Sweden has fewer drug problems than any other European nation. Could this be a consequence of the adoption of US drug war rhetoric? Sven Ake Lindgren argues that Swedish policy needs an emphasis on care, not control.

INTRODUCTION

The risk is increasing that a protest party could have a serious impact on the Swedish political scene during the 1990s. In addition to the usual protest issued such as reduced taxes and welfare benefits, a cap on immigration and lower alcohol prices, we can now count on a new candidate: demands for the death penalty for felony drug crimes. Fantasy? Maybe. But it is worth noting that the second largest party in the Swedish parliament today - the Conservative Party - demands life sentences for felony drug trafficking. And the death penalty is becoming an increasingly common feature in the global war on drugs: Iran, Singapore, Thailand, Malaysia, China, Sri Lanka are among the 20 or more countries that have put capital punishment into practice. If the death penalty ever does become an issue in the Swedish political debate, it will almost certainly be brought up as a weapon in the war on drugs.

From this opening, with its tone of science fiction, let’s look a bit more closely at today’s realities and the character of Sweden’s drug problem:
Drug abuse is in no way a mass phenomenon. A Government Commission on drug abuse estimated in 1979 that there were approximately 10000-14000 addicts in the entire country. Subsequent research in the three largest cities in recent years indicates no significant increase. At the same time, the average age of heavy drug abusers is rising, indicating that new recruits are fewer. Among teenagers, drug use (mostly of an experimental character) is decreasing. In the early 1970s roughly 15 per cent of ninth grade pupils reported ever having tried drugs. At the end of the 1980s the number was about 4 per cent. The proportion, of military conscripts (18-year-old boys) who report trying drugs varied during the same period from 19 per cent to 6 per cent. To a great extent we lack facts about drug use among ordinary adults. According to surveys in 1988 and 1989, 8 per cent of the adult population said that they had use of drugs at least once. To analyse the patterns of daily use among different groups has always been a neglected issue, irrespective of which Government Commission has been exploring the drug scene. This is probably a result of the one-dimensional, juridical definition of drug abuse, declaring that all kinds of use should be viewed as abuse, and the widespread myth that it is only a small step from casual use to a ruined life in the shadow of the needle. In the official rhetoric, there is simply no space for social-recreational use among adults.

Hash is the most common drug, followed by amphetamines, which are the dominant drugs among intravenous drug abusers. This overwhelming position of amphetamine use among heavy users constitutes a unique feature of the Swedish drug problem. The number of heroin addicts hardly surpasses 3000 and by tradition this kind of abuse is centred on Stockholm and the very south of the country near Copenhagen. According to criminal statistics (number of drug cases reported to the police and number of drug seizures by police and customs), cocaine still constitutes an insignificant part of drug consumption in Sweden. In fact, the number of seizures of sleeping pills and tranquillisers is far greater than the sum of seizures of cocaine. In 1989 approximately 6000 people were convicted of offences under the 1968 Narcotics Drug Act. About 61 per cent of the arrests were for hash, 28 per cent for amphetamines, 6 per cent for opiates and 5 per cent for sleeping pills and tranquillisers; for cocaine the cases reached 109. These numbers show a doubling of the number convicted since the late 1970s, a development caused by harsher rules with regard to abstained prosecution for minor offences; this, in turn, is an apparent manifestation of a hardening political climate on drug issues.

If we look at the more obvious indication of damage caused by drug abuse, we can see that 519 intravenous drug abusers were clinically reported as HIV positive up to December 31 1989. At
the same time the number of cases of AIDS among intravenous drug abusers was 10. According to official statistics, the number of deaths from overdoses or with drug abuse as an underlying cause has never exceeded 100 per year (Swedish Council for Information on Alcohol and other Drugs, 1990).

A BROAD RESPONSE

The Swedish drug problem is a relatively recent phenomenon. This means that Swedish policy in the field was developed late in relation to international control policies, and also that many packaged concepts and problem definitions, mostly of American origin, were imported and made their mark on Swedish debate and policy. But it goes without saying that drug abuse programmes were also influenced by the Swedish model of relying on sociopolitical controls to fight social problems, as well as the tradition of close cooperation between the State and popular movements (trade unions, temperance organisations, parent-teacher groups etc.). This gave the developing policy a wide and ambitious band of support. It was first formulated in concrete terms in a 10-point programme adopted in 1968. The programme included an inventory of the problem and suggestions for action presented by the Drug Abuse Treatment Committee, formed in early 1966. Five basic fields can be identified: surveying/research, preventive measure, control efforts, care/treatment and international cooperation. This structure has remained in place since its creation. It can be said that the Drug Abuse Treatment Committee formulated a broad response to the growing problem, with the versatility being a distinctive characteristic. Of course, not all areas have benefited equally; control measure have always had a dominant position. Resources for care and treatment were not seriously developed before the late 1970s, and those aspects of preventive work that were directed at improving basic living conditions have followed sociopolitical cycles. Surveys - in the form of counting individuals and charting changes in abuse patterns - have had precedence over actual research in the field. International cooperation, apart from the cooperation in the context of the United Nations, for the most part been focused on team-work between Swedish control authorities and their foreign colleagues.

PROBLEM DEFINITION IN POLICE TERMS

Taking these points as a start, we go on to discuss and investigate several development trends.

As has been pointed out, control measures have always had a dominant position, but it can be
asked whether the police view has ever previously had the decisive status that it now enjoys. All handling of drugs has been criminalised. Drug use itself is now punishable, and we can expect that the next round of political decisions will approve urinanalysis as evidence. The definition of the abuser as a criminal threat to society is now a widely accepted concept in most camps. A consequence of this is that most cooperative projects between various authorities are based on this view. This in turn means that authorities such as the social services, schools, recreation centres, employment offices etc. have adopted a fundamentally police-oriented problem definition, becoming more influenced by enforcement thinking than ever before.

During the 1980s many of Sweden's 282 municipalities launched local action programmes against drugs. In the process of programme formulation as well as implementation, local police forces, social workers and teachers, emerging as moral entrepreneurs, have been playing dominant roles. The programmes were framed in a climate of moral panic, and the vested interest of different political groups and professions constitutes the key force in this attempt to give a more literal meaning to war on drugs. Expanded resources and harsher means of countering the supply of illicit drugs are, of course, predictable measures in programmes such as these, but the new emphasis is on traditional controls to fight, the demand for drugs. Many declarations and claims never went further than the report stage; in some municipalities, however, the programmes have resulted in police strategies focused on street-level drug abuse, intelligence activities against and surveillance of suspected teenagers in schools, implementation of urinanalysis in schools and workplaces, an increase in the fear level of information campaigns, demand for tougher penalties and more units prepared to work in compulsory treatment etc. The network of local power has been activated within a uniform and repressive strategy with the purpose of creating a drug-free society. For hundreds of casual users, as well as known abusers, the result of this offensive is a drastic reduction of social alternatives. Once an individual is defined as a drug abuser, tight social control is required, executed by officials who believe that drug abuse is the gravest of threats to society and that action is the best solution to the peril. The repressive trends of the 1980s have been described elsewhere by Gould (1988, 1989).

If we go back about 10 years we come to the decisive turning point in Swedish drug policy, when the view of 'the abuser as the only irreplaceable link in the drug chain' was launched on a broad front. This view was naturally presented as something new and revolutionary. Control policies were to be aimed at punishing or frightening every individual abuser away from drug use. In reality, this was an old American strategy that had been dusted off. It was the favourite thesis of the Ameri(an drug hawks and the dominant characteristic of American drug policy for over 30 years. The peak was reached during the general paranoia of the 1950s, when drug abuse was as un-American as communist sympathies and when lifetime sentences could be
handed out for minor drug offences. Demands during 1960s for de-criminalisation and legalisation can be seen as a revolt against this odious social climate combined with the witch-hunt of individual abusers.

It is commonly claimed that American abuse patterns are imported to Sweden with a delay of about 5-10 years. But anyone who takes the time to look can see that this is simply not so. Still, Swedish policy on drugs is much more influenced by American control strategies than we usually admit.

This 'influence can be traced back to the 1890s, when the Swedish government first promulgated instructions for teaching about intoxicating substances (primarily alcohol, morphine, tobacco) in the elementary school. In the parliamentary debate, attention was focused on American experiences, and a copy of a Louisiana law from 1888, which prescribed mandatory teaching about the nature and effect of liquors and narcotic substances, was incorporated in the protocol. Similarly, when the more elaborate and comprehensive ordinance against narcotics was enacted in the early 1930s, the references to the American situation and legislation were common in the debate, especially from police officers. Through the years, American definitions, concepts, causal explanations - as well as solutions - have coloured different aspects of Swedish policy. Some examples are sociological and criminological theories about social deviance, influence- W.... treatment programmes such as Synan and DayTop-Village, models for successful information campaigns and the idea of methadone blocking the use of heroin. Today this impact is manifested in the widely spread interest for therapies based on transactional analysis, offshoot and applications of the 12-point programme of Alcoholics Anonymous to the field of drug abuse, The latest illustration can be taken from teaching about drugs and other evils. More than 30 per cent of Sweden's intermediate-level teachers have been trained in and teach the Lion's 'Quest' programme of ethical standpoints, which among other subjects includes instruction about saying 'no' to drugs.
A CRITICISM OF SWEDISH DRUG POLICY

Written by Sven Ake Lindgren

INSTITUTIONS AND PSYCHIATRIC ITREATMENT

Swedish drug abuse treatment is in an expansion phase. Both quantitative and qualitative growth have been extensive in recent years. In spite of this, there are any number of problems to reflect upon:

1. Expansion of treatment has not benefited the most serious abusers. On the contrary, ever-increasing numbers of those in greatest need seem to be excluded from treatment.

2. Privatisation has taken place quickly in this part of the public sector. Profiteering and the quest for quick money are now common features, whereas official control and oversight have been weakened. In the end, the individual abuser hears the heaviest burden.

3. Expansion has unfortunately also been applied to the destructive practice of compulsory treatment of adults. Along with that, the latest changes in Sweden's Law on the Care of Minors will bring about an increase in court orders for compulsory treatment of young people. The Law on Treatment of young people (LVU), which took effect on January 1 1982, provides for compulsory care of minors over the age of 15 if their behaviour constitutes a serious danger of health or development. Drug abuse is one such danger. Compulsory care can be ordered until the age of 21, but a new order is required every 6 months. The Law on Treatment of Abusers (LVM), which went into effect January 1 1982 and was amended in January 1989, provides for compulsory care of a maximum of 6 months for adults with severe drug or alcohol abuse problems.

4. Psychiatric theories and models depending on diagnostics are rapidly expanding within voluntary care. Old concepts such as asociality and social pathology have experienced an unexpected comeback. This development is an expression of growing professional interests of various personnel groups, which are trying to increase their professional status by copying vocabularies; they are being approached by more respected professionals such as physicians and psychiatrists. Whether this trend is truly in the patients' best interests is very much in doubt.

In the late 1980s, the expansion of drug abuse treatment seemed to be happening without any comprehensive planning. Suddenly there was plenty of money: within the framework of 'offensive drug treatment' some 50 million dollars were recently allocated (outside regular state support). This money had to be invested. According to the National Board of Health and
Welfare, there are now more than 1000 beds in various types of institutions for abusers in need of more extensive treatment. Still, there is talk of a shortage of beds, and some regions are clearly behind. What is missing is critical discussion of care expansion and its effects; health care authorities are aware that development of facilities beyond a certain level does not lead to better health, but can conceivably conceal and block other measures. It is also well known that the expansion of treatment systems is affected by a number of factors other than concern for the health of the individual. Within drug treatment there is still a naive pioneer spirit born through the misconception that political and organisational interests always coincide with those of the patient.

The model for institution-based treatment, coupled with the specialised outpatient centres now spreading around the country, can be summarised as 'morals first, bread later', i.e. first undergo a treatment often long term, sometimes involuntary, then we'll see about housing and a job. We dare to speculate that this treatment model is not likely to lead to lasting social rehabilitation for many of its patients. In fact, some findings show that important aspects of a person's welfare decline during some types of treatment. For instance, loss of dwellings while incarcerated for compulsory treatment is not an unusual experience. In addition, important questions are concealed or blocked by an extensive and one-sided investment in treatment: on the one hand, expansion of outpatient programmes that focus on housing and jobs instead of psychiatric treatment and, on the other, the sociopolitical actions, based on the needs of the weakest groups, attacking the inequities of the housing and labour markets in a preventive perspective.

THE DOGMATIC FIGHT AGAINST AIDS

The struggle against the spread of HIV and AIDS among narcotic abusers is marked by ambivalence. From one side there is great effort made to deal with it within the framework of drug abuse treatment; on the other there is dogmatic attachment to certain notions.

It is now slightly more than 5 years since the Swedish parliament approved an ambitious programme aimed at reaching all drug abusers with information, HIV testing and inducement to enter treatment. It is impossible to say to what level the goals have been achieved to date. There are a number of indications, however, that most of the highest-risk group remain outside the programme. Nevertheless, there is little to indicate any willingness to evaluate the effort and re-direct resources. It is possible that a decision to increase the ceiling for admissions to methadone programmes from 300 to 450 can be taken as a sign that the problem has received attention. Until the early 1980s, methadone maintenance treatment was conducted, on a very limited scale, in the form of a research project at Ullerakers Hospital in Uppsala. At that time, the National Board of Health and Welfare declared methadone treatment as an accepted and
functional form of treatment. Methadone treatment for outpatients was introduced and the programme has steadily expanded: from 150 to 300 and now to a maximum of 450 patients.

Sweden's AIDS delegation, led by former Social Affairs Minister Gertrud Sigurdsen, apparently does not see any conflict between this decision and the nation's restrictive drug policies. The fact that a large percentage of Stockholm's heroin abusers can now receive state-sanctioned drugs implies that methadone distribution is no longer interpreted as giving the wrong signals. But that is the conventional attitude towards distribution of disposable syringes, an issue about which Sweden clings to its narrow view. During 1990 the Council of Europe's Ministers Committee adopted a series of farreaching recommendations for HIV/AIDS policy. Among other things, the committee established that the government should offer intravenous drug abusers clean needles. The Swedish Government dismissed not only this recommendation, but also the entire document. This means that HIV-infected people in Sweden are denied a number of basic rights taken for granted in the rest of Europe. Swedish laws on the spread of contagious diseases are applied mainly against female heroin abusers, despite the fact the prostitution is responsible for a small and shrinking share of HIV transmission (3 presumed cases of 2500 infected). According to Swedish law on contagious diseases, AIDS is classified as a socially dangerous disease. Anyone spreading such disease, or suspected of doing so, who does not voluntarily comply with an order to cease, faces compulsory isolation in hospital for 3 months, followed by 6-month periods under court order. The fact that the Ministers'

Committee has flatly ruled out incarceration of HIV carriers gives an indication of the differences in perceptions of the value of human rights within the European Community.

A GLOBAL PROPOSAL

Sweden has played and continues to play an active role in cooperative international efforts against drugs. The Swedish Government recently presented an intitiative for a 'global action programme against drugs' within the framework of the United Nations. The aim is to achieve better coordination, more resources, and a higher priority of efforts against drug production,
trafficking and demand. We would like to point out a few noteworthy points in the proposal. Based on contributions to the debate from Prime Minister Ingvar Carlsson and the Swedish memorandum to the General Assembly’s special session on international cooperation against drugs in February 1990, the following can be established:

The Swedish proposal is aimed at the production of opium, coca and cannabis in developing countries. This reflects a traditional - and fundamentally American - view of the drug problem: a one-way traffic from these countries poses a threat to the developed nations. The spread of industrially produced drugs from the developed countries to the less developed countries is not mentioned once, whether in the form of illegal production of amphetamines in the USA or the pharmaceutical industry's sedatives. Estimates from Bangladesh indicate that there are a million cases of abuse of sedatives; extensive abuse of amphetamines and benzodiazepines is reported from the poorest countries of Africa and from Latin America. Japan estimates approximately half a million abusers of stimulants; reports from Egypt and Pakistan show widespread abuse of industrially produced drugs and so on (United Nations, 1987). But, according to the Swedish scenario, evil is symbolised by cocaine traffic from Colombia. This reductionism represents a new trend for Swedish policy in the field. Sweden had earlier considered the spread of industrially produced drugs as a serious problem and had clearly stated such a position. This policy line meant support for the developing countries' battle against the ravages of the chemical industry. Since the early 1960s Sweden has argued within various UN agencies for tighter controls on industrially produced narcotics such as amphetamines (and similar central nervous system stimulants) and benzodiazepines. This position has met stiff opposition from countries with powerful pharmaceutical industries.

It is also worth noting that the Swedish Governincur had an excellent opportunity to protest against the increasing use of the death penalty for drug offences. For example, in Iran more than 60 000 persons have been arrested and put into camps, ~ ind some 1500 people have been executed for drug crimes since the Iranian leaders started a massive anti-drug campaign in 1989. As Amnesty International has pointed out, there is reason to believe that the Iranian Government is using the war on drugs to get rid of politically inconvenient people and groups. But the Swedish Government also chooses the easiest path on this question. Suddenly, the Government is terribly careful about getting mixed tip in the internal affairs of another country.
As stated, Swedish drug policy shows unique and valuable traits. The question is what experience we actually have to offer in international work. An important aspect of Swedish policy is the earlier linkage to a more general social policy “aimed at alleviating economic and social injustice. One might have hoped that the Swedish policy would be linked to a more general society policy aimed at alleviating economic and social injustice. One might have hoped that the Swedish proposal for programme of global action would emphasise the fundamental importance of our policy of social and economic equality. Unfortunately, we can only establish that the weight of the proposal has been placed instead on traditional control efforts, such as more effective legislation, more effective customs and police, more effective attacks on illegal production and refining, and so on. Why does the Government remain so low-key about our genuinely meaningful experiences and resources?

CONCLUSION

Drug-related issues have been polarised on the international scene. On one side there is an escalating war led by the US policy of militarisation. On the other is a fast-growing movement with legalisation at the top of its agenda. Where does Sweden stand in this power struggle? With a few examples we have tried to point out what seems to be a general trend in this country's drug policy: more room for a definition of the problem based on policing, increasing repression, the fight against drugs becoming more and more divorced from general social policies, and an adaptation of the American view of international drug trafficking. Sweden is escalating the war on drugs - both at home and abroad. This is remarkable for two main reasons: in view of the limited Swedish drug problem, which is actually decreasing, and in light of the independent Swedish foreign policy, which once stressed solidarity with the poor and developing countries of the world. Perhaps we are observing a more profound shift of politics, a breaking of trends that is due to the fact that the Social Democratic model of welfare is breaking up. But there is still time to move in another direction. In the same way that the question of unemployment as a means to fight inflation is not yet lost (one of the major issues of parliamentary elections in September), there are plenty of reasons to fight for a model that puts the welfare of people in the forefront of drug policy.

Sven-Ake Lindgren
Sociologist, Gothenburg University
Chairman, The Swedish Association for help and assistance to drug abuser
REFERENCES