news focus

Swedish massage

The perception that low drug use in Sweden is a direct result of the country's tough anti-drugs policy is finding considerable traction in the UK. But, argues **Steve Rolles**, it is both simplistic and misleading.

IAN Duncan Smith is flagging up the success of Sweden's drug policy in his new role as chairman of the Social Policy Review Group, currently overhauling Tory drug policy in the run up to the next general election. David Cameron visited the country in February in an attempt to distance himself from his days of cannabis smoking. In the words of the *Daily Mail* he "praised the tougher approach in Sweden, which does not distinguish between cannabis and harder drugs such as heroin, and practises a zero-tolerance policy."

In September last year the UN Office of Drugs and Crime produced a report titled 'Sweden's successful drug policy: a review of the evidence'. Launching the document, UNODC Director Antonio Costa repeated his catchphrase that 'societies have the drug problem that they deserve' noting specifically that "in the case of Sweden, the clear association between a restrictive drug policy and low levels of drug use, is striking".

Sweden's 'successful' policy closely follows, in both letter and spirit, that espoused by the UNODC. Because Sweden has low levels of drug use compared to the rest of Europe it is perhaps unsurprising that the UN's drugs office chooses to proclaim the country as a model of good practice, especially given the backdrop of rising drug use globally. Sweden, perhaps not coincidentally, is the UNODC's third largest state funder (nine per cent) after the US (13 per cent) and Italy (11 per cent), and has the clearly stated and unambiguous aspiration to a 'drug free society'. This manifests in its tough zero-tolerance approach involving heavy handed policing, the widespread rejection of harm reduction principles, and a focus on coerced abstinence-based treatment.

However, by putting the emphasis so heavily on prevalence success, the UNODC conveniently brushes over some of the less positive aspects of Sweden's drug policies. According to the country's nascent user movement, the aversion to harm reduction (shared with the UNODC but notably not the WHO, and UNAIDS) has contributed to Sweden's drug death figures doubling from around 200 to 400 since 1990, placing it high in the Euro rankings. Problematic drug use has almost doubled since 1980 to a level hovering around the European average.

Furthermore, Costa's suggestion that there is a obvious causal relationship between prevalence and UNODC-style drug control policy appears unsustainable. Various countries have comparable or lower levels of drug use than Sweden but have very different drug policies. Greece, for example, (according to the EMCDDA), has the lowest level of drug use in Europe but spends approximately one-fiftieth on per capita drug-related expenditure that Sweden does. Holland, also has well below the European average drug use, spends more than Sweden per capita, but has a tolerant, harm reduction-led policy that is the polar opposite of the Sweden UNODC model. Conversely, another repressively oriented country – third in the Euro drug-related expenditure tables – is the UK, which sits at the top of most European drug use prevalence tables. We have yet to see a UN report titled 'The UK's unsuccessful drug policy: a review of the evidence', indeed if the UK Government buys into Costa's analysis they must be wondering what they have done to 'deserve' our high prevalence rates.

Dr Peter Cohen, Director of the Centre for Drugs Research at the University of Amsterdam, has argued that Sweden's low level of drug use and repressive drug policy, rather than being causally linked, are in fact both merely expressions of its historically temperance oriented culture, noting that Sweden also has historically low levels of alcohol, tobacco and prescription drug use. It is also worth pointing out that Sweden has low levels of social inequality, social depravation, and unemployment, combined with a very high level of health and social welfare spending.