. When the reform documents claim that users of the public system want to be close to the services provided, they fail to notice that not all kinds of users agree. When citizens contact their municipality in order to find childcare facilities for their children, exposure to the local community may be irrelevant. Thus, what is emphasised in the reform document is a vision of 'normal', self-managing users and their demands for simpler access, whereas users with deviant behaviour or stigmatising attributes are not given a voice.

Furthermore, in the process of making the system more effective, open,

transparent and flexible for users, it has been decided that information should flow more easily between different municipal departments – for instance, giving counsellors in the finance department access to a drug user's social treatment records. Peter, a manager, explains that this will probably lead to information being kept out of the records:

> Social workers in the drug treatment sector are often quite loyal to the drug users. I've spoken to counsellors who stopped writing things in the records because they knew that other departments in their municipality had access to these records … they know that what they write affects the lives of the drug users, for instance in relation to their children, grants from the state etc. …You only make that mistake once, then you stop writing. (Interview, Peter).

To maintain a trusting relation between drug users and counsellors, counsellors may bypass rules and regulations. In this sense, the creators of the structural reform have not foreseen that bureaucrats have their own agendas, and that they may be convinced that they can serve drug users better by manipulating official policy. Sometimes the counsellor's agenda is so much in conflict with a neo-liberal vision of what are 'good' and 'right' public services that it may blur the actual outcome of the new policy, because counsellors will try to handle the system according to their own worldviews. I am well aware of the fact that a policy cannot take into account all possible uses, but to understand how a policy is implemented in practice, investigations of lived experiences in the drug field are essential, and this is something which I analyse in the next section.

From policy to bureaucratic practice

Where do the above insights leave us in relation to a policy perspective? In practice, despite its apparent coherence and one-dimensional neo-liberal inspiration the Danish reform policy is characterised by being open to interpretation due to its lack of concrete suggestions. This leads me to the last level of analysis (C), which concerns the way in which bureaucrats in the drug treatment field try to handle challenges and take advantage of ambigui-

ties in the reform process. In this sense, a policy may become a vehicle for bureaucrats trying to push their own personal agenda. In order to grasp this, I will return to Lipsky's point:

> I argue that the decisions of street-level bureaucrats, the routines they establish, and the devices they invent to cope with uncertainties and work pressures, effectively *become* the public policy they carry out. I argue that public policy is not best understood as made in legislatures or top-floor suites of high-ranking administrators, because in important ways it is actually made in the crowded offices and daily encounters of street-level workers (Lipsky 1980: xii).

In an everyday practice characterised by ambivalent and often chaotic conditions, counties, municipalities and drug treatment centres are often left on their own with regard to implementing new policies. Policies are open to interpretation and manipulation, and the structural reform is no exception to this.

Interviewing informants and observing bureaucratic practice, I discovered that many solutions for the future of drug treatment had an ad hoc character, and were not based on rational discussions. One part of one of the drug treatment centres I studied, Bakkegården, ended up being placed under regional administration after the structural reform. This was primarily due to old working conflicts between bureaucrats in the larger municipality and the smaller ones. The small municipalities in the region had always felt bullied by the large municipality, and refused to work alongside it. This refusal also extended to drug treatment. The large municipality was not interested in supplying the smaller ones with services. Initially the bureaucrats at the drug treatment centre were pleased with this solution. The drug treatment centre could continue as always – more or less autonomously. However, it gradually became clear that the conditions for the drug treatment centre would change after the structural reform, since it was now placed under a double bureaucracy. It suddenly had to negotiate with and please both the regional bureaucratic system and the new consumers – the municipalities. Not exactly the flexibility and de-bureaucratisation intended by the structural reform. In other words, the future of this drug treatment centre was not based

upon profound considerations in relation to the well-being of the drug users. The intention of an 'open and attentive, simple and effective' social service was not pursued in practice. In this case, when policy was transformed into bureaucratic practice, it was used as a weapon in an older working conflict between various parties.

Ambiguities, dilemmas and fractions in overall policy allow space for interpretation by bureaucrats who are able to interpret the policy to meet their own ends. I also interviewed Carlos, the manager of the drug treatment centre in Øby. Carlos had hoped that his drug treatment centre would be given a regional role, so he and his employees could carry on working more or less as before the structural reform. However, the drug treatment centre was taken over by a small municipality, so that it could provide drug treatment for a number of nearby municipalities in the future. Carlos quickly realised that he might as well benefit from the new situation during the implementation of the structural reform. While everyone else in the field was preoccupied with negotiating with new municipal and regional partners, or worrying about how to handle the twilight zone between commodification and jurisdiction in practice, Carlos and his drug treatment centre succeeded in being the only applicant for funds from the Ministry of Social Affairs. Carlos had figured out that if he managed to keep cool there would be plenty of possibilities, because the other drug treatment centres were 'looking the other way', so to speak. In this spirit he and a couple of employees spent half a day writing seven applications which all paid off. In his opinion the ambiguities and uncertainties created by the reform process were actually of great advantage in relation to his agenda, or as he dramatically put it:

> We see an unsafe ground [due to the structural reform], where we have great opportunities for catching a big fish in regard to public funds and employees from other drug treatment centres. Our strategy is to float upon the troubled waters, while herons fly and dolphins swim. (Interview, Carlos).

In this sense, the ambiguities and uncertainties are vehicles for bureaucrats to push their own personal agendas. I do not think this phenomenon is new to the field. Bureaucrats have always taken advantage of the possibilities avail-

able to them. I have argued that the conditions accompanying the structural reform have enhanced and underlined differences which were already present. In other words, ambiguities, fractions and dilemmas caused by the reform policy influence drug treatment, because the effects of the structural reform structure the opportunities of drug users to obtain treatment, for instance via increased resources for treatment at some drug treatment centres. However, these possibilities are limited by the structural reform and its neo-liberal perspective in the sense that manoeuvring has to take place within the overall framework. The bureaucrats cannot transgress this framework, but they try to take advantage of any small chance of pushing their own personal agendas through in everyday practice.

Summary and future research perspectives

By analysing the structural reform in Denmark and its effects at three different levels (A, B, C), I have shown that it is important to study various types of data in order to understand how and why policy influences everyday practice in the drug treatment field.

I have analysed the structural reform as a policy attempting to push through a specific vision for the public sector, and by implication also for the drug treatment field. The structural reform represents a vision of the public sector which resonates with a more general development toward a neo-liberal public sector. The keywords of the policy such as 'choice', 'decentralisation', 'close to the citizen', 'efficiency', 'evidence', 'economy' and 'competition' resonate with visions of the public sector as only servicing individualised, demanding, self-managing and entrepreneurial users. In this sense, the structural reform underlines and accentuates tendencies already existing in the field. Future users are increasingly seen as consumers of public welfare, and drug treatment is framed as if it was a commodity on a competitive market.

However, a closer inspection of the reform initiatives reveals ambiguities and contradictions in practice. The conditions of public drug treatment centres are far from being as flexible as those facing private organisations. As a consequence of this, the field seems to find itself in what one could call a 'twilight zone' after the structural reform. This makes it difficult for

managers and staff to calculate the immediate consequences of these new policies. Furthermore, the demands of the reform policy regarding meeting the users' need to be close to the system and increasing transparency do not seem self-evident in the everyday practice of drug treatment.

On the other hand, giving policies life in practice does not happen through a simple determinism of rules and regulations, as functionalism would have it. Bureaucrats have a degree of influence on the outcome of a policy, and the structural reform is no exception. Bureaucrats who try to keep cool and know how to navigate within the overall framework of the system can sometimes affect the policy outcome in a way which is positive for the users of their drug treatment centres. Others may end up being caught between interests based on old conflicts, leading to a less flexible and transparent system than before.

Future research suggestions: In the light of my findings, I suggest that the re-organisation of the drug treatment field is monitored closely in the years ahead to analyse whether and how the field continues to develop towards a more customer- and market-oriented perception of drug treatment. Will bureaucrats like and perhaps even embrace the new conditions after a certain period of time? Will they all become entrepreneurs, or will the hierarchies and obligations of the public sector counteract this tendency? Will the bureaucrats try to detach their practices in relation to NPM visions and continue to pursue what they consider to be 'fair' and 'good' administration of the drug treatment field? Will the users profit from the re-organisation rather than feeling exposed in their local community? There are several other unanswered questions which can only be answered through ongoing investigations and analysis of the drug treatment field. If we consider the developments of the public sector in the UK, where NPM reforms have been far more radical, we might learn something about where Danish public drug treatment is heading.

As part of my investigation, I visited a substance misuse treatment centre in England in 2007. Here I learned that one consequence of NPM and welfare reforms in the UK is the use of more standardised drug treatment services which are decided by a national board (www.nta.nhs.uk). On the one hand, bureaucrats in the drug treatment field argue that standardisation may have resulted in raising the level at some treatment centres. On the other hand,

it has resulted in less variety, less creativity and less individualised types of treatment offered to people in drug treatment, because national standards limit the local and individual initiatives – thereby counteracting some key elements of the NPM visions. In addition, the demand for standardisation has led to a tremendous increase in the amount of paperwork (documents and forms) which has to be completed and handed in to the national board on a monthly basis. At the same time, the British bureaucrats experience much more competition between drug treatment suppliers looking for annual contracts with the NHS (National Heath Service) involving the provision of drug treatment. This has caused a large amount of job uncertainty, and many bureaucrats have chosen to find jobs elsewhere, so the field is now characterised by a constant turnover of bureaucrats – and the users have to get used to new counsellors on a very frequent basis. It is difficult to predict or estimate the extent to which these changes will occur in a Danish context. However, based on British experiences it does seem likely that Denmark will undergo some similar developments, because as a result of NPM and the structural reform drug treatment in Denmark now has to be measured, compared and commodified to a degree which has not been seen so far.

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Eric Jensen

DRUG WARS IN THE UNITED STATES: THE CONSTRUCTION OF PROBLEMATIC CONDITIONS[1]

The United States has experienced a series of wars on drugs, and the effects of each drug war have laid the groundwork for the subsequent ones. These anti-drug crusades began in the 1870s with the opium scare targeted at the West Coast. Subsequent drug wars were launched in the wake of the Harrison Act of 1914, the anti-cannabis drive from 1914 through 1937, the anti-narcotic revival of the 1950s, the Nixon-era drug war of the 1970s, and the 1986 War on Drugs (see Jensen & Gerber 1998 for a brief overview of the US drug wars). One important new element of the 1986 War on Drugs is the expansion of these punitive policies into social welfare, workplace, and education policies. An explication of these expansions of drug control policy into selected areas of the civil realm will be the focus of this article.

The anti-drug crusade, which followed the passage of the Harrison Act of 1914 at the federal or national level of government, resulted in the 'dope fiend mythology' (Lindesmith 1940; see also Dickson 1968).[2] This image of drug users was promulgated by the Narcotics Division of the US Treasury Department to increase its role in the control of illegal drugs, and to eliminate the accepted practice of physicians treating users of hard drugs.

The dope fiend mythology became an integral part of the Division's effort to demonize and marginalize users of illicit substances. The dope fiend mythology contained the following elements: the drug user is a violent criminal, the drug user is a moral degenerate (i.e. a liar, thief, etc.), drug sellers and drug users want to convert others into drug users, and the drug user consumes illegal drugs because of an abnormal personality (Lindesmith 1940; see also Christie & Bruun 1991). Although this mythology was created almost a century ago, these images are strong in the mindsets of many

Americans. In addition, these images were reified by the claims made in each of the subsequent drug wars. One feature of these anti-drug crusades is that they regularly reoccur. Over the past 130 years the US has experienced six drug wars; so drug wars are not new to the USA.

One theme that runs through these US drug wars is a focus on scapegoating either powerless, marginalized groups or the "dangerous classes" (Duster 1970; Helmer 1975; see also Musto 1973; Jensen & Gerber 1998; Reinarman 2003). "... drug scares are about the use of a drug by particular groups of people who are, typically, *already* perceived by powerful groups as some kind of threat" (Reinarman 2003: 143). The original anti-opium drive originated in a San Francisco city ordinance which targeted the Chinese and smoking opium only – not the over-the-counter remedies containing opium which were commonly used by the Anglo population (Brecher 1972; Bonnie & Whitebread 1974). The first anti-cannabis crusade originated at state level in California and southwestern states,[3] and targeted Mexican Americans and African Americans (Bonnie & Whitebread 1974). The federal anti-narcotic revival of the 1950s concentrated its propaganda efforts on the Chinese Communists, who were viewed as smuggling heroin into the country to 'hook' the youth of the nation (ibid). The Nixon federal-level drug war in the 1970s targeted young males who opposed the Vietnam War (i.e. anti-war protestors) and African Americans (Baum 1996). The federal 1986 War on Drugs focused on African Americans from low-income backgrounds living in the ghettos of large cities (see Beckett & Sasson 2004; Reeves & Campbell 1994).

A second theme in the drug wars is that they were often constructed by state managers or politicians with the assistance of the media. The post-Harrison Act drug war was championed by the Narcotics Division of the US Treasury Department (Brecher 1972). The anti-cannabis effort was started by local governmental officials with a large boost of assistance from the powerful Hearst newspaper empire, and later from the US Bureau of Narcotics, which had replaced the Narcotics Division (Bonnie & Whitebread 1974). The anti-narcotics revival was launched by Harry Anslinger and his Bureau of Narcotics (ibid). The drug war of the 1970s was driven by high-level personnel in the Nixon administration (Baum 1996). The 1986 War on Drugs was eventually spearheaded by then President Ronald Reagan following a struggle with Democrats in Congress for control of the war (Jensen & Gerber 1998).

Although there is often a kernel of truth about an increase in the use of illicit drugs (i.e. heroin in the 1950s), or a new drug coming onto the scene (i.e. LSD in the 1960s and 1970s, crack cocaine in the 1980s), state managers and the media tend to greatly exaggerate the scope and severity of the problem.

The social construction of drug wars has become a frequently discussed topic in US criminological literature, particularly since the largest drug war was launched in 1986 (see Reinarman & Levine 1989; Reinarman 2003; Beckett & Sasson 2004). While several theories had been developed to explain the social construction of social problems, we found the extant theories not fully equipped to explain the creation of the 1986 War on Drugs (see Spector & Kitsuse 1987; Mauss 1975; Randall & Short 1983). Thus, Jensen, Gerber and Babcock (1991) combined elements of existing theories to develop a new theory to explain the social construction of the most recent American drug war (Jensen et al. 1991; see also Jensen & Gerber 1993). We argue that many social problems are constructed as a result of the claims made by politicians, and that they pass through a series of four stages:

Incipiency: In this stage of the social construction of a social problem, some members of the general public may be concerned with the emerging issue but neither formal organization nor strong leadership exist to champion the condition as a problem.

Coalescence: This stage may or may not be present in the social construction of a social problem. If it occurs, formal and informal organizations begin to form out of segments of the public and members of interest groups that are concerned with the issue. In the coalescence stage groups organize around the perceived social problem and begin to take action on their social policy agenda. If the coalescence stage occurs, both informal and formal organizations come to the forefront to act as collective claims-makers.

Creation and Policy Formation: The creation and policy formation stage is central to this theory. In this stage, powerful interests such as politicians or governmental agency personnel claim the existence of a harmful condition, argue for the legitimacy of their claims, and develop a 'solution' to the con-

structed problem in an attempt to advance their own interests. Their claims are spread by the media.

Legitimation: By publicizing their claims, politicians or other governmental officials attempt to create or strengthen public support for their position. In addition, these state problem constructors must establish the legitimacy of their claims and remedies in the eyes of the public to gain support for their political, ideological or organizational interests. The media also play a major role in disseminating these efforts by claims makers.

Our research on this theory supported its accuracy (Jensen et al. 1991; Jensen & Gerber 1998). Indeed, overall illicit drug use as measured by self-report surveys of nationally representative samples reached its peak in the years 1979 to 1982, not in the mid-1980s as claimed by national politicians. The two exceptions to this downward trend in use were powder cocaine among 25-34 year olds, and the emergence of crack cocaine use during this time (i.e. the kernel of truth). In addition, public opinion polls did not show concern about illicit drugs. Yet following the claims-making activities of national politicians, the concern about illegal drugs in public opinion polls exploded (Jensen & Gerber 1998)

It has also been argued that the conservative politicians championed the illicit drug issue at this time because numerous other social problems were becoming objectively more serious (i.e. increasing economic inequality, unemployment, the dislocation of manufacturing plants to other regions of the country or overseas in search of less expensive labor, etc.) but these are not the type of social issues that conservatives in the U.S.A. are concerned with or that they want to leave to the 'free market system' to correct (Reinarman & Levine 1989). Politicians can rely on the dope fiend mythology to gain points for them in the opinion polls, while they ignore other serious problems in society.

Thus, the most recent war on drugs was created. While President Reagan spearheaded the war, President George Bush Sr. pushed the war further by drastically increasing sentences for crack cocaine at federal level (see Everett 1998). The neo-conservative 'solution' to the drug problem is criminal prosecution and incarceration, not treatment. Neo-conservatives wanted federal

'get tough' initiatives to 'trickle down' to state level; and their wishes have come true. As would be expected, the impacts of the most recent drug war on the criminal justice system and public expenditure in the US have been overwhelming (see Caulkins & Chandler 2006).

Changes in the Laws Regulating Drug Offenses

Perhaps the most draconian criminal sanctions that emerged from the War on Drugs are contained in the federal statutes on 'crack' cocaine. The first new federal statute was enacted soon after the drug war had been declared by President Reagan. This law is entitled the Anti-Drug Abuse Act of 1986. According to one criminologist, the statute "was not the product of lengthy deliberation and careful evaluation of the research evidence" (Everett 1998: 95). One indicator of this problem was noted in a quotation from Eric Sterling, then counsel to the House Judiciary Committee: "We didn't even have hearings on this, which is really extraordinary" (ibid). "In fact, it moved through Congress on the heels of several sensational media stories concerning the horrors of crack cocaine" (ibid).

The Anti-Drug Abuse Act of 1986 established a 100:1 crack (or base) to powder cocaine ratio in the weight/sentencing calculus.[4] In other words, possession of five kilograms of powder cocaine or 50 grams of crack cocaine were established as equivalent under the law for sentencing: a ten-year mandatory minimum sentence. A five-year mandatory minimum sentence was established for 500 grams of powder cocaine or five grams of crack cocaine. A revision to the Act in 1988 under then President George Bush Sr. made crack cocaine the only drug with a mandatory minimum sentence for a first offense of simple possession. A first conviction for possession of five grams of crack cocaine brought a five-year mandatory minimum federal prison term (Everett 1998). These are the only laws which establish differential sanctions for two forms of the same drug. The federal government anticipated that these tough new sentences would 'trickle down' to influence similar changes in state statutes.[5]

Impacts on the Criminal Justice System

As one would expect, these changes in sanctions and the accompanying increased pressures on law enforcement to seek out and arrest drug offenders have led to major impacts on the criminal justice system.

Arrest data is readily available in the US, and can be used to measure the effects of the drug war on law enforcement activities. The annual number of adult drug arrests increased from 811,000 in 1985 to over 1.8 million in 2005.[6] 82 per cent of these arrests were for possession of an illegal substance, and 18 per cent were for sales or manufacturing in 2005. The largest number of arrests was for possession of cannabis. Between 1985 and 2005 arrests for sale/manufacture increased by 76 per cent, while arrests for possession increased by 143 per cent.

In the USA, prisons exist under both federal and state jurisdictions. Prison sentences are for one year or more. A person who is convicted of violating a federal criminal law may be sentenced to federal prison. Likewise, a person who is convicted of violating a state law may be sentenced to a state prison. Persons may also be incarcerated in jails. Jails are operated by the federal government, county governments, and city governments. Sentences to jails are for one year or less. Jails are also used for pre-trial incarceration, and as holding facilities after a person has been sentenced to prison and is awaiting transportation to prison.

Incarceration data is less readily available than arrest data. While data on persons incarcerated in federal prisons is reported by offense on an annual basis, data on persons incarcerated in state prisons and local jails is reported less often. Federal prisons incarcerate the smallest number of persons, and local jails incarcerate the largest number of persons.

In their recently published research, Caulkins & Chandler (2006) estimate the number of persons incarcerated for drug offenses from 1972 through 2002 in all three types of confinement. The researchers use several sources of data to estimate the number of persons incarcerated for drug offenses, and the type of drug offense for which they are incarcerated. According to their research, in 1985 there were 7,201 persons incarcerated in federal prisons for drug offenses. By 2002 this number had grown to 63,898. This is a nine-fold increase. In 1985 state prisons held 38,900 persons for drug offenses. By 2002 this number had increased to 252,249 – more than a six-fold growth. In 1985

local jails incarcerated 35,584 inmates for drug offenses. In 2002 local jails held 164,372 persons for drug offenses. This is more than a four-fold growth rate.

Caulkins & Chandler (2006) also ask how many inmates are incarcerated for sales compared with the number incarcerated for possession. This is an important question since opponents of this massive incarceration of drug offenders claim that most of the prisoners are incarcerated for possession of small amounts of an illegal substance. They see this as a misguided policy. Advocates of incarceration for drug offenses often argue that this sanction is most often used to remove sellers from society, thereby reducing accessibility to drugs. Caulkins & Chandler estimated that 13.6 per cent of all inmates in federal prisons were convicted of possession in 1992. In 1997 – the last year for which they report estimated data – this had decreased to 11.5 per cent. Nearly 43 per cent of inmates in federal prisons were estimated to have been convicted of sales in 1992. This had increased slightly to an estimated 45.5 per cent in 1997. Thus, there was a small decrease in the proportion of total federal prisoners who were incarcerated for possession, and a small increase in those incarcerated for sales. In state prisons, 2.7 per cent of all inmates were incarcerated for possession of illegal drugs in 1985, and this had increased to an estimated 8.8 per cent in 1997. The proportion of persons in state prisons for sales was 5.3 per cent in 1985, and this had increased to an estimated 11.6 per cent in 1997. Thus, in state prisons the proportion of all inmates incarcerated for possession increased nearly threefold, and the proportion incarcerated for sales more than doubled. With regard to jail populations, in 1985 6.4 per cent of all jail inmates were incarcerated for possession of illegal drugs. By 2002 this had increased to 10.8 per cent. In 1985 6.7 per cent of jail inmates were incarcerated for drug sales. By 2002 12.1 per cent of all jail inmates were incarcerated for sales (Caulkins & Chandler 2006). Thus, the proportion of persons incarcerated in jail for possession of a controlled substance increased by about 70 per cent, and the number of persons incarcerated in jail for sales increased by 80 per cent.

In summary, the changes in the proportion of persons incarcerated for possession of illegal drugs in the comparisons above were largest for state prisons and second largest for jails. Thus, the weight of the evidence is on the side of the critics. In other words, the incarceration of persons convicted of

possession of controlled substances has grown at a more rapid rate than has that of those convicted of sales. These explosive impacts are to be expected when a 'get tough' criminal sanction regime is instituted. What was new, and perhaps even more deleterious to the social fabric of the nation, is the expansion of sanctions for drug offenders into the social welfare, workplace, and educational institutions of society.

Impacts of the Drug War on Social Policy

The origins of the spread of drug control policy into the realm of non-criminal sanctions in the early 1970s were two-pronged: drug testing of military personnel during the Vietnam War, and the civil forfeiture of assets in drug-related cases. In the late 1960s and early 1970s perceptions of a heroin 'epidemic' among members of the US military in Vietnam were widespread (Normand, Lempert & O'Brien 1994; Baum 1996). These rumors reached the very top levels of power in the federal government, including President Nixon. In efforts to deter heroin use among the military and to provide treatment for troops returning from Vietnam, in 1971 President Nixon ordered random drug testing of military personnel. Later a policy emerged which required members of the military to 'test clean' for heroin before they could return to the US from Vietnam.[7]

The civil forfeiture of assets in drug-related cases was first put into law in the Comprehensive Drug Abuse and Control Act of 1970. This statute was enacted at a time when Congress was responding to the 'crime wave' mentality of time and in concert with the Nixon-era war on drugs (Jensen & Gerber 1996). This statute was based in part on the premise that organized crime and drug trafficking were motivated by the financial rewards gained from these illegal activities. Asset forfeiture was designed to deter the targeted crimes by reducing their financial rewards (Jensen & Gerber 1996).[8]

In 1978, Congress greatly expanded the scope of drug-related asset forfeiture. Forfeiture was extended from all controlled substances, materials and equipment used in the manufacture of illegal drugs, and vehicles used or *intended* for use to distribute illicit drugs, to include:

> All monies, negotiable instruments, securities, or other things of value furnished or *intended* to be furnished by any person in exchange for a controlled substance in violation of this [subchapter], all proceeds traceable to such an exchange, and all monies, negotiable instruments, and securities used or *intended* to be used to facilitate any violation of this subchapter (21 US Code Section 881 [a][6] [1978]). (Emphasis added).

With the establishment of these two drug control policies in the USA, the expansion of sanctions for drug-related offenses into social policy, the workplace, and education policy began. In the following sections I describe the way in which drug policy has an impact on social policies.

Drug Testing and Employment

As discussed above, the first large-scale spread of drug testing outside of the prison/jail population was among the military during the Vietnam War in the 1970s. The Nixon administration believed that a heroin 'epidemic' existed among military members returning to the US (Normand et al. 1994). This represented the first major intrusion of drug testing into the workplace. In 1980 drug testing expanded in the US military. The Navy "following a series of incidents that highlighted the pervasive use of marijuana among their personnel announced a policy of 'zero tolerance' for illicit drugs" (Ibid: 178). Within two years, all branches of the military had instituted extensive testing programs for illegal drugs.

Drug testing in the workplace expanded from the military into the civil realm in subsequent years. A report to the National Academy of Sciences stated: "The main impetus for the rapid diffusion of these programs appears to have evolved from the preeminence given by the Reagan and Bush administrations to their 'war on drugs' policies … the substantial amount of publicity given to … tragic accidents, and numerous governmental regulations and directives. Favorable court rulings have also substantially contributed to making drug testing common in corporate America" (Normand et al. 1994: 216-217). (See also Crowley 1998; Gerber et al. 1990).

As a spin-off of his War on Drugs, then President Reagan signed Executive Order #12564 in 1986, which mandated the testing of federal government employees for illicit drugs. This Executive Order laid the groundwork for

all subsequently adopted workplace drug testing. This legislation grew out of Reagan's belief that substance abuse had increased considerably and was threatening the productivity of the government and businesses.

The Drug-Free Workplace Act of 1988 initiated widespread drug testing among private employers. This legislation required entities which had contracts with the federal government in the amount of $25,000 or more to certify that they were maintaining a drug-free workplace. The contract could be terminated if they failed to do so. Contractors were not required to drug test employees, but could do so to demonstrate compliance with the law (Normand et al. 1994: 285).

In 1991 the Omnibus Transportation Employee Act (OTEA) was signed into law by then President George Bush, Sr. This Act mandates illicit drug and alcohol testing for all individuals who are employed in or apply for 'safety-sensitive' jobs in the transportation industry. Public and private employers are required to implement drug testing programs in line with the OTEA.

Employment-related drug testing is now of three types: 1) pre-employment testing of job applicants, 2) incident driven or cause testing of employees, and 3) post-employment testing without a specified cause; these tests are often random (Normand et al, 1994). Pre-employment drug testing is the most common. 78 per cent of private employers require drug testing of job applicants (Tunnell 2004). It has been estimated that 66 per cent of private companies drug test employees. The larger the company, the more likely it is to have workplace drug testing. Drug testing has become a multi-billion dollar per year business in the US (ibid).

A study conducted for the National Research Council concluded over a decade ago: "Despite beliefs to the contrary, the preventive effects of drug-testing programs have never been adequately demonstrated. Although there are some suggestive data … that allude to the deterrent effects of employment drug-testing programs, there is as yet no conclusive scientific evidence from properly controlled studies that employment drug-testing programs widely discourage drug use or encourage rehabilitation" (Normand et al. 1994: 235-236). A more recent report conducted in Europe concluded: "The evidence on the links between drug use and accidents at work, absenteeism, low productivity and poor performance was inconclusive. … There is no

clear evidence that drug testing at work has a significant deterrent effect" (Independent Inquiry on Drug Testing at Work 2004: 2).

Thus, drug control policy has been expanded into the realm of the workplace. Ironically, most drug testing in the workplace is for illegal drugs only, yet the research shows that alcohol abuse is a much greater problem at work (Normand et al. 1994).

Public Housing for Low-Income Persons

Federal law *requires* public housing agencies and providers of subsidized housing for low-income persons and providers of other federally assisted housing to deny housing to certain individuals. The policies relevant to this paper are as follows:

1 "Individuals who have been evicted from public, federally assisted ... housing because of *drug-related criminal activity* are ineligible for public or federally assisted housing for three years." (Legal Action Center n.d.b). The three-year period begins on the date of conviction.

2 Any household with a member who is *illegally using drugs* is ineligible for public, Section 8 or other federally assisted housing. Current residents who are using illegal drugs must be evicted (Legal Action Center n.d.b).

The housing provider has the discretion to reduce the three-year period for those engaged in drug-related criminal activity, and to permit individuals accused of illegally using drugs to be admitted to, or remain in such housing if the person demonstrates certain activities such as: 1) participation in a supervised drug rehabilitation program, 2) completion of a supervised drug rehabilitation program, or 3) successful rehabilitation in some other manner (Legal Action Center, n.d.b). In addition, federal law *permits* public housing agencies and providers of Section 8 voucher programs and other federally assisted housing to deny housing to households if a member has certain types of criminal record. Individuals who have engaged in any "drug-related criminal activity" that would adversely affect the health, safety, or right to peaceful enjoyment of the premises may be denied public, Section 8 voucher programs, and other federally assisted housing if the criminal activity oc-

curred a "reasonable" time before the person applies for housing. The statute does not define how recent a conviction must be to constitute "reasonable" grounds for denying housing (Legal Action Center n.d.b).

Immigration Law

From 1988 to 1996, the US Congress amended the Immigration and Nationality Act seven times to increase the negative consequences of convictions of non-citizens accused of crimes. As a result, immigrants who have had contact with the criminal justice system and who are not US citizens "even if they have been lawfully admitted to the United States for permanent residence – may now be subject not only to ineligibility for citizenship, but also to mandatory deportation and permanent inadmissibility to return to the United States" (New York State Defenders Association, Inc. n.d.). Seven offenses trigger this action, both felonies and misdemeanors.[9] One category of these offenses is drug offenses (with the exception of a single offense for possession of 30 grams or less of cannabis) (New York State Defenders Association Inc. n.d.; see also Vargas 1999).

Other clauses in this revised immigration legislation are: 1) an immigrant may be deported due to an alleged offense from the past – there is no statute of limitations; 2) Congress has restricted or eliminated the waivers of deportation based on factors such as long residence or family ties in the US (New York State Defenders Association, Inc. n.d.); and 3) mandatory detention – "there is no longer any statutory right to release on bond pending completion of removal proceedings" (Vargas 1999: 3). In addition, a person may be excluded from immigrating into the country if they are "a drug abuser or addict." A standard for determining if a person is a drug abuser or an addict is not specified. The federal statute also states that the spouse, son, or daughter of a drug addict or abuser will not be allowed to immigrate.[10]

These sanctions grew out of the Reagan/Bush drug war and the partial scapegoating of national ills onto immigrants. These sociopolitical constructions and related draconian actions have characterized the conservative politics of the USA since the Reagan era (Reinarman & Levine 1997; Jensen & Gerber 1998; Sutton 2000; Beckett & Sasson 2004).

Driving Licenses

In 1992, the US Congress passed a law that withholds 10 per cent of specified federal highway funds from a state unless it enacts a law revoking or suspending the driving license of anyone convicted of any drug offense for at least six months subsequent to the time of conviction. States can choose to not adopt the law, but they then lose 10 per cent of certain federal highway funds. States can also limit the law "to drug convictions related to driving such as driving under the influence of a controlled substance, and impose a longer period than six months" (Legal Action Center 2004: 17). Twenty-seven states suspend or revoke driving licenses for some or all drug offenses. Twenty-three states either suspend or revoke driving licenses only for driving-related offenses or have not adopted the federal law. Four states revoke or suspend driving licenses for longer than six months for drug convictions unrelated to driving. Thirty-two states make restrictive driving licenses available to individuals whose driving privileges could be suspended to allow them to commute to work, attend drug treatment, or participate in an educational program (Legal Action Center 2004). Public transportation is inadequate in many areas of the USA, so possessing a valid driving license (and a vehicle) is important for obtaining transportation to work, drug treatment, heath care, job training, child care and educational institutions.

Financial Assistance to Low-Income Families

In 1996 the federal government passed the most significant domestic social welfare legislation since the 1960s: the Personal Responsibility and Work Reconciliation Act. This legislation created a new financial assistance program for low-income families called Temporary Assistance to Needy Families (TANF), and is commonly known as "welfare reform". President Bill Clinton was a major advocate of this policy change.

The major goals of this policy are to move single mothers with children in their households into the workforce and off public financial assistance. Although Aid to Families with Dependent Children (AFDC), the program which preceded TANF, was very restrictive in its eligibility criteria and levels of financial assistance compared to other Western postindustrial societies, TANF is even harsher. One of the changes was a time limit on benefits. For example, the federal legislation created a five-year lifetime limit while allow-

ing states to set their own time limits within the five-year limit. With AFDC a parent was eligible until their youngest child living in the household reached 18 years of age. One of the most stringent policies in the nation was enacted in the state of Idaho with a 24-month lifetime limit. The Idaho lifetime limit also counts the time TANF was received by the head of household in other states.

As indicated in the above example, federal legislation allowed states to create their own TANF programs within certain federal guidelines. So the requirements and benefits vary considerably from one state to the next.

The relevant provision of federal welfare reform legislation for this article is the restriction on eligibility for public financial assistance for individuals with criminal convictions. Federal legislation contains a provision stating that individuals with felony drug convictions after August 22, 1996 are permanently ineligible to receive TANF unless the state enacts legislation to modify or opt out of this clause. Seventeen states have adopted this ban without modification. Among this group are two of the states with the largest populations: California, the most populous state, and Texas. Twenty-one states have modified the ban. Seven states have modified the ban by requiring that the person undergo treatment. Eleven other states have modified the policy by limiting the ban to distribution or sale offenses, or by requiring submission to drug testing. Twelve states have entirely opted out of this policy. New York, Pennsylvania, and Michigan are among these states (Legal Action Center 2004).

Federal legislation does not require investigation of felony drug convictions. This information is to be obtained through self-reporting (Legal Action Center, n.d.a). In other words, the information that a person has been convicted of a felony drug offense is obtained from a form which the applicant completes, or from a personal interview; the law does not require that it be substantiated by obtaining an official record of the conviction.

Thus, today low-income families with children are permanently banned from the receipt of public financial assistance in one-third of the states. In addition, drug conviction-related restrictions on the receipt of cash assistance exist in another 36 per cent of the states as discussed above.

Food Assistance

The primary food assistance program for low-income persons in the USA is termed food stamps. After meeting the eligibility requirements, an individual is provided with either paper food stamps, which are similar in appearance to paper currency, or a plastic card similar to a credit card to purchase a designated dollar amount of food in a given month. The financial eligibility requirements for food stamps are less restrictive than for TANF, and thus the program reaches many more low-income people. In fiscal year 2004, 23.9 million persons, an estimated 8 per cent of the national population, received food stamps.[11]

The Personal Responsibility and Work Reconciliation Act of 1996 also banned the receipt of food stamps by individuals with felony drug convictions; once again part of the Clinton legacy. The states have the option of adopting the policy, altering it, or not adopting it. Seventeen states have adopted the lifetime ban. Nineteen states have adopted modified versions of the ban. Fourteen states have not adopted the ban. In summary, today over 70 per cent of the states deny or restrict eligibility to food stamps for low-income persons because of a felony drug conviction.

Student-Direct Postsecondary Education Funding

The Higher Education Amendments of 1998 also restrict the availability of student financial assistance (i.e. financial aid) for persons to attend institutions of postsecondary education (i.e. higher or vocational education after high school) when they have been convicted of a drug violation. This law was championed by Representative Mark Souder, a conservative Republican from Indiana.

The statute stated: "A student who has been convicted of any offense under any Federal or State law involving the possession or sale of a controlled substance shall not be eligible to receive any grant, loan, or work assistance under this title during the period beginning on the date of such conviction" (Higher Education Amendments of 1998). The ineligibility periods are specified as follows:

Possession of a controlled substance	Ineligibility period
First offense	1 year
Second offense	2 years
Third offense	Indefinite
Sale of a controlled substance	Ineligibility period
First offense	2 years
Second offense	Indefinite

The law contains a rehabilitation clause that reads as follows:

> A student whose eligibility has been suspended … may resume eligibility before the end of the ineligibility period … if the student satisfactorily completes a drug rehabilitation program that … complies with such criteria as the Secretary shall prescribe … and includes 2 unannounced drug tests; or … the conviction is reversed, set aside, or otherwise rendered nugatory (Higher Education Amendments of 1998).

This policy was recently revised. If a student is not convicted while enrolled, that student will not be denied federal aid. If convicted while receiving financial aid, a student's ineligibility periods and rehabilitation requirements remain the same as in the 1998 statute (Washington Defender Association, 2007:24). This policy has been estimated to have delayed or denied federal financial aid for college to more than 180,000 persons convicted of drug offenses between 2000 and 2006 (Mulligan et al. 2006).[12]

Another effect of this federal policy has been to influence state-based financial aid programs. Although federal law does not require states to enact or enforce policies that forbid student financial assistance to persons convicted of drug offenses, many states extend this policy to state-based aid programs by using the federal application form determination to decide eligibility for state financial assistance programs (Mulligan et al. 2006: 4). Although seven states have adopted laws denying financial assistance to persons with drug or other criminal convictions, 17 other states rely on the federal form determination of eligibility and thus de facto deny financial aid to persons who

self-report drug convictions on the form. State student aid offices in eleven states allow eligibility determination to be made by the college or university to which the person has applied. Fifteen states and the District of Columbia ignore the drug conviction question when evaluating an applicant's eligibility (Mulligan et al. 2006: 4).

Thus, the opportunity to complete a postsecondary education program is restricted for those convicted of a drug-related offense; in some cases by law, and in other cases by convenience (i.e. the de facto cases at state level). Postsecondary education is the most effective avenue to a reasonably secure occupational career and upward mobility (Hauser & Daymont 1977; Jencks et al. 1979), with the exception of inheritance for the wealthy. This legislation serves to marginalize those convicted of drug violations and to reduce the life chances of those for whom postsecondary education is a potential avenue toward occupational attainment.

Drug Testing in Schools

The most recent attempt at expanding the pernicious net of drug policy into the civil realm is the drug testing of students in schools. President George W. Bush has made suspicion-less drug testing of students in schools a cornerstone of his drug policy agenda. The federal government has encouraged schools to adopt this policy through publicizing its purported benefits and offering grant funding to initiate drug testing of students. The Office of National Drug Control Policy claims that drug testing in schools deters young people from using illicit substances, and that it can be used to identify illegal drug users early so that treatment or counseling can be provided to them (see Robinson & Scherlen 2007).

Research conducted before the George W. Bush administration's effort to spread drug testing in schools found that in national samples of middle and high schools between 1998 and 2001, 19 per cent of schools reported using drug tests. Drug tests were most often given to students suspected of using drugs (Yamaguchi, Johnston & O'Malley 2003). This research also concluded that drug testing in schools was not associated with students' reported illicit drug use. In other words, drug testing in schools did not have a deterrent effect on student use of illicit drugs.

Conclusions[13]

The conclusions to be drawn from this review of the expansion of drug control policy in the US into the realms of social policy, education policy, and the workplace are obvious: the marginalized groups that are disproportionately subjected to these draconian policies are further marginalized as a result. The reduced life chances of the American underclasses have been exacerbated by the application of these policies.

Despite the claims of the advocates of these policies, many criminologists would expect crime among those affected by the expansions of drug control policies to increase in the civil realm. In other words, since opportunities for educational attainment and employment are restricted by these policies, the informal social controls inherent in educational attainment and meaningful employment are lessened or absent (Sampson and Laub, 1993). If a person has also been incarcerated, his or her opportunities for success in the conventional world are further attenuated (Sampson & Laub 1993; Western & Beckett 1999; see also Spohn 2007; Chiricos et al. 2007).

We can understand the consequences of these civil penalties for drug offenses through the lens of John Braithwaite's (1989) reintegrative shaming theory. Braithwaite states that "communitarian" societies are characterized by interdependencies in which persons are "densely enmeshed" and "which have the special qualities of mutual help and trust" (Braithwaite 1989: 100). Shaming is reintegrative in communitarian societies. In other words, the shaming process is part of the sanction for harming society but the offending individual is forgiven once their criminal sanction is completed and they are allowed to return to society without the negative stigma of "criminality" or "marginality." "… disapproval is dispensed without eliciting a rejection of the disapproved …" (ibid: 102). These societies, such as Japan, have low rates of criminal behavior.

Noncommunitarian societies, or societies low on communitarianism, continue the stigma of criminals after they have completed the imposed legal sanction. In these societies the person is marginalized and the likelihood of participation in criminal subcultures is increased. "… a high level of stigmatization in a society … encourages criminal subculture formation by creating populations of outcasts with no stake in conformity …" (ibid). Thus, the stigmatized are attracted to criminal subcultures as an alterna-

tive to the conventional society that excludes them. The risks of continued criminal behavior and its escalation are then heightened. Often lacking the positive social bonds that are inherent in interdependencies and which serve to reintegrate the former offender, those persons at risk of criminal behavior (e.g. young males, the unmarried, recent immigrants, etc.) experience further attenuation of their bonds. As a result, they are less committed to conventional society and more susceptible to the attractions of criminal subcultures. This erosion of communitarianism, then, results in societies with high crime rates such as the USA. The expansion of sanctions for drug offenses into the realm of social policy has exacerbated the pre-existing low degree of communitarianism in US culture.

Braithwaite also points to the existence of structural inequalities as a factor contributing to criminal behavior. He writes: "the other major social variable which fosters criminal subculture formation is systematic blockage of legitimate opportunities for critical factions of the population" (1989: 103). Even though it is one of the most affluent societies in the world, the USA is well known for its widespread inequities grounded in economics, the social stratification system, and racial/ethnic relations. Indeed, the withdrawal of social welfare supports associated with drug offenses further attenuates the ability of these marginalized groups to succeed in American society. Protective factors have been eliminated by law, and as a result the risk factors in American society have increased.

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NOTES

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2 Criminal laws are enacted at federal (or national) level and state level (e.g. California) in the USA. Federal criminal statutes are passed by Congress and tried in federal courts. The question regarding what areas Congress may regulate has long been a source of controversy, but it certainly includes offenses that occur on federal property (e.g. a federal office building or a military base) or that fall within areas thought to involve interstate and international commerce. State criminal laws are enacted by state legislatures and governors, and are tried in state courts. State criminal laws apply to offenses that occur within the boundaries of the specific state (e.g. New York). In general, state laws cannot contradict federal laws. There is at least one exception in drug control policy, however. Some states have moved to make medicinal cannabis available to designated patients, but this is illegal under federal law. The federal Drug Enforcement Administration often conducts raids of the sources of medicinal cannabis within the states.

3 Prior to the 1930s, the states were somewhat more autonomous of the federal government than they are today. Since that time the US Supreme Court has applied the Bill of Rights to the states, and has adopted a more expansive definition of the power of Congress to regulate commerce.

4 At the time of writing, three bills which would alter the 100:1 ratio had been introduced into Congress in 2007. One of the bills would eliminate the weight-based disparity in sentencing

between crack and powder cocaine and lower the penalties for crack to equal those of powder in federal law.

5 The US Supreme Court recently ruled in two cases (*Kimbrough v. U.S.* [No.06-6330] and *Gall v. U.S.* [06-7949]) that federal judges have the discretion to sentence persons to prison terms well below the punishment range set by the federal crack sentencing guidelines. Shortly thereafter the US Sentencing Commission voted to allow federal prisoners to seek reductions in their sentences for crack offenses. A complete change in cocaine sentencing disparities can only come with action from Congress, however.

6 www.ojp.usdoj.gov/bjs/dcf/tables/arrtot.htm

7 Later drug testing found that only 4.5 per cent of returning troops tested positive for heroin (Tunnell, 2004: 14).

8 Under civil asset forfeiture policies, the government seizes property through a civil proceeding when a drug offense is suspected. The civil proceedings force individuals to forfeit their property despite the fact that criminal charges are never brought or that defendants are eventually acquitted of drug-related charges (Yoskowitz, 1992). The property has no rights of due process as would the person in a traditional proceeding. In essence, the property is defined as a 'guilty criminal', yet it has no protection against seizure by the government.

9 A felony is a serious crime punishable by one or more years in state or federal prison, or death. A misdemeanor is a less serious crime that is punishable by less than one year in jail. Persons convicted of felonies and misdemeanors may also be subject to fines and other sanctions.

10 A recent US Supreme Court case has limited the applicability of this law for certain drug offenses. In Lopez v. Gonzales (No. 05-547) (December 5, 2006) the Supreme Court ruled in a 8-to-1 decision that conviction of a drug crime that is a felony under state law, but is a misdemeanor under federal law, is not the type of offense that results in mandatory deportation, with the exception of possession of more than five grams of crack cocaine and possession of flunitrazepam (New York State Defenders Association Immigrant Defense Project, 2006; Denniston, 2006).

11 www.fns.usda.gov/fns/services.htm

12 Since 2001, bills have been introduced into Congress to repeal entirely the 1998 amendment to the Higher Education Act restricting student aid because of drug convictions. The most recent was introduced into the US Senate during June, 2007.

13 Major civil liberties problems are involved in this expansion of drug control policy into the realm of social policy also, but these issues are beyond the scope of this chapter (see Gerber et al., 1990; Jensen and Gerber, 1996; Crowley, 1998; Glasser and Siegel, 1997; Sagatun-Edwards, 1998; http://aclu.org/crimjustice/warondrugs).

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