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# A path forward for Swedish drug policy?

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## Abstract

**Aims and premise:** The primary aims of this article are to: describe some major aspects of the theoretical basis of the Swedish drug policy model, present alternative theoretical understandings which may pave the way for changes in drug policy, depict some problems with the Swedish model, introduce the primary principles for "the experimenting society", and give concrete examples of when these have/have not been applied in Sweden. **Some findings:** Sweden's predominantly biochemical approach should be replaced by a biopsychosocial model. The idea that all non-medical consumption of drugs is abuse is counterproductive. Differences between recreational and problematic consumers are discussed. The question of people's motives for taking drugs has not been incorporated into Swedish drug policy. The stepping-stone hypothesis is examined. It was found that recreational and problematic consumption do not co-vary, indicating that these are two essentially different phenomena. **Conclusion:** After four decades with the current Swedish drug policy model we are further from our pronounced goal of striving towards becoming a drug-free society than when we started. Access to, and demand for, drugs has continually increased, and our drug policies have caused serious collateral damage. Consequently, there is good reason to re-think the course we have chosen. The Swedish version of the war on drugs has failed to achieve its goals and it is time to make peace. It is time to accept that we will never be drug-free and therefore must learn to live with narcotics. As nobody knows what is the best way to achieve this, we should approach the task with humility. We need to put prestige aside and become "the experimenting society"; that is, one that would vigorously try out possible solutions and make stringent, multidimensional evaluations of outcomes. When the evaluation of a reform shows it to have been ineffective or harmful, we should try other measures.

## Keywords

biopsychosocial perspective, drug policy, experimenting society, problematic consumption, recreational consumption, Sweden

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In 2020, the European Union's drug agency published a report comparing drug-related deaths per capita in member states. Sweden has the highest rate; almost four times the EU average (EMCDDA, 2020, pp. 67–68). While there are methodological problems in collecting drug statistics, and international comparisons are even more difficult, these numbers are too extreme not to take seriously. More than 800 drug-related deaths per year, in a country with a population of 10+ million, is far too many to ignore.

In February 2020, a parliamentary committee charged the Swedish government with appointing a drug commission. Several such commissions have been established over the years, but their directives have always excluded examining central aspects of drug policy. Therefore, a debate broke out concerning the new commissions directives. As I write, a year has passed and no commission has been appointed.

In a short article, it is not possible to present a nuanced discussion of all that is problematic with the Swedish prohibitionist drug policy – the so-called "Swedish model". The ideas presented here are among those expounded upon in my book, *Legalisera Narkotika? Ett Diskussionsunderlag* [*Legalise narcotics? A basis for discussion*] (Goldberg, 2011). In this book, I investigate what I consider to be the major issues, and possible ways of finding solutions. However, I do not present definitive answers. While the title may seem provocative, I chose it to indicate that all possible solutions, even those that some consider extreme, should be closely examined. The question mark in the book's title is indicative of my position – we need to question whether we really know what to do about psychoactive drugs.

## Aims and premise

The primary aims of this article are to:

- describe some major aspects of the theoretical basis of the Swedish model,
- present alternative theoretical understandings which may pave the way for changes in drug policy,
- depict some problems with the Swedish model,
- introduce the primary principles for "the experimenting society", and give concrete examples of when these have/have not been applied in Sweden.

In the early 1980s, when US president Ronald Reagan rejuvenated former president Richard Nixon's war on drugs, many countries, including Sweden, jumped on the bandwagon. When at war, nuances disappear. There's right and there's wrong, and little in between. Those who are on your side are righteous, all others are evil. When a situation is defined thusly, things that otherwise would not be tolerated become possible; i.e., radically changing priorities, ignoring costs, dismissing rational arguments without justification, instituting (self-)censorship etc. Unfortunately, all of this is easily recognisable in conjunction with Swedish drug policy.

In Sweden's version of the war on drugs, almost everything asserted by those who claim to be against drugs is automatically accepted, while those who advocate less repressive or less restrictive measures find that they themselves, rather than their ideas, are called into question. Those who do not toe the line are malevolently called "drug liberals", "a threat to our children", "naïve" etc. This grants license not to consider their arguments, and they are often stonewalled, making it extremely difficult to initiate a dispassionate examination of the arguments proposed and the measures taken. Preserving the Swedish model has been a goal in itself. As Danish criminologist Jørgen Jepsen (1992, p. 58) wrote: "The war on drugs is also a war on alternative definitions and understandings of reality."

Despite all our efforts, after four decades with the Swedish model we are further away from the original goal – a drug-free Sweden – than when we started. Realising that a drug-free society is impossible, defenders of the Swedish model changed the wording of their goal – it is now "to proceed towards becoming drug-free".

However, we have been heading in the opposite direction the entire time, and it is therefore time to formulate new goals and new solutions.

## Problematic consumers – Recreational consumers

In the field of drug policy, Sweden has all too often prioritised ideology, the "politically correct" and emotional responses. For example, a common Swedish approach is to arouse fear, i.e., by emphasising emotionally charged terms such as dependency, kidnapped brain, abuse etc. We need new, and less emotional, terminology.

Swedish drug policy is based on the postulate that all non-medical use of narcotics is abuse. Consequently, it is considered reasonable to place smoking an occasional joint in the same category as injecting heroin multiple times per day. Using this conceptualisation, Sweden has claimed that its drug policy has been successful. The "proof" consists of statistics from the annual "School Studies" that indicate that cannabis consumption among Swedish 16-year-olds is lower than among comparable cohorts in most EU countries. By focusing on this single statistic, we can avoid looking at more serious problems, i.e., daily and intravenous consumption of drugs, which we seldomly collect national statistics on. The few studies that have been carried out have given results that contradict Swedish claims of success. Therefore, to get a realistic picture of the drug issue we need a terminology that differentiates between different kinds of consumption.

As I use the term, *problematic consumers* are people who prioritise a psychoactive substance to the extent that it becomes the *central activity* in their lives (Fingarette, 1989, pp. 101–102). Aspects of life that most people prioritise, i.e., family, social relationships, work, economy, health, etc., are secondary. *Recreational consumers* subordinate drug consumption to other values, activities and human relationships (Peele, 1998, p. 8). They find meaning in activities without drugs and do not feel particularly uncomfortable without psychoactive substances in their bloodstreams. The difference is easily understood if one looks at the ways people use alcohol. Both "skid row alcoholics" and people drinking wine with a festive meal use the same drug, but in different ways and with different goals.

A principal tenet behind the Swedish model is that when people start experimenting with narcotics, biochemical changes in their bodies cause them to lose control over their behaviour and force them to increase consumption. This has led to the conclusion that long-term recreational consumption is impossible. But is this true?

### *Does drug consumption necessarily lead to loss of control?*

Looking upon people as *subjects* implies considering them to have wills of their own. Their behaviour is directed towards goal-achievement, and they feel some responsibility for what they *choose* to do or not do. To see someone as an *object* implies that they do not act, they react. I exemplify the difference between viewing drug consumers as objects contra subjects:

> **Drug consumers as objects** – "That the individual has become chemically steered and *sorely lacks or has completely lost self-control* in relation to drugs constitutes . . . the essence of narcotics abuse." (Bejerot, 1979, p. 90, emphasis added)
>
> **Drug consumers as subjects** – "The stereotypes of heroin will depict someone's involvement with the drug as nothing more than a horrible chemical enslavement which is impossible to throw off, whereas heroin users' own accounts are better understood as those of *people exercising choices and decisions in their lives* – even though they will often come to regret those same choices and decisions." (Pearson, 1987, p. 5, emphasis added)

The idea that chemicals control human behaviour is common in Swedish thinking about both alcohol and narcotics. For example, many

Swedes believe that people are not really themselves, and do not really want to do what they do, while intoxicated. But if this is the case one can wonder why individuals who are sober (in control) sometimes choose to get drunk and "lose control"? The idea of loss of control is problematic. "It is unclear . . . whether the experience is truly one of losing control rather than one of deciding not to exercise control" (Edwards & Gross, 1976, p. 1060).

What would it imply if we were to consider the way people behave after taking psychoactive substances as an expression of their personal needs rather than drug coercion? This implies looking for motives behind "losing control". Human behaviour is not simply random. People use their limited energy to try to achieve goals. They may not always be cognisant of them but goals are still there. By emphasising what people do, rather than what they say, we can ascertain what they are trying to achieve by taking psychoactive substances.

Because biochemical understandings fail to shed light on motives, they do not help us formulate policies that address this issue. We need a broader understanding. People's motives for taking drugs must be comprehended in conjunction with: (1) their experiences as members of a society, (2) their individual biological and psychosocial preconditions, (3) the biochemical effects of drugs, and (4) the situation they are currently in.

Put succinctly, the Swedish model is built upon the idea that it is the drugs themselves that are the problem. This point of view helps us avoid having to deal with other social problems.

## The stepping-stone hypothesis

The "stepping-stone hypothesis" (gateway theory, Swedish "inkörsportsteorin") is an important foundation of the Swedish model. This hypothesis states that when people experiment with narcotics, sooner or later biological changes will cause them to lose control and start using more potent drugs. This implies that problematic consumers are merely recreational consumers who have become dependent. Therefore, Sweden places great emphasis both on stopping adolescents from testing illicit substances, and on identifying and rehabilitating those who have started to take drugs, in order to prevent their brains from being "kidnapped".

If the stepping-stone hypothesis is correct the number of problematic consumers will escalate when recreational consumption increases, and conversely, problematic consumption will decrease when recreational consumption diminishes. To investigate if such is the case, I have compared the results of available estimates of problematic consumption in Sweden, with the changing levels of recreational consumption as measured by the annual "School Studies" (Table 1).

Comparing columns 3 and 5 shows that recruitment to problematic consumption does not co-vary with the number of recreational consumers. In the 1980s, when recreational consumption decreased dramatically, recruitment to problematic consumption increased. In the 1990s, both types of consumption increased, but recruitment to problematic consumption increased substantially faster. And in the early 2000s, recreational consumption continued to increase while the pace of recruitment to problematic consumption appears to have decreased.[1]

What has happened after 2007 is not entirely clear. The "School Studies", 2008–2018, found that recreational consumption remained fairly constant at 6–8%. However,

> . . . due to a lack of studies of problematic consumption in the new millennium we must use indirect sources, i.e. disease- or death statistics, to get an indication of the extent and effects of abuse. These types of sources point to an increase in problematic consumption during the 2000s, and suggest historically high levels during the past five years [2014–2018]. . . . Such sources suggest that recruitment to problematic consumption is more likely to have increased rather than decreased during the 21st century. (CAN, 2019, p. 5)

**Table 1.** Recruitment to problematic consumption in relation to recreational consumption.

| | Recreational consumption | | Problematic consumption | |
|---|---|---|---|---|
| Year | Average percentage of 16-year-olds who have tried narcotics (almost exclusively cannabis) | Difference compared to previous period | Recruitment to problematic consumption[a] | Difference compared to previous period |
| 1971–1979 | 9.5% | | 700/year | |
| 1980–1992 | 4.7% | –51% | 750/year | +7% |
| 1993–1998 | 6.3% | +34% | 1,700/year | +127% |
| 1999–2007 | 7.4% | +17% | 1,200/year | –29% |

[a]The calculations upon which these statistics are based are explained in detail in Goldberg (2010, pp. 317–320).
*Sources*: Recreational consumption – CAN (2019, Table 40). Problematic consumption – Narkomanvårdskommittén (1969, p. 73), Olsson et al. (2001, p. 36), Missbruksutredningen (2010, p. 27).

Thusly, even statistics from 2008–2018 imply that recreational and problematic consumption do not co-vary.

Clearly, reducing recreational consumption does not necessarily lead to reduced problematic consumption. This indicates that problematic consumers are not merely recreational consumers who have become dependent. The most probable explanation is that *recreational consumption and problematic consumption are essentially different phenomena*.

Added support for this conclusion is provided by available statistics which show that the percentage of people in Sweden who have tried narcotics, and then at some point in their lives become problematic consumers, is very low – about 4% (Goldberg, 2010, pp. 318–319). The other 96% either stop taking drugs entirely or remain recreational consumers. Contrary to the stepping-stone hypothesis prediction, *it is an unusual exception rather than the rule that a person in Sweden who has used cannabis will become a problematic consumer of narcotics*.

## The psychosocial life experiences of problematic consumers

Problematic consumption of narcotics is uncommon in Sweden. From 1967 to 2007 only about 0.4% of the population had ever been problematic consumers (Goldberg, 2010, pp. 317–321). To explain why I have developed a labelling theory model (Goldberg, 2010, pp. 147–238). Here I will limit myself to clarifying the primary motives problematic consumers have for taking drugs, based on my extensive participant observation studies of the drug scene in Stockholm.

Problematic consumers of narcotics have at least some, and most often all, of the following goals when they take illicit substances:

1. confirm their strongly negative self-image,
2. attempt to escape from their own and other people's demands,
3. self-destructiveness,
4. revenge.

Labelling processes have caused prospective problematic consumers to have a strongly negative self-image – before they start taking drugs. Others have repeatedly chastised them and gradually they have come to accept that they are contemptable. They try to flee, i.e. with the help of psychoactive substances, but they have already internalized the derogatory judgments and they can't escape what they bear within.

Due to all their negative experiences while living on the drug scene, they confirm for themselves that they deserve to be severely punished; after all, they have harmed others and are destroying their own lives. As time passes, and the quantity and severity of their negative experiences accelerate, they become even more convinced

> that they are reprehensible and deserve to be severely punished. Their pattern of life increasingly becomes a process where they see to it that "justice is served". Others have condemned them, they have accepted the verdict, and they become their own executioner. But at the same time, by stealing from them, scaring them, giving them a bad conscience etc. problematic consumers wreak revenge on members of the society that has passed judgement. (Goldberg, 2010, pp. 162–163)

Studies of the lives of problematic consumers before they started using drugs have found extremely negative life experiences, most often including several of the following elements: poverty, physically and/or emotionally abandoned by at least one biological parent, problematic drug consumption in the family, physical abuse, sexual abuse, being subjected to diffuse demands and inconsistent use of punishment, serious conflicts in the family, receiving little encouragement, having been spoiled or severely frustrated, chronic physical and/or mental disorders in the family etc.

Furthermore, the prospective problematic consumer usually shows several symptoms of psychological ill-health: depression, headaches, stomach troubles, insomnia, low stress tolerance, anxiety, nervousness, aggressiveness, projection, brittle ego-defence etc.

And finally, several of the following characteristics can be identified in problematic consumers' childhood and adolescence: inability to form positive social relationships, insecurity, emotional distress, distrust of others, hostility, difficulties in taking initiative, giving up in the face of difficulty, poor adjustment in school, early tobacco debut, extensive alcohol consumption, criminality (i.e., shoplifting, violence, theft, vandalism), frequent contact with the police and/or child-welfare authorities, feelings of inferiority, a negative self-image.

Two conclusions that can be drawn from the above:

1. The general fear in Sweden that anyone can become a problematic consumer of narcotics is unfounded. Only a relatively few people have such extremely negative life-experiences that they would be willing to accept life on the drug scene. Problematic consumers do not merely buy drugs, they also buy an extremely self-destructive way of life. *People who are not self-destructive do not become problematic consumers*. It is therefore reasonable to hypothesise that there is little risk that particularly many Swedes will become problematic consumers of narcotics.
2. The "drug problem" cannot be resolved with drug policy alone. General social welfare policies are of utmost importance.

## The biopsychosocial perspective

Increasingly, scientists agree that humans are not only biological organisms but also social beings. However, there are significant differences between interpretations of what this implies. A key question is, how much of human behaviour can/should be explained by biochemical (biological and/or chemical) variables, and what is of psychosocial origin? This can be illustrated with a continuum (Figure 1).

The positions at either end of a continuum represent extreme points of view. Those who place themselves at the biochemical end believe

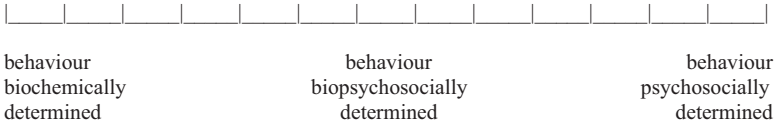


**Figure 1.** Biopsychosocial perspective.

that psychosocial variables are irrelevant, that is, they believe that human behaviour is entirely determined by genes, instincts, impulses, hormones etc. Human activity is reduced to biochemical processes (so-called biological reductionism).

Correspondingly, those who place themselves at the psychosocial end of the continuum rule out any influence of biochemical variables. However, both extremes have lost ground among serious researchers. Currently there is much support among researchers for *biopsychosocial thinking*, in which, at least to some extent, both biochemical and psychosocial variables are considered important. However, different researchers put greater or lesser emphasis on one side or the other – they are spread out across the continuum. There are widely divergent points of view among those who see themselves as advocates of a biopsychosocial perspective.

Swedish drug policy was established at a time when biochemical theories of drug consumption were in vogue, and the Swedish model lies far towards the biochemical end of the continuum. However, in recent years many countries/states, especially in Europe and the Americas, have moved towards the psychosocial end of the continuum. Even Sweden has moved somewhat in this direction, but not nearly as far or as quickly as many other nations/states.

Without aspiring to be comprehensive, I shall examine a few aspects of biochemical thinking that remain evident in Swedish drug policy, and present how psychosocial perspectives provide alternative explanations.

*Positive reinforcement* is based on the idea that when people do something and are subsequently rewarded, they are encouraged to repeat the activity. When applied to drug consumption, there are two important assumptions behind this thought – both of which are contradicted by my participant observation research findings. The first is that everyone wants to have as much pleasure in life as possible, and taking drugs should be interpreted as a way to achieve this. The second is that before problematic consumers started taking drugs they did not differ significantly from the rest of the population. From this point of view it is first when people become dependent on drugs that their behaviour becomes unsound. For instance, the founder of the theory behind the Swedish model writes:

> Drugs that cause dependency give euphoric sensations that the individual, after a period, is unwilling to be without . . . (Bejerot, 1979, p. 119)
>
> Once dependency has been established, it becomes biologically deviant to discontinue consumption. Instead it is normal to concentrate all efforts on maintaining the instinct, which becomes stronger than the sexual drive. (Bejerot, 1979, p. 160)
>
> The addict does not generally suffer from his disease, he enjoys it. . . . the drug effects take on the strength of libidinal desire and outweigh all the mental, physical, social and economic complications arising from the abuse. (Bejerot, 1970, p. xvii)

While this type of thinking has many supporters among Swedish politicians, and has been drilled into the heads of the Swedish populace through "drug education", at least some biochemically oriented researchers choose to emphasise the importance of the anguish that dominates the lives of problematic consumers.

*Negative reinforcement* is used to describe when "people do something, not to get a certain reward, but to avoid something unpleasant" (Heilig, 2004, p. 39). In conjunction with drugs this is most often taken to mean avoiding abstinence. Researchers leaning towards the biochemical end of the continuum usually think of abstinence as physical abstinence. A major problem with this conceptualisation is that the withdrawal symptoms commonly associated with severe physical abstinence, i.e., cold sweats, vomiting, diarrhoea, weight loss, sleeplessness, severe muscular pain, twitching etc., have never been particularly common in

Sweden. For instance, in a study at the Coercive Care Unit at Serafen Hospital in Stockholm, Fugulstad found: "Based on assessments by medical doctors, estimates were made of the difficulties patients had during the detoxification process. . . . Somewhat unexpectedly most detoxifications were uncomplicated and *there often wasn't any actual abstinence*" (1989, p. 10, emphasis added).

Researchers leaning towards the psychosocial side of the continuum often think of abstinence as primarily psychological abstinence, which manifests itself through symptoms such as dysphoria, depression, irritableness, angst etc. A common interpretation is that these symptoms originate in negative social relationships, especially in early life: that is, the same negative relationships that led to the individual starting to take drugs to begin with. These symptoms are ever present in problematic consumers but if they have psychoactive drugs in their bloodstreams they can somewhat deal with them. But when they are without drugs the symptoms surface (the so-called rebound effect) and problematic consumers seek relief by actively seeking out drugs. But to accept this interpretation one must distance oneself from the idea that problematic consumers are just anybody who happened to be foolish enough to experiment with drugs and let his/her brain be "kidnapped". The rebound effect is based on there having been a psychological disorder prior to using psychoactive drugs.

Put concisely, over-emphasising biochemical processes has led Swedish policies in the wrong direction. But this is not to say that we should ignore biochemical variables. For example, Nora Volkow, director of the US National Institute on Drug Abuse conducted Positron Emission Tomography (PET) studies on people who have never been problematic consumers, and found large differences in the number of $D_2$ receptors in different individuals. When she then gave her research subjects a stimulant drug (Ritalin), the reactions varied greatly. Only about half liked the drug, and these were the people who had few $D_2$ receptors. Those with many $D_2$ receptors found Ritalin unpleasant (Agerberg, 2004, p. 64). Volkow:

> . . . believes that people with many dopamine receptors have an inbuilt protection against drug abuse. . . . People with fewer dopamine receptors are less sensitive for natural stimuli, but they can get a kick out of drugs. There is an increased risk that they will continue taking drugs, which then causes their dopamine receptors to be tuned down even further. (Agerberg, 2004, p. 64)

In conclusion, the results of modern biochemical research are in sharp contrast to the over-simplified biochemical conceptualisation behind the Swedish model. Our drug policies need input both from psychosocial variables and from a more complex understanding of biochemical processes, i.e., epigenetic.

## Some pivotal drug policy concepts

*Decriminalisation* denotes that certain kinds of dealings with narcotics remain a crime, but reactions are changed from penal sanctions to, for instance, administrative or therapeutic measures. This can be achieved by changing the laws and/or the way laws are enforced.

*Depenalisation* is one kind of decriminalisation. Either milder penal sanctions are written into the law, and/or judges give milder penalties, i.e., short(er) prison sentences (preferably probation), fines, treatment, counselling, education, performing a community service etc. Depenalisation has increasingly become a central element in many nations' drug policies, and is used to some extent in Sweden; i.e., adolescents caught with small quantities of cannabis are often referred to social workers for counselling.

Another type of decriminalisation is based on an expressed policy not to pursue perpetrators of certain drug crimes under certain circumstances. The police can be ordered: not to intervene, to prioritise other crimes, to issue warnings instead of making arrests etc. And prosecutors can have as a general

praxis not to bring certain types of drug-related cases to trial.

In general, decriminalisation seeks to avoid labelling drug consumers as deviants (if they do not commit other crimes). Decriminalisation can be described by the terms de jure (law in the books) and de facto (law in practice). Decriminalisation implies that de jure and de facto need not necessarily be the same.

*Legalisation* means that under certain formally defined circumstances, possession, consumption, production and sales of a hitherto illicit psychoactive substance are no longer crimes.

*Regulation* means that there is a legal market for drugs which is controlled through administrative measures. Models for how this can be implemented have already been developed for prescription drugs, alcohol and tobacco.

Until the turn of the millennium there was widespread distaste in Sweden for all these concepts. This resistance was based upon a basic tenet behind the Swedish prohibitionist model – we shall not do anything to make it easier for people to use drugs, regardless of the consequences. But in recent years Sweden has slowly started to accept a basic tenet of the harm-reduction paradigm – drug consumers are citizens and, like other citizens, have the right to as good a life as possible.

## Principles of an effective drug policy

The International Drug Policy Consortium (IDPC, 2012, p. 1) has proposed five basic principles for drug policies and strategies. These should:

- be based on an objective assessment of priorities and evidence,
- be fully compliant with international human rights standards,
- be focused on reducing the harmful consequences of drug use and markets,
- seek to promote the social inclusion of marginalised groups,
- work to build open and constructive relationships between governments and civil society.

## Once a problematic consumer, always a problematic consumer?

As noted above, a basic tenet of the Swedish model is that narcotics "kidnap"/restructure the brains of consumers. If it were true, as prohibitionists claim, that these changes are both permanent and of central importance for future behaviour, no problematic consumer could either totally abstain from drugs or become a recreational consumer. However, there is ample research indicating the contrary. For instance, in a now classic study of American Vietnam War veterans, Robins et al. (1980, p. 214) found that after returning to the US only 12% of those who had been problematic consumers of heroin in Vietnam had been a problematic consumer of this drug during any part of the three-year follow-up period – even though they had access to heroin. In another study, Robins et al. concluded:

> It does seem clear that the opiates are not so addictive that use is necessarily followed by addiction nor that once addicted, an individual is necessarily addicted permanently. *At least in certain circumstances, individuals can use narcotics regularly and even become addicted to them but yet be able to avoid use in other social circumstances*. (Robins et al., 1975, p. 961, emphasis added)

Taken together, the arguments presented in this article indicate that it is not self-evident that an alternative drug policy would lead to a significant increase in problematic consumption. But given our present state of knowledge, claims that this will not happen are also uncertain. Both interpretations are hypotheses that need to be tested. We cannot know which is correct without first experimenting with alternative policy measures for a period of time, and carrying out scientifically stringent evaluations of what transpires thereafter.

## Principles of the experimenting society

Former President of the American Psychological Association, Donald T. Campbell (p. 291),

writes that the experimenting society is one "that would vigorously try out possible solutions to recurrent problems and would make hard-headed, multidimensional evaluations of outcomes, and when the evaluation of one reform showed it to have been ineffective or harmful, would move on to try other alternatives." Some major principles of the experimenting society are:

- *Willingness to question one's own "truths"*. (ibid, p. 292)
- *Understanding that we cannot be sure in advance that we are right* - a certain degree of trial and error is necessary. (ibid, p. 293)
- *Honesty* – a commitment to testing reality, being self-critical, avoiding self-deception and facing up to facts. (ibid)
- *Action research* – action as research rather than research as an excuse to postpone taking action. (ibid)
- *Remaining open to new ideas*. (ibid)
- Evaluation – when funding is granted for a program, financing for evaluation of both short- and long-term effects must be included. (ibid, pp. 303, 308)
- *Avoiding the overadvocacy trap* - even good and effective programs are not perfect and if too much is promised, it creates a fear of being evaluated. (ibid, p. 299)
- *Whistle-blowing* – It is both a right and a duty to publish reports that contradict accepted truths, and those who do so should not be punished. (ibid, p. 305)

Put concisely, the experimenting society is based on science rather than belief. Honesty, open criticism, experimentation and willingness to change accepted theories when these are contradicted by tenable evidence, are highly valued. And most importantly, we must steer clear of the "tendency on the part of our legislatures and executives to generate token or cosmetic efforts designed more to convince the public that action is being taken than to solve the problem." (Campbell, 1988, p. 299)

## Two examples from alcohol policy where Sweden has applied the principles of the experimenting society

### *Medium strong beer (Swedish "mellanöl")*

In 1965, as a part of the Swedish government's attempts to reduce total alcohol consumption, Parliament passed a bill permitting the sale of medium strong beer in supermarkets. It was thought that people would be satisfied with this beer and not bother to go to Systembolaget (the state monopoly alcohol stores) where stronger beer, wine and whiskey are sold.

However, after supermarket sales began, adolescent drunkenness increased significantly. So, as of mid-1972, the sale of medium strong beer was limited to people over the age of 18. Parliament wanted to continue the experiment with this beer and hoped that this age limit would curb adolescent drinking. But such was not the case. Furthermore, total alcohol consumption increased. Consequently, the experiment was terminated in 1977. Thereafter both total alcohol consumption and adolescent drinking decreased (Johansson, 2008, p. 461).

*In accordance with the principles of the experimenting society, a reform was initiated, the results were stringently evaluated, and subsequent decisions were based on this research*.

### *Opening Systembolaget stores on Saturdays*

A basic principle behind Swedish alcohol policy during the 20th century was that to reduce alcohol-related problems spirits should not be easily accessible. One of the measures taken was to limit Systembolaget's business hours. However, for many decades there has been a discussion as to where to draw the line between governmental regulation and individual responsibility. As an experiment, starting in February 2000, Systembolaget's stores in

six counties (Swedish "län") were kept open on Saturdays. Funding to evaluate the results was provided.

A baseline study was conducted five years before the experiment began, and two follow-up studies were carried out. The following variables were researched: Systembolaget's sales, indoor abuse of women where the victim and perpetrator knew each other, all types of abuse of women outdoors, drunk driving, and inpatient care for alcohol diagnoses (Norström & Skog, 2003, p. 3). The research found that sales had increased by almost 4%, but none of the other variables showed negative effects (Norström & Skog, 2003, p. 3). All Systembolaget stores are now open on Saturdays.

## A few examples from drug policy where Sweden has not applied the principles of the experimenting society

### *Censorship*

The Swedish model is based on the belief that the drugs themselves are the root of the drug problem. Those who have questioned this assumption have been met with censorship and sometimes even reprisals.

After a debate at Stockholm University where the central role of dependence was challenged, an editorial in the prestigious newspaper, Dagens Nyheter, proclaimed that Swedish drug policy is based upon "instilling that all use of narcotics is a serious breach of norms. The reaction when this is questioned is therefore uncompromising, as the policy needs broad support from the general public to be effective" (Friborg, 1998, p. A2). This quotation reflects a tenet of Swedish drug policy: to save us from narcotics we must abstain from an open and factual exchange of ideas.

Sweden has never seriously discussed the implications for policy, and for democracy, of asserting that measures taken by the government must not be questioned.

### *Scare tactics instead of factual information*

Swedish society is based upon citizens behaving responsibly and having control over themselves. Given the Swedish interpretation that the biochemical effects of narcotics cause loss of control, psychoactive substances have come to be considered a threat to our very existence. This has led to a willingness to let ends justify means. For instance, instead of giving scientific explanations about drugs in our schools, thereby appealing to pupils' intellects, we rely heavily on scare tactics and exaggerations, thereby appealing to pupils' emotions. But, if we want responsible citizens this is hardly a way to school people in rational decision making.

### *Failure to evaluate implemented drug policy measures*

There is an unwillingness to scientifically evaluate the results of Swedish drug policy. There seems to be no desire to carry out research on measures that align with the assumptions of our prohibitionist paradigm. For instance, Sweden is one of few countries that have criminalised consumption of illicit substances. Taking a toke on someone else's joint is a criminal act, with penalties that allow coerced blood and urine testing. The rationalisation given for this intrusive measure is that it aids us in uncovering potential problematic consumers early in their careers, so that we can help them desist before they become dependent. In the more than quarter century since this legislation was enacted we have never investigated the actual effects of this invasive law.

### *Belief instead of knowledge*

In a summary of Swedish drug policy, the Swedish National Institute of Public Health (1995, p. 24) wrote:

> The restrictive line taken on needle exchange programmes is prompted by fears of such

> programmes conveying an ambiguous message about society's attitude to drug abuse. Widespread exchange activities could be taken, by drug abusers, by potential abusers and by the general public, to imply a cachet of social approval (or at least acceptance) of i.v. drug abuse.

Note the language in this quotation. In defence of Swedish restrictive drug policies, the Swedish National Institute of Public Health refers to a *fear that any deviation from restrictive policies might possibly lead people to draw counterproductive conclusions*. Unfortunately, decision makers have never seen a need to investigate if this interpretation is valid. An unsubstantiated fear was allowed to determine policy!

One the other hand, there are some positive signs. After many long and hard battles, Sweden has now accepted both needle-exchange and methadone maintenance. This can be interpreted as indicating that Swedish beliefs about drugs have been modified, and there is a willingness to change. For some people, and to some extent, this is certainly true. However, let us withhold judgment until we see if the government appoints a new narcotics commission, and, in such case, who is appointed to it, and what directives are given.

## Concluding remarks

For about half a century we have lived with the dream of becoming an (almost) drug-free society, and we have instituted many restrictive and repressive measures in our attempts to achieve this. But despite our efforts we are further from the goal now than when we started. Access to, and demand for, drugs has continued to increase, and many novel psychoactive substances have become available. At the same time our drug policies have caused a great deal of collateral damage. Consequently, there is good reason to re-think the course we have chosen.

It is time to end the war on drugs. It is time to make peace. *It is time to realise that we will never be anywhere near drug-free, and therefore must learn to live with narcotics*. Since nobody knows the best way to achieve this we should approach the task with humility. We need to put prestige aside, experiment with different measures, and conduct stringent evaluations of the results. We will surely make mistakes along the way, and we need a willingness to make changes, time and time again if necessary. It is also important to keep in mind that *no matter what we do we will never come to the point where no-one is adversely affected by narcotics and by our policies*. For all these reasons, we should change our goals from attempting to eradicate narcotics to minimising the quantity and severity of damage caused by psychoactive substances, and to, as far as possible, compensate those who suffer because we've enacted policies that are advantageous for the majority.

### Note

1. As the 2007 study uses a different methodology, it is unclear the extent to which the results are comparable to the other studies.

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