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The Swedish drug problem: Conceptual understanding and problem handling, 1839–2011

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ABSTRACT

AIM – To analyse the Swedish drug question by examining dominant concepts used to portray the problem in the years 1839–2011. Theoretically, we understand these concepts as ideological tools that shape the political initiatives and administrative efforts to deal with the problem. The study is based on two kinds of source material: articles in medical journals from the years 1839–1964 and public reports on vagrancy, the alcohol problem, mental health and the drug problem from the years 1882–2011.

FINDINGS – During the nineteenth century and the first part of the twentieth century the drug problem remained an individual problem handled by doctors. When the Swedish drug problem was established as a political question from the 1960s on, it also came to disengage itself from the medical frame of understanding. Medically oriented descriptions of "dependence" and "addiction" have appeared adequate or attractive when, for example, the socially motivated coercive treatment solution has been discredited (as in the 1970s), when there has been a desire to connect with an internationally accepted terminology (as in the 1990s) or when a new organisational model with a stronger professional support has been on the agenda (as in the 2010s). But otherwise the social problem description has called for concepts that have more or less explicitly dissociated themselves from speculations in physiological or psychological predispositions for substance abuse.

KEYWORDS – Sweden, history, 20th century, 19th century, drug problem, concepts

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Introduction

The aim of this article is to analyse the Swedish drug question by examining dominant concepts used to portray the problem in the years 1839–2011. During the 1800s, drugs never qualified as a social problem in a broader sense and in the 1887 edition of a famous Swedish encyclopaedia (*Nordisk familjebok*, 1887, p. 810), the word "narcotics" is described as referring to "depressant substances" in a presentation with a medical and pharmacological approach. Drug abuse was not discussed

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at all, because this was a little-noticed phenomenon outside of the medical domain. Our search for the naming and problem formulation of the drug issue therefore begins by reading the medical specialist press.

By the turn of the nineteenth and twentieth century, social problems were being debated with a totally new intensity. The dominant problem description – the social question – can partly be described as a uniform problem, partly as a problem with many faces. It was about poverty, the individual's but also the newly awakened industrialised nation's relative poverty. The decades before and after the turn of the century were characterised by industrialisation, modernisation, urbanisation and widespread concern about the population's qualities and ability to live up to the new demands of the future. Emigration, fear of degeneration, drunkenness and prostitution were highlighted as selected parts of a social problem complex that in earlier research has been termed the labour question, the poverty question or the alcohol question (Edman, 2004). This potentially opens up for a description of drugs in a broader context: as part of, for example, the problem of vagrancy, alcohol or mental health.

Theoretically, we understand the investigated concepts as ideological tools that structure political initiatives and administrative efforts to deal with the drug problem. The ambition has not been to nail down the conceptual definitions to any particular ideology, but rather to show how the work of concepts has been politically driven – i.e. based on political ambitions to achieve some reforms rather than on how best to describe a certain phenomenon. As historian Willibald Steinmetz (2002) has formulated it: what can be said (*das Sagbare*) structures what can be done (*das Machbare*). Every attempt to settle a normative vocabulary can therefore be regarded as an ideological action (Skinner, 1999). As has been shown in alcohol and drug history studies (e.g. White, 2004; Edman & Stenius, 2014), this also means that comprehensive changes in the field can be derived from the analyses of used concepts.

Our study is based on two kinds of source material: articles in medical journals from the years 1839–1964 and public reports on vagrancy, the alcohol problem, mental health and the drug problem from the years 1882–2011.[1] The medical journals cover a period when the drug issue was not discussed in the public material, and a more extensive analysis of this material has previously been conducted by Börje Olsson (1994). The use of public reports has proven fruitful especially since the recognition of drug consumption as a public problem from the late 1960s on. Previous studies of some of this material have been conducted for the period up until 1982 (Edman, 2012; Edman & Stenius, 2014).

The empirical investigation has been chronologically structured. After analysing the long period between 1839 and 1964, when the drug problem was mainly a marginal issue for the medical profession, we turn our focus to different conceptual framings of the drug problem from the mid-1960s up until today. The article concludes with a summarising discussion.

The medical privilege to define the problem (1839–1964)

The development of the Swedish drug problem is in many respects unique. This

applies to both the epidemiological development of drug use and abuse as well as to the ensuing drug policy. In order to understand the dominant concepts that make up the "modern" drug question, it is absolutely critical to have some basic knowledge of the historical picture. This is especially true when attempts are made to compare the Swedish drug policy with the situation in other countries. In the following section, the history before the modern Swedish drug problem will therefore be analysed in terms of descriptions of perceived problems, prescribed solutions and dominant concepts used to define its different aspects. The analysis will cover the time period from 1839 to 1964. During this time, drug problems were almost exclusively dealt with within the medical field. In this article we highlight only a few illustrative examples of this. The analysis focuses specifically on how drug use, abuse and problems have been discussed and defined in medical journals. The studied articles are essentially representative of how the issues were discussed in Swedish medicine during this period (Olsson, 1994), and with few exceptions the medical discourse on drugs was tantamount to how the issue was discussed in the wider community.

The medical problem description before the Second World War

During the period from the mid-1800s until about 1900 drug abuse was problematised rarely and mostly indirectly. The articles mention or talk about abuse in three ways: 1) as temporary abuse leading to severe poisoning; 2) as abuse of easily accessible and often over-the-counter combination drugs containing narcotic substances, and; 3) as abuse that had started as legitimate medical use of drugs. The articles treat the first and second category in a neutral way in stating that some people either use drugs more than the doctor has prescribed or entirely outside the legitimate medical system. In both cases the term abuse [*missbruk*] refers to these non-acceptable ways of using drugs. It was indeed risky to use them incorrectly, and in these cases such use constituted the very meaning of the term abuse.

However, neither of these two forms of abuse had any real effect on what later would become the dominant perceptions of drug abuse in the formation of the modern drug problem. It turned out differently with the third form of abuse described above. Abuse that had started as legitimate medical use of drugs was an immediate consequence of a common treatment practice within the health care system. The doctors used available knowledge to diagnose diseases, resorting to the pharmacological substances at hand. Since awareness of the addictive capacity of the substances was limited, medical use occasionally transcended into abuse:

> During the slow healing process the patient suffered severely, which is why subcutaneous morphine injections were used for a longer period of time. After being discharged from hospital, he continued his medication but was constantly increasing the dose (Södermark, 1875, p. 671).

The cause behind abuse was thus primarily ascribed to the inherent addictive capacity of the substance in combination with the abusers' somatic or psychologi-

cal conditions. To some extent, also a lack of individual moral character was linked to the emergence of abuse. Although the descriptions of abuse were mostly neutral, one could still sense a moral tone in many. Even if it was not openly claimed, it was lack of character that made some persons disobey the doctor's prescription, and consequently give in to pleasure.

> […] the cause of the disease is mainly, and often only, nourished by a *weak and deteriorated willpower*. Even if the willpower has been strong and dynamic before the beginning of morphine use, sooner or later anaesthesia occurs which will affect both morality and physical capacity (Wetterstrand, 1896, p. 369).

No actual descriptions were made about what abuse really was, other than it was simply said to be a disease. Empirical data suggests that drug abuse was phrased as a problem only in the sense that excessive use was not good, rather like saying that it was not good to use too much of any risky product. It would lead to a gradual destruction of mental and physical health, while problem descriptions of a social, economic or criminal nature were missing altogether. These views on the causes and problems related to drug abuse explain why the solutions to the perceived problems were placed within the medical system. Detoxification and treatment were seen as the main components in solving the problems, supplemented with an administrative sharpening of how the substances were supplied from pharmacies. All in all, drug abuse was seen as a medical and individual problem.

The period from the beginning of the twentieth century until about the Second World War involved several important changes that affected the views on drug use, abuse and problems. New drugs appeared in medical practice at the same time as older ones were ruled out. This was of course due to medical innovations but also the result of increased knowledge about the detrimental effects accompanying older medical substances. Among the new drugs introduced during this period were barbiturates and various central nervous system stimulants such as amphetamines. It was still common to refer to foreign experiences of drug abuse during this period, i.e. experiences that particularly concerned morphine and, over time, the growing abuse of heroin. It is not possible to discern a more generally distributed definition of what constitutes abuse. Still, "abuse" referred to such use as did not conform to medically prescribed ways, pertaining in practice to both temporary and more regular drug use. In the discussion about potential drug problems, however, it is clear that the focus was on the frequent and habitual use of drugs, usually in high doses.

The most obvious change in relation to the concept of abuse was the actual link to the users/abusers. "Abuse" was constructed from an empirical and clinically driven approach that was common in contemporary medical practice as patients were observed and treated. Yet there were no deeper insights in psychiatry, brain research was not especially developed, and research of social processes was rudimentary, which excluded elaborated definitions related to these areas. On the other hand, drug users have always been before the

eyes of the doctors, and in the absence of other information immediate impressions of them created the concept. What we saw in the early twentieth century was partly a growing group of people with serious mental problems using/abusing drugs, not least because barbiturates were prescribed for such diseases; and amphetamine abuse that was socially and culturally conditioned rather than medically induced. Two different perceptions of abuse grew out of these different sources of information. The first, which was also the clearest and most widely used in the medical literature, generated a definition based on disease concepts. The other linked abuse to the users' social status. This became more common towards the end of the period as amphetamine use increased. It must be stressed that there were no real discussions about the concept of abuse in the medical journals, neither in the nineteenth century nor during the first part of the twentieth century. In other words, one has to be careful not to draw too firm conclusions in those cases where terms such as substance abuse or dependency were used.

Abuse was conceptualised as a disease without further reflection or discussion, and we can distinguish two ways of using the disease concept. First, some form of disease existed already before abuse arose. In these cases abuse developed either through a process where narcotic substances were used as part of the treatment, or through a primary disease which in one way or another caused abuse. In the former, emphasis was put on the pharmacological substance while the latter focused on the sick individual. The following statements are typical of the period and illuminate the latter conception:

> Inclination for abuse of the medicine occurs only in patients with psychopathic traits [...] (Alfvén, 1940, p. 1032).

> […] most of these patients who have a more or less pronounced tendency to develop drug abuse are neuro-psychopaths (Lindner, 1939, p. 2292).

The conceptualisation of long-term, regular abuse of drugs in high doses as a disease was linked to the pathological conditions that followed upon such behaviours. The persons/patients were thus considered to be sick. Typical psychological consequences of more prolonged abuse could be:

> […] insomnia, hypersensitivity, neuralgia, anxiety, depression and excitation (Jäderholm, 1878, p. 672).

Abuse seen as caused by social conditions was of a different character and yielded other meanings and contents of the concept. As we get further into the 1900s, socio-cultural aspects are slowly gaining ground as an important part of the drug problem:

> While morphinists often are older persons, the pleasure-seeking users of heroin and cocaine are mostly young people. While morphinists hide away in solitude with their secret use of poisonous substances, the two other categories socialise, gather at cafés, form clubs and enjoy their happy intoxication in society (Santesson, 1926, pp. 889 f.).

This quotation relates to heroin and cocaine. Abuse of these drugs was a relative-

ly new phenomenon in the early twentieth century and played only a minor role in how drug problems were perceived and defined. Despite efforts to investigate the cocaine situation in Sweden, only a few cases of cocaine abuse were detected (Riksarkivet, 1933). The requirements for a tightening of the drug laws that were articulated at the time were never realised, and an analysis of the situation in the 1920s shows that the medical definitions of the drug problem were not significantly affected (Lindgren, 1993; Olsson, 1994). However, something that soon would come to play a crucial role in the formulation of the Swedish drug problem was the introduction of amphetamines in the late 1930s. Initially, the disease concept, as developed within the medical system, was transferred also onto amphetamine use. However, as time passed, the incongruence became ever clearer between the traditional approach and the images that slowly began to emerge around the use of amphetamines. This caused the medical profession to gradually withdraw from the drug issue towards the mid-1960s. This was also instrumental in how drug abuse was conceptualised differently in Sweden compared to most other countries.

The medical problem description after the Second World War

During this period significant changes occurred in terms of substances used as well as in who the users/abusers were. Synthetic medicines were now widely introduced in health care. The most important substance group in relation to the definition of the drug problem was central nervous system stimulants. Less attention was paid to opiates, which had previously in many ways shaped the image of drug abuse. However, one important aspect of opiate dependence still influenced perceptions of abuse, even if heroin abuse was practically non-existent in Sweden during this period. Images of heroin abuse came from international sources, which depicted narcomania as a very difficult dependence disorder with serious consequences.

Also new was the fact that the drug problem was for the first time discussed without reference to specific substances: for the first time, drug use was formulated as a problem of its own. The articles begin to discuss drug users as a group, the social implications of drug use and the linkage to criminality. In addition, explicit links are made to the youth as a risk and problem group. The social aspects were foregrounded, but when drug abuse or dependence as a phenomenon was defined, a clear medical and disease-focused definition was still applied and dominated, at least until about 1960. This definition was similarly inspired by foreign experiences of heroin and other opiate abuse. The links to diseases are exemplified by the following quotations:

> Drug abuse often develops on […] the basis of compulsive neurotic problems (Lindner, 1953, p. 2782).

> All categories of drug abusers must be treated as patients, not as criminals, if we are to achieve results (Narkomaner är sjuka, 1958, p. 81).

Established medical knowledge and the composition of patients that physicians encountered were probably the most important factors behind the dominant per-

ceptions and definitions of drug abuse. The strong emphasis on psychiatric disorders as causing and being a part of drug abuse became even more prominent with the introduction of barbiturates in the early twentieth century. Considered safe and harmless, they were initially prescribed for various mental problems in a very liberal manner. Many psychiatric patients developed dependency on barbiturate use and, accordingly, drug abuse became even more pronounced as a disease concept.

What changed perceptions of drug problems more than anything else at the time was the spread of amphetamine use/abuse in certain segments of the society. Initially, the use was praised and legal medical practice involving hundreds of thousands of Swedes:

> It can be estimated that in 1942–1943 there were about 200,000 users of amphetamines in Sweden, corresponding to 3 per cent of the adult population (Goldberg, 1968, p. 4).

This increased to over 300,000 users in 1959 (Olsson, 1994). Growing awareness of the risks of central nervous system stimulants and stricter control measures reduced the number of occasional users dramatically in just a few years. However, parallel to this development more frequent forms of amphetamine use spread into the criminal subculture, to some bohemian circles and finally started to reach certain youth groups. This was the main reason why the drug problem in Sweden started to transform from an individual and medical problem to a public and social problem. The introduction of amphetamines in an already established criminal subculture caused existing explanations and moral attitudes toward crime and criminals to be transferred to drug users in general. The profile of the drugs issue as a social problem was further strengthened when drug use was increasingly identified as a threat to various youth groups. Another factor that significantly increased concerns about amphetamine use was the fact that, probably in the early 1950s (Bejerot, 1969), oral use of the substance was complemented with an injection technique. Thus, the effects of the intake became stronger, including the negative consequences, which in turn affected the perception of drug use and abuse. The old and still dominating medical notions and definitions began to be challenged.

The social problem descriptions made their way into the drug discourse because most of the amphetamine users could not be described as sick and, in particular, as carriers of severe and frequent psychiatric problems. Instead, their social situation and lifestyles came into focus. Through the development of Swedish social medicine these perceptions found their way also into the medical field. Doctors could now write as follows:

> That narcomania, like alcoholism, is a socio-medical problem is something that all Swedish medical professionals agree upon; I hope […] (Hesterskog, 1955, p. 2930).

Even within the leading medical professional organisation, The Swedish Society of Medicine, the social aspects of the drug problems were increasingly appreciated:

> The problem must substantially be seen from a socio-medical point of

> view. The prevalence of drug abuse is strongly correlated to all other negative social phenomena […] (Svenska Läkaresällskapets förhandlingar, 1961, p. 608).

Towards the mid-1960s the drug problem reached such (perceived) proportions that concerted governmental actions were deemed necessary. It led to the appointment of the first large governmental inquiry with the task of analysing the drug problem and proposing measures for coming to grips with the problems. This was also the first time a serious attempt was made to define what abuse really was, i.e. how the term should be defined. It was no longer obvious that the dominant medical perceptions could serve as a basis for overall drug policy.

The drug problem as a public problem

Since the drug problem was not formulated as a political or a public problem before the 1960s, we find only casual remarks on the drug problem in the public reports from the late nineteenth century and early twentieth century (Edman, 2012). To a small degree, it was nevertheless a part of the alcohol question. When the Poor Relief Legislation Committee presented its draft law on compulsory treatment of alcohol abusers in 1911, the problem of drug consumption had emerged as a question of whether the proposed law should also cover the abuse of narcotics. The Committee had taken stock of foreign coercive legislation in the area and found numerous laws applied against "persons who indulge in an immoderate use of other narcotic substances such as opium, morphine, chloral, cocaine" (*Förslag till lag om behandling af alkoholister*, 1911, p. 101). The word "other" is central here, making another appearance in the description of "narcotics and stimulants other than alcohol", and suggesting that narcotics is a generic term which also covers alcohol (*Förslag till lag om behandling av alkoholister*, 1911, p. 101; *Alkoholen och samhället*, 1912, p. 192) One important conclusion was that drugs certainly could be more damaging to the individual than alcohol, but that drug use hardly led to the social harm that the law was aimed against.

The issue of the compulsory treatment laws' applicability to drug consumers was raised again in an investigation in 1929. A sustainable description of narcotics emerged: these were substances that promoted "habituation" and increased "tolerance" – and even a moderate dose of morphine would make the user "a helpless slave to the need" (SOU 1929:29, p. 122). The requirement for dose escalation was a part of the problem scenario and was therefore also socially expressed:

> No desire is as demoralising as this poison hunger. Lies and deceit, fraud and falsifying medical prescriptions, theft and burglary are the roads which the morphinist does not hesitate to take. One does wisely in assuming that a morphinist cannot under any circumstances tell the truth, when it comes to the coveted poison (SOU 1929:29, p. 123).

Two value systems were able to co-exist here, a more biological perspective focusing on the addictive element and a more traditional and moral view. First, we have the description of an imperative "poison

hunger". At the same time, this poison hunger was "demoralising", affecting the character traits that the individual was assumed to possess.

The search for a suitable terminology was taken up in 1939 by an inquiry on the vagrancy issue. In this report, the generic term for alcohol and drug abuse was "poison abuse" (SOU 1939:25, App. C, p. 133). Drug abusers were described as "narcomaniacs" and their condition as "narcomania" (SOU 1939:25, App. F, p. 106). The last pre-1960s attempt to define drug usage in a public report stems from 1951, when a new terminology – *vänjning* and *tillvänjning* – was tested. The former was translated as "habituation" by the Committee and defined as "the changed reaction of the organism to a substance, if supplied regularly over a long period" (SOU 1951:44, p. 25). The latter was translated as "addiction" and seen as synonymous with narcomania. Here, the increased tolerance signified an unwillingness to give up the supplied substance as well as severe withdrawal symptoms. The substances capable of inducing narcomania included alcohol, opium, morphine, heroin and hashish. The committee named these "addiction-promoting" substances (SOU 1951:44, p. 26*).

The political need for a medical framing (1964–1969)

The political conceptualisation of the contemporary drug problem originates from the 1964 report by the Mental Health Legislation Committee. The Committee constructed a distinction between narcomania [*narkomani*] and drug abuse [*narkotikamissbruk*]. Narcomania consisted partly of "toxicomania" ("abuse of toxic substances") and partly of "eufomania" – "substances with a mood-boosting (euphoric) effect" (SOU 1964:40, p. 126). But the salient feature of narcomania was that it would lead to "addiction". Addiction, and by this token narcomania, was primarily characterised by the developing of dependence. Drug abuse was defined in relation to narcomania as an "illegitimate consumption of non-recurring or repetitive or routine nature, where the typical changes of narcomania […] have not occurred" (SOU 1964:40, p. 233). The drug abuser was, unlike the narcomaniac, not mentally ill, and compulsory treatment in mental hospitals was therefore not needed. The work with definitions was undoubtedly political; it was about "trying to achieve legislation which allows admission and treatment of narcomaniacs in mental hospitals" (SOU 1964:40, p. 235).

When the report was published in 1964, there were hardly any visible drug problems to speak of in Sweden. Although Sweden had a very widespread use of amphetamines in an international perspective, this was not yet defined as either a public or a social problem. But the investigation led to new legislation before the committee appointed to investigate this newly discovered problem – the Drug Rehabilitation Committee – had even published their first report in 1967. Thus, the Mental Health Legislation Committee had managed to establish a conceptual framework and a solution to relate to. Partly because of this, the Drug Rehabilitation Committee did not aim to create a new treatment area nor incorporate the care of drug users within existing treatment of alcohol abusers. The Committee did however conduct a thorough investigation, start-

ing with the Greek origins of the concept of narcomania and clarifying that international drug conventions had defined both stimulating and depressant substances as narcotics. The Committee then discussed the WHO definitions, where narcotics and narcomania were primarily recognised for their dependence-causing characteristics. Every attempt to distinguish between narcomania (translated to "addiction" in English by the Committee) and habit formation (which the Committee translated as "habituation") was, according to the Committee, abandoned in the early 1960s, mainly for political reasons. Dependence, "the need to continue to consume the substance", was highlighted as a common factor, and the narcotic substances were described as "dependence-producing drugs" (SOU 1967:25, p. 22).

The Committee settled on a legalistic definition of narcotics as those substances that were held as narcotics in relevant laws, regulations and registers. Drug abuse designated "all non-medical use of narcotics", and narcomania was "an imperative need to continue the abuse of narcotic substances" (SOU 1967:25, p. 22). Such definitions gave no political guidance, however, and things came to a head when the issue of drug abusers' compulsory treatment was discussed. The Mental Health Legislation Committee had kept drug abuse and narcomania apart but the Minister of Health and Social Affairs had corrected the Committee on this point in an attempt to avoid a "strict separation between narcomania and drug abuse" (Prop. 1966:53, p. 166). The Drug Rehabilitation Committee agreed with the minister's conceptual innovation completely, signalling that the question of who was mentally ill or not depended on political rather than medical considerations. Compulsory treatment should be an alternative for "such abusers for whom hospital care is urgently called for" (SOU 1967:25, p. 161).

The Drug Rehabilitation Committee helped to transform the meaning of drug abuse into something quite new and – in view of forthcoming legislation – much more useful. Narcomania had been twinned with dependence, which legitimated compulsory care. This now applied also to drug abuse. Based on the arguments put forward by the Committee, a revision of the psychiatric compulsory treatment law in 1969 elucidated this legislation's applicability on drug users (SFS 1969:212). But by then, the Drug Rehabilitation Committee had already distanced itself from the medical problem description.

The Narcotics Criminal Code came into force in 1968, after the Committee had published their first two reports. Drug treatment facilities were established, contrary to what the Committee had planned, to a great extent outside the health care system. The Committee's final reports from 1969 also noted that the coming together of psychiatry and drug abusers had been a mutual disappointment. Drug abusers were treated badly, while the health care sector could not solve the basic problem. A contributing factor to this misfit between drug abusers and the medical system was that the population of abusers predominantly consisted of relatively young, physically and mentally relatively healthy criminals who embraced amphetamine use in their subculture. They did not meet the traditional and dominant image of drug abusers, i.e. heroin addicts with severe problems (Olsson, 1994). The

overall description of drug abuse as a disease was of no use if the problem could not be treated within the health care sector. This made dependence not so much a consequence of abuse as the ultimate symptom of an underlying problem. In some formulations, dependence was also both intentional and rational: "Dependence often represents an attempt to find a way out of psychic conflicts and anxiety" (SOU 1969:52, p. 339).

The Committee dissociated itself from a terminology that had not been widely approved. This became particularly clear in the Committee's final report (SOU 1969:53) in which a number of researchers published their studies of different aspects of the drug problem. Here, the terminology appeared to be free and inquiring. One study spoke simply of "drug consumption" with no descriptions of psychological or physical dependence (Herulf, 1969, p. 13). Another study used "drug use" and "drug users" without any further attempt to define the concepts, whereas a third discussed "drug abuse" and "toxicomania" without defining the terms (Jonsson & Svedugård, 1969, p. 43; Agrell, Netz & Wolff, 1969, p. 68). Without offering any definitions, study after study discussed narcotics abuse, abuse of narcotics, drug abusers, *abusus alii*, medicine abuse, narcotics use, limited abuse, advanced abuse, severe abuse, narcomaniacs, uninterrupted narcotics use or simply just abuse. Drug policies and drug rehabilitation programmes had already been launched, together with supplementing compulsory psychiatric care of drug consumers of an unknown quality. The Committee's final examinations showed no obvious need for a rigorous conceptual apparatus.

Taken together, the Drug Rehabilitation Committee's reports contained a great deal of variation in their conceptual precision. At decisive moments the Committee nevertheless delivered what was politically demanded: a definition of narcomania which was primarily characterised by the drugs' addictive features and which could be equated with an illness to be cared for – with or without the patient's will – in psychiatry. Added to this concept of the dependent and care-needing drug consumer was yet another category, that of drug abusers. And once drug abuse had been defined as all non-medical use of drugs, political conceptual work made alternative interpretations more or less impossible.

Away from medicine (1974–1981)

In 1974 the Social Inquiry published their first report. The Committee's task was to get away from the patchwork of social legislation that had been in the making since the 1950s. Preventive and curative measures against alcohol and drug abuse should now be regulated within the same legislation. This was rather a challenge, since the compulsory care of alcohol and drug users was based on radically different problem descriptions: the socially troublesome "alcohol abuser" met the "sick drug abuser".

We can detect a clearly structuring factor for the Social Inquiry's ability to conceptualise drug abuse, a theoretical preunderstanding that had been suggested already in the texts of the Drug Rehabilitation Committee. Drug use was considered a symptom of social or psychological background factors, and it was these factors that really should be the focus of

social work. The Social Inquiry therefore almost apologised for even discussing drug abuse, which they did only because "abuse of such substances often creates special problems that are worth some further elucidation" (SOU 1974:39, p. 293). The Inquiry settled for "dependence-producing substances" as a main category including such substances as alcohol, drugs and various technical preparations (SOU 1974:39, p. 293). However, faithful to the ambition of creating a law for both alcohol and drugs abusers, the Inquiry did not separate the possible problems or suitable solutions for different substances. Also, the Inquiry would rather not use the terms narcomaniac and narcomania. These were *medical* concepts, whereas the new legislation was aimed towards *social* measures. Nor did the Social Inquiry immerse itself in the question of what constituted abuse, other than when this allowed coercive measures.

Abuse was defined primarily as a social phenomenon in terms of the consequences for individuals, families or society. The individual could incur physical or psychological damage, be pacified or dramatically impair relations to those nearest to her/him. This could result in ever-increasing abuse, locking the person – frequently described as "the dependent" – in a vicious circle (SOU 1974:39, p. 301). Dependence remained a central characteristic of the problem description. Even if individual treatment aimed at resolving medical, psychological, social and economic problems, the goal remained that the individual would "liberate himself from his dependence on alcohol or drugs" (SOU 1974:39, p. 307). The Social Inquiry's definition of abuse related to dependency but the definition was never particularly concrete, not even in discussions about compulsory care.

After the Social Inquiry's first report was published in 1974, the 1976 parliamentary elections led to a change of government after more than 40 years of social democratic government in Sweden. A bourgeois coalition government took over, which affected the investigative mission of the Social Inquiry. They now had the task of designing two proposals for compulsory care: one without compulsory treatment enshrined in the new social legislation but with maintained psychiatric coercion (even for alcohol abusers) and another with compulsory care as an essential part of the new social legislation. The Social Inquiry's second report from 1977 is therefore a good example of how politics had the upper hand in the investigation system and how the work with concepts reflected political ambitions.

Most of the Inquiry members advocated psychiatric coercion. In the light of a social debate in which social coercion of alcohol abusers often was condemned as repressive class legislation, psychiatric coercion was sometimes called the voluntary solution, which must be regarded as fairly innovative linguistically. But in order to be treated within the framework of compulsory psychiatric care legislation one would have to be ill in some way. The suggested law allowed caring for the "alcohol or drug sick" against their will, given that they were considered to be suffering from mental illness (SOU 1977:40, s. 536). The client could also refer to a person "who abuses dependence-producing substances" (SOU 1977:40, s. 537).

In the alternative proposal, where com-

pulsory care remained within the remit of social legislation, there was no use for a terminology of disease. Instead, coercive measures could be legitimated by several complex factors: abuse, need for treatment, inability to understand one's need for treatment, and an assumption that the loss of care could be expected to result in serious danger for the abuser's life or health or serious social harm to him or her. The need for treatment was central. The potential client's status – whether he/she was a drug abuser, dependent, sick and so forth – was secondary and was not investigated at all.

In the bill which followed the Social Inquiry's reports, the right-of-centre minority government suggested continued psychiatric compulsory care, which also became a new kind of coercive treatment for alcohol abusers. The government was once again forced to argue that drug users *and* alcohol abusers were to a great extent sick people in need of compulsory psychiatric treatment. But when the Minister of Health and Social Affairs also sought to broaden the treatment criteria to cover drug abusers *in need of treatment* but not necessarily mentally ill, he met with serious resistance from the council on legislation, the standing committee on social questions, and the Parliament. The proposal was scrapped and sent back to be examined by yet another investigation, the Social Drafting Committee (Edman, 2009; Edman, 2011).

The Social Drafting Committee discussed "alcohol and drug abusers", not sick people (SOU 1981:7, p. 3). The proposed legislation suggested compulsory care in order to "get away from abuse of alcohol or other addictive substances" (SOU 1981:7, s. 11). In the light of strong criticism levelled against political attempts to expand psychiatric compulsory care, the Committee distanced itself from medical-psychiatric descriptions of abuse. There was talk of a *need for care* as a criterion for intervention, a need which resulted from relatively regular consumption. But the Committee did not speculate whether any kind of dependence existed; this demarcation of abuse was more or less treated as mysticism:

> The advantage of linking to the abuser's current condition or situation (caused by abuse) is, among other things, that specific conditions are easier to test than the subjectively coloured concepts by which we otherwise have to classify abuse. This is important for the legal rights of the individual (SOU 1981:7, p. 37).

Dependence was classified as one of those "hard-to-define abstract concepts" that explained less and confused more (SOU 1981:7, p. 38). By refraining from elaborating on the dependent criterion, one could possibly also enable earlier interventions in some cases, when dependence could not yet be discovered.

The Social Services Act and the new compulsory treatment law – LVM – came into force on 1 January 1982, representing the legal regulation of the care of both alcohol and drug abusers. The compulsory treatment legislation made no mention of disease-like conditions. Words such as dependence, tolerance increase, narcomania, etc., did not occur. The need for care could either manifest itself when the abuser put "his physical or mental health

in grave danger", or when he "as a result of abuse was likely to come to seriously harm himself or those nearest to him" (SFS 1981:1243, § 3). The Social Drafting Committee was able to avoid an in-depth conceptual discussion on the meaning of abuse by focusing on the acute conditions of the clients and the need to counteract these by compulsory means.

Social descriptions and conceptual fumbling (1984–2000)

The reform of 1982 institutionalised the problem description and brought some conceptual stability to the field for the rest of the twentieth century. The final report from the Drug Commission in 1984 did not explicitly deal with treatment activities, causal thinking or associated conceptual clarification. Causal mechanisms were briefly discussed as an important area for research before the commission turned to addressing "drug abuse", without any medical implications (SOU 1984:13, pp. 55 & 94 f.). In 1987, the so-called Insemination Investigation delivered a report on societal measures against pregnant abusers. The report was written from a non-medical angle and spoke of "abuse" and "overconsumption" (SOU 1987:11, p. 9). In the same year, the Social Drafting Committee published a report (SOU 1987:22) on the compulsory treatment legislation that had by then been in effect for five years. This report mainly discussed consequences of drug use: physical and mental injuries, unemployment and social exclusion, crime and prostitution, mortality and the relatively new threat of AIDS/HIV. The possibility of earlier compulsory intervention based on a problem description that took on both the social and medical consequences of abuse was ventilated, but in the end the Committee remained faithful to its disapproval of the predisposing basic diagnoses. Causes of drug abuse were not discussed at all – not even possible social causes.

With the revision of LVM in 1989, the treatment services had found their form, and it was not until the mid-1990s that the next major study took on the drug problem. In 1994 the Social Services Committee published a draft for a new Social Services Act. Drug problems and drug treatment took up only a small part of the proposed revision of this great legislative complex. The report spoke of abuse and abusers, but at some point also about "narcomaniacs" (SOU 1994:139, p. 234). This was not any conscious attempt to shift the meaning of the studied object. Neither was the aetiology of abuse discussed in this part of the investigation. It is on the whole notable that the investigation did not have very much to say about abuse and substance abuse treatment, and when it did, it was almost exclusively about alcohol treatment. Therefore, it comes as something of a surprise when the Committee, late in the report, justified the proposed new law:

> In the new law, the word abuse has been replaced with the word dependence, which is an internationally recognised concept in the care of people who abuse alcohol, drugs or other dependence-producing substances (SOU 1994:139, p. 312).

That was it: no discussions on the signification of the concept of abuse, or on its applicability on high-grade consumption of alcohol or drugs, no discussions on

causation at all, just a short statement that the terminology would be aligned with "an internationally recognised concept". However, the proposed conceptual change did not make its way into legislation (SFS 1997:313).

The Social Services Committee's conceptual shift was an attempt to provide the drug problem with a diagnosis and a psychiatric aetiology, although it was a relatively imprecise proposal. But the treatment legislation was still grounded in social considerations and the Committee had no ambition to change this. In a report by the Coercive Psychiatry Committee in 1998 one can however detect some ambivalence. Abuse was still described as a social problem; the Committee discussed "abuse problems or other social problems" (SOU 1998:32, p. 25). However, the Committee argued that not only mental disorders but also certain living conditions brought about by drug abuse could be a determining factor in assessing the need for psychiatric care. But although some abusers were treated and – according to the Coercive Psychiatry Committee – should continue to be cared for in psychiatric care, there was no speculation on any psychiatric constitution as a ground for substance abuse. Abuse and abusers were the most common concepts; such words as narcomaniac or narcomania were conspicuously absent. "Dependence condition" occurs once as a diagnosis, and in reviews of older and other legislation there are references to "dependence on narcotic substances" and "dependence-producing substances" (SOU 1998:32, s. 123, 215 & 258). However, the Committee made no attempt to discuss the concept of dependence.

Dependence was by no means a widely spread concept during the 1990s, and the Government Grants Committee also desisted from talking about substance abuse in terms of dependence or narcomania in their report (SOU 1998:38) published in 1998. Instead, terms such as abuse, drug abuse and narcotics abuse were used. In another study (SOU 1998:140) from the same year, in which the organisation of compulsory treatment was considered, the chosen words referred to abusers and treatment of abusers. In the interim report "Drug statistics" from 1999, "abuse" and "narcotics abuse" were the most common terms, and "narcomaniac" and "narcomania" were used a couple of times without being defined. The phrase "abuse and dependence" occurred in one section, while there was speculation in another place on whether some need for treatment could be determined by means of definitions that took on "some form of dependence concepts" (SOU 1999:90, p. 19 & 85). The study did not contribute to any clarification of what was meant by this, but was considerably more helpful in explaining why this concept had come into use more frequently in the late twentieth century. According to the report, this was a consequence of Swedish EU membership, leading to an enhanced possibility of obtaining comparative studies of EU countries' drug problems. The question of a common definition of the studied phenomenon had thus arisen, and initially the solution pointed toward a medicalisation of the drug problem:

> Since the drug problem in most European countries has, in comparison with Sweden, a more "medical" and treatment-oriented profile, it became

> natural to initially try to find a definition that linked to the dependence concept (SOU 1999:90, p. 85).

The possibility to use the criteria for dependence raised in ICD-10 was discussed but this was waived, as it would have required detailed knowledge of several aspects that could not be known. Instead, the pragmatic solution was to differentiate between problematic and unproblematic drug use.

In the first investigation (SOU 2000:38) of the drug abuse problem of the twenty-first century, abuse was still the common term (narcomania was used at one isolated occasion). Dependence was not used at all. In "The choice – The drug political challenge", published in 2000, such terms as abuse and abuser were still the most common. But there were also references to "dependence and abuse of narcotics", "dependence on narcotics", "dependence and abuse", "dependence and abuse development", "dependence", "drug dependence", "dependence problems", and "abuse and dependence development" (SOU 2000:126, pp. 21, 108 f., 147, 151 f., 165, 167, 288 f. & 300). The word "narcomaniacs" (with inflected forms) occurred a couple of times, the word "injecting narcomaniacs" once (SOU 2000:126, pp. 76, 175, 187 f.). One can clearly detect an intensification of the use of the dependence concept as seen here; there was talk of abuse *and* dependence, but the difference between them was never made clear. Neither was the role of the dependence diagnosis otherwise elucidated. Swedish substance abuse treatment was described as primarily emanating from a social perspective. The phenomenon subjected to treatment was consistently entitled abuse and there was no discussion on any specific dependence problem. Dependence did not play any part in the section on future research needs either, and the overall impression is that this internationally accepted concept was being used without being given any specific meaning.

Toward conceptual reformulation? (2001–2011)

The somewhat vacuous use of the dependence concept changed when the State's Drafting Committee for Medical Evaluation (SBU) presented their report "Treatment of alcohol and drug problems" in August 2001. In accordance with the subtitle, this was an "evidence-based knowledge compilation", and the fact that the question was investigated from an explicit medical perspective would have affected the description of the problem. Throughout the report, SBU used both abuse and dependence as descriptive terms, but unlike previous investigations they also delivered definitions of the terms by referring to the ones used in DSM-IV. In accordance with DSM, *abuse* meant that one of four social criteria was met in a year's time, i.e. repeated contacts with the justice system as a result of the abuse. *Dependence* was defined as a situation where three of seven criteria – both social and medical – were met during the last 12 months, among them the need for increasing doses to achieve an intoxication effect or neglect of important social, occupational or recreational activities.

The purpose of the SBU report was to compile the results of other studies on treatment. The report's conceptual tendency was further strengthened by the fact

that most of the reviewed studies had used the DSM classification, which reasonably should have made the selection relatively medicine-oriented. This meant that the SBU made use of a diagnostic system developed by the American Psychiatric Association on the basis of quite specific professional and cultural purposes. However, the Committee did not explain or develop their view on the essence of the studied phenomena; it was only found that alcohol and drugs could "cause a physical dependence and increased tolerance, which makes larger doses required to elicit intoxication" (SBU 2001:156/1, p. 12).

Compulsory treatment once again

The State's Drafting Committee for Medical Evaluation clearly put dependence on the conceptual map and showed that it was a term to use not instead of but together with abuse. Dependence was equally clearly grounded in psychiatric diagnostic systems. The Committee's institutional roots and the selection of treatment studies allowed a more medicalised perspective on drug use, but the question is to what extent this affected the public discourse in general. One indication can be found in the most ambitious attempt to revise compulsory care legislation since LVM came into force in 1982, in the reports from the LVM-Investigation in 2004.

As shown above, compulsory treatment had several times proven to be a touchstone for conceptual use in the field. Would the long tradition of coercive interventions based on social indications now be broken? Would the parentheses of the 1970s make a comeback? Not at all. The governmental directives to the investigation neither made use of the word dependence nor speculated in any causal mechanisms in line with this concept. To be sure, there are references to dependency in the report: "hazardous use and dependence"; "dependency"; "dependency problems"; "dependency condition", "drug dependency", "cannabis dependence" (SOU 2004:3, pp. 158, 240, 249, 286, 300 f., 364, 409, 455 & 457). Most commonly, however, dependency occurs as part of an agreed terminology for substance abuse treatment: "dependency health care"; "dependency care"; "dependency clinics"; "dependency units" (SOU 2004:3, pp. 47 f., 229 f., 277, 282 ff., 340, 352, 381 & 442). Narcomaniac occurs as a term for drug users, but without being anchored in any definition or diagnosis, and abuse was by far the most common name of the focused problem in a report that carefully refrained from speculating in medical causal terms.

In the public inquiry on heavy abuse which was published the year after, both abuse and dependence was used, but it was mainly abuse that described the investigated phenomenon. This investigation refrained from referring to any fixed diagnostic system and therefore came to the conclusion that there was no general agreement on what was meant by heavy drug abuse. Terms such as abusers were also avoided since this reduced the individual to her or his diagnosis. Instead, the investigation's targeted group was described as "people with heavy abuse" (SOU 2005:82, p. 32). Dutifully, the definitions of abuse and dependence in DSM-IV were outlined, without being used in the investigation. These definitions were described as applicable to health and dependence care, not as generalised descriptions of the phenomena.

The report "A better supervision of the

abuse treatment" from 2006 was – in accordance with the title – about abuse, not dependence. On two separate occasions "narcomaniacs" were used in an unspecified way, and some references were made to "dependence-producing substances" (SOU 2006:57, pp. 21, 44, 59 & 63). Drug consumption problems were described in one place as "abuse and dependence", but otherwise the report talked about variations of abuse and abusers (SOU 2006:57, s. 114).

A medical final?

It is evident that the investigations after the 1982 reform have generally lacked the ambition to discuss the studied phenomenon's epistemological character on a more fundamental level. An established social label – abuse – has been preferred, but neither this nor other concepts have been defined or used in an arguing context. This trend was to some extent broken by the extensive Narcotics Investigation survey of proposals for a new drug and doping legislation published in 2008. The investigation moved seemingly without bias between the concepts and used a number of variations of the dependence concept to characterise the investigated phenomenon: dependence, dependence-producing, dose-dependent, drug-dependent, dependence risk, dependence condition, dependence potential, drug dependence, dependence mechanisms. Most common, however, were variations and combinations of the abuse concept: abuse, abuse substances, narcotics abuse, abuse patterns, abuse purpose, drug abuse, pharmaceuticals abuse, abuse environment, abuse dose, abuse market, abuse career, mixed abuse. Variations of narcomania occurred only in the accounts of older problem descriptions and diagnostic systems.

But the investigation's task also called for a more precise discussion of what might be meant by drugs and abuse. This proved to be difficult. In the first sentence of the report the investigation stated: "For thousands of years, narcotics have been used as pharmaceuticals and as intoxicating substances" (SOU 2008:120, p. 21). This statement, albeit somewhat imprecise, might not have been so strange if the proposed legislation had not defined narcotics as "pharmaceuticals or hazardous goods with euphoric effects" (SOU 2008:120, p. 83). Thus, pharmaceuticals had been used as pharmaceuticals for thousands of years. This tautological reasoning was in some ways typical of the investigation's work on definitions. A drug was, for example, defined as "a pharmaceutical, a chemical substance, a plant material or a preparation used for the purpose of abuse or intoxication" (SOU 2008:120, p. 150). But the definitions of the act and the agent – the consumption of drugs and the drug consumer – were not very informative and actually narrowed down the description of drugs: drug abuse and drug abusers were defined legally from the understanding "that the substances used are criminalised preparations that the drug user is not allowed to use" (SOU 2008:120, p. 152). This would then mean that the definition of drugs (substances used for purposes of abuse) was reduced to criminalised substances.

Although the investigation presented some problems with the current legislative definition of narcotics, they chose to keep it. The Abuse Investigation of 2011 also kept the definition simple and legalistic: "By narcotics is understood those

substances that are included on the National Board of Health and Welfare's lists of narcotics" (SOU 2011:35, p. 517.). But when it came to the actual consumption of drugs, the investigation chose to consistently speak of abuse and dependence as two separate phenomena (narcomaniacs and narcomania were however totally absent from the text). The investigation leaned hard against the DSM-IV and defined abuse as "a harmful use of psychoactive substances, without dependence, that leads to disability or suffering" (SOU 2011:35, p. 485). But the investigation also made use of a rather established and legalistic definition: "Abuse of narcotics refers to all non-medical use of narcotic preparations" (SOU 2011:35, p. 517). This must reasonably be understood as the investigation bringing together non-medical use and use causing suffering. The essence of this convergence was however never investigated.

With reference to ICD-10, harmful use was defined as "a use of substances that can cause physical or psychological harm" (SOU 2011:35, p. 486). Dependence was defined, with reference to both diagnostic systems, as "harmful substance use leading to significant impairment or distress" (DSM) and as "a group of physiological, behavioural and cognitive phenomena in which the use of the dependence-producing substance is given a much higher priority for the individual than other behaviour, which had previously been held in such a significant position" (ICD) (SOU 2011:35, p. 486). The Abuse Investigation thus returned to the SBU's perspective and made arrangements for a new view on the studied phenomenon:

> When it comes to the perception of abuse and dependence, the current legislation reflects the fact that abuse and dependence mainly are seen as social problems. With new knowledge, however, abuse and dependence have increasingly come to be regarded as states of disease. Abuse (harmful use) and dependence are parts of the internationally recognised diagnostic systems within health care and medical treatment, ICD and DSM (SOU 2011:35, p. 24).

As so often before, it was once again discussions on compulsory treatment that made a concretisation of these statements necessary. Current legislation and motives for current legislation were turned upside down when the investigation approached the 1970s requisites for psychiatric compulsory treatment. The criticism that had met this proposal at the end of the 1970s was now dismissed already at the investigation stage:

> Abuse and dependence are classified as psychiatric diagnoses according to the international diagnostic systems DSM and ICD. The survey of compulsory care in different countries commissioned by the investigation shows that many countries have come to the conclusion that it is consistent with the Hawaii Declaration to make serious dependence the basis for psychiatric coercion (SOU 2011:35, p. 317).

The investigation's characterisation of the abuse phenomenon is the most medicalised description ever presented in any public inquiry. The proposed compulsory

psychiatric treatment was motivated by the notion that "states of dependence are becoming ever more understandable in light of neurobiological and neuropsychological research" (SOU 2011:35, p. 317). The investigation's concrete proposal was to integrate LVM with psychiatric compulsory care legislation (LPT) within the frames of a revised LPT. A revised LPT would be applicable to the current LVM clientele. This argument was based on the notion that the current LVM clientele could be described as severely mentally disturbed. The idea that abuse and dependence, regarded as psychiatric diagnoses, also legitimised compulsory care within the confines of psychiatric compulsory care legislation was however the investigation's own conclusion and could not be argued with reference to the diagnostic systems.

The investigation claimed that the scope of the new compulsory treatment law could hardly be broader than in the current LPT. According to the investigation the new version of LPT was only aiming to "more clearly mark where to draw the current limit" of mental disturbance (SOU 2011:35, p. 318). It was therefore somewhat surprising when the investigation first claimed that two-thirds of the current LVM clientele met "the criteria for one or more psychiatric diagnoses", and a few pages later made the assessment that "*all* those who today may be committed to LVM care will in the future be able to be committed to LPT care" (SOU 2011:35, pp. 295 & 321; our italics). The investigation apparently contributed to a broadened diagnosis of a kind that it otherwise renounced, an impression reinforced by the fact that it also wanted to translate LVM's social indication to conditions and behaviours which led to "an indispensable need of psychiatric care" (SOU 2011:35, p. 321).

The last document to be analysed in this article is the 2011 report on "Sweden's international involvement in the narcotics field". It is a relatively small study, interesting primarily because it was published after the Abuse Investigation's grand attempt to shift the drug problem's positions and concepts, but also because it had the ambition to relate to the international arena that had often legitimised domestic positions on these matters. The report drew on the idea that Sweden could impact on the drug policy even beyond the national borders. The investigation is to a large part a defence of the restrictive Swedish drug policy. Words such as abuse and abusers are frequently used; treatment is discussed with such concepts as abuse treatment and dependence treatment. The argument for the Swedish position and against the more liberal drug forces seen as a threat demanded a clarification. This included how to relate to harm reduction measures that sometimes challenged the Swedish zero tolerance. It was important for the Swedish position to clarify whether "narcotics dependence is considered a disease or learned behaviour" (SOU 2011:66, p. 71). However, this was not easy: "The question of whether narcotics dependence is to be considered a disease or disease-like state or a learned behaviour does not have any official answer" (SOU 2011:66, pp. 69 f.).

Concluding remarks

The history of problem definitions and concepts used in relation to the Swedish drug question is certainly not linear, rational or consistently built on increasing empirical knowledge. A variety of factors have

influenced how we have discussed and understood these issues. One of the most important is who at every given opportunity happens to have the alleged problem before their eyes. Other important factors concern which part of the problem is in focus, who the bearers of the problem are and, of course, the knowledge that is available at any given time. All of these aspects are illustrated quite clearly in our review of how the issue was handled in the latter half of the 1800s and the first part of the 1900s. Those who saw the problems were essentially medical doctors, what they saw were various negative side effects and, to some extent, dependence on various drugs they had prescribed to their own patients. Thus, the drug problem remained an individual problem that the doctors handled themselves, the main issues were to avoid side effects and, to the extent possible, to cure drug addiction with the medical expertise that was available. The explanations for the problems were essentially linked to the preparations' intrinsic effects and to certain characteristics of the patients themselves (such as their mental attributes).

The transformation of drug use to a serious public and social problem started with the introduction of amphetamines and similar stimulants around the time of the Second World War. Based on very positive views of the substances' medical properties among physicians, amphetamine use became rapidly popular, and the use spread to large segments of the population over the next two decades. However, as amphetamines became an important part of the criminal subculture, new moral connotations adhered to drug use. The phenomenon started to be depicted as a serious threat to young people. As medical perceptions and disease concepts were ill-suited to describing and understanding the process underway, the medical perceptions faded away, giving way to alternative legal and social explanatory models.

When the Swedish drug problem was established as a political question from the 1960s on, it also came to disengage itself from the medical frame of understanding that the problem had been embedded in since the mid-1800s. The compulsory treatment issue did produce a loosely defined medical terminology in the late 1960s, but at the prospect of enacting specific compulsory treatment legislation aimed at drug users in the early 1980s this problem description and terminology was abandoned. The social description that the drug problem was given at this point is still very influential despite several attempts – mainly in the 2000s – to reformulate the problem in medical terms. The Abuse Investigation's proposals of reorganisation and psychiatric compulsory drug treatment – with an accompanying conceptual shift – will not be realised. Already in January 2013, the responsible Minister decided to hold on to a more socially-oriented description of the mechanisms of abuse and not to reorganise the treatment of abusers in line with the proposals from the Abuse Investigation (SoU 2012/13:SoU18*).*

When compared to other countries, coercive treatment has clearly been an important part of Swedish substance abuse treatment over the last 100 years (Lehto, 1994). Comparative studies have also shown that a social, non-medical, problem description has held a strong position in Sweden (Kaukonen & Stenius, 2005; Edman & Stenius, 2007). It is reasonable to see this as communicating certain ideas:

the non-medical problem description has been a prerequisite for paternalistic treatment described as a measure against the social consequences of abuse. Coercive treatment has been a yardstick in discussions of principle about how to treat an individual's drug consumption and to what extent this treatment could be based on this consumption being described as a disease. Already when the first coercive treatment laws against alcohol abuse were enacted in the 1910s, these arguments of principle led to a dismissal of the disease description (Edman, 2004). With the exception of coercion in psychiatric drug treatment in the 1970s, it has since been difficult to anchor such efforts in the descriptions of drug use as a disease.

Concepts are political tools used for describing (or expressing an apprehension of) phenomena that go beyond supposedly objective descriptions of the actions and conditions that have been the focus of this article. Medically-oriented descriptions of "dependence" and "addiction" have appeared adequate or attractive when, for example, the socially motivated coercive treatment solution has been discredited (as in the 1970s), when there has been a desire to connect to an internationally accepted terminology (as in the 1990s) or when a new organisational model with a stronger professional support has been on the agenda (as in the 2010s). But otherwise the social problem description has called for concepts that more or less explicitly have dissociated themselves from speculations in physiological or psychological predispositions for substance abuse. At the time of writing the use of concepts appears somewhat fragmented when both research in the field and the media debate assume a relatively medicalised description while regulatory legislation and the administrative organisation of problem management are still socially oriented to a great part. The convincing conceptual description of drug use in future is of course hidden in the obscurity of speculation, but one thing we do know: it will give expression to a political solution that appears attractive to dominant stakeholders.

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NOTE

1 We have analysed 598 articles published in three Swedish medical journals – *Hygiea*, *Läkartidningen* and *Social-Medicinsk Tidskrift*. Also, eight reports on vagrancy from the years 1882–1962 have been examined; 21 reports on the alcohol problem from the years 1911–1968; and ten reports on mental health treatment from the years 1923–1998. Reports that explicitly deal with the drug problem have been read more selectively. These include four reports from the late 1960s when the problem was being articulated more clearly; three reports from the 1970s and early 1980s when the problem was conceptually reformulated; and 16 reports from the years 1984–2011 leading up to the contemporary conceptual handling and problem formulation of the drug issue.

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