Sweden's "War on Drugs" in the Light of Addicts' Experiences

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Mind-altering substances have been used throughout human history. However, the specific substances that have been preferred and socially accepted, or feared, condemned and subjected to bans have varied with time and place. Likewise, there have been varying ways of reacting to and dealing with those whose substance use, or behaviour when under the influence, has been deemed to be deviant. In fact, the extent to which the use of a certain drug is likely to put the user in serious straits or evolve into an addiction, may be just as dependent on these reactions as on the pharmacological properties of the drug in question (cf. Room 1985; Blomqvist 1998a). At the same time, the way in which the environment reacts towards problem users is likely to have a strong impact on these users' options for coming to terms with their problems (e.g. Klingemann et al. 2001). Moreover, it has been shown that reliance on problem users' own understanding of their predicament is conducive to a successful outcome of interventions (e.g. Hänninen & Koski-Jännes 1999; Hubble et al. 1999). Thus, one reasonable way of evaluating a certain society's drug policy might be to examine it in the light of present and former problem users' own perceptions about their addiction and path out. This chapter gives an overview of the development of the Swedish version of the "war on drugs" and presents a summary of addicts' and ex-addicts' experiences of drug use and recovery as they appear in a recent study. On this basis the chapter proceeds to highlight some dilemmas in Sweden's present way of dealing with narcotic drugs and in its response to individual problem users in particular.

The Governing Image of Narcotic Drugs and Drug Addiction in Sweden

Sweden is one of the countries that has historically paid most attention to, and spent most resources on, countering the use and misuse of psychoactive substances (Klingemann et al. 1992). At the same time, there have been and still remain wide differences between the "governing images" of alcohol and narcotic drugs respectively, as well as between the ways in which official alcohol policy and drug policy have developed. According to Hübner (2001) alcohol and drinking were historically institutionalised as social problems in a process of open debate and compromise between articulated opposing interests. This formative process developed essentially "from below", and has over time

engaged large parts of the population, most of whom have been able to relate to the debate through personal experiences. By and large, the "Swedish model" of handling alcohol problems represents a "middle way" (Johansson 1995) that has adapted to shifting social, political and economic realities, and that has been in line with changing popular majority views (Blomqvist 1998b). In summary, this model has century-long relied on a governing image of alcohol as a legitimate, albeit potentially harmful product, and the main thrust of society's interventions, throughout periods of shifting specific policies, has been towards the minimisation of such harm (cf. Hübner 2001).

The social construction in Sweden of the use of narcotic drugs as a serious social problem has a rather different history. Far from representing a "middle way" in drug policy, Sweden rather belongs to a small group of countries where the end of creating a "drug-free society" has justified not only enormous costs, but also far-reaching curtailments of the individual's civic rights (Barker 1998). This first section of the chapter gives a brief account of the historical development of this policy and its main underlying assumptions

Drug Use and Policy in Sweden – Some Historical Notes

As has been shown by Olsson (1994), the use of morphine and cocaine, and to a lesser extent cannabis, for medical purposes was widespread in Sweden as early as the 19th and the first part of the 20th century. There was also an appreciable consumption of the same substances as ingredients of various "patent drugs" that were sold openly as remedies for a great number of everyday ailments (ibid.). During the 1940s and 1950s, along with the rapid growth of the pharmaceuticals industry, central stimulants became popular as a means of performance enhancement and, with time, as remedies for overweight problems. It has been estimated that in the early 1940s, about three per cent of the Swedish population were to some extent users of central stimulants (Goldberg 1968). Nonetheless, in contrast to what had been the case with beverage alcohol, the drug issue did not raise much concern. On the contrary, the medical profession's evaluation of central stimulants in particular was for long almost unanimously favourable – something that has contributed to the atypical pattern of drug misuse in Sweden where amphetamine, not opiates, is the main "problem drug" (Olsson 1994; Boekhout van Solinge 1997). As Hübner (2001) puts it, as long as the medical profession essentially controlled the substances, which are today collected under the heading of "narcotics", they were handled as both legal and legitimate.

The first discussions on drug use as a major social problem can be traced to the late 1950s, when the "social locus" of the use of central stimulants started to shift from intellectual and cultural circles and well integrated citizens to more marginalised groups (Olsson 1994). In response to this, and to the growing habit

in these groups of dissolving the tablets and injecting them intravenously, a number of the most popular substances were classified as narcotic drugs. This led to the emergence of a black market for central stimulants, which in turn contributed to the realisation in 1964 of the Narcotics Decree. This decree, which stated fines or a maximum of two years' imprisonment for the manufacture, sale and possession of narcotic drugs, represented a significant new step in drug legislation and can be seen as the starting-point for contemporary Swedish drug policy (Olsson 1994). Four years later, the government issued a 10-item programme to combat the drug problem, and Parliament adopted a new Narcotic Drugs Act that raised the maximum penalty for major drug offences to four years' imprisonment[1] (cf. SOU 1967:27; 1967: 41). The 10-item programme identified three primary lines of action, namely legal control, preventive measures and treatment; three "pillars" to which the official rhetoric has since clung. Nevertheless from the 1970s onwards the emphasis in drug policy has gradually shifted from what Lindgren (1993) terms a "care and treatment strategy" towards a "control and sanction strategy". A watershed in this development was the adoption by Parliament in 1978 of a "drug-free society" as the ultimate goal of Swedish drug policy. This has remained the principal clause through shifting political majorities, and has been used to legitimate increasingly repressive measures towards the individual drug user (ibid.; Tham 1999). Thus, in 1983 facilitating a drug deal was made a criminal offence, in 1985 a maximum penalty of six months' imprisonment was introduced for possession for personal use, and in 1988 personal use in itself became punishable by fines. Eventually, in 1993, the maximum penalty for personal use was raised to six months' imprisonment, thereby adding to the already extensive rights of the police in fighting drugs, the right to use coerced urine and blood tests on the suspicion of drug use, whether past or present (cf. Boekhout van Solinge 1997).

Assessments of the impact of these regulations on the incidence of drug use and addiction have varied. Although the interpretation of official statistics has caused some debate (Goldberg 1997; Olsson et al. 2001), there seems to be fairly broad consensus that recreational as well as problematic use of narcotic-classified drugs reached a peak in the late 1970s, but decreased substantially during the following decade (e.g., CAN 1993; Olsson et al. 2001). Two nationwide surveys did identify about 15,000 "heavy drug abusers"[2] in 1979 and about 19,000 in 1992 (Olsson et al. 2001), but on the basis of the age distribution in the two surveys and other available information[3] it may be rather safely deduced that the annual number of new "heavy addicts" did in fact decrease during most of the 1980s (ibid.). Whereas the official line has been that these figures prove the

[1] Further raised to six years in 1969 and to ten years in 1972.

[2] Defined, with some variation over the years, as any intravenous use and/or daily or almost daily use of narcotics-classified substances during the past four weeks.

[3] E.g. data on recreational use and drug-related mortality, and data from customs and police on the availability of narcotic drugs.

effectiveness of Swedish drug policy, critics have claimed that the decrease in consumption largely preceded the tougher sanctions and had other reasons. In addition, many have maintained that an increasingly repressive drug policy has generated as much harm as it has prevented, among other things by threatening openness and democracy and by fostering distrust towards society in the young generation (von Hofer et al. 1998; Tham 1998; Hilte 1998).

During the past fifteen years, the basic prerequisites for Swedish drug policy have changed in important respects. Rapid and deep-going geopolitical changes, not least in Eastern Europe, have led to an increasing inflow of both traditional and "new" substances (EMCDDA 2003a). At the same time, new influences and changing sentiments in the wake of ongoing globalisation have meant that the traditionally strong barriers against even experimenting with drugs have started to erode, not least in many youth groups (EMCDDA 2003b). Finally, Sweden's accession to the EU has made border control and the prevention of illegal import tangibly more difficult (Rikspolisstyrelsen och Tullverket 2003). On the structural level, all this has coincided with what Oscarsson (2001) describes as a transition from an inclusive and cooperative society towards a differentiating "competitive society" in which utilities such as housing, jobs and education are no longer defined as basic civic rights, but as something that the individual has to "deserve" or compete for. Along with these changes, the incidence of recreational drug use has climbed back close to the figures recorded in the 1970s (CAN 1997; 2001), and the number of "heavy drug abusers" has risen to about 26,000 in 1998 (Olsson et al. 2001)[4]. However, in contrast to what has been the case with alcohol policy (cf. Abrahamson 1999), Swedish drug policy has remained rather unaffected by these changes. Thus the new Drugs Commission, appointed in 1998 to evaluate prevailing policy, maintains that increasing drug-related harm can largely be attributed to negligence in the enforcement of this policy, not to deficiencies in the policy itself. Despite the exacting title of the Commission's main report, *The Choice of Road. The Challenge in Drug Policy* (SOU 2000:126), the core message is that all three parts of the traditional strategy need to be strengthened in the continued pursuit of the "drug-free society". The means applied to this end, thus far, have included the appointment of a national Drug Co-ordinator and the launching of a nationwide campaign, *Mobilisation Against Drugs* (Government Proposition 2001/02:91). In a critical comment Bergmark (2001) contends that the Commission's directives have left room only for conclusions that lie "between the already given and the impossible" (p.314). As a consequence, the appellation of a "choice of road" has become no more than a rhetorical symbol – a means of handling the growing tensions between the ordained strategy of continuity and increasing evidence that this strategy has not worked (ibid.).

[4] From national surveys, it can be calculated that the annual incidence of "heavy drug abuse" was on average 800 from 1979 to 1992 (cf. O. Olsson et al.1993), and about 1,900 from 1991 to 1998 (cf. Olsson et al. 2001).

The Reigning "doxa" and Why It Has Prevailed

Using a term borrowed from Bourdieu (1977), Bergmark and Oscarsson (1988) have characterised Swedish drug policy as a "doxic" field. By the concept of "doxa", they refer to a set of undisputed and allegedly indisputable themes which provide the unreflected basis for any public debate on, and public actions targeting, the drug problem. One such theme is the conviction that narcotic drugs present a serious or "high profile" problem. Another is the view of narcotic drugs as inherently dangerous (with the corollary that all use is equal to "misuse" or addiction). A third and a fourth theme are the depiction of the drug misuser as a powerless victim of the drug's pharmacological properties, and the notion that long-term and intense treatment is necessary in order to save him or her from the perils of the drug. According to the authors, the "doxic" character of these themes effectively inhibits any moderation concerning the seriousness of the problem and the necessary resources to eliminate it. Thus, for example, it allows for including ever new substances under the rubric of "narcotics", based on a discovery of their alleged dependence-generating properties, and it excludes the interpretation of drug use as an intentional activity as well as the idea that people might stop using drugs on their own (ibid.). Theoretically, the "doxa" draws on the assumption that narcotic drugs are capable of "short-cutting" the brain's pleasure system, thereby obliterating the user's ability to execute his/her own free will (e.g., Bejerot 1972; 1980). In addition, drug use is assumed to have an epidemic character, meaning that every drug user can "contaminate" a number of other susceptible persons (cf. Bejerot 1969; 1975). As a consequence, restricting or eliminating the availability of narcotic drugs should be the main goal of national drug policy, and sanctions should first and foremost be directed towards reducing the demand for narcotic drugs, i.e. towards the individual consumer.

There have been various, partly complementary ways of accounting for the perseverance of this singularly Swedish version of the "war on drugs". Boekhout van Solinge (1997) maintains that one potentially important factor has been Sweden's traditional "temperance culture", which is claimed to have provided a receptive ground for the demands for swift and ruthless action against the "new danger" that were put forth by a small, but insistent and vociferous opinion in the late 1960s (ibid.). A leading part in this crusade for a new, more repressive policy is ascribed to the medical doctor and debator Nils Bejerot (cf. above), whose ideas soon proved to have strong popular and media appeal. In addition, they were picked up by various lay organisations such as the National Association for a Drug-Free Society, Parents Against Drug Abuse, and Hassela Solidarity. According to Boekhout van Solinge (1997), these and other lobby groups for tougher restrictions have continued to exert a strong influence on Swedish drug policy till the present day, not least through gaining important posts in policy-making and influence-exerting bodies.

Christie and Bruun (1985), in a seminal analysis, describe Swedish (or Nordic) drug policy as a symbolic war aimed at preserving the illusions of safety, national unity and rational social progress at a time when deep-going structural, economic and politico-ideological changes have created disintegration and widespread distrust of traditional authorities. In this war, narcotic drugs stand out, for several reasons, as "the ideal enemy". One such reason is that the problem, thus defined, directly concerns only a rather small minority of mostly socially marginalised people. Another is that this enemy is vague enough to make a thorough scrutiny of the alleged seriousness of the problem impossible, and can thus, without much objection, be depicted as evil, inhuman and alien. Since this makes the final defeat of the alleged enemy impossible, the "war" may go on forever, and serve as a scapegoat for more awkward political issues that cannot be attacked without challenging powerful circles (ibid.).

In a summary evaluation, Hübner (2001) contends that drug use and addiction in Sweden, in contrast to the case with alcohol problems, were historically defined and institutionalised as serious social problems "from above", in a dialogue between a rather limited number of influential lobbyists, government officials, and the media. According to Hübner the strong popular support for an increasingly repressive policy can be attributed to the fact that relatively few are able relate to this issue through personal experiences, and that views opposing the reigning official doctrine have been virtually non-existent, particularly in the media. Rather, the public debate on the drug problem has been characterised by "a spiral of silence"[5], which has repressed even modest objections to the reigning "doxa", in the face of the threat of being defined as a "drug liberal" and being excluded from the debate (ibid.).

Reflections of the "doxa" in the Treatment Field

One way of stating the core difference between alcohol and drug policy in Sweden is to say that drinking is basically seen as a legitimate activity, whereas drug use is seen as a sign of moral and social deviance (cf. Hübner 2001). This difference is also reflected in the way that problem users have been approached in the treatment field at large.

The treatment of drinking problems in Sweden dates back to the late 19th century. During the first half-century this was largely a disciplinary excerise, targeting a rather small group of social outcasts (Fredriksson 1991; Blomqvist 1998b). From the 1960s the emphasis has shifted towards professional voluntary treatment, and the content has become more diversified and more therapy-oriented, the main orientation changing with time from psycho-dynamic concepts through social-

[5] The expression is borrowed from Noelle-Neumann (1995).

psychological models towards 12-step ideas and cognitive-behavioural methods (e.g., Oscarsson 2001). In quantitative terms, the treatment of alcohol problems reached its peak in the mid-1970s, and has declined tangibly with the recession of the early 1990s. The latter has also meant a transition from residential towards open care, and a growing reliance on voluntary and self-help organisations (Blomqvist 1998b).

The way that society deals with individual drug misusers has developed rather differently. As discussed earlier, drug problems were seen as a purely medical matter until the 1950s, and therefore dealt with by the medical profession. It was not until the 1960s that specialised treatment for drug misusers started to emerge outside the medical sector. Initially, these initiatives borrowed much of their form as well as their content from contemporary alcohol misuse treatment. However, as the "control and sanction strategy" gained influence, a tougher approach to dealing with individual drug misusers soon emerged in the treatment field as well. Many enterprises started to criticise the therapeutic orientation of alcohol misuse treatment, and to lean rather on ideas from e.g. the hierarchical American Daytop and Phoenix House movements. Another initiative that gained strong influence in the early 1980s was the domestic "Hassela Pedagogic" for young misusers, relying on re-education, "socialist fosterage", adult staff members as role models and authorities, and on coercion (cf. Bergmark & Oscarsson 1990; Fridell 1996). It is also worth noticing that one of the explicit motives behind the new coercive legislation, which was rapidly instigated in 1982 and which ran counter to the principle of voluntarism that permeated the new Social Services Act of the same year, was the perceived need to force drug misusers into treatment. The same is true of the revision of the coercive care legislation in 1989, which broadened the requisites for compulsion and raised the maximum duration of involuntary treatment from two to six months. By and large, whereas the approach to problematic drinkers has over time become more "therapy oriented", and more diversified with regard to both professional ideologies and methods (Abrahamson 1989), the approach to drug misusers has developed in a more unitary way, directed at control and socialisation (Bergmark & Oscarsson 1988), relying on "regulating" and "instructing" activities (Hilte 1990)[6], and aiming to break down the client's "junkie identity" and to build up a new identity as a norm-abiding and socially respected citizen (Svensson 1996).

In quantitative terms, drug misuse treatment reached its highest level in the late 1980s, following the detection of HIV/AIDS and the subsequent government initiative, "Offensive Drug Abuse Care", which led to a rapid and massive expansion of residential care. However, with the economic recession around 1990, this investment more or less ceased, making many of the new treatment

[6] Referring to Bernstein (1976), Hilte (1990) distinguishes between four types of "socialisation contexts", namely "fantasy-inducing", "interpersonal", "instructing" and "regulating" contexts.

homes extremely short-lived (Bergmark & Oscarsson 1993). Mostly for economic reasons, the past decade has seen a partial "implosion" of drug misuse treatment into alcohol misuse treatment (Bergmark 1998). However, there are clear indications that the decrease in treatment referrals during the first part of the 1990s has essentially concerned alcohol misusers, whereas the number of admitted drug misusers has remained rather constant (SoS 2001). There are also rather clear indications that the two fields continue to show different ideological and methodological orientations. Thus, for example, a reanalysis of recent data from the National Board of Health and Welfare (SoS 2000) shows that contemporary alcohol misuse treatment is typically outpatient and inclined towards 12-step and cognitive/behavioural methods, whereas drug misuse treatment is to a much greater extent residential, relying for instance on social-pedagogical methods and social skills training (cf. Blomqvist 2002a).

Paths into and out of Drug Addiction – Addicts' Own Experiences

How, then, do the assumptions underlying the Swedish "doxa" compare with the "lay theories" of those concerned? This section summarises what 75 former or active problem users have to say about their drug experiences and about what it takes to "become clean". The data used originate from a recent study aimed at attaining a better understanding of the processes of change in successful solutions to drug addiction problems, as well as of the main forces behind these processes (Blomqvist 2002a&b). The study sample comprised 48 stable remitters from severe addiction to amphetamine and/or heroin, 23 with and 25 without the help of treatment[7]. In addition 27 persons with ongoing drug problems, 14 of whom were previously untreated and 13 of whom had received treatment, were interviewed[8]. Partly due to the strict inclusion criteria, all respondents had previous or present drug problems similar to those in common treatment populations as regards severity, duration and negative consequences. Methodologically, the study used a combined strategy. On the one hand detailed recordings were made, year by year, of the development of the subjects' drug use, the severity of their drug problem, and drug-related negative consequences, as well as the occurrence of significant life events in seven vital areas. In addition, standardised inventories were used to assess the subjects' own attributions of factors important in motivating and maintaining the resolution. On the other hand, in a effort to obtain a more unbiased view of the subjects' own understanding, all of them were also asked to give a spontaneous autobiographical account of their lives and their drug experiences (cf. Alasuutari

[7] These respondents were all solicited by media advertisements.

[8] Most of the non-resolved subjects were recruited via social services or treatment facilities.

1986; Klingemann 1991; 1992). Even if the respondents did not constitute a random sample of problem drug users in Sweden, there are other circumstances that speak for the relevance of their experiences in the present context. One is that while being largely comparable to treated populations as concerns the severity and duration of their drug problems, these users represented clearly different positions in terms of treatment experiences and long-term outcome. Another is that the life course perspective adopted in the study, and the way in which it combined quantitative and qualitative methods, may be claimed to have generated in-depth and essentially trustworthy descriptions of the addiction experience and path out.

Becoming a Drug Addict

A first hint of what the study has to say about what it takes to develop an addiction to amphetamine or heroin can be derived from data on the respondents' social and family background. For example, even though 50 per cent or more of the respondents came from split families, had parents with alcohol or drug problems, and/or displayed early signs of psycho-social discomfort, more than one-third of them grew up in "normal" and what they described as happy families. In other words, although weak social resources and various types of individual strain, for instance, are likely to make people more susceptible to later drug problems, the results indicate that these are not necessary conditions for being snared in an addictive life-style. The fact that the age at onset of drug use varied between 12 and 29 years raises further doubt about the notion that there is one single route to addiction. It may be noted that a family history of substance use problems was somewhat less common among later remitters than among respondents with prevailing problems, and that respondents who never sought treatment had a somewhat later onset of drug use than those who did. The later self-changers stand out as the group with the greatest overall social and family resources.

As concerns the respondents' own attributions of the reasons for starting to use narcotic drugs, the later remitters in particular gave rather elaborate and complex accounts, no doubt partly due to the fact that re-assessing their own life history had been part of the solution. A categorisation of the reasons mentioned most often showed that more than half of the men and one-third of the women solely or partly referred to *"peer pressure"*:

> Since I was into music, well, the whole culture was permeated by cannabis and flower power and using drugs, so it wasn't actually anything strange. Everyone did it. Even your pals' parents smoked the occasional joint, just to show that they were hip, and with a tie around their forehead (untreated remitter; male).

Another commonly endorsed reason was using drugs as a means of *"social recognition"* or as an admission ticket to more advanced circles that were perceived to be "cool" or exciting:

> During those years you are extremely susceptible and you want to be "in" and to be tough and you do things other people do, to be liked….And in the beginning I really thought that I was popular, that they liked me as a person (untreated remitter; female).

This type of reason was mentioned by one-third of both male and female respondents. In addition, many respondents claimed that their initial drug use had at least to some extent been an active search for a remedy for, or refuge from, depression, anguish, self-contempt or psychological "emptiness". Almost half of the women, but less than one-fifth of the men described their initial drug use as some form of *"self-medication"*:

> I went to school and was bullied, and I went home and was humiliated. And it just kept on like this, and I crept into myself, more and more….And then when I turned 14, everything changed. We moved to X, and there they were doing Preludin, and there I took Preludin and there I was born. That was my salvation. If I hadn't used drugs, I would have gone up in smoke, I would have just vanished (untreated remitter; female).

Almost as many respondents, mostly men, further described their initial drug use as part of a general *"revolt"* against parents, teachers and other adult authorities:

> Above all I think it was a revolution against the parents, I mean that happens at that age. And I came from the upper classes, so I suppose I had more to protest against….But I must say that another part of that liberation was a social and political consciousness, that prevails, even today (treated remitter; male).

In addition, quite a few of the women said their older *partners* had introduced them to drugs:

> And then I meet what I think is real love. We meet at work, and it was just so romantic. And he has left his wife and children, and he moves in with me. And that is how I happened to start using amphetamine (untreated remitter, female).

Finally, five respondents reported that they were first introduced to drugs while in *hospital or youth care*. Overall, "self-medication" and "recognition" were more commonly endorsed reasons among women than among men, and later self-changers were more inclined than other respondents to refer to "peer pressure". Taken together, these data may be claimed to belie "contagion theory" as a single explanation, and to clearly indicate that there are many different paths to drug use and addiction.

Living as a Drug Addict

As already mentioned, the respondents as a group were generally comparable to clinical samples with regard to the severity and duration of their drug problems. In hard figures this means, for example that the mean duration of drug use was 16.2 years, that almost one-third had used three or more different drugs, and that about nine out of ten admitted to intravenous use. Further, although more than half of all respondents had in a life-time perspective used both heroin and amphetamines, more than two-thirds stated that amphetamines had been their preferred drug, whereas about one-third had mainly used heroin. However, even though these figures are largely in line with the traditional pattern of "heavy" drug misuse in Sweden, it should be noted that heroin as the main drug was less common among future self-changers than in the other groups. Further, the treated groups scored somewhat higher on overall severity[9] and negative consequences.

As for the development from recreational or experimental use to severe misuse, a few respondents did indeed claim that they had become addicted almost instantaneously

> And when I ran into amphetamine, then everything was, like, done. Like falling in love. I knew at once that nothing would be able to get me away. Because this was the most powerful thing I had met (treated remitter; female).

At the same time, almost as many explicitly described their addiction as a deliberate choice:

> I got tired of being a mother and at the same time doing drugs just during the weekends. So I made up my mind to become a full-time addict. I made a choice there. I know that I thought it over carefully. It was a choice (untreated remitter; female).

Generally, however, the respondents described a process in which using drugs at first was a rather pleasurable and positive activity, or at least fulfilled its function as an effective remedy for, or refuge from, the strains of life:

> There are many good things with drugs as well. Because they can certainly make you happy. And of course that is the trap, that is the great danger. If it were as terrible as the anti-drug prophets claim, no-one would ever start using them (untreated remitter; male).

> And the drugs gave me all this. I didn't see any negative aspects until I fell ill, but I rather liked living in this world. I felt that I was in charge of my own life. That was what it was about (untreated remitter; female).

The sense of freedom and the social cohesion in the peer group of drug users, and the stimulating and disinhibiting effects of the drug – not least sexually –

[9] According to a brief version of Drug Abuse Screening Test (Skinner 1982).

were commonly endorsed positive aspects. It was only with time that most respondents realised they had been caught up in an addiction – a way of life in which most of their thoughts, feelings and actions had come to centre around the drug. In fact, one respondent maintained that her drug use did not evolve into an addiction until after 17 years, and the average duration from onset to the first insight that drug use had become problematic was 4.0 years.

The respondents' overall circumstances during their drug misuse also seem to have differed widely, depending on such factors as family background, gender and socio-economic status. Thus, more than one-third were employed during most of their addiction, almost half lived with children, and more than two-thirds had a stable housing situation. At the same time, more than seven out of ten were involved in selling drugs, almost as many in other forms of criminal activity, and 12 per cent in prostitution. A good third had also spent time in prison. Generally, non-resolved subjects had been more immersed in a criminal life-style than resolved subjects. As for the dynamics of the "addiction circle", the narratives provide a rather complex picture of interacting forces. References to the drug per se are rather scarce, and mainly limited to a few mentions of the anticipation of the horrors of heroin abstinence as an effective barrier to quitting. Instead, most respondents hint at some form of social-psychological process in talking about their addiction in terms of having been caught up in a destructive life-style rather than having been simply "hooked" by the drug.

> In a way, it was an effective self-medication. But at the same time, because of the things you do in that world, you need ever more drugs to escape from having to deal with the real world and your own feelings (untreated remitter; female).

> I think that everyone discovers, sooner or later, that you spend twenty-four hours a day hunting, to be able to pay debts, to fix new drugs and so on. And it's like a vicious circle because you need more and more drugs to get the energy to get through with this (treated remitter; female).

All in all, about one-third of the respondents, mostly men, describe themselves as having been immersed, at least temporarily, in what may be called a "junkie" life-style (cf. Stimson 1973). At the same time, quite a few of the women describe themselves as "loners" (ibid.) or depict their addiction mainly as an integral part of their all-encompassing and passionate relation to a man who also used drugs. However, the majority, and the later self-remitters in particular, describe what may be termed a "double life", characterised by continuous efforts to "keep up the facade" in front of neighbours, relatives, and social services, in spite of the narrator's drug use and participation indealing and petty crime. This type of description was about as common among women as among men, but the reasons for wanting to conceal one's involvement with drugs differed by gender. Thus, whereas women more often talked about their fear of being questioned as mothers, and deprived of their children if exposed as drug misusers, men more often talked about the need to hide their predicament from employers or various

authorities. It is also worth noting that half of the respondents, twice as many women as men, reported having interrupted their drug use on one or more occasions, sometimes for periods of a year or more. Among women the most cited reason for taking such a "pause" was pregnancy or childcare. Other reasons given were changes in the drug market or altered living circumstances. To sum up, the narratives may be claimed to give an eloquent illustration of Svensson's (1996) thesis that drug addicts' lives do not necessarily follow a unitary and predictable "regressive" course, but rather exhibit "a kaleidoscopic character", entailing a number of seemingly conflicting commitments and being open to different interpretations[10].

Leaving the Addiction Behind

Quitting Drugs

As we have seen, more than half of the respondents had long since left their drug problems behind, either with or without the help of treatment. The average time elapsed since finding a solution was 9.7 years, with no significant difference between the treated and the untreated groups. However, a detailed recording of the subjects' drug use and consequences as well as of the occurrence of negative and positive life events during a period covering four years before and two years after the resolution or the past treatment experience, points to other differences. A series of variance analyses reveals that help-seeking, whether or not this had led to recovery, had generally been preceded by increasing drug use and increasing negative consequences, as well as increasing negative events in several vital life areas, and few rays of hope in the overall life context. Respondents who continued to use drugs after treatment, were not on average more severely addicted than respondents who quit their drug misuse after treatment, but they had been more often in trouble with the law, and had experienced even fewer positive events. Self-changers, on the other hand, exhibited a severe but relatively stable misuse pattern during the years preceding the resolution, and had in some cases even tapered down their drug use before quitting altogether. Moreover, in addition to experiencing powerful negative stress, most of them also reported at least some significant positive events in vital areas during the last year before the resolution. Thus, whereas help-seeking commonly seems to have occurred in a situation where the drug use, as well as

[10] *"It is a life with many dramatic elements, a life with different rules, norms and traditions, but it is also a life in the ordinary society. This means that drug addicts sometimes, in periods of intense use, are close to the cultural stereotype, but also that they at times are extremely normal, eating hot dogs, chatting about football, dreaming about a house of their own, letting themselves be entertained by TV, and reading newspapers, just like us"* (Svensson 1996, 338).

the strains of living as a drug addict, had reached some kind of peak, self-change seems rather to have been motivated by a combination of negative and positive incentives.

As for the respondents' own explanations as to what had made them quit, it may be noted that self-changers more often mentioned "inner" reasons for their emerging wishes to change, and more often quoted situational change and positive "key events" as important incentives. Treated remitters, on the other hand, typically described their decision to seek help as the result of having exhausted most of their personal and social resources, and often related their initial resolution to a specific turning-point or a "rock bottom" experience. Overall, women reported more intra-psychic and long-term motives for recovery, whereas men more often mentioned work and financial reasons, and pressure or advice from other people. Notably, half of the female self-changers attributed their decision to quit, partly or entirely, to becoming pregnant or realising their responsibility for the children they already had. Among female treated remitters, the hope to regain custody of children taken into care by the social services was a common reason for seeking help. Among men, meeting a new partner was the most quoted single motive for change, and only two men made some reference to their children in this context. Finally, it may be noted that whereas the most frequently reported barrier towards seeking help among male self-changers was having believed in their own capacity, female self-changers more often referred to the fear of being exposed, questioned as a mother and, perhaps, subjected to some form of coercion. In sum, these results corroborate that the odds for self-change regarding drug problems, as well as the outcome of drug misuse treatment, are heavily dependent on individual human and social resources (Granfield & Cloud 1999), as well as environmental influences that evolve over time (Tucker et al. 1994; 1995). They are also in accord with the notion that professional or formally organised treatment, although often playing an important and even crucial role, is neither a necessary nor a sufficient condition for overcoming an addiction.

Maintaining the Resolution

A common experience among drug addicts is that the real challenge is not quitting, but staying drug-free (cf. Pearson 1987). The respondents of the study discussed here constitute no exception. Thus, in most cases the whole process from quitting to a true sense and conviction that the addiction was history, lasted several years, and was shaped by a variety of interacting internal and external influences. The great majority mention the role of internal changes (e.g. increasing will-power or self-control, taking on new responsibilities or spiritual involvement) as well as support from significant others (partner, other family members or friends) as important reasons for their having been able to maintain

the resolution. About half of the respondents further make references to other habit changes (diet, smoking, physical exercise, etc.), changed life conditions (work, residential and financial changes) and/or social life changes (making new friends, engaging in new leisure activities, wanting to preserve a new social status). Some of the treated remitters further report that treatment was a maintaining rather than a motivating factor (cf. Tucker et al. 1995). Except for the role of treatment, the attributions of what had helped the respondents stay drug-free differed less between treated and untreated remitters than their inferences about what was important in the motivational process. However, it is worth noticing that more than half of the treated remitters, as compared to one-third of the self-changers, worked at the time of the interview in the health and welfare sector. Moreover, a quarter of the former actually worked in the substance misuse treatment field[11]. As concerns gender differences, it may be noted that men more often mentioned the role of a significant other (in most cases the new spouse) and improvements with regard to job or finances, whereas women more often mentioned having acquired a new social role and gained other people's respect. Indeed, most of the men, to whom a new partner often played a role in initial recovery, reported living with a new family at the time of the interview. In contrast, most of the women, who often had experienced physical and psychological abuse by their addicted partners, had chosen to be single after the resolution, although quite a few lived with their children. Overall, women also more often reported having struggled with feelings of guilt and shame after quitting. At the same time, they had more often taken up and completed higher studies after the resolution.

In summary, these results further underline the role of environmental factors and other people's support in lasting solutions to drug problems (cf. Granfield & Cloud 1999). More specifically, they also hint that the odds for leaving the addiction behind are better for people who have not exhausted their personal and social resources than for those who have (ibid.). Finally, a comparison with treated and untreated remitters from alcohol problems indicates that drug addicts have a more difficult path out, requiring stronger incentives to start contemplating change, as well as more profound changes in the overall life context to maintain the resolution (cf. Blomqvist 1999b; 2002b).

Rewriting One's History

The data presented thus far may be claimed to show not only that the ways in which one may "get hooked" by narcotic drugs are manifold, but that there are as many ways to "leave one's lover" (cf. Klingemann et al. 2001). This conclusion is further corroborated by a narrative analysis of the recovered respondents'

[11] This may partly be due to solicitation bias, partly to the fact that this is one of the careers that is most readily available to former drug abusers (cf. Klingemann 1997).

spontaneous life stories. In short, the choice to supplement data from standardised inventories with such an analysis was based on Davies' (1997) reminder that all people do not necessarily share the same "variable profile", and on Bruner's (1986) discussion of the paradigmatic and narrative approaches as two complementary ways of ordering human experience: the one aimed at abstraction and generalisation, the other explicitly interested in subjects' interpretations of their own world. The analysis started out from the idea of narrators as "theorists of their own lives", drawing on various culturally prevailing popular beliefs, convictions and theories. Drawing on previous work by Andersson and Hilte (1993) and Hänninen & Koski-Jännes (1999), an attempt was made to detect fundamentally different ways of accounting for the addiction experience and the path out[12]. As a result, four "story types" were discerned, reflecting different basic explanations of the addiction, and different attributions of what was the "key" to recovery.

In short, the typical *maturation story* depicted a childhood characterised by personal or social isolation and lack of positive feedback, which resulted in feelings of alienation and low self-esteem. Initial drug use was described as a means of obtaining access to and being accepted by coveted social circles, and of avoiding or postponing the shouldering of adult responsibilities. Being a drug addict, according to this story, meant adopting a submissive role in relation to a dominant and drug-using partner and/or to the rules of the "drug world". The recovery process typically began when something happened that made the protagonist realise that s/he wanted something else out of life and had the capabilities to shape her/his own future. Over time, the process involved breaking loose from oppressive relationships and/or environmental restraints and starting to build up a new personal and social identity, at first in the form of a rather lonely and isolated struggle, at later stages as a valued member of a new social network. This type of story, leaning on ideas from developmental psychology and the notion of hidden capacities, was told almost exclusively by self-changers, and more often by women than by men.

The *willpower story* typically conceives of initial drug use and entering the drug-using subculture as acts of free will. The drug experience is described as much in positive as in negative terms, and being part of the "drug world" as a way of gaining influence or a means of "easy money". The turning-point in this type of

[12] In short, the procedure meant that subjects' accounts were first categorised according to the basic explanations of addictions that they reflected and the views on the key to recovery that they expressed. By combining these dimensions, four basic categories, reflecting four different conceptions of addiction and recovery, were obtained. Thereafter, a composite story of each type was constructed, using material from several original accounts. Finally, each individual account was compared with the "type stories" and classified as belonging to one of these categories or as an interlaced story; i.e. a combination of two story types (cf. Gergen 1997). See Hänninen & Koski-Jännes (1999) and Blomqvist (2002a).

narrative occurred when the protagonist realised that the price for leading this kind of a life was becoming too high, and/or that s/he no longer was in full control of the situation. What was required to resolve these problems was self-determination and strategic action (moving to a new place, finding new social networks, etc.), and the long-term solution involved finding new arenas on which to give vent to the protagonist's competence and energy (a new family, a new job, new leisure activities, etc.). This type of story, drawing on the ancient "hero saga" and/or the concept of "Homo Economicus", is told by both self-changers and treated respondents, but is most common among the men in the former group.

The *liberation story* typically starts with a description a traumatic childhood where the protagonist was unloved and unseen, and where any expression of negative emotions was banned. Addiction is described as a vicious circle of anguish, depression and attempts at self-medication by drugs and other addictive behaviours. Recovery was typically achieved through a cathartic process in which the narrator came into contact with his/her true feelings, understood his/her own motives, and dared to face up with reality. This type of story, which may be said to be modelled on a classical psychotherapy discourse, is told by more than one-third of the women – in both the untreated and treated groups – as compared with less than one quarter of the men.

The *conversion story*, finally, may be described as being modelled on the typical AA narrative and/or on the cultural stereotype for religious conversion. In this type of story addiction is attributed to the protagonist's "nature" and/or the "power" of the drug and often depicted as a love relation. The solution is described as being preceded by a long history of denial and increasing problems, until the narrator realised that he/she had to choose between destruction or seeking help. Life after the resolution is characterised by gratitude, humbleness and commitment to assist one's fellow sufferers. This type of narrative is endorsed by both women and men in the treated group, but is rare in the self-change group.

On a general level, these results are concordant with the conclusion that treated respondents had been more deeply immersed in the "drug world" than the self-changers, and had to a larger degree exhausted their personal and social resources prior to seeking help. They are also in line with the interpretation that women relied more often on their own "inner strength" and had a longer path out, whereas men were more dependent on external influences and partner support, and more inclined to "seize the opportunity". More importantly, the narrative analysis may be claimed to support the notion of exit from drug addiction as an active process, where people make use of the available "cultural tool-box" (Bruner 1990), actively adapting and transforming prevailing theories or beliefs to fit with their own experiences (Andersson & Hilte 1993; Hänninen & Koski-Jännes 1999).

The Role of Treatment

Besides exploring the long-term processes of change, an important objective of the study was to gain a better understanding of the specific role of various professional or formally organised interventions in various stages of the recovery process. To this end the two treated, resolved and non-resolved groups were compared with regard to the development of their drug use and consequences, as well as the occurrence of significant, positive and negative life events, during the years prior to and following their last treatment experience. In addition, the respondents were asked for a narrative account of this experience, and to rank a number of potentially crucial treatment elements according to their overall significance and whether they had had a positive or a negative influence.

Whereas for the resolved group the inclusion criteria guaranteed that they had quit their drug use permanently during or soon after treatment, the first-mentioned analyses showed that to the non-resolved group treatment had not meant much more than a temporary hiatus in drug use. Furthermore, and more importantly, whereas to the latter group treatment had had no significant impact on other life areas, the overall life context of the resolved group had started to improve in vital areas already while in treatment, a development that continued after discharge. A reasonable interpretation is that these changes were as much the prerequisite for as they were the consequence of coming off drugs permanently. As for the role of treatment in the long-term change process, it should first be noted that the treatment experiences of the resolved and non-resolved groups did not differ on average with regard to setting, type of programme, theoretical ground or professional ideology. However, from the respondents' narratives and their ranking of various treatment elements, a number of factors could be discerned that seem to have been common to successful treatment experiences and to have distinguished these from treatment that did not work. Among these factors were having been "seen" as a person and met with respect, having felt that their own ideas and wishes were taken seriously, and having developed a close and trustful relationship with an individual helper. Further, the respondents in the resolved group mentioned far more often that they had received help in dealing with social, financial and other problems in their overall life situation, that they had been subjected to some emotionally shaking experience, and that they had taken part in some form of specific therapy that they could name. In most respects, these differences between successful and less successful treatment experiences paralleled those found among former and active problem drinkers (Blomqvist, 1999a&b). By and large, these results indicate that treatment success depends, to a large extent, on a number of "common factors" that are not specific to various treatment ideologies or techniques (cf. Frank & Frank 1991; Blomqvist 1996; Hubble et al. 1999). Thereby, they further underline that effective help to substance misusers

is best conceived of as a means of evoking, facilitating, accelerating and/or strengthening their own efforts to change (cf. Moos 1994; Blomqvist 1996).

Addiction in the Life Course Perspective: the "doxa" vs. the Addicts' View

Although the data reviewed were not primarily collected as a "test" of Swedish drug policy, and although caveats must be made regarding overall representativity, it is clear that what the interviewed drug addicts and ex-addicts have told about their experiences point at some dilemmas regarding Sweden's present way of dealing with drug problems.

According to the reigning "doxa", the substances subsumed under the legal definition of "narcotic drugs" will, irrespective of their varying chemical properties, rapidly and almost inevitably give rise to a psychological dependence in the individual user, making him or her a powerless slave under their addiction. Further, the prevailing public discourse depicts living as a drug addict as entering an alien and frightening world "which is screened off from the rest of the society, which is permeated by criminality, prostitution, violence, illness and death, and which is extremely difficult to get out from" (Kristiansen 1999, 9). Thus, to break the vicious circle, determined interventions on behalf of society are warranted, including long-term residential treatment, into which it may be necessary to coerce people who do not realise what is best for them. Finally, given the allegedly strong dependence-generating properties of all narcotic drugs and the contagiousness of drug use, far-reaching controlling, disturbing and punitive interventions on the part of the authorities are seen as legitimate.

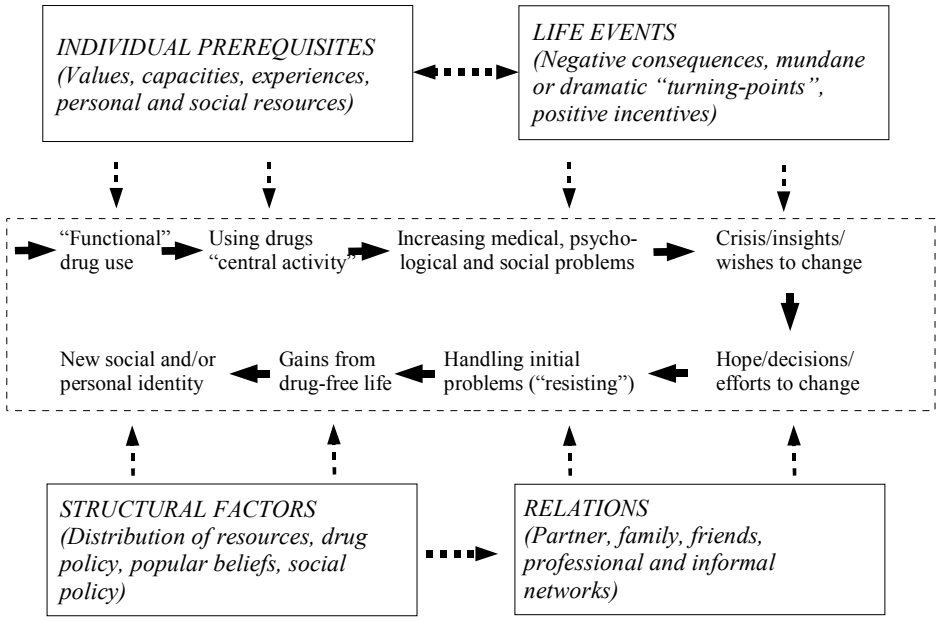
Without in any way denying or diminishing the pain and suffering that drug addicted persons may cause themselves, those closest to them, and others in their environment, it must be acknowledged that what the respondents have told about their experiences is in many ways at odds with the notion of drug misuse as an easily delineated, inexorably progressive and largely predictable pathological condition, which is contained in the prevailing "doxa". As for the entry into drug addiction, the data certainly indicate that "peer pressure" is a common reason for starting to use use drugs, a fact that may be interpreted as support for "contagion theory". However, some respondents rather describe their addiction as a deliberate choice, quite a few depict it as the effect of a voluntary, albeit misdirected attempt at self-medication of various psychological ailments, and some claim to have become addicted while in custody of the social services authorities, for instance. Moreover, most respondents give rather complex and modulated motivations both for starting drug use and for having been caught up in the addiction circle. Overall, the study results strongly indicate that there are many ways in which one may come to centre one's life around an addictive

habit, and that the specific path varies widely, among other things, with gender, socio-economic background, and the historical period during which one made one's acquaintance with the drug.

The lapse of time from initial use to full-blown addiction also varied, both between study groups and between individuals in the same group. As for the character of the addiction circle, the narratives depict a changeable process that is driven by a complex web of personal, psychological motives and external, social and structural forces, and frequently interrupted for longer or shorter periods for personal reasons or by altered external conditions. There is also great variation – both between individuals and over time for the same individual – in the descriptions of what it has meant to live as a drug addict. Indeed, some of the narrators recount how they have been more or less immersed in the "drug world" with its deviating norms, rituals and rules, supporting themselves by dealing, other forms of crime and prostitution. However, most respondents – even if they too have experienced powerful negative consequences in the form of violence, psychological oppression, deception, physical and psychological distress, feelings of anguish, guilt and inferiority – seem to have led some form of "double life", with at least some bonds to the surrounding "normal society". For instance, many of the women actually functioned as mothers during the whole or most of their addiction, a number retained at least some ties with the labour market, and quite a few tried to keep up at least some close relations with non-addicted friends or relatives.

Finally, the path out of the addiction, whether assisted or unassisted, is commonly described as a protracted process, the specific character of which seems to have been strongly influenced by the narrator's personal values and social resources, other people's reactions, and a number of sometimes unpredictable naturally occurring events. *Figure 1* attempts to summarise the "internal logic" of the addiction process and the path out, as well as the major driving forces in these courses.

Figure 1. Entry into and exit from drug addiction. "Inner logic" and main driving forces.



Rather than supporting the prevailing "doxa", more than anything this description fits in with the notion of drug addiction as a "central activity" in the addict's way of life (Fingarette 1988; Blomqvist 1998a), or as an adaptive albeit destructive reaction to the strains of life (e.g. Peele 1985; Drew 1986). As for the path out, this may best be pictured as a "salutogenic process" (Antonovsky 1979), that is as the result of each individual's way of making use of various "resistance resources" – whether indigenous, naturally existing or provided in the form of treatment – in his or her striving to make their world intelligible, manageable, and meaningful (cf. Hedin & Månsson 1998; Blomqvist 1999a; 2002a).

Some Implications for Practice

The Need to Place "Treatment" in Context

To help clarify some implications of the reviewed data for individual problem-handling, it may be useful to refer to the discussion by Brickman and colleagues (1982) of models of helping and coping. The authors start out from the assertion that moral attributions actually involve two questions, the issue of blame and the issue of control. The first question is about the extent to which an individual is

considered to be responsible for causing his/her problem. The second is about the extent to which he/she is considered to be responsible for and capable of solving the same problem. Based on the answers, four different approaches to personal and social problems can be formulated. Under the assumptions of the *"moral approach"*, people are held responsible for both creating and solving the problem, which means that help essentially takes the form of punishments and rewards. Under the assumptions of the *"medical approach"*, on the other hand, problems are seen as having been caused by forces beyond the subject's own control, and as curable only by professional experts. By and large, these two models correspond to the classical "badness-illness" dichotomy (cf. Mäkelä 1980). To this common figure of thought, however, the authors add the *"enlightenment or spiritual approach"*, according to which people are deemed responsible for having caused their problems, but are at the same time seen as incapable of solving them. As a consequence, the subject's best hope for a solution lies in submitting to a higher moral authority that can help him or her master their destructive impulses. Finally, according to the *"compensatory approach"* people are seen as subjected to various handicaps or obstacles, imposed on them by the situation or by nature, but as basically responsible for and capable of managing their own lives. Accordingly, they may be entitled to certain help, given on their own terms, and aimed at empowering them to do this on the same conditions as other citizens.

In another context (Blomqvist 1998b), I have concluded that the handling of drinking problems in Sweden has developed during the past century by and large from the moral to the medical, and to some extent the spiritual approach. The handling of drug problems, for its part, may rather be claimed to have developed from a medical approach (even in the strictest sense of this term) to what stands out as a hybrid between the moral, medical and spiritual approaches (Blomqvist 2002a). On the one hand, drug use, and intravenous use in particular, is conceived as "the incarnation of the most abominable deviation we can imagine" (Olsson 1994, 198). On the other hand, the misuser is depicted as a powerless victim, in need of long-term specialised treatment – or possibly spiritual "conversion" – to be able to rid him/herself from the spell of the drug.

A common feature of the moral, spiritual and medical approaches is that they all aim at remedying, by exhortations and punishment, by expert treatment or by conversion, some – alleged or real – moral, physiological or psychological – inner defect (Blomqvist 1998b). Closely in line with this idea, the treatment of drug – and alcohol – problems in Sweden (and indeed elsewhere) has traditionally been conceived as a situation where a professional therapist (or some other "authority") applies expert knowledge to more or less ignorant clients or patients (cf. Orford 1986; Cameron 1995). Most typically, this has been in the format of time-limited, albeit long-term, programmes in an in-patient setting (Lindström 1986; Blomqvist 1991). The manifest goal,in drug misuse treatment in particular, has been a total and lasting cure achieved in one

treatment occasion (Lindström 1993). In addition, most programmes seem to have been designed with a view to clients who are seeking help for the first time (Blomqvist 1991) and who from the outset have a strong motivattion for change (Prochaska et al. 1992). Still, coercion is perceived as a viable and justifiable means of urging drug addicts in particular into treatment. The reasonableness and effectiveness of such a format in helping people to change their addictive habits have often been questioned (e.g. Mäkelä 1980; Mulford 1988; Blomqvist 1991). However, neither this critique nor the generally meagre overall outcome of traditional treatment (e.g. Lindström 1992; Bergmark & Oscarsson 1993) seem thus far to have had very much impact on the organisation and content of society's efforts to persuade substance misusers to quit using. It is true that there has been an increasingly loud call for "evidence-based methods" in social work and substance misuse care in Sweden (e.g. SBU 2001). It is also true that the new "Mobilisation Against Narcotics" campaign, even if it essentially clings to the "control and sanction strategy", emphasises the need for more and better treatment (Action Plan 2002). However, the resources allotted to this end are relatively scarce, there is no specification of what the intended improvements would contain in more concrete terms, and there is, overall, little to signal a readiness to reassess the traditional notion of drug misuse treatment in a more thorough sense (Blomqvist 2002a).

Turning to the interviewed ex-addicts' own experiences, it is easy to see that much of what they have recounted stands in rather stark contrast to the assumptions of any of these models, as well as with the traditional "doxic" notions of what it takes to move away from one's addiction. For one thing the study, in accordance with similar research in other settings (cf. Klingemann et al. 2001), has shown that even severe drug misusers may under certain circumstances find a lasting solution to their predicament without professional treatment or other formally organised interventions. Although this finding provides no arguments for cutting the overall resources for helping substance misusers[13], it clearly belies the notion of long-term expert treatment as a necessary and basically sufficient condition for full and enduring recovery. Further, the study results support previous findings which indicate that factors such as clients' expectancies (e.g., Blomqvist 1996), a warm and confiding "therapeutic relationship" (e.g., Frank & Frank 1991) and adapting what is done in treatment to each client's specific constellation of human and social capital (Granfield & Cloud 1999), may be as decisive for a beneficial outcome as, for

[13] Potential selection bias prevents any conclusion as concerns the prevalence of such solutions. Taking into account Moos's (1994) reminder that the distinction between "treatment" and "life context" is rather arbitrary, it is quite possible that many of the self-changers would have found a quicker and less strainful path out, had they been offered professional help of a kind that they had found relevant (Blomqvist 2002a). At the same time, it is not unlikely that self-change from drug misuse is more prevalent in countries that are less "treatment-inclined" and/or have not taken as strong a stance against all drug use as Sweden (cf. Klingemann 1992; Blomqvist 2002b).

instance, the programme's professional ideology or the specific methods or techniques it endorses. Finally, the study indicates that there are many different paths out of severe drug problems, that moving away from the addiction is typically a long-term process, and that different sets of interacting psychological and social factors are crucial in different stages of this process (cf. Prochaska et al. 1992). All in all, these findings support the notion that formal treatment is at best only one part of the complex web of internal and external influences that may eventually lead a drug addict to an enduring solution (cf. Edwards 1989; Humphreys et al. 1997).

Consequently, it seems doubtful whether allocating more resources to, and introducing new treatment techniques into, the traditional drug misuse care system will be enough to achieve the goal of significantly increasing the number of addicts who will permanently leave their addiction. Certainly, there are no reasons to question per se the ambition to strengthen society's overall capacity to help substance misusers, to dismiss what can be learned from scholarly outcome research, or to refrain from using the best "tools" available in assisting people to change their life-styles. However, as the study referred to here has shown, there is more to a lasting solution to an addiction problem than being subjected to time-limited "treatment", including even the best of treatment techniques. Thus, to really improve the overall outcome of the drug misuse care system, the notion of treatment must be placed in context in a more fundamental sense.

In short, the findings and arguments presented above speak for arranging society's assistance to alcohol and drug misusers according to the "compensatory approach" (Brickman et al. 1982). Unlike the three other approaches, this approach conceives of help-recipients' troubles essentially as life-style problems that are strongly influenced by contextual, environmental factors, and sees the individual as basically capable and responsible, and as striving to make his or her life endurable and valuable as best s/he can. However, in spite of its close affinity with the traditional Swedish social welfare ideal, the compensatory approach has – for reasons that have been discussed elsewhere (Blomqvist 1998a; 2002a) – as yet been largely absent from the country's alcohol and drug misuse care system. Without going into the details, some crucial aspects of a transition from the moral/spiritual/medical or "expert" model to the compensatory approach can be delineated. Among these are that it is vital "to start where the client is" (Blomqvist 1996), that the helper needs to acknowledge each individual's own views and expectations (Hubble et al. 1999), that what is done has to build on his or her personal and social resources (Granfield & Cloud 1999), and that the helper needs to identify, support and interact with various "healing forces" in the natural environment (Lindström 1992). Further, since motivation to change is perishable goods, help must be easily available and provided in an unthreatening and unstigmatising setting. Finally, it needs to be recognised that the client may subjectively have perfectly "good reasons" for his

or her drug use, and that improvement in vital life areas may in some cases be an acceptable and viable goal. Of these claims, the last two are probably the ones that are hardest to reconcile with the prevailing "doxa", tending to regard anything but zero tolerance as a serious threat to the vision of a "drug-free society", and to misconstrue "harm reduction" as "drug liberalism".

Drug Problems and Larger Social Realities

As already indicated, the core message of Sweden's new campaign against narcotic drugs is that the traditional "control and sanction strategy" has proven its effectiveness, and that increasing drug problems and drug-related harm during the past decade should be attributed to deficiencies in the enforcement of this policy. Others opposed to this view have interpreted Sweden's "war on drugs" as mainly a symbolic activity, without much relevance for actual developments with regard to the prevalence of severe drug misuse or the total sum of drug-related harm (e.g. Christie & Bruun 1985; Tham 1995). Lenke and Olsson (1996) maintain that Sweden's comparatively low prevalence of drug problems until rather recently, has been due less to specific drug policy measures than to the country's "protected" geo-political location and a strong welfare policy, which has guaranteed low unemployment and a high degree of social integration. According to such a perspective, the proper way to handle today's situation, when the conditions have changed for the worse in both these respects, is hardly more controlling and repressive measures based on a traditional paternalistic perspective. Rather, what is needed is a policy that takes into account the personal experiences of those concerned and tries to adapt to today's social and economic realities (Olsson 1999).

The data reviewed in this article provide no solid ground for deliberations over the potential effectiveness of traditional Swedish drug policy in preventing people from starting to use or experimenting with narcotic drugs. What they do indicate however, is that a true strengthening of the "third pillar" of Swedish drug policy, i.e. getting more addicts to quit, would also require a basic shift of perspective. For example, the accounts of the interviewed ex-addicts have clearly shown that an enduring solution, whether with or without the assistance of professional helpers, has entailed much more than simply to stop using. Gaining hopes for the future and finding credible alternatives to a life centred around the drug have in most cases been crucial aspects of the motivation for trying to alter one's life-style. Similarly, maintaining the resolution has not only required finding a rewarding life-situation in terms of proper housing, decent jobs and satisfying social activities. It has also required support from the environment and finding an option to build up a new social role as a responsible and valued citizen. Further, it is rather obvious that the strain it has taken to move out of one's addiction, as well as the amount of formally organised support that has

been necessary, has been strongly related to each respondent's total amount of "rehabilitation capital" (cf. Granfield & Cloud 1999). Indeed, the respondents who, in spite of extensive treatment experiences, have not been able to quit have differed from the "remitters" less in terms of the severity and duration of their addiction than in terms of personal and social resources. In addition, the study results indicate that there are strong barriers to seeking help, due to the stigma attached to coming out as a drug addict, and the perceived risk of being exposed and questioned in one's capacity of a parent, a neighbour or an employee. Moreover, they hint, at least indirectly, that the prevailing "doxa" may jeopardise the environment's inclination to put faith in and support the recovering drug addict, as well as his or her trust in their own capacity, thereby functioning to a degree as a self-fulfilling prophecy (cf. Klingemann 1992; Blomqvist 2000). These results may be claimed to support the interpretation that the increase in the number of "heavy drug misusers" during the past decade has been the result not primarily of weakening legal control, or even an alleged reduction in the number of treatment options, but rather of the social and structural changes undergone by Swedish society, making it increasingly difficult to establish a dignified and rewarding life as an ex–drug misuser (cf. Lander et al. 2002; Oscarsson 2000; 2001[14]). Thereby, they also point to the need to acknowledge the extent to which phenomena such as addiction or dependence are tied to the structural matrix of late modern society, and embedded in the misusers' social and cultural context.

A more detailed discussion of what such a shift from a largely control and treatment oriented view towards a wider, socio-cultural and structural perspective would entail, or which new strategies it might generate, falls beyond the scope of this chapter. Indeed, several authors have claimed that addiction is actually "a basic condition" of the late modern or market economy society (e.g., Alexander 2000). Svensson (1996) maintains that drug addicts' tendency to prevail in their misery, in the face of obvious negative consequences, can to a great part be attributed to the fact that living as a drug addict provides a – largely illusory – solution to many of the "dilemmas of modernity" delineated by Berger (1977)[15]. Giddens (e.g. 1991; 1994) discusses repetition, i.e. addiction, as a panacea for handling existential agony in a society where, in the wake of the

[14] Oscarsson (2001) claims that the conviction of many practitioners that treatment resources have been dramatically cut may be partly illusory, reflecting rather their frustration over the lack of viable alternatives for former drug misusers after treatment.

[15] In short, being part of the "drug world" means living in the present, in a context where the drug is cult, surrounded by routines and rituals for financing, acquiring and consuming the psychoactive substance (Svensson 1996). Thereby, living as a drug addict can be seen as a way of trying to handle the secularisation of the modern society, as well as its inevitable "future-directedness", its alienation of the individual from the traditional community, and the compulsory freedom of choice (cf. Berger 1977).

collapse of tradition, the individual self has become a "reflexive project" that must be continuously constructed and re-constructed without guidance from any given constellation of social institutions. Notions such as these may make any attempts to solve the addiction problem within the limits of the prevailing order seem rather futile. However, as the saying goes, it might not be necessary to regard "the best" as the enemy of "the second best". For instance, Giddens has pointed out that precisely the "boundlessness" that characterises late modern society, entailing loss of meaning and the dissolution of traditional social institutions, may also create room for new institutional arrangements and new forms of social integration. Following this train of thought, Granfield and Cloud (1999) have pointed to local popular mobilisation, aimed at increasing the local community's aggregate amount of "social capital", as a more constructive and productive way of countering addiction and other social problems, than expert treatment, initiated by various authorities and targeting this or that specific "problem group". Similar ideas on how to deal with alcohol problems on the local level have been described earlier by Mulford (1979; 1988).

As for the Swedish drug situation, Lander et al. (2002), in their plea for a more realistic drug policy, put faith in the hope that the Swedish welfare state model will prove not to have exhausted its potential in this field; i.e. that stronger social policy measures will again be able to counter social and ethnic segregation, widespread unemployment and housing problems, thus creating alternatives to choosing a life as a drug addict. Possibly, and considering the obvious significance of widespread "grassroot commitment" in achieving such goals, these hopes main gain some support from Rothstein's (1994) claim that the way in which public institutions are organised will influence civic values (cf. Blomqvist 1998b). If nothing else, one might argue that if making the alternatives visible is a necessary condition of change, this should be valid not only for drug addicts' efforts to alter their life-style, but also for society's attempts to assist them in doing so. Whatever the odds for such a shift of focus, there is much to indicate that a real "choice of road" in Swedish drug policy would entail not only paying attention to perceived "risk factors", but also, and to a much greater degree than presently, to the structural, social and psychological "resistance resources" that may help people cope with their lives, without taking refuge through chemical means. After all, in trying to prevent certain behaviours that are deemed unacceptable, it would make more sense to target the conditions that produce and maintain these behaviours than to just control, punish or try to reform those who exhibit them. To paraphrase Granfield and Cloud (1999): there may not be much point in trying to get people to "say no" to drugs, unless we can show them something more attractive and more fulfilling to "say yes" to.

References

Abrahamson, M. (1989): Synen på missbruk – 80 år av diagnostisk rundgång. *Nordisk Sosialt Arbeid, 9,* 38-49.

Abrahamson, M. (1999): *Alkoholkontroll i brytningstid – ett kultursociologiskt perspektiv.* Stockholms universitet: Institutionen för socialt arbete: Rapport nr 88.

Action Plan 2002. *Aktionsplan 2002 för narkotikapolitisk mobilisering och samordning.* Stockholm: Socialdepartementet.

Alasuutari, P. (1986): Alcoholism in its cultural context: the case of blue-collar men. *Contemporary Drug Problems,* 13, 641-686.

Alexander, B. K. (2000): The globalization of addiction. *Addiction Research,* 86, 501-526.

Andersson, B. & Hilte, M. (1993): *Förändringens väg. Självförståelse och strategier i frigörelsen från drogmissbruk.* Research reports, Network for Research in Criminality and Deviant Behaviour at Lund University.

Antonovsky, A. (1979): *Health, Stress and Coping: New Perspectives on Mental and Physical Well-Being*. San Fransico: Jossey Bass.

Barker, J. (1998): Thunder and Silence in Drug Treatment: Four Nations in Moral Concert. In: Klingemann, H. & Hunt, G. (Eds.): *Drug Treatment Systems in an International Perspective*, 61-66. London: Sage.

Bejerot, N. (1969): *Narkotikafrågan och samhället.* Stockholm: Aldus/Bonniers.

Bejerot, N. (1972): *Narkotika och narkomani*. Stockholm: Aldus/Bonniers.

Bejerot, N. (1975): Drug Abuse and Drug Policy – An epidemiological and methodological study of drug abuse of intravenous type in the Stockholm police arrest population 1965-1970 in relation to changes in drug policy. *Acta Psychiatrica Scandinavica, Supplementum 256.*

Bejerot, N. (1980): Addiction to pleasure. In: Lettieri, D.J.; Sayers, M. & Wallenstein Pearson, H. (Eds.): *Theories on Drug Abuse. Selected Contemporary Perspectives*. Rockville: NIDA. Research Monograph 30.

Berger, P. (1977): *Facing up to Modernity*. USA: Basic Books.

Bergmark, A. (1998): Expansion and Implosion. The Story of Drug Treatment in Sweden. In: Klingemann, H. & Hunt, G. (Eds.): *Drug Treatment Systems in an International Perspective,* 33-47. London: Sage.

Bergmark, A. (2001): Anteckningar om den svenska narkotikakommissionens betänkande. *Nordisk Alkohol- & Narkotikatidskrift,* 18, 311-315.

Bergmark, A. & Oscarsson, L. (1988): *Drug Misuse and Treatment - A Study of Social Conditions and Contextual Strategies.* Stockholm: Almqvist & Wiksell International.

Bergmark, A. & Oscarsson, L. (1990): Vad får det kosta att rehabilitera missbrukare? In: Pettersson, U. (Ed.): *Etik och socialtjänst,* 47-64. Stockholm: Gothia.

Bergmark, A. & Oscarsson, L. (1993): Behandlingseffekter inom narkomanvården. In *Redovisning av satsningen offensiv narkomanvård*, 101-117. Stockholm; Socialstyrelsen.

Bernstein, B. (1976): Socialklass, språk och socialisation. In: Gregersen, F. et al.: *Klasspråk. Sociolingvistik och utbildning. En antologi.* Stockholm: Gidlunds.

Blomqvist, J. (1991): *Rätt behandling för rätt klient – ingen enkel match*. Stockholm: Socialförvaltningen: FoU-byrån. FoU-rapport 1991:14.

Blomqvist, J. (1996): Paths to recovery from substance misuse: Change of lifestyle and the role of treatment. *Substance Use and Misuse,* 31 (13), 1807-1852.

Blomqvist, J. (1998a): *Beyond Treatment? Widening the approach to alcohol problems and solutions.* Stockholm University: Department of Social Work.

Blomqvist, J. (1998b): The "Swedish model" of dealing with alcohol problems: historical trends and future challenges. *Contemporary Drug Problems, 25 (Summer)*, 253-320.

Blomqvist, J. (1999a): *Inte bara behandling. Vägar ut ur alkoholmissbruket*. Stockholm: Bjurner & Bruno.

Blomqvist, J. (1999b): Treated and Untreated Recovery from Alcohol Misuse. Environmental Influences and Perceived Reasons for Change. *Substance Use and Misuse, 34 (10)*, 1371-1406.

Blomqvist, J. (2000) Att sluta missbruka: behandling och andra inflytanden. In Berglund, M. et al. *Behandling av alkoholproblem. En kunskapsöversikt*, 128-148. Stockholm: CUS and Liber Förlag.

Blomqvist, J. (2002a): *Att sluta med narkotika – med och utan behandling.* Socialtjänsten i Stockholm: FoU-enheten. FoU-rapport 2002:2.

Blomqvist, J. (2002b): Recovery with and without treatment: A comparison of resolutions of alcohol and drug problems. *Addiction Research and Theory,* 10(2), 119-168.

Boekhout van Solinge, T. (1997): *The Swedish Drug Control System*. Amsterdam: CEDRO.

Bourdieu, P. (1977): *Outline of a Theory of Practice.* Cambridge University Press.

Brickman, P.; Rabinowitz, V. C.; Karuza, J.; Coates, D.; Cohn, E. & Kidder, L. (1982): Models of helping and coping. *American Psychologist,* 37, 368-384.

Bruner, J. (1986): *Actual Minds, Possible Worlds*. Cambridge: Harvard University Press.

Bruner, J. (1990): *Acts of Meaning.* Cambridge: Harvard University Press.

Cameron, D. (1995): *Liberating Solutions to Alcohol Problems. Treating Problem Drinkers Without Saying No.* Northvale, N.J.: Jason Aronson Inc.

CAN (1993): *Alkohol- och narkotikautvecklingen i Sverige*. Stockholm: CAN (Swedish Council for Information on Alcohol and other Drugs) Rapport 93.

CAN (1997): *Alkohol- och drogutvecklingen i Sverige*. Stockholm: CAN (Swedish Council for Information on Alcohol and other Drugs) / FHI (National Institute of Public Health): Rapport 97.

CAN (2001): *Drogutvecklingen i Sverige* . Stockholm: CAN (Swedish Council for Information on Alcohol and other Drugs). Rapport nr 63

Christie, N. & Bruun, K. (1985): *Den goda fienden. Narkotikapolitik i Norden*. Stockholm: Rabén & Sjögren.

Davies, J. B. (1997): *Drugpeak. The analysis of drug discourse.* Amsterdam: Harwood Academic Publishers.

Drew, L.R.H (1986): Beyond the disease concept of addcition: drug use as a way of life leading to predicaments. *Journal of Drug Issues,* 16(2), 263-274.

Edwards, G. (1989): As the years go rolling by: Drinking problems in the time dimension. *British Journal of Psychiatry,* 154, 18-26.

EMCDDA (2003a): *Annual report 2003: the state of the drugs problem in the acceding and candidate countries to the European Union.* Luxemburg: EMCDDA.

EMCDDA (2003b): *Annual report 2003: the state of the drugs problem in the European Union and Norway.* Luxemburg: EMCDDA.

Fingarette, H. (1988): *Heavy Drinking. The Myth of Alcoholism as a Disease.* L.A: Univ. of California Press.

Frank, J. D. & Frank, J. B. (1991): *Persuasion and Healing: A Comparative Study of Psychotherapy*. Baltimore: Johns Hopkins University Press.

Fredriksson, R. (1991): Social alkoholpolitik i Sverige 1900-1939. In: Gustafsson, A. (Ed.) *Alkoholister och nykterister*, 79-96. Skrifter från Etnologiska institutionen, Uppsala universitet.

Fridell, M. (1996): *Institutionella behandlingsformer vid missbruk: organisation, ideologi och resultat*. Borås: Natur & Kultur.

Gergen, K. (1997): *Realities and Relationships. Sounding in Social Construction*. Cambridge: Harvard Univ. Press.

Giddens, A. (1991): *Modernity and Self-Identity: Self and Society in the Late Modern Age.* Stanford University Press.

Giddens, A. (1994): Living in a post-traditional society. In: Beck, U.; Giddens, A. & Lash, S. (Eds.): *Reflexive Modernization*, 56-109. Cambridge: Polity Press.

Goldberg, T. (1997): The Swedish Narcotics Control Model – A Critical Assessment. *International Journal of Drug Policy,* 8 (2).

Goldberg, L. (1968): Drug abuse in Sweden. *Bulletin on Narcotics, 1*, 1-31.

Government Proposition 2001/02:91 *Nationell narkotikahandlingsplan (National Drug Action Plan).*

Granfield, R. & Cloud, W. (1999): *Coming Clean. Overcoming Addiction Without Treatment.* N.Y Univ. Press.

Hänninen, V. & Koski-Jännes, A. (1999): Narratives of recovery from addictive behaviours. *Addiction Research,* 94, 1837-48.

Hedin, U-C. & Månsson, S-A. (1998): *Vägen ut: om kvinnors uppbrott ur prostitutionen*. Stockholm: Carlssons.

Hilte, M. (1990): *Droger och disciplin. En fallstudie av narkomanvård i Malmö*. Lund Studies in Social Welfare IV. Lund: Arkiv Förlag.

Hilte, M. (1998): Narkotikakriget – det öppna eller slutna samhället. *Oberoende, 1-2*.

von Hofer, H.; Lenke, L. & Tham, H. (1998): En mindre repressiv narkotikapolitik sparar liv. *Oberoende, 3.*

Hubble, M. A.; Duncan, B. L. & Miller, S. D. (1999): *The Heart and Soul of Change. What Works in Therapy*. APA Books.

Hübner, L. (2001): *Narkotika och alkohol i den allmänna opinionen. Stockholms universitet, Institutionen för socialt arbete*. Rapport nr 99.

Humphreys, K.; Moos, R. H. & Cohen, C. (1997): Social and community resources and long-term recovery from treated and untreated alcoholism. *Journal of Studies on Alcohol,* 58 (3), 231-238.

Johansson, L. (1995): *Systemet lagom. Rusdrycker, intresseorganisationer och politisk kultur under förbudsdebattens tidevarv 1900-1922*. Lund University Press: Bibliotheca Historica Lundensis, 86.

Klingemann, H. (1991): The motivation for change from problem alcohol and heroin use. *British Journal of Addiction, 86,* 727-44.

Klingemann, H. (1992): Coping and maintenance strategies of spontaneous remitters from problem use of alcohol and heroin in Switzerland. *International Journal of the Addictions, 27,* 1359-88.

Klingemann, H.; Takala, J-P. & Hunt, G. (Eds.) (1992): *Cure, Care or Control. Alcoholism Treatment in Sixteen Countries*. New York: State University of New York Press.

Klingemann, H. (1997): Addictions careers and careers in addiction. Paper presented at the KBS symposium in Reykjavik, June 1997.

Klingemann, H.; Sobell, L.; Barker, J.; Blomqvist, J. et al. (2001): *Promoting Self-Change from Problem Substance Use.* Dordrecht: Kluwer Academic Publishers.

Kristiansen, A. (1999): *Fri från narkotika. Om kvinnor och män som varit narkotikamissbrukare.* Umeå University, Department of Social Welfare: Social Work Studies 28.

Lander, I.; Olsson, B.; Rönneling, A. & Skrinjar, M. (2002): *Narkotikamissbruk och marginalisering. Slutrapport från MAX-projektet.* Rapport nr 65. Stockholm: CAN.

Lenke, L. & Olsson, B. (1996): Sweden: Zero tolerance wins the argument. In: Dorn, N.; Jepsen, J. & Savona, E. (Eds.): *European Drug Policies and Enforcement*. London: McMillan Press.

Lindgren, S-Å. (1993): *Den hotfulla njutningen. Att etablera drogbruk som samhällsproblem 1890-1970*. Stockholm: Symposion Graduale.

Lindström, L. (1986): *Val av behandling för alkoholism*. Stockholm: Liber Förlag.

Lindström, L. (1992): *Managing Alcoholism. Matching Clients to Treatments*. Oxford University Press.

Lindström, L. (1993): Socialtjänsten och den hemlöse alkoholisten. *Sociologisk Forskning, 30(1)*, 29-45.

Mäkelä, K. (1980): What can medicine properly take on? In Edwards, G. and Grant, M. Editors *Alcoholism Treatment in Transition*, 225-233. London: Croom Helm.

Moos, R. (1994): Treated or untreated, an addiction is not an island unto itself (editorial). *Addiction,* 89, 507-509.

Mulford, H. (1979): Treating alcoholism versus accelerating the natural recovery process: a cost-benefit comparison. *Journal of Studies on Alcohol,* 40, 505-513.

Mulford, H. (1988): Enhancing the natural control of drinking behavior: catching up with common sense. *Contemporary Drug Problems,* 15, 321-334.

Noelle-Neuman, E. (1995): Pulic opinion and rationality. In: Glasser, T. H. & Salmon, C. T. (Eds.): *Public Opinion and the Communication of Consent*. New York: The Guilford Press.

Olsson, B. (1994): *Narkotikaproblemets bakgrund. Användning av och uppfattningar om narkotika inom svensk medicin 1839-1965.* Stockholms universitet: Sociologiska institutionen/CAN:s rapportserie nr 39.

Olsson, B. (1999): Sammanfattning och kommentarer. In: Guttormsson, U.; Helling, S. & Olsson, B.: *Vad händer på narkotikaområdet? Narkotikamissbruk och marginalisering – tendenser inför millenieskiftet. MAX-projektet, delrapport 1*, 105-109. Stockholm: CAN.

Olsson, O.; Byqvist, S. & Gomér, G. (1993): *Det tunga missbrukets omfattning i Sverige 1992.* Stockholm: CAN. Rapport nr 28.

Olsson, B.; Adamson-Wahren, C. & Byqvist, S. (2001): *Det tunga narkotikamissbrukets omfattning i Sverige 1998. MAX-projektet, delrapport 3.* Stockholm: CAN. Rapport nr 61.

Orford, J. (1986): Critical conditions for change in the addictive behaviors. In: Miller, W. R. & Heather, N. (Eds.) *Treating Addictive Behaviors. Preocesses of Change*. New York: Plenum Press.

Oscarsson, L. (2000): Den socialtjänstbaserade missbrukarvården under 1990-talet – förutsättningar, utveckling och behov. In: Szebehely, M. (Ed.): *Välfärd, vård och omsorg. Antologi från Kommittén välfärdsbokslut*. SOU (Public Government Report) 2000.38.

Oscarsson, L. (2001): Missbrukarvården och samhället – utvecklingen under 90-talet. *Socionomen,* 5, 20-25.

Pearson, G. (1987): *The new heroin users*. Oxford: Basil Blackwell.

Peele, S. (1985): *The Meaning of Addiction. Compulsive Experience and Its Interpretation*. Toronto: Lexington Books.

Prochaska, J. O.; DiClemente, C. C. & Norcross, J. C. (1992): In search of how people change. Application to addictive behaviors. *American Psychologist,* 47, 1102-114.

Rikspolisstyrelsen och Tullverket (2003) *Narkotikasituationen i Sverige. Årsrapport 2002.* Rikspolisstyrelsen, 2003:4; Tullverket, A 3819/03.

Room, R. (1985) Dependence and society. *British Journal of Addiction, 80,* 133-139.

Rothstein, B. (1994): *Vad bör staten göra? Om välfärdsstatens moraliska och politiska logik*. Stockholm: SNS förlag.

SBU (2001): *Behandling av alkohol- och narkotikaproblem. En evidensbaserad kunskapssammanställning* (Volym I och II). Stockholm: Statens beredning för medicinsk utvärdering (Swedish Council on Technology Assessment in Health Care).

Skinner, H. A. (1982): The Drug Abuse Screening Test. *Addictive Behaviors,* 7, 363-371.

SoS (2000): *Insatser och klienter i behandlingsenheter inom missbrukarvården den 31 mars 1999 (IKB 1999)*. Stockholm: Socialstyrelsen (National Board of Health and Welfare)

SoS (2001): *Missbrukare och övriga vuxna – insatser år 2000.* Statistik. Socialtjänst 2001:6. Stockholm: Socialstyrelsen (National Board of Health and Welfare)

SOU (Public Government Report) 1967:27 *Narkotikaproblemet – kartläggning och vård. Betänkande avgivet av medicinalstyrelsens narkomanvårdskommitté.*

SOU (Public Government Report) 1967:41 *Narkotikaproblemet – kontrollsystemet. Betänkande avgivet av medicinalstyrelsens narkomanvårdskommitté.*

SOU (Public Government Report) 2000:126 *Vägvalet – den narkotikapolitiska utmaningen. (The choice of road – the challenge in drug policy).* Stockholm: Socialdepartementet.

Stimson, G. V. (1973): *Heroin and behaviour*. Shannon: Irish University Press.

Svensson, B. (1996): *Pundare, jonkare och andra – med narkotikan som följeslagare.* Stockholm: Carlssons.

Tham, H. (1995): Drug control as a national project: The case of Sweden. *Journal of Drug Issues* 25 (1), 113-128.

Tham, H. (1998): Avskaffa parollen ett narkotikafritt samhälle. *Oberoende,* 1-2.

Tham, H. (1999): Hur bra är "den svenska modellen" egentligen? *Social Forskning* 1/99.

Tucker, J. A.; Vuchinich, R. E. & Gladsjo, J. A. (1994): Environmental events surrounding natural recovery from alcohol-related problems. *Journal of Studies on Alcohol,* 55, 401-411.

Tucker, J. A.; Vuchinich, R. E. & Pukish, M. M. (1995): Molar environmental contexts surrounding recovery from alcohol problems by treated and untreated problem drinkers. *Experimental and Clinical Psycho-pharmacology,* 3 (2), 195-204.