Care of the Self, Somaestethics and Drug Addiction: An Exploration on Approaching and Treating Problem Drug Use

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Abstract: *Can a person use dangerous substances and still take care oneself and be healthy? Is it right to give people directions and tools for using substances, which, in the worst case, could be lethal to them? This article provides empirical examples of practices and policies designed to offer those who inject drugs opportunities and methods for taking care of themselves and, thus, the chance to lead a more balanced life, in spite of it all. Images of problem drug use have traditionally been associated with despair and devastating marginalization. Harm-reduction policies, initiated in the 1980s to combat the spread of HIV and other blood-borne viruses among drug users, raised the issue of drug use in the context of health and healthcare, and gave users new ways to think about themselves. Critics refer to this development as "biopower," in which drug users have become "docile bodies," who are expected to follow safe injecting practices and other such procedures under the surveillance of healthcare professionals. However, the users themselves have been more positive and consider harm-reduction policies not only as life saving, but life altering. This article touches on different aspects of harm-reduction policies in the context of the Foucauldian discussion of "care of the self." A somaesthetic framework is applied to understanding harm reduction as a set of practices in which helping drug users goes through their body and not through their will, as in traditional approaches to addiction. Focusing on the body provides users with new ways of thinking about their existence and relationships with themselves and others.*

Keywords: *problem drug use, addiction, care of self, somaesthetics.*

Prologue

Former Canadian health minister Jane Philpott found herself in a tight corner on May 14, 2017. It was the opening ceremony of the biannual meeting of Harm Reduction International, a global network that promotes evidence-based public health and drug policies and the human rights of drug users. Philpott was to give speech as a representative of the Canadian government. The evening had already been emotional. In 2016, it was estimated that 2,300 people in Canada had died from opioid overdoses, and the deaths continued in 2017. One of the victims was Raffi Balian, a Canadian harm-reduction and human rights activist who had died of an overdose just

a few months before the conference, and whose work and contributions to the harm-reduction community were mentioned in the ceremony by grieving friends and colleagues.

When it was Philpott's turn to talk, she faced an angry crowd of protestors. Signs held by the protestors read "TheyTalkWeDie" and "LifeWon'tWait," indicating that the Canadian government had not taken sufficient action to combat overdose deaths. Some of the protestors turned their back on Philpott while she desperately tried to convince them and other members of the audience that she took their criticism seriously. An article about the ceremony that appeared in Canada's "Now Magazine" a couple of weeks later noted that "Minister Philpott appeared shaken" and that for some "it was difficult to see an overseer of tangible progress take the brunt of so much collective frustration and anger." According to Hugh Gibson, the author of the article, for the protestors, "it also wasn't a time to be warm and cuddly."[1]

After her speech, Philpott left the stage with a slightly nervous smile. "Stop smiling," one of the protestors shouted angrily. "Thousands are dead, and you're smiling."

Two weeks later, Philpott continued the discussion in an interview with the Canadian Broadcasting Corporation (CBC)[2], in which she again reassured users and their families that she had taken note of their concerns. One of her solutions was to provide heroin-assisted treatment to people suffering from severe opioid addiction. She stated "although a challenging concept for some people," it could "save lives." Researcher Eugenia Oviedo-Joekes, who was asked to comment on the minister's suggestion in the interview, saw it as an important step toward seeing drug users as people. "[It's] very important that a minister of health is saying those words," Oviedo-Joakes stated. "We need to change the way people see our patients. We are not kind to our patients. People need to stop thinking about the drug and start thinking of the people."

Introduction

The World Health Organization's (WHO) Burden of Disease (GBD) reports provide data on mortality and loss of health as a result of diseases, injuries, and risk factors for all world regions. The original GBD study was commissioned by the World Bank in 1991, and provided burden of disease estimates for 1990. Later, the project was extended to provide estimates for the years 2005, 2010, and 2013. The task of Australia's National Drug and Alcohol Centre (NDARC) was to calculate the global levels of disease, injury, and death associated with illicit drug use and dependence. To date, the findings of its study have pointed out that burdens of death and illness caused by illicit drug use are notably high in the U.K., U.S.A., South Africa, and Australia. The most pronounced source of the burden is opioid addiction, and the burden of this disease falls most heavily on men aged 20–29 years old. Disability and illness caused by opioid dependence increased more than 74% between 1990 and 2010. Another central cause of death and illnesses associated with illicit drug use is amphetamine addiction.[3]

It is not only the users of illicit drugs who carry the disease burden related to drug use. For example, opioids are highly addictive substances, and their medical use can have adverse and irreversible consequences. In the U.S., consumption of opioid pain relievers (OPR) and the harm associated with their consumption has soared in the 2010s. Overdose mortality quadrupled

1 Hugh Gibson, "Dispatches from Montreal's International Harm Reduction Conference," *Now* 26.5.2017. https://nowtoronto.com/news/dispatches-montreals-international-harm-reduction-conference/

2 Catherine Tunney, "Jane Phillpot says pharmaceutical heroin a potential livesafer in opioid epidemic," CBC 20.5.2017 https://www.cbc.ca/news/politics/philpott-heroin-addiction-opioids-1.4123233

3 Summary of the NDARC's findings and background on GDP reports can be found from their website https://ndarc.med.unsw.edu.au/project/global-burden-disease-mental-disorders-and-illicit-drug-use-expert-group)

between 1999 and 2011. The period 1997–2011 saw a 900% increase in people seeking treatment for opioid addiction, as well as a sharp increase in the number of visits to emergency rooms caused by drug use.[4] The U.S. Centers of Disease Control and Prevention (CDC) referred to the situation as the worst drug overdose epidemic and added opioid-related deaths to its list of five public health challenges. President Trump has also taken a stand, calling the situation "a health emergency." In Canada, the government has referred to its situation as a national opioid crisis and a public health emergency.[5] One of the government's solutions has been to launch the Good Samaritan Drug Overdose Act, to help Canadians save a life during an overdose situation.

In Europe, opioids, especially highly potent synthetic opioids, such as fentanyl and karfentanyl, are considered a growing health concern along with new psychoactive substances (NPS) produced in small laboratories across the world and sold and bought on the dark web. In addition, injecting drugs continues to be problem.[6]

Given the magnitude of the problem related to opioid use, and drug use generally, our ability to deal with these problems is surprisingly limited. Also, we easily resort to traditional approaches to understanding drug use and its causes and effects. As researcher Oviedo-Jokes noted in the CBC interview mentioned above concerning heroin-assisted treatment, "Do you know how hard it is to know that there is a medication that works, but no one seems to just do it?" Prominent public health experts have raised a similar question: Why do we continue to invest heavily in criminal and legal enforcement measures, although there is very little scientific evidence of their effectiveness?[7]

This article poses two questions. First, why is it so difficult and, in some cases, even unthinkable, to apply new and alternative ways, such as heroin-assisted treatment, to deal with opioid problems and drug addiction? Second, have we overlooked some important issues regarding drug users' health, well-being, and their maintenance and, because of this, contributed to their degradation?

In a vein similar to that of Helen Keane[8], my starting point in this article is that one of the problems is our understanding of drug problems and addiction as a total lack of individual control and the use of drugs as inherently pathological. Surely, as Keane notes, living with drug addiction is often extremely difficult and many want it to end. However, there seems to be only few options available for how this could be done. For instance, we tend to forget that many quit their drug use without formal help and that there could be other ways of approaching drug problems, outside the demands of normality and complete recovery from addiction.[9]

The present article makes use of Michel Foucault's "care of the self" concept and Richard Shusterman's somaesthetic framework to argue for drug policies and treatment practices that would take as their starting point problem drug users' ability to make rational decisions and choices regarding their health and well-being without coercion and control, if they were given a proper chance and the tools to do this. The context is a drug policy orientation called harm reduction, which consists of a range of public health policies, programs, and practices that aim to

4 A. Kolodny, D.T. Courtwright, C.S. Hwang, P. Kreiner, J.L. Edie, T.W. Clark, C.G. Alexander, "The Prescription Opioid and Heroin Crisis: A Public Health Approach to an Epidemic Of Addiction," *Annual Review of Public Health* 18:36 (2015), p. 557-9

5 Ibid.

6 Jane Mounteney, Paul Griffiths, Roumen Sedefov, Andre Noor, Julián Vicente & Roland Simon, "The drug situation in Europe: an overview of data available on illicit drugs and new psychoactive substances from European monitoring in 2015," *Addiction Review* 111 (2016), p. 34-48

7 Thomas F. Babor, Jonathan P. Caulkins, Griffith Edwards et al., *Drug Policy and the Public Good* (Oxford: Oxford University Press, 2010)

8 Helen Keane, *What's Wrong with Addiction?* (Melbourne: Melbourne University Press, 2002)

9 Ibid., p. 8.

reduce the harm associated with drug use. Typical interventions are needle and syringe exchange programs, overdose prevention and other forms of health and social counseling related to drug use, and opioid substitute treatment. In addition, harm-reduction advocates for users' rights and includes their views in the development of drug and welfare policies.

For Foucault, as cited e.g. by Didier Eribon,[10] drugs weren't something that one could or should either support or reject. They are part of our culture, and there are good and bad drugs and their effects, as there is good and bad music. His ethics were based on an idea of individual existence that would be independent of present categories and discourses of normality, developed particularly in the fields of the medical profession and human sciences, such as psychology. The key question is how can a person take care of him/herself and develop meaningful ways of existence.[11]

Richard Shusterman's somaesthetics is used to highlight the importance of practices based on the drug users' bodies and surrounding environments in users' rehabilitation and re-integration into society.[12] According to Peter Ferenzy,[13] in the heart of the modern understanding of addiction, there has been an understanding of repression from which the individual should be liberated. Traditional treatment, for its part, has concentrated on overcoming this repression by treating users' minds and "wills."[14] However, as will be shown in the empirical part of this article, focusing on the body may provide the users with new ways to think about their existence and relationship to self and others.

Images and theories of drug addiction

Previous research has demonstrated many problems in the ways that societies handle drug problems and drug addiction. Nordic sociologists Nils Christie and Kettil Bruun referred to drugs as societies "good enemy."[15] As they claim, it is very easy as well as politically convenient to wage a war on drugs and drug users, because they are often alien to many. It is also very hard to say anything positive about drugs without being labeled suspicious, while it is very easy to project everything that is wrong in society on them and on people who use them.

Drug users themselves often feel that they carry a stigma, which prevents them from participating in society or normal life. The International Network of People Who Use Drugs (INPUD) has criticized the criminalization of drugs, which, according to them, produces many of the harms associated with drug use. Also, the general understanding of drugs and drug users is often inaccurate and crude, stigmatizing people who use drugs as deviant criminals.[16] There is a growing body of evidence indicating that even basic social and health policy services may be out of reach of drug users or fail to offer proper treatment and help for them.[17]

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10 Didier Eribon, *Michel Foucault* (Translated by Betsy Wing) (Cambrigde: Harvard University Press 1991)

11 Eribon, 1991, p. 394

12 see e.g. Richard Shusterman, *Thinking Through Body. Essays in Somaesthetics.* (Cambridge: Cambridge University Press 2012); Richard Shusterman, *Performing Live. Aesthetics Alternatives for the Ends of Art* (London: Cornell University Press)

13 Peter Ferenzy, "Foucault and Addiction" *Telos* 125 (2002), pp. 167-191

14 Ibid.

15 Nils Christie and Kettil Bruun, *Den Goda Fiende. Narkotikapolitik I Norden* (Universitetsförlaget, 1985)

16 See e.g. INPUD, "Drug User Peace Initiative. Stigmatizing People Who Use Drugs" (London: INPUD Secretariat 2014)

17 Hatcher, E. Alexandrea, Sonia Mendoza & Helena Hansen,"At the Expense of a Life: Race, Class, and the Meaning of Buprenorphine in Pharmaceuticalized "Care," *Substance Use & Misuse* 53:2 (2018), p. 301-10; Julie Netherland & Helena Hansen,"White opioids: Pharmaceutical race and the war on drugs that wasn't," *Biosocieties* 12:2 (2017), p. 217-238.; Anna Leppo & Riikka Perälä, "Remains of Care. Opioid Substitution Treatment in the Post-Welfare State," *Sociology of Health and Illness* 39:6 (2016), pp. 959-978.; Philippe Bourgois & Jeff Schonberg, "Righteous Dopefiend" (Berkeley: California Series in Public Anthropology, 2009); Nina Mulia, "Ironies in the pursuit of well-being: the

Culturally speaking, drug use, especially problem drug use and opioid addiction, has indeed been depicted as one of the most devastating vices of Western societies. Caroline J. Acker looked at the construction of opiate addicts in the field of psychiatry and psychology.[18] According to her, by the mid-twentieth century, heroin addiction came to symbolize an incurable deviance. Heroin addicts, in turn, came to be perceived as inherently flawed and morally corrupt personalities who were incapable of living in a normal society. According to Acker, the effects of these constructions can be seen in the field of drug policy, which legitimizes the criminal control of drug users. They have also had an effect on the popular cultural image of drugs and drug use, which is routinely associated with criminality and violence, while people who use drugs are depicted as desperate and immoral "junkies."

Robin Room[19] has discussed addiction narratives as a form of (horror) story-telling with certain reoccurring characters and events: a good person turning into a bad one because of addiction, a lonely struggle against addiction where the hero or heroine of the story meets different obstacles and setbacks and usually fails, and the betrayal of ones' family members and friends, often in horrible ways. Sometimes help is available, especially for men in the form of "a good woman," but usually the process of addiction is described as inevitable degradation – "first to the poorhouse and then to the grave as in the cautionary tales of the temperance movement" [20]– and the loss of one's humanity. This story has also been prevalent in treatment, where loss of control over drinking and drug use – and later over one's entire life – has been depicted as one of the quintessential features of addiction. Further, this condition can be treated only by the addicted individual her/himself with the help of various confessional procedures, where one admits her/his problem with alcohol or drugs, and uses her/his entire willpower to overcome the problem.[21]

All of this is partly true, as Room notes,[22] and drugs indeed have destructive effects.[23] Problem drug users suffer from many different problems and many live outside the normal curriculum of societies. Users themselves have considered addiction as a fruitful and re-assuring way to understand their behavior

However, discourses of addiction, as Keane[24] notes, are also engaged in the production of truths about drugs and drug users. More importantly, they have maintained policies and identities that have been damaging to users, such as denying them, as addicted individuals, a possibility for autonomous agency and proper subjectivity.

Care of the self and somaesthetics as frameworks of addiction

For Foucault, as previously mentioned, drugs weren't an undisputable "bad," but also a source of physical pleasure. Foucault did not discuss addiction in his scientific work, but he might as

perspectives of low-income, substance-using women on service institutions" *Contemporary Drug Problems*, 29 (2002), pp. 711-4

18 Caroline J. Acker, *Creating an American Junkie. Addiction Research in the Classic Era of Narcotic Control.* (Baltimore: The John Hopkins's University Press, 2002)

19 Robin Room, "The Cultural Framing of Addiction", *Janus Head* 6:2 (2003), pp. 221-234

20 Ibid., pp. 230-231

21 Ibid., pp. 230-231

22 Ibid., p. 232

23 Keane, 2003, p. 9

24 Keane, 2003, p. 11

well have, as Ferenzy[25] has argued, because the discourses on addiction formulated in the field of medicine and psychiatry entail themes similar to the discourses on sexuality in which Foucault was interested.

Foucauldian ideas of power and governance are often associated with iron-cage-like images of control and power, where the individual is merely an effect of different power relationships and discourses.[26] This has also been the case in the field of drug research. For example, the harm-reduction policies looked at in this article have been described as a new medical discipline and control that represses drug users rather than supports them. Peter G. Miller[27] used Foucault to discuss harm reduction as "surveillance medicine" and "new public health" thinking, where drug users are seen not only as entitled, but also obliged to take responsibility for their own health. Since then, this view has been cited in several journals and has gained ground as a prominent critique of harm-reduction policies.[28]

Miller points out the pitfalls that one should be aware of while conducting and developing harm-reduction policies and public health policies in general; however, what is problematic in these kinds of views is that they often overlook Foucault's ideas of resistance and possibilities for change.[29] Later in his career, Foucault became interested in alternative modes of living that would allow for a more heterogeneous form of existence than those found in Western societies based on Christian morality.[30] This led him to investigate practices of the sexual care of the self of ancient Greece and Rome, and later, as Kevin Thompson and Amy Allen demonstrate in their analyses on Foucault's ideas of power and resistance[31], to strive for practices of care of the self in which both our individuality and relationship with others could be renegotiated and refashioned. Next, I will discuss Foucault's ideas about what Foucault called "care of the self," and developed in his later works, lectures, and interviews. After this, I will turn to Richard Shusterman, who used Foucauldian ideas to formulate his own somaesthetic discipline. In the empirical part of the article, I will use Foucault and Shusterman's ideas to search for forms of working with drug users that would move away from treatment techniques based on coercion, control, and normalization, still typical of many drug treatment interventions today.[32]

The notion of care of the self, as Foucault starts to explain the theme of his lecture series at the College de France in 1982, is his best translation of the complex Greek notion of epimeleia heatou, which refers to practices of care of oneself in Greek culture. In the lecture, Foucault portrays Socrates as the first person associated with the idea, which subsequently remained

25 Ferenzy, 2003

26 On discussion see e.g. Amy Allen, "Power, Subjectivity, and Agency: Between Arendt and Foucault," *International Journal of Philosophical Studies*, 10:2 (2002), pp. 131-149, 145

27 Peter G. Miller, "A Critical Review of the Harm Minimization Ideology in Australia," *Critical Public Health*, 11:2 (2001), pp. 167-178

28 see e.g. Benedict Fischer et al., "Drug use, Risk and Urban Order: Examining Supervised Injection Sites (SISs) as Governmentality," *International Journal of Drug Policy*, 15 (2004), pp. 357-365

29 Amy Allen, "Rethinking Resistance; Feminism and the Politics of Ourselves," *Eurozine*, 5:5 (2010); Eribon 1992; Alan Rosenberg and Alan Milchman, "The Final Foucault; A Central Issue in Governmentality and Government of the Self," in Sam Binkley and Jorge Capetillo (eds.), A *Foucault for the 21st Century: Governmentality, Biopolitics and Discipline in the New Millennium* (Newcastle upon Tyne: Cambridge Scholars Publishing, 2011), pp. 62-72

30 Eribon 1992; Kevin Thompson, "Forms of Resistance: Foucault on Tactical Reversal and Self-Formation," *Continental Philosophy Review*, 36 (2003), pp. 113-138

31 see also Kevin Thompson, "Spaces of Invention; Foucault and the Question of Transformative Institutions" (University of Chicago Political Theory Workshop November 28, 2011). Available online at: http://ptw.uchicago.edu/Thompson11.pdf

32 See e.g. Julian Randall & Iain Munro, "Foucault's Care of the Self: A Case from Mental Health Work," *Organization Studies* 30:11, pp. 1485–1504. I am indebted to Julian Randall and Ian Munro's analysis on care of the self and mental health, which inspired me to use the notion care of the self in the context of harm-reduction measures.

as the fundamental philosophical idea of the Greek, Hellenistic, and Roman cultures.[33] In the summary of the course[34], Foucault brings to the fore some of the most important aspects of this practice. First, care of the self is an activity that requires some regularity, methods, and objectives, not just "an attitude or a form of attention focused on oneself." Second, care of the self is a critical and pedagogical practice, a struggle, where one takes responsibility for oneself and changes oneself with the help of the aforementioned regular practices. Third, it is a relationship that requires a master, a guide, or anyway someone else, as care of the self is also about the person becoming part of the society he or she lives in.

Care of the self does not mean, like many of Foucault's critics often assume, retreating to self-centered individualism or freedom to do what one wants. As Julian Randall and Iain Munro have summarized Foucault's conception of ethics in their investigation on care of the self in the context of mental health, in the heart of Foucault's ethics, there is a principle of equality, where one actively shapes oneself with the help of others – friends, family, or an advisor – and, in this way, transforms oneself.[35]

For the purposes of this article, what is particularly interesting in practices of care of the self is the role of medicine. It is not considered as a controlling discipline, but rather a supportive one. In the third and final volume of his book *The History of Sexuality: The Care of the Self*[36], Foucault cites the ideas of Plutarkhos and Celcus. In their writings, medicine is not be conceived of solely in the context of illness, "as a remedy or an operation," but also as a form of practical philosophy, a "medical perception of the world," which provides the individual with knowledge of and rules for a good life. What is especially important is the individual's relationship with his/her environment. As Foucault cites Celcus's ideas of "health practices" (*hygieine pragmateia* or *techne*): a certain change in a surrounding environment could have morbid effects on the body. On the other hand, a weak body may benefit from a certain environment.[37]

Richard Shusterman discusses Foucault's analysis of Socrates and Diogenes as examples of Foucault's idea of philosophy that would not be just a matter of text, but also an embodied life practice.[38] Shusterman himself separates three different branches of somaesthetics into a discipline that tries, among other things, to "think through the body" the possibilities for new forms of creative self-fashioning and aesthetic pleasure.[39] Analytical somaesthetics is a theoretical field that describes the basic nature of our bodily practices and demonstrates how these practices can be shaped by different power relationships and discourses. Pragmatic somaesthetics is concerned with different methods of somatic improvement and their comparison and tries, in this way, to make some sense of their contribution to the human body. Lastly, practical somaesthetics is about the actual practice of these body practices as well as about physically engaging in the care of the body.[40]

At the center of somaesthetic theory is Shusterman's critique of traditional philosophy,

33 Michel Foucault, *The Hermeneutics of the Subject. Lectures at the College de France 1981-1982* (New York: Palgrave McMillan 2001)

34 Ibid.

35 Randall & Munro

36 Michel Foucault, *The Care of the Self. The History of the Sexuality. Volume 3* (New York: Random House 1988)

37 Ibid.

38 Richard Shusterman, 'Somaesthetics: A Disciplinary Proposal', *The Journal of Aesthetics and Art Criticism*, 57: 3 (Summer, 1999), pp. 299-313

39 Shusterman, 2012

40 Shusterman, 2000

particularly its prejudice of the body and its maintenance.[41] Yet, as Shusterman[42] writes, ancient philosophers like Socrates noted the value of the body for human activities. Even the act of thinking required a healthy body, whereas ill-health could lead to serious mistakes. One should not ignore the role of the body in the formation of our self-knowledge, which Shusterman considers one of philosophy's prime cognitive aims.[43]

In fact, Shusterman asserts that improving awareness of our body and its states can influence our moods and attitudes. For example, some malfunctions of the body can become so habitual for us that we do not even recognize them anymore. Nonetheless, they may have a profound impact on our activities as well as on our thinking. Also, the ability to act as we will act depends on somatic efficacy. What is more, our bodily operations are deeply intertwined with our possibilities for virtuous and right action and a good life.[44] Body can also work as a site of resistance, as Shusterman writes, commenting especially Foucault's ideas of body as a site of inscribing social power.[45]

As for the questions posed in this article, Shusterman[46] asks an interesting question: "Why so much inquiry has been devoted to the ontology and epistemology of pain and so little to its psychosomatic management, to its mastery and transformation into tranquillity or pleasure?" With respect to addiction, the question could be, why are we so preoccupied with describing and thinking about the pains of addiction and not with providing addicted people chances for finding peaceful and meaningful ways of existence with their injured body?

Research Setting

I will now turn to the empirical part of the article, where I will discuss Foucault and Shusterman's theories in the context of harm-reduction policies. Most of the data used in the article is derived from a needle and syringe exchange facility for injecting drug users, which was founded in the southern part of Finland at the beginning of 2000 and which follows a harm-reduction ideology. This facility was the first of its kind in Finland and part of a radical and rapid change in Finnish drug policies toward harm reduction.[47]

Harm-reduction policies are conducted all over the world, but in very different contexts and with very different possibilities. In Central Europe, harm reduction has become mainstream, and many countries, such as the Netherlands, Portugal, Denmark, and Switzerland, consider it as the central tenet of their drug policies. Finland, Sweden, and Norway follow a dual track (Tammi 2007), where harm reduction is applied along with a strong focus on the criminal prevention of drugs. In some countries where the emphasis is on "the war on drugs," harm-reduction measures are considered illegal.

It is interesting that, although a great deal of data on the effectiveness of harm reduction is available, its measures are still often questioned or bypassed by many prominent actors. For

41 Shusterman, 1999

42 Ibid.

43 Ibid.

44 Ibid.

45 Ibid.

46 Ibid., p. 330

47 Pekka Hakkarainen and Christoffer Tigerstedt, "Ristiriitojen huumepolitiikka–huumeongelman normalisaatio Suomessa," in M. Heikkilä, and M. Kautto (eds.), *Suomalaisten hyvinvointi 2002* (Helsinki: Sosiaalialan tutkimusja kehittämiskeskus 2002) ["Conflicting Drug Policy–the normalization of drug problem in Finland," in M. Heikkilä, and M. Kautto (eds.), *Well-being in Finland 2002* (Helsinki: National Research Institute for Social Welfare and Health, 2002)]

example, the WHO has taken criminal control as a given in the case of drugs, whereas other "dependence-producing" substances, such as alcohol and tobacco, have been managed within a public health framework.[48] At the moment, services to reduce drug-related harm and provide clean needles and syringes for injecting drug users have failed to keep up with the growing need, although, for instance, the UN has pledged to end AIDS by 2030. In some countries the number of harm-reduction services has even fallen.[49]

In all, the data examined in the article entail 150 pages of field notes, as well as interviews with clients and employees (N = 25 and N = 17), which were carried out during my ethnographic investigation in the harm-reduction facility between 2004 and 2007. The employees had professional background as nurses, health nurses, and social workers. The clients injected drugs, mainly bubrenorphine and other medical opioids and amphetamine. Most of the drugs were obtained illegally from the street. The age range of my client interviewees was 19–57 years old. I did not ask all of them specifically when they had started injecting drugs, but statistically the clients of the services had started injecting when they were 16–18 years old. My interviewees told me that they had started injecting "in high school" or "at adolescence." One of them told me that she had started when she was 40 years old.

Altogether I spent a year and a half in the field, in short, 2–3 month periods. The analysis is based on following observation and interview data: (1) following the client and employees' interaction and activities in different parts of the service, as well as following the different ways clients used the service; (2) following the health education courses that were arranged for the voluntary clients for the prevention of drug-related harm during or outside the opening hours (altogether four courses); and (3) interviews that handled various themes from the prevention of drug-related harm and the realization of harm-reduction policies to user and employees' views about the current service system and about the activities that took place in the facility.

For the purposes of this article, I looked at parts of my data, where the users and staff discuss the possibilities of harm-reduction practices to help the users in ways other than treatment orientations, or where I made these kinds of observations myself. This was not the initial starting point of my investigation, but it turned out to be a very relevant theme. Importantly, harm-reduction services did not only provide sterile needles and syringes, but also possibilities to look at problem drug use in new ways.

In the upcoming analysis, I will interpret my data through Foucault and Shusterman's theories and provide a more systematic view of what I see could be possible harm-reduction policies to contest prevailing treatment approaches. I will focus on three themes: (1) harm reduction as a drug policy orientation, which provides drug users with a regular curriculum and a possibility to organize their lives in new ways by focusing on their physical well-being; (2) harm reduction as a set of practices that gives users a chance to think about their life and relationship with others in a new light; and (3) harm reduction as a new way of organizing the relationship between the users and drug treatment professionals.

48 Suzanne Taylor, Victoria Berridge and Alex Mold, 'WHO Expert Committees and Key Concepts for Drugs, Alcohol and Tobacco', In Matilda Hellman, Victoria Berridge, Karen Duke & Alex Mold (eds.) *Concepts of Addictive Substances and Behaviours across Time and Place* (Oxford: Oxford University Press 2016)

49 Katie Stone, *The Global State of Harm Reduction 2016* (Harm Reduction International, 2016)

Results

Finding structure and content in life with the help of harm reduction

While reading Foucauldian analyses of power and societal governance, one cannot escape the conclusion that administering to the well-being and health of individuals in contemporary societies is something negative: a way of achieving societal order or suppressing individuals. Also, harm reduction, as was shown earlier in the article, has been described as this kind of discipline. In my data, on the other hand, what turned out to be one of most interesting feature of the harm-reduction service was its ability to provide users who came to the facility with the chance to organize and structure their lives in a context and an institutional surrounding that made sense to them and gave content to their lives.

During the first week of my fieldwork, I described my impressions about the facility and its clients in my field journal as follows.

> *"The clients came to the facility for various things, not just for clean paraphernalia. The organization of the service is surprisingly smooth and predictable. I am already familiar with the routines and wishes of some of the clients. One regular visitor uses thick, 0.8 mm needles while injecting, which the staff does not recommend, but the man insists on. There is always a small discussion around that when he comes to the facility, but the workers do not want to moralize. "We try to softly direct and lure them into making healthier choices," one of the workers explains to me. One, on the contrary, is terrified of injecting, and wishes for as thin needles as possible. One is waiting behind the door every morning, when the facility opens at noon, and comes mainly for food and a chance to talk to somebody. Everyone I meet and get a chance to talk to greets the service. "This is the best place in town, write that in your book," "This facility has saved my life," and "I would be in the gutter without this."*

From the point of view of the Foucauldian discussion on the care of self and Shusterman's somaesthetics, a noteworthy aspect of users' views is that, instead of feeling as if they were being supervised in the facility or obliged to concentrate on their health, many clients told me that they "finally" had the possibility to take care of their health and themselves. Many of the clients came to the facility regularly, 2–3 times a week, and some of them could spend the entire opening time (four hours) there. Some popped by many times during the day. My interviewees told me that coming to the service provided them with "a timetable," as well as access to information they said they had not had before. "I can spend my days here, instead of at my flat. And there is always something interesting going on here," as a young man in his 20s summarized his feelings about the service to me.

Shusterman[50] discusses our culture's deepening preoccupation with the body and its well-being. I realized very soon that the clients of the harm-reduction facility shared this preoccupation and strived for better health and life, in spite of their drug use. For example, many wanted to be tested for HIV and Hepatitis C regularly and were generally worried about their health. Many considered drug use as an "addiction disease," from which they suffered, and wanted to take as good care of themselves as possible, despite their condition. For example, in the interviews, many described how relieved they were when the HIV test result turned out to be negative. "It would have been a death sentence. I could not have dealt with that," as one of them summarized his feelings to me. The nurse of the facility described that the testing situations

50 Shusterman, 2000

were always very emotional. According to her, the relief of a client after the test turned out to be negative showed as a relaxation of his/her entire body and appearance. "They don't want to die. In fact, I think that they are survivors and very strong people, who have kept themselves together in conditions, which are sometimes intolerable. We try to direct this energy toward healthier things," she continued.

The exchange of clean needles and syringes had become "a matter of the heart" for many, and some had also started to exchange clean paraphernalia among their peers who didn't visit the facility, gaining in this way status and experience as peer workers and harm-reduction experts. This work also provided a clear structure to their lives. One of the most active clients, a woman in her 40s, explained to me her relationship with the service as follows.

> "*I come here every Tuesday and Friday to change clean paraphernalia. I am a "super exchanger", so I get to change 300 needles and syringe at a times, whereas the other ones get to change maximum 40 at a time. On Mondays and Fridays I exchange needles and syringes among my friends and then I bring the used ones back here.*"

I followed her use of the facility throughout my entire fieldwork period. She had started to use the services a little more than a year before and was already very familiar with the staff, calling them "my angels." Although she did not quit using drugs during my research period, her use was much more under control by the end the research period than at the beginning. She had also become an active member of the user organization that was founded by the clients of the facility during my research period, as well as one of the first "peer workers" to accompany the facility's staff to different harm-reduction lectures and events, both in Finland and other parts of the world.

One of the nurses at the facility explained her impressions of the meaning of the service and the work done there:

> *"There is so much potential in these people (the drug users). And here (in the facility), it becomes visible as we take them as they are, and they don't have to pretend that they are not using or that they want to recover. It is very liberating for many.... Many of them also strive for a normal life and better health, and are happy that they have the possibility to come here to pursue these things.*"

One of the benefits of the service was that it was seen as being neutral in its orientation. Clients often compared the service with other services by saying that, in other treatment institutions, one was supposed to answer a list of questions before "getting down to business," "how much [drugs] you have consumed and so on," as on one of my interviewees explained. Instead, at the facility, the focus was on everyday matters and problems of the users. What the clients appreciated in particular was that they could receive information on what was really bothering them, whether it was high blood pressure, a mysterious rash, or how to look after yourself and your friends while injecting.

From the viewpoint of Foucault's care of the self and Shusterman's somaesthetics, it was interesting that all of this happened through various practices that were somehow regular in nature, although not codified. For example, needle exchange was seemingly an important ritual for many. Not only did the user receive clean paraphernalia, he/she also had the possibility to ask the staff about different topics linked to injecting, which method was safe, what kind of needles

should they use, and so forth, as well as have contact with someone. Later, the service started to supply harm reduction opioid maintenance treatment, which many clients saw as "life saving." According to them, they received not only medicine in this treatment, but also a regular and stable structure to their lives.

The facility manager reflected this in her interview. Life for the clients was often chaotic and even violent outside the facility, but inside they had the possibility to reveal their "soft" side and relax for a while. I wrote in my field journal after one particularly nice and relaxing afternoon (May 2007) that many of the clients seemed to enjoy the possibility of just sitting and spending time in the facility and looking at other people, which, in turn, was something that made them feel "more normal" or an "ordinary human being," as many of them often sighed. The feeling of normality, for its part, was for many the first step toward a life without drug use or, at least, toward a more controlled use.

Next, I will look more closely the therapeutic effects services operations had on the clients.

Feeling like "a human being" again

According to Shusterman,[51] the body needs care in many ways and for many reasons. For drug users who came to the harm-reduction facility, care was something that made them feel like a "human being again."

A very important element in creating this feeling was, first, the fact that the staff did not fear or judge the clients in any way. This was a deliberate policy that was regularly discussed by the staff. The clients, in turn, saw this as the staff's respectful attitude toward them, which they appreciated. Many were ashamed of their bodies, which often had bruises and infected needle marks. Some of the clients had lost their limbs and sat in wheelchairs or had walkers. Many had bad teeth caused by their drug use. In the facility, however, the clients and their injuries were always addressed in a very polite way, and the staff made a concerted effort to ensure that the clients felt accepted and as normal as possible.

A nurse working in the facility explained to me her views of what took place in the facility:

> *"They (the clients) sense that their problems are taken seriously here. If they go to for instance emergency rooms, they are often turned away, because they are intoxicated. Also, all of their troubles are almost always interpreted through drug use, which they should stop in order to receive help. Here we help them without conditions. It is seemingly liberating for many to be treated like a regular customer, who has issues with his/her health, and not just a "junkie"."*

A female client in her 30s discussed the meaning of the service and compared its orientation with the stereotypical notions of drug users in a very similar manner:

> "*The discussion goes always like "drug injecting is a death sentence" and that person will use drugs "forever". Some people do live on the streets and have a lot of problems for sure, but many also have homes and, you know, we watch television and all (laughs). Here (in the service) I get information, which I can really use of in my everyday life.*"

Our discussion was brief and the woman did not explain further to me what kind of

51 Shusterman, 2000

information she was talking about. The discussion, however, took place during a health education evening, where the woman participated actively in the discussion about the prevention of overdose deaths and the use of emergency services in these kinds of situations.

A man in his 50s explained to me his transformation as a "paradox." Before starting at the facility, he had tried many treatment orientations, but always left them "in anger."

> *"There is no use in controlling and forcing a person to do something, if he hates authorities, you know".*

He continued to describe that, in the facility where this kind of coercion did not exist, for first time, he took responsibility for himself by himself:

> *"First, I came here once and a while to exchange needles and syringes. Then I started to talk to some of the workers about the educational leaflets that were available in the facility and commenting on them. You know, how they depicted drug injecting et cetera. Then I got interested in peer work and here I am now, a chair of the user organization."*

From the point of view of Shusterman's somaesthetics, it was interesting that concentration on physical well-being seems to liberate clients from constant reflection on their drug use and life in general, which they found relaxing. Many of the clients described the facility as their "home" or "closest thing to home," where they were looked after and got help without conditions. Vice versa, they did not have to "pretend" to be sober or want to end their drug use. Harm-reduction orientation also provided them with opportunities to help others besides themselves. In the following excerpt, one of the peer workers of the facility, a woman in her 40s who was in opioid substitution treatment, described her activities:

> *"I just took this one girl to a birth control clinic and on Wednesday I escorted this one to a drug treatment evaluation. Now, I was able to bring these three girls here from their apartment. Just to get them out of there. I have some clothes reserved for them [...]"*

These kinds of accounts come close to Foucault's ideas of care of the self as a collaborative effort, where an individual's relationship with him/herself and others is rethought and refashioned. As demonstrated earlier, drug users are often depicted as tough and amoral criminals, incapable of living as or with normal people. I, on the other hand, observed very early that many of the users were as caring as any other person and also wished to be taken care of.

The question arises, can we strengthen these kinds of elements in treatment somehow? In the last part of this chapter, I will look more closely at some of the factors in the operation of the service and particularly in the operation of its workers that helped the users acquire new things and perspectives in life.

Towards new professionalism

I have written elsewhere that the emancipatory nature of the facility owed a lot to its nature as a place that had more faith in the drug users' own initiative than average drug treatment facilities. The clients were not pressured to do anything against their will. Instead, the employees wanted to give them time to get used to the facility and staff, and take the initiative when they felt like

it.[52] For me, this was very surprising at first, because problem drug use is often depicted as a total lack of interest toward anything else other than drug use.

According to the staff, it is important to gain the trust of the users who came to the facility. Without trust, as clients explained to me, it was useless to promote any other goals. However, if trust is gained, many a user reveal a new side. The following story by a social worker resonates well with Foucault's ideas of care of the self as a relationship that strives for an individual's self-realization with collaborative, not coercive, methods and demonstrates the positive effects that efforts to build a confidential relationship with a client can have:

> *"This one man came here almost every day for a couple of years and just exchanged needles and syringes. Didn't say a word and looked like he wanted to kill everybody. But I always greeted him, said hi and goodbye and see you again. And then one day he started talking. And there was no end to it (laughs). It's was like a lamp had turned on in his head or something. Now he is one of our most active peer workers."*

Other employees told similar stories. In them, particularly three themes stood out as relevant. First, the workers did not do anything special, but just were there for the clients. What was particularly important was that they had time and "did not look at the clock all the time." Second, clients started to change their behavior, if they were given enough chances and, again, time and space to do this on their own terms. Third, clients appreciated that they were not treated paternalistically in the service, but were treated as adults who could make their own decisions and judgments. Many of the clients, for instance, stated that they wanted "information," not "moral guidelines." Also, the clients easily saw that, if they were looked down on by the employees or if their judgment was questioned, it became a situation that usually led to the client leaving the service in anger. This, however, did not take place often, as the employees knew how to be careful and not offend the clients.

In fact, I was often very surprised how close and playful the employees were with the clients, as the sociological classics had taught me that the most crucial features in the operation of different treatment institutions was the conflict between the clients or "the inmates." One of the employees explained her working orientation in the interview in the following way, which comes close to Foucault's ideas of care of the self as an equal relationship between the individual and her/his aid:

> *"I use elements of friendship in my work. I talk with the clients about regular stuff that takes place in their life and in my life as well, such as films, pets, music et cetera. After a while, they get interested in the other things we have here as well, which is of course my ultimate goal. But, I'm not cheating them or anything. I truly enjoy discussing about things with them, and many of them are very bright. But of course, there is also a professional orientation on the background as well."*

According to another employee, the lack of the "controlling function" gave the clients the possibility to work with the workers more openly than they can with the representatives of the social services and other public institutions. As she explained, "they don't have to, for instance, lie to us that they don't use drugs, and they also feel that they can tell us other unpleasant things about their lives."

52 Anna Leppo & Riikka Perälä, "User Involvement in Finland: The Hybrid of Control and Emancipation" *Journal of Health Organization and Management* 23:3 (2009), pp. 359–371

Different first aid training and overdose prevention education evenings and workshops were very popular among clients. In somaesthetic terms, these activities could be described as a combination of analytical and practical somaesthetics, where the clients were first taught about their body's various functions, and then, how to take care of the body through different practical measures. I attended four of these evenings, and they were an eye-opening experience for me in many ways. What was especially surprising for me was how engaged the clients were in these evenings and how actively they shared their experiences and thoughts about the themes that were handled in them. Many of the clients liked one anesthesiologist in particular, who used scientific terms while discussing overdose prevention and did not paint moralistic pictures of the harms of drug use. "You are pretty different from the others doctors I've met," one of the participants told him during one session.

The leader of the user organization described his feelings about the course and similar activities:

> *"Finally someone has realized that, hey, let's involve the drug users in the development of the services as well. It was "a stroke of genius" in many ways. I mean, my god, how good it feels when you are asked to be part of something."*

Conclusions

In this article, I asked first why it is sometimes so difficult and, in some cases, even unthinkable to apply new and alternative approaches, such as heroin-assisted treatment, to deal with drug problems and drug addiction. The second question was, is it possible that we have overlooked some important issues regarding the drug users' health, well-being, and their maintenance and, because of this, contributed to their degradation?

As for the first question, I demonstrated how according to the traditional and stereotypical understanding of addiction and problem drug users, it is still even impossible for us to see that drug users could be interested in maintaining their health and be capable of looking after themselves and each other. However, as I demonstrated in the empirical section, even the most problematic drug users seek a better health and life if there are proper chances and infrastructures available for this. Working with the user's physical well-being, in particular, seems to resonate well with many of the users' needs to be taken care of.

In light of my analysis, there is considerable potential for somaesthetic thinking in the field of health and social policy, particularly in the work with people living on the margins of society. As shown in the article, addiction treatment has traditionally been about dealing with one's inner pathologies, using different psychiatric and psychological methods. This "confession" leads to recovery, as the addicted person sins against him/herself and others. Yet, as I have demonstrated, the focus on the body can be a more neutral tool for recovery, while also providing people who suffer from addiction with ways to live with their addicted body.

The use of Foucault's ideas of care of the self has emphasized factors in harm-reduction measures that have provided professionals with tools to reach problem drug users without coercive or involuntary methods. There is already quite a lot of research on the political activism of drug users in the harm-reduction field, as well as public-health-oriented research about the effectiveness of harm-reduction measures. The focus in my analysis has been on the actual, everyday practices of harm reduction, which have been discussed and investigated less, but could offer important insights into how to deal with drug problems in future.

Particularly significant themes in users' paths to transformation in this analysis have been employees trust in users' own initiative, the respectful attitude of the employees toward them, and the close collaboration between the clients and the employees over users' health. The harm-reduction facility was, in many ways, a community, where the users were welcomed as they were, and where they were helped and taken along without too many conditions. Contrary to many analyses, use of medical knowledge was also considered liberating, providing the users with information on their condition and tools and daily structures that helped the users live with them.

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