

THE BECKLEY FOUNDATION
DRUG POLICY PROGRAMMEWHAT CAN WE LEARN FROM
SWEDEN'S DRUG POLICY EXPERIENCE?*Christopher Hallam¹*

The Beckley Foundation Drug Policy Programme (BFDPP) is an initiative dedicated to providing a rigorous, independent review of the effectiveness of national and international drug policies. The aim of this programme of research and analysis is to assemble and disseminate material that supports the rational consideration of complex drug policy issues, and leads to a more effective management of the widespread use of psychoactive substances in the future. The BFDPP is a member of the International Drug Policy Consortium (www.idpc.net), a global network of NGOs and professional networks who work together to promote objective debate around national and international drug policies, and provide advice and support to governments in the search for effective policies and programmes.

INTRODUCTION

Sweden is well-known for its commitment to a vision of “the drug-free society”. In recent years, Sweden’s drug policies have been the focus of considerable attention and debate, which may be seen in the context of both the ten year United Nations General Assembly Special Session on the World Drug Problem (UNGASS)¹ review of international drug control and a much broader discourse of drug policy reform that has achieved growing political salience in many parts of the world. The Swedish example has been deployed by those arguing for a zero tolerance approach to drug policies and abstinence-driven treatments for dependent use (for example, the UK Conservative party),² together with those (such as Antonio Maria Costa at the United Nations Office on Drugs & Crime) seeking to defend the current UN treaty-based system from widespread calls for change. In a 2006 report entitled *Sweden’s Successful Drug Policy*, the United Nations Office on Drugs and Crime (UNODC) reviewed the country’s policy model and tracked the development of its progressively more restrictive approach following a brief experiment with relatively liberal policies in the 1960s. In its conclusions, the report argued strongly that Sweden’s unambiguously repressive stance had resulted in low levels of the prevalence of drug use, that these policies were therefore successful and should be adopted by other nation states.³ As a consequence of this and other interventions, Sweden has begun to function as a symbol of

the efficacy of restrictive drug laws and policies, a utopia against which the allegedly dystopian potentials of more tolerant societies can be measured. At the same time, for drug policy reformers and advocates of harm reduction, the country encapsulates the failures that may be expected to flow from policies driven by an over-arching ideological commitment to abstinence. This briefing paper will analyse Swedish drug control policy in its legal, clinical, political, social and cultural dimensions and consider the claims and policy-objectives it has been used to support. In the course of this analysis, it will explore the implications of Sweden’s model, if any, for other countries. Such an undertaking is, of necessity, a complex one, involving a wide-ranging discussion of the factors implicated and an argument possessed of many strands.

Sweden’s illicit drug market

Sweden is a country which, in general, has relatively low levels of illicit drug use. Historically, the country’s experience of substance use issues has changed considerably over time; while alcohol has been problematized and viewed as an issue for social intervention since the 19th century, it was amphetamines that first drew governmental attention to the use of other psychoactive substances. These stimulants were widely used in the 1930s and 40s, when they were legally available on prescription. Popular use of all drugs increased in the 1960s, and it was at this point that the influence of the medical profession, which had until then tended to dominate the drugs

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field, was largely replaced by popular social movements and the professional association of social workers. After receding across the intervening decades, prevalence increased steeply during the 1990s, in common with many European societies. Lifetime drug use rose from 7% to 12% amongst 15-75 year old Swedes in the decade to 2000, while problematic use expanded by more than a third, drug-related deaths doubled and treatment demand grew by more than half. Drug prices decreased sharply despite increased seizures.⁴ Prevalence trends have reduced since 2000, though they remain above their pre-1990s levels; problem drug use has stayed fairly constant at around 26,000 people, although this figure is subject to some dispute. Sweden's major form of problematic use centres on the injection of amphetamines, which made up 34.7% of the 6,480 clients entering treatment in 2007, and on heroin, with opiate users constituting 25.7% of that population.⁵ As in most European countries, cannabis (originating in Morocco and entering Sweden via Spain or Portugal) is the most widely used and frequently seized of illicit drugs.

SWEDEN'S DRUG CONTROL REGIME: AN OVERVIEW

We will now examine the arrangements currently prevailing in Sweden's drug control system, before charting its historical trajectory and the broader social and political framework within which it sits.

Strategy

In February 2008, the Swedish Ministry of Health and Social Affairs produced a fact sheet on its *Action Plan on Narcotic Drugs 2006-2010*. The primary objective of the country's strategy is there summarized as follows: "The drugs policy is based on people's right to a dignified life in a society that stands up for the individual's needs for security and safety. Illegal drugs must never be allowed to threaten the health, quality of life and security of the individual or public welfare and democratic development. The overall objective of the Swedish drugs policy is: *a drug-free society*." (Original italics).⁶ The 2006-2010 Action Plan breaks down into three programmatic areas: prevention, or "recruitment to drug abuse must decrease", treatment or "drug abusers must be induced to give up their abuse" and supply reduction.

By the term *strategy*, we refer here to the fundamental philosophical underpinning of a country's drug control policy. Whereas the Netherlands, for example, has a pragmatic, health-oriented strategic focus that seeks to manage the consequences of drug consumption, Sweden seeks to realize the goal of a

society without drug use. While rhetorical support for a drug-free social landscape is a familiar political tactic in many societies around the world, Sweden is unusual in making such explicit linkage of this objective to policy formulation. It is notable that this commitment is framed primarily in terms of "the individual's need for security and safety", and society's protection against a collective threat. We will return to this theme later in the briefing.

This strategic vision has a number of specific practical consequences for Sweden's policy responses. At the level of legislation and enforcement, it results in an emphasis on the end-user which, again, is unusual in contemporary European policy; whereas enforcement resources in other EU states are directed mainly at networks of supply and distribution, in Sweden the consumer is deemed equally or more worthy of intensive police attention, being viewed as the fundamental unit of the illegal drug market. Likewise, in its treatment interventions, Sweden is untypical in its determination to enforce abstinence upon the recalcitrant drug user, rather than manage the consequences of use and ameliorate their severity. This emphasis, it should be noted, is not viewed in punitive terms by its advocates, but rather as providing protection, assistance and support; it bears a strong resemblance to the American discourse of 'tough love'. As Goldberg has observed, a key assumption underlying the Swedish conception of drugs is that the user is 'out of control', with individual self-will having been replaced by the drug's own 'chemical control', or, in a version theoretically elaborated by the psychiatrist Nils Bejerot (discussed below), controlled by instinctive drives that subvert rationality. Thus, the dependent user needs the society to take control back from the drug, by coercive means if necessary.⁷

Legal framework

The most important element of drug control legislation is the 1968 *Narcotics Drugs Punishment Act* (NDPA), which has been amended several times over subsequent years and which defines those acts and substances to be prohibited. These include the standard categories such as possession, production and distribution of narcotic drugs, in addition to drug use *per se*, which is explicitly criminalized and can result in a prison sentence. Drug use itself was made a criminal offence in 1988, "in order to signal a powerful repudiation by the community of all dealings with drugs."⁸ Within the terms of the Act, narcotic drugs are viewed as medicines or other substances which are hazardous to health, possess addictive properties, and/or produce a state of euphoria in the consumer. The law provides three degrees of severity of offences: *minor*, *ordinary* and *serious*, the designation as one or another determined principally by the substance involved and its quantity. Minor offences are punished by fines or up to

six months imprisonment, ordinary offences up to three years imprisonment, and serious offences by between two and ten years imprisonment. Alternatives to incarceration do exist in Sweden, and drug offenders can receive suspended sentences or probation; however, cases classed as serious must be dealt with by either a prison sentence or treatment. In 1993, the government announced that the minor offence category would apply only in the very mildest of cases. In the same year, the police were given legal authority to enforce drug testing on those they suspected of having consumed drugs. Drug testing plays an important role in the Swedish model and will be discussed further below. Trafficking activities are dealt with under the auspices of the *Law on Penalties for Smuggling* (2000), which includes penalties identical to those contained in the NDPA. Supply offences almost invariably result in incarceration. A further group of laws may also be applied to drug offences, such as those regulating the compulsory institutionalization of adults and compulsory drug treatment of the young. As discussed below, the Swedish drug control regime has become increasingly restrictive during the course of the last few decades. On the ground, in the quotidian existence of drug users, the Swedish approach is characterised by the continuous application of a generalized repression. As stated by the Police representative to a government task force in 1990: “We disturb them (the drug users) in their activities, and threaten them with compulsory treatment and make their life difficult. It *shall* be difficult to be a drug misuser. The more difficult we make their living, the more clear the other alternative, i.e. a drug-free life, will appear.” (Original emphasis).⁹

Drug Treatment

According to the Social Welfare Act of 1980, “The Social Welfare Committee shall actively ensure that the individual addict receives the help and care that he or she needs to escape from addiction.”¹⁰ The treatment system is closely tied to the notion of a drug free society and to the enforcement of abstinence; abstinence-based interventions form the greater part of Sweden’s treatment provision.

As pointed out by the UNODC in its very positive account of the country’s approach, Sweden was the first European country to make Methadone Maintenance Therapy (MMT) available, at Uppsala in 1966, using the model developed by Dole and Nyswander. Despite this historical provenance, MMT has not been widely utilized in Sweden in the intervening years. According to the country’s 2002 Reitox Report¹¹, methadone maintenance is provided in only four locations (Uppsala, Stockholm, Lund and Malmo), and patient numbers have been limited by parliament to a maximum of 800 persons. Entry protocols are restrictive, with entrants required to have been known to the authorities for at least two (formerly four) years, to have tried other treatment methods unsuccessfully, and so

forth; they are tested regularly to enforce compliance. If they are found to have used illicit opiates, they are removed from the programme. The 2006¹² Reitox Report states that new regulations on substitution treatment came into force in 2005, and have apparently expanded the use of methadone, as well as providing detailed regulations around the prescribing of buprenorphine, the only other medication employed in Swedish substitution therapies. According to the 2006 Reitox Report, 62 treatment units (including 20 private) had “expressed an interest” in offering substitution treatment by October 2006. The Report states that 2,700 patients were in medically assisted treatment in the year to June 30th 2006, of whom 1,500 used buprenorphine. It is unclear how many of the methadone patients were in short-term detoxification, using medication in a “reduction” context, as opposed to MMT.

Compulsory or coerced treatment is permitted in Sweden, though its use is less prevalent than is often supposed. As of November 2005, 6% of drug users in institutional treatment were there on a coerced basis.¹³ Both adults (of 20 years and above) and juveniles can be committed to coerced institutional treatment, the former by reference to the *Care of Alcohol and Drug Abusers Special Provisions Act*, the latter by the *Care of Young Persons Special Provisions Act*. Though coercive treatment is in general used comparatively rarely, it is employed rather more often in the case of alcohol dependence. The compulsory treatment of adolescents is more frequent, as is the employment of threatened coercion as a device to “encourage” participation in voluntary treatment.

Therapeutic communities have traditionally been the most popular treatment modality in Sweden; these communities are usually located in rural districts, and many are privately run. In the 1980s, a two year stay in such a facility was commonplace for an injecting drug user in recovery, but, partly as a result of the more stringent economic climate prevailing in subsequent years, the duration of stay has decreased to something in the region of 6 months. Moreover, outpatient treatment has become increasingly popular over recent years. Most outpatient treatment is based around the ‘12 Step’ model.

The role of social workers is very important in the Swedish treatment system, as these professionals provide the links within the ‘care chain’. Composed of outreach, detoxification, institutional facilities, aftercare and rehabilitation, the care chain is an important concept that ties together the various elements of the drug control regime. Thus, working in close cooperation with the police, social workers play a key role in the initial identification of drug users on the streets; if the police locate a drug user, they bring him or her to the attention of a social worker who will decide upon the proper course of action. Social workers as a profession have also played a significant political role, which will be discussed below.

Harm reduction services

Harm reduction is not a phrase that is used in Swedish drug control discourse; its founding assumption, that some people cannot or will not stop using drugs and therefore require services that minimise the associated damage, is, indeed, alien to the Swedish approach. With the advent of HIV in the 1980s, the provision of needle and syringe exchange services—perhaps the paradigmatic harm reduction intervention—was debated at length. The government subsequently announced that needle exchange would be made nationally available in 1988. The proposal was greeted by a storm of protest from pressure groups and professional associations, and was quashed by the Swedish parliament the following year. New legislation passed in 2006 does permit needle exchange services to be set up by local authorities, but there are, to date, only two such services, one in Malmo and the other in Lund, both having been set up on an experimental basis in the 1980s and operating successfully since that time. These services cater for roughly 1,200 individuals, or some 5% of the nation's total injecting population.¹⁴ Injecting equipment is not obtainable in pharmacies except on prescription. As discussed below, the inadequate provision of harm reduction services has resulted in Sweden being criticized by the UN's Special Rapporteur on the Right to Health.

Testing & Prevention

Since 1993, the police have had the power to enforce drug testing on those they suspected of using drugs. This, along with legislation permitting the imprisonment of even minor drug cases, was a fundamental part of the increasingly restrictive measures that accompanied Sweden's steep rise in drug prevalence and severe economic downturn during the 1990s. It should be noted that blood and urine tests could only be deployed where offences were of sufficient seriousness to warrant a prison sentence, and that these two laws should therefore be seen as mutually enabling. The objective of testing was defined as follows: "to provide opportunities to intervene at an early stage so as to vigorously prevent young persons from becoming fixed in drug misuse and improve the treatment of those misusers who were serving a sentence."¹⁵ In defence of the policy of testing, then Health Minister Bengt Westerberg claimed that it was necessary to target the user, who was "the motor of the whole drug carousel."¹⁶

Normative interventions are an important and ongoing aspect of the Swedish regime. The government ran a 2006 media campaign, based largely on the use of the internet but also involving youth media such as MTV, entitled *Drugs Are Poo*. This was aimed at reinforcing in young people the continued disapproval of drug use; according to the 2007 Reitox Report, the campaign was successful. Surveys reported that 9 out of 10 young urban Swedes support the government in such

interventions, and 56% had heard someone repeat the slogan *Drugs are Poo*.¹⁷ Nonetheless it seems likely that those drawn to such interventions are likely to be those who do already support the orthodox stance.

THE CONTEXT OF SWEDEN'S DRUG STRATEGY

We have provided an overview of the main elements in Sweden's drug control regime. However, in order to comprehend its objectives and the terms in which it is framed, one must take into account certain aspects of Swedish history and culture; without doing so, it is impossible to understand how and why the current system developed. We will briefly explore the most important of these factors here. At the outset, it is important to avoid a possible misunderstanding. In the course of this discussion, we will identify various tendencies within Swedish culture that we believe help to explain the country's attitudes and responses to illicit drug use; these should be read as general trends and characteristics present within the social milieu, and not as referring to some essential, fixed or innate Swedish or Nordic 'personality-type'. They are generalizations that nonetheless do reflect the realities of Sweden's social and cultural life, and are the result of specific and discernible social and historical circumstances.

Sweden, Modernity and the Good State

Despite its standing as one of the most wealthy, well-ordered and secure of modern nation states, Sweden was a late arrival to the condition of modernity. Halfway through the 19th century it was one of the poorest countries on the European continent, with nearly three quarters of its population of 3.5 million working on the land. The country became connected to global trading networks in the second half of the 19th century, and industrialization gathered pace only then. The early decades of the 20th century continued to be marked by a widespread poverty that drove hundreds of thousands to emigrate, mostly to the United States and Canada.

By 2008, Sweden's population had risen to just over 9 million. Its transition from a feudal society, with wealth and power controlled by a tiny aristocratic elite, to a modern social democracy was, in comparative terms, a very rapid one. While 2008 figures put the urban population at 85%,¹⁸ most people still have relations and cultural roots in the countryside, lending Swedish culture a distinctive blend of the traditional and the modern. The social democratic party was the driving force behind the building of the *folk-hemmet* or 'people's homeland' in the 1930s; the *folk-hemmet* offered its citizens prosperity

and security; the latter category, *trygghet* in Swedish, has proven to be of critical importance in the nation's political life, and has deeply infused the national culture. The state has endowed Swedish citizens with one of the world's highest standards of living, combining a dynamic market economy with extensive welfare provision and an exemplary human rights record. The state or system has thus been experienced in Sweden as an overwhelmingly beneficent force, and a belief in the effectiveness of state-sponsored solutions to political, economic and social problems, or 'social engineering', has been widely diffused throughout Swedish society. A powerful ethic of conformity has co-existed with this implicit faith in the Good State, generating a suspicion of social difference and its identification with social *deviance*. Boekhout von Solinge points out that Sweden's geographical location on the western limit of Europe, far from the cosmopolitan melting-pots of Paris, Berlin and London has perhaps contributed a certain provinciality and insularity to the country's outlook.¹⁹ In short, despite its social democratic tradition, it appears that Sweden is, in the social and cultural register, a conservative country.

Political culture & Social movements

The Social Democratic party elected in the 1930s instituted a political culture based on consensus; both private sector employers and trade unions were committed to this consensus, leading to the success of the corporatist and collectivist 'Swedish Model', and resulting in extended periods of full employment, generalized prosperity and a capacious safety net of social welfare measures. Another essential element in the establishment of this harmonious order has been the influence of popular social movements, groups and associations, often organized around a specific cause or set of values. These trends anticipated the single-issue pressure groups that have been influential in other contemporary democracies. Though membership in Sweden's popular social movements has declined—partly because they have been so successful, and their objectives largely integrated into the state and its mechanisms—many of the older generations of Swedes can still recall their personal participation in constructing the Good State. Swedish society is, perhaps understandably, proud of its social and political achievements.

This very active political pluralism has had a large impact on the development of Swedish drug policy, which has widespread popular support. The country remains to this day a strongly protestant society, with some 87% of the population belonging to the Lutheran church. The denomination has a strong temperance tradition, and has been politically influential since the 19th century, when its campaigning resulted in the passing of laws forbidding the home distillation of alcohol. Temperance has historically coexisted with a Nordic drinking tradition in which alcohol is consumed with the objective of

getting very drunk, very quickly.²⁰ The discourse of temperance, in a form strongly committed to the achievement of abstinence, was central to two social movements highly active in the drug policy field from the late 60s onward: *The National Association for a Drug Free Society* (RNS) and *Parents Against Drugs* (FMN). As Lindberg and Haynes observe: "RNS was started by a doctor, Nils Bejerot, who believed that the solution to the narcotic problem was to restrict supply and to compel addicts to enter treatment. Bejerot saw the cause of drug addiction as a social illness, like a transmitted infection, and that older drug addicts taught younger people how to use drugs. Prohibition was believed to be the only answer and this was to be achieved by strict law enforcement and the compulsory treatment of drug misusers. RNS was supported by many social workers, some doctors, teachers and members of the general public. RNS also was supported by the FMN which had the same philosophy and solution to the problem."²¹ It should be noted, in addition, that the police play a powerful political role in Sweden, and have tirelessly advocated the restrictive model. Bejerot was consulting psychiatrist to the Stockholm police²² in the late 1950s and 60s, his ideas finding immediate favour in the service, which was strongly against the Stockholm experiment with legal prescribing.

Between 1965 and 1967, Sweden experimented with the medical prescription of drugs to dependent users. This phase is regarded by some as the root of the country's drug problem, and advocates of its zero-tolerance model argue that the repressive policies introduced subsequently were responsible for reducing the prevalence of drug use. However, the prescribing experiment was not scientifically planned or structured; no control group was established against which to measure its effects, and it is consequently difficult to draw conclusions from it. The project was much smaller than is sometimes supposed, with a total of 120 patients being prescribed over the two year period. Claims that injecting drug use increased during the project's lifetime and were lower before and after it are based on the work of Nils Bejerot. Bejerot's work in this regard—which, despite being subjected to intensive scientific critique, attracts widespread belief both in Sweden and internationally—is based on police statistics on the prevalence of injection marks amongst arrestees. Such data lack sufficient scientific validity and reliability to ground any but the most tentative of conclusions, since they may reflect police practice rather than the reality of drug use (increased searching, the over-zealous use of interpretive categories and so on). Even if injection *was* more widespread, this cannot be safely attributed to the effect of the prescribing experiment: the 1960s saw a generalized expansion of drug use in all forms, and the police data used by Bejerot do not offer any way of isolating the effect of the prescribing project from the general social and cultural context in which the behaviours were situated.²³

Altogether, Nils Bejerot has nonetheless had an enormous impact on Sweden's drugs strategy. He became active in the field following the experiment with prescribing, and was at the centre of the dissemination of the zero tolerance model. Despite Bejerot's own medical qualifications, however, the most powerful professional input into the groups pressing for more restrictive policies came not from doctors but from social workers. Already having a higher professional status than their counterparts in Britain, Swedish social workers became, according to Lindberg and Hayes, the leading elite grouping in Swedish drug policy formation at this time. Closely involved with both RNS and FMN, they were able to exert influence on policy makers by successfully deploying their expert status and specialized knowledge, in a way somewhat analogous to the medical profession in the UK, though with very different results.²⁴ Unlike UK medics, Swedish social workers were able to tap into an anti-expert strand in the culture, contrasting their own 'hands-on' engagement with the problem on the streets with the allegedly remote pronouncements of doctors and academics. The call for widespread needle exchange services in Sweden to counter the HIV epidemic in the 1980s was effectively defeated by this alliance. To quote Lindberg and Hayes once more, "The emphasis in our historical account is on the activities of professional groups and interest lobbies. These groups seek to define a social problem and then hand over a solution to the politicians. If a policy is going to succeed, then there has to be a linkage between the politicians and these groups. If there is no such link, the politicians will not formally legitimate the suggested definitions of the problems and the solutions that are presented."²⁵ In the case of Sweden, the link did exist, and the restrictive model advocated by the RNS was taken up by politicians and embedded in the country's legal and medical institutions.

Social and cultural context

The cultural conservatism referred to above is compounded by Sweden's high degree of ethnic and social homogeneity. Until the last couple of decades, the majority of such immigration as there has been has involved people from other Scandinavian nations, especially Finland, with which Sweden shares a border. In a work exploring the links between social anxieties, immigration and drug policy, Gould describes a Swedish government report entitled "*We will Never Surrender*"; the cover displays some significant iconography, with the title emblazoned over a photograph of Sweden's rocky coastline, standing eternally vigilant against the depredations of the ocean and that which might try to come across it. The report develops the theme of drugs as alien material, coming from outside Sweden, whose borders must be defended against the intrusion of disorder from without. Gould recognizes that, "there is a rational connection between migrant labour and drugs (it would be surprising if migrants did not take their

native drug habits with them on their travels, as they do other aspects of their cultures)...", but points out that "the concern... has been with the irrational, exaggerated, mutually reinforcing fear of both."²⁶ This linkage is also discussed by criminologist John Pratt, who notes that "an immigrant underclass" has recently begun to emerge in Sweden's largest cities, with up to 50% of some immigrant groups unemployed. The country has seen the highest volumes of immigration anywhere in Scandinavia, and some 26% of those in the state's prisons are foreign citizens, compared with 6% of the general population.²⁷ He notes that the social and ethnic homogeneity of Sweden had "played an important part in reaffirming egalitarian values, tolerance and trust; people who are similar to each other are more likely to be content with inclusionary rather than exclusionary punishments for lawbreakers, who are less likely to be understood as alien others."²⁸ While Sweden has been a tolerant, liberal society in respect of its immigrant labouring populations in the past, recent immigration patterns have generated a more ambivalent response, particularly in the case of asylum seekers and refugees. Extreme Right-wing parties have had some local successes, while instances of crime by foreigners have generated public outrage amongst "normal" Swedes.²⁹

In a case which fits a well-established historical pattern, it seems that drugs in Sweden have assumed a symbolic role in which they have become linked with foreigners and with fears of 'the outside' in general. The fact that Sweden has very little historical experience with intoxicating substances from other parts of the world (comparable with Britain or France and their Asian and North African colonies, for instance,) has helped to establish the essentially 'foreign' quality of drugs originating from these regions. As Pratt notes, " 'Getting tough on crime' then becomes a way of providing gestures of reassurance against a common enemy—uniting the public, restoring security, reaffirming homogeneity and solidarity." This is particularly the case with drugs. The more that homogeneity has come under threat, he states, "the more the dangers of drugs become...acute. There is a symbolic link between the two sets of concerns. In all societies, purity (represented here by Scandinavian homogeneity) and danger (drugs) are important symbols. Purity conveys a sense of order and homogeneity; danger conveys disorder and disintegration... The more that which is pure comes under threat, the more it becomes necessary to take dramatic action against that which endangers it."³⁰ Pratt makes reference here to the anthropologist Mary Douglas's celebrated work *Purity and Danger*³¹ and the way these categories work to establish sacred and profane spaces and materials in human societies. The reason that Swedish culture constructs drugs as an extreme danger, despite the fact that their prevalence is relatively low in the country, is related to a specific set of historical and cultural factors that add to the sense of risk,

threat and uncertainty. These may be said to be linked in one way or another to the phenomenon of globalization.

Globalization

Sweden, like most other states, is becoming increasingly integrated into a global world. In 2007, 66% of Swedes had cable or satellite television³²; in 2008, 84% of households had an internet connection—and 71% were broadband³³. These are amongst the highest figures in the EU, which Sweden joined in 1995 amidst fears that liberal European drug policies might swamp Sweden's own restrictive model. Sweden's high-tech economy and communications connect it to the rest of the world and the political, economic and socio-cultural forces that flow through it. This can be an uncomfortable situation for a people which sees itself as distinct, though Sweden is, of course, far from alone in feeling that kind of discomfort. Uncertainties about national and other forms of identity, and a perception that national sovereignty is leaking out into the chaos of the late modern world, are all too familiar in many nation states. But as a consequence of the specific social and cultural history of Sweden, drugs have come to symbolize in a particularly acute way that disorder and the sense of powerlessness it can engender. We will return to consider these questions at the conclusion of this paper.

SWEDEN'S DRUG POLICY- SUCCESSFUL OR OTHERWISE?

Prevalence

While we provided a brief overview of Sweden's drug market above, we will now look in a little more detail at the claims made about the successes and failures of its drug policy. The low prevalence of drug use in the Swedish population is one of the major areas to which advocates of the model point. In terms of prevalence of drug use amongst the general population, it does indeed appear that Sweden is 'successful', being below European and North American averages in most of the key indicators.³⁴ The general rise in drug use in the 1990s was mentioned previously, as was the fact that trends have fallen once again since the year 2000. In 2007, lifetime prevalence of cannabis use amongst young adults (15-34) was 18.1%, against an EU range of 2.9% to 48%.³⁵ For comparative purposes, we might note that countries with similar prevalence figures include Hungary (19.1%) and Portugal (17.0%). Amongst all adults (15-64), the Swedish figure was 12.8% against an EU range of 1.5% to 38.6%; similar figures are found for Latvia (12.1%), Luxembourg (12.9%) and Portugal (11.7%). For last year cannabis use amongst young adults, Sweden's figure was

4.8% (EU range 0.9% to 20.9%), and for all adults it was 2.1% (EU range 0.4% to 14.6%). Interesting comparisons arise with Portugal, for which these figures were respectively 6.7% and 3.6%. For school students, Sweden's figures are even lower, lifetime prevalence of cannabis use for 15-16 year olds standing at 7% (EU range 4% to 45%), and last year prevalence at 2% (EU range 1% to 5%). To reiterate, it seems from these data that the prevalence of cannabis use is lower than the EU average, sometimes much lower. The same general trend may be observed for other illicit drugs. Low prevalence data is the primary measure used by the UNODC in concluding that Sweden's is a 'successful drug policy.' However, it should be noted that a number of other countries, including Portugal, which employs a very different set of drug control measures, have broadly similar prevalence levels (and lower levels in some categories), and could, in principle, have been selected as exemplary policy templates by the UNODC.

Some further reservations must be made. Firstly, in terms of the content of these data, one must be very careful about drawing any firm conclusion that they accurately reflect the reality of drug consumption. Prevalence data are based on surveys of the general population, conducted by face to face interview or postal questionnaire. In a country where the authorities adopt such a restrictive posture in relation to drug use, and where community disapproval is so powerful, it would be somewhat surprising if citizens *did* provide entirely candid replies: so it is very likely that the figures underestimate consumption. Moreover, anecdotal narratives speak of rising levels of drug use among young Swedes³⁶ as they become progressively more integrated into global youth cultures. Researchers have identified club-based dance cultures in which drug use is part of the process of forging identities defined against the tightly enforced norms of Sweden's mainstream society³⁷. Schools-based research, in its latest 2008 study, discovered that cannabis use had increased from 5% to 7% amongst female students and from 7% to 9% for males over the past year.³⁸ Notwithstanding this, it is likely that prevalence rates of recreational drug use remain relatively low. This leads us onto a second point: a comparatively low overall prevalence rate of drug use tells us little about the patterns of use that *do* exist, and the problems that may be associated. It is necessary to ask, what levels of problematic drug use are there, what kinds of harms cluster around it, and how effective is the policy response to these harms?

Problematic drug use and the response within the Swedish model

As noted previously, official figures estimate there to be approximately 26,000 problem drug users in Sweden, though again the actual numbers may be higher.³⁹ The problem drug use prevalence rate is put at 0.45% by UNODC, slightly below

the EU average of 0.51%. Nonetheless, UNODC acknowledges that problematic drug use *as a proportion of overall drug use* is very high in Sweden. 1 in every 5 to 6 Swedish users is included in this category, compared with 1 in every 12 or 13 in the UK.⁴⁰ Amphetamines and opiates are widely injected by this population, and the drug and policy-related harms are significant. While HIV infection rates in Sweden are relatively low, injection-related HIV increased by 52 new cases in 2007 compared to an average of 21 new cases annually over the previous five years.⁴¹ It may be significant that these were very strongly centred in the Stockholm area (49 of the 52 new cases in 2007). Though Stockholm is by far the largest population centre in Sweden, it does not have needle-exchange facilities. The two cities that do, Malmo and Lund, saw no new HIV cases between 2001 and 2006. Furthermore, injecting drug users (IDUs) represent 57% of all hepatitis C infections in Sweden, and the Swedish Institute for Infectious Disease Control estimates that 95% of IDUs will test positive for hepatitis C infection within two years of initiating injecting.⁴²

In the late 1990s, the then Director General of the Swedish National Institute for Public Health spoke out against the tightly restricted use of methadone, stating that: “Mortality among heroin addicts is twice as high in Stockholm as in other European cities. The only treatment method that is reasonably effective, methadone, is held in check by Swedish drug policy.”⁴³ The remark was made in the context of steeply climbing drug related mortality seen during the 90s, and the longstanding and still evident tendency for discussion of drug-related deaths to be seen in terms of the ‘international legalization movement’, the perceived threat of which drives Swedish debate to be extremely cautious about sending out the ‘wrong message’. The adoption of measures to minimize harms to drug users is seen as condoning and even encouraging drug use. According to the National Cause of Death Registry, drug-related deaths rose to a peak of 403 in 2001, and have declined gradually since then to 310 in 2006.⁴⁴ Interestingly, the Selection B definition of drug-related deaths, the system preferred by the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA), shows a slightly different trend. Using more restricted criteria for classifying mortality as drug-related, EMCDDA figures for Sweden similarly show a peak in the year 2000 (191 deaths), but since then the trend has remained steady at 162 in 2001, 160 the next year, and 157 in 2006. On the evidence of the Selection B trend, drug-related deaths appear to have remained level since the late 1990s, with some possibly anomalous event causing the spike in 191.

The lack of harm reduction measures in the face of this serious situation led Paul Hunt, the UN Special Rapporteur on the Right to Health, to criticize Sweden following his mission to the country in 2006. He noted that, while Sweden’s international commitment to human rights is exemplary and its government

has signed up to many international treaties recognizing the right to health, “this human right is less firmly entrenched in Sweden’s domestic laws and policies.”⁴⁵ Expressing his “surprise” that the very successful needle exchange in Malmo, which he visited, was one of only two in the country, Professor Hunt concluded that, “The Special Rapporteur emphasizes that the Government has a responsibility to ensure the implementation, throughout Sweden and as a matter of priority, of a comprehensive harm-reduction policy, including counselling, advice on sexual and reproductive health, and clean needles and syringes.”⁴⁶

During the preparation of this Briefing paper, a further significant intervention has been made in support of harm reduction measures in Sweden, this time from within the country itself. The Director General of the National Board of Health and Welfare, together with the Directors of the Infectious Diseases Institute and the Institute of Public Health have called for local authorities to make use of the provisions under the 2006 Act enabling them to set up needle exchange services for drug users.⁴⁷ These three prominent clinicians point out that this is a health measure supported by the United Nations, the World Health Organization, the International Red Cross and the World Bank, and that neighbouring Finland, which shares a restrictive approach, has successfully introduced low threshold needle exchanges that are “free, non-judgmental and..anonymous”. Amongst EU countries, only Sweden and Greece continue to deny this health service to their citizens, the authors go on to say, urging their country’s authorities to act according to the principles of the Dublin Declaration, which Sweden signed in 2004. The Dublin Declaration commits signatories to ensure that syringe exchange services are available to at least 60% of IDUs. As already noted, the two services presently operative in southern Sweden reach some 5% of this vulnerable population.

CONCLUDING DISCUSSION

UNODC has argued that while causal relations are notoriously difficult to establish, “in the case of Sweden, the clear association between a restrictive drug policy and low levels of drug use is striking.”⁴⁸ In his foreword to *Sweden’s Successful Drug Policy*, Antonio Maria Costa is frank enough to confess that, “It is my *firm belief* that the generally positive situation of Sweden is a result of the policy that has been applied to address the problem”⁴⁹ (italics added). While overall prevalence remains low, the extent to which this is due to Sweden’s drug policy, or to wider social, historical and geographical factors, cannot be easily surmised from the available information. Judgements regarding the efficacy or otherwise of Swedish policies therefore inevitably involve wider sets of value and belief, firm or otherwise. As mentioned above, the country has acquired a symbolic status for adherents and opponents of its approach. Nonetheless, based on the complex threads of empirical evidence and the social and cultural ground covered in the foregoing discussion, we may draw some tentative conclusions.

1. Whether or not Sweden’s policies are ‘successful’ depends on the definition of success and the strategic measures in which that definition is embedded. In its own terms, the Swedish government can claim success as a result of the country’s relatively low prevalence of recreational drug use. This claim is endorsed by the Executive Director of UNODC, on the basis that low prevalence constitutes the most important policy objective.
2. In terms of the management of harms associated with drug use, however, particularly as these are linked to dependent patterns of drug consumption, it is much more difficult to consider the strategy as successful. Harm reduction and other public health measures seem inadequate to meet the realities on the ground, and the restrictive model may in fact exacerbate this situation. The failure of Sweden to address these associated harms is undoubtedly linked to the ‘vision’ of a drug free society, which militates against a pragmatic response to these health challenges. As with most utopias, the Swedish system does not deal well with those obdurate realities (such as the continued use of drugs in sometimes risky ways) that fail to fit into its design for perfection.
3. More fundamentally, there are no firm grounds for attributing the low levels of drug use in Sweden to the action of its drug policy measures—a fact which may be demonstrated by employing comparative sources. The United States and Sweden share a great deal in terms of their policies and strategies regarding drug use, yet the former has the highest levels of drug use in the world while the latter is amongst the lowest. This poses what appear to be insuperable problems for any causal understanding of the relations between policy and patterns of usage, and points to a powerful role for the influence of culture. Both Sweden and the United States share similar, restrictive policy models, and both have historically strong temperance movements. However, the US comprises a much more heterogeneous social landscape, where temperance discourse competes with hedonism and expressive consumerism, alongside several ethnic cultures of substance use deriving from its status as an immigrant society; the result is that the US is both politically restrictive of, and socially conducive to, drug consumption.
4. Sweden’s culture is, by contrast with that of the US or the UK, a socially, culturally and ethnically homogeneous society. It is traditional and conformist, and suspicious of certain kinds of outsiders, for whom drugs have come to stand as a symbol. Our evidence and analysis indicates that the marginal place of illicit drug consumption in Sweden stems from historical, social and cultural circumstances that are specific to the nation. If we take into account the US and its deeply conflicted relations with illicit drugs, the facts tend to support the contention that culture plays a very significant role in determining levels and styles of drug consumption, a role that is more significant than that of government policy. This evidence strongly contradicts Mr Costa’s claim that, “the achievements of Sweden are further proof that, ultimately, each government is responsible for the size of the drug problem in its country. Societies often have the drug problem they deserve.”⁵⁰
5. In terms of the advocacy of the Swedish model and its application in other countries, it would appear that these policies would not be successful, appropriate or perhaps even acceptable elsewhere. The norms of Swedish culture are specific, and quite unlike those prevailing in most other late modern societies. Even within Scandinavia, where several countries until recently shared many elements of the restrictive model, a more pragmatic tendency has begun to take hold.⁵¹ To attempt to transfer the policy model is to ignore the extent to which it is profoundly and thoroughly embedded in Swedish history and culture, and supported by the country’s moral ecology.
6. Finally, it is important to note that even within Sweden, it appears that the social foundations on which the strategy of the drug free society is built are beginning to shift inexorably. Swedes are increasingly losing the implicit faith they once had in the Good State, as the

twin forces of globalization and neo-liberalism erode both the ethnic and cultural homogeneity of the social body and the belief in political rationality as embodied in state intervention. As noted above, Sweden's youth are becoming increasingly integrated in postmodern global culture⁵², and 'sensible' drug use is very much a part of that culture.⁵³ The old Nordic drinking patterns are being replaced among the young by new, European imbibing cultures⁵⁴; even the surveys conducted around the *Drugs are Poo* campaign found that many young people believe the vision of a drug-free society to be unrealistic.⁵⁵ This demonstrates that the country's youth is not a monolithic category, and that divergent views of drugs are present in Swedish society. As the world becomes more and more interconnected, it seems likely that the political and social conditions underpinning Sweden's zero-tolerance approach will be transformed, leading future generations to look toward alternative ways of dealing with the choices and problems posed by the global presence of diverse intoxicants.

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