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Non-hierarchical experimentation: the outpatient treatment of drug-using young people in Finland, 1969–75

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In 1966, the social physician Lenni Lehtimäki described the drug scene in the capital city Helsinki by concluding that 'narcomania' in Finland was of 'luckily modest proportions', although he emphasised that it was important to monitor this phenomenon, which was also referred to as an 'epidemic disease' (Lehtimäki, 1966: 128). In the latter half of the 1960s, the extent of drug use in Finland changed significantly. The new drug scene was primarily young and experimental, emphasising psychoactive drugs, particularly cannabis (Hakkarainen, 1992; Salasuo, 2003). However, there was also a user segment that took drugs on a more regular basis (Kainulainen *et al.*, 2017; Parhi, 2021), and fear among the public that the phenomenon would spread was evident.

This chapter analyses the development of expertise in treating drug-using young people in the metropolitan area of Finland. The focus is on the role of psy-sciences[1] in new forms of outpatient care, which were situated on the border between social work and medicine. The main argument is that the psy-sciences exerted a major influence on drug treatment, but not directly. Instead, they were embedded in practices that stemmed from various sources, such as folk healing, the Mental Research Institute in the United States and therapeutic communities. The influence was also reciprocal; the subculture that influenced drug use internationally also influenced psy-sciences (e.g. Halliwell, 2013: 260–87; Richert, 2019).

Drug use in Helsinki proliferated earlier than in the provinces, which explains why it was also the main location for new treatment

experiments. At the time, the drugs varied significantly; for example, according to a list collected by medical students in 1969–70, 156 different 'misused drugs' were found, grouped into analgesics, antihistamines, psychostimulants, antipsychotics, muscle relaxants, sedatives, cough medicines and others (Parhi, 2023). This chapter introduces two significant facilities: Arkadian (poli)klinikka (henceforth the Arkadia Clinic) and Nuorisoasema (henceforth the Youth Station), set up in 1969 and 1970 respectively. Both were popular among young people. For example, in 1970 alone, 1,207 clients attended the Arkadia Clinic, and the Youth Station reported 484 visits (*Tietoa huumausaineongelmaan*, 1972: 6). In 1976, these facilities were merged into one due to Arkadia's financial problems (Ahonen, 2005: 192–3). Around the same time, the number of drug-using people dropped. Finnish drug policy scholars refer to waves of drugs; the second wave emerged only in the latter half of the 1990s (Hakkarainen, 1992: 58–72; Partanen and Metso, 1999: 143–9).

This chapter builds on oral history sources, supported by archival data, research reports and published sources. The oral material consists of three semi-structured interviews with experts who witnessed and took part in developing treatment for young people aged between 13 and 25 in the 1960s and 1970s. Their own experiences have a focal role in the analysis – without trying to find the 'historical truth', these personal understandings of the past (see Haapala, 2021) are tied into a commentary on expertise and its formation through experimental practice. The interviewees would possibly not call themselves experts; they typically had their own ideological ways of defining their roles in drug treatment. In defining expert position, I follow the sociologists Michael Meuser and Ulrike Nagel, who define expertise as active participation. The status of an expert goes beyond the professional role and includes actors who acquire special knowledge through their actions because they have privileged access to information. The information is derived from structures of relevance – insider groups and networks (Meuser and Nagel, 2009: 18–31). The interpretation of expertise is rendered flexible by this definition, which is crucial in understanding drug treatment at the time. It also helps in rethinking drug treatment historiography, which tends to focus more on political and academic debates than on those working in the field and on the practices there.

The historian Johan Edman has characterised Swedish drug treatment from 1968 until 1981 as heterogeneous and as primarily an ideological rather than a therapeutic project (Edman, 2013). While this characterisation also relates to neighbouring Finland, the following sections exemplify how experimentality characterises Finnish drug treatment far more accurately. The first section introduces the facilities, the three interviewees and their professional positions. The second section analyses the variety of approaches in treating drug-using young people in the facilities. The third section focuses on the development of expertise through experience and sums up the perspectives adopted by the interviewees as most suitable for their work. Overall, the sections demonstrate processes of professionalisation and discuss expertise based on actions.

The original principles

Both facilities, the Youth Station and the Arkadia Clinic, were established as alternatives to traditional institutions, such as prisons, reform schools and mental hospitals, and were experimental from the outset. The idea was in line with the international process of deinstitutionalisation which assumed many forms (for Finland, see Korkeila, 1988), and applied to young people in particular as it was believed that those in need of the new services had been institutionalised earlier in their lives. The new services should thus be positive experiences in comparison to institutions, i.e. non-hierarchical. Medical expertise was needed in both facilities, but it was to be offered in a non-hierarchical way.

Despite the experimental nature of the facilities, establishing new forms of outpatient treatment was in line with state policies. From a legislative point of view, developing outpatient care was seen in a positive light, as both the Act on Public Welfare (Huoltoapulaki 116, 1956) and the Act on the Treatment and Care of Abusers of Intoxicating Substances (Laki päihdyttävien aineiden väärinkäyttäjien huollosta 96, 1961) encouraged the use of outpatient services. Since the 1930s, the national treatment of alcohol abuse had been based on social work. The operations can be characterised as strict social control (Rosenqvist and Stenius, 2014: 552). The Finnish 1961 Act on the Treatment and Care of Abusers of Intoxicating Substances

used the term 'intoxication' to refer to the treatment of alcohol and drug problems. Drug users, who had had very few treatment options prior to the passing of the Act, were thus included under the same category as alcohol abusers. Even after the change, the number of treatment facilities for drug users was still scarce. Some experts by experience have confirmed this in interviews about their experiences in the 1960s and 1970s (Rönkä, 2017: 175–6). None of the existing facilities were geared specifically to young people, which is not surprising given that use among young people was rare. Before World War II, drug abuse in Finland had been uncommon in general (Ylikangas, 2009). Until the mid-1960s the total number of users remained low.

Throughout the 1960s, drug use increased internationally (e.g. Stephens, 2003; Marquis, 2005; Marchant, 2014), and the situation in Finland, too, gave rise to concern. On 14 April 1968, the Finnish government set up a committee to gather information about drugs and to find means for treatment and prevention. The committee believed that voluntary care would be more successful than 'official' forms of care in reaching drug-using young people and achieving results in their treatment, so it recommended increasing the voluntary treatment options and experimenting with novel methods. Among other suggestions, the committee recommended that the A-Clinic Foundation establish a youth station and a care home for recovering drug users (Committee on Narcotic Drugs, 1969: preface, 180–1). The A-Clinic changed the foundation's regulations to include young drug users, who were characterised as 'intoxicant abusers' (Ahonen, 2005: 185). The A-Clinic Foundation, founded in 1955, was and remains a non-profit, non-governmental organisation for the prevention of substance abuse. It differed from the strict social control characteristic of Finnish alcohol abuse treatment at the time, and instead it laid the foundation for therapeutic social work (Toikko, 2005: 183). The foundation's outpatient care was progressive and can be characterised as psychosocial, which meant focusing on the individual's psychological and social issues (Kuusisto and Ranta, 2020: 122–5). In 1970, the A-Clinic Foundation opened youth stations in various cities. The Helsinki Youth Station was an outpatient unit with sixteen beds for inhouse treatment.

One of the interviewees, Tapani Ahola, is a social psychologist who worked at and led the Youth Station from its beginning until

the 1980s, initially while still a university student. Among the most important principles of the Youth Station Ahola mentioned was that it was not led by physicians – 'it was not medicalised in that sense' (Ahola, 2019). The Youth Station clients had the option to remain anonymous, and the station contacted family members or officials only with the client's consent. The aim in interaction between staff and clients was to create trusting relationships and provide information (*Medisiinari*, 1970: 5). According to the A-Clinic Foundation, young drug users perceived other existing services as 'alienating and undemocratic' (Mattila, 1970: 8–9). Dr Katriina Kuusi, the second interviewee from the Youth Station, was recruited to work as its physician in 1969. At the time, she was in her twenties and had qualified as a general practitioner. The Youth Station preferred general practitioners to psychiatrists (Sirén, 1977: 27–8).

Similarly to the Youth Station, the Arkadia Clinic, named after the street Arkadiankatu, where the first premises were located, was founded after alarmed discussions: the city officials in Helsinki had raised concerns about young people and their use of drugs. The Mannerheim League for Child Welfare, which was and remains an NGO promoting the wellbeing of children and their families, suggested organising first aid services for young drug users. The league recruited one of the interviewees, Aulis Junes, described in the clinic documents as a deacon and a social worker, to lead and plan the operations of the Arkadia Clinic. The Clinic was characterised by the league in 1969 as 'the first and unique experiment to help drug-abusing children and young people', up to twenty-five years of age. Among the early treatment strategies were training former substance users to work at the clinic, and operating as a 'non-hierarchical care community' that learned from experiences in the field.[2]

The Arkadia Clinic staff consisted of social workers, a psychiatrist, a general practitioner, a psychologist, and medical and psychology undergraduates. Despite the availability of medical expertise, no medical procedures were conducted at the clinic. If there was no risk of unconsciousness so hospitalisation was not necessary, the clients could sleep at Arkadia for one night, and the following day they got a chance to talk. The staff helped in contacting parents or officials, if needed.[3] The psychiatrist Dr Pekka Sävy characterised the role of the psy-sciences: 'The therapeutic work is done almost entirely by social workers and psychology undergraduates – the

psychiatrist and psychologist acting only as consultants' (*sic*).[4] While leading the Arkadia Clinic, Aulis Junes opposed prescribing medicine: 'I did not want to medicalise the place', he recalled, and positioned himself in opposition to biological psychiatry. 'I said we don't write prescriptions, we heal people with the mind, not with drugs' (Junes, 2019).

Chaotic beginnings

Both facilities experienced a disorganised beginning. The problems concerned a lack of experience. According to a research report on the first year of the Youth Station, the staff were 'young and open-minded, but inexperienced', and got 'the opportunity for quite some time to independently, by trial and error, search for guidelines' (Sirén, 1977: 7). The staff felt that the situation was not entirely under control (Ahonen, 2005: 187–8). The interviewees Ahola and Kuusi confirmed this in their interviews: 'We had no fucking clue … We took in everyone off the streets and then we started wondering [what to do]. It was total chaos', Ahola reminisced. He remembered a night shift when out of sixteen people staying in the care home of the Youth Station, twelve were tripping (Ahola, 2019). Kuusi elaborated the feeling of an uncontrolled beginning: 'We were too gullible.' Someone stole her expensive suede jacket and Kuusi believed it was sold or traded for drugs. Many people came by and, according to Kuusi, the staff did not know who was there for treatment and who was just hanging out. The open doors operated on a 'low threshold' basis so that it would be easy for anyone who came to ask for help. The staff did not test the clients for drugs enough. And some of the Youth Station inhabitants would suddenly disappear. The constant surprises sapped most of Kuusi's energy.

According to Kuusi, the group meetings, inspired by Maxwell Jones's idea of therapeutic communities, were chaotic. The rules at the Youth Station had been made together with the clients, and Kuusi thought in retrospect they were cruel. For example, others wanted to eject inhabitants who relapsed (Kuusi, 2019). According to the psychiatrist Matti Isohanni, therapeutic communities had been increasingly accepted in Finland since the 1960s after the psychiatrist Veikko Tähkä adopted ideas about therapeutic milieus

from Austen Riggs in the United States at the beginning of that decade (Isohanni, 1983: 32–3), and since then they have continued as a form of drug treatment (e.g. Selin, 2010a). The Youth Station, however, was only learning how therapeutic communities worked.

The new staff received professional training before the Youth Station opened. According to Kuusi, at the time the ideology was that young people understand other young people (Kuusi, 2019). The average age of the employees was 24 (Sirén, 1977: 32). Initially there were thirteen employees, and the number grew to seventeen by the end of 1970. It is noteworthy that twelve people resigned during the first year (Sirén, 1977: 32–3). The theoretical training included lectures by experts in different fields, study visits, seminars, studying literature and introductions to various treatment models. The training also included practical training in existing institutions and organisations such as A-Clinics, the Arkadia Clinic and the Hesperia Hospital (Mattila, 1970: 8–9). According to Kuusi, she was trained for the job before the Youth Station was established, but in her opinion no one knew how young drug users should be treated. She recalled a demonstration of a therapy session as part of her training: 'It was pseudoanalysis, playing analytic therapy without proper training.' She remembered criticising how one should also talk about the drugs. Kuusi argued that the only thing she remembers from the training was how skilfully the patient in the demonstration, not even a drug user but a person with a history of alcoholism, spoke 'psy-language' (Kuusi, 2019). The expertise available in the form of professional guidance was of high quality, 'the best that was available in the country', Kuusi said, but in her view the problem was that even the experts – the psychoanalyst Pirkko Siltala and group and family therapist Heimo Salminen – did not know how to treat young drug users (Kuusi, 2019).

The use of prescribed drugs in the Youth Station was modest; some were used when the client was suffering from withdrawal symptoms or if the symptoms were psychotic. Mostly, the staff organised group meetings and private discussions. Kuusi remembered ideological differences. At first, the A-Clinic, which was responsible for the personnel training, was in favour of a psychotherapeutic approach. 'We tried to do family work, but no one at the time was trained for family therapy … We should have had firm structures for implementing it', she said (Kuusi, 2019). Family therapy was

developed in the United States in the 1950s and 1960s. The core idea was to search for the source of pathology in family interaction (Weinstein, 2013: 2). According to the interviewee Tapani Ahola, the Youth Station initially tried to adopt the idea of homeostasis, which referred to the family dynamic in coping with addiction: when one family member got clean, another fell ill (Ahola, 2019). Originally, the concept of homeostasis had been used in connection with the ability of an organism to self-regulate, but the idea was used as a way to explain the family's internal environment, an inner capacity to register and counteract deviations (Weinstein, 2013: 52, 59–60). Ahola did not look back fondly on his memories about their homeostatic interpretations: 'It was awful. If I ask, why does your son take drugs, there is an indirect accusation in the question. Asking "why" produces an explanation that includes accusations – in practice' (Ahola, 2019). Ahola remembered how attempts were made to separate young people from their drug-taking peers, but he thought this should not be done by force: 'I quickly realised that their most important relationships were, well, they had families, but many of them came from broken homes. Their peer group is important at a certain age' (Ahola, 2019). In addition to paying attention to the importance of their peers, Ahola realised that daily routines were crucial: studying and working were efficient forms of social control. Some of the clients travelled in big Nordic cities such as Gothenburg or Copenhagen: 'They started living outside society, there was no control in a positive or negative way. It became absolutely crazy', Ahola recalled (Ahola, 2019).

During the first days of the Arkadia Clinic in April 1969, no one showed up; but when a local gang heard about it and spread the word, the facility soon became crowded. According to Arkadia Clinic reports, the operations were initially 'informal' and the employees hosted callers and served them tea and beef broth. Problems followed when the gang members started using the clinic as their regular base, and during the first summer there was also drug use on the premises. Some clients used the clinic as their base at night, borrowed money and drugs during the day, loitered on the beach, and then returned to the Clinic. In November the same year the staff made new, tighter rules, which significantly reduced the number of clients.[5]

The interviewee Aulis Junes saw himself as a folk healer and his approach at the Arkadia Clinic was what he understood to be folk

healing. 'Folk healing' is the term Junes used at the time I interviewed him in 2019. His idea of folk healing, however, is in line with his views presented in the Arkadia Clinic records in the 1960s and 1970s: he emphasised a critical approach toward the psy-sciences, preferring presence, warmth and respect, which he associated with folk healers. The sociologists Meuser and Nagel refer to new forms of knowledge production that loosen the link between expert knowledge and the professional role. They refer to a development that has occurred since the 1960s, heading towards a growing scepticism regarding science (Meuser and Nagel, 2009: 20). Aulis Junes had a leading role in this perspective as he took an active part in public and among drug-using young people and was portrayed as an expert on problem youth. This expertise was also criticised. According to Junes, for many, he was too 'unorthodox' in his work (Junes, 2019). In the interview, Junes saw himself as antiauthoritarian – besides referring to himself as a folk healer, he also considered himself an anarchist. Junes's antiauthoritarian attitude was evident in the way he educated the clients. He compared himself to Socrates in Plato's park academy as he let the young people read psychiatric, psychoanalytic and cognitive literature. His idea was to avoid 'outsider consultants' and to work with other employees as a group. Junes emphasised how he wanted to avoid leadership. As an anarchist, as he underlined, he was inspired by Erich Fromm's interpretation of a strong ego. 'I did not want to be an authority at the clinic. If someone with a powerful ego like myself, a narcissist, is an opinion leader, he will soon be wearing jackboots, jodhpurs and a cheesecutter cap, and raising his arm in salute' (Junes, 2019). Junes thought that his recruits – former alcoholics and drug users – were experts in interacting with the young people. He juxtaposed medical expertise and expertise through experience: 'I took an old skid row alcoholic to work as a janitor … He had been sober for two years already. He was extremely good, like a grandfather there … He was so calm. An outsider asked if he was the clinic doctor? I said yes, kind of' (Junes, 2019).

In the course of time, the Arkadia Clinic introduced new activities, including summer camps, peer counsellors in schools as a preventative measure, an outpatient centre for clients and their families, guidance on finding accommodation, a group home, and field social work for young people who needed help but did not come to the clinic.[6]

In addition, the Arkadia Clinic had a sobering up or detoxification station. Although some of the Arkadia Clinic experiments were less successful than others, the Clinic psychiatrist Pekka Sävy did not perceive the experimental method in a negative light in 1970: 'Nobody had any experiences of treating these young abusers of new drugs in Finland. Old methods were inadequate. Models of functioning in other countries were probably not valid in Finland. The personnel had to start experimenting without prejudice by using flexibly the trial and error method' (*sic*). Even more so, Sävy deemed it a necessity: 'The experimental aspect is important because it gives us fresh and direct information about the out-patient treatment of drug abusers. Maybe private institutions are best: they are allowed to make mistakes and learn from them whereas government authorities don't even know that such process exists, mistakes are not allowed, that is admitted' (*sic*).[7]

Learning by doing

As the staff gained more experience of young people and gathered more information about ways to help them, they found new approaches which worked well for them. Katriina Kuusi's experience at the Youth Station may have been troubling for her, but around the same time she became increasingly interested in democratic communities, which were inspired by antipsychiatry. Already in 1970, Kuusi started to work part-time in Veikkola, which was a private psychiatric hospital that was also known for taking in drug-using young people. After a while, Kuusi was offered a full-time job there, and she left the Youth Station in 1971. Based on her article on youth in treatment, published in 1972, it seems that Kuusi preferred Veikkola's heterogeneous sample of patients, as she criticised communities with patients based on one symptom or characteristic: 'No one is just "young" or an "alcoholic". Instead, there are a lot more important common characteristics between individuals' (Kuusi, 1972: 122).

Kuusi admitted retrospectively that she escaped from the Youth Station when she got a chance to work full time in Veikkola. The Youth Station left its mark: 'For some years after the Youth Station experience, when I passed the place on the bus, I felt uneasy in my

stomach. It was rough' (Kuusi, 2019). Kuusi compared the inexperience of the Youth Station to the more experienced staff in Veikkola. According to her, some social workers in the Youth Station came straight from university with no experience of working life. Moreover, she thinks that Veikkola also had more authority than the newly founded Youth Station because it was a private hospital, and hospitals as such were organisations with long, respected traditions. 'Health care enjoys a much higher status in our society than social care, it makes no sense to claim otherwise!' Kuusi concluded (Kuusi, 2019).

For Katriina Kuusi, her work experience in Veikkola sanatorium was a significant phase in her life: 'We felt we were part of an international reform movement, that gave us more energy, that we have to do something about hospital democracy in Finland' (Kuusi, 2019). Veikkola sanatorium evoked interest in international spheres and Kuusi remembered visitors such as Thomas Szasz, the Italian psychiatrist Franco Basaglia and David Cooper. According to Kuusi, Basaglia's work in the Gorizia asylum[8] was of particular inspiration to her and the physician-in-chief Claes Andersson. The main idea in Veikkola was to have a democratic community. The treatment included compulsory meetings, groups and family meetings. Kuusi was particularly proud that the first patient association was established in Veikkola (Kuusi, 2019). Since the 1970s, Kuusi has had a long career as a psychiatrist and family therapist (Kuusi, 2019).

Tapani Ahola continued working in the Youth Station, but he adopted the principles of brief therapy, an approach that focuses on the present. Frykman was close to Milton H. Erickson, an influential psychiatrist and psychologist, referred to as the father of modern clinical hypnosis and known to have influenced brief therapy, solution-focused brief therapy and neurolinguistic programming (Gorton, 2005). Frykman had been the founding director of the drug treatment programme in Haight Ashbury Free Clinic in San Francisco, California. During his visit to Helsinki, Frykman described his methods and thus introduced Ahola to brief therapy (Ahola and Furman, 2014: 21–2). This is how Ahola learned more about the Mental Research Institute and its form of family therapy, which differed from homeostasis. Ahola was fascinated by the Institute's take on problems: 'They studied what people do when they successfully solve problems. Not what causes them' (Ahola, 2019). Brief therapy training began in the 1980s and Ahola was one of its

significant advocates. His brief therapy institute Lyhytterapiainstituutti, founded in 1986, has also published a version of *Uncommon Therapy: The Psychiatric Techniques of Milton H. Erickson, M.D.* (Haley, 2016) translated into Finnish.

Ahola perceived brief therapy as an alternative to psychodynamic therapy: 'The most common model to solve problems has been causal-linear thinking: problems have been explained by other problems. If you take drugs, they study what other problems you have. In the 1960s, we had this psychoanalytic, psychodynamic thinking.' Brief therapy did not focus on problems: 'They never ask, if you go to their appointment … "what is your problem?". They ask, "what would be a good result from this conversation?" There is a wish to change built into every problem.' And life could be good without long-term therapy, which could help some people, but not enough: 'Even when people do stupid things, there is the goal of a good life in the background, and they have the right to it' (Ahola, 2019).

Ahola was critical in the interview of psychiatric treatment of drug problems: 'Traditional psychiatry cannot cope with substance users and asocial ones. The system, the psychiatric hospital system, does not work, it breaks down.' He characterised psychoanalytic psychotherapy as a pessimistic way of thinking, which he associated with incompetence: 'When I started doing brief therapy, I bragged about it at the psychiatric clinic. When they said there are hopeless cases, I said bullshit, there are no hopeless cases, only hopeless employees. They said they have such clients and I said, send them to me, I'll take care of them' (Ahola, 2019).

The Arkadia Clinic legacy as the pioneer of youth drug treatment is evident because various city and child guidance officials recognised its importance in documents preserved among the Arkadia Clinic records. At the same time, Junes's contrary character seems to have hampered the reputation. In December 1975, Aulis Junes defended the Arkadia model. He characterised it at that time as a 'treatment chain including a detoxification station and an outpatient clinic, attached to the contact centre, group spaces, operations for acquiring a home, and to the youth hotel'.[9] According to Junes, the most important aspect of the treatment chain was that there were employees acting at different stages of the chain, creating long-lasting relationships. Junes characterised young drug users as people with many problems. These people had experienced setbacks in their social and

emotional lives, and they had often had short-term relationships, exacerbated by periods of institutionalisation. Yet Junes proclaimed that drug treatment should not be seen as psychiatric or clinical. 'Drug use is not an artificially induced drive that is so powerful it overcomes the sexual drive, as some doctors claim. It is not an independent and separate problem or a contagious illness that anyone can get'.[10] Despite his criticism, Junes perceived the psychiatric guidance of work to be necessary because it offered the 'needed theoretical ground for the outpatient clinic'. Polyclinic procedures without coercion and fear of punishment were essential in drug treatment.[11]

In his interview, Junes stated that his method was to ask what the person wanted to talk about. He believed that solving problems in therapy was a mistake. 'When they started telling me I have this kind of problem, I used to say, that is not a problem. What you have deep down in your childhood and youth rises to the surface over time, for either good or ill.' He wanted to save children from their parents, teachers and professional helpers, and be a sensible adult in finding the right way. When the child found the right path, it was his turn to step back. 'In folk healing, the human being is seen as a whole. Instead of diagnosing the client, it is crucial to listen which concepts the client uses, and what the client thinks about life and its troubles, and his or her family, mother, and father', Junes explained. He was reluctant to 'rummage in people's mouldy cellars', by which he meant going over past events: 'There is no yesterday, no one knows about tomorrow, we only have this day' (Junes, 2019). Junes referred to the healing persona of the therapist, by which he meant a warm and humane ability to care for others, which was based on the parents' and grandparents' care in childhood (Junes, 2019).

The Mannerheim League for Child Welfare ceased to fund the Arkadia Clinic in 1976. The primary reason was financial, as the clinic had originally been designed as an experiment, and it became much more expensive than the Mannerheim League for Child Welfare had planned. However, the Clinic records also contain some hints of disputes. For example, the city of Helsinki criticised the Clinic for not having sufficient control over its operations, and there were challenges in collaboration between the various officials providing help for young people.[12] In another meeting, the staff talked about

different collaboration options. A willingness to do so was reported among the employees, but 'the differences of opinion among the directors and their desire to stay at the forefront were detrimental to co-operation in the field'.[13] Tapani Ahola recalled Junes as an uncooperative character (Ahola, 2019). Junes was unwilling to compromise, and he admitted it: 'In this unorthodox work of mine, I am a hate individual, I do not hate anyone, but I am Socrates' soulmate. I do not want to adjust in this civilisation in any way, and yet I will not drink the poisoned chalice' (Junes, 2019). Junes dedicated his life to working with young people – for example, he was one of the founders of Aseman Lapset (Children of the Station), a non-profit organisation aimed at promoting the well-being of children and young people.

Conclusion

This chapter has been a case study about two new and experimental outpatient facilities that focused on young people, a new user segment that emerged in Finland in the latter half of the 1960s. Influenced by the process of deinstitutionalisation, the new Finnish substance use-related legislation and international approaches, these facilities sought new ways to deal with the new drug user segment. The approaches in both facilities, the Youth Station and the Arkadia Clinic, were influenced by the psy-sciences. On the one hand, both facilities exemplify processes in which psychiatry was embedded in social work. On the other hand, the role of psychiatry in Finnish treatment of young drug users in the 1960s and 1970s was limited in daily practice.

The reminiscences of the interviewees extend and challenge the history of Finnish drug treatment by bringing to the fore three aspects about expertise in this field. First, if the definition of expertise in the field was based on expert appearances in public, the role of medical expertise would seem more influential and straightforward, as certain medical experts were active and significant in public debates, including disputes in the Finnish parliament (Hakkarainen, 1990: 294–8; Putkonen and Parhi, 2019: 636–7). As this chapter demonstrates, the role of medical expertise was more diffuse in daily work, and social work had a significant role. The psy-sciences were, however,

more significant in the social services field than is apparent in contemporary Finnish journals of social work and social care (see Rosenqvist and Stenius, 2014). Rather than seeing the history of drug treatment expertise as a competition for power between the two, my interpretation is closer to what the historian Greg Eghigian has termed a 'collaborative enterprise' (Eghigian, 2011: 210).

Second, if expertise was based on publications, the treatment of drug-using young people would look different. The sociologist Jani Selin has researched theories about drug use in Finnish medical publications in the 1960s and 1970s. According to Selin, psychodynamic psychiatry had a focal role in explaining drug use and addiction, and the emphasis was on the role of the family and childhood trauma as the main causes for use (Selin, 2010b: 253–5). This perspective is far from everyday treatment practice. The facilities did not focus on ascertaining the causes of drug use. On the contrary, they developed and adopted treatment methods that were based on the present moment, not the past. The interviewees all referred to the pervasive influence of the psychodynamic approach in treatment for drug addiction at the time, but in practice, not many young people encountered psychodynamic treatment. One of the interviewees, Tapani Ahola, characterised the situation as follows: 'These asocial young people, only a fraction of them is in the hands of youth psychiatry. They are in institutions!' (Ahola, 2019). By institutions, Ahola meant prisons, children's homes, and former reform schools – the very places that were seen to create the need for something different and new.

Third, the definition of expertise changed in the 1960s and 1970s. For example, Finnish physicians started discussing their hierarchical position, and the attitude toward patients gradually changed from authoritarian to more empathetic. The change was in general slow, but the field of drug addiction treatment appealed to the so-called radicals. The discussion was led by a small but vociferous minority (Aalto, 2010a, 2010b), which was also interested in the treatment of marginal groups (see Parhi and Myllykangas, 2019). The definition of expertise was in flux and the change paved the way to different kinds of professional roles. There were also structural predispositions that enabled the gaining of expertise through experimentation. Welfare scholars Pia Rosenqvist and Kerstin Stenius have commented on the increased role of the medical perspective in understanding the

drug problem since the 1990s. They compare the small Finnish welfare system of the 1960s to the mature version in the 1990s: in the 1960s, there was a general social and political mobilisation, which was conducive to open debate. By the 1990s, the welfare system had become conservative and difficult to change. This, among more obvious causes such as the medical expertise needed in opioid substitution treatment, strengthened the weight of medical expertise (Rosenqvist and Stenius 2014: 565). Another aspect that enabled experimental methods in the 1960s and 1970s was related, as Johan Edman and Kerstin Stenius have pointed out, to the social democratic welfare state: there was a general belief in structural solutions to social problems (Edman and Stenius 2013). Drug-related expertise was and is political. The sociologist Tuukka Tammi has problematised expertise in drug policy because different professions and interest groups aim to increase their power to promote the drug policies they support – Tammi refers to the 'ownership' of drug problems (Tammi, 2005). There are many layers of expertise in connection with the treatment of drug use: more recently, users have also been recognised as experts (Tammi, 2006; Mold and Berridge, 2008).

Overall, this chapter has shown that the Arkadia Clinic and the Youth Station in the 1960s and 1970s were both significant pioneers in the development of new treatment methods, and their approaches were unprecedented in the era. The experimental nature of the facilities was both a strength and a weakness: they experienced chaos, but at the same time seem to have thrived on it, as they managed to develop methods and practices that the interviewees were pleased with and have since then used in their work with children and young people.

Notes

1 Psychiatry, psychology, psychotherapy and psychoanalysis.
2 The National Archives of Finland, Helsinki, Mannerheimin Lastensuojeluliiton arkisto II, Arkadian poliklinikka (hereafter NA), S23/274, Perustamisvaiheet, 22 October 1969, pp. 1–4.
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10 *Ibid*.
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