Aug. 21, 2006

The Right Honourable Stephen Harper, PC, MP
Prime Minister of Canada
Office of the Prime Minister
80 Wellington Street
Ottawa, K1A 0A2
Canada

Dear Sir,

It has come to my attention that the government of Canada is considering significant drug policy changes, and that representatives of the Canadian government will be visiting Sweden in the near future to learn more about Swedish experiences. As an associate professor at Stockholm University and drug researcher I would like to take this opportunity to provide some thoughts on the subject.

For more than a quarter of a century Swedish drug policy has been based on a paradigm known as "prohibition". The basic idea has been that by giving a clear and consistent message to our youth that drugs are not tolerated, and by making the lives of drug consumers as difficult as possible, we would be able to achieve a drug free society. In spite of all our efforts we currently have more illicit drugs available and more problematic consumers than ever before.

In its proposal for new legislation in 2002 the Swedish government showed that it is aware that the then current drug policy was not optimal. Since then a gradual change of course has been in progress. The three most important changes thus far are:

1. Realizing that ideology is not sufficient the Swedish government has called for more research and stated that measures taken must be based on scientific evidence. In the past four years the government has provided extra funding for drug research through the office of the Swedish National Drug Policy Coordinator to a value of approximately eight million Canadian dollars.
2. Previous limits on the number of people permitted in substitution treatment programs (methadone and buprenorphine) have been removed and these programs are expanding. This is partially a result of the lack of evidence that drug free treatment is effective, but also to scientific evidence that substitution treatment functions well for many people who are addicted to heroin.
3. It will now be legal to provide needle exchange in all parts of Sweden. Until 2006 needle exchange had been outlawed in the entire country, with the exception of two cities in the southernmost province, where it has been permitted on a trial basis since the 1980s.

Both substitution treatment and needle exchange are measures which have traditionally been considered a part of the harm reduction paradigm and contradictory to prohibition. Prohibitionists have argued that such measures encourage illicit drug consumption. However, the bulk of scientific evidence does not support this conclusion.

Swedish drug policy is slowly changing but Sweden is not a country prone to radical and rapid transformation. Instead change is being instituted one step at a time. Therefore much of the Sweden's prohibitionist policy is still in place and probably will remain so in the immediate future. For instance we do not have supervised injection facilities, in spite of all the advantages they provide, such as greatly reducing fatal overdoses, reducing the risk of sharing needles and transmitting HIV, reducing the number of people injecting in public places and leaving infected syringes where children may find them, etc. It does not appear to be politically feasible to implement supervised injection facilities in Sweden so shortly after the measures taken above. This is very unfortunate as many lives will undoubtedly be lost as a result.

Sweden has an extremely high death rate among problematic consumers of illicit drugs – more than 400 deaths per year. In a country with a little over 500 deaths per year in traffic accidents the number of drug related deaths is extremely high. It is also very high in comparison with other similar countries. For instance the number of drug related deaths per capita in Sweden is approximately twice the per capita rate in the Netherlands.

What is the relationship between supervised injection facilities and death rates among problematic consumers? In recent doctoral thesis, fatal overdoses in Sweden, the Netherlands and the U.S. were compared. Stress was identified as one of the most important causes in Sweden. If for instance one is injecting in a public place, such as a park or the hallway of an apartment building, there is always the danger of being discovered and reported to the authorities. As drugs are always diluted before being sold on the streets problematic consumers never know how much they are injecting. In a stressful situation the entire content of the syringe is often injected at one time causing an overdose if the purity is higher than expected. Furthermore there is nobody present to help if one should take an overdose. In a supervised injection facility, on the other hand, there is no hurry. One can take a part of the contents in the syringe and see what happens. If the solution is too strong one simply saves the rest for another time. And if one should inject too much there are trained personnel ready and willing to help. The idea is to keep people alive until they become motivated to change their life situation. And by helping in this way the personnel become personal contacts which can be of great help when a problematic consumer is ready for change. It is important to sustain problematic consumers until they get to this point as it is not possible to rehabilitate them after they have passed away.

It has also been brought to my attention that the Canadian government is interested in Swedish compulsory treatment. In Sweden a person can be kept in such treatment for up to six months if it is deemed that he is not in control of himself and that he may hurt himself or other people who are close to him. The thought behind the legislation was that compulsory treatment would save lives. However, evaluations show that over the years there has consistently been an extremely high death rate among those who have been in compulsory treatment. Supporters of this measure are of the opinion that this is natural as only the most difficult cases are put into such treatment. However, this is far from a complete explanation and in my opinion it is based on a faulty analysis of what causes problematic consumption of illicit drugs. In my own research I have shown that

problematic consumers have extremely negative self images. These have been established over the course of their entire lives and are a result of destructive relationships with people who have been important to them (significant others). Problematic consumers do not like themselves and their drug consumption is a part of a self-destructive life pattern. The basic flaw with compulsory treatment is that one cannot force a person to like himself or to feel that he has the right to have a decent life. This can only be accomplished in mutual, voluntary relationships, such as can be established by social workers who leave their desks and work in the field. It can also be achieved by personnel at needle exchanges and supervised injection facilities who provide help and show problematic consumers that there are people who are willing to work with them rather than trying to force their will upon them. Compulsory treatment centers tend to have the opposite effect. When forced into such institutions many problematic consumers become all the more convinced that there is no help to be found. This contributes to the extremely high death rates shortly after leaving compulsory treatment centers in Sweden.

There is no drug policy which has only positive benefits for everybody. Advantages and disadvantages for different groups of people must be weighed against each other. Problematic consumers are people who have had more than their share of pain in their lives. That much of the suffering which has taken place after puberty is self-inflicted does not change this fact. In order to accept oneself one must first be accepted by others in a way that one is capable of relating to. Accomplishing this is one of the greatest challenges for drug policy.

Very truly yours,

Ted Goldberg, Ph.D.