



Folkhälsomyndigheten
PUBLIC HEALTH AGENCY OF SWEDEN

2014 National Report (2013 data) to the EMCDDA

by the Reitox National Focal Point





**2014 NATIONAL REPORT
(2013 data)
TO THE EMCDDA
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**SWEDEN
New developments and trends**

REITOX

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Foreword

The 2014 National Report on the drug situation in Sweden has been produced for the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

The report is mainly an update of previously delivered data in areas where new information has developed or where the guidelines provided by the EMCDDA have been changed. The report has been prepared in cooperation with national agencies, institutions and experts.

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Mr Johan Carlson

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Summary

The main objective of the Swedish drug policy is a society free from narcotics and doping, reduced medical and social harm from alcohol and a decrease in the use of tobacco. The current national strategy covering 2011-2015 contains seven long-term objectives with associated priority goals. The Public Health Agency of Sweden is responsible for monitoring and coordinating the implementation of the national strategy.

An analysis of the prevalence of cannabis use in Sweden over a longer period (2004-2013) shows a stable trend for both sexes, both in terms of experimental use and more regular use. Amphetamine is the second most common substance among both sexes, followed by cocaine, hallucinogens and opioids.

Persons who inject drugs are a hard-to-reach and vulnerable risk group heavily burdened by infectious diseases. Among this group, Hepatitis C (HCV) continues to be the most common infection, with 2,066 cases reported in 2013. Regarding HIV, two cases were reported in 2013 compared to nine cases in 2012. Among persons who inject drugs, 14 cases of acute hepatitis B were reported in 2013, indicating a continuing decline in the number of reported cases, probably as a positive effect of the ongoing vaccination of the prevention group.

Official data on drug-related deaths in Sweden is acquired from the national Cause of Death Register and in 2013, this data shows an increase in the number of deaths compared to 2012. The number of deaths involving methadone and buprenorphine continues to increase and constitutes more deaths compared to heroin/morphine.

Approximately 90% of seized drugs are smuggled to Sweden from another country within the European community and most seizures are made in the south of Sweden. Over a period of ten years, the number of seizures of cannabis, methamphetamine, heroin and cocaine has increased, whereas amphetamine seizures have decreased. Seizures of ecstasy declined until 2009 but show a large increase in 2013.

A decrease in the number of convictions for drug-related crimes was observed in 2013, following a long-term increase since the 2000s. In 2013, an increase of about 2% was noted for offences against the Act on Penal Law on Narcotics and the number of convictions with drug violations as the main crime increased by 8%. The offences were considered minor in 87% of cases and serious in 1% and amphetamines and cannabis remain the two most common substances in the conviction statistics. The number of people convicted of drug offences increased every year between 2003 and 2012. The number of convictions fell by 8% from 2012 to 2013. Despite this decrease, drug convictions have more than doubled (increased by 105%) over the last 10 years. The average number of drug users entering prison has remained fairly stable over an extended period of time.

Chapter 1: Drug policy, legislation, strategies and economic analysis

1.1 Introduction

In March 2011, the Swedish Parliament decided on a cohesive strategy for alcohol, narcotics¹, doping and tobacco (ANDT) policy. The overall objectives of the Swedish ANDT policy are a society free from illicit drugs and doping, less alcohol-related medical and social harm, and reduced tobacco use. The aim of the overall strategy is to facilitate state management of public support in the ANDT sphere and to deal with the problems that the use and abuse of substances pose as a whole, both to the individual and to society at large. The strategy aims to facilitate a long-term perspective and better coordination and cooperation between agencies and other actors and to emphasise the responsibility of all actors involved.

ANDT work in Sweden is cross-sectorial and comprises several authorities' areas of responsibility, regulations and legislation. The Swedish Prison and Probation Service, the Swedish Police, the Swedish National Board of Health and Welfare, the National Board of Institutional Care, the Swedish National Council for Crime Prevention and the Swedish Customs are other national authorities that play a central role in the narcotics field.

The Public Health Agency of Sweden is responsible for the overall follow-up of the ANDT strategy and the coordinated follow-up system for the alcohol, narcotics, doping and tobacco policy.

The Public Health Agency of Sweden was established on January 1, 2014 and is a merger of the Swedish National Institute of Public Health (Folkhälsoinstitutet) and the Swedish Institute for Communicable Disease Control (Smittskyddsinstitutet). Most of the work concerning environmental health and the responsibility for environment and public health reports at the National Board of Health and Welfare (Socialstyrelsen) was also transferred to the new agency.

1.2 Legal Framework

Laws, regulations, directives or guidelines in the field of drug issues (demand & supply)

Penal Law on Narcotics (SFS 1968:64)

In Sweden, narcotic drugs are defined as drugs or goods dangerous to health, with addictive properties or that create a state of euphoria, or goods that can easily be

¹ In this report, the terms narcotics, narcotic drugs, illicit drugs and illegal drugs all refer to the use of substances prohibited by Swedish or international law.

converted to products with such properties or effects, and that, on such basis, are objects for control according to international agreements that Sweden has supported, or have been declared by the Government to be considered illicit drugs according to the law (SFS 1968:64).

The aim of the legislation is to regulate drugs and other products that, due to their intrinsic properties, entail harm to people's life or health and that are, or can be assumed to be, used for the purpose of inducing intoxication or other effects.

Narcotics may only be used for medical, scientific or other purposes useful to society that are particularly important (SFS 1968:64, SFS 1992:860). All other possession or use is punishable.

If the offence concerning the handling or use of narcotics, with regard to the nature and quantity of narcotics and other circumstances, is considered to be:

- minor, the penalty is a fine or imprisonment for a maximum of six months
- serious, the penalty for a serious narcotics offence shall be imprisonment for a minimum of two and a maximum of ten years.

In judging whether an offence is serious, particular consideration shall be given to whether or not it has been part of large-scale or professional activities, has involved especially large quantities of narcotics or has in any other way been of a particularly dangerous or unscrupulous nature. The judgment shall be based on a joint consideration of the circumstances in the particular case.

Regarding narcotic precursors, the Act on Penal Law on Narcotics states that any person who intentionally:

- transfers, manufactures, acquires, procures, processes, packages, transports or in some other way handles narcotic drugs which are intended for the illegal manufacture of narcotic drugs, or
- keeps, possesses or otherwise handles such narcotic precursors

shall be sentenced for illegal handling of narcotic precursors to imprisonment for not more than two years.

If, considering the nature and the quantity of narcotic precursors involved and other circumstances, an offence is judged to be:

- minor, a fine or imprisonment for a maximum of six months shall be imposed.
- serious, the sentence shall be imprisonment for at least six months and at most six years.

In judging whether an offence is serious, particular consideration shall be given to whether it has been part of large-scale or professional activities, has involved manufacturing of especially large quantities of narcotics or has in any other way been of a particularly dangerous or unscrupulous nature.

All illicit drugs/narcotics are included in the Medical Products Agency's (MPA) register of Illicit Drugs (Läkemedelsverket). Hence, only substances that are on this list are considered to be narcotics according to the law. In total, the list of illicit drugs contains about 300 substances and, indirectly, a number of mushrooms that contain psilocybin or psilocin.

The Public Health Agency of Sweden has the responsibility to monitor and investigate the need for classification as narcotics or goods dangerous to health of such products that are not medicines (SFS 2009:267), for which the Medical Products Agency is responsible. If one of the authorities finds a need to control a substance (goods), a proposition is sent to the government, who then make a decision.

Act on the Prohibition of Certain Goods Dangerous to Health (SFS 1999:42)

The Act on the Prohibition of Certain Goods Dangerous to Health (SFS 1999:42) applies to goods that, due to their inherent characteristics, entail a danger to human life or health and are used or can be assumed to be used with the aim of inducing intoxication or other effects. Hence, it does not apply to goods defined as narcotics according to the Act on Penal Law on Narcotics (SFS 1968:64), substances that are the subject of the Act on the Prohibition of Certain Doping Substances (SFS 1991:1969), or medical products approved within the European Union (EU).

Goods covered by the Act (SFS 1999:42) may not be: imported, transferred, produced, acquired with a view to transfer, offered for sale, or possessed. A penalty consisting of a fine or imprisonment for a maximum of one year can be imposed on individuals who violate the provisions stated in the Act. However, unlawful importation shall be punished in accordance with the provisions of the Act on Penalties for Smuggling (SFS 2000:1225).

The government stipulates the goods to which the law shall apply in the Ordinance regarding the Prohibition of Certain Goods Dangerous to Health (SFS 1999:58). These are listed in the appendix to the ordinance.

Goods dangerous to health is a Swedish concept that has no direct equivalent internationally. It is the responsibility of the Public Health Agency of Sweden to monitor and investigate the need for control of such goods (SFS 2009:267) that are not medicines, for which the Medical Products Agency is responsible.

Narcotic Drugs Control Act (SFS 1992:860)

So-called precursor chemicals are listed in a special registry. According to the Act on the Control of Narcotic Drugs, a precursor chemical is a substance that can be used for the illegal production of illicit drugs (SFS 1992:860). Further, precursor chemicals (SFS 1968:64) are substances listed in Regulation (EC) No 273/2004 or in Council Regulation (EC) No 111/2005.

A regulation in the Act on the Control of Narcotic Drugs (SFS 1992:860) enables narcotics to be handled for industrial purposes. The purpose of this was to allow GBL and 1.4-BD to be regulated as narcotics.

Act on the Destruction of Certain Substances of Abuse Dangerous to Health (SFS 2011:111)

New legislation regulating the destruction of certain substances of abuse dangerous to health entered into effect on 1 April 2011. The new law aims to prevent the use of substances dangerous to health (SFS 2011:111).

A dangerous substance is a substance that is not yet regulated or is in the process of being regulated as a narcotic drug under the Narcotic Drugs Control Act (SFS 1992:860) or as a substance dangerous to health under the Act on the Prohibition of Certain Goods Dangerous to Health (SFS 1999:42).

According to this law, police and customs have the right to confiscate a substance awaiting a destruction decision by a prosecutor.

The substances covered by the Act are substances which:

1. have been ordered by the Government to be listed as narcotics or as goods dangerous to health in a legal proposal not yet in force
2. have been declared narcotics through an international convention to which Sweden adheres, but where listing has not entered into effect
3. can be presumed to be listed by the Government as narcotics or goods dangerous to health.

A statement is required from the Public Health Agency of Sweden or the Medical Products Agency confirming that the substance can be assumed to be classified as a narcotic or dangerous to health.

All these matters are handled according to the Administrative Procedure Act (SFS 1986:223) and are not considered criminal offences. Certain protocols must be used and the decision can be appealed in court.

In order to facilitate the prosecutors' work and to inform the general public, all statements from the Public Health Agency are published on a public website (www.folkhalsomyndigheten.se). Since the new law came into effect, statements have been issued regarding 157 (2014-09-12) substances. More than 2,900 destruction orders have been issued by prosecutors.

Laws concerning harm reduction

In 2006, the Act on Exchange of Syringes and Needles entered into effect (SFS 2006:323). The purpose of the Act is to prevent the spread of HIV and other blood-borne infections through the exchange of syringes and needles in needle and syringe programmes. Such intervention is to be carried by the healthcare in connection with interventions aimed at motivating the individual to accept care and

treatment. Needle and syringe programmes should also involve cooperation with the social services. These programmes may not be set up without the permission of the National Board of Health and Welfare.

Other laws

In Sweden, there are also a number of other relevant laws: the Social Services Act (SFS 2001:453) which covers the possible forms of care for drug users; the Act on the Treatment of Drug Abusers (SFS 1988:870) covering compulsory institutional care; the Care of Young Persons Special Provisions Act (SFS 1990:52) which makes it possible to arrange compulsory care of juveniles on the grounds of drug use; and the Autopsy Act (SFS 1995:832) regulating the forensic examination of deaths.

The Health and Medical Services Act (SFS 1982:763) and the Social Services Act (SFS 2001:453) were amended on 1 July 2013. The changes mean that county councils and municipalities must agree to collaborate on matters concerning people who abuse alcohol, illicit drugs, other dependence-inducing agents, pharmaceuticals or doping agents.

The purpose of the changes is for county councils and municipalities to be able to better satisfy these groups' need for care, support and treatment. Please see chapter 5 for more details.

Laws implementation

Laws implementation

In 2013, twenty substances, were controlled as narcotics according to the Act on the Control of Narcotic Drugs (SFS 1992:860) and the Act on Penal Law on Narcotics (SFS 1968:64) and were thereby listed in the amendment to the Ordinance on the Control of Narcotic Substances (SFS 1992:1554). Ten substances were regulated under the Act on the Prohibition of Certain Goods Dangerous to Health (SFS 1999:42).

Table 1:1: Substances classified in 2013

Classified in 2013		
as narcotics		as goods dangerous to health
Pentedrone	25I-NBOMe	UR-144
alpha-PPP	EAM-2201	5-MAPB
alpha-PVP	AH-7921	5F-PB-22
AM-2233	3-MMC (3-metylmetskatinon)	STS-135
AM-1220	4-MA	JWH-018 N-(5-kloropentyl)
MAM-2201	25D-NBOMe	JWH-018 adamantyl karboxamid
2-FMA	25B-NBOMe	AB-001
3-FMA	25H-NBOMe	5F-AKB48
4-MA		AKB48
2-FA 2-fluoramphetamine		5F-UR-144
3-FA (3-fluoramphetamine)		
25C-NBOMe		

1.3 National action plan, strategy, evaluation and coordination

National action plan and/or strategy

A five-year strategy covering the years 2011 to 2015 was adopted by the Swedish Parliament in March 2011 (Ministry of Health and Social Affairs Sweden, 2011).

The strategy's main objective is a society free from narcotics and doping and decreased medical and social harm from alcohol as well as a decrease in the use of tobacco.

As described in the preface to the summarised version of Government Bill 2010/11:47 (Ministry of Health and Social Affairs Sweden, 2011), the strategy aims to facilitate state management of public support in the ANDT sphere. The strategy establishes the goals, priorities and direction of public measures for the period 2011–2015. It covers a range of areas: local preventive action, measures designed to limit supply, the fight against drugs, care and treatment, alcohol and tobacco supervision, and EU and international efforts. Further, the strategy aims to facilitate a long-term perspective and better coordination and cooperation between agencies and other actors and to emphasise the responsibility of all actors involved. With the strategy, the Government stresses that cooperation between the spheres of health promotion, disease prevention, crime fighting, treatment and rehabilitation should be intensified.

The 2011-2015 strategy contains seven long-term objectives of lasting relevance, listed below, with accompanying priority goals that are to be achieved during the strategy period (Ministry of Health and Social Affairs Sweden, 2011).

1. Curtailment of the supply of illegal drugs, doping substances, alcohol and tobacco

- Effective and coordinated supervision of alcohol and tobacco
- Effective measures to combat illicit trading
- Effective measures to combat illicit sales via digital media
- Effective local and regional collaboration and coordination of ANDT prevention and crime prevention efforts

2. Protection of children from the harmful effects of alcohol, narcotic drugs, doping and tobacco

- Fewer children born with harmful or disabling conditions caused by exposure to alcohol, illicit drugs, doping substances or tobacco
- Appropriate support for children in families where abuse, mental illness or mental disability is present
- Better knowledge of alcohol and tobacco marketing practices via digital media, and of the effect of digital marketing on consumption

3. Gradually reduction in the number of children and young people who begin using tobacco, illicit drugs or doping substances or begin drinking alcohol early

- Reduced initiation of illicit drugs and doping abuse
- Development of methods to deter children and young people from starting to use tobacco products
- Wider use of available, effective means of postponing drinking onset and reducing alcohol consumption
- Emphasis on health promotion in schools
- Greater participation by parents, non-governmental organisations and the business community in preventive work

4. Gradual reduction in the number of people who become involved in harmful use, abuse or dependence on alcohol, illicit drugs, doping substances or tobacco

- Intensified efforts by the healthcare services to prevent ANDT-related ill-health (brief intervention and screening)
- Reduced risk use and less intensive alcohol consumption among students and young adults with mental health problems
- More scope for the dental care service to focus on tobacco prevention
- Greater opportunities for the early detection and prevention of ANDT problems in working life

5. Greater access to good quality care and support for people with substance abuse or addiction

- Greater access to knowledge-based care and support inputs
- A clearer and more appropriate allocation of competencies among the bodies principally responsible for substance abuse and addiction care
- Reduced disparities in quality, availability and results at regional and local level

6. Reduction in the number of people who die or suffer injuries or damage to their health as a result of their own or others' use of alcohol, illicit drugs, doping substances or tobacco

- Fewer deaths and injuries in road accidents due to alcohol or other drugs
- Fewer deaths and injuries due to alcohol-related, drug-related or doping-related violence
- Lower mortality rate among teenagers and young adults due to alcohol poisoning or drug experimentation
- Greater awareness among the population of the health impact of ANDT use

7. Promotion of a public health based, restrictive approach to ANDT in the EU and internationally

- Active efforts to ensure compliance with UN conventions in the illicit drugs field
- Active efforts to ensure implementation of the EU and WHO strategies on alcohol and health
- Active efforts to ensure compliance with the WHO framework convention on tobacco control
- Active efforts to ensure compliance with UN conventions in the illicit drugs field
- More effective coordination and increased prioritisation of Nordic cooperation in the ANDT sphere

Annual action programme

The one-year action programme covers all areas of the ANDT strategy and describes the priorities for the coming year in more detail than the full action plan/strategy.

The 2014 action plan (Ministry of Health and Social Affairs 2014) focuses on major changes, development trends, external monitoring and a special prioritisation of the international effort.

A discussion of the future ANDT policy also began in 2014. The ANDT strategy runs until and including 2015 and the work of drawing up a new plan for ANDT policy will begin during 2014. The most important task will be to secure the long-term structure of the ANDT work in order to create a foundation for a long-term approach and to follow up the results of the government's initiatives at all levels. At the same time, the future ANDT policy needs to keep pace with developments as regards new knowledge and new prerequisites (Socialdepartementet, 2014c).

Implementation and evaluation of national action plans and/or strategy

Evaluation of the 2011-2015 strategy

The Public Health Agency of Sweden is responsible for the overall follow-up of the ANDT strategy and the coordinated follow-up system for the alcohol, narcotics, doping and tobacco policy. The aim of the follow-up is among other things to further develop the coordinated follow-up system and make it accessible and create a structured coordination of data collection in respect of the indicators included in the system. Knowledge regarding the follow-up system is also to be disseminated to the ANDT coordinators at the county administrative boards and an in-depth report is to be submitted to the Government Offices by 1 October 2015 at the latest.

The follow-up system has been made accessible via the website "andtuppfoljning.se". Time series for all core indicators are available in the system and goals have been set for the further development of data and analyses. Training for the county administrative boards' ANDT coordinators in how to use the follow-up system, including as a basis for strategic planning, has begun. Procedures for reporting indicators have been drawn up. The procedures will also be further developed to enable the authorities or organisations responsible for the respective indicators to be able to upload data to the database directly by means of a control function. The work of assessing goal attainment in the ANDT strategy was also begun during the year.

The national strategy will also be evaluated externally by the Swedish Agency for Public Management. The Agency will analyse to what extent government efforts contribute to fulfil the objectives of the strategy and if the design of the ANDT policy is appropriate as regards fulfilment of these objectives and if necessary suggest changes.

The aim of the Swedish Agency for Public Management's commission is to provide the Government with a basis for designing the policy for the next period, from 2016 to 2020. The agency's report is to be submitted to the Government Offices by 15 April 2015 at the latest.

Previous strategies

The previous National Action Plan against narcotic drugs covered the years 2006–2010 and was adopted by the Swedish Parliament in April 2006 (Regeringens proposition 2005/06:30).

The plan established that the overall objective of the drug policy in Sweden should be a society free from illicit drugs. In the 2006–2010 action plan, certain measures were stressed as particularly important, e.g. to improve cooperation at all levels, improve preventive work and to develop treatment and care.

The work on local level was described as crucial to successful results, highlighting the municipalities' work. Children, young adults and parents were particularly prioritised target groups.

Other drug policy developments

A few government inquiries that have relevance for drug policy were concluded during 2013 and 2014 and are described below. For previous inquiries, see the National Report for 2013.

Particularly serious narcotics crimes (SOU 2014:43) - Report by the commission on narcotics crime penalties

The aim of the commission was to investigate and propose changes that are needed to institute modern penal legislation concerning narcotics crimes and narcotics smuggling that clearly reflects a stringent, fixed and consistent attitude towards illicit handling of narcotics.

The current scale of penalties for serious narcotics crimes and serious narcotics smuggling is relatively wide and ranges from two to ten years' imprisonment. The serious crimes comprise several different types of behaviour of varying degrees of severity. According to the study, certain types of behaviour can be distinguished that are so serious that they should entail penalties in the upper part of the current scale for serious crimes, e.g. handling very large quantities of narcotics.

The authors propose that the penalties for serious narcotics crimes and aggravated narcotics smuggling, at present imprisonment for a minimum of two and a maximum of ten years, be separated into serious crimes and particularly serious crimes. For serious narcotics crimes or aggravated narcotics smuggling, the penalty should be imprisonment for a minimum of two and a maximum of seven years.

For narcotics crimes or narcotics smuggling that are considered particularly serious, the penalty should be imprisonment for a minimum of six and a maximum of ten years.

The purpose of a two-tier scale of penalties is to make the legislation clearer and to create prerequisites for the courts to issue appropriate sentences. It is not the

intention to influence the levels of punishment overall. The proposals mean that sentences will be made more severe for certain crimes that concern handling of very large quantities of narcotics and constitute a clear indication of a very stringent view of illicit handling of narcotics.

It is proposed that the changes come into force on 1 July 2015 (Justitiedepartementet, 2014).

Coordinated expertise on health and medical care and social services (Ds 2014:9)

In March 2014, the government put forward a proposal that aims to create long-term prerequisites for effective channelling of expertise by the state, among other things through efficient cooperation between the authorities concerned. It is proposed that this channelling be based on patients' and users' needs and the profession's and the principals' needs and wishes (Socialdepartementet, 2014b).

Coordination arrangements

The ANDT secretariat, under the Ministry of Health and Social Affairs, is the Government's coordinating function for the alcohol, narcotics, doping and tobacco policy. The secretariat's tasks is to strengthen the development and coordination of the work done by the Government Offices, which will lead to clearer, more coordinated and more efficient control.

The secretariat is also tasked with the dissemination and implementation of the entire ANDT strategy and was especially active in the beginning of the strategy period. The ANDT secretariat is also assigned to compile the Government's annual action programme for the ANDT policy.

The material on which the annual action programme is based is derived from several sources: the ministries concerned, the ANDT Council, relevant government agencies and documentation of outreach activities at the regional and local levels, and also the separate status reports submitted to the Government by authorities in the area on 1 October every year. The overall process is illustrated in Figure 1.1.

The ANDT Council² consists of representatives from central authorities and organisations as well as researchers with the main function of advising and keeping the government updated on issues, new research and inquiries of relevance to the design of policy in the ANDT area.

² <http://www.regeringen.se/sb/d/3133/a/181185>

Narcotics policy is included in the responsibilities of four ministries: the Ministry of Health and Social Affairs, the Ministry of Justice, the Ministry of Finance and the Ministry for Foreign Affairs. The ministries have different assignments:

Ministry of Health and Social Affairs

- Coordination in the Government Offices
- Health issues
- Preventive work
- Care and treatment
- Legislation on drugs control

Ministry of Justice

- Correctional treatment
- Penal law
- Police work

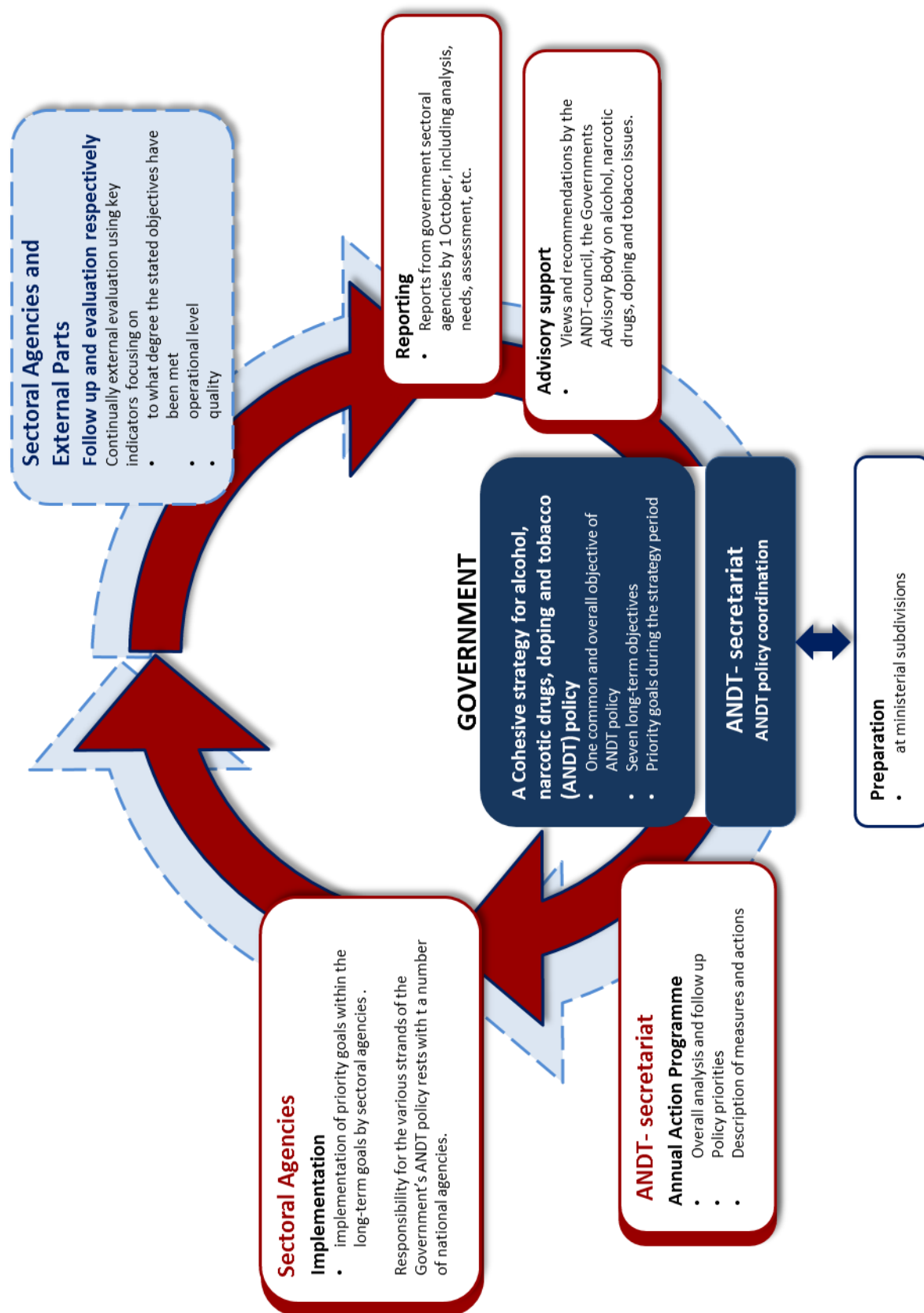
Ministry of Finance

- Customs issues
- Legislation on smuggling

Ministry for Foreign Affairs

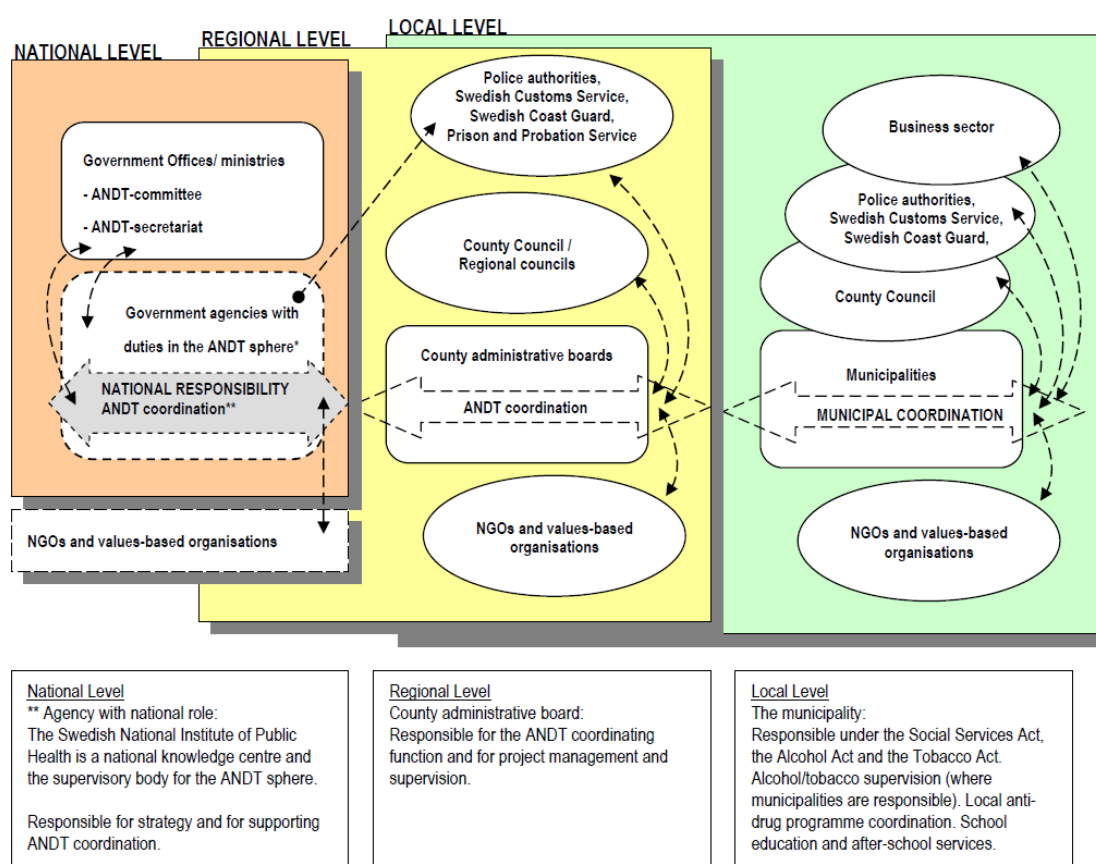
- Foreign affairs and drugs-related development assistance

Figure 1.1: Schematic illustration of the formation of the annual action plan and additional processes (Government Offices of Sweden, 2012).



ANDT coordinators at Sweden's county administrative boards are responsible for supporting regional coordination of preventive work and to contribute to the implementation of relevant parts of the ANDT strategy's goals. The Public Health Agency of Sweden is responsible for supporting the county administrative boards and to implement the monitoring system regarding alcohol, narcotics, doping and tobacco.

Figure 1.2: Overall organisation to attain the national ANDT goals described in the 2011-2015 strategy (Ministry of Health and Social Affairs Sweden, 2011).



1.4 Economic analysis - Public expenditures

Cost of the drug problem

Over the years, a number of studies have estimated the cost of the drug problem in Sweden. The results are shown in Table 1.1. As can be seen, the estimates have varied between EUR 330 million in 1991 and a highest level of EUR 3 000 million in 2003. The difference in estimate can largely be explained by different methodologies and assumptions.

Table 1.2: Estimates of drug-related public expenditure in Sweden.

Year	Sectors included	Estimate	Reference
1991	Health care, treatment, probation care, social services, the correctional system, the judiciary system, the social welfare system	€ 330 million	The Swedish National Audit Office 1993
1996	Treatment, probation care, social service, the correctional system, the judiciary system, the social welfare system, police, customs	€ 660 million	Fölster and Säfsbeck 1999
1999	Not clear	€ 847 million	The Swedish Commission on Narcotic Drugs 2000
2002	All institutions dealing with drug users	€ 495-1,385 million	Ramstedt, 2006
2003	Direct costs of the Society (alcohol and narcotics)	€ 3000 million	National Board of Health and Welfare, 2010-3-15
2007	All institutions dealing with drug users	€ 528-1,474 million	Update of the 2002 estimate using the consumer price index
2011	All institutions dealing with drug users	€ 2,618 million	(SOU 2011:6)

Budget

The government annually allocates funds for work within the scope of the ANDT strategy (including gambling), provided Parliament makes funding available. For 2014, the government allocated almost SEK 300 million for this work. However, it is not

Funding from other policy areas that may be relevant to the ANDT area is in addition to the above figure.

Social costs

Care and treatment for drug users are costly and resources are often inadequate. Only a few Swedish studies exist on the social costs of a continued drug use compared to the costs of treatment/prevention. No Swedish studies have been found in the scientific literature regarding estimated costs of society for drug users and how much can be saved by preventive/treatment measures.

Chapter 2: Drug use in the general population and specific target groups

2.1 Introduction

A number of different efforts to monitor illicit drug use in the general population have been made over the years. The most consistent and systematic monitoring of illicit drug use in the general adult population has been conducted by the Public Health Agency of Sweden (formerly by the Swedish National Institute of Public Health) through the annual National Public Health Survey. The survey is conducted in a random sample of the general population in Sweden aged 16-84 and a question regarding the use of cannabis has been included every year since 2004. Among adolescents, an annual survey of drug use has been conducted since 1971 by the Swedish Council for Information on Alcohol and Other Drugs (CAN). It is a school-based teacher-monitored survey among a nationally representative sample of 9-grade elementary school students 15-16 years old. Since 2004, studies have also been carried out in the second year of upper-secondary school (11th grade) among students aged 17-18. In these annual surveys of adolescents, questions are asked about their use of a wide range of different substances and illicit drugs.

Most of the population based studies measuring drug use contain questions about illicit drug use in the past 30 days, in the past 12 months, and at any time in life. Having used illicit drugs at any time in life is defined as experimental use, use of cannabis during the past 12 months is defined as current use, while the use of illicit drugs in the past 30 days is interpreted as more regular use. The lack of consistency in the questions used to monitor illicit drug use, study methodology, and sampling make comparisons between studies uncertain. However, the two annual surveys described above have used similar measures throughout the years and will provide the bases for the results regarding changes in drug use over time presented in this chapter.

In addition to these regular monitoring studies, a number of separate studies with varying methodology, sampling, and questions used to monitor illicit drug use have been conducted in Sweden over the years. Among these, two nationally representative population-based studies of drug use with question regarding a large range of different substances will be presented in this chapter, as well as a number of studies concerning drug use in specific target groups.

2.2 Drug use in the general population

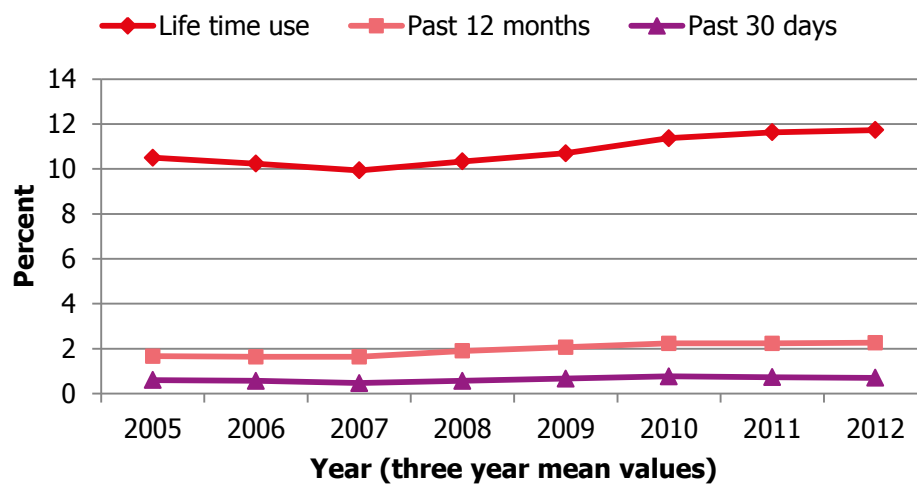
Cannabis

Every year since 2004, the Public Health Agency of Sweden (formerly the Swedish National Institute of Public Health) conducts an annual National Public Health Survey. It is a questionnaire study sent to a random sample of approximately

20,000 people aged 16-84. The overall aim of the study is to monitor the health situation in the population and to collect data on health determinants as part of the follow-up of the Swedish public health policy. One question in the survey concerns use of cannabis and is intended to indicate prevalence and potential change over time. Response rates for this survey have steadily decreased and have been around 50% in recent years.

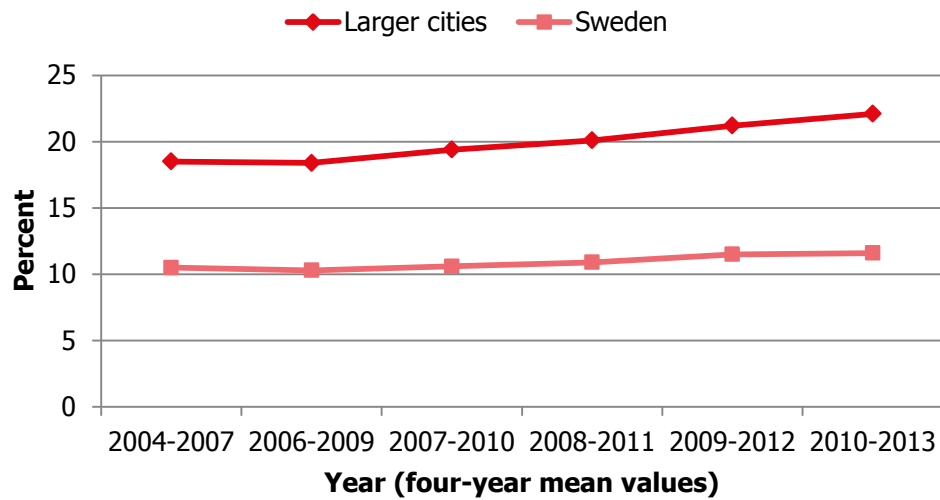
Figure 2.1 shows the results from the annual surveys of cannabis use for the total group of respondents aged 16-84. The time series show that the trend has been fairly stable over time in terms of both life-time use and more regular use. Annual and monthly prevalence are considerably lower than lifetime prevalence.

Figure 2.1: Lifetime prevalence, annual prevalence and monthly prevalence of cannabis use expressed as percentages from 2004 to 2013 among respondents aged 16-84.



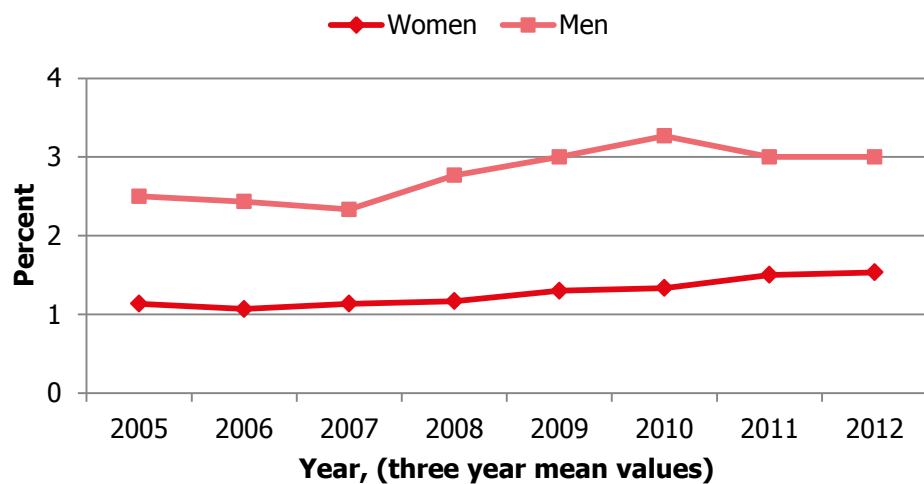
Life-time use of cannabis is considerably higher among individuals living in larger cities as compared to those living in smaller cities or rural communities, see Figure 2.2. The trend over time also indicates a small but significantly increasing proportion of younger individuals reporting life time use of cannabis. The increase over time has been greater among those living in larger cities.

Figure 2.2: Proportion of individuals, 16-34 years, living in larger cities as compared to the total population in Sweden reporting use of cannabis during the past 12 months.



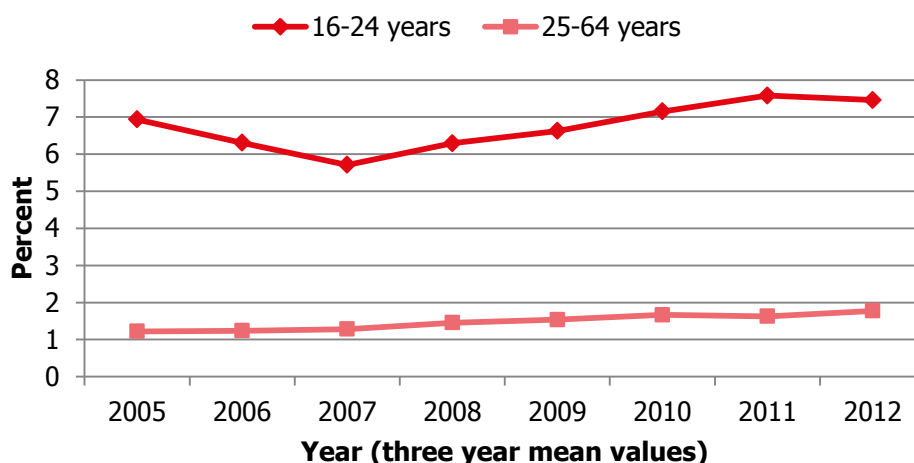
There are substantial gender differences in cannabis use, see Figure 2.3. Women are significantly less likely to report use of cannabis and this pattern is consistent over time and between age groups.

Figure 2.3: Proportion of women and men aged 16-84 reporting cannabis use in the past 12 months.



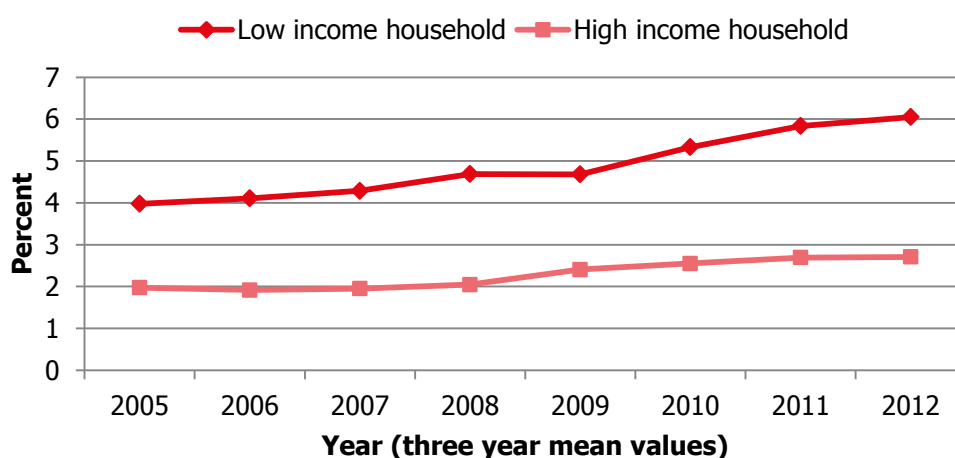
Reported use of cannabis is significantly higher in the younger age groups as compared to older age groups, see Figure 2.4.

Figure 2.4: Proportion of men in different age ranges reporting cannabis use in the past 12 months between 2004 and 2013.



To compare the prevalence of cannabis use in different socio-economic groups, the prevalence of reported cannabis use in the past 12 months was compared for individuals younger than 65 living in high vs. low income households, see Figure 2.5. Individuals living in high-income households (i.e. the 20% of respondents with the highest household income) were less likely to report use of cannabis as compared to those living in low-income households (i.e. the 20% of respondent with the lowest household income). The proportion reporting use of cannabis showed a slow but significant increasing trend over time from 2004 to 2013, in particular among those living in low income households.

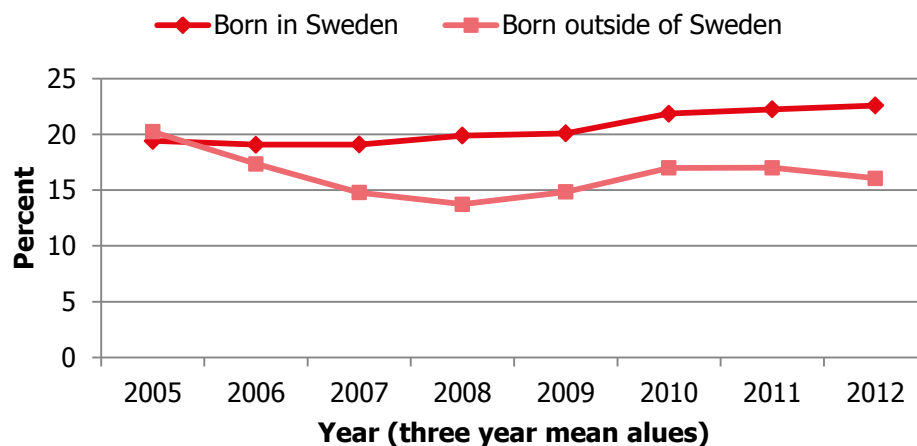
Figure 2.5: Proportion of respondents aged 16-64, living in high- and low-income households reporting cannabis use during the past 12 months.



To explore the difference in use of cannabis based on ethnicity, the proportion of respondents reporting ever having used cannabis among those born in Sweden and

those not born in Sweden is shown in Figure 2.6. During the first years of the survey, no differences were found between Swedish natives and those born outside of Sweden. However, over time there was a slight decrease in proportion of lifetime use of cannabis among those born outside Sweden

Figure 2.6: Proportion of respondents aged 16-34 born in and outside Sweden reporting ever having used cannabis.



Over all, illicit drug use is less common in Sweden compared to many other European countries. It is also difficult to assess consumption patterns given the low response rates. It is further possible that those who use illicit drugs might be hesitant to participate in surveys and the population studies we report results from might therefore underestimate the actual prevalence (Statens folkhälsoinstitut, 2010b).

Use of illicit drugs other than cannabis

In addition to the yearly assessments of cannabis use, a few specific studies have been conducted to monitor use of illicit drugs other than cannabis in the Swedish population. One large scale questionnaire study specifically concerned with illicit drug use was conducted in late 2008 and early 2009 (Statens folkhälsoinstitut, 2010b). It used a large random sample of the Swedish population aged 15-64 (58,000 individuals). The response rate was low with a total of 22,095 individuals (38%) returning the questionnaire. The study indicated that 23% of the men and 12% of the women had used illicit drugs (including cannabis) on some occasion in their lives. In addition, 4% of the men and 8% of the women had used potentially addictive pharmaceutical drugs in a non-prescribed way (i.e. without a doctor's prescription or to a larger extent than prescribed). The highest proportion of regular illicit drug users (past 30 days) was found among young men aged 15-24 (2%). Among women, those 25-34 years of age reported the highest regular use of drugs (1%). Overall, regular use of illicit drugs decreased with increasing age. Many of the regular illicit drug users also reported use of several different substances, and a large proportion of them also reported high rates of alcohol consumption. In the study, 58% of the regular illicit drug users were categorized as at-risk users of

alcohol and among regular users of pharmaceutical drugs in a non-prescribed way, 72% were classified as at-risk users of alcohol. Among men, amphetamines were the second most common substance reported after cannabis and 6.8% of men aged 15-64 reported having used it at some time in their lives, followed by cocaine (3.8%), hallucinogens (3.5%), opioids (2.3%), and ecstasy (2.2%). Among women aged 15-64, amphetamines (3.0%) were also the second most common drug ever used, followed by cocaine (2.5%), hallucinogens (2.3%), ecstasy (1.8%), and opioids (1.3%). Of those who had used illicit drugs in the past month, almost 8% said that they had injected a narcotic substance at some time in their lives (Statens folkhälsoinstitut, 2010b).

In 2013, an additional cross-sectional study of drug use was conducted in a nationally representative sample of the population in Sweden (Ramstedt, 2014). A total of 15,576 individuals (59.3% of the total sample) participated in the study and 10.5% reported that they had used an illicit drug or used some prescription medication in a non-prescribed way during the past 12 months. In this study, cocaine and amphetamines were the most common illicit substance reported after cannabis. Among men and women aged 17-64, 3.3% reported having used cocaine and 3.0% reported having used amphetamine at some time in their lives, followed by ecstasy (2.4%), opioids (2.2%), and hallucinogens (2.1%). Use of prescription medication was much more common and 6.5% reported having used painkillers in a non-prescribed way and 2.8% reported having used sedatives/tranquilizers in a non-prescribed way during the past 12 months.

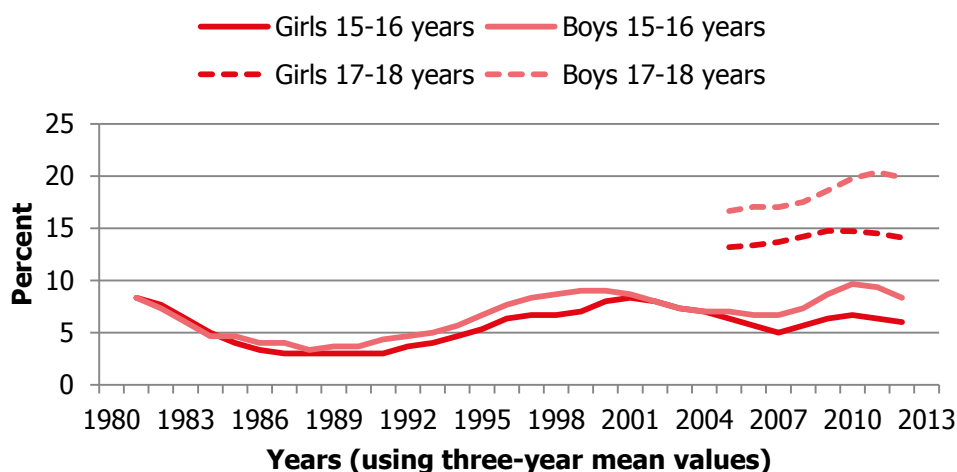
2.3 Drug use in the school-age and youth populations

School-age populations

The Swedish Council for Information on Alcohol and Other Drugs (CAN) conducts annual national studies of the alcohol and drug use of school-age children. Since 1971, they have conducted school-based teacher-monitored surveys among a nationally representative sample of 9th grade elementary school students 15-16 years old. Since 2004, studies have also been carried out in the second year of upper-secondary school (11th grade) among students aged 17-18. In these annual surveys of adolescents, questions are asked about their use of a wide range of different substances and illicit drugs.

In the latest published measurement from the surveys conducted in 2013, the lifetime prevalence of use of any type of illicit drug among 15- and 16-year-old boys and girls was 7.3% and 5.7% respectively (Centralförbundet för alkohol och narkotikaupplysning, 2014c). Cannabis was by far the most common drug, and the change over time in the proportion of boys and girls reporting use of drugs is presented in Figure 2.7. The prevalence reached a low level in the mid- to late 1980s and early 1990s, and have had a somewhat higher and varying level during the past 20 years.

Figure 2.7: Proportion of boys and girls, 15-18 years, reporting ever having used an illicit drug.



In the older age group i.e. 17- and 18-year-old students, the lifetime prevalence of ever having used an illicit drug was 19.4% for boys and 13.8% for girls (Centralförbundet för alkohol och narkotikaupplysning, 2014c). Among those who had used an illicit drug, the most common drug was cannabis, although some level of use of benzodiazepines, cocaine and amphetamines was also reported. Very few students reported use of drugs before the age of 14, 2% of the boys and 1% of the girls, and these results have remained the same over the past 20 years.

The survey also showed that there was a strong association between the experience of drug use and other potentially health-detrimental behaviours. Among students aged 15-16, approximately 40% of those who had used drugs also reported a large consumption of alcohol and this was a much higher proportion than among students with no reported drug use (8%). Further, among students aged 17-18, there was a large difference between students with and without experience of drug use with regard to extensive alcohol consumption, although the difference was not as large as for students aged 15-16 (Centralförbundet för alkohol och narkotikaupplysning, 2014c). There was also an association between reported drug use and binge drinking. Among students who reported drug use, almost 57% of 15- and 16-year-olds and 74% of 17- and 18-year-olds reported monthly binge drinking. This is a considerably higher percentage than could be found among students with no drug experience. Use of tobacco was also more common among students with experience of drug use, compared with students with no drug experience (Centralförbundet för alkohol och narkotikaupplysning, 2014c).

2.4 Drug use in specific groups and settings at national and local level

In 2007 - 2008, the Swedish National Institute of Public Health conducted a number of studies on behalf of the national drug prevention coordination body at that time - Mobilization against Narcotics. A report with the main results from these studies was published in 2010 (Statens folkhälsoinstitut, 2010b). In addition to the large scale nationally representative population study reported above, three separate questionnaire studies were conducted targeting specific groups of individuals, with increased risk of illicit drug use. The studies targeted music festival participants, restaurant personnel, and university students.

Music festival participants

In 2007, participants at two music festivals were studied and they reported considerably higher levels of drug use as compared to the general population. Among men, 61% had used illicit drugs at some time in life, while the corresponding proportion among women was 50%. Regular use was reported by 26% of the men and 16% of the women. These high figures could partly be a result of the use of a different survey methodology as compared to the population-based studies. One conclusion from this study was a need for more research into the effects of using various study methods when collecting data on illicit drug use (Statens folkhälsoinstitut, 2010b).

Restaurant employees

An additional targeted study involving employees at restaurants was conducted in 2007 and 2008. Most participants were between the ages of 18 and 34 year, and the results showed that 31% of the men and 18% of the women reported use of illicit drugs at some time in life. Regular use in the past month was reported by 3.7% of the men and 1.1% of the women, which is similar to the levels reported in the general population in this age group (Statens folkhälsoinstitut, 2010b).

University students

In 2008, a study of drug use was conducted among university student in Sweden. In this study, the aim was to survey illicit drug use among full-time university students (Statens folkhälsoinstitut, 2010b). Students aged 18-34 were included in the analyses. 35% of the men and 33% of the women reported use of illicit drugs at some time in their lives. The results from this study did not support a more extensive use of illicit drugs among university students as compared to other groups of the population.

Chapter 3: Prevention

3.1 Introduction

Organisational framework of prevention

Prevention is a main component in the five-year ANDT-strategy covering the years 2011 to 2015, adopted by the Swedish Parliament in 2011 (Government Offices of Sweden, 2011). To read more about the strategy, see chapter 1.

Besides activities and structures at national level, there is a “county coordinator” in each of the 21 counties in Sweden in 2014, who has the role of supporting preventive work on alcohol, narcotics, doping and tobacco (ANDT) at the county level. The county administrative boards are commissioned to work with the implementation of the national ANDT strategy in the county, to contribute to the development of long-term and knowledge-based prevention activities at the regional and local level. They shall also contribute to the coordinating and intersecting work in the municipalities and the county, support the cooperation at local, regional and national level and support education and in-service training (Regeringen, 2012).

In 2013, eleven out of 21 counties had a regional strategy for the preventive ANDT work. The Public Health Agency of Sweden is supporting the county administrative boards’ ANDT-coordination with further knowledge and organises network meetings. In Sweden, the implementation of prevention is generally the responsibility of the municipality, where the preventive efforts are often coordinated by ANDT-coordinators. In 2013, 75% of the 290 municipalities were able to appoint local coordinators for the work on narcotics-prevention. The same person often coordinates prevention efforts against different addictive substances (Folkhälsomyndigheten, 2014b).

On a local level, prevention efforts are normally summarised in a municipal policy for alcohol and drugs. In 2013, about 68% of the municipalities had such a political programme. 62% of the programmes had measurable objectives and 60% had a follow-up plan. In 67% of the programmes, there was an implementation plan with appointed responsible actors and in a third of the cases funds were allocated for the implementation of activities according to the plan (Folkhälsomyndigheten, 2014b).

Monitoring tools

The Public Health Agency annually collects information from the local and regional ANDT-coordinators on illicit drugs and the prevention work at the local level and reports the information in the County Report. The support of municipal management is a key component of the prevention work (Allebeck et al., 2012). Indicators of the priority of drug prevention include the adoption of a drug policy,

the appointment of an ANDT-coordinator and the allocation of funds for prevention work.

3.2 Environmental prevention

The overall policy objective in the ANDT strategy (Government Offices of Sweden, 2011) is “a society free from illegal drugs and doping, with reduced alcohol-related medical and social harm, and reduced tobacco use”.

Alcohol policies

Legislation

Restrictive alcohol legislation and policies, along with effective supervision, are among the principal instruments for achieving reduced alcohol-related medical and social harm. (Swedish Ministry of Health and Social Affairs, 2011). On 1 January 2011 the current Alcohol Act (SFS 2010:1622) came into force. This law replaced the former Alcohol Act (SFS 1994:1738) and the Act on the Sale of Technical Spirit and Substances Containing Alcohol (SFS 1961:181). Related provisions pertaining to the alcohol act can be found in the Alcohol Ordinance (SFS 2010:1636). The new legislation included changes relating to for example serving licenses, production, marketing, supervision and handling of alcoholic beverages.

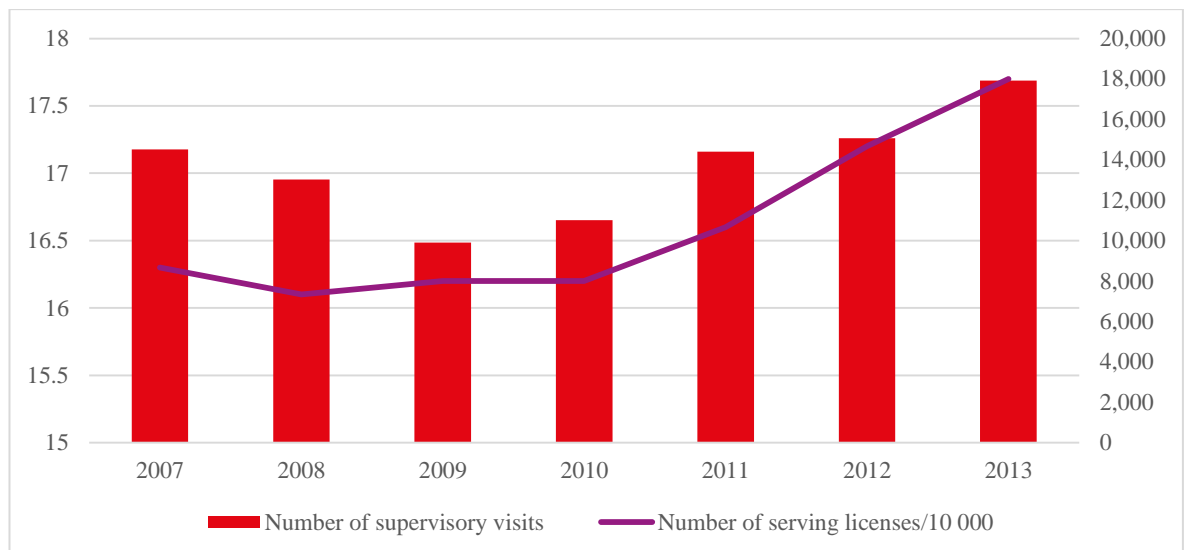
In Sweden it is not permitted to operate a vehicle with a blood alcohol concentration (BAC) of 0.2 ‰ or more. This is equivalent to 0.1 mg alcohol or more per litre exhaled air. Means of identifying drunk drivers include blood or urine analysis of individuals suspected of drunk driving, random breath testing and sobriety checkpoints, observational assessments and blood or breath tests of crash-involved drivers in some but not all cases. Penalties include fines, suspension or revocation of driving licence, imprisonment, community service and mandatory ignition interlocks. A clear majority, about 90 %, of all cases of drunk-driving relate to young or middle-aged men. A blood alcohol concentration of 1.0 ‰ or more, equal to 0.5 mg alcohol or more per litre exhaled air, constitutes aggravated drunk driving in Sweden. The regulations pertaining to drunk driving are strict and well enforced (Swedish Transport Administration, 2010).

In contrast to the former Alcohol Act the current legislation enables catering companies to acquire permanent serving licences, hotels that have serving licences along with restaurant services to serve alcohol through room service and allow serving licence holders to use a mutual serving area. The present legislation also includes changes in the requirements pertaining to kitchen equipment and food preparation. Applicants for serving licences are required to pass a test relating to their knowledge of the regulations concerning alcohol serving. The new Alcohol Act also gives holders of permanent licences to serve alcohol to the general public and wholesalers the possibility to arrange trade fairs or similar activities that offer product sampling to the general public. The right to offer product sampling was also extended to farm producers of alcoholic beverages. Municipalities are required to provide guidelines relating to the regulations surrounding serving licences, as

well as to establish plans for supervision that are to be reported to the county administrative boards. Municipalities have been given the possibility to send out reminders to serving licence holders who have infringed the regulations, prior to potentially sending warnings. Both a reminder and a warning should normally precede a possible revocation of a serving licence. In conjunction with serious offences it is however possible to revoke licences without any prior reminder or warning.

One of the indicators in the ANDT strategy is the number of serving licenses per 10,000 inhabitants and data shows that the number of licences has increased every year since 2010. The number of supervisory visits from the local authorities increased as well. See figure 3:1.

Figure 3:1: Number of supervisory visits in relation to number of alcohol serving licenses per 10 000 inhabitants in Sweden 2007-2013 (Folkhälsomyndigheten, 2014b).



On-premise sales

In order to limit inebriation and alcohol-related nuisance there are regulations surrounding the serving of alcoholic beverages. If a municipality has not decided otherwise serving of alcoholic beverages, other than beer containing less than 3.5 % alcohol by volume (ABV) may not begin earlier than 11 a.m. or end later than 1 a.m. All on-premise establishments are required by law to supervise their sales during the entire serving time, either by the serving licence holder him-/herself or a person assigned for the task. Staff-members responsible for the serving of alcoholic beverages are required to exercise moderation and ensure that disturbance relating to intoxication is avoided. On-premise establishments are required to be able to provide a varied menu of food until 11 p.m. and thereafter a simpler range, which helps limit inebriation. No one may take spirits, wine, strong beer or other fermented alcoholic beverages out of an on-premise establishment. On-premise sales are also regulated as regards hours of selling, locations of sales and specific events (e.g. sports events or concerts). There are no national regulations regarding

restrictions on alcohol consumption in specific areas such as parks and streets, but the municipalities may apply local regulations.

In order to limit violence and harm related to alcohol consumption in restaurants, bars and nightclubs, a method entitled “Responsible Beverage Service” was introduced by an organization called Stockholm Prevents Alcohol and Drug Problems (STAD) in Stockholm County in 2003. Responsible Beverage Service aims to create a culture surrounding the serving of alcoholic beverages where minors or noticeably intoxicated individuals are not to be served alcohol and potential risk situations are more easily identified and handled. The method has three basic components: education about Responsible Beverage Service, primarily for serving staff but also restaurateurs, security personnel and other staff, coordination of stakeholders (primarily municipalities, police and restaurateurs) and supervision conducted by both municipalities and police (primarily during evenings and nights). Results show that municipalities adopting the method have had fewer violent crimes reported to the police, than municipalities that did not adopt it. Municipalities using all three components showed a decrease in the number of reported violent assaults by approximately 9 % (a 3.1 % reduction per extension by any component). The observed positive effect was mainly noticed in smaller municipalities (i.e. municipalities with 20 serving licences or less). Of the different individual components of the programme, coordination of stakeholders (i.e. the presence of a steering group) had a significant effect on the reduction of assaults (Trolldal, 2013).

Retail sales

The Alcohol Act (SFS 2010:1622) prohibits retail sale of alcoholic beverages to minors under the age of 20, other than beer containing 3.5 % alcohol by volume (ABV) or less which may not be sold to individuals under the age of 18. On-premise serving of alcoholic beverages in Sweden is permitted to individuals aged 18 and over. Alcoholic beverages may not be handed over as gifts, loans or offers to individuals who are under the age of 20, except for beer containing 3.5% alcohol by volume or less, in which case the age limit of 18 applies. It is permitted to offer a smaller quantity of alcohol to a person under the age of 18, provided the beverage is consumed at the location where it was offered under orderly circumstances, taking into account that this is tenable with regard to the person's age, development and other circumstances.

In May, 2014, the Alcohol Act (SFS 2014:121) was amended to enable municipalities to perform control purchases of alcohol in retail sales. A control purchase is a method that municipalities can use in their supervision. The purpose is to control that the person selling the goods ensures that the customer is over 18. In simple terms, this means that a person over 18 with a youthful appearance tests whether it is possible to buy alcohol without an age check (Sveriges riksdag, 2013).

The Public Health Agency was assigned to implement training and awareness around control purchases as a supervision method. The assignment means specifically that the authority shall develop training and information and educate the county administrative boards so that they can provide knowledge about the method further to the municipalities.

Systembolaget AB has a monopoly on all retail trade of alcoholic beverages, other than beer or other beverages containing less than 3.5% alcohol by volume (ABV), which may be sold by grocery stores. Systembolaget's sales generally take place in retail shops and in some extent through delivery points in most villages or small towns that have no retail shops. These deliveries account for less than one per cent of total sales. At the end of 2013, there were 426 retail shops and 500 delivery points in Sweden. The delivery points do not keep products in stock, but order them upon request by customers. Systembolaget's mandate from the Swedish state is to help limit the medical and social harm caused by alcohol. This includes restricting availability through, for example, the number of stores and opening hours and following the regulations regarding retail trade (such as conducting ID-checks, refusing to sell alcoholic beverages upon suspicion of illegal resale or refusing to sell to intoxicated individuals). Opening hours are chosen with regard to local customer's needs, within the permitted opening hours decided upon by the Swedish Parliament. Generally, this means opening hours between 10 a.m. and 6 p.m. Monday to Friday and 10 a.m. to 1 p.m. on Saturdays (Systembolaget, 2013).

In 2008, it became legal for private individuals to import alcoholic beverages into Sweden acting through a designated independent intermediary or professional carrier. Since then actors have appeared on the Swedish market who, for commercial purposes, convey the sale of alcoholic beverages from abroad or otherwise contribute to such sales. Several Swedish companies in various industries have also launched various types of cooperation with such mediators or brokers of alcoholic beverages (SOU 2014:58, 2014).

Consumption

Alcohol consumption in Sweden reached a peak in 2004 after steadily increasing since the mid-90s. Due to revised methodological considerations of handling respondent data on unregistered consumption new figures have been published covering 2009-2012. This revision does not appear to affect the overall development trend that earlier estimates indicated, and seems to only marginally affect the estimate of total consumption of alcohol. The overall view is that Sweden has seen a decreasing total consumption since the mid-00s. This decrease, however, is not as substantial as the increase it followed. Revised figures indicate that the total consumption of alcohol in Sweden amounted to 9.9 litres of pure alcohol per inhabitant aged 15 and over in 2013. Compared to 2012, this is an increase in consumption of 8%. The largest increase is for private imports and smuggling, but also e-commerce increased - from 0.5% to 2% of total alcohol consumption (Leifman, 2014).

Use and abuse of ANDT and alcohol-related harm to a third party in Sweden have been estimated for the first time. The results showed that abuse of or addiction to alcohol are something that nearly 450,000 people (4.9%) of the population suffer from (36% women and 64% men). 15% had been adversely affected by relatives who drink too much. The estimates are tainted with the usual problems associated with questionnaires on sensitive topics and should be viewed as minimum estimates (Ramstedt, 2014).

Price

In addition to a Value Added Tax (VAT) rate of 25% of the selling price (excluding excise), most alcoholic beverages are also subject to specific excise duty. The current tax rates have applied since 1 January 2008. Excise taxes on alcoholic beverages are currently not adjusted for inflation. Excise on alcoholic beverages is regulated by the Act on Excise Duty on Alcohol (SFS 1994:1564).

Table 3:2: Tax classes and excise duty rates relating to alcoholic beverages in Sweden 1995 – 2014.

Tax classes and excise duty rates relating to alcoholic beverages in Sweden. 1995-2014. ¹⁾										
Type of alcoholic beverage		Per cent (%) alcohol by volume (ABV)		Excise duty rates (SEK) per tax class and date (YYYY-MM-DD) ²⁾ from which the rates apply						
				1995-01-01	1996-01-01	1997-01-01	1998-01-01	2001-12-01	2008-01-01	2014-01-01
Ethyl alcohol	³⁾	1.2 < ABV	⁴⁾	474,00	485,04	494,00	501,41	501,41	501,41	506,42
Wine and fermented beverages other than wine or beer		1.2 < ABV ≤ 2.25	⁵⁾	0,00	0,00	0,00	0,00	0,00	0,00	0,00
		2.25 < ABV ≤ 4.5	⁵⁾	9,00	9,21	9,20	9,34	7,58	7,58	8,11
		4.5 < ABV ≤ 7	⁵⁾	13,30	13,61	13,60	13,80	11,20	11,20	11,98
		7 < ABV ≤ 8.5	⁵⁾	18,30	18,73	18,70	18,98	15,41	15,41	16,49
		8.5 < ABV ≤ 15	⁵⁾	26,20	26,81	26,80	27,20	22,08	21,58	23,09
		15 < ABV ≤ 18	⁵⁾ ⁶⁾	43,50	44,51	44,50	45,17	45,17	45,17	48,33
Mid-range products	⁷⁾	1.2 < ABV ≤ 15	⁵⁾	26,20	26,81	26,80	27,20	27,20	27,20	29,10
		15 < ABV ≤ 22	⁵⁾	43,50	44,51	44,50	45,17	45,17	45,17	48,33
Beer		0.5 < ABV ≤ 2.8	⁸⁾	.	.	0,00	0,00	0,00	0,00	0,00
		ABV < 2.8	⁸⁾	.	.	1,45	1,47	1,47	1,66	1,78
		0.5 < ABV ≤ 2.25	⁸⁾	0,00	0,00	.	.	.	.	.
		2.25 < ABV ≤ 3.5	⁸⁾	0,91	1,21	.	.	.	.	.
		ABV < 3.5	⁸⁾	2,33	2,38	.	.	.	.	.

¹⁾ Source: Swedish Tax Agency

²⁾ Date from which new tax rates apply. Valid until the day before the next specified date.

³⁾ Corresponds to spirits. Also including mid-range products derived to CN-number 2208 with an alcohol content of more than 1.2 per cent ABV and products derived to CN-numbers 2204, 2205 and 2206 with an alcohol content of more than 22 per cent ABV.

⁴⁾ Excise duty (SEK) per litre of 100 per cent alcohol.

⁵⁾ Excise duty (SEK) per litre alcoholic beverage.

⁶⁾ This tax class and excise duty rate applies only to wine.

⁷⁾ Mid-range products derived to CN-numbers 2204, 2205 and 2206 with an alcohol content of less than 22 per cent ABV.

⁸⁾ Excise duty (SEK) calculated as excise duty rate multiplied by the volume (litre) of alcoholic beverage multiplied by the volume percentage.

Tobacco policies

A report from the National Board of Health and Welfare shows that smoking killed approximately 12,000 smokers a year between 2010 and 2012. The four major national diseases, i.e. lung cancer, chronic obstructive pulmonary disease, stroke and cardiac infarction, accounted for approximately 8,000 smoking-related deaths a year. In addition to these, approximately 4,000 smokers died of some 40 other ailments caused by smoking (Socialstyrelsen, 2014a).

Legislation

The Framework Convention on Tobacco Control consists of evidence-based measures to decrease tobacco use. One of the most effective measures is higher taxation (World Health Organisation, 2003). Sweden ratified the WHO Framework Convention on Tobacco Control in 2005 (Framework Convention Alliance). In March 2014, the Council of the European Union adopted the Tobacco Products Directive. The member states have two years to implement the legislative changes stipulated in the directive before it comes into force (EUROPAPARLAMENTET, 2014). In Sweden the Tobacco Act was implemented in 1993 and a number of amendments tightening the law have since been introduced (SFS 1993:581).

All indoor public places in Sweden have been non-smoking areas since the implementation of the Tobacco Act in 1993 and school grounds were included in 1994. There is protection from exposure to tobacco smoke in all indoor workplaces and it is prohibited to smoke in public transportation (SFS 1993:581). Sweden implemented non-smoking restaurants and pubs in 2005 (designated smoking rooms are allowed under special exceptions) and there is a high level of compliance and satisfaction with the regulation. Exposure to second-hand smoke decreased after 2005 when smoke-free restaurants and pubs were implemented (Folkhälsomyndigheten, 2014c).

In recent years, almost all county councils and more than half of the municipalities have voluntarily adopted policies for smoke-free working hours for their employees. A regulation is in place that prohibits smoking during working hours and contributes to protecting non-smoking employees from exposure to tobacco smoke. A few county councils and municipalities also include snus (moist snuff) in their regulations (Statens folkhälsoinstitut, 2010c, Tobaksfakta, 2012). Sweden does not have legal restrictions on outdoor areas such as those of restaurants, bars,

beaches, parks and bus stops etc., but the Government assigned the Public health agency of Sweden the task of investigating possible areas to make smoke-free in the future, the final report was submitted to the government in October 2014 and provided recommendations as to where outdoor public non-smoking areas could be implemented (Folkhälsomyndigheten, 2014e).

Retail sales

The Tobacco Act prohibits sales of tobacco products to minors under the age of 18 (SFS 1993:581). Although the law has existed for 15 years, more than one third of 15-year-olds reported in 2011 that they buy tobacco by themselves (Henriksson and Leifman, 2011).

Sweden has a comprehensive ban on all tobacco advertising, promotion and sponsorship, but tobacco products are still displayed and visible at points of sale (SFS 1993:581).

In May, 2014, the Tobacco Act (SFS 2014: 119) was amended to enable municipalities to perform control purchases of tobacco in retail sales. A control purchase is a method that municipalities can use in their supervision. The purpose is to check that the person selling the goods ensures that the customer is over 18. In simple terms, this means that a person over 18 with a youthful appearance tests whether it is possible to buy tobacco without an age check (Sveriges riksdag, 2013).

Consumption

In 2013, the proportion of daily smokers in Sweden was 11% among women and 11% among men. Similarly, the proportion of daily snus users (moist snuff) was 4 % among women and 18% among men (Folkhälsomyndigheten, 2014d)

In recent years, the Government of Sweden has prioritised tax increases on tobacco products (Socialdepartementet, 2012b). The prices of tobacco products are, however, still low compared with some other EU member states and Norway (European Commission, 2012).

The National Board of Health and Welfare has developed and disseminated appropriate, comprehensive and integrated guidelines for tobacco cessation based on scientific evidence (Socialstyrelsen, 2011c). Sweden has a national tobacco helpline to help smokers quit. Local healthcare centres offer tobacco cessation treatment.

There has been a decrease in the number of cigarette smokers in the adult population, (Statens folkhälsoinstitut, 2012c) but there is no such development among adolescents. The proportion of adolescent smokers is almost the same level as 10 years ago, although there has been a small decrease the past two years, especially among girls (Centralförbundet för alkohol och narkotikaupplysning, 2014d). Even if Sweden is a country with few daily smokers, there is still have a

high total number of tobacco users due to moist snuff (Statens folkhälsoinstitut, 2012c). Increases in excise duties on tobacco and the introduction of smoking bans in bars and restaurants in 2005 are two efforts in particular that have had an impact on reducing tobacco use in recent years (Statens folkhälsoinstitut, 2011a).

Price

Sweden has mainly specific excise duty rates for tobacco products. In 2014 the tax rate on cigarettes consists of 1,41 SEK specific excise duty per cigarette, plus 1 % ad valorem and 20 % value added tax (VAT), which are included in the inclusive retail price (European Commission, 2014). For snus (moist snuff) the tax rate is 385 SEK specific excise duty per kilo and 20 % value added tax (VAT), which is included^[2] in the inclusive retail price (The Swedish Tax Agency, 2014).

3.3 Universal prevention

Drug prevention activities in Sweden have increased in many areas for a number of years. National efforts focused on research, development and the dissemination of preventive methods, regional coordination and local activities (Statens folkhälsoinstitut, 2010a). To extend the national action plan the Government adopted the ANDT-strategy 2011-2015, which changed and somewhat broadened the scope.

The Government's primary focus for prevention during the first strategy period 2011-2015 was the use of cannabis among young people. In June 2011, the Public Health Agency of Sweden was commissioned by the Government to implement a national effort targeting cannabis use. About SEK 11 million was distributed to ten projects that aimed at increasing knowledge about cannabis and, in some cases, served as models for counties and organisations interested in implementing cannabis preventive measures. Workshops were also conducted with the aim of sharing knowledge about the projects and providing participants the opportunity to discuss the information activities that were being planned or implemented (Statens folkhälsoinstitut, 2012d).

In spring 2012, the Government presented a new commission focused on compiling research and evaluations of implemented actions related to drug use and cannabis use, in particular. The new commission has been allocated SEK 4 million per year and the final report is to be submitted by December 2015. Coincidental with the new Government assignment, a joint effort to address cannabis problems began involving the state and the three largest cities in Sweden: Stockholm, Gothenburg and Malmö. The project, Trestad 2, is part of a one year effort that extends to 2014 and has a total budget of SEK 12 million, focused on raising awareness of cannabis among young people and parents. The goal is to reduce the use of cannabis among

^[2] Note however that 25 % value added tax (VAT) are added to a VAT exclusive retail price.

young people under the age of 25. To achieve this, the cities work on three parallel levels: prevention, early intervention and treatment services.

Trestad 2 and the Public Health Agency of Sweden are both taking part in a Swedish version of the European Drug Prevention Quality Standards (Prevention Standards Partnership EDPQS, 2014), a manual intended to provide a framework for planning, implementing, and evaluating drug prevention activities.

School

Swedish schools have a long tradition of offering education about alcohol, narcotics and tobacco. Research has shown that school-based drug education only has transient preventive effects (Prevention Standards Partnership EDPQS, 2014), and an increasing number of schools consequently now focus on health-promoting school development, which also constitutes one of the objectives of the national ANDT strategy. The Swedish National Agency for Education emphasizes four key areas of importance for ANDT use based on research: social and emotional learning, cooperation between school and parents, student health and school-extracurricular activities. As a result of a Government commission in 2011 to improve ANDT education, the Swedish National Agency for Education reported that the educational activities will have two main objectives: 1) to provide participants with assistance in developing high quality education about alcohol, narcotics, doping and tobacco, and 2) to provide participants with knowledge of how issues related to school achievement, school satisfaction and parental cooperation can affect students' use of ANDT (Skolverket, 2013). The Swedish National Agency for Education don't implement specific programmes for drug prevention.

In recent years, the causal link between alcohol, tobacco and illegal drugs, and its importance for prevention, has increasingly been raised (Statens folkhälsoinstitut, 2012a). Research shows that drug use in adolescents develops gradually and that smoking or alcohol is usually the first step (Folkhälsomyndigheten, 2012). The risk of commencing cannabis use also increases as age at the onset of tobacco use decreases. With this knowledge in mind, the tobacco prevention efforts in schools are also of importance to the prevention of illegal drugs. In 2013, about 60 % of the municipalities undertook measures to promote smoke-free school grounds and about 40 % of the local authorities had structured programs to prevent tobacco debut in primary school (Folkhälsomyndigheten, 2014b).

Family

In recent years, there has been an increase in the number of municipalities that report on activities for parents in drug prevention work (Statens folkhälsoinstitut, 2012b). In 2009, the Government set up a national strategy for developing parental support. The aim of the strategy is to encourage local collaboration on support and assistance to parents in their parenting. The focus is on universal preventive parenting, that all parents are offered the same opportunities for support and help. In the context of the strategy, the Public Health Agency of Sweden has distributed almost SEK 200 million in support to over 25 local development projects.

“Effect: Tobacco” is a new prevention programme within Trestad2 which aims to prevent tobacco use and in the long-run cannabis use. It is directed to parents with

The National Board of Health and Welfare commissioned three universities in Sweden to conduct a study comparing the most used parental support programmes in the country. The results indicate that all programmes show positive results but the difference between the programmes is small and that the results remain at least one year after finishing the programme (Folkhälsomyndigheten, 2013).

Methods directed at parents that are used in about a quarter of the municipalities, include Vägledande samspel [International Child Development Programme – ICDP], ÖPP/Effekt, and Parental programmes conducted to a lesser degree (reported by less than 20% of the municipalities) are for example: Community Parent Education (COPE), FöräldraStegen [ParentLadder], Aktivt föräldraskap [Active parenthood], Nya STEG [New STEPS], De otroliga åren [The incredible years], , ABC [All children in focus] and Föräldrakraft [Parent Power] (Folkhälsomyndigheten, 2014b).

Community

As the national body responsible for county coordination, the Public Health Agency of Sweden receives yearly reports from the county administrative boards about their work. The results compiled for 2013 shows that cooperation has increased between the coordinators of the prevention work and the officers responsible for the supervision of alcohol and tobacco, both located at the county administrative board. The report also shows an increased focus on collaboration between the municipalities and crime prevention efforts (Folkhälsomyndigheten, 2014b).

Collaboration and coordination between crime prevention and drug prevention are highlighted clearly in the national ANDT strategy, which is natural because much of the handling of various substances is illegal, especially narcotics and doping. In addition, supply reduction is an essential measure for successful drug prevention. Results from annual questionnaires sent to the 290 local authorities indicate that virtually all municipalities cooperate with the police. Many municipalities and local police authorities also have written agreements for this work. An important

part of the work to prevent illicit drug use is to create and supply positive recreational settings. In Sweden, these activities usually take place in the non-profit sector. Many municipalities cooperate with sports organisations, the temperance movement and various churches in alcohol and drug prevention work. Sports organisations are the most common type of non-profit organisation that municipalities cooperate with.

Most of the Swedish municipalities conduct activities to establish a drug-free upbringing for children and adolescents, more than 80% reported organising drug-free activities in 2013. Also in 2013, about 65% of the municipalities conduct local alcohol- and/or drug-use surveys and about 80% of the municipalities send out information about drugs to parents (Folkhälsomyndigheten, 2014b).

3.4 Selective prevention in at-risk groups and settings

At-risk groups

Together with the social services, the Swedish Police Authority is an important participant in the establishment of a drug-free environment and a common partner of municipalities.

“Community interventions teams” is the name of a new project from the Swedish Government to the Police with the aim to combat juvenile delinquency which ran from March 2011 to October 2012. The goal was to improve collaborative methods and strengthen the social networks surrounding young people (Polisen, 2012).

Another method used by the police is the “Linköping Model” that focuses on controlling drug use among young people. At the slightest suspicion of a young person’s drug use, the parents are contacted and the district-level narcotics police make a visit to the young person’s home (usually together with a representative of the social services) (Statens folkhälsoinstitut, 2009).

Several projects are running in different parts of the country with the aim of early intervention when individuals are suspected of drug abuse. The “Maria Ungdom Motiverande Intervention” (MUMIN) [Maria Youth Motivating Intervention] project, which started in Stockholm in 2004, has led other cities to conduct similar activities. The MUMIN-project is currently under evaluation at Stockholm University.

Another method directed at at-risk groups is “Samverkan mot alkohol och droger i trafiken” (SMADIT), [Cooperation against alcohol and drugs in traffic], also referred to as the “Skellefteå Model”. This method is based on cooperation between the police, the social services and addiction treatment services, in connection with the apprehension of intoxicated drivers. The basic idea is that Drivers under the Influence of Drugs (DUID) are most open to receiving support immediately after being apprehended. The DUID – directly after interrogation and the taking of samples – will thus be referred to an initial contact with the social services or healthcare services for addicts – preferably within 24 hours. In 2012, all police

authorities worked according to the method. Örebro County applies an extended version of SMADIT, which, among a few other factors, differs from SMADIT by including people suspected of minor drug offences (Rikspolisstyrelsen, 2011).

The Public Health Agency was in 2011 commissioned to support the ANDT-preventive work at student health receptions (the project runs until the end of 2014). The work has among other things included various courses directed at staff members, the production of an information sheet on cannabis, implementing the Responsible Drinking Services method at student pubs and facilitating regional cooperation between student receptions.

At-risk families

Interventions are offered in Swedish municipalities in different settings to children living in families where one or both parents are addicted to either alcohol or narcotics, often in cooperation with NGOs. In about 60% of the municipalities, some group-based activities for these children were offered in 2013 (Folkhälsomyndigheten, 2014b)

Because all children between seven and 16 years are obliged to attend elementary school this setting is an important arena for identifying and supporting children at risk and their parents. In order to examine policy and practice in Swedish school settings pertaining to children of substance abusing parents/caregivers, a cross-sectional survey involving 443 randomised schools was carried out (Elgán and Leifman, 2010). The authors conclude that it appears as if a policy document does not directly predict whether schools identify students having substance abusing parents. However, it does influence whether respondents have participated in further training, which subsequently predicts the identification of students with substance-abusing parents. Within the national ANDT strategy, the Public Health Agency of Sweden has assignments regarding parental support. One project led by the National Board of Health and Welfare concerns support for at-risk children in families with substance abuse problems, mental illness or mental disability (Folkhälsomyndigheten, 2014a).

Recreational settings

Restaurants, bars and clubs are considered important settings in the fight against drugs. The “Clubs against drugs” project was initiated in Stockholm in 2001. Intensive efforts have since been conducted in order to develop methods and update training programmes.

A study published in 2007 showed that it has become more difficult for drug-impaired people to enter those nightclubs/restaurants that are involved in the project in Stockholm (Gripenberg et al., 2007). In 2007, the National Drug Policy Coordinator also initiated a national initiative to spread this method and supported

11 municipalities in Sweden in efforts to prevent illicit drug use in recreational settings. The focus lay on mapping the illicit drug situation in restaurants, policy work and training of restaurant staff. Since 2008, the network has continued its work with financial support from the Public Health Agency of Sweden. A website containing information about current activities and local studies (www.krogarmotknark.se) has also been set up. That method was in 2013 applied in 19 % of the municipalities which is an increase from 2012 (Folkhälsomyndigheten, 2014b).

In 2008, results from the evaluation showed that illicit drugs were less common in the restaurants in Stockholm where the staff have taken a more restrictive approach to drugs and where the staff significantly decreased their own consumption of illicit drugs (Gripenberg, 2008).

3.5 Indicated prevention

No measures initiated.

3.6 National and local media campaigns

No national or local media campaigns during the last two years.

Chapter 4: High Risk Drug Use

4.1 Introduction

The analyses and estimations regarding number of high risk drug use (HRDU) is based on the definition for problem drug use (PDU). No new calculations or definition have been made for high risk drug use. The Swedish definition of PDU/HRDU is based on problems that have arisen as a consequence of using narcotics. That can be compared to the earlier term “Heavy narcotics abuse”, which was defined as a certain kind of drug use (injection) or how often narcotics were used, e.g. daily. However, there is no official or well-established definition of problematic, high risk or harmful drug use in Sweden today, rather different terms are used at different studies.

Persons who use drugs that could be categorised as problematic drug users are generally a hard-to-reach population, making it difficult to obtain a picture of population size and development (Statens folkhälsoinstitut, 2010b). Also, drug users who seek treatment for various complications from drug use, e.g. depression and infections, tend not to provide information about their drug use and in the majority of cases are not asked about illicit drug use. In most of these treatment episodes, drug use or diagnoses of harmful use or dependence are not recorded (Beijer et al., 2011).

4.2 Prevalence and trends in HRDU/PDU

Indirect estimates of high risk drug users

The latest estimate of problematic drug use, based on data from 2007, was published in 2010 (Statens folkhälsoinstitut, 2011b). Prior to that, a number of special studies had been conducted to estimate the extent or nature of problematic drug use but all had been made in slightly different ways and under different external conditions, which makes any comparison difficult. Table 4.1 shows the results of the studies that have been made hitherto. The first study of heavy narcotics abuse in Sweden was made as long ago as 1967 and national surveys were conducted in 1979, 1992 and 1998.

Table 4.1. Estimated number of individuals with heavy/problematic use based on different studies.

	1967	1979	1992	1998	2010
Estimated number of individuals with heavy/problematic use	6,000	15,000	19,000	26,000	29,500
Inclusion criteria	Heavy use	Heavy use	Heavy use	Heavy use	Problematic use

Heavy use = injected over past year or daily use in past month. Problematic abuse = diagnosis according to ICD code (F11-16; F18-19; O35.5; P04.4; T40; T43.6; Z50.3; Z71.5)

The main purpose of the 2010 joint study by the National Board of Health and Welfare and the Swedish National Institute of Public Health was to present a method of estimating the extent of problematic drug use more effectively than before. “More effective” in this context means lower cost, faster updates, less time-sensitive (through data being collected from registers) and better possibilities to create time series. The method used is a Truncated Poisson Model and comprises data from both the inpatient register and the correctional system and also includes the hidden population. For more detailed information on methods used, please see previous national reports to the EMCDDA (Statens folkhälsoinstitut, 2010b, Swedish National Institute of Public Health, 2012).

People who inject drugs (PWID)

From an infectious disease perspective, there is a significant difference between a PDU and a PWID with regard to risk-taking and disease outcome. In 2013, the National Board of Health and Welfare used a new method to estimate the number of PWIDs in Sweden. The method uses patient registries and applies a condition based on ICD-10 codes which distinguishes between those who receive a diagnosis of abuse and those who receive any diagnosis related to injecting drug use. The method estimates the number of PWID at about 8,000 for the whole of Sweden in 2011. 57 % of these live in any of the three metropolitan cities: Stockholm, Gothenburg, and Malmö (National Board of Health and Welfare, 2013 (Unpublished)).

The above estimate also includes the hidden population, i.e. PWID who maintain a functioning life style and who does not seek help for drug use or any health consequence directly linked to drug use. The estimate is further believed to contribute to prevention efforts being tailored according to needs. The method is to be seen as an attempt to methodologically approach an alternative way with regards to previous PDU estimates, where information was self-reported by a non-randomised number of key information providers, from a non-randomised selection of Swedish regions.

For instance, the key information providers in the 1998 case study were asked to estimate the number of PDUs and PWID in their catchment area, sometimes based on the individual and probable interpretation. The authors also urge caution with generalisation of the results outside the study setting. The 2011 estimate of PWID on national level is considered to be conservative in its estimation of the hidden population.

Estimates of incidence of problem drug use

The most recent PDU prevalence figure described above (i.e. 29,500) was based on data from the hospital in-patient registry and correctional system and is regarded as a measure of point prevalence. There is no information about the incidence rate.

Chapter 5: Drug-related treatment: treatment demand and treatment availability

2014 Sweden will provide information regarding treatment in the new reporting format.

Chapter 6: Health correlates and consequences

6.1 Introduction

Surveillance of communicable diseases in Sweden is carried out by the Public Health Agency of Sweden in close collaboration with the County Medical Officers of Communicable Disease Control. The basis of this surveillance is the approximately 60 registered notifiable diseases listed in the Communicable Disease Prevention and Control Act (SFS 2004:168, 2004) and the Communicable Diseases Prevention and Control Ordinance (SFS 2004:255). Physicians are obliged to report suspicious and confirmed cases (diagnoses) of the listed communicable diseases and notification is made in parallel to the Public Health Agency of Sweden and the County Medical Officers by both clinicians and laboratories. The surveillance data is collected and analysed with the help of a computerized and web based reporting system, SmiNet. After further data processing and analysis, the surveillance data is fed back to stakeholders via the Public Health Agency's website and annual reports.

Behavioural surveillance data focusing on variables connected to STIs, HIV and hepatitis is collected through KAB (Knowledge, Attitude and Behaviour) surveys. To monitor trends in risk behaviours in people who inject drugs (PWID), a second generation surveillance programme, Svenska häktesprogrammet, has been conducted in remand prisons in Sweden's two largest cities, Stockholm and Gothenburg (since 2011 only in Stockholm). In this programme, nurses systematically test and vaccinate PWIDs held on remand, as well as providing risk reduction counselling. In addition, the nurses conduct behaviourally oriented interviews targeting the PWIDs' knowledge, attitudes and practices in relation to blood borne infections and STIs. As 80% of all PWIDs are estimated to pass through remand prisons over a three-year period, this setting has been chosen for regular data collection regarding PWIDs and risk behaviours. Preliminary data shows that approximately 2,500 PWIDs have participated in the programme and 31 new HIV infections were diagnosed between 2002 and 2011. The data currently collected in this programme is not representative of PWIDs in Sweden.

Since the late 1980s, needle-syringe exchange programmes have been run in one county in Sweden (Skåne). In May 2012, another county, Kalmar, started a needle-syringe exchange programme, and since April 2013 also a programme is operating in Stockholm, meaning that three out of 21 counties today have operating needle-syringe programmes. The counties has the responsibility (and possibility) to decide whether to establish needle-syringe programmes in their county.

In Sweden, forensic examinations are carried out to establish the cause of death whenever there is an unexpected death or when the police suspect an unnatural death, such as suicide, crime or fatal accident. There are six forensic departments that conduct examinations (Umeå, Uppsala, Stockholm, Linköping, Gothenburg and Lund). When a forensic examination is performed, body fluids (such as blood and urine) are collected and analysed at the forensic department in Linköping.

Table 6:1: Total number of deaths and forensic autopsies (including extended forensic examination) and total number of cases with toxicological analysis received from forensic examinations and from health care (Rättsmedicinalverket, 2012, Socialstyrelsen, 2013).

Total number of deaths and forensic autopsies	2010	2011	2012
Total number of deaths	90,519	89,941	91,990
Total number of forensic autopsies	5,220	5,182	5,231
Cases with toxicological analysis from forensic examinations	5,228	5,000	5,051
Cases with toxicological analysis from health care (illicit drugs)	5,652	5,943	6,487

The official death statistics in Sweden are administered by the National Board of Health and Welfare: in the national Cause of Death Register. Data in the register originate from the National Board of Forensic Medicine's databases. Almost three quarters (72%) of the total number of deaths occurred at 75 years of age or above (Socialstyrelsen, 2013).

6.2 Drug-related infectious diseases

People who inject drugs

People who inject drugs (PWID) are a hard-to-reach and vulnerable risk group heavily burdened by infectious diseases. The incidence of infectious disease within the group, primarily hepatitis and HIV, is mainly driven by continued sharing of injection equipment.

Drug related infectious diseases

The basis of the communicable disease surveillance is the approximately 60 registered notifiable diseases listed in the Communicable Disease Prevention and Control Act (SFS 2004:168) and the Communicable Diseases Prevention and Control Ordinance (SFS 2004:255). Physicians are obliged to notify cases (diagnoses) of the listed pathogens. The surveillance data is collected and analysed with the help of a computerized reporting system, SmiNet and is used to tailor preventive efforts. Behavioural surveillance data is collected through programmes within the remand prisons and needle exchange programmes (NEP).

Hepatitis C

Hepatitis C (HCV) continues to be the infection that most commonly affects PWID. Several sources indicate that the median age to debut with injection is below 20 years where approximately 50 percent contract HCV after only two years of injecting. In Sweden the prevalence of HCV among PWID is high. In various studies conducted during the last 15 years, the prevalence has been reported to be between 60 and 92 percent (EMCDDA, 2009). Sharing of injection equipment is the dominant route of transmission. In total, 2,066 cases of HCV were reported in 2013, of which 22% were reported as infected abroad and 26% lacked information on country of infection. 1,383 cases (67%) were men and the mean age at diagnosis was 38 years compared to 36 years for women. Among young PWID (age 20-24 years) 34 new cases were reported in 2013, an increase from the last 5 year average of 25 cases per year, indicating that there is a continued ongoing recruitment among young people who are at risk for starting to inject drugs.

HIV

Domestic spread of HIV among PWID continues to decrease. Only two cases infected in Sweden were reported in 2013 compared to nine cases for 2012. In total 12 of 14 notified HIV cases among PWID in 2013 were reported to have been infected abroad, mostly before immigration to Sweden.

Hepatitis B

Between 100 and 200 cases of acute hepatitis B are reported annually in Sweden. Among PWID, 14 cases of acute hepatitis B were reported in 2013, indicating a continued decline of number of reported cases, probably as a positive effect of the ongoing vaccination of this prevention group.

Risk behaviours among PWID

PWID are subjected to different risk factors and behaviours where the most prominent are:

Sharing syringes and needles

- Sharing paraphernalia
- To have a combined use of heavy drugs especially opiates / stimulants
- Having sex without a condom
- Buying or selling sex
- Not having sufficient knowledge of how various infectious diseases are passed on
- Not having enough knowledge of available preventive activities in the society.

Available non-representative data indicate continued high risk behaviour among the PWID population.

Analysis of the current situation

The HCV-epidemic among PWID remains a challenge. Efforts to strengthen the knowledge base for future preventive work have begun. At the moment, five needle exchange programmes are running in the whole of Sweden.

Need for action 2013-2015

The Public Health Agency of Sweden is planning to launch a national guideline for health promotion and disease preventive work for PWID in late 2014. The guideline will support national and regional efforts to suppress the HCV epidemic and to keep the number of new HIV cases among PWID at a low level. HCV among PWID remains a challenge and future intervention efforts should be prioritised.

6.3 Other drug-related health correlates and consequences

No such activities during the last year could be identified.

6.4 Drug-related deaths and mortality of drug users

The Swedish Cause of Death Register (CDR)

In the CDR, all cases where drugs are stated as an underlying or contributing cause of death are coded according to the ICD-10 system (excluding the diagnosis T40.4, where dextropropoxyphen is found, see below). It is estimated that 99% of all deaths occurring in Sweden are included in the CDR (Stenbacka et al., 2010). Professional coders code the diagnoses based on death certificates and assign the underlying cause of death. The National Board of Health and Welfare is the registrar for the CDR. For international reporting to the EMCDDA, only cases where illicit drugs are stated as an underlying cause of death are included (Selection B, version 3.1). This may be compared to the national definition that includes both underlying and contributing causes.

The CDR includes all deaths among Swedish residents ($n = 91,505$ in 2012), whether the deceased was a Swedish citizen or not and whether the death occurred in Sweden or abroad. However, a study showed that a death certificate was missing in about 1.1% of deaths in 2013, which is an decrease compared to 2011 and 2012 (Socialstyrelsen, 2013). These incomplete cases are listed in the CDR but without any medical information. Non-residents who die in Sweden are not included in the CDR.

It should be noted that the underlying cause of death stated in approximately 20% of the cases is not the condition that began the chain of events according to the death certificate. This may occur if a particular instruction in ICD-10 indicates that a different and more informative condition also mentioned on the death certificate is to be regarded as the underlying cause of death.

Until 2011, deaths coded ICD-10 T40.4 (i.e. poisoning with other synthetic illicit drugs) have not been included in the time series. The reason was that the group was dominated by accidental poisonings with the analgesic pharmaceutical Dextropropoxyphene. Dextropropoxyphene was deregistered as a drug in March 2011 and the most frequently occurring substances of group T40.4 today are the opioids buprenorphine and fentanyl. In 2012, changes were made in the national CDR so that deaths coded T40.4 are now incorporated in the CDR, except for deaths where code T40.4 stands for Dextropropoxyphene. Figures for previous years have been recalculated correspondingly (Socialstyrelsen, 2013).

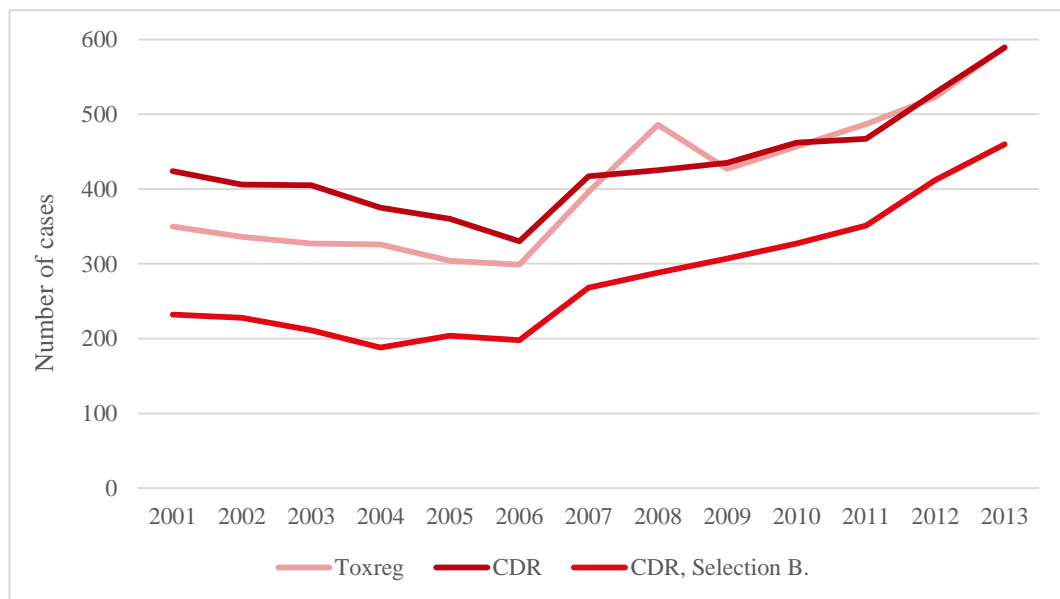
Special Mortality Register (SMR)

In addition to the CDR, there is a research register called Toxreg, comprising all deaths where illicit drugs are found at forensic toxicological examination.

Toxreg uses a system where cases with presence of illicit drugs at toxicological analysis are listed according to the substance most likely to be relevant to the cause of death. When several illicit substances are present, the death is listed in the highest ranked substance category according to the following order: morphine, methadone, buprenorphine, fentanyl, amphetamine, cocaine, other drugs and THC (tetrahydrocannabinol, the main psychoactive ingredient in the *cannabis plant*).

Over the years, this special mortality register has developed and substances have been withdrawn and/or added. In 2011, both methadone and buprenorphine were included and as of 2012 fentanyl is included as a separate substance. Such changes have consequences for both the total number of deaths and for deaths in other substance categories several years back. To try to avoid cases that might be attributed to suicide with legally prescribed morphine among the elderly, the number of cases with presence of morphine includes cases only between 11 and 60 years of age.

Figure 6.3: Number of deaths according to national registers and case selection procedures.



Mortality and causes of deaths among drug users (mortality cohort studies)

In Sweden, all citizens are given a unique personal identification number that is recorded in different databases. This personal number (PNR) makes it possible to identify and extract specific information, e.g. regarding drug-related deaths. However, complications exist, such as the fact that PNR cannot be used to obtain certain information involving drug-related treatment for legislative reasons. This makes it difficult to conduct follow-up studies in some especially interesting cohorts, such as problem drug users in treatment.

In 2013-2014 a few Swedish scientific articles were found to be drug-related mortality cohort studies, e.g.:

Wikner et al studied opioid-related mortality in relation to prescriptions for buprenorphine and methadone. During 2003-2010, the mortality related to buprenorphine and methadone increased from 1 to 49 cases and from 19 to 81 cases respectively. . In the study one-fifth of the fatal cases had a filled prescription for the substance assessed as the cause of death. Further studies are needed to investigate the possibilities to reduce the illicit use of OST substances. ((Wikner BN, 2014).

Among a group of hospitalized drug users in Stockholm Fugelstad et al studied mortality among individuals infected with the human immunodeficiency virus (HIV). However, most of the deaths were from other causes than acquired immune deficiency syndrome, such as heroin intoxication. The anti-retroviral therapy

introduced in 1996 might have contributed to a decreased number of deaths from HIV-related causes.

For previously reported mortality cohort studies, see the national reports for 2010-2012 (Fugelstad A, 2014).

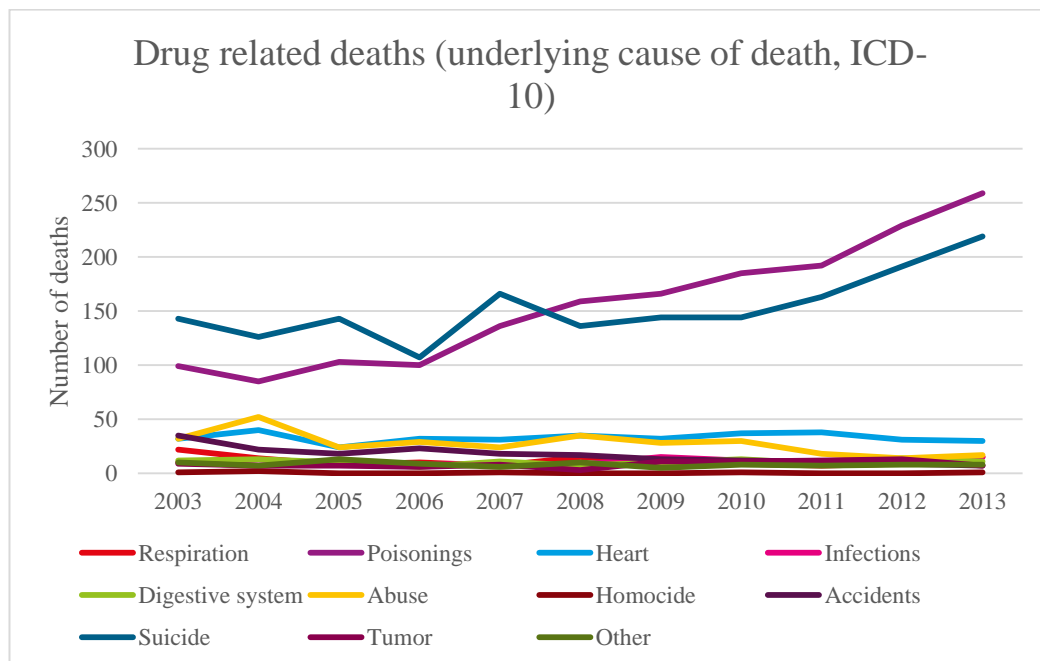
Specific causes of mortality indirectly related to drug use

As noted above, the Swedish Cause of Death Register (CDR) includes in the national definition both underlying (Selection B) and contributing causes of death. Although the national definition lists more deaths compared to Selection B, the difference in number of deaths between the registers shows a decreasing trend (figure 6.3). The same trend is also evident when Toxreg and the CDR are compared.

Regarding contributory causes of death, the CDR use the definition provided in ICD-10; “Other significant conditions contributing to the death, but not related to the disease or condition causing it”. Contributing cause of death is thus used as a collective term for all other causes of death, apart from the underlying cause, that might have been relevant for the death.

Approximately 100 deaths differ between the CDR and Selection B, and as the latter should comprise all deaths with drug use as underlying cause of death, these 100 cases might be regarded as indirectly drug-related deaths.

Figure 6.4



In 2013, the number of narcotics-related deaths was 589 according to the national definition, 155 of which were women and 434 men. Many of the narcotics-related deaths are in the poisonings category, which includes both narcotics and

pharmaceuticals. Another category of significance for the figure is suicides, which also includes injuries where the intent is not clear (Socialstyrelsen, 2014b).

The statistics also contain deaths where drugs do not have any discernible medical connection with the death, for example tumour diseases (94 between 2003 and 2013) and murders (6 between 2003 and 2013). The explanation why these deaths are counted as narcotics-related lies in the construction of the index used for narcotics-related deaths; it is sufficient for at least one cause of the death to be categorised as narcotics-related regardless of its explanatory value. This may be a contributory cause of death but where the underlying main cause of death is another, e.g. suicide. If the deaths that according to the underlying causes of death are due to diseases of the respiratory organs, cardiovascular diseases, diseases of the digestive system, murder, tumour diseases and other diseases are added together, they make up half of the narcotics-related deaths (Socialstyrelsen, 2014b).

The overall picture is that the deaths included in the official statistics have a considerable span as regards their connection to narcotics, ranging from cases where there is a direct linkage, e.g. overdoses, to cases where a narcotic medication, e.g. painkillers, had been prescribed (Socialstyrelsen, 2014b).

Unfortunately, the CDR does not contain detailed information on type of substance, and although the SMR does contain such detailed information, this register does not provide a quality control of the data. The SMR thus only provides indirect information on drug-related deaths. In table 6.2, data from the SMR/Toxreg is shown. Please note that information from Toxreg consists only of data from the toxicological analyses at the National Board of Forensic Medicine and as such, there is no quality control or causal relationship between the toxicological findings and the outcome. It is not confirmed that these deaths are drug-related. We have no detailed substance information in our CDR.

Table 6.2. Number of drug-related deaths 2003-2013 according to toxicological analysis from the SMR (6-AM = 6-acetylmorphine; THC = Tetrahydrocannabinol) (Statens folkhälsoinstitut, 2013b).

Table 6:2

Year	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Morphine (6-AM)	134 (51)	128 (42)	138 (60)	110 (33)	142 (65)	144 (46)	135 (52)	120 (34)	143 (39)	154 (41)	167 (53)
Methadone	29	26	25	22	48	74	76	94	86	120	113
Bupre-norphine	2	7	16	15	22	52	37	59	66	70	88
Fentanyl	7	5	4	5	12	11	15	17	32	44	44
Amphetamine	98	96	72	97	107	105	80	90	76	65	80
Cocaine	18	10	9	6	9	13	7	10	5	10	16
Other drugs	7	6	9	3	11	16	7	5	10	4	6
THC	32	47	28	41	44	63	63	56	60	56	76
Total	327	325	301	299	395	478	420	451	478	523	590

From table 6.2 it is evident that the number of cases with methadone and buprenorphine present in their blood at time of death has increased and is now higher than cases with heroin/morphine. It is not established from where these substances originate, e.g. from leakage from opioid substitution programmes or from other sources. It is also clear that findings of fentanyl have increased in recent years, whereas finding amphetamine shows a decreasing trend.

7. Responses to health correlates and consequences

7.1 Introduction

The most efficacious measure to limit health correlates is to prevent initiation of drug use and to work with disease prevention and health promotion for drug users. The National Board of Health and Welfare (NBHW) in Sweden provides guidelines to treatment providers on different methods for drug use and the Public Health Agency of Sweden provides guidelines for effective disease prevention and health promotion.

7.2 Prevention of drug related emergencies and reduction of drug-related deaths

Medically-assisted treatment

In 2007, the National Board of Health and Welfare published national guidelines for drug use and dependency care for the first time. This year, in 2014, the guidelines have been revised and a final version of the updated guidelines is planned for 2015.

Since 2007, the methodology for developing national guidelines has been improved. This has resulted in a standardised way to study and assess the scientific evidence. These revised guidelines are also a means to implement prioritization in this area for the first time.

According to a study by the NBHW in 2012, medically assisted drug therapy for opioid dependence was available at 114 treatment units in Sweden, and the number of patients was estimated to about 5200 (Socialstyrelsen, 2012). Considering to the latest figures stating around 8000 IDUs, Sweden has a relatively high proportion of users in treatment

Measures taken to prevent illegal use of buprenorphine has been to a) increase availability of maintenance programs, b) to transfer prescription from Subutex to Subuxone – a tablet in which buprenorphine are combined with naloxone (opiate antagonist) preventing illegal use, and c) stricter rules for medication handling within programs and by local initiatives such as the MATRIS-study, fast-tracking people into medically-assisted treatment (Håkansson, 2012).

Unfortunately, there is no precise estimate of the number of individuals taking part in drug-free treatments, although it is reasonable to assume that the frequency of this type of treatment has decreased during the last 10 years due to the expansion of maintenance treatment programmes.

In the study "Involuntary discharge from medication-assisted treatment for people with a heroin addiction – patient's experiences and interpretations" (Svensson B, 2011), the effects on involuntary discharged participants in a maintenance treatment program in Malmö were studied by qualitative methodology. A deteriorating physical and mental health status were generally described by the participants. It is well established that patients with an interrupted drug use (and decreased tolerance) are at higher risk for injury.

Swedish research has shown good results in clinical trials with highly structured treatment based on positive reinforcement of desired behaviours (Kakko, 2011). In an evaluation of a drug-assisted programme for female prostitutes in Malmö, two success factors are mentioned: effective liaison with social services and mental health care and a reasonable programme size. Small-scale programmes create an organizational vulnerability while large-scale programmes increase the risk of neighbourhood problems and therapeutically unfavourable patient compositions (Laanemets, 2007).

Two studies on the non-medical use of buprenorphine have indicated that such use was very common among drug users, but the researchers made no attempt to study how users come across preparations. A study has been set up to explore how, why and to what extent medically prescribed drugs spread (or 'leak') from opioid substitution programmes in Sweden. As it is hypothesized that patients are unwilling to admit distribution of medicines, data will be collected through interviews conducted both by researchers and by specially-trained patients, which might allow for a comparison of how willing respondents are to provide information (Johnson, 2011).

In a Swedish study (Ekendahl, 2011), the aim was to identify and analyse the discourses that service providers in Swedish opiate addiction treatment refer to in their efforts to legitimize opiate substitution therapy (OST). Twenty-eight interviews focused on OST-related issues were conducted with Swedish social workers and health care workers. The material was analysed qualitatively according to discourse theory.

Three key features of OST were identified: as *therapeutic intervention*; as *beyond harm reduction* and as *pragmatic solution*. The respondents constructed OST as a necessary medical and psychosocial treatment aimed at rehabilitation and patients' complete break with drug abuse, which reflects a policy-context where solutions to drug problems are supposed to be resolute, thorough and abstinence-oriented. According to the author the service providers handled the controversy between science and values by drawing on a *decent-life discourse*, where opioid addiction problems are solved with a pragmatic stance towards evidence and where only interventions that make patients' lives allegedly decent are considered legitimate and therefore exclude for example heroin prescription and liberal methadone distribution (Ekendahl, 2011).

Naloxone injection

A pilot study covering training and distribution of a naloxone injection kit is planned in Sweden. Opiate antagonists are generally used in order to prevent overdose following heroin use in emergency wards. The majority of overdoses occur within the company of others and a naloxone injection kit has been shown to increase the probability of overdose reversal.

Psychiatric comorbidity

See previous national reports for detailed information about psychiatric comorbidity.

7.3 Prevention and treatment of drug-related infectious diseases

The health related and infectious disease preventive work with for example, hepatitis and HIV in Sweden for people who inject drugs, is governed by the National Strategy on HIV / AIDS and other communicable diseases (Government Bill 2005/06:60). The aim of the strategy is to prevent and limit the spread and impact of infections, for society as well as the individual. Implementation of the strategy is led by the Public Health Agency of Sweden but much of the operational work is undertaken by regional or local actors with the support of non-profit organizations. During 2014 the agency aim to develop a guidance for this work, as part of the strategy's mission to support the health promotion and prevention efforts for PWID, a key population lifted as a prioritized group in the prevention of HIV and hepatitis by the UN, EU and WHO. The work highlights relevant research and knowledge and provides a framework and instruction for strategic work on regional level. The guidelines may also be used as a knowledge base in education and in various forms of decision-making and ultimately aim to reduce disease-related consequences for PWID.

The guidance highlights areas such as:

- Needle/syringe exchange programmes
- Low-threshold health care centres

Low-threshold centres (LTHC) for drug users offer health-related services (e.g. basic health care, needle exchange, medical services, counselling, etc). In Sweden, to participate in a NSP a person has to identify himself and to be 20 years of age or older).

- Sexual and injecting risk behaviours
- Voluntary counselling and testing
- Information, education and communicative interventions (IEC)
- How to create a user-friendly atmosphere
- How to involve peers in the activities

7.4 Responses to other health correlates among drug users

Injecting drug use may lead to exposure to a range of carcinogenic agents. In a new Swedish study the risk and distribution of cancers among individuals with a history of injecting drug use were investigated. Cancer incidence in a cohort of longitudinally followed participants in an NSP, recruited between 1987 and 2007, was compared to that in the Swedish general population, matching for age group and gender. The standardized incidence ratios were significantly increased for five cancer types among men; primary liver, laryngeal, lung, oropharyngeal and non-melanoma skin cancer and for cancers of endocrine organs among women.

Although the standardized overall cancer incidence in this relatively young PWID cohort was similar to that in the general population, the risk of specific types of cancer was significantly increased, suggesting that PWID confers elevated risks for certain malignancies. According to the authors, these findings prompt further studies to investigate causative factors and suggest the need to monitor people with a history of PWID (Reepalu et al., 2012).

Chapter 8: Social correlates and social reintegration

8.1 Introduction

According to the latest social report from the National Board of Health and Welfare, long-term poverty has continued to decrease in all population groups in Sweden (Socialstyrelsen, 2010c). During the same period, the income gap has increased. Poverty is increasingly more common among immigrants and illness often leads to worsened economic conditions.

Legislation and policy

For the period 2011-2015, the ANDT-strategy include priority goals on i) greater access to knowledge-based care and support inputs, ii) a clearer and more appropriate allocation of competence among the bodies principally responsible for substance abuse and addiction care and iii) reduced disparities in quality availability and results at regional and local level.

Services for drug users are provided at three levels. At the municipality level, specialised services for problem drug users are provided (the social service system) based on the Social Services Act and the Care of Alcoholics and Drug Abusers Act (handling compulsory care) (SFS 2001:453), (SFS 1988:870). The Social Services Act states that the municipal social services should provide users with the help and care they need to get away from their problem substance use. The social services have a special responsibility for people with problematic drug use that includes both preventive and individual interventions.

The county councils (the regional health care system) are obliged to provide services in accordance with the Health and Medical Services Act. (SFS 1982:763). For alcohol and drug users, this means providing detoxification and other emergency services, medical and psychiatric care for alcohol- and drug-related disorders and pharmacological treatment such as methadone and Suboxone (op. cit.).

In 2014, the National Board of Health and Welfare published a preliminary revised version of the national guidelines for the care of those suffering from substance abuse and addiction. The guidelines consist of recommendations on instruments for diagnosing and screening, medical tests, medicine assisted treatment and psychosocial treatment regarding alcohol, benzodiazepines, cannabinoids, stimulants and opioids. They also address medicine assisted treatment and psychosocial treatment at comorbidity and psychosocial treatment for adolescents. The guidelines target both the healthcare and the social services and they comprise

indicators for monitoring compliance to the recommendations, some outcome measures and user influence. The National Board of Health and Welfare perceive that the new guidelines will require changes regarding cooperation, education and training and initially more resources in order to ensure an increased availability.

Monitoring

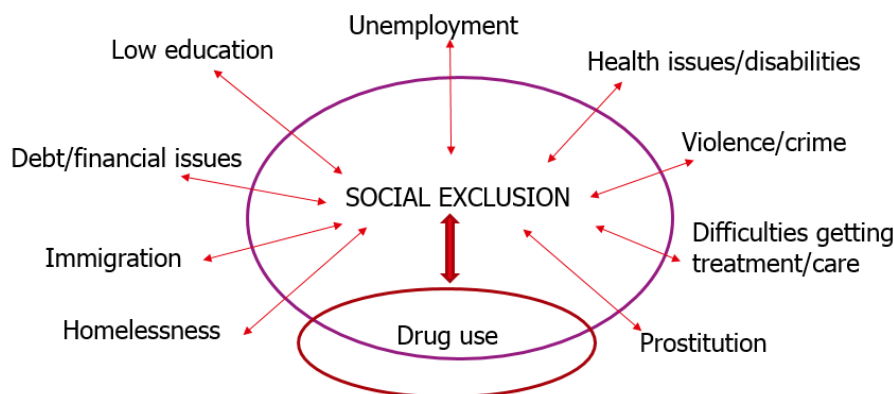
In addition to the monitoring system tailored to evaluate the implementation of the new guidelines, mentioned above, there are some other relevant monitoring systems. Data on measures taken by the social services targeting people who suffer from substance abuse and addiction, have been collected annually since 1994 (Socialstyrelsen, 2014c). Data is collected from all municipalities in Sweden and include both voluntary and compulsory care. Open comparison questionnaires are conducted both on substance abuse and addiction (started 2009) and on homelessness and social exclusion (started 2012) (Socialstyrelsen, 2014e), (Socialstyrelsen, 2014d). These questionnaires also use data collected from all municipalities together with data from national registries. In the area of homelessness and social exclusion, there have also been more comprehensive mappings every sixth year since 1993 (Socialstyrelsen, 2011b).

In recent years the Swedish governments overarching political aim has been to reduce exclusion through integration to the labour market. The overarching aim of Sweden's national public health policy is to create social conditions that will ensure good health, on equal terms, for the entire population. Universal welfare policy creates the basis on which to prevent poverty and social exclusion and is therefore the foundation on which the Swedish action plan for social inclusion is built. Universal welfare helps to reduce the divides between different groups in society, but it must be supplemented by support targeted at the most vulnerable groups in society so that social inclusion that covers everyone is attained. The government sees the issue of social exclusion as a long term priority (Government Offices of Sweden, 2008).

8.2 Social exclusion, homelessness and drug use

Drug use can be viewed as either a consequence or a cause of social exclusion (EMCDDA, 2003). Problem drug abuse and various forms of homelessness, criminality, unemployment, health problems etc. are all closely related to social exclusion and well known to society. Research has shown that a substantial proportion of homeless people are problem drug users. Further, research has shown that drug use is a risk factor for homelessness and homelessness is a risk factor for drug use (Palepu et al., 2010). The term social exclusion is used in many different contexts and has come to include alcohol and drug use, prostitution, criminality, homelessness, poverty and unemployment (EMCDDA, 2003).

Figure 8:1. Association between social exclusion and drug use



Social exclusion among drug users

Roughly 100 000 people in Sweden have contact with the health care system or social services due to substance abuse or addiction (including alcohol) (Centralförbundet för alkohol och narkotikaupplysning, 2014a). In November 2013, about 2400 of these were enrolled in institutional care whereof 90% voluntarily (Socialstyrelsen, 2014c). Among people aged 21-29 the number of people in institutional care increased between 2012 and 2013. More than 6200 people had social assistance regarding housing and 10200 people had other types of individually adjusted social assistance.

Drug use among socially excluded groups

The implementation of the strategy has been evaluated (5 million Euro) has been distributed to 23 different projects (Socialstyrelsen, 2010a).

A national mapping of homelessness³ in Sweden, conducted in April 2011 show an increase in the number of homeless people – from approximately 18 000 in 2005 to 34 000 in 2011 (Socialstyrelsen, 2011a). The large increase in reported homeless people mainly concerns people who live in relatively long-term housing solutions, such as training flats and apartments with social contracts.

About 13% of the reported homeless people were judged to be in acute homelessness, where several individuals slept outside or in public places. About 16% were receiving institutional care or living in different forms of category housing. About 40% were living in long-term housing solutions and another 20% in short-term housing solutions they had arranged themselves (Socialstyrelsen, 2011a).

³ According to the definition formulated by the National Board of Health and Welfare in 2011.

The National Board of Health and Welfare also made an attempt to identify substance abuse among homeless people. Of all participants in the mapping, 40% were judged to have drug and alcohol issues and of these 21% were women and 79% men. The most common issue was alcohol abuse, 65%, with psychostimulants such as amphetamines, cocaine being the second most used group of substances. About one third mainly used cannabinoids.

Approximately one fifth also used opiates. Mental ill-health among substance abusers is also common; about half of those with mental ill-health issues also abuse various forms of substances.

Figure 8:2

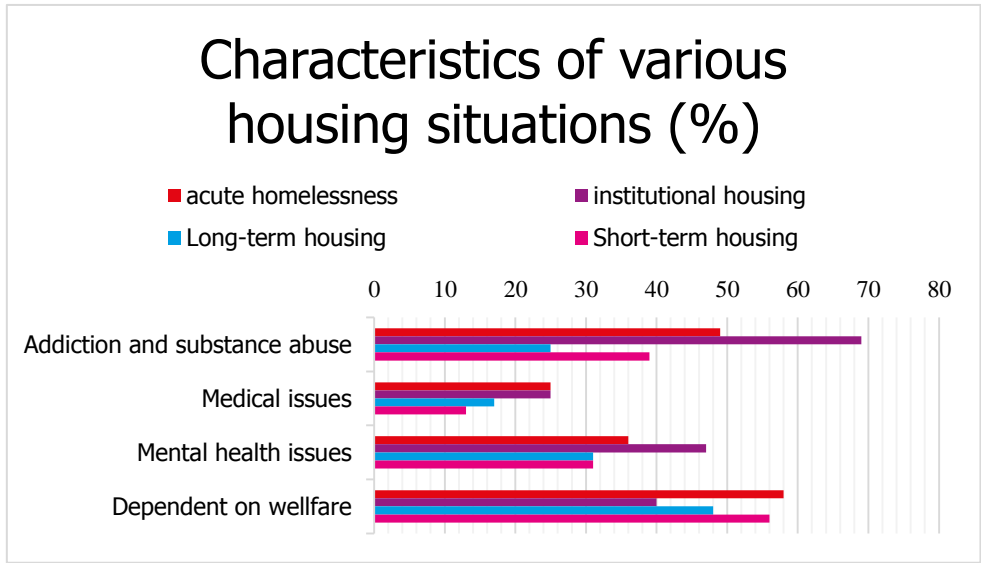


Figure 8:3

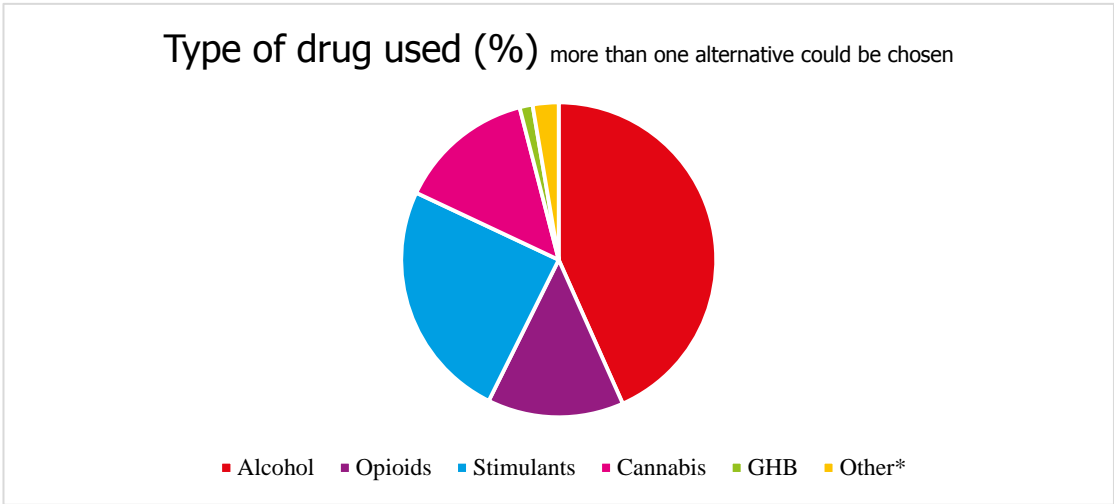


Table 8:1. Foreign-born and those born in Sweden, who are receiving welfare, substance use, mental illness and no known problem in addition to a lack of housing, the same person could be several variables are identified. The results are reported in percent.

Profile (%)	Born abroad	Born in SWE	Total
Substance use	22	50	40
Mental illness	28	39	36
Economic welfare	54	47	49
No other known problem besides lack of housing	25	14	17

A higher percentage of those born outside of Sweden receive economic welfare. However, a considerably lower number of the above mentioned group use various substances than the people born in Sweden. Moreover, worth noting is that one fourth of the foreign-born individuals had no other known problem besides their lack of housing, compared to 14% of the Swedish-born.

The most usual reason for being homeless in the foreign-born group is not being approved on the regular housing market. For 20%, substance use and mental illness were the main reasons for the lack of housing. Compared to the total group of homeless people mapped, reasons among the foreign-born were to a lesser extent eviction, substance use and mental illness, while family-related problems were much more common (Socialstyrelsen, 2011a), (Socialstyrelsen, 2010c).

8.3 Social reintegration

Since 2008, there has been an agreement between the Swedish Association of Local Authorities and Regions (SALAR) and the government on support for the implementation of the national guidelines for the care of those suffering from substance abuse and addiction. The central idea in the agreement is that the local authorities and county councils will assume a joint responsibility for development. SALAR undertakes to maintain the know-how and expertise that exists locally and regionally and to build up a long-term structure for knowledge acquisition and development. This entails, in collaboration with the principals at the county level, building up to a structure for professional support to local authorities and county councils and developing structures for collaboration between local authorities, country councils, local research and development (R&D) bodies and universities and colleges. The development work is conducted under the name “Knowledge to Practice” and was evaluated by the Swedish Agency for Public Management in 2013 (Statskontoret, 2013). The evaluation shows that the regional structures play an important role in supporting a knowledge-based practice within the social services, and that the regions might be willing to take responsibility for management and funding of the regional structures in the future.

In the recently conducted open comparison questionnaire to the municipalities, concerning their abuse and dependency care, systematic follow-ups and assessment of the care were pointed out as areas for improvement (Socialstyrelsen, 2011b, Socialstyrelsen, 2014e). For instance, only 38% of the municipalities had followed up the results of their activities on individual level and only 15% of the municipalities had compiled this information on group level. The share of municipalities with routines for collaboration between the abuse and dependency care and other areas within the social services had increased since 2011. Still, only half of the municipalities have routines for collaboration between the abuse and dependency care and support for people with psychiatric disability.

Housing

Homelessness is a complex problem and a core aspect of the definition used in Sweden is that it does not describe a person, but a situation in which an individual might be during a shorter or longer period of time. The definition of homelessness used by the National Board of Health and Welfare in their national mapping consists of four situations: i) acute homelessness, ii) institutional care or category housing, iii) long-term housing solutions (the secondary housing market) and iv) provided by the social services in the municipalities and short-term insecure housing solutions that the homeless people organized themselves (Socialstyrelsen, 2011a).

In the government's Homelessness Strategy 2007-2009 four objectives were stated:

- Everyone shall be guaranteed a roof over his/her head and be offered further co-ordinated action based on the needs of the individual.
- There shall be a reduction in the number of women and men who are in prison or at a treatment unit, or live in supported accommodation and who do not have anywhere to live before being discharged or released.
- men who are in temporary and transitional, supported accommodation, provided by the social services or others.
- The number of evictions shall decrease and no children shall be evicted.

Several authorities received assignments in order to implement the strategy, and 40 million SEK were allocated as development means for the municipalities. An evaluation from University of Lund, showed that the local projects had not been able to contribute to long-term methodological development and that there had been little progress in relation to objective 1-3 above (Denvall et al., 2011).

Regarding eviction, several projects had shown positive results. The evaluation also suggested a future focus on strategic activities on both national and local level, a functional housing policy and continued state funding of a few long-term, local projects. The evaluation also advocates full-scale testing of Housing first in one or more municipalities.

In 2012, the government commissioned all county councils to give support to the municipalities in their work against homelessness (Socialdepartementet, 2012a). The government also appointed a national homelessness coordinator in 2012, who had the task of providing municipalities with support in their efforts to combat homelessness and exclusion. The objective of the coordinator has been to give local support to create long-term, sustainable structures and functional routines and to acknowledge eviction prevention (Socialdepartementet, 2014a).

Research has assessed different special collective housing interventions for instance targeting homeless addicts (Blid and Gerdner, 2006). Findings show that category housing has a positive direct effect on the housing stability of the residents, and their opinion of their quality of life, but not on their substance misuse (op. cit.). Further, the increased housing stability seems to be more a direct result of their staying on the programme, rather than a long-term effect.

A different theoretical model has been gaining ground during the last few years in Sweden, viz. the Housing First approach. The idea behind the model is based on everyone's right to housing and is the converse of the staircase model in the sense that it reverses the "ladder" and begins with normal housing, usually in combination with some type of case management. The Housing First approach offers stable housing to chronically homeless, alcohol-dependent individuals without requiring abstinence or treatment.

An evaluation of the method was conducted in the city of Helsingborg, where the Housing First method was implemented in September 2010 (Kristansen Arne, 2013). The evaluation indicated very promising results with more than 80% of the participants still living in the housing provided through the project. Although most of the tenants before they came into the project lived in homelessness and substance abuse, and in most cases also had mental health problems, for a long time, they have in a relatively short time improved their lives in many respects, in particular with regard to their substance abuse issues, their finances, their social relationships and overall health.

In autumn 2013, Housing first became a permanent part of the work against homelessness in Helsingborg. The model has further been tested in the three major cities in Sweden, Stockholm since 2010, Malmö since 2012 and Göteborg since 2013 (Stockholms stadsmission, 2013). In the latest mapping of local measures targeting homelessness in Sweden from 2013, one third of the municipalities worked with Housing first.

Findings related to housing stability and reductions in service have translated into considerable cost savings. Other studies demonstrated that Housing First consumers generated less housing and service costs than those in Treatment First programmes (Stanhope and Dunn, 2011).

Education, training

Groups with low or incomplete grades from compulsory school are at significantly higher risk of future psychosocial problems, such as serious criminality, dependence on social assistance, substance abuse or suicidal behaviour (Socialstyrelsen, 2010b). Low or incomplete grades from compulsory school are 5–6 times more common among children whose parents are unskilled workers than among children whose parents are higher grade professionals. Between 2006 and 2011 the proportion of children with incomplete grades from compulsory school increased among children to parents with low education (Statens folkhälsoinstitut, 2013a).

The evidence indicates that the negative effect on educational outcomes of smoking or poor nutrition is greater than that of alcohol consumption or drug use. Most of the studies investigating the relationship between drug use and school achievement focus on marijuana use. In this case all research similarly concludes that using marijuana resulted in a significant negative impact on both short- and long-term educational outcomes. (Angelin, 2010).

Employment

Employment is, to a great extent, a necessary requirement for full entitlement to social security. When employment decreases considerably in the labour market it leaves those not previously established, such as young people, excluded from the system and forced to apply for means to provide for themselves (Angelin, 2010).

Weak connection to the labour market will have great impact on living conditions, e.g. an increasing risk of psychological ill health (Socialstyrelsen, 2011b).

Research has shown that peoples' sense of coherence decrease the longer they are unemployed and at the same time their ill health increases (Angelin, 2010). Those outside the labour market miss out on support from the social insurance system.

Young adults are a particularly vulnerable group with three times higher unemployment rate than among middle-aged adults (Socialstyrelsen, 2010b).

9. Drug-related crime, prevention of drug related crime and, prison⁴

9.1 Introduction

One of the prioritized goal in the ANDT strategy is well-functioning local and regional collaboration and coordination between ANDT prevention and crime prevention (Regeringen, 2012). A national plan has been in place since 2007 to strengthen the collaboration between the police and the local municipalities. The plan involves the police and the municipalities signing a contract regulating collaboration towards one or more target areas to promote security and to fight crime. In this contract, the target area will be concretized so that measurable goals can be set. Drug-related crime is one of the proposed target areas. The aim of the plan is to enhance local collaboration and communication between the police and local government and provide a better understanding of the various roles in crime prevention (Rikspolisstyrelsen, 2007).

When it comes to alternatives to prison and the prevention of reoffending after release, the Swedish law (SFS 2006:431) was amended on the 1 January 2007. The aim was to ease transition into society and offer a structured transition period before release for more inmates and for a longer part of their sentence. Already existing transitional measures like family or residential treatment and electronic surveillance were to be complemented with halfway houses.

The changes in the law are as follows:

- Intensive supervision with electronic monitoring is changed to conditional discharge with the flexibility to remove the electronic monitoring (ES) at the end of the sentence. The target group for ES is extended to include those with 6 - 18 month sentences. Conditional discharge can begin after half the sentence has been served (three months at the earliest). Long-term sentences can be permitted to have conditional discharge up to one year.
- Transition through halfway houses is introduced for those who have long sentences but do not meet the prerequisites for conditional discharge, but have no need for residential treatment.
- The earlier paragraph 34-placement⁵ is replaced with “residential care” and the requirements are lowered. The decision is also transferred from the probation committee to the Swedish Prison and Probation Service (SPPS).

⁴ Unless stated otherwise, the information in chapter 9 (Drug-related crime, prevention of drug related crime and, prison) originates from the National Council for Crime Prevention and/or the Swedish Prison and Probation Service.

⁵ Placement outside prison for treatment.

The purpose of the change was for more inmates to end their sentence with measures outside prison, in particular treatment outside prison for drug addicts. During 2010, the number of placements outside prison has decreased, which may be related to the close inspection and accounting of cooperative arrangements that subsequently led to cancelled contracts with treatment organizations (Kriminalvården, 2011).

According to the National Council for Crime Prevention (NCCP), the period directly after release from prison is a critical time when the risk of reoffending and drug use is considerable. This is particularly true of those who have long sentences (Brottsförebyggande rådet, 2010b, Sundström and Brottsförebyggande rådet [Brå], 2010).

The NCCP makes the following suggestions for the SPPS to be able to better live up to the Government's intentions:

- A less restrictive policy; inmates at a higher risk should be able to be conditionally discharged.
- The time in conditional discharge for the old target group should be the same as before the change in the law.
- The target group for the halfway houses should be better defined.
- The number of inmates in family or residential treatment should increase, not decrease.
- The application procedures should be simplified to shorten the administrative processing time.
- There should be a uniform practice in judgement and decisions (Sundström and Brottsförebyggande rådet [Brå], 2010).

Many drug users now have the opportunity to receive treatment in prison. The NCCP has conducted an impact study of treatment of drug users in prison that shows a decrease in relapses into crime between a treatment group (n=741) and a matched control group. At a 12-month follow-up, 58 % of the control group had relapsed compared with 50% in the treatment group. The difference in relapse into crime as measured by new sentences was somewhat larger, 11% less in the treatment group. For women, no significant differences were found between the treatment group and the control group.

The best results were for:

- Men (9%) compared with women (3%, non-significant)
- Those who completed treatment had fewer relapses than those who did not (10-12% to 3-10% compared with control).
- The differences were only significant for the group of inmates over 29 years old.
- The 12-step oriented programmes had better results (11%) than the non-12-step programmes (5%).
- Longer treatment (≥ 138 days) had better results (12%) than shorter treatment ((76-137 days = 5%), (≤ 75 days = 7%))

- Those who could end their sentence with treatment outside prison seemed to have better results (12%) than those who did not (5%, non-significant).

One conclusion from the study is that the Prison and Probation Service is on the right track when it comes to interventions targeted at drug use, but there is still potential to improve treatment in prison.

9.2 Drug law offences

According to Sweden's official criminal statistics for 2013, about 96,200 offences against the Act on Penal Law on Narcotics were reported in 2013, an increase of almost 2% compared to 2012. The number of convictions with drug violations as the main crime decreased by 8% (about 1,910 convictions) compared to 2012. Of the 20,800 convictions in 2013 with a drug offence as the main crime, 13% involved women and 28% adolescents between the ages of 15 and 20. The offences were considered minor in 87% of cases (18,103), not minor in 12% (2,456) and serious in 1% (206), as reported in the 2013 Swedish Official Crime Statistics from the NCCP.

Table 9.1: Number of individuals convicted of a drug related offence as the main crime in Sweden 2003- 2013.

Year	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
n	10,106	10,808	11,862	13,932	15,179	16,817	18,525	20,021	21,482	22,672	20,765

The NCCP has published tables of reported offences on their website, which break down reported drug offences into the subcategories of peddling etc., drug possession, drug use, possession and use and production. The table below shows the trend in reported drug offences for those categories for the years 2003 to 2013.

Table 9.2: Number of reported drug-related offences annually in Sweden 2003- 2013⁶.

Reported drug offences	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	%*
Peddling, etc (1-3a §)	3,766	4,031	3,915	5,539	5,645	6,390	6,440	8,141	7,862	11,137	10,672	-4
Drug possession (1-3 §)	14,526	15,249	17,624	22,083	23,150	24,764	25,432	27,368	28,785	30,591	34,205	12
Drug use (1-3 §)	18,583	21,726	26,645	37,544	42,414	46,569	47,847	51,766	52,134	52,177	50,451	-3
Possession and use (1-3 §)	3,766	3,876	3,418	1,421	2	-	-	-	-	-	-	-
Production (1-3 §)	219	211	205	270	335	465	537	615	655	697	850	22
Total	40,860	45,093	51,807	66,857	71,546	78,188	80,256	87,890	89,436	94,602	96,178	2

*Changes between 2012 and 2013, in %.

⁶ <https://www.bra.se/bra/bra-in-english/home/crime-and-statistics/crime-statistics/statistical-tables.html>

^[1] The category possession and use has been removed, which is the explanation for the sharp fall in the possession and drug use category. A change in practice has occurred and this combined offence is now judged in a different way and thereby the cases are accounted for in each category instead.

The table above shows that the total number of reported drug offences increased by 2% between 2012 and 2013. The highest increase concerns production (22%). The number of reported cases of drug possession and drug production increased by 12% and 22% between 2012 and 2013.

The following statistics that refer to type of offence and substance are special narcotics statistics published for the years 2003-2006 and 2009, (Brottsförebyggande rådet, 2010a). Figures from other areas such as sanctions, age distribution and gender distribution are taken from the official statistics of people found guilty of criminal offences.

Table 9.3: Number of individuals found guilty of drug offences annually in Sweden, by type of offence, 2003-2009*.

Type of offence	Year				
	2003	2004	2005**	2006	2009
Court sentence and fine issued by the prosecutor	14,491	14,774	15,877	17,619	21,253
Drug use	5,816	6,525	7,716	9,397	12,034
Drug possession	4,590	4,531	4,837	5,021	5,619
Possession, use	1,641	1,580	1,522	1,291	1,174
Peddling, peddling and possession	963	948	842	965	1,110
Possession, use and peddling	148	109	102	102	79
Production	6	18	25	17	59
Drug smuggling	982	657	556	509	908
Other offences and combinations	345	406	277	317	269
Waivers of prosecution	2,522	2,692	2,941	4,065	6,893
Total	17,013	17,466	18,818	21,684	28,146
Minor offences	13,429	13,645	..	16,002	21,216
Non-minor offences	3,131	3,336	..	5,248	6,472
Serious offences	452	485	..	434	456
Minor offences (%)	79	78	..	74	75
* No statistics are available for the years 2007 and 2008.					
** No statistics are available for the seriousness of the offence in the year 2005.					

The number of people convicted of drug offences increased every year between 2003-2012. In 2012-2013, there was a decrease in convictions of 8%. Despite this decrease, drug convictions have more than doubled (increased by 105%) over the last 10 years.

Two of the following paragraphs (Type of offence and Substances) are quoted from the 2009 NCCP report referred to in the table above.

Offence severity

In 2013, minor offences accounted for approximately 87% of all convictions (approximately 18,100 convictions). Non-minor offences accounted for 12% (about 2,460 convictions) and serious offences for 1% (206 convictions). The proportion of convictions for minor drug offences has decreased somewhat since 2012.

Sanctions⁷

The most common sanction issued to those convicted of drug offences is a fine, in the form of either a summary fine issued by the prosecutor or a court sentence. Those issued fines accounted for 62% of all those convicted of drug offences in 2013. In 2013, 24% of convictions for drug offences took the form of waivers of prosecution, whereas 5% led to prison sentences.

The total number of people convicted of drug offences over the past ten years is also mirrored as an increase in most of the different sanctions. The number of fines has more than doubled over the period examined, from just over 5,200 fines in 2003 to about 12,900 in 2013. The number of people sentenced to a prison term has on the other hand decreased from approximately 1,750 in 2003 to just over 1,030 in 2013. The average length of prison terms issued in 2013 was 13 months.

Regional distribution

Relative to the size of the population in the different counties in Sweden, counties in the country's metropolitan areas have a higher proportion of drug convictions than the others. The metropolitan counties, which are home to half of the national population, account for 57% of all drug convictions in Sweden in 2013. Since 2003, this proportion has remained stable at between 57% and 62% of all those convicted in the country as a whole.

⁷ Figures are from the 2013 official statistics of people found guilty of offences.

Age distribution⁸

In 2013, young people aged 18–20 had the highest level of drug convictions in relation to their numbers within the population at large, with 1,134 convictions per 100,000 of population. The groups aged 50 or over have the lowest number of convictions, with 34 convictions per 100,000 of population.

Gender distribution

Of the total number of people convicted of drug offences in 2013, approximately 13% were women. This proportion has remained relatively stable over the past 10 years. The number of men and women convicted of drug offences has more than doubled over that period. Between 2012 and 2013, both the number of men and women convicted of drug offences decreased by 8% and 9% respectively.

Types of offence⁹

At 57% (12,034 convictions) and 26% (5,619 convictions) respectively, drug use and drug possession were the two most common offences committed by people convicted of drug offences in 2009. Drug smuggling and distribution¹⁰ accounted for 4% and 5% of all drug convictions, respectively. The proportion of convictions relating exclusively to personal use increased by 28% between 2006 and 2009 (from 9,397 to 12,034 convictions). The proportion relating to possession offences increased by 12% over the same period (from 5,021 convictions in 2006 to 5,619 in 2009).

Substances¹¹

Amphetamines and cannabis remain the two most common substances in the conviction statistics. In 2009, these accounted for 27% and 42%, respectively, of all substances mentioned in criminal convictions. Over the past 10 years, there has been a shift in the proportions accounted for by cannabis and amphetamines, respectively, cannabis now being the most common substance in criminal convictions.

9.3 Prevention of drug-related crime

The most recent study conducted by the Swedish National Council for Crime Prevention, regarding prevention of drug-related crime was made in 2008 and presented a systematic review, including a statistical meta-analysis, of the effects

⁸ Calculations made per 100,000 of mean population are from the 2013 official statistics of people found guilty of offences.

⁹ Refers to summary fines and court adjudications only, as the offence type cannot be discerned in the case of waivers of prosecution.

¹⁰ Distribution and distribution in combination with possession.

¹¹ Refers to convictions in which the drug offence was the principal offence.

of drug treatment programmes on crime (Holloway et al., 2008). The analysis combined the results from a large number of evaluations considered to satisfy a list of empirical criteria for measuring effects as reliably as possible. The analysis then used the results from these previous evaluations to calculate and produce an overview of the effects that drug treatment programmes do and do not produce.

9.4 Interventions in the criminal justice system

Alternatives to prison

The Swedish penal code lists crimes and their sentences. The sentences listed in the penal code are fines, imprisonment, conditional sentence, probation and committal for special care. Sanctions implemented by the Swedish Prison and Probation Service (SPPS) are prison, intensive supervision with electronic monitoring ('tagging'), conditional sentence with community service, probation, probation with community service and probation with contract treatment. In deciding the sanction, the court must take into account whether there are any particular factors which would favour a sanction other than imprisonment. There are twice as many clients on probation than in prison and remand prison altogether. The clients are out in society and they number about 14,000 a day, compared with just under 5,000 prison inmates per day.

Special measures before release

The prison law (SFS 2010:610) stipulates that every prisoner is entitled to special measures before release, "Utsluss". The period at the end of the prisoner's sentence is devoted to preparing the inmate for a life outside prison. The aim is to reduce the risk of the inmate reoffending and facilitate his or her reintegration into society. Note that this is a continuation of the prison sentence where they are still counting penalty time. There are four special release actions, depending on the needs of the inmate.

- Activity release means that during the day a prisoner carries out work, receives treatment or takes part in education, training or a specially arranged activity away from the prison during daytime.
- A stay in care means that a prisoner is placed in a home for family care home or care and treatment centre for the purpose of participating in various treatments, for example treatment for a substance use disorder.
- A stay in a half-way house means that a prisoner is placed in a home under the control of the Prison and Probation Service that is designed to give the prisoners supervision and special support.
- Extended activity release (intensive supervision with tagging) means that a prisoner serves the prison sentence under controlled forms in his or her home. Extended activity release may be granted if;

- (1) at least half of the sentence, but at least three months, has been served,
- (2) there is no significant risk that the prisoner will commit crime, evade the full enforcement of the sentence or otherwise seriously misbehave.
- (3) he or she has access to housing, and
- (4) he or she is carrying out work, receiving treatment or participating in education, training or a specially arranged activity.

In 2012, 1,303 "utsluss" activities started. Some of them, 506, underwent stay in care. It is hard to manage to prepare for a stay in care when the sentences are short but there is no lower limit in law for such a stay.

The action plan against illicit drugs, alcohol, anabolic steroids and tobacco

The SPPS has an action plan against alcohol misuse, illicit drug use, use of anabolic steroids (defined by law SFS 1991:1969) and tobacco. The use of prescription medication without prescription is considered use of illicit drugs.

The SPPS works to reduce the use and misuse of alcohol because there is a strong correlation with criminality, for example drunk driving and crimes with elements of violence. There is also some evidence that the use of tobacco underpins and enhances the effect of other drugs. All prisons and remand prisons are by law (SFS 2010:610) constituted non-smoking facilities. This goes for employees as well as inmates. Smoking is only permitted in designated areas. However, the main reason why the SPPS works with reducing tobacco use, is that it has negative effects on a person's general health.

Finding the users

The SPPS objective that all users of alcohol, illicit drugs and anabolic steroids in correctional treatment should be identified and motivated to accept treatment is in general fulfilled. It should be guaranteed that all inmates wanting help are also offered help. Between 2010 and 2012 more than 22,000 people in custody had motivational interviews aimed at persuading them to participate in treatment.

Treatment programmes

The aim of the Swedish Prison and Probation Service is to only implement evidence-based treatment programmes. In order to secure effectiveness, the programmes shall be reviewed by a scientific panel and only programmes fulfilling the requirements will be granted accreditation. The work on various treatment programmes has advanced rapidly over the past 10 years.

To be approved, a programme must among other things include:

- a clear model of change, based on scientific evidence
- use of effective methods
- site accreditation, including monitoring of implementation and staff competence.

Before applying for accreditation the programme is usually tried out on a small scale during development. After accreditation the aim is to offer the programme to all suitable offenders, according to assessed risk and needs.

An important part of development is to analyse the effectiveness of the programmes with regard to reoffending. All treatment programmes will be evaluated once they have been carried out for so many clients that evaluation is possible.

The 12-step and Dare to Choose programmes are two examples in the field of treatment for drug misuse. Participation in 12-step programmes was associated with a modest but significant (16-17%) reduction in post-treatment reoffending after controlling for confounding variables. This applied to the full treatment group as well as completers only compared with non-treated peer controls. Dare to Choose was found to yield a 14% statistically significant reduction in post-treatment reoffending in the treatment group compared to peer controls after controlling for confounding variables. A third programme, PRISM, was evaluated during 2012. The programme is individually provided to clients with criminality associated with substance abuse. The evaluation showed that those who had completed the programme had a 30% lower risk of reoffending compared to those who did not receive any treatment.

Important to the implementation of the programmes is integration with other activities in prison and probation. Education and supporting work are arranged so that a larger part of the staff can motivate the inmates. The motivational dialogue should be based on the principles of Motivational Interviewing. The need for programmes should always be judged in relation to the sentence planning.

Programmes in use for general offending:

- Breaking with crime
- One to one
- ETS - Enhanced Thinking Skills

Substance abuse programmes:

- Dare to Choose
- PRISM - Programme for Reducing Individual Substance Misuse
- Twelve-step programme
- Prime for life
- Relapse prevention programme

All programmes with the exception of Twelve-step and Dare to Choose are suitable both for prison and probation. A specific group at the head office is responsible for the training of all personnel who manage programmes in prisons and probation. This includes responsibility for the quality and certification of personnel who manage programmes as well as strategy, goals and follow-up of treatment programmes.

Supportive factors for implementation

The Prison and Probation Service makes an effort to reduce recidivism by increasing knowledge and understanding among the prison population. In addition to traditional methods, for example education, vocational training and social rehabilitation, there are a number of national treatment programmes that specialize in various types of behaviour related to offending. Some of them are group work programmes, others are individual programmes. Most of the programmes are based on Cognitive Behavioural Theory. Five specifically target offenders with drug and/or alcohol abuse/dependency. There is today also a gambling programme, which has been run as a trial project since 2011.

The purpose of all the programmes is to reduce the risk of reoffending and give offenders an insight into the cause of his/her criminal and/or addictive behaviour and the consequences of such behaviour for the individual, victims, families and society as a whole.

The Swedish Prison and Probation Service aims to implement only evidence-based treatment programmes. In order to secure effectiveness, the programmes are reviewed by a scientific panel and only programmes fulfilling the requirements will be granted accreditation. To be approved, a programme must among other things include a clear model for change based on scientific evidence, the use of effective methods, and site accreditation including monitoring of implementation and staff competencies. Before accreditation is applied for, the programme is usually tried out on a small scale during its development. After accreditation, the aim is to offer the programme to all offenders who, according to assessed risk, are in need of such intervention. In 2012 about 5 500 prisoners and about 3 700 people in community sanctions completed a treatment programme.

9.5 Drug use and problem drug use in prisons

The average number of drug addicts in prison has been fairly stable over an extended period of time. On 1 October 2012, 56 % of the women and 62 % of the men in prison were drug-dependent, alcohol included.

One measure of an inmate's use of illicit drugs is a urine test. The SPPS take urine samples in many different situations, for example;

- When the prisoner arrives, for example when he/she been on a permitted leave
- When there is a suspicion of drug use
- When there is a suspicion of drugs present inside prison
- After an unsupervised visit from a relative or friend
- After being tested positive for illicit drugs
- Random testing

Some illicit drugs, for example cannabis, may be detectable in urine a very long time after ingestion of the drug, while other drugs have a detection time ranging from a few hours to a few days. Urine tests can therefore not be considered a measure of drug use inside prison. However, the test may give some indication of which drugs are most commonly used by inmates. Urine tests can also detect changes in use that occur over time. Some prisons in Sweden take a large number of urine tests, while others take comparatively few. This may vary with the client composition and the proportion of inmates with a substance use disorder.

In 2012, the SPPS conducted 90,804 drug tests. 5,029 of these were positive for illicit drugs. This must be compared to the fact that 14,212 inmates have to some extent been placed in prison. Most of the tests, 84,348, were urine tests while 61 were blood tests and 6,395 expiration tests. Cannabis and benzodiazepines were the most common positive tests. A large proportion of the positive tests are tests that are carried out when the prisoner has been on a permitted leave. Urine tests can therefore not be considered a measure of the use of illicit drugs inside prison.

The SPPS also carries out a special activity twice a year when five dates in a month are selected, e.g. everybody who was born on day 1-5. On a Monday morning, all those prisoners comprised in the selected criteria give a urine sample without prior notification. This means that approximately 15-18% of the whole Swedish prison population is involved. The samples are analysed for the 7 most common drugs. For 10 % of the 15 – 18 % a more detailed analysis is made, a so called M86 screening which tests for 80 drugs, including RC-drugs.

Additional tests are performed on some of the samples to detect so-called research chemicals or internet drugs in prisons where there is reason to believe there may be some such drugs.

Approximately 1.5% of the tests (12-15 out of about 7-800), are positive for drugs not prescribed by a doctor.

Drug detection dogs

Many measures have been taken over the past ten years to prevent drugs from being smuggled into prisons. An intelligence service has been established with the aim of obtaining information about, among other things, how drugs are smuggled into and distributed inside prisons. Other control measures are searches of visitors, searches of cells and premises, and drug monitoring by means of urine tests. Drug detection dogs play an important role in this work. Ten years ago, the SPPS had only a few dogs to search for drugs. Today there are 22. They cover all prisons and remand prisons and can also be used to search visitors for drugs. The dogs are owned by the Prison Service but managed at work and when they are off-duty by a dog handler, who is a member of the staff. Dog and handler work together as a team.

Control efforts against smuggling and handling of drugs have therefore increased over time. Despite major efforts being made, there are fewer confiscations of drugs, indicating that drug use in prison has declined.

9.6 Responses to drug-related health issues in prisons

Treatment of opioid dependence

Opioid dependents in prison and probation should be informed about the possibilities for treatment and how to come in contact with an addiction clinic. To initiate maintenance treatment in prison, there must be a prior undertaking by the medical care services outside prison to continue the treatment after release.

Since 2007, the Stockholm Addiction Centre and the SPPS have been cooperating in a project called Integrated Team for Opioid-dependent Clients (ITOK). Clients with opioid dependence are identified at the remand prisons in Stockholm and, following an investigation, are offered the opportunity to participate in a maintenance programme.

The cooperation model is being used in a similar project in southern Sweden (where the project is named SITOK, which means South ITOK). One problem there is that the waiting list for maintenance treatment is very long. In Gothenburg cooperation is between the probation service, social services and health care. Appropriate people are found and an active collaboration begins.

The integrated teams include staff from both the probation service (probation inspector and coordinator) and the addiction centre (medical staff). The addiction centres are responsible for medical treatment and the Prison and Probation Service contributes cognitive programmes that focus on both criminal behaviour and substance abuse. The social services are involved in each individual case for social support.

Places for maintenance treatment with methadone and buprenorphine were available at prisons during 2012; in Fösse in Region South, Storboda and Täby in Region Stockholm and Högsbo in Region West. The places should be used before release if the treatment is to continue outside.

ADHD among prisoners – occurrence/diagnosis/treatment/follow-up

SPPS have a special action plan concerning investigation and treatment of ADHD. This implies that screening under certain circumstances can be carried out within the prison service. This is handled by staff who are able to use the Wender Utah Rating Scale (WURS) and Autism Spectrum Rating Scale (ASRS) tools. Staff may also interview relatives and use the QB test, which measures all three core signs of ADHD – hyperactivity, inattention and impulsivity in patients between 6 and 60 years of age. The test system is used to support diagnosis and to show response to and progress of treatment, regardless of whether the therapy is pharmacological, non-pharmacological or a combination of these. After collecting files from care outside, an assessment is made by a psychiatrist.

Investigations are on-going in youth departments and with special resources. During 2012, 7-21 investigations per month were made. In the Stockholm region, the Public Health Agency collaborates with the prisons in Storboda, Färingsö and Täby.

In a study published in 2012, researchers from Karolinska Institutet (Lichtenstein, Långström) show that people with ADHD treated with pharmaceutical preparation commit 30% less crime during the treatment time compared to time when they were not undergoing treatment.

9.7 Reintegration of drug users after release from prison

Education and training

The Prison and Probation Service provides education and vocational training to give the inmates the opportunity to increase their skills and knowledge in order to promote their personal development during their prison sentence and to enhance their reintegration into society. Education and vocational training is an important complement to drug treatment, providing the inmates with skills that will help them to not use drugs, continue with further education and find employment.

The education available for prisoners includes basic formal adult education, vocational training and post-secondary education. The Prison and Probation Service is responsible for general education, under the supervision of the Swedish Schools Inspectorate. Around 120 qualified, special subject teachers, covering a wide range of subjects at different levels (basic, secondary and upper secondary),

are employed by the Prison and Probation Service. A Learning Centre has been established at each prison. Distance learning is used to complement local learning, which secure continuation when a student is transferred to another prison. He or she keeps the same teacher throughout the course. Furthermore, distance learning makes all subjects available from all Learning Centres even though there are only a few teachers at each prison. Vocational training is mainly offered in co-operation with the Swedish Public Employment Service, thanks to a special agreement between the two organizations.

In 2012, there were 14,212 inmates serving their sentence in prison. 4,330 participated in some kind of education/training at some time during the year. The picture over the last three years is that about a third of inmates attend some kind of education/training. In 2012, the number of inmates participating in vocational training increased from 669 to 754. It is known from surveys that inmates want more vocational training. The established co-operation between the Swedish Public Employment Service and the Prison and Probation Service is important and has been intensified. An increased provision of vocational training may explain the result.

The Employment Service and the Prison and Probation Service have also collaborated according to a National Agreement since 2008. There are employment officers at each prison and vocational training is offered at 35 of the 51 prisons, 19 Krami cooperations in 15 cities, four of them directed only at women, and common written support for the staff at both authorities on how to cooperate in the prisons and the probation service.

Krami is a cooperation that began in the city of Malmö in 1980 between the Employment Service, the Probation service and the Municipality (social services). At least one member of staff from each organization work together in a common locality in the city. The main goals of Krami are to find employment, live a life without crime, and become self-sufficient.

10. Drug Markets¹²

10.1 Introduction

One of the highest priorities of the Swedish Customs is to stop and prevent drugs from entering Sweden. To stop or prevent the smuggling of drugs, Swedish Customs cooperates with both domestic and international authorities. The Swedish Customs and the Swedish Police share responsibility for involvement in the EMPACT Synthetic Drugs and Cocaine/Heroin projects within the EU Policy Cycle. In the framework of the Nordic Customs and Police Co-operation (PTN), the Swedish Customs and the Swedish Police have liaison officers based in a number of strategic countries, e.g. Germany, Russia, Turkey, Colombia, Serbia and China. All PTN liaison officers, both customs and police liaison officers, give service to their home agencies within the police and customs in all the Nordic Countries.

To find drugs, the Swedish Customs use technical equipment such as portable and stationary X-ray machines that can detect drugs in luggage, vehicles and containers, fibre optic instruments and drug detection dogs. In their work to combat drugs, the Swedish Police are increasingly using an intelligence lead approach to identify, map and combat drug-related organised criminality.

To discover new trends, such as the use of new psychoactive substances (NPS), Sweden has developed a system for early detection with a focus on interagency co-operation. The system, provides a way to monitor the Swedish drug market and to control dangerous substances within a relatively short time span.

The NADiS collaboration (Deltagare i Nätverket för den aktuella drogsituationen i Sverige, NADiS) continues with the aim of detecting at an early stage, collecting and exchanging information, knowledge and experience about NPS, both through Internet scouting and buying and sharing material between laboratories.

Analysis procedure

At the Swedish National Laboratory of Forensic Science (SKL), substances are identified using different analysis techniques. The standard method for identification has been accredited according to ISO 17025 and allows new substances to be added to existing methods in a controlled way within a flexible scope. When a new substance is discovered in a seized sample its structure is determined and the compound is added to a reference library.

In recent years, the composition, variety and number of NPS seized by the Swedish police have increased. This is due to a more scattered drug market and a widely

¹² Unless stated otherwise, the information in chapter 10, (Drug markets) originates from the Swedish Police, the Swedish Customs or the Swedish Council for Information on Alcohol and Other Drugs.

spread knowledge of designer drug synthesis, in combination with a more hidden drug scene and aggressive Internet marketing. During 2012, 90 NPS were added to SKL's reference library. The structure of 39 of these substances was determined by the chemists at SKL while the remaining 51 could be purchased as certified references. Most of these substances were synthetic cannabinoids and phenethylamines. In 2013, Sweden reported 42 NPS to the EMCDDA; for 13 substances, Sweden was the first country to detect and report them.

10.2 Availability and supply

Perceived availability of drugs, exposure, access to drugs

Approximately 90% of seized drugs are smuggled to Sweden from another country within the European community. As regards quantities, most of the seizures are made in the south of Sweden, specifically at the Öresund Bridge in Malmö and the ferry port of Helsingborg. Important reasons behind this are most likely the rapid transportation to Sweden; the bridge is open 24 hours every day of the year and the ferries between Helsingborg and Helsingör in Denmark take only about 20 minutes from port to port.

Seizures of cannabis can be as large as 100 kilograms when the smugglers use vehicles, which is quite common at the Öresund Bridge and the ferry port in Helsingborg. Over 95% of the smuggling of the drug khat to Sweden comes over the Öresund Bridge. The quantities are generally in the range of 50 to 300 kilograms per smuggling attempt.

The most rapidly increasing modus operandi to order drugs on internet and to smuggle drugs to Sweden is by mail. More than half of all drug seizures are made in postal consignments. There are only two places in Sweden where postal consignments arrive from abroad; Arlanda Airport in Stockholm and the postal terminal at Toftanäs in Malmö.

New Internet shops keep appearing on the market, focusing on substances that are not yet regulated in Sweden. Newly discovered sites are shared with other governing bodies within the NADiS cooperation.

Among all illicit drugs that appear on the Swedish market cannabis preparations, resin and marijuana are the most freely available. The reasons for this are the extensive supply to all parts of the country and the widespread demand for this category of drugs. Amphetamine and methamphetamine are also available countrywide but demand is more concentrated to urban areas. The same is true of cocaine and other central stimulating drugs. Heroin is even more a drug of abuse for city-dwellers and has in general declined in frequency on the drug market. Drugs like Kath and opium are almost solely abused within ethnic minority communities.

The number of calls to the Swedish Poison Information Centre regarding NPS has increased over the past three years from approximately 200 calls from hospital admissions in 2011 to 650 in 2013. There has also been, in the reports from The National Board of Forensic Medicine, an increase in deaths where an NPS has been detected in the blood at the time of death from 11 in 2011 to approximately 380 in 2013. In terms of deaths, in most cases it is a result of poly-drug use. Sometimes it may also be an already regulated substance (such as heroin) that is the cause of death even though NPS was found in the blood. 51 fatalities between 2007 and spring 2014 have been linked to an individual new psychoactive substance. The number of reference materials in the analysis has increased over the years, so more substances are in screening now than in 2011.

Drugs' origin: national production versus imported

In addition to an increasing domestic production of marijuana, Sweden is also a market for drugs that are produced abroad. The most important source countries for the supply of illicit drugs in Sweden are Lithuania (amphetamine and methamphetamine), the Netherlands (amphetamine, cannabis resin and marijuana) and Poland (amphetamine). For drugs like heroin and cocaine, Sweden is an end recipient country for source countries in South America and Central Asia.

Professional, full-scale illegal indoor cultivation of marijuana, initially concentrated to the southern parts of Sweden, is now observed in other parts of the country as well. These crops are still part of transnational organized crime activities. The number of cultivations organized by local criminals has also increased.

Small kitchen labs for the production of synthetic drugs are found on less than one occasion per year in Sweden. Most of the domestically abused illicit drugs are smuggled over the bridge connecting Sweden and Denmark, via ports and international airports, by airfreight or carried in luggage. Other entering points for smuggled drugs to Sweden are via ferry ports with connections to the Baltic States and Poland. Further distribution mainly takes place from the three largest cities: Stockholm, Gothenburg and Malmö. Besides the traditional distribution channels, an increasing proportion of all kinds of drugs, including legal substances are distributed by post or in parcels after being purchased over the Internet.

With the exception of marijuana, which is also produced in cannabis cultivations in Sweden, most kinds of illicit drugs are smuggled into Sweden. Marijuana abuse has increased from approximately 2006, when Vietnamese organised crime established several extensive large plantations in Sweden. As a continuation, Swedish criminals adopted the activity and have set up several production sites for marijuana. At the same time, seizures of marijuana are still being made at the borders. During the period from 2007 until today, marijuana has remained the most common drug in customs seizures.

Trafficking patterns, national and international flows, routes, modi operandi; and organisation of domestic drug markets

Organised crime

Drug-related organised crime that supplies the Swedish abuser market can in general be divided into three groups based on where they operate geographically:

- Criminals who deal in illicit substances are mainly active domestically and are often related to gangs, such as motorcycle and ethnic gangs, and other criminal individuals and networks. These categories of criminals are members of, or have contact with, networks with international connections in order to obtain the drugs needed. The drugs are either for personal use or for further distribution to customers. In order to combat domestically active criminals, the Swedish National Bureau of Investigation co-operates closely with the police authorities in the different parts of the country.
- Drugs produced in neighbouring countries and some EU member states are smuggled into Sweden by regionally active criminal organisations and networks. These criminals mainly act from their home countries, but often use criminals resident in Sweden to distribute the drugs to Swedish users. In the case of countries in the Baltic Sea Region, such contacts are often with criminals residents in Sweden who have ethnic ties to the source country of the drug. Within the EU, much of the law enforcement co-operation takes place via Europol and regionally through the Task Force on Organised Crime in the Baltic Sea Region and the Nordic Police and Customs Co-operation (PTN).
- Drugs originating in countries outside the EU are produced and smuggled by globally active criminal organisations or networks. In this scenario, Sweden is of less importance to the overall criminal activity and finances. However, domestically active criminals rely on the supply of such drugs for their income and criminal activities within Sweden. Since Sweden is only of marginal importance to the globally active criminal organizations, efforts to combat them take place both through international organizations, such as Europol and Interpol, and domestic efforts targeted at exposing criminals who distribute such drugs within Sweden. On some occasions, Sweden also co-operates bilaterally with important transit or producing countries when feasible and necessary.

Precursor chemicals used in the manufacture of illicit drugs

The manufacture of illicit drugs requires so called precursor chemicals (except for the drugs used in their natural form, such as khat or cannabis). Precursor chemicals are chemicals used both legally and illegally and are usually manufactured under rigorous security measures. The most important chemicals for producing illicit drugs, mainly piperonyl methyl ketone (PMK), benzyl methyl ketone (BMK, the most important chemical in the production of amphetamines) and ephedra (ephedrine in its natural form), are manufactured in only a few places in the world. For this reason, there is a possibility to stop smuggling by focusing on specific routes. Criminal organisations are aware of the slow procedures for changing the international control regulations for precursor chemicals. An expression of this is the use of chemically modified versions of attractive precursor chemicals e.g. APAAN that easily can be converted to BMK. No seizures of APAAN have been reported in Sweden.

Possibilities to divert essential precursor chemicals listed in categories I and II by Sweden are limited to the trade. Only chemicals listed in category III are manufactured in the country. No serious diversion attempts have been exposed in Sweden since 2005. However, the threat of Sweden and Swedish companies being used for precursor diversion for illicit synthetic drug production in some of its neighbouring countries is very real and should be considered. Consequently, Sweden has established a national interagency Chemical Control Working Group in which the National Bureau of Investigation and Swedish Customs co-operate with representatives of the national chemical industry's two main trade organisations. Thanks to this co-operation, most Swedish companies are aware of the threat and have taken proper measures to ensure safe handling of such chemicals.

The efficient control of precursor chemicals requires a combination of administrative control by regulatory agencies and restrictive measures by law enforcement. Most exposed diversion attempts have been closely linked to organised crime activities. In some cases, the commercial operator was not aware of the problem, but some diversions were made possible through bribes or corruption.

In spite of the above, the number of seizures of precursor chemicals has been almost nil since 2005. Before 2005, large seizures were made in the major ports in continental Europe, mainly in traffic coming from China. The seizures made today are mainly shipments bound for the Latin American market, originating from China or India and only using Europe as a transit region.

10.3 Seizures

The judicial system has devoted increasing resources to narcotics cases since the 1990s. An increase in seizures may be a result of intensifying work and may also be due to more illicit drugs being in circulation.

Quantities and numbers of seizures of all illicit drugs

Table 10.1: Number of seizures analysed according to police and customs forensic laboratories, 2001-2013. (National Swedish Police, National Bureau of Investigation)

	Narcotics-classified medicines	Cannabis ¹³	Heroin ¹⁴	Amphetamine	Meth-amphetamine	Ecstasy	Cocaine
2001	3,214	6,929	1,271	5,513	275	621	328
2002	4,511	7,351	1,052	6,66	250	631	440
2003	4,317	8,243	1,057	6,657	301	489	545
2004	4,715	8,102	900	6,773	244	411	524
2005	5,347	8,345	804	6,501	386	381	546
2006	6,032	9,365	800	6,842	359	309	772
2007	7,443	10,052	871	6,477	485	268	725
2008	7,375	10,996	688	5,304	846	231	813
2009	7,917	12,108	671	4,986	1,086	42	792
2010	8,374	12,107	493	5,014	704	127	724
2011	7,987	12,742	314	3,542	608	189	633
2012	7,794	14,373	363	3,006	603	441	1,019
2013	na	16,158	485	4,303	238	743	1,452

Seizures of pharmaceuticals classified as narcotics (mainly benzodiazepines) show an increasing trend. This increase may be due to an increase in medicines sold illegally over the Internet. The large number of seizures is partially due to the fact that these drugs are often used in combination with other drugs.

The number of cannabis seizures shows an increase, indicating a substantial supply of cannabis on the drug market. Amphetamine seizures, on the other hand, show a slight decrease since 2006, whereas methamphetamine has increased over the last 10 years. Methamphetamine nonetheless seems to have stabilised somewhat since 2008/2009.

¹³ Marijuana and cannabis resin

¹⁴ White and brown heroin

The increased seizures of cocaine indicate an increased availability. Seizures of ecstasy decreased dramatically in the beginning of the 2000s until 2009, however, the last three years the number of seizures has increased dramatically.

The seizures of heroin show a decrease since the beginning of 2000s.

Quantities and numbers of seizures of precursor chemicals used in the manufacture of illicit drugs

In Sweden, cross-border smuggling of precursor chemicals is limited as Sweden is mainly a recipient country for drugs, and only a small amount of drugs requiring chemicals is produced. There is a risk that Sweden is being used as a transit country for the shipping of precursor chemicals to countries where production of illicit drugs does take place. However, from 2008 and to the end of 2013 no serious illegal transactions involving precursors were detected.

Only small quantities of precursors (only ephedrine) are seized by Swedish Customs.

10.4 Price/Purity

Price of illicit drugs at retail level

Information on street-level prices comes from the Swedish police and has been collected since 1988 regarding cannabis resin, marijuana, amphetamines, cocaine and heroin (brown and white heroin separately since 1993). Since 2000, price information is also collected on ecstasy, LSD, GHB and khat. Here, the term "street level" refers to "typical" quantities purchased by the final consumer, recalculated (if necessary) into grams or tablets. It is up to the regional informant to decide what amount per drug is typical.

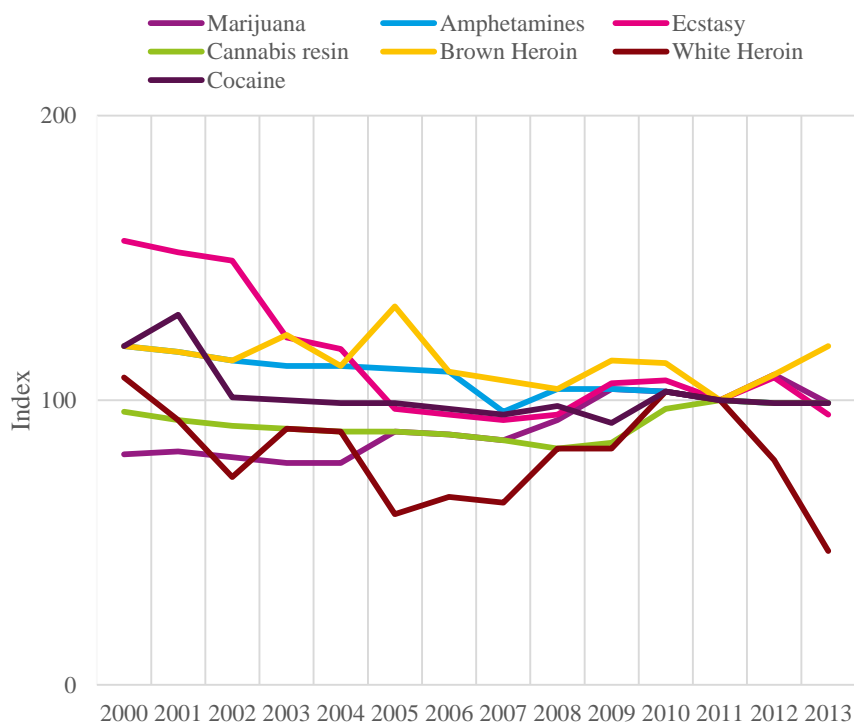
Since 2000, information on drug prices is collected from police intelligence officers from all 21 Swedish county police departments (Centralförbundet för alkohol- och narkotikaupplysning, 2012). The information was formerly collected by police only in the 15 most populated municipalities, covering close to 30% of the population.

As information on prices has been collected for several years, it is of importance to adjust for inflation when long-term trends are presented. This is normally done using the Consumer Price Index provided by Statistics Sweden (SCB). However, data reported to EMCDDA in standard tables are raw data not adjusted for inflation. Since 2010, information is also available on wholesale prices for six illicit drugs, with wholesale level referring to quantities in kilograms/1,000 tablets.

Considering inflation, real prices for several drugs have remained relatively stable for the last 10 years.

Over the past 3 years, increases in price seen for some drugs may not be spectacular, but unique in a long-term perspective since several illicit drugs have now increased in price at the same time. Amphetamines and brown heroin have however not yet shown any tendency to increase. Figure 10:2 shows the less common drugs that have been monitored from 2000 and since prices for these substances are less frequently reported they show more unstable trends.

Figure 10.1: Median street-level prices, SEK per gram for cannabis resin, marijuana, amphetamine, ecstasy, cocaine, and white brown heroin, 2000-2013.



Since 2010, prices of illicit drugs are collected at a wholesale level (defined as price /kilograms or price per 1,000 tablets). A comparison between wholesale and street-level prices (quantities in grams) shows that street-level prices are often roughly three times higher than wholesale prices. This applies to both narcotic substances that are not cut with dilution agents, such as cannabis resin, marijuana and ecstasy, as well as illicit drugs like amphetamines, heroin and cocaine that are diluted with relatively inexpensive, inactive substances (Centralförbundet för alkohol och narkotikaupplysning, 2014b).

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