



European Monitoring Centre  
for Drugs and Drug Addiction



Swedish National Institute  
of **Public Health**

**2013 NATIONAL REPORT (2012 data)**

**TO THE EMCDDA**

**by the Reitox National Focal Point**

**SWEDEN**

**New development and trends**

**REITOX**



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## Foreword

The 2013 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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Ms Anna Bessö

Director, Department of Monitoring and Evaluation

Östersund, October 2013

# Summary

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

The cohesive national Alcohol, Narcotics, Doping and Tobacco strategy covering the years 2011 to 2015 is the central document in Swedish drug policy. The main objective includes a society free from narcotics and doping, less medical and social harm from alcohol and a decrease in the use of tobacco. The strategy contains seven long-term objectives with associated priority goals. Measures are detailed in annual action plans and a total of SEK 257 million per year is allocated to work in the areas of alcohol, illicit drugs, doping and tobacco.

As of 1st January 2014, the Government has decided to form a new authority with responsibility for public health issues, the Public Health Agency of Sweden. The work currently assigned to the Swedish National Institute of Public Health, the Swedish Institute for Communicable Disease Control and the tasks of the National Board of Health and Welfare relating to public health and environmental health reporting will be transferred to the new agency and at the same time the Swedish National Institute of Public Health and the Swedish Institute for Communicable Disease Control will be discontinued.

Since 17th October 2013, the Swedish National Institute of Public Health is responsible for monitoring and coordinating the implementation of the goals in the national Alcohol, Narcotics, Doping and Tobacco strategy.

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

Cannabis is the most common narcotic substance in Sweden and amphetamines is the second most common substance among both sexes. An analysis of the prevalence of cannabis use over a longer period (2004-2012) in Sweden shows that the trend is relative stable for both sexes, both in terms of experimental use and more regular use.

However, following a drop in prevalence figures in 2008 for cannabis use, fluctuations can be seen in many groups and for various attributes (e.g. age, gender, lifetime, year and month). Similar trends are found when looking at data from school surveys.

Despite some increases in recent years, compared to the rest of Europe Sweden is among the countries with the lowest prevalence of illicit drug use.

## Chapter 3: Prevention

Drug prevention activities in Sweden have been increasing in many areas for a number of years and such activities is a key element in the 2011-2015 national drug strategy.

In spring 2012, the Government initiated a new commission focused on compiling research and evaluations of implemented actions related to drug use and cannabis use in particular. The Swedish National Institute of Public Health will disseminate

the compiled knowledge about effective prevention measures to municipalities, county administrative boards and non-governmental organisations.

In 2012, important areas for the work against the use of illicit drugs include parent support, school-based activities and interventions for children living in an unsafe family setting. About three quarters of the 290 municipalities had appointed local drug coordinators for their work on alcohol, narcotics, doping and tobacco prevention in 2012. A joint effort (Trestad 2) is also going on to address cannabis use in the three largest cities in Sweden.

#### **Chapter 4: Problem Drug Use**

The Swedish description of problematic drug use is based on problems that have arisen as a consequence of using narcotics. However, there is no national or well-established definition of problematic, heavy, high risk or harmful drug use in Sweden today; rather different terms are used at different occasions.

A number of studies estimating problematic/heavy drug use have been performed in Sweden. The latest, from 2010, estimates the population with problematic drug use at almost 30,000 individuals.

In 2013, the National Board of Health and Welfare and the Swedish Institute for Communicable Disease Control estimated the number of injecting drug users in Sweden at about 8,000.

#### **Chapter 5: Treatment Demand Indicator**

Drug treatment is organised by the social services in the local community, hospitals or therapeutic communities. In severe cases, drug users might be committed to an institution for compulsory treatment provided by the National Board of Institutional Care.

In 2007, the National Board of Health and Welfare published evidence-based national guidelines for the treatment of persons with substance abuse and dependence problems. These guidelines are under review for an update which is planned to be concluded in the spring of 2014. Data for the Treatment Demand Indicator is collected by pooling data from a few separate information systems that all function on a voluntary basis.

#### **Chapter 6: Health correlates and consequences**

In 2012, 22 cases of HIV were reported, somewhat fewer than the previous year but at the same level as the average over the past decade. By the end of 2012, injection drug use accounted for 5% of all people living with a known HIV infection in Sweden. In May 2012, a small outbreak of HIV (5 cases) was detected among IDUs in Kalmar.

In 2012, 82 cases of acute hepatitis B were reported, whereas 1,981 cases of hepatitis C were reported in 2012. Intravenous drug use is the dominant transmission route and most cases are domestic. Viewed in a longer perspective, the total number



of reported cases is decreasing. However, when viewed by age group, no falling trend can be seen in 15-29 year-olds over the last 10 years.

Official data on drug-related deaths in Sweden is acquired from the national Cause of Death Register, and in 2012, data show an increase in the number of deaths compared to 2011.

### **Chapter 7: Responses to health correlates and consequences**

The most efficacious measure to limit health correlates and consequences is to prevent drug use, or, if drug use is already present, to limit harm by evidence based methods. According to the National Board of Health and Welfare, medication-assisted treatment for opioid addiction was available at 114 treatment units in Sweden in 2012. Access to medication-assisted treatment for opioid addiction has increased significantly in Sweden since 2006, although there are a relatively low proportion of users in treatment.

In 2013, there were five needle and syringe exchange programmes in Sweden (in Malmö, Lund, Helsingborg, Kalmar and Stockholm).

### **Chapter 8: Social correlates and social reintegration**

The Swedish Government's overarching political aim is to reduce exclusion through integration to the labour market, which together with the Swedish public health policy, aims to create social conditions to ensure good health on equal terms for the entire population. The Government has tasked a special homelessness coordinator for the period 2012-2013 to support municipalities in their efforts to create long-term and sustainable structures and efficient routines in reducing homelessness.

Problematic drug use, homelessness, criminality, unemployment, health problems etc. are all closely related to social exclusion. The main results after an evaluation of the national strategy for counteracting homelessness and exclusion show that the largest problem is that neither the projects nor the local social services are able to influence housing provision in the municipalities.

### **Chapter 9: Drug-related crime, prevention of drug related crime and, prison**

Compared to 2011, data from 2012 show an increase of about 2% for offences against the Penal Law on Narcotics, and the number of convictions with drug violations as the main crime increased by 6%. The offences were considered minor in 88% of cases and serious in 1%, and amphetamines and cannabis remain the two most common substances in the conviction statistics.

One aim of the Swedish Prison and Probation Service is that all people using alcohol, narcotics and doping in correctional treatment should be identified and motivated to accept treatment. It should be guaranteed that all inmates wanting help are also offered help. The average number of drug users in prison has been fairly stable over an extended period of time. In 2012, 56 % of the women and 62 % of the men in prison had substance use disorders, alcohol included.

## **Chapter 10: Drug Markets**

One of the highest priorities of the Swedish Customs is to prevent drugs from entering Sweden, a work involving both domestic and international cooperation. 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.

Over a period of ten years, the number of seizures of cannabis, narcotics-classified pharmaceuticals, methamphetamine and cocaine has increased, whereas the number of seizures of amphetamine and heroin has decreased. Seizures of ecstasy declined until 2009 but show a dramatic increase in 2012.

# 1. Drug Policy: Legislation, strategies and economic analysis

## 1.1 Introduction

In March 2011, the Swedish Parliament decided on a cohesive strategy for alcohol, narcotics<sup>1</sup>, doping and tobacco (ANDT) policy. The overall objective of Swedish ANDT policy is a society free from illicit drugs and doping, less alcohol-related medical and social harm, and reduced tobacco use. The aim of the strategy is to set forth the objectives and emphasis of how societal efforts will be carried out, coordinated and followed up over the period 2011-2015. Every year, an action programme is issued with the aim of implementing the strategy.

ANDT work in Sweden is cross-sectorial and comprises several authorities' areas of responsibility, regulations and legislation. At the political level, work is coordinated by the ANDT secretariat (Ministry of Health and Social Affairs) which is supported by an ANDT council, whereas the implementation of the monitoring system and the implementation of ANDT strategy's goals is the responsibility of the Swedish National Institute of Public Health. The Swedish Prison and Probation Service, the Swedish Police, the Swedish Institute for Infectious Disease Control, the Swedish National Board of Health and Welfare and the Swedish Customs are other main authorities that have a central role in the narcotics field.

## 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 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 lives 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.

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<sup>1</sup> 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.

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 Swedish National Institute of Public Health 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 makes 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 Swedish National Institute of Public Health 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 (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.

The 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 as 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 Swedish National Institute of Public Health or 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 Swedish National Institute of Public Health are published on a public website ([www.fhi.se](http://www.fhi.se)).

Since the new law came into effect, statements have been issued regarding 95 substances. More than 1,500 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 out in connection with interventions aimed at motivating the individual to accept care and treatment. Needle and syringe 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***

In 2012, seven substances, (5-MEO-DALT 4-HO-MET, Methoxetamine, RCS-4 Ortho isomer, AM-2201, and AM-694) 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). Five substances (4-APB, 5-APB, 6-APB, DMAA and 5-IT) were regulated under the Act on the Prohibition of Certain Goods Dangerous to Health (SFS 1999:42).

## 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. The 2011-2015 strategy also states that the overall goals from previous national action plans continue to apply.

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 actions, 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.

During the strategy period, the objective is to establish an appropriate organisational system for open comparisons, follow-ups and evaluations of the strategy's goals. Part of this work will involve submitting proposals for the establishment of a monitoring and reporting system to comply with the agreements currently in place in the EU and internationally.

In the political sphere, Ms Maria Larsson has had national responsibility for alcohol, narcotics, doping and tobacco issues as Minister for Children and the Elderly at the Ministry of Health and Social Affairs since 2006.

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

1. Curtailing 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. Protecting children against 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 reducing the number of children and young people who initiate the use of tobacco, illicit drugs or doping substances or begin drinking alcohol early

- Reduced initiation of illicit drugs and doping abuse
- Development of methods for deterring 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. Gradually reducing 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 service 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
- Improved opportunities for the early detection and prevention of ANDT problems in working life



#### 5. Improving 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. Reducing 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. Promoting 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 action programme for 2013 (Regeringen, 2013a) includes a number of efforts to achieve the goals set forth in the 2011-2015 strategy. Many of the actions stated in the 2013 action programme are on-going. Measures include:

- Funding (SEK 15,000,000) for multidisciplinary research on alcohol, drugs, doping, tobacco and gambling by the Swedish Research Council for Health, Working Life and Welfare in 2013.
- Efforts to reduce homelessness, especially among families with children.
- Commission to propose (by the Swedish Council on Health Technology Assessment) how to establish a national health library containing scientific knowledge, guidelines and care programmes.

- Commission to the National Board of Health and Welfare to support implementation of the national guidelines.
- Develop the knowledge on medication assisted treatment in opioid dependence.
- Funding to the Swedish National Institute of Public Health to reduce cannabis use and strengthen the monitoring and analysis of new psychoactive substances.
- Commission to the Swedish National Agency for Education to design educational activities to support ANDT education.

### ***Implementation and evaluation of national action plans and/or strategy***

#### **Evaluation of the 2011-2015 strategy**

In addition to providing a framework for policy goals and priorities, the current ANDT strategy aims to establish a structure for monitoring developments in the areas of consumption and abuse, medical and social harm, and interventions and measures (Ministry of Health and Social Affairs Sweden, 2011).

Official statistics are already available in many parts of the ANDT area. In addition, numerous national, regional and local studies, data collections and questionnaire-based surveys are undertaken by agencies and organisations. However, a comparison between different datasets is not possible since these are drawn from different sources, based on different methods and, in some cases, different definitions of key terms and issues.

The Government intends to continue developing and coordinating the official statistics and data collection activities. The aim is to track developments in such areas as ANDT consumption and harm, abuse, care consumption and the effects of different types of public input on the individuals concerned and their families. A further aim is to facilitate economic evaluations within a comprehensive, integrated perspective.

Through a series of reports, the Government has proposed a number of indicators for follow-up and evaluation of the ANDT strategy (Regeringen, 2012b, 2013b, 2013c). In late 2013, the Swedish National Institute of Public Health has been assigned the responsibility to monitor and coordinate the implementation of the strategy's goals.

The strategy will be evaluated externally by the Swedish Agency for Public Management and the evaluation will focus on two specific concerns: (i) the degree to which the stated objectives have been met; and (ii) operational level and quality. The national evaluation will also include an international comparison to enable an assessment of the extent to which changes at national and regional level have been influenced by changes elsewhere in the world (Ministry of Health and Social Affairs Sweden, 2011).

The Swedish Agency for Public Management 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.

### **Evaluation of the 2006-2010 strategy**

SNIPH was given the task of evaluating the strategy for the period 2006-2010 and a final report was published in autumn 2010 (Statens folkhälsoinstitut, 2010d). In summary, a more negative development was observed for narcotics than for alcohol, with increasing harm in the form of ill-health, mortality and crime. While efforts to attain the goals in the area of alcohol have intensified, efforts in the area of narcotics have stagnated. Additional information about the evaluation is available in previous national reports (Swedish National Institute of Public Health, 2012).

### ***Other drug policy developments***

A few government inquiries that have relevance for drug policy have been finalised and are described below.

#### Inquiry on Sweden's international commitments in the narcotics field (SOU 2011:66)

This inquiry mapped Sweden's international involvement in the area of narcotics. In October 2011, the investigator presented proposals for how Sweden can promote the preservation of and respect for the UN narcotics conventions and how to attain improved coordination and use of available resources (SOU 2011:66). As stated in the 2012 action programme (Regeringen, 2012a), the proposals from the inquiry are under preparation by the Swedish government.

In its summary, the Committee of Inquiry states that it “urges an active approach, both at the negotiating table and in the public debate.” Due to the limited resources available, the inquiry further proposes that political and strategic cooperation should be focused on cooperation in the UN and EU, but also an increased Nordic cooperation, especially on an operational level.

The Committee also states that “Sweden's position in drug policy should be clarified in respect of a number of recurring issues in international discussions and negotiations. These include criminalisation of the use of drugs, the position on addiction as an illness or a habit, the role of prevention, police action against illegal drug use, harm reduction and the legalisation of cannabis.”

#### Better interventions in substance abuse and dependence (SOU 2011:35)

In 2008, the Government decided to appoint a special investigator to conduct a review of Swedish substance abuse and addiction care. The investigator's final report was submitted on April 27, 2011 (SOU 2011:35).

The inquiry had the task of reviewing the regulations in the Social Services Act (SFS 2001:453), the Care of Alcoholics, Drug Abusers and Abusers of Volatile Solvents Act (SFS 1988:870), the Health and Medical Care Act (SFS 1982:763) and the Compulsory Mental Care Act (SFS 1991:1128). The assignment included considering how the responsibilities of county councils and municipalities can be clarified to ensure that individuals with substance abuse and dependence receive adequate help.

After being drafted by the Government Offices, the Government presented Bill 2012/13:77, “God kvalitet och ökad tillgänglighet inom missbruks- och beroendevården” [Good quality and greater accessibility in abuse and dependence care] on 19 March 2013 with proposed amendments to the Health and Medical Services Act (SFS 1982:763) and the Social Services Act (SFS 2001:453). The amendments introduce an obligation for county councils and municipalities to enter into joint agreements on collaboration on matters concerning people who abuse alcohol, illicit drugs, other dependence-inducing agents, pharmaceuticals or doping agents. If possible, the organisations representing these people and their relatives

should be given the opportunity to comment upon the content of the agreements. The purpose of these changes is to strengthen collaboration between county councils and municipalities to better satisfy the target group's need for care, support and treatment.

Once the final report "God kvalitet och ökad tillgänglighet inom missbruks- och beroendevården" [Good quality and greater accessibility in abuse and dependence care] had been debated, the Government decided on 15 May to submit a proposal to the Council on Legislation in accordance with what was stated in Government Bill 2012/13:77.

In addition to the investigations above, there are some on-going inquiries that may have impact on activities, function and organisation in the illicit drugs area.

National coordination commission to combat criminality in connection with sporting events (Ku 2011:03)

The assignment includes analysing and, when necessary, making proposals on what is needed for sporting events to be able to be conducted in a safe and pleasant way and the significance of the use of alcohol, narcotics and doping agents in connection with sporting events.

The final report "Mera glädje för pengarna" [More Joy for the Money] was submitted to the Government Offices (Ministry of Culture) on March 21<sup>st</sup> 2013 (SOU 2013:19) and contains some 60 proposals with an emphasis on prevention and the sporting movements' responsibility in matters concerning for example security, use of alcohol and other drugs.

Patient empowerment commission (S 2011:03)

The Patient Empowerment Commission submitted its final report on "Ansvarsfull hälso- och sjukvård" [Responsible Health and Medical Care] (SOU 2013:44) to the Government on 26 June 2013 (SOU 2013:44). The report contains proposals for a new law governing the organisation of health and medical care to replace the current Health Care and Medical Services Act (1982:763). It makes proposals among other things for how health care and medical services can be provided on more equal terms and a new law governing the organisation of health and medical care. The commission earlier presented an interim report containing proposals for new patient legislation, how the patient's care options can be strengthened further, how the patient's need of support, advice and information should be handled within the framework of the health care guarantee and freedom of choice in health care and how the authorities concerned should work to strengthen the patient's position.

## ***Coordination arrangements***

The ANDT secretariat, at the Ministry of Health and Social Affairs, is the Government's coordinating function for the alcohol, narcotics, doping and tobacco policy. Assignments of the secretariat 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. 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 but 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 Council<sup>2</sup> consists of representatives from central authorities and organisations as well as researchers with the main function of advising and informing the Government on issues, new research and inquiries of relevance to the design of policy in the ANDT area. The Council is chaired by Ms Ragnwi Marcelind, State Secretary at the Ministry of Health and Social Affairs.

Regarding narcotics, 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

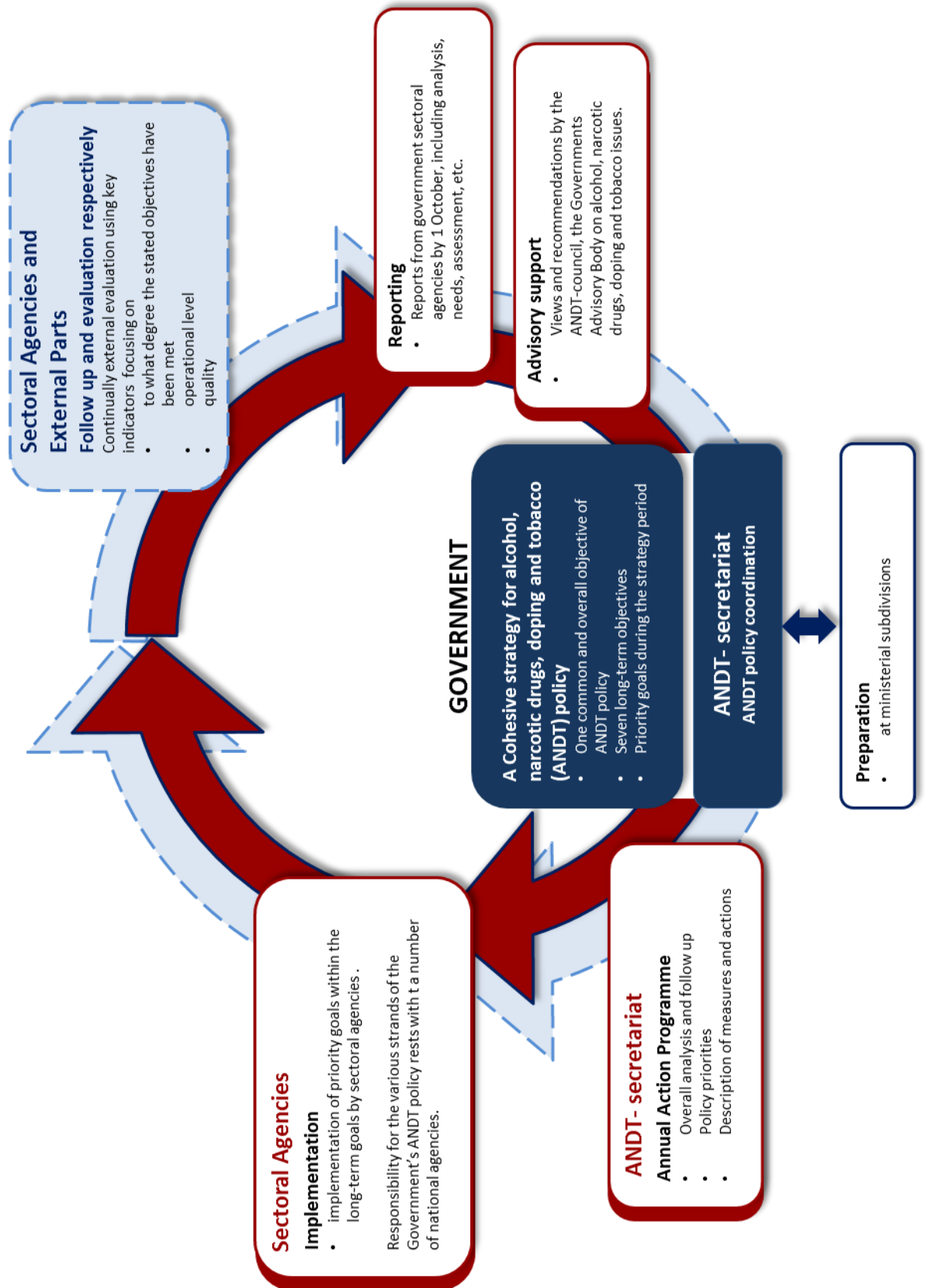
- Customs issues
- Legislation on smuggling

### Ministry for Foreign Affairs

- Foreign affairs and drugs-related development assistance

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

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



As the national knowledge centre for methods and strategies in the public health sphere, the Swedish National Institute of Public Health plays a central role in implementing the Swedish national ANDT strategy covering the period 2011-2015 as well as subsequent action plans. The tasks of the Swedish National Institute of Public Health include supporting the ANDT coordinators at the county administrative boards as well as coordinating the monitoring the implementation of the 2011-2015 ANDT strategy's goals.

As of 31<sup>st</sup> December 2013, the Swedish National Institute of Public Health and the Swedish Institute for Communicable Disease Control are shut down. Instead, the assignments currently comprised by the two authorities will be incorporated in a new public health agency: the Public Health Agency of Sweden.

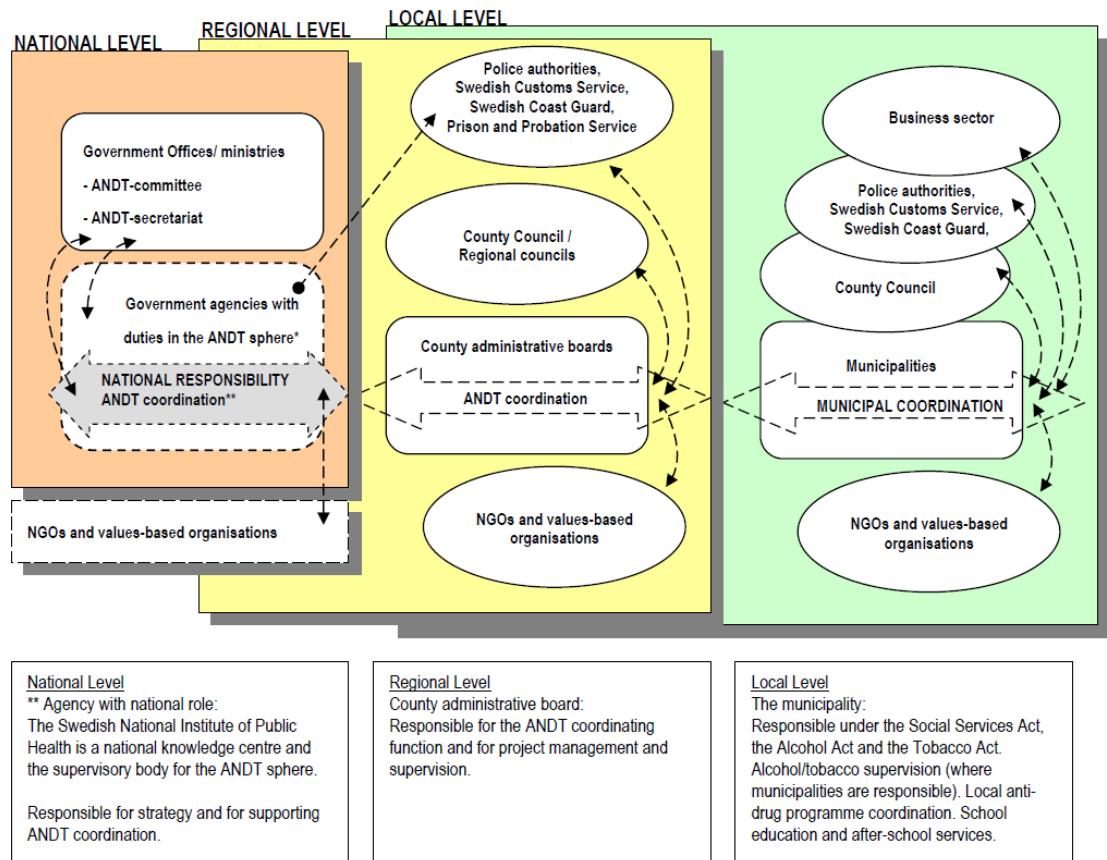
### **A new public health agency**

The Government has decided to implement the formation of a new authority for public health matters, Folkhälsomyndigheten, [The Swedish Public Health Agency] as of 1 January 2014. The tasks now the responsibility of the Swedish Institute for Communicable Disease Control and the Swedish National Institute of Public Health will be transferred to the new agency, which will also take on the National Board of Health and Welfare's tasks in the areas of people's and environmental health reporting, environmental objective work and some of the National Board of Health and Welfare's tasks concerning health protection. The amalgamation will give better prerequisites for more efficient, knowledge-based work in the field of public health. The change will allow public health matters to be addressed in a holistic integrated fashion and develop forms for knowledge support that will lead to efficient, focused methods having a practical impact on the principals concerned. The amalgamation may also contribute to Sweden being able to participate more effectively in EU and international collaborations. The change means that the Swedish National Institute of Public Health and the Swedish Institute for Communicable Disease Control will be discontinued as of 31 December 2013. The reorganisation is part of the Government's efforts to develop the agency structure in the area of health care and medical services where a heavy emphasis is placed on the health-promoting and disease-preventing perspective (Regeringen, 2013a).

The National Board of Health and Welfare is the administrative authority for activities related to health care and other medical services regarding alcohol and drugs of abuse. The Board shall promote good health and social welfare as well as promote support efforts, care and high quality care on equal terms for the entire population.



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 different projects have tried to estimate 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 up to a highest level of EUR 3 000 million in 2003. Different estimates can largely be explained by different methodology and assumptions.

Table 1.1: Previous estimates of drug-related public expenditure in Sweden.

<b>Year of the estimate</b>	<b>Sectors included</b>	<b>Estimate</b>	<b>Reference</b>
1991	Health care, treatment, probation care, social serviced, 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)

## Funding for prevention

The Swedish National Institute of Public Health (SNIPH) has been commissioned by the Government to allocate funding regarding prevention in the alcohol, narcotics, tobacco and doping area. The aim is that these funds will contribute to the implementation of national action plans in the ANDT area by supporting, for example, the county administrative boards and the civil sector.

SNIPH has been instructed by the Swedish Government to fund the regional ANDT coordinator functions placed at the county administrative boards. For this purpose, SEK 24 million was distributed to the 21 county administrative boards in 2011 (Stockholm, Skåne and Västra Götaland receives 2 million each, others 1 million). An additional SEK 6 million was distributed to the county administrative boards to fund specific projects aimed at developing and improving prevention efforts. In 2011, SNIPH was also instructed by the Government to distribute funding (SEK 12 million) to the county administrative boards to improve alcohol and tobacco law enforcement efforts.

In addition, in 2012, SNIPH allocated a total of SEK 40 million to be used to:

- support the implementation of already known and effective methods and procedures that need to be spread geographically or to more groups
- develop new methods and approaches for generating new knowledge about effective methods
- share experiences of successful and well-documented work

For the allocation of grants for new initiatives, the following key priority areas for project funding were established in 2012:

- Limitation of supply and availability, incl. efforts in digital media
- Preventive measures aimed directly at the target group of children and young
- Prevention efforts targeted at parents and pregnant women
- Prevention efforts targeted at young adults and people with hazardous drinking habits
- Information / knowledge transfer

Over half of the projects that received funding were NGOs. SNIPH has partnered with the University of Örebro in documentation and evaluation, and support for NGOs.

From this SEK 40 million, a total of 81 projects received funding for ANDT preventive efforts in 2012.

Table 1.2: Number and proportion of applications and total approved and requested grants divided into granted and rejected applications as well as type of applicant organisation.

Type of applicant organisation	Number	SEK (thousands)	% of number of granted applications	% of total amount granted
NGOs	51	20,899,820	62	52
Municipalities	6	3,897,580	7	10
County council/ administrative board	15	8,616,500	18	21
University	8	5,912,895	10	15
Other	1	670,000	3	2
Total	81	39,996,215	100	100

### **Budget**

The Government annually allocates funds for work within the scope of the ANDT strategy (including gambling), on condition that the Swedish Parliament makes funding available. For 2013, the Government allocated almost SEK 300 million for this work.

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 considered by many to be costly and resources are often inadequate. Nevertheless, only a few Swedish studies exist on the social costs of drug use compared to costs of treatment/prevention. Nilsson and Wadeskog (Nilsson & Wadeskog, 2008), have estimated costs of society for drug users and provided estimations on how much can be saved by preventive/treatment measures. The results indicate a substantial annual return when, for example, a drug user is drug-free for a long time and without relapses.

## 2. Drug use in the general population and specific target groups

### 2.1 Introduction

In the general population, cannabis is the only type of illicit drug that has been regularly studied in Sweden. A question regarding the use of cannabis has been included in the national annual public health survey conducted by the Swedish National Institute of Public Health since 2004. Before 2004, studies of illicit drug use in the population were conducted by the Swedish Council for Information on Alcohol and Other Drugs (CAN) in cooperation with the Swedish National Institute of Public Health and others. Examples of such studies include the interviews conducted by Sifo and Temo in the period 1988-2000. The formulation of the questions has changed over time, which means that comparisons between different studies can be called into question. There are also other reasons to avoid comparisons between different studies, such as differences in the selections and study methods.

Attitudes and consumption habits were previously studied among those reporting for compulsory national military service, but these studies were discontinued after 2006. However, there are other studies that are conducted regularly and make it possible to estimate illicit drug use in different target groups. Most of the studies are aimed at adolescents and contain questions about illicit drug use in the past 30 days, in the past 12 months and any time in life. Having used illicit drugs at any time in life is defined as temporary or experimental use, while the use of illicit drugs in the past 30 days is interpreted as more regular use. From an international perspective, Sweden is among the countries that have a low prevalence of illicit drug use.

The Swedish Council for Information on Alcohol and Other Drugs (CAN) conducts annual, nationally representative studies in Year 9 of compulsory school where the students are 15 to 16 years old. Since 2004, studies have also been carried out in the second year of upper-secondary school (Year 11) among students aged 17-18.

In 2010, the Swedish National Institute of Public Health published a report (Statens folkhälsoinstitut, 2010e) that presents results from a number of studies conducted in 2007-2008 on behalf of the anti-narcotics coordination body of the time called Mobilization against Narcotics. Among these were four questionnaire studies, the largest of which was a population study. The other questionnaire studies targeted students, restaurant personnel and festival participants. Various methods were tried to reach people with problem drug use, including a technique called respondent-driven sampling (RDS). In addition, register methodology was used to estimate the number of problem drug users in Sweden. More information on the register methodology is provided in Chapter 4.

## 2.2 Drug use in the general population

### ***Cannabis***

The Swedish National Institute of Public Health annually conducts a national public health survey in the form of a questionnaire study that is sent to a random selection of approximately 20,000 people. The national public health survey targets people between the ages of 16 and 84. Statistics Sweden<sup>3</sup> is commissioned to conduct the questionnaire survey. The objective of the study is to show how the population is doing and to monitor changes in health over time as a part of the follow-up of the public health policy. One question in the survey concerns cannabis use and is intended to indicate prevalence and potential change over time. This question makes it possible to describe the cannabis use trend in Sweden, rather than measuring differences from year to year. Response frequency in the surveys has been around 50% in recent years.

Table 2.1: Cannabis use in various age groups by gender expressed as percentages. Lifetime prevalence, annual prevalence and monthly prevalence, 2004-2011.

<b>Lifetime prevalence (%) – sometime in life</b>										
		<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
16-64	Men	17.6	15.5	15.6	16.4	14.6	18.5	18	17.2	17.5
	Women	9.9	9.7	8.9	9	8.4	9.2	10.4	11	12.2
16-34	Men	25.5	22.1	23.7	22.3	19.7	26.8	24.3	24.2	23.6
	Women	16.3	16	15.4	13.8	13.5	14.9	16.5	18.6	20.7
16-24	Men	23.3	18.7	16.2	15.5	11.8	20.6	17	18.6	18.8
	Women	14.7	13.3	15.4	13.3	12.3	11.4	13.2	16.1	16.4
<b>Annual prevalence (%) – past year</b>										
		<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
16-64	Men	3	2.8	2.6	2.8	2.6	4.3	3.7	3.6	3.8
	Women	1.5	1	1.4	1.3	1.4	1.5	1.8	1.6	2.2
16-34	Men	6.6	6.6	6.7	6.3	5.8	9.8	7.8	8.3	8.2

<sup>3</sup> Statistics Sweden (SCB) is an administrative agency. The agency's main task is to provide customers with statistics for decision-making, debate and research. It is mainly assigned these tasks by the government and various agencies, but SCB also has customers in the private sector and among researchers.

	Women	3.8	2.5	3.6	3.3	3.6	3.8	4.6	3.9	5.7
16-24	Men	9.7	10.2	6.2	5.9	4.8	11.1	8.6	8.5	11.5
	Women	4.8	3.9	6.2	4.7	5	5.5	5.8	5.9	7.7
<b>Monthly prevalence (%) – past month</b>										
		<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
16-64	Men	1.2	1.2	0.9	0.8	0.7	1.5	1.4	1.2	1.4
	Women	0.3	0.4	0.3	0.3	0.3	0.3	0.5	0.6	0.4
16-34	Men	2.5	2.7	2.3	1.8	1.5	3.1	3	2.5	3.1
	Women	0.7	0.8	0.9	0.7	0.7	0.9	1.2	1.5	0.9
16-24	Men	4	4.7	1.8	2.3	1.5	3.8	3.3	3.1	4.5
	Women	1	1.4	1.8	0.7	0.9	1.2	1.1	2.2	1.3

To meet international criteria, the results for the 16-64 age group are presented here, see Table 2.1. It can also be noted that cannabis use in the older population (65-84 years of age) is almost non-existent in Sweden.

An analysis of the entire time series shows that the trend is stable at the same level for both sexes, in terms of both experimental use and more regular use. Lifetime prevalence for men was higher at the beginning (2004) and at the end (2009-2012) of the time series. Among women, lifetime prevalence was higher at the end of the time series. Annual and monthly prevalence are considerably lower than lifetime prevalence for both genders.

Over the period that the studies were under way, some changes<sup>4</sup> can be statistically confirmed. Among others, an increase can be confirmed among women's lifetime

<sup>4</sup> **Change in lifetime prevalence for men, women and various age groups, CI (95%)**

Men 16-64 [2004 (16.4 – 18.7), 2008 (13.4 – 15.7), 2009 (17.2 – 19.9)]

Women 16-64 [2008 (7.6 – 9.2), 2010 (9.5 – 11.4)]

Men 16-34 [2004 (23.1 – 27.9), 2008 (17.3 – 22), 2009 (24 – 29.7)]

Women 16-34 [2008 (11.8 – 15.3), 2011 (16.4 – 20.8)] [2009 (12.9 – 16.8), 2012 (18.3 – 23)]

Men 16-24 [2004 (19.7 – 27), 2008 (9 – 14.6), 2009 (16.8 – 24.4)]

**Change in annual prevalence for men in various age groups, CI (95%)**

Men 16-64 [2008 (2 – 3.1), 2009 (3.7 – 5)]

Women 16-64 [2005 (0.6 – 1.4), 2012 (1.7 – 2.7)]

prevalence (16-64 years of age) in 2010 relative to 2008. There was also an increase in the younger women's lifetime prevalence (16-34 years of age) between 2008 and 2011. A recent increase among women (16-34 years of age) was observed in 2012 relative to 2009. At the last measurement, the lifetime prevalence for women in these age groups was 20.7%. Annual prevalence among women also increased between 2005 and 2012. However, no increase has so far been observed among the youngest women (16-24). Both lifetime and annual prevalence for women show the highest value in 2012 - compared with previous measurements, see Table 2.1.

The development of prevalence among men varies more than among women. It is also significantly higher among the men. Lifetime prevalence is highest among men aged 16-34, see Table 2.1. Lifetime prevalence for men in this age group was 23.6% at the latest measurement. Annual and monthly prevalence are also highest among young men. An increase in the annual prevalence for men in all age groups was confirmed in 2009 relative to 2008. Annual prevalence for men between 16-24 years was 11.5% in 2012. Monthly prevalence for men in the same age group also increased between 2008 and 2009. According to the latest measurement, the monthly prevalence for this group was 4.5%.

Prevalence varies to an unreasonable extent among men 16-24 years of age, in for example 2008 and 2009. Statistics for this group are more uncertain than for the other groups. The reason the statistics are uncertain in this group is that the sample size is not suited to study young men's cannabis habits in particular. There are too few men who participate in the national public health survey with regard to the cannabis habits variable. Although the population study is good, there is a limitation with regard to distinguishing several age groups. There are also problems related to low response frequencies. Moreover, it can also be noted that more women participate in the survey than men and the response tendency increases with age.

Comparisons between the national public health surveys and CAN's school surveys are not recommended because the surveys are aimed at entirely different target groups and are structured accordingly. Recurring general surveys among young people (16-24 years of age) are needed to be able to study the entire group more closely, where cannabis use tends to be the highest of all age groups.

Cannabis use in Sweden does not exhibit declining tendencies. The fact that the time series tends to have a higher prevalence at the end is interpreted here as a risk that cannabis use is increasing. Annual and monthly prevalence vary less than lifetime prevalence. Approximately 4% of the men and 2% of the women had used cannabis

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Men 16-34 [2008 (4.4 – 7.1), 2009 (7.9 – 11.7)]

Women 16-34 [2005 (1.4 – 3.5), 2012 (4.3 – 7)]

Men 16-24 [2004 (7.1 – 12.2), 2008 (2.9 – 6.7), 2009 (8.2 – 14.1)]

**Change in monthly prevalence for men (16-24 years of age), CI (95%)**

Men 16-64 [2008 (0.4 – 1), 2009 (1.1 – 1.9)]



in the past year. The survey in 2012 showed that 1.4% of respondents had used cannabis in the last month. Last month prevalence rate for women was under 0.5% and for men just under 1.5%. Illicit drug use is uncommon in the population, it is furthermore difficult to assess consumption patterns given low response rates. Those who use illicit drugs can generally be described as a stigmatized group and may hesitate to participate in surveys (Statens folkhälsoinstitut, 2010e).

### **Other drugs**

The report issued by the Swedish National Institute of Public Health in 2010 (Statens folkhälsoinstitut, 2010e) presents results from a number of studies. The objective of the studies was to estimate how many people in Sweden use illicit drugs and to describe the life situation of these people.

In the largest questionnaire study begun in 2008, the aim was to study the population in Sweden (aged 15-64). Because illicit drug use in the population is uncommon, large samples are required to capture a sufficient number of illicit drug users. To be able to indicate illicit drug use in various population groups, a random selection of 58,000 individuals was therefore assumed to be required. The actual response frequency after collection was 38 %, a total of 22,095 people.

1,000 of those who did not respond to the questionnaire were selected and contacted by phone to participate in an interview with an abbreviated version of the questionnaire. Some of the results from the study are presented below.

The population study indicated that 23% of the men and 12% of the women had used illicit drugs at some time in their lives. In addition, 4% of the men and 8% of the women had used narcotics classified as addictive pharmaceuticals without a doctor's prescription or to a greater extent than prescribed.

Illicit drug use in the past 30 days was counted as regular illicit drug use. The highest proportion of regular illicit drug users in the population study was young men aged 15-24 (2%). Among the women, it was the 25-34 age group that had the highest regular use (1%). Regular illicit drug use then decreased with increasing age. Many of the regular illicit drug users used several drugs at the same time and a large proportion of them were large-scale consumers of alcohol. In the population study, 58% of the regular illicit drug users were also at-risk users of alcohol. Among regular pharmaceuticals users, 72% were at-risk users of alcohol.

Cannabis was the most common narcotic substance that 23% of the men and 11% of the women said they had used at some time in life. Amphetamines (6.8%) were the second most common substance among men, followed by cocaine (3.8%), hallucinogens (3.5%), opioids (2.3%) and ecstasy (2.2%). Nearly 1% of the men said they had used another drug. Among women, amphetamines (3%) were also the second most common drug, closely followed by cocaine (2.5%), hallucinogens

(2.3%) and ecstasy (1.8%). Approximately 2% of the women said they had used another drug. Opioid use (1.3%) occurs more rarely among women.

Of those who used illicit drugs in the past month (approx. 6,000 people in the population), almost 8% said that they had injected a narcotic substance at some time in their lives. Around 10,000 people in the population used narcotics more than one year ago, of which slightly more than 1% said that they had injected a substance at some time in life (Statens folkhälsoinstitut, 2010e).

## 2.3 Drug use in the school and youth population

### **School population**

The Swedish Council for Information on Alcohol and Other Drugs (CAN) annually conducts national studies of the alcohol and drug habits of school children. In 2012, the national school survey was also carried out among students turning 16 and 18, which means that a majority were 15 and 17 years old, respectively, since data was collected in March.

The lifetime prevalence (2012) of any drug for 15- and 16-year-old boys and girls were 9 and 6% respectively, which for boys is the same percentage as the year before and for girls 1% less. The past-30-day prevalence was 2% for boys and 1% for girls. Cannabis was by far the most common drug in the surveys among 15- and 16-year-olds, irrespective of sex.

Lifetime prevalence (2012) of ever having used an illicit drug among the 17- and 18-year-old students was 20% for boys and 14% for girls, which for boys was 1% lower than in 2010, but 2% points higher than in 2009. The past-30-day prevalence was 5% for boys and 3% for girls, respectively. Among those who had used an illicit drug, the most common drug of choice was cannabis, but benzodiazepines, cocaine and amphetamines were also reported.

According to CAN's 2012 school population survey (Centralförbundet för alkohol- och narkotikaupplysning, 2013), very few students used drugs before the age of 14; 2% of the boys and 1% of the girls. The percentage of students who reported drug use before the age of 14 has been stable over the last 20 years.

The percentage of students (15-16 years of age) who had had an opportunity to try drugs (for the first time) increased at the end of the 1990s and the increase continued until 2000 when 27% reported in the survey that they had had the opportunity to try drugs. From then on, the percentage decreased again and in 2012 it was 18%. The percentage of older students (17-18 years of age) who had had an opportunity to try drugs is somewhat larger, approximately 32% (Centralförbundet för alkohol- och narkotikaupplysning, 2013).

The results from the same school population survey show that there is a strong correlation between the experience of drug use and extensive alcohol consumption. Among students aged 15-16, approximately 40% of those who had used drugs were also consuming large quantities of alcohol, compared with students with no reported

drug use where the proportion was 8%. In addition, among students aged 17-18, there was a large difference between students with and without experience of drug use with regards to extensive alcohol consumption, though the difference was not as large as for students aged 15-16 (Centralförbundet för alkohol- och narkotikaupplysning, 2013).

There is also a correlation 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 report 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, 2013)

## 2.4 Drug use among targeted groups / settings at national and local level

In 2008, the Swedish National Institute of Public Health conducted a number of studies on behalf of the coordination body of the time, Mobilization against Narcotics. The report that presents the results from these studies was published in 2010 (Statens folkhälsoinstitut, 2010e). Three questionnaire studies targeted groups that were assumed to be in the risk zone for more extensive illicit drug use than the general population. The studies targeted festival participants, restaurant personnel and students.

### ***Festival participants***

The participants at the two festivals studied described considerably higher levels of drug use than their peers in the general population. Of the men, 61% had used illicit drugs at some time in life, while the corresponding figure among the women was 50%. Regular use was indicated by 26% of the men and 16% of the women. These high figures are probably partially due to the use of a different survey methodology at the festivals, which led to a significantly higher response rate. These results illustrate the need for a qualified study of various study methods (Statens folkhälsoinstitut, 2010e).

### ***Restaurant personnel***

The study directed at restaurant personnel, where most participants were between the ages of 18 and 34, shows that 31% of the men and 18% of the women said that they had used illicit drugs at some time in life. Regular use in the past month was indicated by 3.7% of the men and 1.1% of the women, which are roughly the same levels as in the general population in these age groups (Statens folkhälsoinstitut, 2010e).

### ***Students***

In the student study, the aim was to survey illicit drug use among full-time university students (Statens folkhälsoinstitut, 2010e). Students aged 18-34 were included in the analyses. The results indicated that 35% of the men and 33% of the women had used illicit drugs at some time in their lives. The results from the student survey do not support a more extensive illicit drug use among university students than others in the same age groups in the population. In the population study, no major difference was found between illicit drug use among students and the gainfully employed. In both cases, 19% said that they had used narcotics at some time in their lives. However, it was more common among university students (1.5%) to use illicit drugs more regularly, in the past 30 days, compared with the gainfully employed.

## 3. Prevention

### 3.1 Introduction

In March 2011 a five-year strategy covering the years 2011 to 2015, “A Cohesive Strategy for Alcohol, Narcotic Drugs, Doping and Tobacco Policy” (ANDT strategy) was adopted by the Riksdag (Swedish Parliament) (Ministry of Health and Social Affairs Sweden, 2011). The strategy builds on earlier Swedish drug policies and includes many activities of different public authorities. The Swedish National Institute of Public Health (SNIPH) has the responsibility to implement many of the activities and also to monitor and follow up the work. To read more about the strategy, please see chapter 1.

Apart from national efforts, a lot of preventive work is performed at the regional level. SNIPH allocates 30 million SEK per year to coordination activities at the county administrative boards, including financing of county coordinators. In 2012 there was a coordinator in each of the 21 counties, who had the role of supporting the preventive work with alcohol, narcotics, doping and tobacco (ANDT) at the county level as well as supporting the municipalities in their local prevention work. During 2012, the county coordinators continued the work of implementing the national 2011-2015 ANDT strategy, which they had begun in 2011. The implementation of the national strategy is facilitated by the development of regional strategies for the preventive ANDT work.

According to the *Länsrapport 2012* [Eng. the County Report 2012 regional strategies and action plans were adopted in half of the counties in 2012 (Statens folkhälsoinstitut, In press 2013).

In Sweden, implementing prevention is generally the responsibility of the municipality, where the preventive efforts are often coordinated by local “drug coordinators”. According to the County Report 2012, about three quarters of the 290 municipalities had appointed local drug coordinators for the work on narcotics prevention in 2012. The same person often coordinates prevention efforts against different addictive substances (Statens folkhälsoinstitut, In press 2013).

On a local level, prevention efforts are normally summarized in a municipal policy for alcohol and drugs. In 2012, about 70% of the municipalities had such a political programme. About 55% of the programmes had measurable objectives and half of the programmes had a follow-up plan. In 68% 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 (Statens folkhälsoinstitut, In press 2013).

## Monitoring tools

SNIPH annually collects information from the local and regional drug 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, Guldbrandsson, & Boman, 2012). Indicators of the priority of drug prevention include the adaptation of a drug policy, the appointment of a drug coordinator and the allocation of funds for prevention work. The recent changes in the Alcohol Act and the onset of the ANDT strategy called for extensive revisions to the 2011 and 2012 questionnaire.

The Ministry of Health and Social Affairs is conducting a survey of the indicators that can be included in an overall follow-up of the objectives of the national ANDT strategy. The development of indicators to allow for follow-up of the objectives of the national ANDT strategy relate to both outcomes and process measures. A first report has been published, including suggestions on indicators such as consumption and harm as well as suggestions as to how work should be governed and organized (Regeringen, 2012b).

## 3.2 Environmental prevention

The overall policy objective in the ANDT strategy (Ministry of Health and Social Affairs 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***

With the purpose of assigning goals and a general orientation towards society's efforts within alcohol, narcotic drugs, doping and tobacco (ANDT) prevention for 2011–2015, the Swedish Parliament adopted the Government bill “A Cohesive Strategy for Alcohol, Narcotic Drugs, Doping and Tobacco Policy”, also known as the “ANDT strategy”, in March 2011. The overall policy objective in the ANDT strategy is “a society free from illegal drugs and doping, with reduced alcohol-related medical and social harm, and reduced tobacco use”. With regards to alcohol this is to be achieved by preventing harmful consumption, e.g. by reducing consumption and harmful drinking habits. Apart from the overall policy objective, there are seven long-term objectives for ANDT policy, which in turn can be broken down into a number of priority objectives for the strategy period (2011-2015). In conjunction with the ANDT strategy a system of indicators has been developed with the purpose of monitoring alcohol-related harm, behaviours, consumption, preventive efforts, early detection, treatment for abuse and addiction, as well as rehabilitation.

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 the 1st of

January 2011 the current Alcohol Act (SFS 2010:1622) came into effect. 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). Connecting provisions pertaining to the alcohol act are 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 contrast to the former Alcohol Act the current legislation enables catering companies to acquire permanent serving licences, permit 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 related to alcohol serving. The new alcohol act also gives holders of permanent serving licences to the general public and wholesalers 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.

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 assortment, 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 titled “Responsible Beverage Service” was introduced by an organization called Stockholm Prevents Alcohol and Drug Problems (STAD) in Stockholm County in 2003. After the method had been spread to municipalities outside Stockholm, the Swedish Public Health Institute was given the assignment of

disseminating it to all municipalities in the country in 2004. 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 to primarily 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. (B. Trollidal, Brannstrom, Paschall, & Leifman, 2013).

The Alcohol Act (SFS 2010:1622) prohibits retail sales 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 that are under the age of 20, except for beer containing 3.5 % alcohol by volume or less in which case the age-limit 18 applies. It is permitted to offer a smaller quantity of alcohol to a person under the age of 18, conditional upon the beverage being consumed at the location where it was offered under orderly circumstances, taking into account that this is tenable with regards to the person's age, development and other circumstances. It is however not permitted to offer alcoholic beverages to individuals under the age of 18 in an on-premise establishment. The regulations pertaining to age-limits are well enforced.

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 take place in mainly 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 2012 there were 421 retail shops and 503 delivery points in Sweden. The delivery points do not keep products in stock, but order them upon request by costumers. 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, 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 for a retail shop 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 18 p.m. Monday to Friday and 10 a.m. to 13 p.m. Saturdays (Systembolaget, 2013).



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 has 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, which culminated in 2004. Revised figures indicate that the total consumption of alcohol in Sweden amounted to 9.2 litres of pure alcohol per inhabitant 15 years and above in 2012. This should be compared to 8.0 litres in 1995 (Ramstedt, Lindell, & Raninen, 2013).

Apart from Value Added Tax (VAT) of 25 per cent of the sales price (excluding excise) most alcoholic beverages are also subject to specific excise duty. The current tax-rates have been applied since the 1st January 2008. Excise taxes on alcoholic beverages are currently not adjusted for inflation. Excise on alcoholic beverages is regulated by the Act (SFS 1994:1564) on excise duty on alcohol.

#### Tax classes and excise duty rates relating to alcoholic beverages in Sweden. 1995-2012.<sup>1)</sup>

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

<sup>1)</sup> Source: Swedish Tax Agency

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

<sup>3)</sup> 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.

<sup>4)</sup> Excise duty (SEK) per litre of 100 per cent alcohol.

<sup>5)</sup> Excise duty (SEK) per litre alcoholic beverage.

<sup>6)</sup> This tax class and excise duty rate applies only to wine.

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

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

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. 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).

## ***Tobacco policies***

### *Prevalence*

In 2012, the proportion of daily smokers in Sweden was 12% among women and 10% among men. Similarly, the proportion of daily snus users (moist snuff) was 4 % among women and 19% among men (Statens folkhälsoinstitut, 2012d). There has been a decrease in the number of cigarette smokers in the adult population, (Statens folkhälsoinstitut, 2012d) 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 in the past two years, especially among girls (Henriksson & Leifman, 2011). Even if Sweden is a country with few daily smokers, we still have a high total number of tobacco users due to snus (Statens folkhälsoinstitut, 2012d).

### *Exposure to second hand smoke*

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 smoking is prohibited on 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. Smoke-free school grounds are an exception, where surveillance does not work. Four out of five students reported that students smoked in the school grounds in 2009. An effort to accomplish smoke-free school hours has been introduced to the municipalities (Statens folkhälsoinstitut, 2010g). Exposure to second-hand smoke decreased after 2005 when restaurants and pubs were made smoke-free by law (Statens folkhälsoinstitut, 2012d). Overall, 3 % of the population are exposed to second-hand smoke in Sweden (European Commission, 2013). 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 the protection from exposure to tobacco smoke for the non-smoking employees. A few of the county councils and municipalities also include snus (snuff) in their regulations (Statens folkhälsoinstitut, 2010f; 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 has assigned the Swedish National Institute of Public Health the task of investigating possible areas to make smoke-free in the future through December 2013.

*Tax*

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). In recent years, the Government of Sweden has prioritised tax increases on tobacco products (Socialdepartementet, 2012b). The prices of tobacco products, however, is still low compared with some other EU member states and Norway (European Commission, 2012). Sweden has mainly specific excise duty rates for tobacco products (European Commission, 2013). In 2013 the taxation rate on cigarettes is 1,41 SEK (specific excise duty) plus 1 % (ad valorem) and 20 % VAT, and for snus (moist snuff) 386 SEK (specific excise duty) per kilo and 20 % VAT (Skatteverket, 2013).

*Cessation*

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 “quit smoking” helpline to help dependent smokers stop. Local healthcare centres offer tobacco cessation treatment, although still at a low intensity. Tobacco cessation is severely inadequate since 300,000 people are estimated to want to quit using tobacco in Sweden (Statens folkhälsoinstitut, 2010f).

*Legislation*

Sweden’s Tobacco Act is from 1993 (SFS 1993:581). Sweden ratified 2005 the World Health Organisation’s WHO Framework Convention on Tobacco Control (FCTC) (World Health Organization, 2013).

Sweden has since 1993/1994 (SFS 1993:581) comprehensive regulation of indoor smoke free areas including for example healthcare, education, transport, public places and workplaces. In 2005 (SFS 2004:485) became restaurants smoke free and 2011 prisons (Kriminalvården).

Since 1997 Sweden has since 1997 applied comprehensive regulations (SFS 1996:941/858) regarding the sale of tobacco to minors, i.e. under the age of 18. The regulations for the business operator have since then gradually become more comprehensive (SFS 2005:369), (SFS 2010:682) and today selling tobacco without registering a criminal offence.

Sweden has had regulations on marketing since 1993 (SFS 1993:581) and today has a comprehensive ban on all tobacco advertising, promotion and sponsorship (SFS 2005:369).

Sweden has had regulations regarding health warning since as early as 1975 (SFS 1975:1154). Health warnings are today regulated according to an EU Directive (EC 2001/37/EG) inkl. (SFS 2002:586), which also regulates ingredients in tobacco products ((SFS 2001:312)/(FHIFS 2001:2)/(FHIFS 2002:4). Some labelling and ingredients regulations regarding snus (moist snuff) and chewing tobacco (LIVSFS 2012:6) have also been in force since 2012. An investigation is ongoing concerning the marketing of tobacco and alcohol in digital media in Sweden.

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 themselves (Henriksson & Leifman, 2011).

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, 2011b). However, from an international perspective, Sweden is lagging behind with regard to tobacco prevention measures. Unlike other countries in the EU, Sweden has not adopted certain tobacco policies in recent years, including bans on advertising exposure of tobacco products at sales outlets and the introduction of pictorial warnings on cigarette packs (Joossens & Raw, 2011).

### 3.3 Universal prevention

Drug prevention activities in Sweden have been increasing in many areas for a number of years. The new national strategy on drugs builds on former efforts and combines the limitation of both supply and demand.

In June 2011, SNIPH 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 organizations interested in implementing cannabis preventive measures. Evaluations of the projects indicates that the level of knowledge among those who have participated in education initiatives has increased and the cooperation between central actors, such as school, social services and police, has improved (Statens folkhälsoinstitut, 2013c).

In spring 2012, the Government replaced the commission with a new commission focused on compiling research and evaluations of implemented actions related to drug use, cannabis use in particular. SNIPH will spread the compiled knowledge about effective prevention actions to municipalities, county administrative boards and non-governmental agencies (Statens folkhälsoinstitut, 2013a). The new commission has been allocated SEK 4 million per year and the final report is to be submitted by 31 March 2015. An important research summary on cannabis use among young people was recently completed by Swedish researchers (Forkby T, 2013).

A joint effort to address cannabis problems is currently being implemented, involving the state and the three largest cities in Sweden: Stockholm, Gothenburg and Malmö. The project, "Trestad 2", is part of an annual 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 young people under the age of 25. To achieve this, the cities work on three parallel levels: prevention, early intervention and treatment services.

## **School**

As a result of a Government commission in 2011 to improve ANDT education in Swedish schools, 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 on how issues related to school achievement, school satisfaction and parental cooperation can affect students' use of ANDT (Hakansson & Berglund, 2013).

In recent years new teaching materials for primary- and secondary schools have been developed in order to improve the education about narcotics and other drugs (Statens folkhälsoinstitut, 2010b), (Statens folkhälsoinstitut, 2010a). In January 2013, The Swedish National Agency for Education published a review on school-based education about alcohol, narcotics, tobacco and doping (Skolverket, 2013). The importance of pupils achieving the learning outcomes in school is currently on the political agenda in Sweden and several measures have been taken to support learning as well as school satisfaction and parental cooperation. More than half of the communities had school based drug prevention programmes involving the parents in 2012.

In recent years, the causal link between alcohol, tobacco and illegal drug use, and its importance for prevention, has increasingly been raised (Statens folkhälsoinstitut, 2012a). Research shows that drug use in adolescents usually develops gradually and that smoking or alcohol is usually the first step. 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 2012, more than 60 % of the municipalities undertook measures to promote smoke-free school grounds, which represents an increase compared to 2011. Furthermore, over one third of the local authorities had structured programmes to prevent tobacco debut in primary school (Statens folkhälsoinstitut, 2012c). The existence of action plans for smoking cessation among pupils in primary school and high school has also increased in the last year as well as structured programmes to prevent tobacco debut in high school (Statens folkhälsoinstitut, 2013c).

## **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, 2012c). In 2009, the Government set up a national strategy for developing parental support, the aim of which is to encourage local collaboration on support and assistance to parents in their parenting. The focus is on universal preventive parenting, i.e. all parents are offered the same opportunities for support and help. In the context of the strategy, the SNIPH has distributed almost SEK 200 million in support to over 25 local development projects. In 2012 the government mandated the SNIPH to carry out regional conferences in order to further spread knowledge about parental support programmes (Socialdepartementet, 2012a). Even within the

national ANDT strategy, the SNIPH has assignments regarding parental support. One is about support for at-risk children in families with substance abuse problems, mental illness or mental disability. Another involves support to child and maternal healthcare (Statens folkhälsoinstitut, 2012b).

Community Parent Education (COPE) is one of several prevention methods focused on parents, and the method was applied in about a third of the municipalities in 2012 according to the SNIPH County Report (Statens folkhälsoinstitut, 2013 (Unpublished), In press 2013). The COPE method aims to give parents of children aged 3-12 tools to understand and handle their children's behaviour, strengthen them in their parenthood, improve the interplay in families and create supportive networks. The programme is based on empowerment and aims to inspire parents to find their own solutions to everyday situations. An evaluation of the method showed significant effects on the children's problematic behaviour as well as the parents' ability to handle their child, their experienced level of stress and their feeling of control in parenthood (Hellström & Torell, 2006).

Other methods directed at parents that are used in about a quarter of the municipalities, include Vägledande samspel [International Child Development Programme – ICDP] and Familjeverkstan [Family Workshop]. Parental programmes conducted to a lesser degree (reported by less than 20% of the municipalities) are: FöräldraStegen [ParentLadder], Aktivt föräldraskap [Active Parenting], Nya STEG [New STEPS], De otroliga åren [The incredible years], Steg-för-Steg [Strengthening Families Programme] and Föräldrakraft [Parent Power] (Statens folkhälsoinstitut, 2012c).

## **Community**

As the national body responsible for county coordination, the SNIPH receives yearly reports from the county administrative boards about their work. As mentioned above the coordinators at the county administrative boards have the task of supporting the municipalities in their drug prevention work. In 2012 an increased number of visits to municipalities were conducted by the coordinators in order to discuss the national strategy (ANDT-strategy) for alcohol, narcotic drugs, doping and tobacco policy. The coordinators have also arranged meetings with local drug coordinators, aimed at further education and exchange of experience.

In order to put the drug issue on the agenda at the community level, local media can be an important channel. According to the national ANDT strategy, awareness in the population about ANDT use and its effects on health should increase. In 2012 over 60 % of the municipalities worked with media advocacy to draw attention to alcohol- and drug-related issues, and in about a third of the municipalities' narcotics were highlighted.

Because much of the handling of various substances in Sweden is illegal, especially as regards narcotics and doping, collaboration and coordination between crime prevention and drug prevention authorities are central in the preventive work. This is also clearly highlighted in the national ANDT strategy. Supply reduction is an essential measure for successful drug prevention and results from the SNIPH annual

questionnaires sent to the 290 local authorities indicate that virtually all municipalities cooperate with the police. Many municipalities and local police authorities have also written arrangements for this work, and the number of agreements has increased during 2012. The share of local authorities cooperating with the business sector in the preventive work, such as restaurants and grocery stores has decreased since 2008 and the same is true for cooperation with NGOs (Statens folkhälsoinstitut, 2012c).

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. According to the SNIPH County Report, many municipalities cooperate with sports organizations, the temperance movement and various churches in alcohol and drug prevention work although there has been a decrease in the number of municipalities collaborating with NGOs. Sports organizations are the most common type of non-profit organization that municipalities cooperate with.

Most of the Swedish municipalities conduct activities to establish a drug-free upbringing for children and adolescents and, according to the County Report, more than 80% reported organizing drug-free activities in 2012 (Statens folkhälsoinstitut, 2012c).

In late 2010, a Swedish study on neighbourhood economic context as a determinant of youth drug use or abuse was published. A cohort of 76,693 adolescents ages 13-15 from 586 urban neighbourhoods in Sweden were monitored for 12 years, from age 16 to age 28. Multilevel modelling was used to analyse neighbourhood variations in hospital admissions due to illicit drug use or abuse. The authors found a variation of 8% by neighbourhood economic status and the risk of being admitted to hospital increased 73% in low-income compared to high-income neighbourhoods. According to the authors, the results suggest that the neighbourhood of residence in adolescence plays a significant role in predicting future health-related behaviours and that drug abuse interventions at a neighbourhood level are urgently needed (Sellström, 2011).

### 3.4 Selective prevention in at-risk groups and settings

#### ***At-risk groups***

The Swedish Police Authority is an important participant in the establishment of a drug-free environment and a common partner of municipalities together with the social services. In many districts, the police work according to a method called 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 from the social services) (Statens folkhälsoinstitut, 2009b). Almost every Swedish municipality was cooperating with the police in matters of illicit drugs in 2012, according to the County Report, and nearly 70% of the municipalities conducted measures related to early detection of drug use among

adolescents that are based on cooperation between the police, primary care, social services and parents (Statens folkhälsoinstitut, In press 2013).

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.

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. Hence the DUID – directly after interrogation and the taking of samples – will be referred to an initial contact with the social services or healthcare services for addicts – preferably within 24 hours. In 2010, over half of the municipalities in the country of Örebro apply an extended version of SMADIT, which, among a few other factors, differs from SMADIT by including persons suspected of minor drug offences (Rikspolisstyrelsen, 2011).

In 2011, the SNIPH was commissioned to support maternal- and child health care in prevention work as part of the ANDT strategy’s goal that fewer children should be born with harmful or disabling conditions caused by exposure to alcohol, narcotic drugs, doping substances or tobacco. The work has continued in 2012 and is focused on informing all parents of and, if necessary, providing counselling on the damage that alcohol, drugs, doping and tobacco can cause to foetuses and young children. The work was based on both evidence and experience from past government assignments (Statens folkhälsoinstitut, 2012b).

### ***At-risk families***

In 2009, the Government gave the SNIPH a three-year commission to map the prevention for children and young people in different risk situations. In the national survey carried out in 2010, local authorities in the municipalities were asked to report on various interventions to support children in vulnerable families. About 80% reported interventions for families with addicted parents, about 65% reported interventions for families where violence occurs and about 55% reported interventions for families with parents with mental disorders (Statens folkhälsoinstitut, 2010c).

In 2011 the SNIPH was commissioned by the government to promote the development of knowledge and quality of the support for families where addiction, mental illness and/or violence occur. In order to support regional and local efforts in the area the SNIPH has allocated around 30 million SEK to 40 projects. Reports from different projects highlights, among other things, effects in terms of improved cooperation between central actors and that school is an important arena for reaching the children at risk (Statens folkhälsoinstitut, 2013a).



Different interventions are offered to children living in families where one or both parents are addicted to either alcohol or narcotics. In Swedish municipalities these interventions are carried out in different settings, often in cooperation with NGOs. In nearly 60 % of the municipalities, some group-based activities for these children were offered in 2012 according to the County Report (Statens folkhälsoinstitut, 2012c).

Many municipalities in Sweden offer programmes for children with behavioural problems. One example of a preventive method used is the “Komet för föräldrar” [Comet for parents] for parents with children and adolescents between the ages of 3 and 18. This method specifically targets those who have children that exhibit externalizing behaviour problems and have additional difficulties establishing positive peer relationships. A Swedish randomized controlled trial among children 3-10 years of age showed significant effects of the method on the children’s problematic behaviour as well as the parents’ ability to handle the child (Kling, Sundell, Melin, & Forster, 2006).

Another randomized controlled trial for assessing the effects of the Komet för föräldrar method, is being conducted by STAD (Stockholm Prevents Alcohol and Drug Problems). Komet has been spread nationally by the School Project and about a third of the municipalities report having offered the method to parents in 2012 (Statens folkhälsoinstitut, 2012c). Some of the preventive methods that generally focus on all parents are also possible to implement with parents of children at risk, such as the COPE method mentioned above.

### ***Recreational settings***

Restaurants, bars and clubs are considered important settings for 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. The method has also been evaluated.

A study published in 2007 showed that it has become more difficult for drug-impaired patrons to enter those nightclubs/restaurants that are involved in the project in Stockholm (Gripenberg, Wallin, & Andréasson, 2007). In 2007, the National Drug Policy Coordinator also initiated a national venture in spreading 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 SNIPH. In 2011, the network received SEK 900,000 to e.g. encompass additional municipalities to the network, initiate more cooperation between municipalities that are geographically located in the same region, implement training programmes for police officers, and proceed with educational programmes for member municipalities. A web page containing information about current activities and local studies and evaluations ([www.krogarmotknark.se](http://www.krogarmotknark.se)) has also been set up.

In 2011, a question about whether the municipality is working with the “Clubs against drugs” method or a similar method was included in the SNIPH yearly questionnaire to the municipalities. According to the County Report the method was applied in about 15 % of the municipalities in 2012, which is higher than in 2011 when one tenth of the municipalities worked according to the method (Statens folkhälsoinstitut, 2012c).

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

However, a published study aimed at examining self-reported drug use among staff at licensed premises, the types of drugs used, attitudes towards drugs, and observed drug use among guests showed that the life-time and past-year prevalence of drug use among staff at licensed premises is high compared with the general population in Sweden. The authors point out that the results highlight the fact that staff at licensed premises represent an important target population in club drug prevention programmes (Gripenberg Abdon, Wallin, & Andréasson, 2011a).

In a recently published paper, results regarding long-term effects of “Clubs against Drugs” are presented. The indicator chosen for the study was the frequency of doormen intervention against obviously drug-intoxicated guests at licensed premises. Professional male actors (i.e., pseudo patrons) were trained to act impaired by cocaine/amphetamines while trying to enter licensed premises with doormen. An expert panel standardized the scene of drug-intoxication and each attempt was monitored by two male observers. At the follow-up study in 2008, the doormen intervened in 65.5% of the attempts (n = 55), a significant improvement compared to 27.0% (n = 48) at the first follow-up in 2004 and 7.5% (n = 40) at baseline in 2003 (Gripenberg Abdon, Wallin, & Andréasson, 2011b).

In order to limit violence and harm relating to alcohol consumption in restaurants, bars and nightclubs, a method titled “Ansvarsfull alkoholserving” [Eng. Responsible Beverage Service] was introduced by an organization called STAD in Stockholm County in 2003. After spreading to municipalities outside Stockholm, the SNIPH was assigned to disseminate the method to all municipalities in the country in 2004. 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 tackled. The method has three basic components: education about Responsible Beverage Service for primarily serving staff (but also restaurateurs, security personal 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 crimes by approximately 9%.

The observed positive effect was especially noticeable in smaller municipalities (i.e. municipalities with 20 serving licences or less) (B. Trolldal, Brännström, L., et. al., 2012).

### 3.5 National and local media campaigns

”Testa dina gränser” [Test your limits] is the name of a communication campaign on cannabis which was conducted during the autumn of 2010. It was aimed at 16-18 year-olds with the objective of getting young people to reflect upon their own attitudes toward cannabis, so that they would ultimately decide, on their own accord, to refrain from trying cannabis. The campaign was conducted as a pilot project in ten municipalities in Skåne County in southern Sweden and was a joint effort between Skåne County and municipalities together with the SNIPH and Swedish Council for Information on Alcohol and Other Drugs (CAN). The approximate cost for the campaign is SEK 2 million.

Medical, social, legal and ethical messages were sent out via a test on attitudes and knowledge, and on posters and banners. The increased use of cannabis in the Skåne region concerns many, thus creating much publicity for articles and press releases that were part of the operation. Two student surveys were conducted at six schools – before the campaign start and at the end of the autumn term. The purpose of the surveys was to measure the students’ knowledge and attitudes towards cannabis – and the results were to be used as the basis of press releases (Statens folkhälsoinstitut, 2011a).

## 4. Problem Drug Use

### 4.1 Introduction

The concept of Problem Drug Use (PDU) is relatively new in Sweden (Statens folkhälsoinstitut, 2011c). The Swedish definition of PDU 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 occasions.

Individuals with drug use that could be categorised as problematic are generally a hard-to-reach population, making it difficult to obtain a picture of population size and development (Statens folkhälsoinstitut, 2010e).

Also, drug users who seek treatment for various complications to 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, Andreasson, Agren, & Fugelstad, 2011).

### 4.2 Prevalence and incidence estimates of PDU

#### ***Indirect estimates of problem drug users***

The latest estimate of problematic drug use, based on data from 2007, was published in 2010 (Statens folkhälsoinstitut, 2011c). 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 made 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 abuse	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, 2010e; Swedish National Institute of Public Health, 2012).

### ***Injecting drug users (IDU)***

From an infectious disease perspective, there is a significant difference between a PDU and an IDU 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 IDUs 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 IDUs at about 8,000 for the whole of Sweden in 2011. 57 per cent 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. IDUs 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 IDUs 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 IDUs 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. Hence, there is no information about the incidence rate.

## 5. Drug-related treatment: treatment demand and treatment availability

### 5.1 Introduction

Drug treatment is arranged by the social services in the local community (at specialized units such as outpatient clinics), hospitals (detoxification or treatment for certain complications from drug abuse such as infectious diseases, e.g. hepatitis, HIV/aids, psychiatric symptoms, etc.) or therapeutic communities. In severe cases, drug users might be committed to an institution for compulsory treatment. Such treatment is provided by the National Board of Institutional Care and is regulated in the Care of Substance Abusers (Special Provisions) Act (SFS 1988:870).

Another treatment environment is the prison and probation system. As roughly half of all prisoners have drug problems, treatment for drug abuse is now offered during prison terms. Persons in detention often have symptoms of acute abstinence, so all custody units have access to a physician to help with a detoxification procedure. After-care following a period in hospital, a therapeutic community or prison is arranged by the social services.

### 5.2 General description, availability & quality assurance

#### ***Guidelines for treatment***

The National Board of Health and Welfare (NBHW) have published evidence-based national guidelines for the treatment of persons with substance abuse and dependence problems (also see Substitution treatment below). The section on narcotics deals with topics such as abstinence treatment, specific treatments for the use of cannabis, hallucinogens, stimulants, benzodiazepines and opioids, as well as social support issues and ethical aspects of treatment. Other sections present evidence-based methods for:

- prevention, detection and early/brief intervention
- assessment and documentation
- pregnancy and substance misuse
- psychiatric co-morbidity (Socialstyrelsen, 2007).

These guidelines are under review for an update which is planned to be concluded in the spring of 2014. These guidelines will be a support for decision makers about how resources should be allocated in the substance abuse and addiction field. Since 2007, new therapies have been introduced and new methods of detection and prevention has been implemented. There is therefore a need for a revision of the current guidelines in order to provide better guidelines for the health care and social services in the use of these methods.

The revised guidelines will address the following areas:

- assessment instruments
- medical tests
- pharmacological and psychosocial treatment
- adolescents / Young Adults
- comorbidity

As the guidelines from 2007 did not include indicators, the work on the revised guidelines will focus on developing relevant indicators of substance abuse and addiction treatment (Socialstyrelsen, 2011d).

Several regional conferences have been held to provide information about the 2007 guidelines, and a special guide has been published as a tool for the local implementation. The guide stresses the need for close cooperation between health-care services and social services in drug treatment.

The Swedish Association of Local Authorities and Regions (SALAR) has been responsible for the actual implementation of the guidelines and has been conducting this in a project since 2008. The work has two objectives:

1. To develop qualified support for municipalities and county councils / regions by providing training and information for practitioners, managers and policy makers about the methods and procedures that have the best effect and to support local governments in the change process.
2. To develop an organisational structure for the exchange of experiences and cooperation between municipalities, counties, local research and development units, colleges and universities.

A guide to treatment has been published for the drug users. It is a booklet called “Your rights and options in treatment and care of drug addicts” and is aimed at informing substance users about how to get access to help. The booklet was produced by Riksförbundet för hjälp åt narkotika- och läkemedelsberoende (RFHL) [eng. National Association for Aid to Drug Abusers], a client-oriented NGO, and the Swedish Association of Local Authorities and Regions and was published in 2008. It addresses drug users directly and is published in five different languages, including English.

## ***Responsibilities***

The following information on society’s responsibilities regarding treatment for drug abuse can be found in from the booklet mentioned above.

Municipalities are responsible for overall long-term rehabilitation through the social services. This is set out in the Social Services Act (SFS 2001:453), which is an outline law. This means that it must be interpreted and it provides scope for individual judgments. It is therefore not an absolute law governing rights – but as a person you can appeal social services decisions in court.

The healthcare services are responsible for the treatment of withdrawal symptoms (detoxification) and psychiatric comorbidity. They also provide maintenance therapy with methadone or Buprenorphine. Healthcare services operate according to the Health and Medical Services Act (SFS 1982:763), and the regulations of the NBHW. This means, for instance, that if you do not receive the care you want in time, you cannot appeal in court. However, healthcare services still have far-reaching obligations to admit you and once you are a patient, you have many rights. They may not refuse you admission in an emergency. Both the Social Services Act and the Health and Medical Services Act emphasize that it is important that care is given on a voluntary basis - as far as possible.

The Swedish Prison and Probation Service are also responsible for the treatment and care of drug addicts, for example in drug free sections. Even if you are serving a sentence, you are covered by the principles and rights described in the booklet (RFHL & Svenonius, 2008).

### ***Data collection for the Treatment Demand Indicator***

Data collection for the Treatment Demand Indicator (TDI) is done by pooling data from a few separate information systems which all function on a voluntary basis. There is no legal obligation for treatment units to deliver TDI data. The National Board of Health and Welfare, which was responsible for collecting TDI data until 2010, had an explicit goal to make TDI the core element of all of these various systems.

One data-source for TDI data collection is KIM (Klienter i Missbruksbehandling; [Eng. Clients in Substance Misuse Treatment]), which is directly tailored from the TDI guidelines with the exception of including alcohol as a drug. KIM collects epidemiological information from as many treatment units as possible that do not already belong to another information system. All known units (about 600) were asked to participate. KIM covers about 25% of existing units of inpatient and outpatient centre type from all regions of the country.

Another source for TDI data collection is DOK, which is a system for quality development: assessment and follow-up of clients and the services provided. As this system was integrated with KIM, it contains all of the TDI-variables. About 130 units of inpatient and outpatient centre type, mostly in the southern part of the country, have joined this system, which is administered by Linnaeus University in Växjö.

DOK is also used within the National Board of Institutional Care, at the 11 homes providing compulsory care for adult substance abusers. Clients at these homes have generally abused a multitude of substances, often concurrently and simultaneously, for a long period of time – including alcohol, drugs (both illicit and prescription drugs) and combinations of these. On admission clients are interviewed with the DOK-questionnaire and the answers form the basis for planning each individual's treatment. The TDI variables are included in the questionnaire and the National Board of Institutional Care thereby contributes annually to the national pooling of TDI data (Emma Stradalovs, 2013).



A special adaption of DOK called UngDOK is now used by the leading outpatient units for young people with drug problems in the three largest cities in Sweden (Stockholm, Gothenburg and Malmö) which contributed TDI data for the first time in 2010.

A third source is a newly established “quality register”, called SBR (“Swedish Dependency Register”), specifically for substance-dependence treatment units – both inpatient and outpatient – in the healthcare sector. This system is also integrated with KIM/TDI. A few inpatient units began to register patient data in this system in 2009 and coverage is gradually increasing.

Lastly, some data is obtained from units that conduct ASI (Addiction Severity Index)-interviews with their clients, mainly prison units. Today ASI is not fully integrated with KIM/TDI.

All the different sources of data make it impossible to check data quality as to whether a person is counted several times or not. Even if there are means for identification, Swedish law makes it complicated to compare data from different sources on an individual level.

### **5.2.1 Strategy/policy**

In the autumn of 2008, a comprehensive government investigation of substance misuse treatment was started and published its final report in 2011(SOU 2011:35). The objective was to prepare an overview of the whole of the Swedish treatment system – all services that are provided by the municipalities, the counties or the state, and includes both its content, availability, responsibilities, and organization – and to suggest improvements (and possibly also re-organization of the treatment system), with the final goal establishing a knowledge-based system for the treatment of persons with substance misuse and dependence, based on the needs of these individuals.

In the Government’s final proposal local municipalities are required to cooperate with counties regarding people who have a problematic use of alcohol, narcotics or doping. It is mentioned in the Government proposal that "if possible," organizations representing the user and their families should be given the opportunity to comment on these agreements.

The government says it will support the implementation of this new duty of cooperation, which came into force July 1<sup>st</sup> 2013 (Regeringens proposition 2012/13:77).

#### **TDI as a base for national quality registers**

The Swedish Dependency Registry is a quality of a specialized addiction services in the country with the purpose of allowing comparisons of outcomes between care units. Another reason is to facilitate comparisons across care units over time and to provide data for certain treatment research and epidemiological research.

It is also seen as desirable to link this to the present day KIM-documentation that collects data from units in the social field. By doing this the two quality-registers will be totally compatible to facilitate epidemiological data from all treatment centres outside prisons.

There is still no “law” in Sweden that makes the use of /TDI/SBR/KIM compulsory but there is a proposal linking this documentation to obtaining authorization to treat people with drug problems.

In the final report (SOU 2011:35), one proposal was to increase the coverage of national quality registers related to drug dependence, i.e. the Swedish Dependency Register (Svenskt Beroenderegister –SBR) and Medication Assisted Rehabilitation of Opioid Dependence (Läkemedelsassisterad rehabilitering av opiatberoende – LAROS) through various incentives. However, in the Government proposal (Regeringens proposition 2012/13:77) only the LAROS is specified.

### ***Characteristics of treated clients and trends in number of clients in treatment***

Data on treatment for problematic (or heavy) drug use at a national level is reported in TDI until 2010. In 2009 the reporting system covered 51% of all inpatient and 31% of all outpatient treatment centres. In 2010 the distribution should be similar even if the exact figures are not known.

One third (1,597 patients) out of the total of 5,155 clients who were reported had entered treatment for the first time. The main drugs of choice by new clients are cannabis and amphetamine, closely followed by the summary category “other opioids”.

Most Injecting drug users (IDUs) in the population of new clients use amphetamine. For all clients undergoing treatment, the use of amphetamine is most prevalent, followed by heroin. The prevalence of amphetamine IDUs is higher than the prevalence of heroin IDUs.

#### **By substance used**

The distribution of drugs changed somewhat in 2008, with cannabis becoming more frequent than heroin. This trend has continued in data for the clients reported from treatment units in 2009: cannabis is now much more frequent than heroin.

Amphetamine is still the most commonly used drug (29%) among the reported drug clients in treatment outside prisons, followed by cannabis (23%), heroin (17%), other opioids – analgesics and buprenorphine (11%) and benzodiazepines (11%).

Cocaine use is still rare as a drug being the reason for seeking treatment (1%), and crack cocaine is almost non-existent in this population, as are methadone, ecstasy and hallucinogens.

#### **By centre types**

Inpatient treatment centres reported 2,606 cases and outpatient units 2,549 cases in 2010. The pattern of distribution of primary drugs differs markedly between the various treatment centre types. The most common primary drug in inpatient treatment centres is amphetamine (36%) and in outpatient treatment centres cannabis (41%).

## 6. Health correlates and consequences

### 6.1 Introduction

Surveillance of communicable diseases in Sweden is carried out by the Swedish Institute for Communicable Disease Control (SMI) 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) and the Communicable Diseases Prevention and Control Ordinance (2004:255). Physicians are obliged to report cases (diagnoses) of the listed pathogens and notification is made in parallel to SMI and the County Medical Officers by both clinicians and laboratories. The surveillance data is collected and analysed with the help of a computerized reporting system, SmiNet. After further data processing and analysis, the surveillance data is fed back to stakeholders via SMI's website and annual reports.

Behavioural surveillance data is collected through KAB (Knowledge, Attitude and Behaviour) surveys. To monitor trends in risk behaviours in Injection Drug Users (IDU), 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 IDUs held on remand, as well as providing risk reduction counselling. In addition, the nurses conduct behaviourally oriented interviews targeting the IDUs' knowledge, attitudes and practices. As 80% of all IDUs are estimated to pass through remand prisons over a three-year period, this setting has been chosen for regular data collection regarding IDUs and risk behaviours. Preliminary data shows that approximately 2,500 IDUs 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 IDUs in Sweden. However, the programme will be promoted with the aim of involving more remand prisons in order to obtain more representative data.

Since the late 1980s, needle-syringe programmes have only been run in one county in Sweden (Skåne). In May 2012, another county, Kalmar, started a needle-syringe programme. A programme has been operating in Stockholm since April 2013.

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).

	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 is administered by the National Board of Health and Welfare: 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

### ***HIV/AIDS and viral hepatitis***

#### ***HIV***

Sexually transmitted infections, such as HIV, are not reported by full identity to the authorities in Sweden. This limits the possibility of following individuals over time and duplicates of notifications concerning the same individual may occur in the surveillance data.

Fewer cases of HIV were reported among injecting drug users (IDU) in 2010-2011 compared to 2008-2009, with 22 cases in 2012. By the end of 2012, IDUs accounted for 5% of all people living with a known HIV infection in Sweden, equivalent to about 400 IDUs (or former IDUs). In May 2012, an outbreak of HIV was detected among IDUs in Kalmar comprising 5 cases. The new needle-syringe exchange programme in Kalmar can hopefully prevent new cases.

Data from non-representative studies based on IDUs tested in remand prisons in Gothenburg and Stockholm in 2009 and 2010 shows an HIV prevalence of 5-9%. The needle-syringe exchange programmes in Skåne appear to have had a positive impact on preventing new HIV cases in the region. No new HIV cases were found among the participants in 2010-2011.

## **Hepatitis B and Hepatitis C**

Like HIV, hepatitis B and C are both notifiable diseases in Sweden. Hepatitis, however, is reported using a personal identification number, which reduces the problem of possible duplicate reports.

### ***Hepatitis B***

Between 100 and 200 cases of acute hepatitis B are reported in Sweden annually. However, fewer cases of acute hepatitis B (82) were reported in 2012 due to fewer cases being reported among injecting drug users. Of all acute hepatitis B cases, 18 were among IDUs (compared with 51 cases in 2010), 17 of whom were infected in Sweden. The median age of IDUs diagnosed with acute hepatitis B in 2012 was 36 (range 19-52) (Smittskyddsinstitutet, 2013).

The number of acute hepatitis B cases among IDUs varies depending on local outbreaks and immunity in the group following vaccination or previous infection. Other relevant factors are frequency in testing, injection behaviour and access to sterile equipment.

### ***Hepatitis C***

In Sweden, the prevalence of hepatitis C among injecting drug users is very high. In various studies conducted during the last 15 years, the prevalence has been reported to be between 60% and 92%.

Altogether, 1981 cases of hepatitis C were reported in 2011. Intravenous drug use is the dominant transmission route and most cases are domestic. Viewed in a longer perspective, the total number of reported cases is decreasing. However, when viewed by age group, no falling trend can be seen in 15-29 year-olds over the last 10 years. In 2012, 693 cases were reported in this age group and 48 cases were reported among those under the age of 20. This indicates that there is on-going recruitment to injecting drug use among young people and an on-going transmission of the disease among young intravenous drug users in Sweden. Hepatitis C among IDUs remains a challenge and future intervention efforts are prioritized. The trend analysis is aggravated by the fact that it is not possible to differentiate between acute cases and chronic cases of hepatitis C in the surveillance data (Smittskyddsinstitutet, 2013).

### **Risk behaviours**

Available non-representative data on risk behaviours in the IDU population indicate high risk behaviour in this group with not more than 65% reporting that they used sterile injecting equipment the last time they injected, and only 8% reporting that they used a condom during their last sexual intercourse.

## 6.3 Other drug-related health correlates and consequences

### Somatic and psychiatric co-morbidity

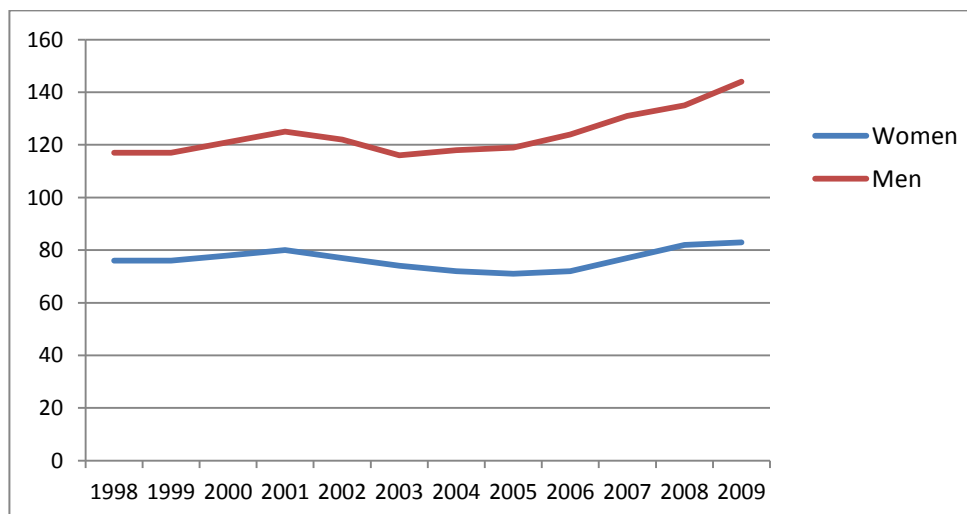
The use of drugs is often closely related to more or less severe health problems. Psychiatric disorders and various infectious diseases are quite common among drug users. It has long been known that morbidity and mortality among drug users is many times higher than in the same age groups in the general population. The reasons for the increased risks can be divided into three categories:

- Damage related to the pharmacological effects of the drugs used
- Damage related to the way the drug is used (injection, sniffing, etc.)
- The conditions under which the drug users live

### Somatic co-morbidity

Statistics from the National Board of Health and Welfare show that 38% of those treated in healthcare for a drug-related diagnosis are women, even though their proportion of the population of heavy drug users is around 27%. The figures for 2009 (no figures are available for 2010) also show a slight increase compared in consumption of somatic care for drug users in recent years as shown in figure 6.4. The figures for 2009 are approximately 144 per 100,000 men and around 83 per 100,000 women.

Figure 6.1: Men and women treated in healthcare for drug related diagnoses<sup>5</sup> 1998 - 2009. Number per 100,000 inhabitants, by gender.



<sup>5</sup> The number of men and women treated for a drug-related diagnosis based on an index consisting of a number of diagnoses according to ICD-10 coding - F11-F16, F18-F19, O35.5, P04.4, T40, T43.6, Z50.3, Z71.5. Statistics provided by the National Board of Health and Welfare. Data is age-standardised. For more details on ICD-10 coding see <http://apps.who.int/classifications/apps/icd/icd10online/>

**Psychiatric co-morbidity**

The results from the yearly public health survey show an association between the use of cannabis and psychiatric health, with a large number of those using cannabis reporting such problems as anxiety, unease, etc. A larger proportion of the users also reported the use of antidepressant medication as well as suicide attempts. The association is probably bi-directional (Statens folkhälsoinstitut, 2009a, 2009b).

Additional information from studies on psychiatric co-morbidity has been detailed in previous national reports. In summary, the various studies indicate that the use of drugs is more common among socially vulnerable individuals and that those who use drugs are in worse health than those who have never used drugs (Hensing, 2008).

## 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, Leifman, & Romelsjö, 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 ( $n = 91,990$  in 2012), whether the deceased was a Swedish citizen or not and whether the death occurred in Sweden or abroad. However, a death certificate was missing in about 1.3% of the deaths in 2012, which is a decrease compared to 2011 (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 shall be regarded as the underlying cause of death.

In 2012, changes have been made in the national CDR; until 2011, deaths coded to 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. 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)***

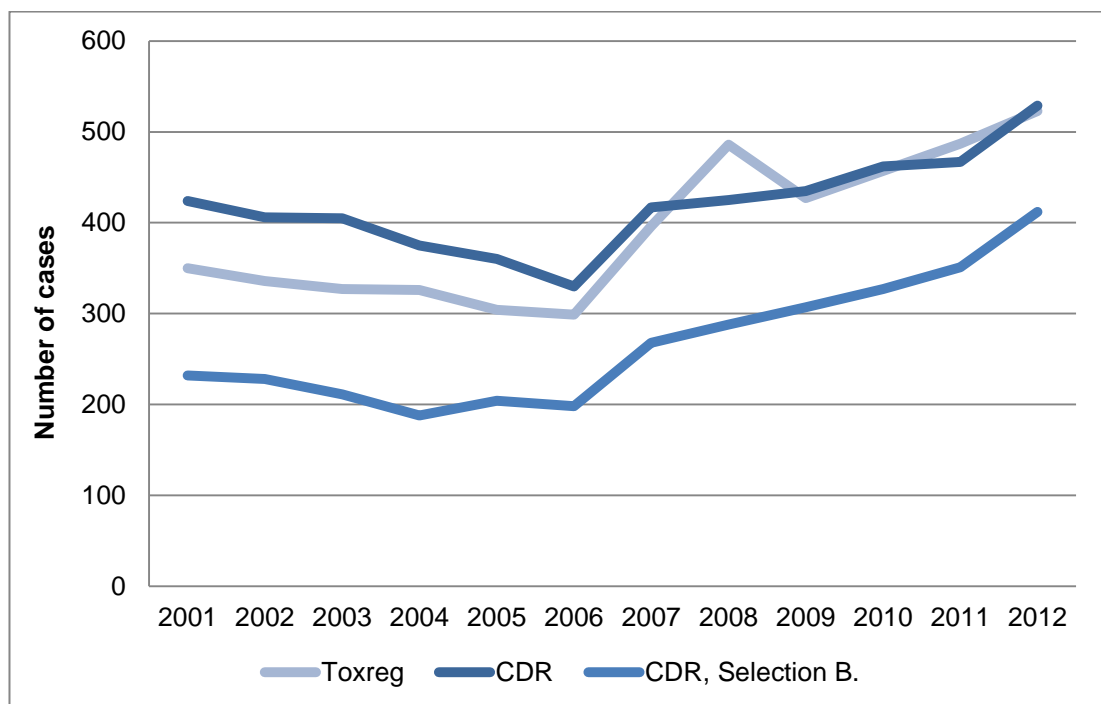
In addition to the CDR, there is a research register called Toxreg, comprising all deaths where illicit drugs are found at forensic toxicological examination.

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 has been separated from the “other drugs” group. . 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 include cases only between 11 and 60 years of age.

Figure 6.2: 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, two Swedish articles were found to be drug-related mortality cohort studies of ex-prisoners interviewed with the Addiction Severity Index (ASI). In one study, the standardised mortality ratio (SMR) was calculated to be about 7 (Hakansson & Berglund, 2013) and in the other to about 4 (Ericsson, Bradvik, & Hakansson, 2013). A majority of the subjects died accidentally or from drug-related causes.

For previously reported mortality cohort studies, please see the National reports 2010-2012.

### **Specific causes of mortality indirectly related to drug use**

As noted above, the Swedish Cause of Death Register (CDR) includes 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 6.2). The same trend is evident also when comparing Toxreg and the CDR.

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.

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 according to toxicological analysis from the SMR (6-AM = 6-acetylmorphine; THC = Tetrahydrocannabinol) (Statens folkhälsoinstitut, 2013b).

Year	Morphine (6-AM)	Methadone	Buprenorphine	Fentanyl	Amphetamine	Cocaine	Other	THC	Total
1994	100 (39)	9	0	3	60	0	0	22	194
1995	110 (37)	12	0	5	45	2	0	17	191
1996	118 (40)	11	0	0	76	1	4	22	232
1997	137 (62)	14	0	2	67	1	5	25	251
1998	142 (55)	9	0	1	72	2	0	38	264
1999	149 (55)	11	0	0	95	5	5	28	293
2000	193 (67)	9	0	2	76	10	12	39	341
2001	198 (69)	17	0	0	78	1	13	43	350
2002	147 (48)	28	1	0	107	6	9	37	335
2003	134 (51)	29	2	7	98	18	7	32	327
2004	128 (42)	26	7	5	96	10	6	47	325
2005	138 (60)	25	16	4	72	9	9	28	301
2006	110 (33)	22	15	5	97	6	3	41	299
2007	142 (65)	48	22	12	107	9	11	44	395
2008	144 (46)	74	52	11	105	13	16	63	478
2009	135 (52)	76	37	15	80	7	7	63	420
2010	120 (34)	94	59	17	90	10	5	56	451
2011	143 (39)	86	66	32	76	5	10	60	478
2012	154 (41)	120	70	44	65	10	4	56	523

From table 6.2 it is evident that cases with methadone and buprenorphine present in their blood at time of death have 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. From table 6.2 it is also evident 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 and consequences is to prevent drug use. The National Board of Health and Welfare (NBHW) in Sweden provide guidelines to treatment providers on how to prioritize between different methods for heavy drug use.

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

#### Medication assisted treatment

A vast number of controlled studies show that medication assisted treatment for opioid dependence (e.g. with methadone and buprenorphine) are efficacious in order to 1) prevent drug related deaths<sup>6</sup>; 2) reduce drug consumption; 3) increase quality of life for injecting drug users (Connock M, 2007). According to National Board of Health and Welfare (Socialstyrelsen, 2012), medication assisted treatment is available at 114 treatment units in Sweden. It is also estimated that the availability of such treatment is satisfactory in about half of the 21 counties.

In 2011, approximately 5200 individuals was estimated to have been participating in opioid maintenance treatment (Socialstyrelsen, 2012), and the total number of individuals with opiate dependence diagnosis was estimated to about 7200<sup>7</sup>, which gives an estimated coverage of about 73%.

There is no precise estimation 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 over the last 10 years due to the expansion of maintenance treatment programmes.

Some Swedish maintenance treatment programmes have "zero tolerance" against lateral use, which means that a patient can be discharged from treatment after a single positive urine test (Heilig & Gunne, 2008). 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 for involuntary discharged participants in a maintenance treatment programme in Malmö were studied by qualitative methodology. A deteriorating physical and mental health status were described by the participants generally. The serious

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<sup>6</sup> According to the latest available toxicological data (please see chapter 6) on drug related deaths, methadone and buprenorphine is implicated in a higher number of deaths compared to heroin/morphine. However, this data does not provide information on whether or not these deaths were related to medication assisted treatment.

<sup>7</sup> It is noted that the method used to estimate the number of individuals with opioid dependence might not include all in need of treatment.

medical risks of discharge were confirmed in a study by Fugelstad (2007) in which mortality in a group of patients expelled from a programme was 20 times higher than in treated patients.

Recent 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).

### **Mobile telephone for follow-up of injecting heroin users**

In a recent Swedish methodology study, the effectiveness of mobile telephone contact for prospective follow-up interviews with injecting heroin users was investigated. Prospective follow-up of heroin users is known to be difficult due to their unstable lifestyle and high follow-up rates have usually demanded major tracking efforts. In Sweden, mobile telephones are commonly used by heavy drug users for drug trading (Hakansson, Isendahl, Wallin, & Berglund, 2011).

Seventy-eight heroin users with mobile telephone numbers were included in the study. Subjects reported using heroin for 28 of the previous 30 days, and only 8% reported they had recently been engaged in work or studies. Clients were contacted between 15 and 21 times over 2 years, with each contact attempt generally involving two telephone calls on consecutive days. During follow-up, 68% of subjects had been successfully contacted for at least one follow-up interview and 25% of follow-up attempts were successful. In 23% of the sample (n = 18), at least 50% of follow-up attempts were successful, and these subjects tended to be older and more likely to be female, whereas follow-up rates were unrelated to baseline heroin use. The authors conclude that despite limited effort, and despite the severe situation of intravenous heroin users, mobile telephone contact can be used with heavy drug users in the present setting (Hakansson et al., 2011).

## **Psychiatric comorbidity**

The Commission report "Better response to abuse and dependence" (SOU 2011:35) concluded that:

- individuals with a more severe psychiatric condition show an increased vulnerability to drug dependence/misuse
- individuals with a condition of drug dependence/misuse show an increased vulnerability to a psychiatric condition
- individuals with a co-morbid diagnosis of drug dependence and a psychiatric condition show increased vulnerability to somatic conditions; prolonged time to

recovery; greater risk of homelessness; increased costs for rehabilitation; decreased quality of life, etc. compared to individuals showing no co-morbid diagnosis.

Both the commission report and NBHW concluded that treatment strategies for comorbid patients should show better results with integrated treatment regimens, where personnel with different professions (e.g. health care, psychiatric care, drug dependence, justice system, social care) are co-located (or otherwise integrated by e.g. case managers) in order to more efficiently integrate interventions for patients with co-morbid diagnoses. There are no official figures on the availability of such programs, but vast regional differences exist in this area, mainly because that dependency care in Sweden are organized with a dual responsibility between county councils and communities, resulting in a large differentiation in the organization of treatment for dependency disorders.

### 7.3 Prevention and treatment of drug-related infectious diseases

#### Needle/syringe exchange programmes (NSP)

In Sweden, a county council wishing to open a Needle Exchange Programme (NSP) must seek authorization from the National Board of Health and Welfare. One condition is that the programme be carried out in cooperation with a municipality. A well-functioning drug treatment unit must be present as a partner and the NSP should be run in close cooperation with either the county council's department for infectious diseases or the drug dependence department.

Today (October 2013), there are five operational needle/syringe exchange programmes in Sweden (Malmö, Lund, Helsingborg, Kalmar and Stockholm).

As is often the case in other countries, NSPs in Sweden were started mainly with the intention of reducing the spread of HIV, but also of HBV and HCV. Another important aspect of syringe exchange in Sweden has been to reach IDUs without contact with health care or social services and connecting them with regular drug services. The NSPs in Sweden have gradually developed to also include efforts to reduce risky sexual behaviour and somatic, psychological and social interventions (SOU 2011:6).

Alanko-Blomé and colleagues (Alanko-Blomé et al., 2011) have made a follow-up covering the 1997-2005 period of 831 IDUs in the NSP in Malmö. In view of the low HIV prevalence among IDUs in Malmö the study focuses on the incidence of surrogate markers of HIV - particularly hepatitis C, because the risk of HBV infection is affected by the introduction of hepatitis B vaccination. HIV incidence remained very low. However, the corresponding incidence rates for HCV were 38.3/100 person-years at risk and for HBV 3.4/100 person-years at risk. RNA (ribonucleic acid) testing showed that 12% were infected with hepatitis C virus already when entering the NSP, but antibodies had not yet developed. If one corrects for those already infected, the HCV incidence rate decreases to approximately 30 per 100 person-years at risk, which is still a high level of blood contamination. When the study period was divided into three periods, there was no trend of improvement

in recent years. Risk factors for anti-HCV seroconversion were injection of both amphetamine and heroin and imprisonment. The strong improvement for hepatitis B may be entirely attributed to the introduction of hepatitis B vaccination<sup>8</sup> (SOU 2011:6).

The aim of a Swedish study from 2011 was to analyse the burden of HCV-associated inpatient care in Sweden, to demonstrate the changes over time and to compare the findings with a non-infected population. The authors conclude that drug-related care was common in the HCV-infected cohort, the demand for liver-related care was very high, and serious liver complications increased notably in the 2000s, indicating that the burden of inpatient care from serious liver disease in HCV-infected individuals in Sweden is an increasing problem (Duberg et al., 2011).

#### Low-threshold primary health care programmes

Low-threshold health care centres (LTHC) offer health services (e.g. needle exchange, medical services) without attempting to control intake of drugs, and provide counselling only if requested. LTHCs may be contrasted with regular treatment programmes ("high-threshold" programmes), in which the user is required to accept a certain level of control. In Sweden, drug-treatment programmes as well as harm reduction interventions (NSPs, maintenance-treatment) are required to apply a high degree of control over participants (e.g. identification, age above 20 etc.). No LTHCs are provided within the regular health care in Sweden. Only a few non-governmental organisations (user organisations) provide basic health care, e.g. prevention measures for infectious diseases, without requiring identification.

#### Safe injecting practices

Safe injecting practices aim at teaching injecting drug users to inject in a safe way (e.g. not sharing needles or syringes). Such practices are included in NSPs in Sweden. However, since the NSPs in Sweden are unevenly spread, a majority of injecting drug users in Sweden still lack the opportunity to reduce major health risks associated with using unsterile or contaminated injecting equipment. County councils in Sweden have developed strategies for reducing risk-behaviours by other efforts, including teaching-programmes for safe injection and motivational interviewing (Norden et al., 2009).

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<sup>8</sup> Over 20% of the visitors to the syringe exchange programme in Malmo have received full protection against hepatitis B, generally at least three consecutive vaccinations (Stenström, 2008).

## 8. Social correlates and social reintegration

### 8.1 Introduction

In recent years the Swedish Governments overarching political aim has been to reduce exclusion through integration to the labour market (Government Offices of Sweden, 2008). The primary 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 gaps 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 (Government Offices of Sweden, 2008).

The following objectives for continued work concerning the national action plan against poverty and social exclusion are based on analyses of the trend in the areas prioritized in the previous action plan and follow-ups of the initiatives that have been implemented. The Government thus considers that the most important objectives in 2008–2010 to combat poverty and social exclusion are to:

- increase the possibility of social inclusion for the elderly
- reduce exclusion among young people
- reduce absence from work due to ill-health
- continue to strengthen groups in particularly vulnerable situations (Government Offices of Sweden, 2008).

### The Social situation in Sweden

The government sees the issue of social exclusion as a priority. However, national data on social exclusion is not collected and processed in a standardized way for official statistics. Information can be gathered from research projects and special investigations, often for a limited cohort. Nevertheless, data from Social Services' care for adults with substance abuse problems is collected on a regular basis by the National Board of Health and Welfare but local drug services are divided between many actors and the collection of statistics differs between various authorities. Furthermore, statistics are kept by multiple authorities, are divided and lack overall coordination. No national guidelines have yet been worked out for monitoring and evaluation of local and regional efforts in the scope of the implementation of the action plan.



## 8.2 Social exclusion and drug use

Problem drug use and various forms of homelessness, criminality, unemployment, health problems etc. are all closely related to social exclusion well known to society. Research has shown that a substantial proportion of homeless people are problem drug users. Research has also shown that drug use is a risk factor for homelessness and homelessness is a risk factor for drug use (Palepu, Marshall, Lai, Wood, & Kerr, 2010).

A national mapping of homelessness<sup>9</sup> in Sweden, which was conducted in April 2011 shows 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 persons were judged to be in acute homelessness, where several individuals slept outside or in public places. About 16% received institutional care or lived in different forms of category housing. About 40% lived in long-term housing solutions and another 20% lived in short-term housing solutions organized by themselves (Socialstyrelsen, 2011a).

The National Board of Health and Welfare has 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, of these subjects 21 % were women and 79 % men. Most common was alcohol abuse 1, 65 %, with psychostimulants such as the amphetamines, cocaine being the second most used group of substances. About one third used mainly cannabinoids. Approximately one fifth also used opioids. Mental ill-health among substance abusers is also common, about half of those with mental ill-health issues also abuse various forms of substances. The biggest proportion of homeless people with substance abuse can geographically be found in the Gothenburg region (Socialstyrelsen, 2011a).

### **Preventive interventions at the national/international level**

Sweden is involved in different actions at European level aiming at preventing social exclusion. The “Active inclusion” strategy is an integrated approach designed to tackle poverty and social exclusion in five European cities and Stockholm is one of the cities. A special project The EUROCITIES Network of Local Authority Observatories on Active Inclusion (NLAO) observes and analyses how this strategy is implemented at local level, in particular regarding access to social services and social and supported housing for people at risk of social exclusion. The municipalities are key actors for the delivery of social services such as housing or social assistance services to especially vulnerable groups.

Sweden also participates as a partner in the Mutual Progress on Homelessness through Advancing and Strengthening Information Systems (MPHASIS), which is an EU collaboration between approximately 20 countries, aiming to find methods to monitor the development of homelessness in Europe and to compare it among the different countries. Further aims with the development of a monitoring system is to collect the information needed to improve the provision of interventions and develop strategies for: preventing homelessness, lowering the number of homeless people,

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<sup>9</sup> According to the definition formulated by the National Board of Health and Welfare in 2011.

taking action against the causes behind homelessness, lowering the harmful effects for homeless people and their families and making sure former homeless people can maintain stable housing.

In February 2007, the Government presented for the first time a national strategy for counteracting homelessness and exclusion from the housing market (Homelessness – multiple faces, multiple responsibilities) (Government Offices of Sweden, 2007). The strategy comprises the period 2007–2009. Four objectives have been pointed out:

- 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 have supported accommodation and who do not have any housing before being discharged or released.
- Entry into the ordinary housing market shall be facilitated for women and 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.

The Government's 2007-2009 strategy, Homelessness- Multiple faces, multiple responsibilities', mentioned above helped increase knowledge about homelessness and exclusion from the housing market. Efforts are now being focused on integrating this knowledge at local and regional levels. The Government has therefore tasked a special homelessness coordinator, Michael Anefur for the period 2012-2013 with supporting municipalities in their efforts to create long-term and sustainable structures and efficient routines in combating homelessness (Government Offices of Sweden, 2012b).

The National Board of Health and Welfare has been commissioned by the government to work together with the National Board of Housing, Building and Planning, the Swedish Enforcement Authority and the Swedish Prison and Probation Service to co-ordinate the implementation of the strategy. In order to assess the effects of measures taken a plan for a monitoring system on a continuous basis has been presented (National Board of Health and Welfare, 2009). The main activity within each objective has been to support local development in relation to work methods and organization. SEK 46 million (5 million Euro) has been distributed to 23 different projects (Socialstyrelsen, 2010). An evaluation of the implementation of the strategy has been made (Denvall, Granlöv, Knutagård, Nordfeldt, & Swärd, 2011). The main results from the evaluation show that the most serious problem is that neither the projects nor the local social services are able to influence housing provision in the municipalities. No new strategy since 2007 has been presented by the government for future actions to prevent homelessness.

## Preventive interventions at the local level

There is a strong correlation between eviction and homelessness. People with a high risk of eviction are those with addiction problems and those with psychiatric disabilities. During the last five years an estimated 3.500 tenants have been evicted each year.

Important conditions and measures in order to pursue eviction preventive work:

- Homelessness issues need to be focused and continuously discussed on the local, political agenda.
- Co-operation between the Social Services, the local Enforcement Authority, housing companies, landlords as well as voluntary organisations is necessary.
- Both the social services and landlords need to act quickly when a person risks eviction.

The Social Services should be able to offer different kinds of support to persons threatened by eviction, such as:

- Financial advice in different forms
- The possibility for the Social Services to undertake the liability for the rent
- Housing support – primarily for persons with psychiatric disabilities and persons with addiction problems
- Access to a personal contact (“PO”) (Socialstyrelsen, 2008).

## 8.2 Drug use among socially excluded groups

A large number of socially excluded people use illicit drugs in Sweden, but most are not socially excluded. However, a clear link between educational level and drug use, or between income and drug use cannot be seen. Drug use is more common in metropolitan areas than in the rest of the country (Statens folkhälsoinstitut, 2010e).

### Women and substance abuse

Drug users, both men and women, are often unemployed, homeless and frequently at the margins of society. Moreover, female drug users most often have less social support and a worse mental health compare to male regular drug users. Most research does not differentiate between genders in their analyses and focus is usually on the male subjects. Women normally make up 20 - 35 % of the subjects in most published studies; however, women often have a more serious addiction. It was assumed that men and women have similar patterns in terms of abuse and experiences. The similarities are evident in terms of unemployment, homelessness and social exclusion. However, men more often than women earn their livelihood illegally (Byqvist, 2006).

The use of drugs does not necessarily lead to criminal activity, although, there is a link between drugs and criminality. It can result from the direct production and distribution activities in the drug trade, or criminality committed under the influence of drugs. However, female criminals have a dual problem with drug abuse; the hardship associated with imprisonment and the difficulties associated with drug abuse in connection with motherhood. Furthermore, many women in addiction live in abusive relationships. In a recent study, which mapped the social situation among

Swedish drug addicts it is indicated that there are several hardships in the everyday lives of drug abusing women. More so, compared with earlier research, the social circumstances of drug users seem to have worsened (Byqvist, 2006).

A study of women injecting heroin (Richert, Månsson, & Laanemets, 2011) shows that they have a worse situation compared with amphetamine users, e.g. when it comes to housing and lack of legal/formal source of incomes. This implies that heroin addicts, in general, are more socially excluded. To a higher extent heroin addicts also have experiences of all types of treatment (op.cit.). Several factors were significantly related to a request for help, whereas heroin as principal drug was the single factor showing a significant positive relation to request for help in statistical analyse. This could be explained by differences in treatment available for the two groups. To this day there is no evidence-based treatment for amphetamine abuse. Treatment options for heroin abuse, on the other hand, are well documented and recognized (op.cit.).

### 8.3 Social reintegration

#### **Organisational framework for services for drug users**

The organization and responsibility of the services for drug users are provided at three levels. At the municipality level, specialized 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 (concerning compulsory care). 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 (Blomqvist, Palm, & Storbjörk, 2009). The social services have a special responsibility for people with problematic drug use including 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. 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 as methadone and Suboxone (op.cit.). In some counties the healthcare system also target specific subgroups such as pregnant women, drunk drivers and people dependent on prescribed drugs (op.cit.). In April 2008 The Swedish Association of Local Authorities and Regions (SALAR) entered into an agreement with 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 country councils will assume a joint responsibility for development. SALAR under takes to uphold 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 a structure for professional support to local authorities and country councils and developing structures for collaboration between local authorities, country councils, research and development (R&D) bodies and universities and colleges. The development work is conducted under the name "Knowledge to Practice".

The National Board of Health and Welfare's national guidelines for substance abuse care forms the basis of a more knowledge based substance abuse care and higher quality. The effort, Knowledge to Practice – the development of substance abuse and dependence care (Kunskap till praktik – utvecklingen av missbruks- och beroendevården), which is based on the national guidelines, is one example of an attempt to bridge the gap between research and practice. At the same time, substantial resources, about € 9 million, are being dedicated to implementation aiming at creating a basic organization for the facilitation of substance abuse and dependence care (Statens folkhälsoinstitut, 2010d).

In an open comparison questionnaire to the municipalities, on their abuse and dependency care, some major shortcomings were found when it comes to follow-ups and assessment of the care (Socialstyrelsen, 2011b). For instance only 30% of the municipalities had actually asked the clients about their experience of the care.

Medication-assisted treatment combined with social-psychological efforts (such as motivational interviewing and other brief interventions) is one evidence-based method developed for both opioid- dependent and alcohol-dependent individuals. Although available, good medicines are still under-utilized in substance abuse care, they are prescribed to a significantly higher degree today than a few years ago.

Knowledge of effective prevention methods has been distributed to the regional and local levels, and this support from the national level to the regional level is generally perceived as functional. However, the development of knowledge and method support is stronger in the alcohol area than the narcotics area.

Services for drug users are an important part of the reintegration of marginalized people. The main responsibility for the long-term care, treatment and potential cure of problem alcohol and drug users lies today with the municipalities' social services. Furthermore, the regional healthcare services are obliged to offer services to users, which means the provision of detoxification and other emergency services, medical and psychiatric care for alcohol- and drug related disorders, and pharmacological treatment, including maintenance treatment with methadone and Subutex (Blomqvist et al., 2009).

In order to increase the quality of the local drug services and to counteract the fact that the responsibility and the division of labour are split between many actors, a thorough investigation has been conducted (SOU 2011:35). Main results and suggestions from the investigation are among other things to clarify responsibility areas between the municipalities and the county councils (the regional health care system) in order to achieve a more effective care. Another suggestion is to strengthen the position of the individual and thereby increase the motivation to participate. Finally, by developing systems for quality assurance, research and dissemination of knowledge and skills will provide the foundation for a more knowledge-based care.

## **Housing**

The primary measures to reintegrated already homeless drug abusers back to a more stable and normal living situation is through the use of different types of housing interventions (Blid, 2008). A common Swedish model to solve the homelessness problem is what has been labelled the staircase model (Sahlin, 2005).

The structure of available shelter and housing for the homeless resembles a staircase and the higher an individual climbs the more “normal” the individuals housing situation becomes. Growing evidence shows that this approach fails to reduce homelessness, rather the opposite and the flipside of this system is the negative impact of falling back down the staircase (Sahlin, 2005). This special-housing sphere (Löfstrand, 2010) keeps growing without any decrease in the number of homeless people, rather adding new groups of homeless people as immigrants families without residence permits and young people.

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

A different theoretical model is at present widely discussed in efforts to decrease homelessness and increase stable housing, the Housing First approach. The idea behind the model is based on every ones right to housing and is the opposite to the staircase model in the sense that it reverses the “ladder” and starts with a 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 any demand for abstinence or treatment.

A recent evaluation of the method was conducted in the city of Helsingborg, where the Housing First method was implemented in September 2010 and will run until December 2013. The evaluation indicates very promising results. An estimated 80 % of the participants are 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, 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 (Arne Kristiansen, 2013).

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

There is a debate about whom the Housing First programme actually is helping and the programme has been criticized for its failure to address broader service outcomes, namely substance abuse or that in fact, the only reason that its substance abuse outcomes were no worse was that the residents were not severely addicted. Further the authors’ state that the programme is suitable for about 18% of the homeless population (Kertesz & Weiner, 2009).

Thus, an uncertainty remains regarding the applicability of Housing First programmes for people with severe and active addiction (Johnsen & Teixeira, 2010). The majority of Housing First studies have involved evaluations of projects catering for chronically homeless people with severe mental illnesses, and existing literature provides compelling evidence as to the effectiveness of Housing First with this group, especially as regards housing retention (op.cit.).

Nonetheless, in order to handle the problem with maintaining stable housing for active drug users and with the research showing no positive effect of the Staircase-model (which is not a Treatment First model), Sweden is now implementing the Housing First model in a few municipalities.

### ***Education and training***

Education is one of the most important factors for young people's future possibilities. The earlier the educational sequence is broken the worse their future possibilities.

Considering the great importance of education on today's labour market it is not a surprising finding that almost half of those young people never marginalized have tertiary education while only 4% of those who were persistently marginalized have studied at this level.

The difference between the groups is striking as those never marginalized are over 10 times more likely to have tertiary education. Among those persistently marginalized there are 40% who only have compulsory education; the rate for a comparison group is 7% (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 decreases the longer they are unemployed and at the same time their ill health increases (Angelin, 2010). Those outside the labour market missing out on the support from the social insurance system.

## 9. Drug-related crime, prevention of drug related crime and, prison<sup>10</sup>

### 9.1 Introduction

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 of removing 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-placement<sup>11</sup> 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).

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 & Brottsförebyggande rådet [Brå], 2010).

<sup>10</sup> 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.

<sup>11</sup> Placement outside prison for treatment.



The NCCP makes the following suggestions for the SPSS 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 & 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 significant 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 even larger, 11% less in the treatment group. For women, no significant differences between the treatment and the control group were found.

The best results were for:

- Men (9%) compared with women (3%, non-significant)
- Those that completed treatment had fewer relapses than those that 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 ( $\geq 138$  days) had better results (12%) than shorter ((76-137 days = 5%), ( $\leq 75$  days = 7%))
- Those that could end their sentence with treatment outside prison seemed to have better results (12%) than those that did not (5%, non-significant).
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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 the 2012 official criminal statistics of Sweden, about 94,600 offences against the Act on Penal Law on Narcotics were reported in 2012, an increase of almost 6% compared to 2011. The number of convictions with drug violations as the main crime increased by 6% (about 1,190 convictions) compared with 2011. Of the 22,700 convictions with a drug offence as the main crime during 2012, 13% involved women and 28% adolescents between the ages of 15 and 20. The offences were considered minor in 88% of the cases (20,027), not minor in 11% (2,444) and serious in 1% (201) as reported in the 2012 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 2002- 2012.

Year	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
n	8,992	10,106	10,808	11,862	13,932	15,179	16,817	18,525	20,021	21,482	22,672

For 2007, 2008, 2010, 2011 and 2012, there are no published statistics that further break down drug offences with regard to convictions.

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 2002 to 2012.

Table 9.2: Number of reported drug-related offences annually in Sweden 2002- 2012<sup>12</sup>.

Reported drug offences	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	*
Peddling (1-3a §)	3,781	3,766	4,031	3,915	5,539	5,645	6,390	6,440	8,141	7,862	11,137	42
Drug possession (1-3 §)	13,561	14,526	15,249	17,624	22,083	23,150	24,764	25,432	27,368	28,785	30,591	6
Drug use (1-3 §)	16,373	18,583	21,726	26,645	37,544	42,414	46,569	47,847	51,766	52,134	52,177	0
Possession and use (1-3 §)	4,155	3,766	3,876	3,418	1,421	2	-	-	-	-	-	-
Production (1-3 §)	135	219	211	205	270	335	465	537	615	655	697	6
Total	38,005	40,860	45,093	51,807	66,857	71,546	78,188	80,256	87,890	89,436	94,602	6

\*Changes between 2011 and 2012, in %.

The table above shows that the total number of reported drug offences increased by 6% between 2011 and 2012. The highest increase concerns peddling, etc. (42%). The reported cases of drug possession and drug production increased 6% respectively between 2011 and 2012. 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 total change between 2011 and 2012 for reported drug offences is similar to the drug offence as the main crime for conviction.

The following statistics that refer to type of offence and substance are special narcotics statistics published every third year. The latest figures are from 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.

<sup>12</sup> <https://www.bra.se/bra/bra-in-english/home/crime-and-statistics/crime-statistics/statistical-tables.html>

Table 9.3: Number of individuals found guilty of drug offences annually in Sweden, by type of offence, 2002-2009\*.

Type of offence	Year					
	2002**	2003	2004	2005	2006	2009
Court sentence and fine issued by the prosecutor	13,891	14,491	14,774	15,877	17,619	21,253
Drug use	5,303	5,816	6,525	7,716	9,397	12,034
Drug possession	4,195	4,590	4,531	4,837	5,021	5,619
Possession, use	1,544	1,641	1,580	1,522	1,291	1,174
Peddling, peddling and possession	917	963	948	842	965	1,110
Possession, use and peddling	143	148	109	102	102	79
Production	7	6	18	25	17	59
Drug smuggling	1,495	982	657	556	509	908
Other offences and combinations	287	345	406	277	317	269
Waivers of prosecution	2,118	2,522	2,692	2,941	4,065	6,893
<b>Total</b>	<b>16,009</b>	<b>17,013</b>	<b>17,466</b>	<b>18,818</b>	<b>21,684</b>	<b>28,146</b>
Minor offences	12,596	13,429	13,645		16,002	21,216
Non-minor offences	2,974	3,131	3,336		5,248	6,472
Serious offences	440	452	485		434	456
Minor offences (%)	79	79	78		74	75

\* No statistics are available for the years 2007 and 2008 since they are only generated every third year.

\*\* Corrected number of waivers of prosecution.

The number of persons convicted of drug offences has increased every year over the past decade. The annual increase has varied, but averaged just below 6% in 2012. This means that drug convictions have more than doubled (increased by 124%) over the last 10 years. Two of the following paragraphs (type of offence and substances) are quoted from the 2009 NCCP report referred to above.

### Types of offence<sup>13</sup>

At 57% (12,034 convictions) and 26% (5,619 convictions) respectively, drug use and drug possession were the two most common offences committed by persons convicted of drug offences in 2009. Drug smuggling and distribution<sup>14</sup> 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% under the same period (from 5,021 convictions in 2006 to 5,619 in 2009).

### Offence severity

In 2012, minor offences accounted for approximately 88% of all convictions (approximately 20,000 convictions). Non-minor offences accounted for 11% (2,444 convictions) and serious offences for 1% (201 convictions). The proportion of convictions for minor drug offences has increased whereas the proportion of convictions for non-minor drug offences has decreased.

<sup>13</sup> Refers to summary fines and court adjudications only, as the offence type cannot be discerned in the case of waivers of prosecution.

<sup>14</sup> Distribution and distribution in combination with possession.

## Substances<sup>15</sup>

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, with cannabis now being the most common substance in criminal convictions.

## Sanctions<sup>16</sup>

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 58% of all those convicted of drug offences in 2012. In 2012, 29% of those convicted of drug offences took the form of waivers of prosecution, whereas 5% involved prison sentences.

The increase in the total number of persons being convicted of drug offences is also mirrored as an increase in virtually all of the different sanctions. The number of fines has more than doubled over the period examined, from 4,580 persons in 2002 to more than 13,100 in 2012. The number of persons sentenced to a prison term has on the other hand decreased from 1,580 in 2002 to 1,140 in 2012. The average length of the prison term issued in 2012 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 58% of all drug convictions in Sweden in 2012. Since 2002, this proportion has remained stable at between 57 and 62% of all those convicted in the country as a whole.

## Age distribution<sup>17</sup>

In 2012, young persons aged 18–20 had the highest level of drug convictions in relation to their numbers within the population at large, with 1200 convictions per 100,000 of population. The groups aged 50 or over have the lowest number of convictions, with 39 convictions per 100,000 of population.

## Gender distribution<sup>18</sup>

Of the total number of persons convicted of drug offences in 2012, approximately 13% were women. This proportion has remained relatively stable over the past 10 years. The number of women and men convicted of drug offences has more than doubled over the same period. Between 2011 and 2012, the number of men convicted increased by 7% whereas the number of women convicted decreased by 1%.

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

16 Figures are from the 2012 official statistics of persons found guilty of offences.

17 Calculations made per 100,000 of mean population are from the 2012 official statistics of people found guilty of offences.

18 Figures are from the 2012 official statistics of persons found guilty of offences.

### 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 of drug treatment programmes on crime (Holloway, Bennett, & Farrington, 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 below 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 noteworthy 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 legal lower limit by 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 work with reducing tobacco use, is that it has negative effects on a person's general health.

### **Finding the addicts**

The SPPS objective that all addicts 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. In 2012 clients were contacted. 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" 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 from the client composition and the proportion of inmates with a substance use disorder.

In 2012, the SPPS took 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 these, 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 taken 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 careful 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 smuggling 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 at leisure 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 initialize maintenance treatment in prison there has to be admittance from the medical care 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 chance to participate in a maintenance programme.

The cooperation model is being used in a similar project in southern Sweden (were 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 from 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.

Maintenance treatment with methadone and buprenorphine was available at 16 places at the prisons during 2012, in Fosie 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 prison service. This is handled by staff who is able to use the tools Wender Utah Rating Scale (WURS) and Autism Spectrum Rating Scale (ASRS). 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 months were accomplished. In the Stockholm region, the Swedish Institute for Communicable Disease Control collaborates with the prisons in Storboda, Färingsö and Täby.

The SPPS collaborate with the Karolinska Institutet on two projects for the treatment of inmates with ADHD. One of the projects is conducted by Ylva Ginsberg, MD, and Nils Lindefors, MD, PhD, of the Department of Clinical Neuroscience, Division of Psychiatry, Karolinska Institutet. An article has been published in the British Journal of Psychiatry.

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 get a job.

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 complete local learning, which secure continuation when a student is transferred to another prison. He or she keeps the

same teacher throughout the whole 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 the 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 through surveys that inmates wish more of 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, which started in the city of Malmö 1980, between the Employment Service, the Probation service and the municipality (social services). At least one member of staff from each organization works together in a common locality in the city. The main goals of Krami are to find, and obtain a job, live a life without crimes and become self-sufficient.

## 10. Drug Markets<sup>19</sup>

### 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. Swedish Customs have liaison officers placed in some countries, e.g. Germany, Russia and China.

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, and fibre optic instruments, and drug detection dogs.

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

#### **Analysis procedure**

At the Swedish National Laboratory of Forensic Science (SKL) substance identification is performed 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 has increased. This is due to a more scattered drug market and a widely 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.

### 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 only take about 20 minutes from port to port.

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<sup>19</sup> Unless stated otherwise, the information in chapter 10, (Drug markets) originates from Swedish Police, Swedish Customs or the Swedish Council for Information on Alcohol and Other Drugs.

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 way to smuggle drugs to Sweden is by mail. More than half the numbers of 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 in Toftanäs, Malmö.

### ***Drugs' origin: national production versus imported***

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

Furthermore, 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 air freight or carried in luggage. 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.

Most kinds of illicit drugs are smuggled into Sweden, but marijuana is an exception here, since cannabis cultivation also occurs in Sweden. In recent years, the police have discovered several large plantations in Sweden. At the same time, seizures of marijuana are still being made at the borders. During the period from 2007 to 2010, marijuana remained the most common drug among 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 addict market can in general be divided into three kinds based on where they act 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. Either the drugs are 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 for distribution of 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.

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 the neighbouring countries exists 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, 2001-2012. (National Swedish Police, National Bureau of Investigation)

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
<b>Narcotics-classed pharmaceuticals</b>	3,214	4,511	4,317	4,715	5,347	6,032	7,443	7,375	7,917	8,374	7,987	7,794
<b>Cannabis<sup>20</sup></b>	6,929	7,351	8,243	8,102	8,345	9,365	10,052	10,996	12,108	12,107	12,742	14,373
<b>Heroin<sup>21</sup></b>	1,271	1,052	1,057	900	804	800	871	688	671	493	314	363
<b>Amphetamine</b>	5,513	6,660	6,657	6,773	6,501	6,842	6,477	5,304	4,986	5,014	3,542	3,006
<b>Methamphetamine</b>	275	250	301	244	386	359	485	846	1,086	704	608	603
<b>Ecstasy</b>	621	631	489	411	381	309	268	231	42	127	189	441
<b>Cocaine</b>	328	440	545	524	546	772	725	813	792	724	633	1,019

	Narcotics-classified medicines	Cannabis <sup>22</sup>	Heroin <sup>23</sup>	Amphetamine	Methamphetamine	Ecstasy	Cocaine
<b>2001</b>	3,214	6,929	1,271	5,513	275	621	328
<b>2002</b>	4,511	7,351	1,052	6,660	250	631	440
<b>2003</b>	4,317	8,243	1,057	6,657	301	489	545
<b>2004</b>	4,715	8,102	900	6,773	244	411	524
<b>2005</b>	5,347	8,345	804	6,501	386	381	546
<b>2006</b>	6,032	9,365	800	6,842	359	309	772
<b>2007</b>	7,443	10,052	871	6,477	485	268	725
<b>2008</b>	7,375	10,996	688	5,304	846	231	813
<b>2009</b>	7,917	12,108	671	4,986	1,086	42	792
<b>2010</b>	8,374	12,107	493	5,014	704	127	724
<b>2011</b>	7,987	12,742	314	3,542	608	189	633
<b>2012</b>	7,794	14,373	363	3,006	603	441	1,019

Seizures of pharmaceuticals classified as narcotics (mainly benzodiazepines) show an increasing trend. This increase may be due to an increase of 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.

<sup>22</sup> Marijuana and cannabis resin

<sup>23</sup> White and brown heroin

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. Yet, methamphetamine seems to have stabilised somewhat since 2008/2009.

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 where 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, in 2008 and 2009 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 that is typical.

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

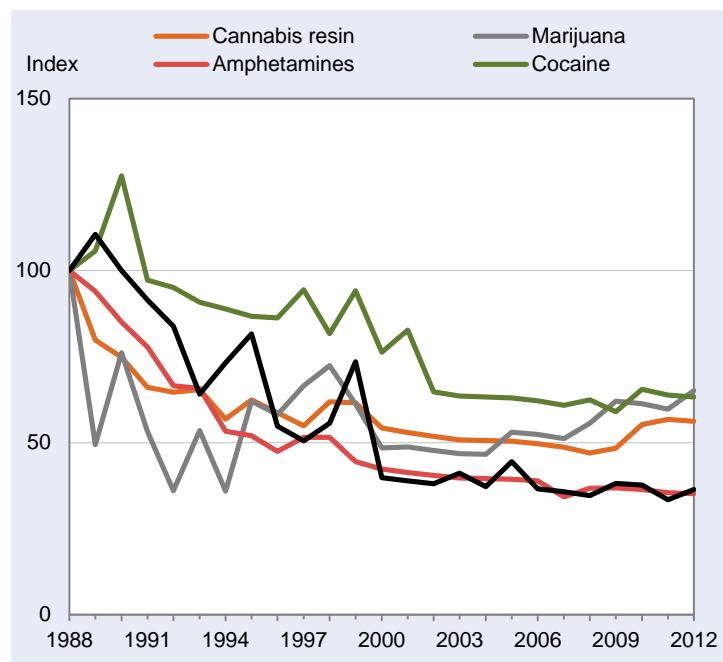
As information on prices has been collected for several years, it is of importance to adjust for inflation when long-term trends are presented. This is normally done using the Consumer Price Index provided by Statistics Sweden (SCB). However, data reported to EMCDDA in standard tables are raw data not 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 has remained relatively stable for the last 10 years. .

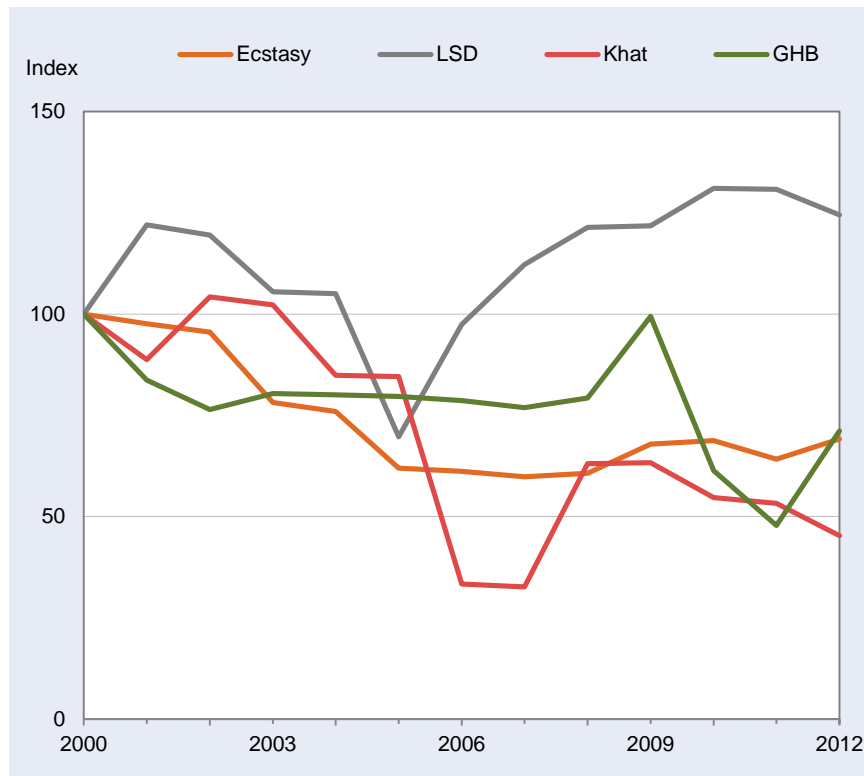
Over the past 3 years, increases in price seen for some drugs may not be spectacular, but unique in a long-term perspective since several illicit drugs have now increased in price at the same time. Amphetamines and brown heroin have however not yet shown any tendency to go up. Figure 10:2 shows the less 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: CPI-adjusted<sup>24</sup> original median street-level prices, SEK per gram for cannabis resin, marijuana, amphetamine, cocaine, and white brown heroin, 1988-2012.



<sup>24</sup> The Swedish Consumer Price Index, Statistics Sweden.

Figure 10.2: Indexed inflation-adjusted 25 median street-level prices for ecstasy, LSD, khat and GHB, 1988-2012.



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, 2012).

<sup>25</sup>The Swedish Consumer Price Index, Statistics Sweden.

## References

- Alanko-Blomé, M., Björkman, P., Flamholc, L., Jacobsson, H., Molnegren, V., & Widell, A. (2011). Minimal transmission of HIV despite persistently high transmission of hepatitis C virus in a Swedish needle exchange program. *Journal of Viral Hepatitis*, 18(11).
- Allebeck, P., Guldbrandsson, K., & Boman, U. (2012). *Lokalt Utvecklingsarbete Med Ambitioner (LUMA)- utvärdering av ett ANDT-projekt i 25 kommuner i Sverige*. Statens folkhälsoinstitut.
- Angelin, A. (2010). *Den dubbla vanmaktens logik: En studie om långvarig arbetslöshet och socialbidragstagande bland unga vuxna*. Doctoral thesis, Socialhögskolan, Lunds universitet, Lund
- Arne Kristiansen. (2013). *Utvärdering av Bostad först-projektet i Helsingborg - Slutrapport*. Helsingborg.
- Beijer, U., Andreasson, S., Agren, G., & Fugelstad, A. (2011). Mortality and causes of death among homeless women and men in Stockholm. [Comparative Study]. *Scandinavian journal of public health*, 39(2), 121-127.
- Blid, M. (2008). *Ett folkhem för alla? Kommunala insatser mot hemlöshet [A people's home for all? Municipal interventions against homelessness]*. Doctoral thesis, Mid Sweden University, Östersund.
- Blid, M., & Gerdner, A. (2006). Socially excluding housing support to homeless substance misusers: two Swedish case studies of special category housing. *International Journal of Social Welfare*, 15, 162-171.
- Blomqvist, J., Palm, J., & Storbjörk, J. (2009). More cure and less control or more care and lower costs? Recent changes in services for problem drug users in Stockholm and Sweden. *Drugs: education, prevention and policy*, 16(6).
- Brottsförebyggande rådet. (2010a). *Narkotikastatistik 2009*.
- Brottsförebyggande rådet. (2010b). *Utökad frigång och återfall: Slutrapport om 2007 års reform av utslussning i Kriminalvården*. Stockholm: Brottsförebyggande rådet [Brå].
- Byqvist. (2006). Drug-Abusing Women in Sweden: Marginalization, Social Exclusion and Gender Differences. *Journal of Psychoactive Drugs*, 38(4).
- Centralförbundet för alkohol- och narkotikaupplysning. (2012). *Narkotikatillgängligheten i Sverige 1988-2011: CAN rapport 132*. Stockholm: Centralförbundet för alkohol och narkotikaupplysning [CAN].
- Centralförbundet för alkohol- och narkotikaupplysning. (2013). *Skolelevers drogvanor 2012, Rapport nr 133* Stockholm: Centralförbundet för alkohol och narkotikaupplysning [CAN].
- Connock M, J.-G. A. (2007). Methadone and buprenorphine for the management of opioid dependence: a systematic review and economic evaluation. *International Journal of Technology Assessment in Health Care*, 11(9).
- Denvall, V., Granlöf, S., Knutagård, M., Nordfeldt, M., & Swärd, H. (2011). *Utvärdering av "Hemlöshet - många ansikten, mångas ansvar" Slutrapport*. Lund: Lunds universitet.
- Duberg, A. S., Pettersson, H., Aleman, S., Blaxhult, A., Daviethsdottir, L., Hulcrantz, R., et al. (2011). The burden of hepatitis C in Sweden: a national study of inpatient care. [Research Support, Non-U.S. Gov't]. *Journal of Viral Hepatitis*, 18(2), 106-118.
- EC 2001/37/EG. *EUROPAPARLAMENTETS OCH RÅDETS DIREKTIV 2001/37/EG*

*om tillnärmning av medlemsstaternas lagar och andra författningar om tillverkning, presentation och försäljning av tobaksvaror.*

Emma Stradalovs. (2013). DOK-systemet på Statens institutionsstyrelse. Stockholm.

Ericsson, E., Bradvik, L., & Hakansson, A. (2013). Mortality, Causes of Death and Risk Factors for Death Among Primary Amphetamine Users in the Swedish Criminal Justice System. *Subst Use Misuse*.

European Commission. (2013). *EUROPEAN COMMISSION, DIRECTORATE-GENERAL, TAXATION AND CUSTOMS UNION. Indirect Taxation and Tax administration - Environment and other indirect taxes* Brussels.

European Commission. (2012). Manufactured tobacco: Excise duty rates Retrieved 2012-08-31, from

[http://ec.europa.eu/taxation\\_customs/taxation/excise\\_duties/tobacco\\_products/rates/index\\_en.htm](http://ec.europa.eu/taxation_customs/taxation/excise_duties/tobacco_products/rates/index_en.htm)

FHIFS 2001:2. *Statens folkhälsoinstituts föreskrifter om varningstexter på tobaksvaror samt innehållsdeklaration för och begränsning av halten av vissa beståndsdelar i cigarettök.*

FHIFS 2002:4. *Statens folkhälsoinstituts föreskrifter om ändring i Statens folkhälsoinstituts föreskrifter (FHIFS 2001:2) om varningstexter på tobaksvaror samt innehållsdeklaration för och begränsning av halten av vissa beståndsdelar i cigarettök.*

Forkby T, O. S., Turner R., (2013). *Cannabisanvändning bland ungdomar - en sammanställning av forskning för en kunskapsbaserad prevention.* Göteborg.

Government Offices of Sweden. (2007). Homelessness: multiple faces, multiple responsibilities: a strategy to combat homelessness and exclusion from the housing market. Retrieved from

[http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/8971/2007-107-20\\_200710720.pdf](http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/8971/2007-107-20_200710720.pdf)

Government Offices of Sweden. (2008). *Sweden's strategy report for social protection and social inclusion.* Stockholm: The Ministry of Health and Social Affairs.

Government Offices of Sweden. (2012a). Ministry of Health and Social Affairs, The ANDT Secretariat.

Government Offices of Sweden. (2012b). Coordinator appointed to combat homelessness and exclusion from the housing market. from

<http://www.government.se/sb/d/15471/a/202084>

Gripenberg Abdon, J., Wallin, E., & Andréasson, S. (2011a). The "Club against drugs" program in Stockholm, Sweden: two cross-sectional surveys examining drug use among staff at licensed premises. *Substance abuse treatment, prevention, and policy*, 6 (2).

Gripenberg Abdon, J., Wallin, E., & Andréasson, S. (2011b). Long-term effects of a community-based intervention: 5-year follow-up of 'Clubs against Drugs'. *Addiction*, 106(11), 1997-2004.

Gripenberg, J. (2008). Narkotika på Stockholms krogar: En jämförelse mellan 2001 och 2007/08. Retrieved 2010-10-15, from

[http://www.stad.org/upload/resultat\\_STAD\\_%2009.pdf](http://www.stad.org/upload/resultat_STAD_%2009.pdf)

Gripenberg, J., Wallin, E., & Andréasson, S. (2007). Effects of a community-based drug use prevention program targeting licensed premises. *Substance Use & Misuse*, 42(12-13), 1883-1898.

Hakansson, A., & Berglund, M. (2013). All-cause mortality in criminal justice clients with substance use problems-A prospective follow-up study. *Drug Alcohol Depend*, 132(3), 499-504.

Hakansson, A., Isendahl, P., Wallin, C., & Berglund, M. (2011). Efficacy of mobile telephone contact for follow-up in injecting heroin users. [Research Support,

- Non-U.S. Gov't]. *The American journal of drug and alcohol abuse*, 37(2), 89-92.
- Heilig, M., & Gunne, L. (2008). Nya riktlinjer behövs mot övergrepp i narkomanvården. *Läkartidningen*, 105(44), 3093-3094.
- Hellström, A., & Torell, L. B. (2006). *COPE Föräldrautbildning. Rapport från utvärderingen av kurser i Uppsala län och Tyresö kommun*. Uppsala: Uppsala universitet.
- Henriksson, C., & Leifman, H. (2011). *Skolelevers drogvanor 2011* (No. 129). Stockholm
- Hensing, G. (2008). Bruk av narkotika – är det maskulint? Könsskillnader och konstruktion av genus i narkotikabruk In S. Andréasson (Ed.), *Narkotikan i Sverige: Metoder för förebyggande arbete: En kunskapsöversikt*. Östersund: Statens folkhälsoinstitut.
- Holloway, K., Bennett, T. H., & Farrington, D. P. (2008). *Effectiveness of Treatment in Reducing Drug-Related Crime: Report prepared for The National Council on Crime Prevention, Sweden*. Stockholm: Brottsförebyggande rådet [Brå] [Swedish Council for Crime Prevention].
- Johnsen, S., & Teixeira, L. (2010). *Staircases, Elevators and Cycles of Change 'Housing First' and Other Housing Models for Homeless People with Complex Support Needs*. London: The University of York.
- Joossens, L., & Raw, M. (2011). *The Tobacco Control Scale 2010 in Europe*. Brussel: The Association of European Cancer Leagues.
- Kakko, J. (2011). *Heroinberoende*. Stockholm: Liber.
- Kertesz, S. G., & Weiner, S. J. (2009). Housing the chronically homeless: High hopes, complex realities,. *JAMA*, 301(17), 1822-1824.
- Kling, Å., Sundell, K., Melin, L., & Forster, M. (2006). *Komet för föräldrar: En randomiserad effektutvärdering av ett föräldraprogram för barns beteendeproblem* (Rapport No. 2006:14). Stockholm: Forsknings- och Utvecklingsenheten.
- Kriminalvården. *KVFS 2011:1*, .
- Kriminalvården. (2011). *Kriminalvården 2010 Årsredovisning*.
- Laanemets, L. (2007). *Navet Om kvinnor, prostitution, metadon- och Subutexbehandling*. Stockholm: Mobilisering mot narkotika [MOB].
- LIVSFS 2012:6. *Livsmedelsverkets föreskrifter om snus och tuggtobak*.
- Läkemedelsverket. *LVFS 1997:12*, : Läkemedelsverket.
- Löfstrand. (2010). Reforming the Work to Combat Long-Term Homelessness in Sweden. *Acta Sociologica*, 53:19.
- Ministry of Health and Social Affairs Sweden. (2011). A cohesive strategy for alcohol, narcotic drugs, doping and tobacco (ANDT) policy. Retrieved from <http://www.sweden.gov.se/content/1/c6/17/26/95/0603f592.pdf>
- National Board of Health and Welfare. (2009). *Plan for continuous monitoring of the extent and character of homelessness: a strategy for disseminating knowledge and information*. Stockholm: Socialstyrelsen [National Board of Health and Welfare].
- National Board of Health and Welfare. (2013 (Unpublished)). New estimates regarding PDU in Sweden. Stockholm.
- Nilsson, & Wadeskog. (2008). *Varje drogfri dag en framgång - socioekonomiskt Bokslut för Metadonprogrammet i Stockholm*. Stockholm.
- Norden, L., Saxon, L., Kaberg, M., Kall, K., Franck, J., & Lidman, C. (2009). Knowledge of status and assessment of personal health consequences with hepatitis C are not enough to change risk behaviour among injecting drug users in Stockholm County, Sweden. *Scand J Infect Dis*, 41(10), 727-734.
- Palepu, A., Marshall, B., Lai, C., Wood, E., & Kerr, T. (2010). Addiction Treatment and Stable Housing among a Cohort of Injection Drug Users. *PLoS ONE*, 5(7).

- Ramstedt, M., Lindell, A., & Raninen, J. (2013). *Tal om alkohol 2012 - en statistik årsrapport från Monitorprojektet* (Forskningsrapport No. 67). Stockholm: Centrum för socialvetenskaplig alkohol- och drogforskning.
- Regeringen. (2012a). *Regeringens åtgärdsprogram för alkohol-, narkotika-, dopnings- och tobakspolitiken 2012*.
- Regeringen. (2012b). *Uppföljning av regeringens alkohol-, narkotika-, dopnings- och tobaksstrategi, #1: Förslag på indikatorer och styrning*. Stockholm: Regeringen.
- Regeringen. (2013a). *Regeringens åtgärdsprogram för alkohol-, narkotika-, dopnings- och tobakspolitiken 2013*.
- Regeringen. (2013b). *Uppföljning av regeringens alkohol-, narkotika-, dopnings- och tobaksstrategi, #2: Förslag på indikatorer avseende de långsiktiga målen i strategin*. Stockholm: Regeringen.
- Regeringen. (2013c). *Uppföljning av regeringens alkohol-, narkotika-, dopnings- och tobaksstrategi, #3: Förslag på indikatorer avseende de prioriterade målen i strategin*. Stockholm: Regeringen.
- Regeringens proposition 2005/06:30. *Nationella alkohol- och narkotikahandlingsplaner*. Stockholm: Regeringen.
- Regeringens proposition 2012/13:77. *Regeringens proposition 2012/13:77 - God kvalitet och ökad tillgänglighet inom missbruks- och beroendevården* Stockholm.
- RFHL, & Svenonius, C. (2008). Dina rättigheter och möjligheter i beroendevården Retrieved from [http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/8706/2008-124-8\\_20081248.pdf](http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/8706/2008-124-8_20081248.pdf)
- Richert, T., Månsson, S.-A., & Laanemets, L. (2011). Kvinnor som injicerar heroin respektive amfetamin: Skillnader i social situation, erfarenhet av behandling och önskemål om hjälp. *Socialvetenskaplig tidskrift* 18(2), 144-163.
- Rikspolisstyrelsen. (2007). Samverkan Polis och kommun - för en lokalt förankrad polisverksamhet i hela landet. Retrieved 2011-10-20, from [http://www.polisen.se/Global/www%20och%20Intrapolis/Rapporter-utredningar/01%20Polisen%20nationellt/Brottsforebyggande/Rapport\\_Samverkan\\_Polis\\_och\\_kommun\\_08.pdf](http://www.polisen.se/Global/www%20och%20Intrapolis/Rapporter-utredningar/01%20Polisen%20nationellt/Brottsforebyggande/Rapport_Samverkan_Polis_och_kommun_08.pdf)
- Rikspolisstyrelsen. (2011). Årsredovisning 2010. Retrieved 2011-10-20, from [http://polisen.se/Global/www%20och%20Intrapolis/Arsredovisningar/01%20Polisen%20nationellt/Arsredov10\\_digital.pdf](http://polisen.se/Global/www%20och%20Intrapolis/Arsredovisningar/01%20Polisen%20nationellt/Arsredov10_digital.pdf)
- Rättsmedicinalverket. (2012). *Årsredovisning 2012*.
- Sahlin, I. (2005). The Staircaser of transition. Survival through failure. *Innovation*, 18, 115-135.
- Sellström, E., O'Campo, P., Muntaner, C., Arnoldsson, G., Hjern, A. (2011). Hospital admissions of young persons for illicit drug use or abuse: Does neighborhood of residence matter? *Health and Place*, 17(2), 551-557.
- SFS 1961:181. *Act on the Sale of Technical Spirit and Substances Containing Alcohol* Stockholm: Swedish Parliament.
- SFS 1968:64. *Narkotikastrafflag*.
- SFS 1975:1154. *Lag om varningstext och innehållsdeklaration på tobaksvaror*;
- SFS 1982:763. *Hälso- och sjukvårdslag*. Stockholm: Riksdagen.
- SFS 1986:223. (1986). *Förvaltningslag*.
- SFS 1988:870. *Lag om vård av missbrukare i vissa fall*.
- SFS 1990:52. *Lag med särskilda bestämmelser om vård av unga*.
- SFS 1991:1128. *Lag om psykiatrisk tvångsvård*.
- SFS 1991:1969. *Lag om förbud mot vissa dopningsmedel*.
- SFS 1992:860. *Lag om kontroll av narkotika*.
- SFS 1992:1554. *Förordning om kontroll av narkotika*.

- SFS 1993:581. Tobakslag. Available from <http://www.riksdagen.se/webbnav/index.aspx?nid=3911&bet=1993:581>
- SFS 1994:1564. *Act on excise duty on alcohol*. Stockholm: Swedish Parliament.
- SFS 1994:1738. *Alcohol Act*. Stockholm: Swedish Parliament.
- SFS 1995:832. *Lag om obduktion m.m.*
- SFS 1999:42. *Lag om förbud mot vissa hälsofarliga varor.*
- SFS 1999:58. *Förordning om förbud mot vissa hälsofarliga varor.*
- SFS 2000:1225. *Lag om straff för smuggling.*
- SFS 2001:312. *Tobaksförordning.*
- SFS 2001:453. *Socialtjänstlag*. Stockholm: Riksdagen.
- SFS 2002:586. *Lag om ändring i tobakslagen (1993:581);*.
- SFS 2004:485. *Lag om ändring i tobakslagen (1993:581);* SFS 2004:485.
- SFS 2005:369. *Lag om ändring i tobakslagen (1993:581).*
- SFS 2006:323. *Lag om utbyte av sprutor och kanyler.*
- SFS 2006:431. *Lag om ändring i brottsbalken*. Stockholm: Riksdagen.
- SFS 2009:267. *Förordning med instruktion för Statens folkhälsoinstitut*. Stockholm.
- SFS 2010:610. *Fängelselag.*
- SFS 2010:682. *Lag om ändring i tobakslagen (1993:581).*
- SFS 2010:1622. *Alcohol Act*. Stockholm: Swedish Parliament.
- SFS 2010:1636. *Alcohol Ordinance*. Stockholm: Swedish Parliament.
- SFS 2011:111. *Lag om förstörande av vissa hälsofarliga missbrukssubstanser*. Stockholm: Riksdagen.
- Skatteverket. (2013). Skattesatser fr.o.m. 1 januari 2013. from <http://www.skatteverket.se/foretagorganisationer/skatter/punktskatter/tobakskatt/skattesatser2013.4.2b543913a42158acf800014457.html>
- Skolverket. (2013). *Undervisning om alkohol, narkotika, dopning och tobak (ANDT) – en praktisknära litteraturgenomgång*. Stockholm: Skolverket.
- Smittskyddsinstitutet. (2013). *Epidemiologisk årsrapport 2012*. Stockholm.
- Socialdepartementet. (2012a). *Uppdrag att genomföra regionala konferenser mm. I syfte att sprida föräldrastödjande aktiviteter i enlighet med regeringens nationella strategi för ett utvecklat föräldrastöd. S2012/2790/FST (delvis)*. Stockholm: Socialdepartementet.
- Socialdepartementet. (2012b). *Åtgärdsprogram för alkohol-, narkotika-, dopnings- och tobakspolitiken 2012*. Stockholm.
- Socialstyrelsen. (2007). *Nationella riktlinjer för missbruks- och beroendevård : vägledning för socialtjänstens och hälso- och sjukvårdens verksamhet för personer med missbruks- och beroendeproblem*. Stockholm: Socialstyrelsen.
- Socialstyrelsen. (2008). *Vräkningsförebyggande arbete: stöd till socialtjänsten och andra aktörer*. Stockholm: Socialstyrelsen.
- Socialstyrelsen. (2010). Hemlöshet - många ansikten, många ansvar: Genomförande av regeringens strategi för att motverka hemlöshet och utestängning från bostadsmarknaden 2007-2009 Slutrapport. Retrieved from <http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/18089/2010-6-33.pdf>
- Socialstyrelsen. (2011a). *Hemlöshet och utestängning från bostadsmarknaden 2011 – omfattning och karaktär*.
- Socialstyrelsen. (2011b). *Insatser år 2010 för vuxna personer med missbruks- och beroendeproblem och för övriga vuxna*. Stockholm: Socialstyrelsen.
- Socialstyrelsen. (2011c). *Nationella riktlinjer för sjukdomsförebyggande metoder 2011: Tobaksbruk, riskbruk av alkohol, otillräcklig fysisk aktivitet och ohälosamma matvanor-stöd för styrning och ledning*. Västerås.
- Socialstyrelsen. (2011d). *Revidering av Nationella riktlinjer för missbruks- och beroendevård*.
- Socialstyrelsen. (2012). *Kartläggning av läkemedelsassisterad behandling vid opiatberoende*.

- Socialstyrelsen. (2013). *Dödsorsaker 2012 (Causes of Death 2012)*.  
SOU 2011:6. *Missbruket, kunskapen, vården: Missbruksutredningens forskningsbilaga*. Stockholm: Fritzes.
- SOU 2011:35. *Bättre insatser vid missbruk och beroende. Individ, kunskapen och ansvaret. Slutbetänkande av Missbruksutredningen*. SOU 2011:35. Stockholm: Statens offentliga utredningar.
- SOU 2011:35. *Bättre insatser vid missbruk och beroende: Individ, kunskapen och ansvaret: Slutbetänkande av Missbruksutredningen*. Stockholm: Fritzes.
- SOU 2011:66. Sveriges internationella engagemang på narkotikaområdet. Retrieved 2011-10-19, from <http://www.regeringen.se/content/1/c6/15/11/82/66380f9e.pdf>
- SOU 2013:19. *Mera glädje för pengarna*. Stockholm: Statens offentliga utredningar.
- SOU 2013:44. *Ansvarsfull hälso- och sjukvård*. Stockholm: Statens offentliga utredningar.
- Stanhope, V., & Dunn, K. (2011). The curious case of Housing First: The limits of evidence-based policy. *International Journal of Law and Psychiatry*, 34.
- Statens folkhälsoinstitut. (2009a). *Det drogförebyggande arbetet i Sverige 2008: Rapport om det förebyggande arbetet mot alkohol-, narkotika-, tobaks- och dopningsproblem* (Rapport No. R 2009:11). Östersund: Statens folkhälsoinstitut.
- Statens folkhälsoinstitut. (2009b). *Länsrapport 2008 [Elektronisk resurs] : [länsstyrelsernas och kommunernas tillsyn enligt alkohol- respektive tobakslagen samt kommunernas övriga alkohol- och drogförebyggande arbete]*. Östersund: Statens folkhälsoinstitut.
- Statens folkhälsoinstitut. (2010a). *Berusing på schemat? Stöd och inspiration för undervisningen om alkohol, narkotika, dopning och tobak - för gymnasieskolan*. Östersund: Statens folkhälsoinstitut.
- Statens folkhälsoinstitut. (2010b). *Berusing på schemat? Stöd och inspiration för undervisningen om alkohol, narkotika, dopning och tobak - i grundskolans senare år*. Östersund: Statens folkhälsoinstitut.
- Statens folkhälsoinstitut. (2010c). *Kartläggning av insatser för barn och ungdomar i risksituationer 2010* (Rapport No. A 2010:10). Östersund: Statens folkhälsoinstitut.
- Statens folkhälsoinstitut. (2010d). *Minskade skador av alkoholkonsumtion och ett narkotikafritt samhälle: Uppföljning av de nationella handlingsplanerna för alkohol och narkotika 2006-2010* (Report No. R 2010:08). Östersund: Statens folkhälsoinstitut.
- Statens folkhälsoinstitut. (2010e). *Narkotikabruket i Sverige*. Östersund: Statens folkhälsoinstitut.
- Statens folkhälsoinstitut. (2010f). *På väg mot ett tobaksfritt landsting: en uppföljning av det tobakspreventiva arbetet i landsting och regioner 2009*. Östersund.
- Statens folkhälsoinstitut. (2010g). *Tonåringar om tobak 2009 - vanor, kunskaper och attityder*. Östersund.
- Statens folkhälsoinstitut. (2011a). En samlad återredovisning av regeringens ANDT-uppdrag till Statens folkhälsoinstitut 2010. Retrieved from <http://www.fhi.se/Documents/Om-oss/redovisade-uppdrag/2011/En-samlad-aterraportering-ANTD-20110331.pdf>
- Statens folkhälsoinstitut. (2011b). *Målområde Tobak: Kunskapsunderlag för folkhälsopolitisk rapport 2010* (No. R nr. 2011:11). Östersund.
- Statens folkhälsoinstitut. (2011c). *Narkotikabruket i Sverige*. Östersund: Statens folkhälsoinstitut.
- Statens folkhälsoinstitut. (2012a). *Cannabis – om spridningen, skadeeffekterna, sambanden med tobak och hur missbruk kan förebyggas*.



- Statens folkhälsoinstitut. (2012b). Familj/föräldrar. Retrieved 2012-10-16, from <http://www.fhi.se/Vart-uppdrag/Barns-och-ungas-halsa/Foraldrarfamilj/>
- Statens folkhälsoinstitut. (2012c). *Länsrapport 2011: Länsstyrelsernas och kommunernas förebyggande arbete inom ANDT och tillsyn enligt alkohol- respektive tobakslagen*. Unpublished Rapport. Statens folkhälsoinstitut.
- Statens folkhälsoinstitut. (2012d). Nationella folkhälsoenhäten: Hälsa på lika villkor. Retrieved 2012-08-07, from <http://www.fhi.se/sv/Statistik-uppfoljning/Nationella-folkhalsoenkaten/>
- Statens folkhälsoinstitut. (2013a). *Lägesrapport ANDT*. Östersund: Statens folkhälsoinstitut.
- Statens folkhälsoinstitut. (2013b). Narkotikarelaterad dödlighet. Retrieved 2013-10-31, from <http://www.fhi.se/Vart-uppdrag/Alkohol-narkotika-dopning-tobak-och-spel/Narkotika/Skadeverkningar/Dodlighet/>
- Statens folkhälsoinstitut. (2013c). *Slutrapport; Regeringsuppdrag att genomföra en satsning mot cannabis 2011-2014*. Östersund.
- Statens folkhälsoinstitut. (2013 (Unpublished)). *Länsrapport 2012 - Länsstyrelsernas och kommunernas förebyggande arbete inom ANDT och tillsyn enligt alkohol- respektive tobakslagen*. . Östersund.
- Statens folkhälsoinstitut. (In press 2013). *Länsrapport 2012*. Statens folkhälsoinstitut.
- Stenbacka, M., Leifman, A., & Romelsjö, A. (2010). Mortality and cause of death among 1705 illicit drug users: a 37 year follow up. *Drug Alcohol Rev*, 29(1), 21-27.
- Stenström, N. (2008). *Sprutbyte vid Intravenöst Narkotikamissbruk: En longitudinell studie av deltagarna i sprutbytesprogrammet i Malmö*. Doctoral thesis, Mittuniversitetet [Mid Sweden university], Östersund. (42)
- Sundström, E., & Brottsförebyggande rådet [Brå]. (2010). *2007 års reform av utslussning i kriminalvården: Delrapport 2*. Stockholm: Brottsförebyggande rådet [Brå].
- Swedish Ministry of Health and Social Affairs. (2011). *A cohesive strategy for alcohol, narcotic drugs, doping and tobacco (ANDT) policy: A summarised version of Government Bill 2010/11:47*.
- Swedish National Institute of Public Health. (2012). *2012 National Report (2011 data) To the EMCDDA by the Reitox National Focal Point: Sweden: New Development, Trends and in-dept information on selected issues*. Östersund: Swedish National Institute of Public Health.
- Swedish Transport Administration. (2010). Rattfylla = inget körkort. Retrieved 2012-10-01, from <http://www.trafikverket.se/Privat/Trafiksakerhet/Din-sakerhet-pa-vagen/Alkohol-och-droger/Rattfylla--inget-korkort/#vadsagerlagen>
- Svensson B, A. M. (2011). Involuntary discharge from medication-assisted treatment for people with heroin addiction – patients' experiences and interpretations. *NORDIC STUDIES ON ALCOHOL AND DRUGS*, 29(2), 173/193.
- Systembolaget. (2013). *2012 Responsibility Report: With financial reports*. Unpublished Rapport. Systembolaget.
- Tobaksfakta. (2012). Rökfri arbetstid. Retrieved 2012-08-13, from <http://www.tobaksfakta.org/Default.aspx?id=9085>
- Trolldal, B., Brannström, L., Paschall, M. J., & Leifman, H. (2013). Effects of a multi-component responsible beverage service programme on violent assaults in Sweden. *Addiction*, 108(1), 89-96.
- Trolldal, B., Brännström, L., et. al.,. (2012). *Ansvarsfull alkoholserving: Effekter på våldsbrottsligheten i landets kommuner*: Stockholm förebygger alkohol- och drogproblem.

World Health Organisation. (2003). *WHO Framework Convention on Tobacco Control*.

World Health Organization. (2013). Parties to the WHO Framework Convention on Tobacco Control. from [http://www.who.int/fctc/signatories\\_parties/en/index.html](http://www.who.int/fctc/signatories_parties/en/index.html)