European Monitoring Centre for Drugs and Drug Addiction

Swedish National Institute of Public Health

2011 NATIONAL REPORT (2010 data) TO THE EMCDDA
by the Reitox National Focal Point

"Sweden"

New Development, Trends and in-depth information on selected issues

REITOX

Contents

Foreword

The 2011 National Report on the Drug Situation in Sweden has been produced for the European Monitoring Centre for Drugs and Drug Addiction.

One major change since 2010 National Report is that the Swedish Parliament adopted a new strategy for alcohol, narcotic drugs, doping and tobacco policy for the period 2011-2015. The main objectives include a society free from narcotics and doping, decreased medical and social harm from alcohol and a decrease in the use of tobacco. The strategy includes everything from local prevention work to international work.

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

Contributors to part A are, from the Swedish National Institute of Public Health, Ms Pia Kvillemo, Ms Elisabet Mörk, Ms Ulrika Owen, Ms Annika Frykholm, Ms Helena Löfgren; Ms Ewa Jonsson, Ms Åsa Domeij and Mr Joakim Strandberg.

External contributors are Mr Ulf Guttormsson, Mr Björn Hibell, Swedish Council for Information on Alcohol and Other Drugs; Ms Frida Hansdotter, Swedish Institute for Infectious Disease Control; Ms Tove Sporre, Swedish National Council for Crime Prevention; Ms Gunilla Nilsson Swedish Prison and Probation Service; Mr Nils Stenström, Mr Mats Blid at Mid Sweden University; Mr Bert Gren, Linnaeus University, Ms Anna Fugelstad, Karolinska institutet and Lotta Rapp, Swedish National Laboratory of Forensic Science.

In part B, the section on “Drug-related health policies and services in prison” is written by Ms Emma Ekstrand, Swedish Prison and Probation Service, and the section on “Drug users with children” is written by Ms Annika Frykholm, Swedish National Institute of Public Health.

The report has been reviewed by Sven Andréasson, senior consultant at the Swedish National Institute of Public Health. Mr Joakim Strandberg and Ms Annika Frykholm, public health officers at the Swedish National Institute of Public Health, have been project coordinators for the National Report 2011.

For possible need of clarification of the reports and publications in Swedish referred to in this National Report you are welcome to contact the Swedish National Institute of Public Health.

Sarah Wamala
Director-General
Swedish National Institute of Public Health

Summary

Chapter 1: Drug policy: legislation, strategies and economic analysis
A new cohesive strategy covering the years 2011 to 2015 was adopted in the spring of 2011 by the Swedish Parliament. The main objectives include a society free from narcotics and doping, decreased 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 to be detailed in annual action plans and a total of SEK 257 million (€ 28.5 million) per year is allocated to the work in the areas of alcohol, illicit drugs, doping and tobacco allocates.

A new legislation that concerns the destruction of certain substances of abuse dangerous to health has been implemented. The legislation aims to deal with the increased use of legal drugs of abuse that have not yet been regulated – substances that can nevertheless be assumed to be hazardous to health.

In 2010, thirteen substances were controlled as narcotics and ten substances were controlled as goods dangerous to health.

Chapter 2: Drug use in the general population.
In the ages 16-64 lifetime prevalence of cannabis use is fairly stable over an extended time period (2004-2010) for both women and men. A stable trend for men and women in all age groups was reported in last month prevalence during the same period.

For 15-16 year-old boys' and girls' lifetime prevalence of any drug was 9 and 7 per cent respectively, which are the same percentages as 2009.

In 2010 lifetime prevalence of ever having used an illicit drug among the 17-18 year-old students was 21 per cent for boys and 14 per cent for girls.

Chapter 3 Prevention
In 2010 important areas for the work against the use of illicit drugs includes parent support, school-based activities and interventions for children with addicted parents. Furthermore, all police authorities worked with a certain method directed to drivers under the influence of drugs, which includes cooperation with the social services and healthcare services for addicts.

Chapter 4: Problem Drug Use
The estimated problem drug use population amounts to almost 30,000 in Sweden. National efforts are being conducted to establish suitable methods for regular estimations of this population. An initial baseline measurement to gauge the extent of the problem drug users in Sweden will be conducted in 2011/2012.

Chapter 5: Drug-related treatment
In 2009, the treatment reporting system covered 51 per cent of all inpatient and 31 per cent of all outpatient treatment centres. In 2010, the distribution is estimated to be similar even if the exact figures are not known.

The implementation of the evidence-based national guidelines for the treatment of persons with substance abuse and dependence problems is on-going. The objectives are to develop a qualified support for municipalities and county councils and to develop an organisational structure for the exchange of experiences and cooperation.

Chapter 6: Health correlates and consequences
About 150-200 cases of acute hepatitis B are reported annually in Sweden. In 2010, 125 cases of acute hepatitis B were reported out of which 51 reported had been infected via injecting drug use in Sweden. In 2010, a total of 1,944 cases of hepatitis C were reported to the Swedish Institute for Communicable Infectious Disease control, which represented a 12 per cent decrease in cases reported compared to 2009.

Compared with many other European countries Sweden has a relatively small proportion of intravenous drug users, (DU) infected with HIV. In the past 5-10 years the proportion of IDUs among the reported HIV cases in Sweden has been between 15 and 25 per cent.

Data on drug-related deaths in Sweden is collected either from the National Cause of Death Register (NCDR) or from a research register on forensically examined deaths with presence of illicit drugs or methadone (Toxreg). Forensic investigations are performed routinely in Sweden at fatal accidents or when there is a suspicion of unnatural death, suicide or crime. Sweden has a good infrastructure for performing cohort studies based on linking register information. In 2010 and 2011 the results of two Swedish cohort studies have been published.

Chapter 7: Responses to health correlates and consequences
Today, there are three operational needle and syringe exchange programmes in Sweden, all which are located in the same county (Skåne). A fourth programme will be set up in Stockholm and will be operational from the end of 2011.

Although access to drug-assisted therapy has increased significantly in Sweden in recent years, long queues still exist in many places. A survey from 2007 showed that only half of the Swedish county councils were able to offer drug-assisted therapy within the timeframes set by the health care guarantee.

A recent evaluation of a drug-assisted programme for opiate dependent patients at the County Hospital in Sundsvall-Härnösand shows very good results. One reason for the successes with the programme is the cooperation between the health care system and the social services.

Chapter 8: Social correlates and social reintegration
The national strategy for counteracting homelessness and exclusion from the housing market has been evaluated. Main results from the evaluation show that the

largest problem is that neither the projects nor the local social services are able to influence the housing provision in the municipalities. Another result is that one of the few evidence-based interventions to help people exit homelessness - Housing-First programmes – have not been implemented in any project.

Chapter 9: Drug-related crime, prevention of drug related crime and, prison
According to the National Council for Crime Prevention, persons with long prison sentences are at considerable risk of reoffending and using drugs in the period immediately after release.

Between 2009 and 2010, offences against the Act on Penal Law on Narcotics increased by almost 10 per cent and the number of persons convicted with a drug offence as the main crime increased by 8 per cent. However, the average number of drug addicts in prison is fairly stable over a longer period of time and represents generally about half of the total prison population. In 2010, 7,342 prison inmates (of whom 456 are women) started at least one treatment programme. This is 550 more programmes than during 2009

Chapter 10: Drug Markets
Seizures of pharmaceuticals classified as narcotics (mainly benzodiazepines) are increasing. A growing amount of pharmaceuticals classified as narcotics are available on the Internet, where drugs are sold without quality assurance or prescription.

Professional, full-scale illegal indoor cultivation of marijuana, initially concentrated to the southern parts of Sweden, is now observed in other parts of the country as well.

Amphetamine seizures have decreased slightly since 2006. A possible explanation for this might be the simultaneous increase in the availability of other and similar drugs, such as methamphetamine.

From a short-term perspective prices have increased for marijuana, cocaine and heroin in recent years. The increase is not spectacular, but unique in a long-term perspective because the prices of several illicit drugs have now increased at the same time. Amphetamines are the only drugs with stable prices.

In recent years, the composition, variety and number of novel substances seized by the Swedish police have increased. During 2010 forty novel substances were added to the Swedish National Laboratory of Forensic Science reference library.

Chapter 11
The aim of this chapter is to describe the population that is in prison with problems related to illicit drug use or a substance use disorder. This is an attempt to assess their characteristics and their health and social problems as well as review the interventions aimed at drug use in prison.

The Swedish Prison and Probation Service, unlike that in most other European countries, does not differentiate between illicit drug abuse, alcohol abuse or the abuse of anabolic steroids (defined by law). In Sweden even tobacco use is considered to be a behaviour that indicates an increased risk for using illicit drugs

and/or excess use of alcohol. The use of prescription medication without prescription is considered use of illicit drugs.

In Sweden, drug and/or alcohol addiction is mainly viewed as a social problem. Consequently the social services are mainly responsible for the care of persons with a substance use disorder. The health care system also has responsibilities for certain parts of the treatment system.

On 1 October 2010 about 60 per cent of the prison population in Sweden had a substance use disorder. According to the personnel who conducted interviews when the inmates entered prison 2,000 persons, or 39 per cent of the inmates, had no drug or alcohol addiction, 11 per cent had an alcohol addiction, 31 per cent abused illicit drugs and 19 per cent abused both alcohol and illicit drugs.

Amphetamine is the predominant drug followed by cannabis. Among users 43 per cent use more than one illicit drug. Amphetamine is the predominant drug among those aged 30-59. For younger inmates (15-30 years of age) it is more common to mainly use cannabis rather than amphetamine. Amphetamine is the main drug for many of the inmates in Swedish prisons. The most common way to take the drug is by intravenous injection. For inmates who use several illicit drugs, intravenous injection is also the most common way to take the drug.

Chapter 12: Drug users with children (addicted parents and child-related issues)

It is not known how many of Sweden's approximately 2 million children and adolescents grow up with one or more caretakers with substance abuse problems. Where there is substance abuse in the family, it is also common to find other problems in the family, such as mental illness.

In the newly adopted strategy for alcohol, narcotic drugs, doping and tobacco policy, one of the objectives is that children shall be protected from the harmful effects of alcohol, narcotics, doping and tobacco.

Since 2009, the Swedish National Institute of Public Health has distributed financial grants to the municipalities for preventive methods against alcohol and narcotics and at least two thirds of these funds were used for children of parents with substance abuse and mental illness. Today, several actors work with substance abuse and dependence and consequently there are large differences in approaches with regard to treatment. In 2007, the National Board of Health and Welfare issued national guidelines for addiction treatment in order to make treatment more clear and uniform.

Part A – New developments and Trends

1: Drug Policy: Legislation, strategies and economic analysis

Legal Framework

Narcotic Drugs Punishments Act (SFS 1968:64)
In Sweden, illicit drugs are defined as ”drugs or goods dangerous to health, with addictive properties or that create a state of euphoria, or substances that can easily be converted to products with such properties or effects, and that, on such basis, are objects for control according to international agreement that Sweden has supported, or, declared by the Government to be considered illicit drugs according to the law” (SFS 1968:64).

The aim of this legislation is to legally regulate “illicit 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”. Illicit drugs/narcotics may be used only for medical, scientific or other purposes useful to society that are particularly important (SFS 1968:64). All other possession or use is punishable.

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

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

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

Regarding narcotic precursors, the Narcotics Punishment Act states that any person who intentionally:

- transfers, manufactures, acquires, procures, processes, packages, transports or in some other similar 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 most 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 grave, particular consideration shall be given to whether it has been part of large-scale or professional activities, has involved especially large quantities of narcotic precursors 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 (LVFS 1997:12). Hence, only substances that are on this list are considered to be narcotics in the eyes of the law. In total, the list of illicit drugs contains about 300 substances and, indirectly, a number of mushrooms that contain psilocybin or psilocin. In practice, however, only around 30 illicit drugs are abused to a greater extent in Sweden.

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

The complementary 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 Narcotic Drugs Punishments Act (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 that are comprised in 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 that 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 goods are listed in the appendix to this ordinance.

The Act on the Control of Narcotic Drugs (SFS 1992:860)

The so-called precursor chemicals are listed in a special registry. A precursor chemical is, according to the Act on the Control of Narcotic Drugs, a substance that can be used for the illegal production of illicit drugs (SFS 1992:860).

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 regulation of GBL and 1.4-BD as narcotics during 2011.

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

On 1 April 2011, a new legislation (SFS 2011:111) that concerns the destruction of certain substances of abuse dangerous to health entered into effect. The legislation aims to deal with the increased use of legal drugs of abuse that have not yet been regulated – substances that can nevertheless be assumed to be hazardous to health.

The new Act on the Destruction of Certain Substances of Abuse Dangerous to Health authorizes a public prosecutor to seize and order the destruction of certain substances. A police or customs officer finding a suspicious substance that can be assumed to fall under this legislation may confiscate the substance pending a decision by a prosecutor concerning the destruction of the substance.

The substances covered by the Act are goods/substances which:

1) have been decided by the Government to be listed as narcotics or as goods injurious to health or
2) through an international convention to which Sweden is adhering but where listing has not entered into effect or
3) can be presumed to be listed as narcotics or goods injurious to health.

The drugs covered by the two first criteria can be inferred by reading the announcements in the Swedish Code of Statutes (Svensk Författningssamling, SFS) or the Statutes from the Medical Products Agency (Läkemedelsverkets föreskrifter, LVFS). The last group (3) can to some extent be inferred from a list published by the Swedish National Institute of Public Health (SNIPH) over substances currently under investigation to be listed.

The Act provides SNIPH and the MPA with a possibility to purchase products that are sold on the Internet and have them analysed in order to investigate their content and active substance. This will improve monitoring, investigation and regulation of new substances of abuse.

Laws implementation

In 2010, thirteen substances were controlled as narcotics according to the Act on the Control of Narcotic Drugs (SFS 1992:860) and the Narcotic Drugs Punishments Act (SFS 1968:64) and were thereby listed in the amendment to the Ordinance on the Control of Narcotic Substances, (SFS 1992:1554): 1-bzp and methylone were previously listed as Goods Dangerous to Health and have been reclassified as narcotics in 2010.

MDPV, Buthylone, N-ethylcathinon, 2-,3-,4-fluormethcathinon, Naphyron and the synthetic cannabinoids JWH-081; JWH-200; JWH-250; JWH-398 were classified as narcotics in 2010.

Ten substances were added to the list related to the Act on the Prohibition of Certain Goods Dangerous to Health (SFS 1999:42) in 2010. JWH-007, JWH-015, JWH-019, JWH-098, JWH-122, JWH-147, JWH-210, (4-metoxyphenyl)(1-pentyl-1H-indol-3-yl)methanon, CP55,940 and WIN55,212-2

Laws concerning harm reduction

In 2006, the new Act on Exchange of Syringes and Needles entered into effect (SFS 2006:323). The purpose of this Act is to prevent the spread of HIV and other blood-borne infections through the exchange of syringes and needles, and this is to be carried out in connection with interventions aimed at motivating the individual to accept care and treatment. Exchanges may not be done without the permission of the National Board of Health and Welfare (NBHW).

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; and 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.

National action plan, strategy, evaluation and coordination

A five-year strategy covering the years 2011 to 2015 was adopted in March 2011 by the Riksdag (Swedish Parliament) (Regeringens proposition 2010/11:47)..

The strategy is similar to previous years, as the main objectives include 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 new five-year strategy also states that the overarching goals from previous national action plans remain.

As described in the preface of the summarised version of Government Bill 2010/11:47 (Regeringens proposition 2010/11:47), 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 five-year cohesive 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 stress 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 setup for open comparisons, follow-ups and evaluations of the ANDT strategy 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 politics, Ms Maria Larsson has national responsibility for alcohol, narcotics, doping and tobacco issues. She was given responsibility for these issues in 2006 as Minister for Elderly Care and Public Health. In the general election of 2010, the incumbent Government's mandate was renewed and Ms Larsson continued in her post. Her present title is Minister for Children and the Elderly, still under the Ministry of Health and Social Affairs

The strategy contains seven long-term objectives of lasting relevance with attached priority goals that are to be achieved during the strategy period (Regeringen, 2011a).

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 alcohol debuts 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 programmes

The 2011 action programme is based on the 2011-2015 strategy. For 2009 and 2010, the annual action programmes were based on the 2006-2010 plan. The one-year action plan covers all of ANDT and describes the priorities for the coming year and in more detail than the full action plan/strategy.

2011
Measures described in the 2011 national action plan (Regeringen, 2011b). include an extended effort to reduce new recruitment into cannabis abuse and a special effort in substance abuse and addiction treatment for a more family-focused approach. This includes the fact that more systematic attention needs to be paid to parenthood and the needs of children in substance abuse treatment. Other measures in 2011 include:
- An assignment to the Swedish National Institute of Public Health to support counties to further develop and initiate cooperation and coordination between small municipalities in the ANDT prevention work.
- An effort to support cooperation and coordination between the three major cities of Malmö, Gothenburg and Stockholm.
- The ANDT Council is provided a clear role in the work of implementing the ANDT strategy.

2010
The action programme for 2010 emphasized the need for a long-term approach and continuity in the work (Regeringen, 2010). It proposed that work continue concerning the indicated prioritised measures from 2009. The need was stressed to strengthen and develop collaboration and/or coordination within a number of additional areas:
- collaboration on action for children and young people at risk
- common starting points for collaboration in school
- collaboration to prevent and combat serious organised crime
- increased knowledge of doping and GHB
- alcohol and drugs on the roads
- marketing and selling on the Internet
- a dialogue for greater collaboration and coordination.

Implementation and evaluation of national action plans and/or strategy

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, i.e. a society free from illicit drugs, will remain unchanged and that political initiatives will be aimed towards the supply and demand on drugs in order to:

- reduce the number of people who will start using drugs
- make it easier for more people with addiction problems to receive treatment
- reduce access to illicit drugs.

In the 2006–2010 action plan, certain measures were stressed as particularly important in order to:

- improve cooperation between authorities and between authorities and non-governmental organisations
- improve the preventive work, for example by developing methods and skills
- develop treatment and care
- make the control system more effective
- improve the methods of monitoring drug use development and society's initiatives
- develop the treatment perspective within the correctional system.

The work on the local level was considered crucial for successful results and the municipalities' work was emphasized. At the same time, more cooperation is needed within the EU and internationally. Children, young adults and parents are particularly prioritised target groups. The Government allocated almost SEK 260 million (EUR 28.2 million) a year for 2008, 2009 and 2010 for work against alcohol and other drugs (Regeringens proposition 2005/06:30).

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, 2010b). 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.

As stated in the evaluation report, the organisation of preventive work at the national, regional and local level is crucial to the development of national objectives in the action plans. At the regional level, impressions of the county drug coordinators' activities are all consistently positive. National support for coordination, as well as the support from the county drug coordinators at the local level, has had a positive impact. The number of coordinators funded by the municipalities has increased during the action plan period, but many municipalities cannot or will not prioritise this function.

The ultimate objective of the narcotics policy – a drug-free society – has not been achieved. However, it should be emphasised that the restrictive narcotics policy long pursued in Sweden has radically reduced the use of narcotics and its harmful effects. Nevertheless, the overall assessment is that the trend during the period up until 2009 went in the wrong direction, with an increase in harmful effects in the form of morbidity, mortality and crime. The evaluation report further states that the narcotics trend is difficult to interpret due to lack of reliable data.

The spread of effective prevention methods to regional and local levels was stated by the evaluator to have worked well, although it was more effective in the area of alcohol than narcotics.

Statistics and follow-ups developed in both the alcohol and narcotics areas in 2006-2009. However, statistics are kept by multiple authorities, are divided and lack overall coordination. No national guidelines have yet been worked out for the follow-up and evaluation of local and regional efforts concerning implementation of the action plans. In accordance with the intentions of the action plans, 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 was stronger in the alcohol area than narcotics area. Developing municipality-based, structured, long-term and coordinated prevention work has the highest priority in the action plan, but narcotics appear to be a neglected area in the municipalities where there is a need for greater support (Statens folkhälsoinstitut, 2010b).

Evaluation of the 2011-2015 strategy

In addition to providing a framework for policy goals and priorities, the ANDT strategy is to establish a structure for monitoring developments in the areas of consumption and abuse, medical and social harm, and interventions and measures (Regeringens proposition 2010/11:47).

Official statistics are already available in some parts of the ANDT sphere. In addition, there are numerous national, regional and local studies, data collections and questionnaire-based surveys undertaken by agencies and organisations. As a rule, comparisons between different sets of data are impossible since these are drawn from different sources, based on different methods and, in some cases, different definitions of key terms and issues.

Representatives of municipalities, county councils and non-governmental organisations have made clear on numerous occasions their desire for greater coordination and long-term thinking on the part of national actors so that they can develop their own procedures for data collection and reporting. In 2010, an initial survey and analysis was accordingly made of existing data collections in the ANDT sphere, as part of the Government's programme of measures for ANDT policy in that year.

The Government intends to continue developing and coordinating these statistics and data collection activities. The aim is to track developments in such areas as ANDT consumption and harm, abuse, care consumption 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. The Government plans to propose a limited number of key indicators for follow-up and evaluation of the ANDT strategy. An initial baseline measurement to gauge the extent of the ANDT problem will be conducted in 2011 in accordance with a follow-up and evaluation structure developed by a working group composed of representatives of relevant agencies and the research community (Regeringens proposition 2010/11:47).

During the coming strategy period, the aim is to present appropriate organisational arrangements for open comparisons, follow-ups and evaluations of ANDT strategy objectives. A system for reporting in accordance with EU and international agreements is also to be put in place.

The strategy will be evaluated externally and 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 (Regeringens proposition 2010/11:47).

National coordination

In 2007/2008, the Government established a function to coordinate issues regarding alcohol, illicit drugs, doping and tobacco (ANDT) - the ANDT Secretariat. Initially, the function had two other components - the SAMANT working group and the ANDT Council.

As of 2011, the SAMANT working group has been terminated and its function – to coordinate policy and work in various ministerial subdivisions and ministries on issues regarding alcohol, narcotics, doping and tobacco is managed by the ANDT Secretariat.

The ANDT Council 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:

<u>Ministry of Health and Social Affairs</u>

- 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

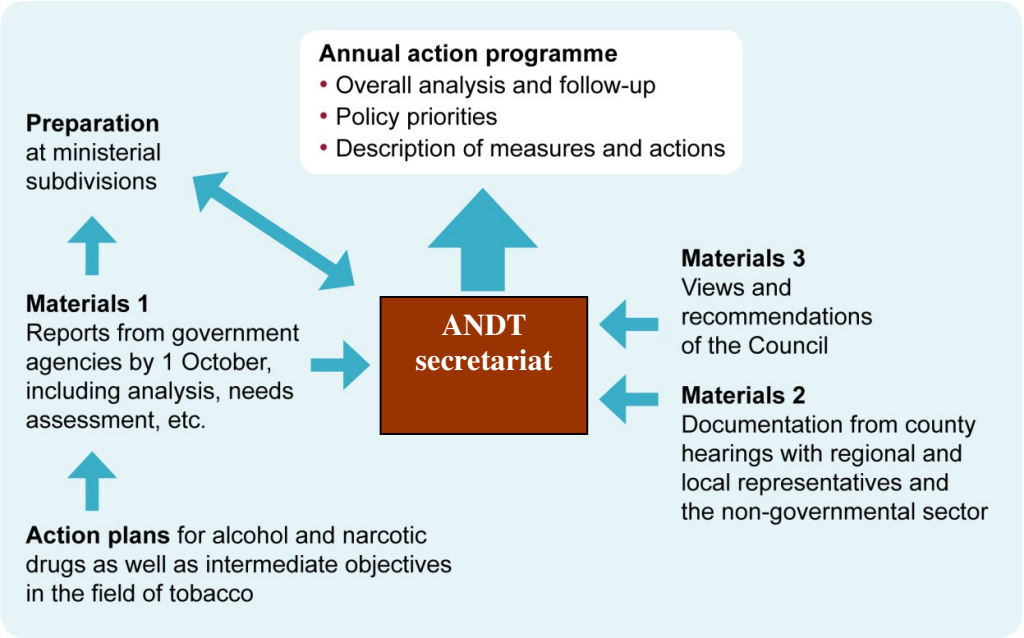
- Customs issues
- Legislation on smuggling

Ministry for Foreign Affairs

- Foreign affairs and drugs-related development assistance

The ANDT Secretariat is part of the Public Health Division and placed under the Ministry of Health and Social Affairs. One of its main duties is to draw up the annual action programme in its area and compile a follow-up and evaluation of the work done to attain the objectives set. It has also been given the tasks of assisting the Government and facilitating and inspiring the efforts of local and regional actors to implement the 2011-2015 national ANDT strategy and to act as a secretariat to the ANDT council.

Figure 1.1. An illustration of the national coordination, analysis and governing structure in the areas of alcohol, narcotics, doping and tobacco.



The material on which the annual action programme is based is derived from several sources: the ministries concerned, the Council established by the Government, various government agencies and documentation of outreach activities at the regional and local levels (Figure 1.1).

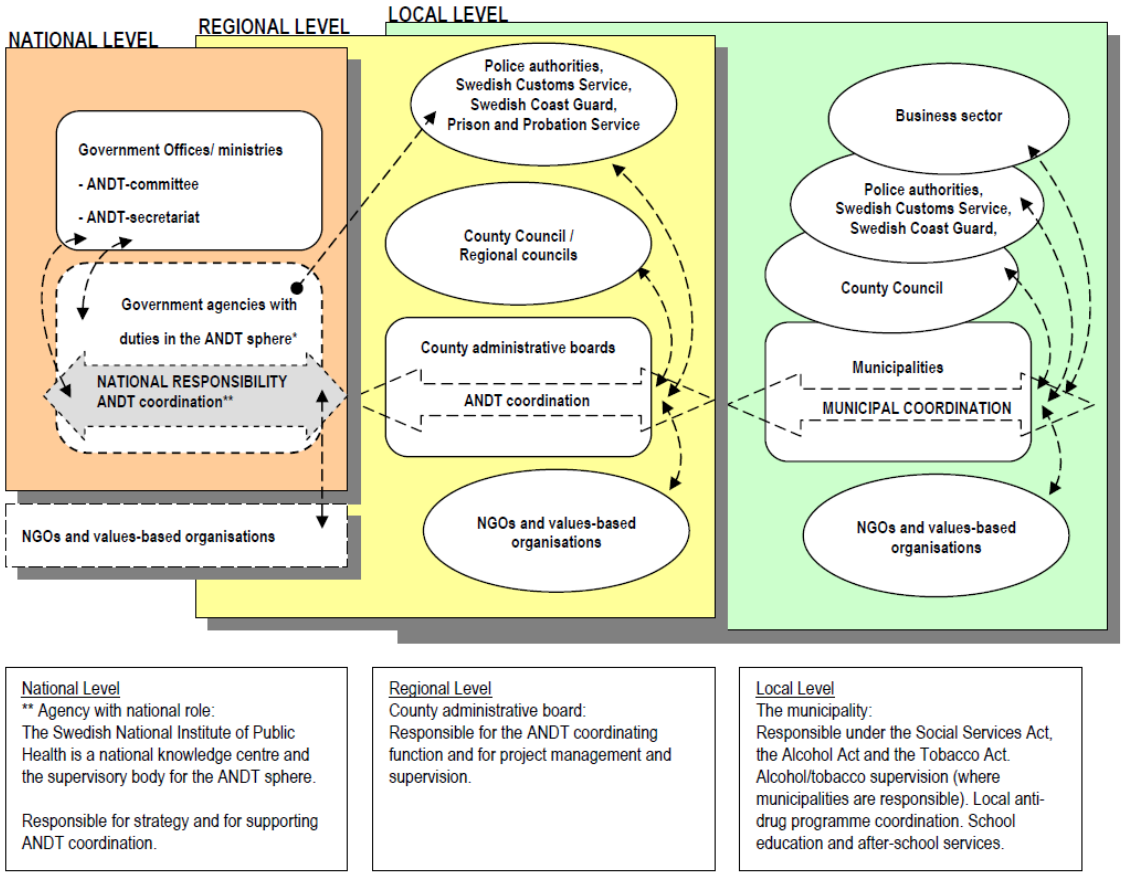
As the national knowledge centre for methods and strategies in the public health sphere, the Swedish National Institute of Public Health (SNIPH) plays a central role in implementing the Swedish national drug strategy covering the period 2011-2015 as

well as subsequent action plans. SNIPH's tasks include supporting the ANDT coordinators at the county administrative boards. SNIPH has also been given the task of supporting the health-promoting and preventive work carried out at institutions of higher education in the ANDT area. SNIPH also has a duty to implement information campaigns to ensure that the objectives for the lifestyle issues of alcohol, illicit drugs, doping and tobacco are met.

The National Board of Health and Welfare has been tasked by the Government to further develop, within its area of responsibility, efforts to attain the objectives established in the national action plans on alcohol and illicit drugs. The NBHW will make use of the knowledge and experience gained through the work of the Alcohol Committee and the Office of the Swedish National Drug Policy Coordinator. This concerns skills, methodology development and cooperation mechanisms capable of promoting development towards knowledge-based substance abuse and addiction services where coordinated interventions are made based on the needs of each individual.

All government agencies monitor their work on a regular basis and report to the Government on developments.

Figure 1.2: Overall organisation to reach the national ANDT goals (Regeringens proposition 2010/11:47).



Other drug policy developments

A special investigator (Assistant Undersecretary Ms Christina Gynnå Oguz) was appointed in August 2010 to map Sweden's international involvement in the area of narcotics (Dir. 2010:82). In October 2011, the investigator will present proposals for how Sweden can promote the preservation and respect for the UN narcotics conventions and how to attain improved coordination and use of available resources.

Problems concerning illicit drugs belong to the challenges that require action at all levels: locally, nationally, regionally and globally. The global narcotics situation and the political and organisational prerequisites for the work are changing. New patterns of abuse are emerging. Narcotics are finding their way to Europe and Sweden along partly new routes. Young people of today are influenced not only by their local environment and the conditions under which they grow up but also by a wider surrounding world and the greater accessibility provided by the Internet. The narcotics situation in Sweden is to a great extent dependent on attitudes to and work against narcotics in other countries. It is important in a national perspective that we obtain more knowledge about international prerequisites and conditions.

The investigator will for instance:

- map existing bodies and contexts for international collaboration in the area of narcotics and describe Swedish contacts and collaborative efforts
- identify how Swedish drugs policy can be conveyed within the EU and to other countries in a more coordinated way
- propose how Sweden can promote the preservation of respect for the UN narcotics conventions.

Economic analysis

Public expenditures

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 shown, the estimates have varied between EUR 330 million in 1991 up to a highest level of € 2,618 million in 2011.

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

Previous estimations:			
Year of the estimate:	***Sectors included:***	***Estimate:***	***Reference***
1991	health care, treatment, probation care, social service, 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
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 has been commissioned by the government to allocate funding in the alcohol, drugs, tobacco and drug prevention area. The aim is that these funds will contribute to the implementation of national action plans in the ANDT area.

Efforts to support local activities and projects carried out in cooperation with NGOs are prioritised. Basic research and data collection aimed at mapping and monitoring developments in this area can also be granted funds.

An equal distribution of funds to the ANDT area is the aim, although the number and quality of the applications received play an important role.

Table 1.2. State funding of the County Administrative Boards for further distribution within the ANDT prevention area, 2006-2010 (Statens folkhälsoinstitut, 2011b)

Year	2006	2007	2008	2009	2010
Amount in SEK (thousands) (€, thousands)*	100,280 (11,260)	100,280 (11,126)	75,280 (8,352)	73,500 (8,155)	75,000 (8,321)

* SEK translated into EUR using average currency rates January to September 2011 (Source: Riksbanken [Sweden's central bank]).

In 2010, SNIPH allocated a total of SEK 30 million (€ 3.3 million). Priority was given to areas of supply reduction, information, children with abusing parents, efforts in health and medical care, and efforts to support local projects in cooperation with NGOs. For most projects, evaluation and final reporting will take place in 2011.

A total of 155 projects received funding for ANDT preventive efforts in 2010 and county administrative boards distributed approximately SEK 30 million (€ 3.3 million) to these projects. Of these projects, 145 were aimed at both sexes and most targeted adolescents between 13-17 years of age - even if parents also constitute a large target group.

Table 1.3. Distribution of funds to the ANDT area allocated by the SNIPH in 2010 (Statens folkhälsoinstitut, 2011b).

Main Area	***Amount (SEK) million***	***Amount (€) million****
Alcohol	12.8	1.42
Illicit Drugs	2.6	0.29
Tobacco	1.0	0.11
Doping	0.2	0.02
Alcohol/illicit drugs	6.7	0.74
Alcohol/illicit drugs/tobacco	6.3	0.70
Alcohol/illicit drugs/Doping/Tobacco	0.7	0.08
Total	30.3	3.36

* SEK translated into EUR using average currency rates January to September 2011 (Source: Riksbanken [Sweden's central bank]).

Table 1.4. Projects aimed at illicit drugs that received funding from SNIPH in 2010 (Statens folkhälsoinstitut, 2011b).

Organisation	**Topic**	**Amount SEK (€)***
Karolinska Institutet	Statistics concerning alcohol and drug related deaths	660,000 (66,570)
STAD (Stockholm Prevents Alcohol and Drug Problems), Dependence Centre, Stockholm County Council	Clubs against drugs	700,000 (77,665)
City of Gothenburg, Office of Social Resource Management	Clubs against drugs	900,000 (99,855)
Västra Götaland County Administrative Board	Knowledge survey regarding GHB, GBL, 1,4-BD	350,000 (38,832)

* SEK translated into EUR using average currency rates January to September 2011 (Source: Riksbanken [Sweden's central bank]).

Budget

The budget proposition in 2011 includes funding for preventive measures in the ANDT area (Regeringens proposition 2010/11:1).. In total, SEK 257 million (€ 28.5 million) is assigned on a yearly basis between 2011 and 2014. This can be compared to previous years: SEK 251 million (€ 27.8 million) in 2009 and SEK 257 million (€ 28.5 million) in 2010.

Approximately SEK 146 million (€ 16.2 million) is earmarked for measures against HIV/AIDS and other contagious diseases related to HIV/AIDS, e.g. sexually transmitted diseases (STI) and blood borne diseases.

The action plan for 2011 describes the following resources concerning ANDT related work (Regeringen, 2011b):

Forskningsrådet för Arbetsliv och Socialvetenskap, FAS (Swedish Council for Working Life and Social Research)

- Approximately SEK 15 million (€ 1.66 million) shall be used in 2011 for a multidisciplinary research programme in the ANDT area.
- An international evaluation of Swedish research in the ANDT area is to be presented in the beginning of 2012.

The Swedish National Agency for Education

- SEK 1 million (€ 0.11 million) has been allocated to the National Agency for Education for the development of educational support concerning ANDT education. The assignment comprises an inventory of the available material and proposes additional material. Final report is to be presented in 2014.

The Swedish National Board for Youth Affairs

- The Government has given the National Board for Youth Affairs the assignment to plan for an attitude and value survey among youth. The plan shall be reported by October 31st 2011.
- An investigation regarding the living conditions among young people shall be reported by a number of authorities to the Board. The Board shall summarise the findings in a report to the Government. Indicators regarding narcotics are the use of narcotics and treatment at hospital, for example.

The Swedish Inheritance Fund

- In 2010, SEK 1.1 million (€ 0.12 million) was distributed for drug preventive work.

Karolinska institutet

- SEK 1.7 million (€ 0.19 million) (Centre for Psychiatric Research) to perform a pilot investigation of problem drug use in the ANDT area. A final report is due 31 January 2012.

Swedish Association of Local Authorities and Regions (SALAR)

- SEK 30 million (€3.33 million) for continuation of the developmental work called “Kunskap till praktik” (Eng. Knowledge to practice)

The National Board of Health and Welfare (NBHW)

- Approximately SEK 39.5 million (€ 4.38 million) for distribution to social organisations within the alcohol and narcotics area.

Swedish Council for Information on Alcohol and Other Drugs (CAN)

- Approximately SEK 14 million (€ 1.55 million) plus the SEK 7 million (€ 0.78 million) from the SNIPH to be used for work concerning youth surveys.

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

Introduction

With regard to the general population, cannabis has been the only illicit drug studied regularly in recent years (2004-2010). A question on the use of cannabis is included in the annual public health survey conducted by the SNIPH. Before 2004, data on drug use in Sweden was mainly collected in the form of drug-use assessments performed by the Swedish Council for Information on Alcohol and Other Drugs (Centralförbundet för alkohol- och narkotikaupplysning, commonly referred to as CAN) in cooperation with SNIPH. However, the wording of the questions is not exactly the same and, consequently, comparability can be called into question. What can be said is that Sweden, from an international perspective, is a low-prevalence country when it comes to both the experimental and regular use of illicit drugs.

The SNIPH has recently (2008-2010) conducted a large-scale prevalence study both in the general population and among specific groups thought to be at higher risk. The overall objective was to clarify how many people in Sweden use illicit drugs and to describe the living situation of these individuals. Various methods for estimating the prevalence of illicit drug use in the population were used. The main study was a large survey, where questionnaires were sent to 58,000 individuals 15-64 years of age, randomly selected from the general population. This study was combined with three questionnaire studies directed at groups assumed to have more extensive drug use than the general population; university students, restaurant employees and festival visitors. The results from these three studies are summarised in this chapter. In addition, various methods were tested to reach people with problematic drug use (see also chapter 4 the section on “Indirect estimates of problem drug users”).

A number of other regularly conducted surveys are also helpful in estimating the prevalence of narcotics use in various populations. However, most of these surveys are directed at adolescents, with questions concerning use over the past 30 days, the past 12 months, and over their lifetime. The latter category is interpreted as temporary or experimental use, and use in the past 30 days is interpreted as a more regular pattern of drug use.

Annual surveys are also conducted in year 9 (middle secondary school) and, since 2004, in the second year of upper-secondary school. Annual surveys among military conscripts ended in 2007 due to changes in national recruitment methods.

In addition to these more regular surveys, several other local or temporally irregular surveys are conducted.

Drug Use in the general population (based on probabilistic sample)

Cannabis

Since 2004, an annual public health survey has been carried out by SNIPH investigating the health and living conditions in the general population (16-84 years). The survey is called “Hälsa på lika villkor” [Eng. Health on equal terms] and includes one question on cannabis use. The cross-sectional method used in data collection implies that general trends should be considered to be more important than differences between two following years. The total number of individuals selected is approximately 20,000. We present the results for ages 16-64 in this report to enable comparability of data on an international level. Cannabis use in the general population above 64 years of age is almost non-existent.

Table 2.1. Lifetime, last year and last month prevalence (per cent) of cannabis use in different age groups for men and women, 2004-2010.

	Lifetime							
Age		**Year**						
		2004	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**
16-64	**Men**	17.6	15.5	15.6	16.4	14.6	18.5	18
	Women	9.9	9.7	8.9	9	8.4	9.2	10.4
16-34	**Men**	25.5	22.1	23.7	22.3	19.7	26.8	24.3
	Women	16.3	16	15.4	13.8	13.5	14.9	16.5
16-24	**Men**	23.3	18.7	16.2	15.5	11.8	20.6	17
	Women	14.7	13.3	15.4	13.3	12.3	11.4	13.2
	Last year							
		2004	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**
16-64	**Men**	3.0	2.8	2.6	2.8	2.6	4.3	3.7
	Women	1.5	1	1.4	1.3	1.4	1.5	1.8
16-34	**Men**	6.6	6.6	6.7	6.3	5.8	9.8	7.8
	Women	3.8	2.5	2.6	3.3	3.6	3.8	4.6
16-24	**Men**	9.7	10.2	6.2	5.9	4.8	11.1	8.6
	Women	4.8	3.9	6.2	4.7	5.0	5.5	5.8
	Last month							
		2004	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**
16-64	**Men**	1.2	1.2	0.9	0.8	0.7	1.5	1.4
	Women	0.3	0.4	0.3	0.3	0.3	0.3	0.5
16-34	**Men**	2.5	2.7	2.3	1.8	1.5	3.1	3.0
	Women	0.7	0.8	0.9	0.7	0.7	0.9	1.2
16-24	**Men**	4	4.7	1.8	2.3	1.5	3.8	3.3
	Women	1	1.4	1.8	0.7	0.9	1.2	1.1

Lifetime prevalence of cannabis use in the ages 16-64 is fairly stable over an extended time period for both women and men (Table 2.1). However, use decreased somewhat during the first part of the period among both sexes. Cannabis use increased significantly among men between the years 2008 and 2009[1]. Even among women, a significant increase appeared between 2008 and 2010[2].

In the ages 16-34, the lifetime prevalence is higher as compared to the level reported among those 16-64 years of age, but use is fairly stable over a longer time period. However, during the years 2004 and 2009, lifetime prevalence among men was significantly higher than in 2008[3].

For ages 16-24, the lifetime prevalence of cannabis use shows differences in use between men and women. It also varies from one year to the next, especially among men; see for example 2008, 2009 and 2010 (Table 2.1). One explanation is that there are fewer young men than women who answer questions about cannabis use in the questionnaire, making data for young men uncertain. Lifetime prevalence for women is lower compared to men and the prevalence for women is also probably more stable because the net response is substantially higher. The total number of young men in the survey is not sufficient to distinguish multiple age groups. Illicit drug use is unusual in the population, which demands large samples and a sufficient net response in all chosen age groups. The net response in the surveys is often around 50 per cent. Younger people are more difficult to reach in the survey and men do not answer as diligently as women.

The prevalence of cannabis use last year among men 16-64 showed a significant increase in 2009[4]. For women in all ages, the development remained stable. A higher prevalence was shown for men than for women. The largest proportion of cannabis users, both lifetime prevalence and last year prevalence, are young men in the ages 16-34 and 16-24.

A stable trend for men and women in all age groups was reported in last month prevalence during the period. Women reported a more stable development. In summary, although there were small differences in cannabis consumption over time, some of the differences were statistically significant.

Other drugs

The large-scale postal survey of the use of illicit drugs that was conducted in 2008 among 58,000 individuals between the ages of 15-64 in the Swedish population was presented in the National Report 2009. The results were published in late 2010 in the report *Narkotikabruket i Sverige* [Narcotics Use in Sweden] (Statens folkhälsoinstitut, 2010c).

[1] CI [$_{\text{Men 2008}}$ 13.4 – 15.7, $_{\text{Men 2009}}$ 17.2 – 19.9]
[2] CI [$_{\text{Women 2008}}$ 7.6 – 9.2, $_{\text{Women 2010}}$ 9.5 – 11.4]
[3] CI [$_{\text{Men 2004}}$ 23.1 – 27.9, $_{\text{Men 2008}}$ 17.3 – 22, $_{\text{Men 2009}}$ 24 – 29.7]
[4] CI [$_{\text{Men 2008}}$ 2 – 3.1, $_{\text{Men 2009}}$ 3.7 – 5]

Drug Use in the school and youth population (based on probabilistic samples)

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. Also in 2010, the national school survey was 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 methods and results are presented in ST2.

The lifetime prevalence of any drug for 15-16 year-old boys and girls were 9 and 7 per cent respectively, which are the same percentages as the year before. The past-30-day prevalence was 3 per cent for boys and 2 per cent for girls. Cannabis was by far the most common drug in the surveys among 15-16 year-olds, irrespective of sex.

Lifetime prevalence (2010) of ever having used an illicit drug among the 17-18 year-old students was 21 per cent for boys and 14 per cent for girls, which for boys was 3 percentage points higher than in 2009. The past-30-day prevalence was 5 per cent and 2 per cent, respectively. Among those who had used an illicit drug, the most common drug of choice was cannabis, but benzodiazepine and amphetamine were also reported.

According to CANs school population survey 2010, very few students have used drugs before the age of 14; 2 per cent of the boys and 1 per cent 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) who have had opportunity to try drugs (for the first time) increased by the end of the 1990s and the increase continued until 2000 when 27 per cent reported in the survey that they had had the opportunity to try drugs. From then on, the percentage decreased again and in 2010 it was 19 per cent. The percentage of older students (17-18 years) who have had opportunity to try drugs is somewhat larger, approximately 35 per cent.

The results from the same school population survey show that there is a strong correlation between experience of drug use and extensive alcohol consumption. Among students in the ages of 15-16 years more than 40 per cent of those who had used drugs were also consuming large quantities of alcohol, compare to students with no reported drug use where the proportion was 10 per cent. Also in the ages of 17-18 years there was a big difference between students with and without experience of drug use with regards to extensive alcohol consumption, though the differences was not as big as for students 15-16 years.

There is also a correlation between reported drug use and binge drinking. Among students who reported drug use 60 per cent of 15-16 year olds and 70 per cent of 17-18 year olds report binge drinking. This is a considerably higher percentage than what could be found among student with no drug experience.

Use of tobacco was also more common among students with experience of drug use, compared to students with no drug experience (Hvitfeldt and Gripe, 2010).

Drug use among targeted groups

One of the studies in the before mentioned prevalence project was among the participants in festivals. Results from the study show that the participants at the festivals studied, reported considerably higher levels of drug use than their peers in the general population.

The study in the prevalence project among restaurant personnel, where most participants were between the ages of 18 and 34, shows that 31 per cent of the men and 18 per cent of the women reported that they used illicit drugs at some time in life. Regular use in the past month was reported by 3.7 per cent of men and 1.1 per cent of women, which are roughly the same levels as in the general population.

The results from the student survey did not indicate that students use illicit drugs more than others of the same age in the general population (Statens folkhälsoinstitut, 2010c).

3: Prevention

Introduction

Organisational framework of prevention

Besides the governmental efforts (see Chapter 1), there was a so called county coordinator in each of the 21 counties in Sweden in 2010, with the role of supporting the preventive work with alcohol, narcotics, doping and tobacco (ANDT) in the region. Half of the counties also had a strategy for the work and 19 counties had allocated economic resources for the coordinators' work, which means a small increase compared to 2009. National responsibility for county coordination is placed at the Swedish National Institute of Public Health (SNIPH). In 2010, this involved an obligation to allocate SEK 24 million (EUR 2.7 million) to prevention work in the counties, as well as the organising of skills development efforts and collegial learning. In 2010, work focused especially on parent support, school-based activities and actions against tobacco use, as well as children with addicted parents and interventions aimed to detect and advise individuals with problematic alcohol consumption (sometimes drug abuse), who visit various types of healthcare services (the so-called Risk Drinking Project).

In Sweden, the implementation of prevention is generally the responsibility of the municipality, where the preventive efforts are often coordinated by "drug coordinators". According to *Länsrapport 2010* [Eng. the County Report 2010] about three quarters of the 290 municipalities have been able to appoint local drug coordinators for the work on narcotics prevention with governmental support. The same person often coordinates prevention efforts against different addictive substances (Statens folkhälsoinstitut, Unpublished-b).

On a local level, prevention efforts are normally summarised in a municipal policy for alcohol and drugs. In 2010, about 80-90 per cent of the municipalities had such a political programme. Half of the programmes had measurable objectives and just as many had a follow-up plan. In 65 per cent of the programmes, there was an implementation plan with appointed responsible actors and in nearly a third of the cases funds were allocated for the implementation of activities according to the plan.

Monitoring tools

SNIPH annually distributes questionnaires to the local and regional drug coordinators to examine the supervision of the alcohol and tobacco legislation, but they simultaneously provide some information on illicit drugs and the preventive work at the local level. The support of municipal management is a key component of the preventive work. 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 preventive work. The information collected through the aforementioned questionnaires is reported yearly in the County Report.

Action plan on alcohol, narcotics, doping and tobacco

In 2010, SNIPH published an evaluation of the action plans to prevent the harmful effects of alcohol and narcotics during the period 2006-2010. The results of the evaluation were presented in the National Report 2009. During 2010, "A Cohesive Strategy for Alcohol, Narcotic Drugs, Doping and Tobacco Policy" was developed, for the period 2011-2015 (Prop 2010/11:47) (Regeringen, 2011a). To read more about the strategy see chapter 1.

Universal prevention

Drug prevention activities have increased in many areas for a number of years. An effective structure was built for the preventive work within the national action plan on drugs 2006-2010. National efforts focused on research, development and the dissemination of preventive methods, regional coordination and local activities. SNIPH is, as mentioned above, responsible for the national coordination of prevention efforts in the areas of alcohol, narcotics, doping and tobacco. Supporting and developing regional prevention efforts are included in this assignment (Regeringens proposition 2005/06:30).

Results from the SNIPH annual questionnaires sent to the 290 local authorities, indicate that the share of local authorities that cooperate with the healthcare system and the police increased slightly between 2009 and 2010. The share of local authorities cooperating with the business sector, such as restaurants and grocery stores was approximately the same as in 2009 and the same is true for cooperation with NGOs (Statens folkhälsoinstitut, Unpublished-a, Statens folkhälsoinstitut, Unpublished-b).

School

Schools have long served as the premier arena for preventing and reducing drug use among students during the school years as well as later in life. Swedish schools have a long tradition of offering education about alcohol, drugs and tobacco. Research has shown that school-based drug education is not likely to have any lasting effects, and an increasing number of school's consequently now focus on preventive programmes instead. In 2005-2007, SNIPH carried out an assignment on behalf of the Government regarding alcohol and narcotics prevention in compulsory schools. A similar assignment, which also included secondary schools and prevention methods regarding tobacco and doping, was carried out in 2009-2010.

According to the County Report, school-based drug-prevention programmes were used to about the same extent in 2010 as in 2009. The Social and Emotional Training (SET) method aimed at developing children's social and emotional capacity and thereby promoting psychological health and preventing the use of alcohol and drugs, was carried out in about half the municipalities in 2010. A Swedish study, conducted with a control group[5], showed positive effects on the promotion of aspects of self-image, including well-being and the hindering of aggressiveness, bullying, attention-seeking and alcohol use (Kimber et al., 2008).

[5] Classes in two schools were chosen as intervention classes, with their students constituting the SET group. For comparative purposes, a school of similar size serving a socio-economically similar population was selected for each SET school, with students in corresponding classes constituting the No-SET group.

The “Komet för lärare (Skolkomet)” [Comet for teachers (School Comet)] method is another example of a method that aims to develop children’s social and emotional capacity. According to the SNIPH County Report, the method was applied in about one fifth of the municipalities in 2010, which is the same share as 2009. A Swedish randomized controlled trial has shown that the programme reduces behavioural problems among the pupils relative to a control group (Forster et al., 2005).

Family

In recent years, there has been an increase in the number of municipalities that report on activities for parents in the drug prevention work. As previously reported, 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 2010 according to the SNIPH County Report. The method has been spread nationally by the School Project. The COPE method aims at giving parents of children of ages 3-12 years tools to understand and handle their children’s behaviour, strengthen the parents in their parenthood, improve the interplay in families and create supportive networks. The programme is built on empowerment and intends to inspire parents to find their own solutions to everyday situations. A Swedish study of the method was conducted with a control group and showed significant effects on the children’s problematic behaviour as well as the parents’ ability to handle the child, their experienced level of stress and their feeling of control in parenthood (Hellström and 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, i.e. reported by less than 20 per cent of the municipalities are: FöräldraStegen [ParentLadder], Aktivt föräldraskap [Active parenthood], Nya STEG [New STEPS], De otroliga åren [The incredible years], Steg-för-Steg [Strengthening Families Programme] and Föräldrakraft [Parent Power] (Statens folkhälsoinstitut, Unpublished-b).

Community

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 organisations, the temperance movement and various churches in alcohol and drug prevention work. Sports organisations are the most common type of non-profit organisation that municipalities cooperate with. About 60 per cent of the municipalities collaborated with sports organisations in alcohol prevention work in 2010 and about 40 per cent cooperated with them in prevention against narcotics. Many municipalities also financially support organisations with youth activities and, according to the County Report, nearly half of the municipalities said they had an alcohol and drugs policy action plan from the organisations to allow the subsidy in 2010 (Statens folkhälsoinstitut, Unpublished-b).

Mentor Sverige [Mentor Sweden] aims to strengthening young people to resist drugs and violence. The mentor programme addresses young people between the ages of 13 and 17 who want more contact with adults. The young people meet with a mentor

a couple of times a month. Between 2007 and 2010, a controlled evaluation of the effects of the method was conducted by Stockholm Prevents Alcohol and Drug Problems (STAD). Factors of study were youth consumption of alcohol and drugs, grades and peer relationships. With alpha-levels corrected for multiple comparisons, analyses revealed no statistically significant outcome differences between the intervention group and the control group. The authors point out, however, that a relatively low statistical power and a low programme dosage preclude any definite conclusions about programme effectiveness (Bodin and Leifman, 2011).

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 per cent reported organising drug-free activities in 2010 (Statens folkhälsoinstitut, Unpublished-b).

The Swedish Police Authority is also an important participant in the establishment of a drug-free environment and a common partner of municipalities together with the social services. 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, 2009). About 90 per cent of the Swedish municipalities were cooperating with the police in matters of illicit drugs in 2010, according to the County Report (Statens folkhälsoinstitut, Unpublished-b).

Selective prevention in at-risk groups and settings

At-risk groups

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. In many districts the police also work with the “Linköping Model”, mentioned above.

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 healthcare for addicts, 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, all police authorities worked according to the method. Örebro County applies an extended version of SMADIT, which, among a few other factors, differ from SMADIT by including persons suspected of minor drug offences (Rikspolisstyrelsen, 2011).

At-risk families

Interventions are offered to children living in families where one or both parents are addicted to either alcohol or narcotics in Swedish municipalities in different settings,

often in cooperation with NGOs. In about 65 per cent of the municipalities, some group-based activities for these children were offered in 2010 according to the County Report (Statens folkhälsoinstitut, Unpublished-b). In a 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 per cent reported interventions for families with addicted parents, about 65 per cent reported interventions for families where violence occurs and about 55 per cent reported interventions for families with parents with mental disorders (Statens folkhälsoinstitut, 2010a). A new survey which addressed this issue in more depth was carried out among 45 municipalities in the beginning of 2011.

In recent years, there has been an increase in activities directed at children with addicted parents among regional and local actors in cooperation with the county coordinators. In 2010 on behalf of the Government, SNIPH and the County Administrative Boards allocated SEK 75 million (EUR 8.14 million) to alcohol and narcotics preventive work, of which more than half went to efforts in the area of children of parents with addiction or mental illness or children in homes were violence between adults occurs (Statens folkhälsoinstitut, 2011b). The numbers of Swedish municipalities that report offering programmes for children at risk (preschool) have also increased. 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 to 18. This method aims specifically at those who have children showing externalizing behaviour problems and who have additional difficulties establishing positive peer relations. 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 et al., 2006). Another randomized controlled trial for assessing the effects of Komet för föräldrar, which targets parents of adolescents with antisocial/externalizing behaviour, is conducted by STAD (Stockholm Prevents Alcohol and Drug Problems). The results will be official in the end of 2011. Komet has been spread nationally by the School Project and about a third of the municipalities report having offered the method to parents in 2010 (Statens folkhälsoinstitut, Unpublished-b). 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.

The importance of detecting children at risk has recently been emphasized in different contexts, including SNIPH’s surveys from 2010 and 2011. Because every child attends school, this setting is an important arena for identifying and supporting children at risk and their parents. In order to examine policy and practice in Swedish school settings pertaining to children of substance abusing parents/caregivers, a cross-sectional survey involving 443 randomised schools was recently carried out (Elgán and Leifman, 2010). The authors conclude that it appears as if a policy document does not directly predict whether schools identify students having substance abusing parents. However, it does influence whether respondents have participated in further training, which subsequently predicts the identification of students having substance abusing parents.

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 et al., 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. In 2008, the activities were expanded to encompass additional municipalities. A web page containing information about current activities and local studies and evaluations (www.krogarmotknark.se) has also been set up.

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 recently 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 last-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 that staff at licensed premises represent an important target population in club drug prevention programmes (Gripenberg Abdon et al., 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 towards obviously drug-intoxicated guests at licensed premises. Professional male actors (i.e., pseudopatrons) 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 per cent of the attempts (n = 55), a significant improvement compared to 27.0 per cent (n = 48) at the first follow-up in 2004 and to 7.5 per cent (n = 40) at baseline in 2003 (Gripenberg Abdon et al., 2011b).

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 to get 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 SNIPH and CAN. The approximate cost for the campaign is SEK 2 million (EUR 217,000).

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 - before the campaign start and at the end of the autumn term. The results of these will be included in the evaluation of the operation.

4: Problem Drug Use

Introduction

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. Sweden also lacks a well-established definition of problematic or harmful drug use. In order to reach a more accurate picture of the Problem Drug Use (PDU) population size, as well as their living conditions, three nationwide studies were conducted in 1979, 1992 and 1998. In these case-finding studies, data was collected from professionals who met drug users in their daily work in e.g. the social services, healthcare, the police, the correctional system, customs and various treatment centres, including NGOs. Within a given period of time, the professionals reported clients or patients that either injected drugs at some point in the past 12 months or used illicit drugs daily or on an almost daily basis in the past four weeks. Those meeting these criteria where classified as problematic drug users. Estimates were obtained through capture-recapture calculations (Olsson et al., 2001).

The population of problematic drug users in Sweden was estimated at approximately 15,000 in 1979, approximately 19,000 in 1992 and around 26,000 in 1998. This means an increase in nominal figures. However, a per capita figure would be more accurate since the general population increased during the same time period. In 1979, there were 1.8 PDUs per 1,000 inhabitants according to the above estimates. In 1998, this figure increased to 2.9 per 1000. Please note that the above figures refer to all ages.

It should be noted, however, that there were some differences with regard to data collection methods (e.g. inclusion criteria, sample size), as well as a changing attitude in society with regard to drug users and to the central gathering of data. It cannot be ruled out that these factors have influenced the figures. In some respects, the differences were dealt with in a re-analysis of data from the 1979 and 1992 studies (Olsson et al., 2001).

The Government Bill (2010/11:47), A cohesive strategy for alcohol, narcotic drugs, doping and tobacco (ANDT) policy states that the Government plans to propose a limited number of key indicators for follow-up and evaluation of the ANDT strategy. An initial baseline measurement to gauge the extent of the ANDT problem will be conducted in 2011 in accordance with a follow-up and evaluation structure developed by a working group composed of representatives of relevant agencies and the research community. Karolinska institutet, Centrum för psykiatriforskning [Center for psychiatric research] has been commissioned by the Government to carry out a pilot survey for the upcoming baseline measurement of problematic use of ANDT in Sweden. The two areas that are in focus for the baseline measurement are the prevalence of problematic use and dependency of ANDT in the population and the harm or negative consequences of problematic use of ANDT on third party, i.e. harm on other persons than the user. The institute has received SEK 2 million (€ 0.22 million) for this purpose. The project will be reported back to the Government on 31 January 2012 (Regeringsbeslut S 2010/6855/FH and S2010/8869/FH).

Prevalence and incidence estimates of PDU

Indirect estimates of problem drug users

As was briefly described in the 2009 national report, an indirect estimation of the number of problematic drug users in Sweden regarding the year 2007 was recently published (Svensson and Arvidsson, 2009) (for references, see Standard Table (ST) 7 and 8). We should be reminded however that the main purpose of this study was to develop effective methods which will be able to produce reliable estimates for a longer period of time. Hence it can be considered more of a methodological study than an estimation of problem drug use per se. In retrospect, it can be concluded that finding a stable model for this particular purpose has proven rather complicated. The main reason is that the extent of data available at a certain point in time is far from permanent.

The results presented here are based on the same source as was the 2009 national report. The results are discussed more in detail in this report, however.

Method

The method used in this study falls in the category of Truncated Poisson Models. As we know, the basic assumptions are a) a closed population b) a homogenous population and c) the probability of being included in the sample is constant over time.

A somewhat artificial way to meet the first assumption is to study a delimited time period. The second assumption is met through a stratification of the study population into strata where individuals are thought to be more alike. The assumption hardest to meet in this particular study is the third, regarding the probability of being included in the sample. Since prison records are part of the sample[6], the probability of being included varies since being imprisoned during the inclusion time frame has a profound effect on the probability of entering the record more than once.

The use of data from the correctional system was motivated by the fact that the primary aim of the study was to validate data from earlier PDU estimates based on in-patient hospital data, and some question marks remained with regard to a) what type of data was available from the correctional system, b) the size of the overlap between the sources and c) the general validity of the hospital data.

Results

Data is stratified regionally, which is a way to meet one of the model's assumptions mentioned earlier: Not only is this a means of approximating a more homogenous population, it is also the geographic boundary for the county council administrations. The county councils are in fact responsible for the treatment system in each region[7], and as such a seemingly obvious stratification variable. Another advantage is that a regional estimate is obtained in the process, not uncommonly sought by various actors.

[6] Data from the correctional system also includes probation and intensive supervision.
[7] The county councils are governed by a political assembly, and administer the treatment system, from primary care to emergency hospitals.

Table 4.1. Estimated PDU, per county, nationally and per capita. Year 2007.

County	Unique individuals in the in-patient registry (PAR)	Unique individuals in the correctional system	Estimated number of PDU	Estimated PDU per 1,000, all ages
Stockholm	2,536	417	6,408	3.3
Uppsala	299	57	797	2.5
Södermanland	230	82	1,148	4.3
Östergötland	294	113	1,107	2.6
Jönköping	360	76	849	2.5
Kronoberg	148	33	366	2.0
Kalmar	128	57	795	3.4
Gotland	68	6	212	3.7
Blekinge	95	43	511	3.4
Skåne	1,316	368	4,469	3.7
Halland	198	44	631	2.2
Västra Götaland	1,901	448	5,328	3.4
Värmland	190	109	1,099	4.0
Örebro	338	77	928	3.4
Västmanland	244	71	994	4.0
Dalarna	196	55	697	2.5
Gävleborg	238	74	1,068	3.9
Västernorrland	238	67	837	3.4
Jämtland	51	10	170	1.3
Västerbotten	238	47	596	2.3
Norrbotten	203	37	509	2.0
Sweden	9,509	2,291	29,513	3.2*

* Please note that the figure refers to all ages in the denominator, see ST7 and ST8 for further information. The estimate for the ages 15-64 is 4.9 per 1,000. Data after 2007 on estimated PDU is not yet available.

In total, the number of problematic drug users in Sweden was estimated at a rounded of figure of 29,500. This number is not directly comparable to the figures previously derived in Sweden due to differences in both the data sources and the methods used. The national estimate relating to population was 3.2 with the “all ages” denominator and 4.9 with the 15-64 years of age denominator (see ST7 and ST8 for details).

One obvious advantage of using the above method compared to earlier case-finding studies is the possibility of being able to rapidly produce time series focusing on development, compared with the sporadic studies that were undertaken in the past. The national in-patient registry dates back to the late 1980s. The registry is updated annually, and is a valuable source in this context as it can be used for the purpose.

A clear disadvantage, on the other hand, is the fact that other relevant data may be non-existent due to the design and content of the registry or registries. In a case-finding study, sought-after information can be made more readily available, such as housing and occupational status, administration routes, drug markets, risk behaviour

etc. The above approach is not without interesting possibilities though. A lot of additional information can be made available through personal identity numbers, such as mortality, socioeconomic data, or health (in terms of registered illness). This would require a more rigorous study, including an approval by an ethical committee, among other matters, and cannot be done on a regular basis (Svensson and Arvidsson, 2009).

As mentioned in the introduction, the idea of finding a fixed model that can be used on a regular basis to describe the epidemiological situation with regard to problem drug use might seem somewhat far-fetched. There is a constant evolution in society that influences what can be done in this area. The use of data from the correctional system also might infringe on the idea with single-sample methods, since it is two separate sources combined into one. Acquiring data from the correctional system is also a rather complicated process.

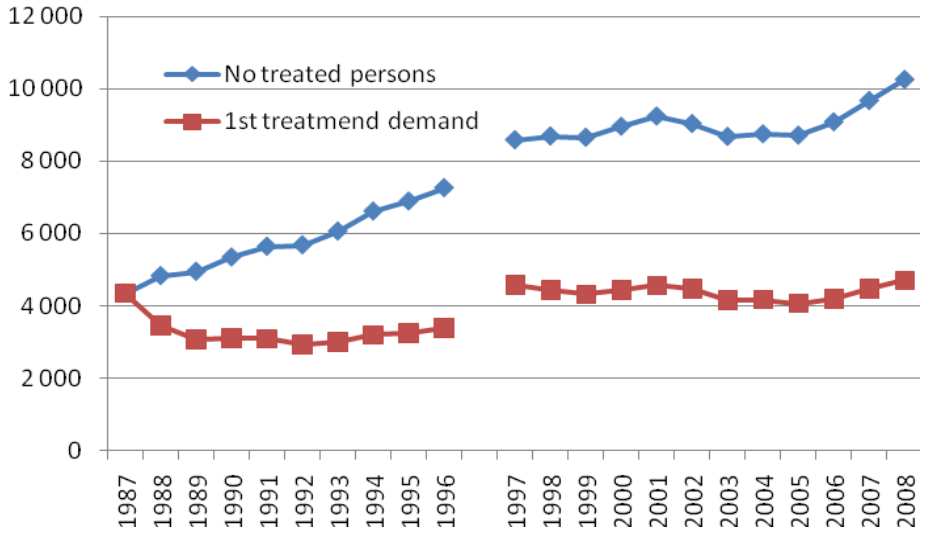
For a period of time, data on drug related diagnoses has been gathered from specialised out-patient treatment[8], and collected in a national registry at the National Board of Health and Welfare. This data can be described as an extension of the in-patient data used in the prevalence estimations described above, in the sense that it is not uncommon for individuals to move between treatment modalities, such as in-patient and out-patient. Thus, it seems reasonable to believe that this additional data can be used to acquire a more adequate picture of the frequency distribution of treatment episodes. It is only in the most recent years that this data is considered to be of reasonable quality (from the year 2008). In future studies of PDU prevalence, this is a path that should be explored. This also distinctly shows the constant evolution of the "audit explosion"[9] and the increase of new data with potential bearing on the PDU issue.

Estimates of incidence of PDU

The prevalence figure described earlier was largely based on data from the hospital in-patient registry. Since this figure can be described as a measure of point prevalence, there is no information about the incidence rate. If we refer to digitised information, data in the registry dates back to 1987. Consequently, it is possible to describe the incidence rate for a relatively long period of time – sometimes also referred to as first treatment demand.

[8] This refers to out-patient treatment provided at hospitals or private clinics.
[9] The term audit explosion is from the book "The Audit Society" by Michael Power and refers to the constant increase of data available to us, in society in general, and the treatment sector is certainly no exception.

Figure 4.1. Number of treated in-patients, and 1st treatment demand, 1987-2008.



The figure above describes a timeline of 21 years and the leap between the time periods 1987-1996 and 1997-2008 refers to the International Classification of Diseases (ICD) 9 and 10 periods. There is a slightly higher level that can be contributed to the new coding system, and thus the separated time series.

The lower timeline (in red) is a description of people who registered for in-patient treatment for the first time since 1987 (defined in the same way as the cases in the PDU sample 2007, see ST7 and ST8 for details). What can be seen is that we are dealing with two periods with rather similar levels in terms of incidence rates. What should be noted, however, is the increasing trend that has been present in the last three years in the figure timeline and that the level of first treatment demand cases is at its all-time high in 2008 (4,700). During the same period, the population grew in number, and the 1990[10] rate of first treatment demand was 0.36/1,000. In 2008, the corresponding figure rose to 0.51/1,000.

Data on PDUs from non-treatment sources

PDUs in data sources other than TDI

CAN regularly assess the development of PDU in their drug reporting system (CRD), which involves information provided by the 15 largest municipalities in terms of population size. The observation period was the second half of 2009, and the reference period the first half of 2009.

[10] In 1987, there was no possibility to control for previous treatment episodes, hence the sudden drop soon thereafter.

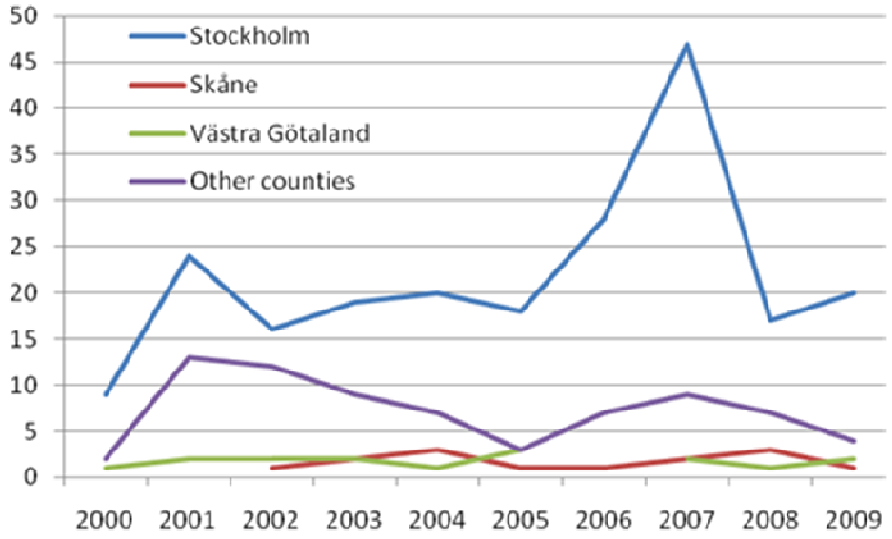
Table 4.2. Perceived changes in the number of problem drug users[11], local informants (CRD). July 2009 – December 2009

	Not occurring	Increase	No change	Decrease	Don't know
Problem Drug Use	1	14	96	2	16

Although not a randomised sample and with a limited coverage, this type of data can be a pointer of the development of problem drug use. The first thing to be noted is that PDU is prevalent to some extent in all 15 municipalities, and only one informant reported differently. With respect to the overall development, it is hard to draw any conclusions, however. Even if the majority of the informants report no change, the "don't know" category comprises quite a few informants. To sum up, this data does not contradict the development described earlier, and is more an indicator of the most recent development.

Data regarding blood-borne infectious diseases can be both an indicator of PDU, and an indicator of the health situation among the users (health correlate). Its development will be analysed in more detail in a different chapter, but some comments are made here as well.

Figure 4.2. Number of HIV-cases reported 2000-2009 with intravenous drug use as transmission route. Source: Swedish Institute for Communicable Infectious Disease Control



In figure 4.2, the 2006-2007 outbreak of HIV among IDUs in Stockholm is quite apparent. Even if the levels now are down to the levels that existed before the outbreak, the crude rate is higher than in other regions, with a risk for new outbreaks.

In 2007, the Human Rights Council Special Rapporteur, Paul Hunt, published a report about the state in Sweden. One important concern was the low availability of

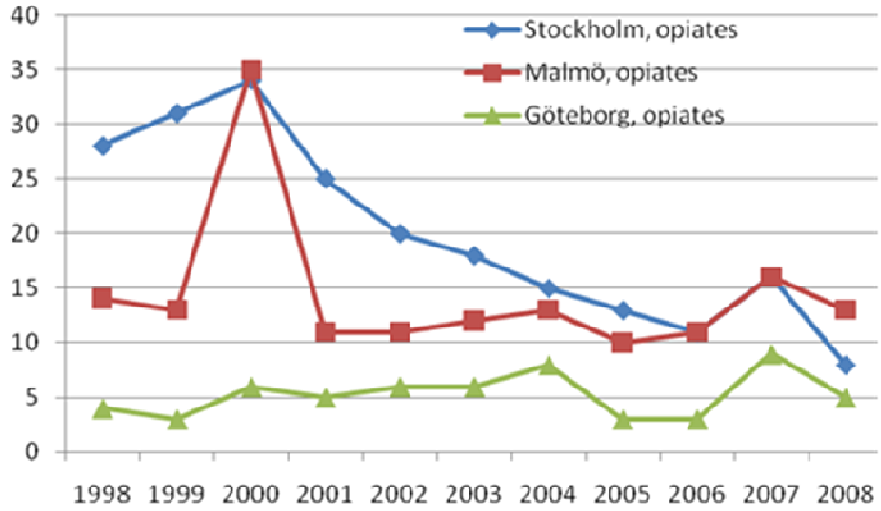
[11] All intravenous drug use, or drug use that is daily or almost daily.

clean needles and syringes. In accordance with the Swedish law, it is left to the discretion of political assemblies at the local and regional level to decide on the existence of such programmes. At the time of the Special Rapporteur report, there were only two needle and syringe exchange programmes (NSEP) running in the country as a whole, one in Lund and the other in Malmö. At present, a third programme has been set up and is running in Helsingborg. These three municipalities are located within the same county council administration – Skåne. In Stockholm, it has been decided that an NSEP programme will be set up and operate from 2012. The programme is described as provisional and will be evaluated.

The law regulating NSEPs also stipulates a minimum age of 20 years before entering the programme. Studies show that the average age of first injection may be below, or in the neighbourhood of this age limit, which leaves the younger IDUs at high risk.

Patterns of drug use in metropolitan areas
The most common drug among PDU in Sweden has always been amphetamine. This is still a fact, but recent mortality data has been used to shed some light on the situation in the three major cities, Stockholm, Gothenburg and Malmö. Questions have been raised regarding the relatively high drug-related mortality in Malmö (in spite of having the only NSEP programmes in the country) and the alleged rarity of heroin in the city of Gothenburg.

Figure 4.3. Numbers of drug related deaths involving opiates in the municipalities of Stockholm, Malmö and Gothenburg, 1998-2008.



Data on drug-related mortality was extracted from the national Cause of Death Registry. The focus was on the three metropolitan municipalities, and not on the regional level, which is common. The problem with a regional analysis is that the cities are only a smaller, although densely populated part of more or less rural areas.

The rate of total drug related mortality in the city of Malmö was 9.8 per 100,000 inhabitants, followed by Stockholm (6.5 per 100,000) and Gothenburg (6.2 per

100,000)[12]. There could be several explanations for this pattern, such as prevalence of drug use, prevalence of infectious diseases, access to healthcare, etc.

Data on opiate drug-related deaths[13] for the three cities supports the idea that heroin is relatively uncommon in Gothenburg. It also supports the assumption that the higher levels of drug-related mortality in Malmö, may very well be attributable to the fact that heroin, with its higher toxicity, is more prevalent compared to the other metropolitan areas. If we look at the 11-year time period as a whole, the proportion of opiate deaths (as compared to the total number of drug related deaths) was 24 per cent in Gothenburg, 31 per cent in Stockholm and 47 per cent in Malmö, thus placing the cities in a rank order where a high proportion of opiate cases coincide with a higher rate of drug-related mortality.

[12] Figures refer to the year 2008.
[13] ICD-codes F11, and T40.1.

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

Introduction

The treatment system

Drug treatment is arranged by the social services in the local community (in ordinary healthcare services or 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 arranged by the National Board of Institutional Care and it is regulated in the Care of Alcoholics, Drug Abusers and Abusers of Volatile Solvents Act, LVM. Yet 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.

Guidelines for treatment

The National Board of Health and Welfare (NBHW) has published evidence-based national guidelines for the treatment of persons with substance abuse and dependence problems (also see Substitution treatment below) (National Board of Health and Welfare). The section on narcotics deals with topics such as: abstinence treatment, specific treatments for the use of cannabis, hallucinogens, stimulants and opiates, 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.

Several regional conferences have been held to provide information about the 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 conduction this in a project since 2008. The work has two objectives:

1. to develop a 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 and 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 titled “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 läkemedelberoende (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 retrieved from the aforementioned booklet:

Municipalities are responsible for overall long-term rehabilitation through the social services. This is set out in the Social Services Act, which is an outline law. This means that it must be interpreted and it provides scope for individual judgments. Therefore it is 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 (detox) and psychiatry. They also provide maintenance therapy with methadone or Subutex. Healthcare services operate according to the Health and Medical Services Act, 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 Act emphasise that it is important that care is given on a voluntary basis - as far as possible.

The Swedish Prison and Probation Service is 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 and 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 is KIM (“Clients in Substance Misuse Treatment”), which is directly tailored from the TDI guidelines with the exception of including alcohol as a drug. KIM only 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. Today, KIM covers about 25 per cent of existing units of inpatient and outpatient centre type from all regions of the country.

Another source is DOK, which is a system for quality development: assessment and follow-up of clients and the services provided. This system is integrated with KIM, and therefore 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 administered by Linnaeus University in Växjö.

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 also provided some data for 2010.

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. To read more about the Addiction Severity Index see chapter 11.

These 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 impossible to compare data from different sources on an individual level.

Strategy/policy

In the autumn of 2008, a comprehensive government investigation of substance misuse treatment was started and, due to a recently postponed deadline, is to publish its final report by 15 April 2011 (SOU 2008:04). The objective is 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 make suggestions for improvements (and possibly also re-organization of the treatment system). The goal is to establish a knowledge-based system for the all treatment of persons with substance misuse and dependence, based on the needs of these individuals.

TDI as a base for national quality registers

One of the areas in the investigation being finalized for political decisions by the end of 2011 is called "Better quality, knowledge and skills" with the overall goal to develop systems for quality assurance, research and dissemination of knowledge and skills to provide the foundations for a more knowledge-based care. This further emphasizes the need for documentation, which opens up a possibility to use the TDI more at a national level.

There is a concrete proposal that SBR (Svenskt BeroendeRegister) shall be an obligatory documentation in the dependency care within the medical treatment

centres. The documentation in SBR is, as have been stated above, today totally compatible with the TDI –protocol.

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-registries will be totally compatible to facilitate epistemological data from all treatment centres outside prisons.

There is still no "law" in Sweden that forces the use of /TDI/SBR/KIM but there is a proposal linking this documentation to getting authorization for treating people with drug problems.

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

The overall picture

Data on treatment for problematic or heavy drug use is reported in TDI (ST 34). For 2010, data is available from a higher number of reporting treatment centres than in previous years. In 2009 the reporting system covered 51 per cent of all inpatient and 31 per cent 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 came into treatment for the first time. The main drugs of choice by new clients are cannabis and amphetamine, closely followed by the summary category "other opiates".

Most 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 are higher than the prevalence of heroin IDUs.

By substance used

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

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

Cocaine use is still rare as a drug being the reason for seeking treatment (1 per cent), and crack cocaine is nearly non-existing in this population, as is also methadone, ecstasy and hallucinogens.

By centre types

Inpatient treatment centres reported 2,606 cases and outpatient units reported 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 per cent) and in outpatient treatment centres cannabis (41 per cent).

6. Health correlates and consequences

Introduction

The 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 for this surveillance is the registration of approximately 60 notifiable diseases listed in the Communicable Disease Prevention and Control Act (SFS 2004:168) and the Communicable Diseases and Prevention Ordinance (2004:255). Physicians are obliged to notify cases (diagnoses) of the listed pathogens and notification is done in parallel to the SMI and the County Medical Officers, both by the clinicians and the 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 a SMI's webpage, yearly reports and the weekly bulletin *Smittskyddsinstitutets nyhetsbrev* (in Swedish).

Behavioural surveillance data is not collected in SmiNet, which limits its capacity to monitor trends in risk behaviours over time. Needle syringe exchange programmes only exist in one county in Sweden. As a way to monitor trends in risk behaviours in IDUs, a programme is on-going in the two biggest cities in Sweden, Stockholm and Gothenburg. In this programme (Svenska häktesprogrammet) nurses systematically test, vaccinate and provide risk reduction counselling to IDUs taken into custody. Also, the nurses conduct behavioural oriented interviews targeting the IDUs' knowledge, attitudes and practises. As 80 per cent of all IDUs are estimated to be taken into custody over a three year period this setting has been chosen for regular data collection regarding IDUs and risk behaviours.

Since late 2010 SMI is responsible for the coordination of HIV and STI prevention at a national level.

Drug related infectious diseases

HIV/AIDS and viral hepatitis

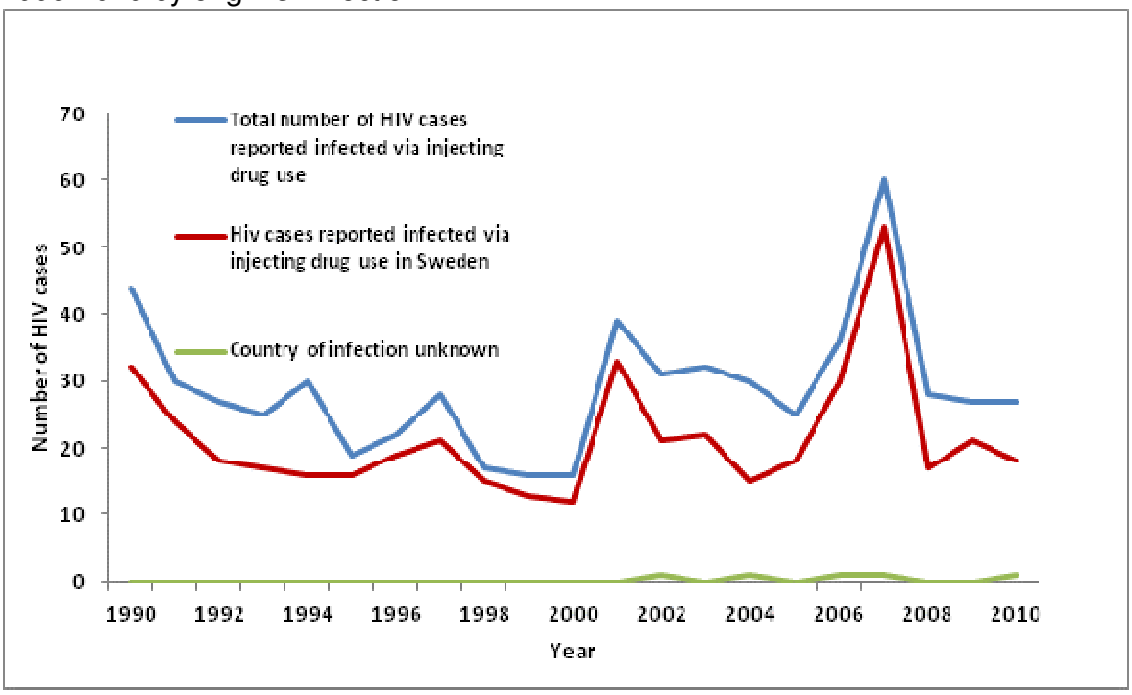
HIV

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

Compared with many other European countries Sweden has a relatively small proportion of IDUs infected with HIV. During the last 5-10 years the proportion of IDUs among the reported HIV cases in Sweden has been between 15 and 25 per cent. Local studies have shown a prevalence of HIV among IDUs of between 0 and 8.4 per cent (EMCDDA, 2009a).

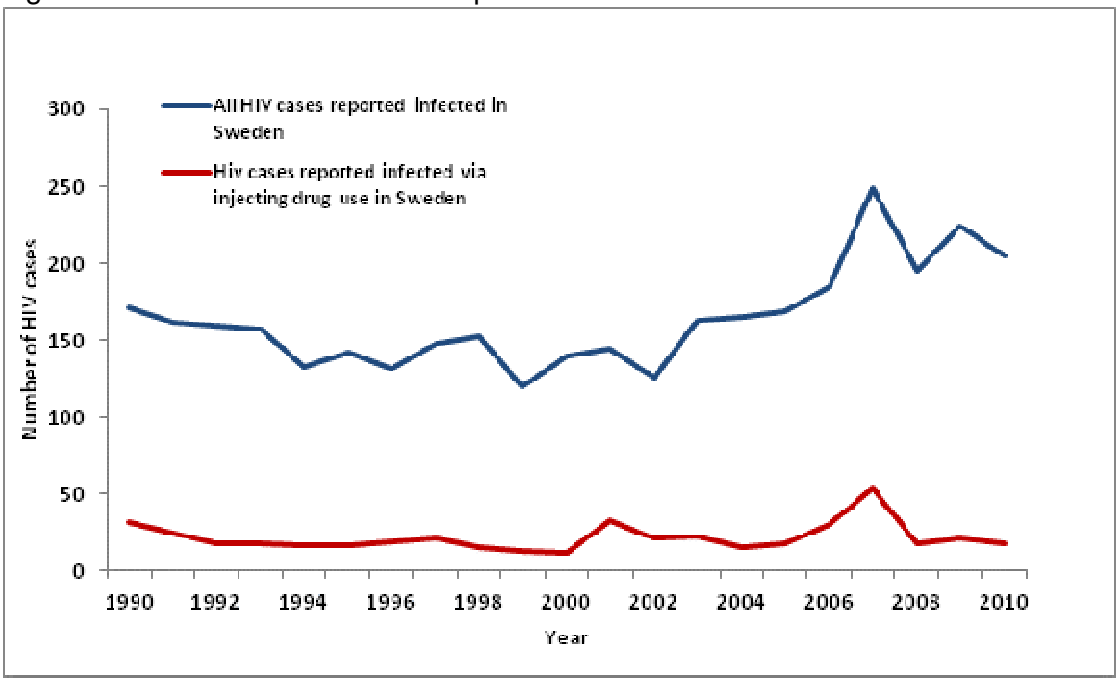
By the end of 2010, a total of approximately 1,000 cases of HIV positive IDUs had ever been detected in Sweden. In 2010 27 HIV cases were reported infected via intravenous drug use. Of those 8 were immigrants infected prior to arrival in Sweden.

Figure 6.1: Number of HIV cases in Sweden reported infected via injecting drug use, 1990-2010 by origin of infection.



In 2006 an HIV outbreak occurred among IDUs in Stockholm. Due to intensified testing many HIV infected IDUs were detected and reported in 2007.

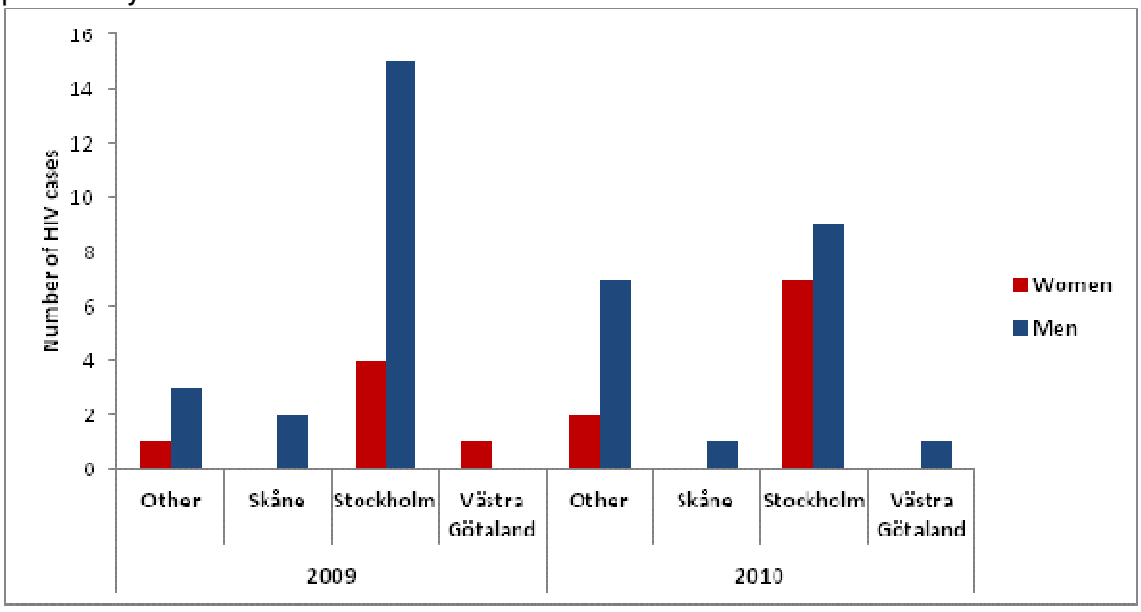
Figure 6.2: Number of HIV cases reported infected in Sweden 1990-2010.



Stockholm County Council
Between 2007 and 2008, a regional study was conducted in Stockholm County (Hillgren and Britton, 2009). The aim of the study was to interview, test and vaccinate IDUs in the region and a total of 1,145 IDUs participated in the study. Of the 1,145 IDUs, 720 had injected sometime during the preceding 12 months and were classified as active IDUs. The mean age of the active IDUs was 40 years and 73 per cent of them were men. Approximately two thirds had been to prison. The majority made their narcotics debut at 15 years of age and their intravenous debut at the age of 19. 75 per cent used amphetamine as their first intravenous drug. Risk behaviour patterns were widespread within the population. 51, or 7 per cent, of the 720 active IDUs tested HIV positive of which approximately one third were new cases detected. 82 per cent were HCV positive (anti-HCV positive) and one per cent chronic HBV carriers (HBsAG positive and anti-HBc IgG positive).

Skåne County Council
In 2010, 829 IDUs participated in the Malmö (Skåne county) needle syringe exchange programme (NSEP) out of which 4 were known HIV positive. The NSEP in Malmö started in the late 1980s and is believed to have had a positive effect on HIV transmission among the participating IDUs. No new HIV cases have been reported among the participants in the last 10 years. Few new HIV cases infected via injecting drug use are reported from Skåne county in general. In Stockholm county, without a NSEP, higher numbers of new cases infected via injecting drug use are reported (figure 6.3).

Figure 6.3: Number of HIV cases in Sweden reported infected via injecting drug use, per county of detection.



Hepatitis B and Hepatitis C
Both hepatitis B and C are, as HIV, notifiable diseases in Sweden. Unlike HIV hepatitis is notified using a personal identification number which reduces the problem of possible duplicates of notifications.

Hepatitis B
In the beginning of the 21st century there was an outbreak of hepatitis B among intravenous drug users in Sweden. Following the outbreak vaccination activities were intensified at prisons and the 2005 vaccination recommendations for risk groups regarding hepatitis B were developed. Despite an increase in vaccination activities local minor outbreaks of hepatitis B among intravenous drug users are still being reported. This indicates that not all IDUs are being vaccinated and that the transmission of hepatitis B is still a problem in this group despite it being a vaccine preventable disease. About 150-200 cases of acute hepatitis B are reported annually in Sweden. In 2010, 125 cases of acute hepatitis B were reported out of which 51 reported had been infected via injecting drug use in Sweden.

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 per cent (EMCDDA, 2009b).

In 2010, a total of 1,944 cases of hepatitis C were reported to the Swedish Institute for Infectious Disease control, which represented a 12 per cent decrease in cases reported compared to 2009. Intravenous drug use is the dominant transmission route and most cases are domestic. Seen in a longer perspective the total number of reported cases is decreasing. However, when looking by age group, no decreasing trend in cases infected via intravenous drug use is apparent in the younger age groups (15-19, 20-24, 25-29). This indicates that there is on-going transmission of the disease among young intravenous drug users in Sweden. 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.

Other drug-related health correlates and consequences

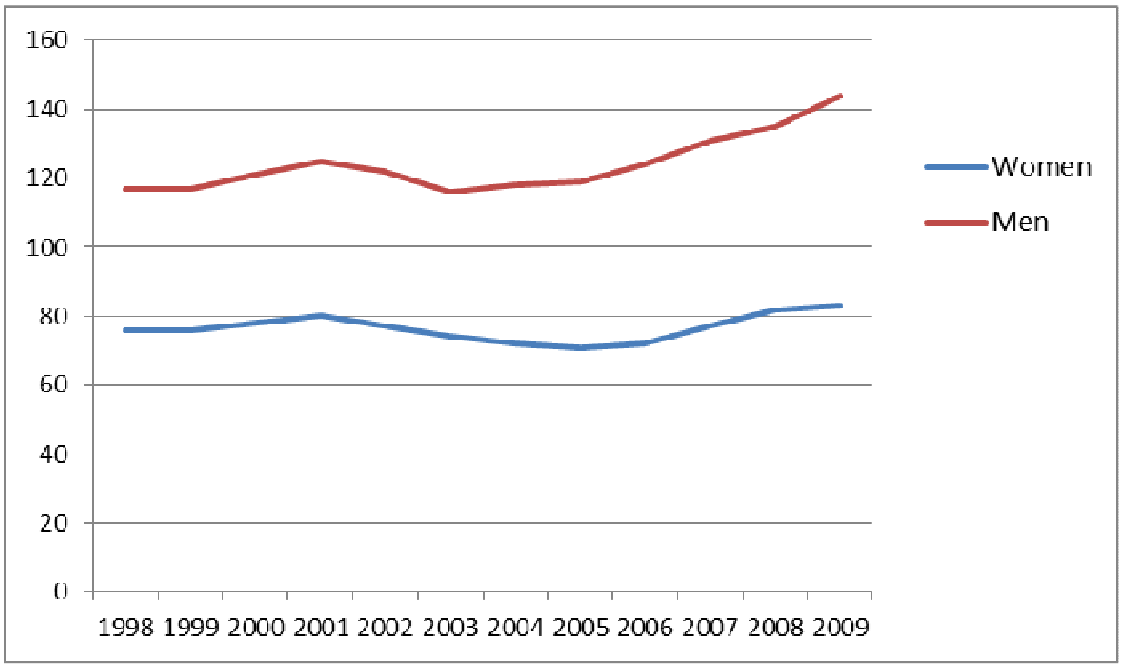
Other topics of interest

Somatic and psychiatric comorbidity
The use of drugs is often closely related to more or less severe health problems. Psychiatric diseases and various infectious diseases are quite common among drug users. It has been known for a long time that the morbidity and the mortality among drug users is many times higher than among the general population in the same age groups. 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 distributed (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 per cent of those that have been treated in health care for drug related diagnosis are women, even though their proportion of the population of heavy drug users is around 27 per cent. The figures for 2009 (no figures are available for 2010) show also a slight rise compared with the last years in consumption of somatic care for drug users 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 6.4. Men and women treated in health care for drug related diagnoses[14]. 1998 - 2009. Number per 100,000 inhabitants, by gender.



Psychiatric co-morbidity

The results from the yearly public health survey shows a connection between the use of cannabis and psychiatric health, with a large number of those using cannabis reporting problems like anxiety, feeling worried. A larger proportion of the users also reported use of antidepressant medication and also suicide attempts. The connection is probably two-way: you use cannabis because you feel bad and you end up feeling bad if you use cannabis (Statens folkhälsoinstitut, 2009).

Several Swedish studies have shown that psychiatric problems are much more common among youth using drugs than among those who have not used any drugs (Falhke, 2006, Tengström, 2006). Research shows that youth who use drugs regularly often also have at least one psychiatric disorder, such as for example depression or conductive disorder. One study of youths and their parents who visited a centre for youths with addiction problems (Maria Ungdom) in Stockholm compared the psychiatric status of these youths with a reference group of youth and parents in a smaller town in Sweden. The results indicate that around 70-95 per cent or the groups from the centre in Stockholm at some point fulfilled the diagnostic criteria for at least one psychiatric diagnosis (including addiction-related ones). Depression was the most common diagnose for the girls and the women and antisocial personal disorder together with conductive disorder was most common among the boys and the men (Tengström, 2006).

[14] The number men and women treated for 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/

In summary, the various studies indicate that the use of drugs is more common among socially vulnerable individuals and that those who use drugs have a less good health than those who never used drugs (Hensing, 2008).

Drug related deaths and mortality of drug users

Reporting routines/system
Data on drug-related deaths in Sweden is collected either from the National Cause of Death Registry (NCDR) or from a research register on forensically examined deaths with presence of illicit drugs or methadone (Toxreg). Forensic investigations are performed routinely in Sweden at fatal accidents or when there is a suspicion of unnatural death, suicide or crime.

The national causes of death register
The cases of drug related deaths in the NCDR have to be correctly coded strictly according to the ICD-10 system, but the ICD-10 diagnosis T40.4 (dextropropoxyphen) has been excluded.

The Selection B, version 3.1 was implemented from 2005 and includes all deaths with drugs as an underlying (=main) cause, with exclusion of T40.4 (see above). Since the new version included three new diagnoses, an increased number of deaths could be expected. A comparison between the 3.0 and 3.1 versions of the data for 2005 showed 28 fewer cases with the 3.0 version. Data for this comparison is retrieved from the national Causes of Death Register held by The National Board of Health and Welfare.

The forensic toxicity registry (Toxreg)
Since 2004, there has been a research register based on forensically examined deaths where illicit drugs or methadone were found in the body. The register is called “Toxreg” and is a joint project between Karolinska Institutet, the Swedish National Board of Health and Welfare and the National Board of Forensic Medicine.

Forensic investigations are performed routinely in Sweden at fatal accidents or when there is a suspicion of unnatural death, suicide or crime. 93 per cent of all deaths from violent causes or intoxication among persons under the age of 65 are examined forensically, including a toxicological examination. Approximately 5,500 deaths are investigated each year. The SNIPH has supported the research and development of data on deaths with illicit drugs present (Toxreg). The figures are based on detection of drugs in body fluids and emanate from the forensic data bases of the National Board of Forensic Medicine. Data is available until 2010. When the method is fully developed it is estimated that a trend could be mirrored within months.

If several illicit substances were present simultaneously, the death was placed in the highest ranked substance category. For instance, if both cocaine and amphetamine was detected, the death was placed in the amphetamine category.

The categories of substances analysed in drug-related cases of death based on forensic data are:

1. Verified heroin: 6-monoacetylmorphine (6-MAM) present. After intake, heroin is rapidly transformed into (6-MAM), which can only originate from heroin. If 6-MAM is present, it can be assumed that death occurred close to the intake of heroin.

2. Heroin/morphine: Deaths with morphine but no 6-MAM present, where morphine levels are equal to or higher than codeine levels. Codeine is usually present as a contamination product at a low concentration in illicitly produced heroin. After ingestion, heroin is transformed into 6-MAM. The 6-MAM is further transformed into morphine, which can also originate from legally prescribed medicine. In this manner, the simultaneous presence of both codeine and morphine strongly suggest death caused by heroin. To further ensure deaths caused by legal medicine were not included, deaths occurring among persons older than 60 were excluded from this specific category. In this manner, suicides with legally prescribed medicine among elderly people were excluded.

3. Methadone, persons older than 60 are excluded.

4. Amphetamine

5. Other illegal drugs: Cocaine, ecstasy-type substances, GHB, LSD, DOB, methamphetamine, 4-methylthioamphetamine

6. Cannabis only: Deaths were only attributed to this category if no other illegal drugs were present.

The short delay in data availability makes the forensic data a very useful tool when looking at trends in acute drug-related mortality. It must be kept in mind that the mere presence of an illegal drug in forensic analyses does not imply causation. Additionally, the chain of causation (of drug-related deaths) also varies for different substances.

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

Data from the National Cause of Death Registry (NCDR), according to EMCDDA Selection B, version 3.1.

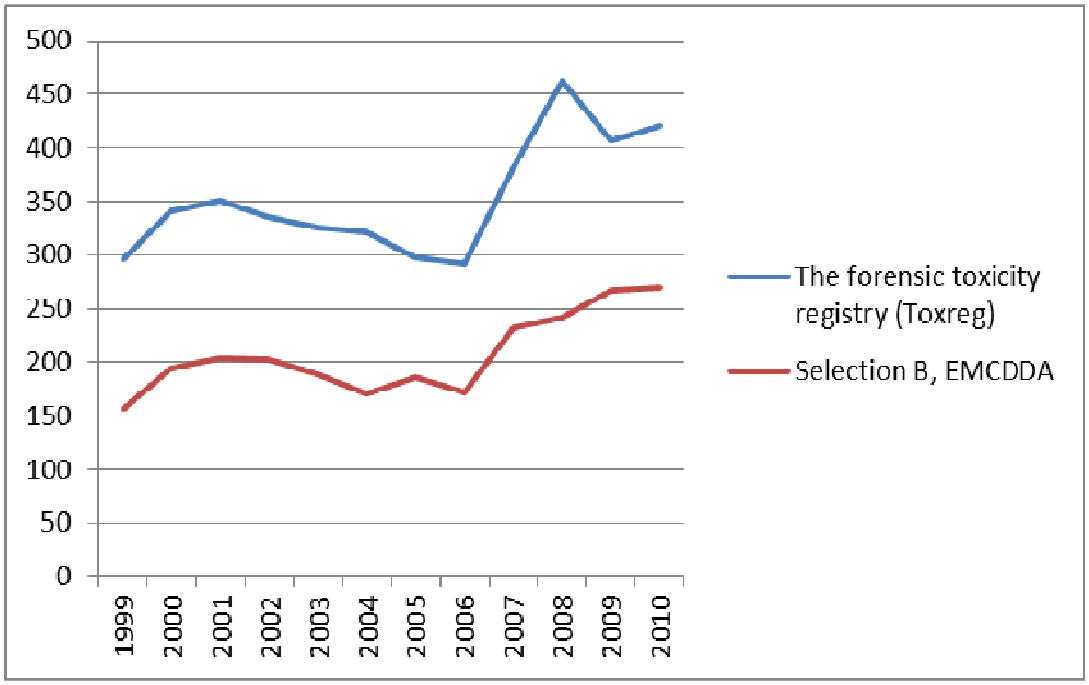
The Selection B, version 3.1 was implemented from 2005 and includes all deaths with drugs as an underlying (=main) cause, with exclusion of T40.4 (as previously, due to the extent of poisonings with dextropropoxifen). The numbers of drug related deaths 1999 – 2010 are shown in table 6.1.

Table 6.1. Total number of cases, number of cases by gender and number of drug related deaths by opiates occurring or not. Standard Table 6 according to the EMCDDA, Selection B 3.1.

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Total number of cases	157	194	204	203	188	170	186	172	232	241	267
Number of cases, male	134	161	170	168	146	146	146	136	176	183	204
Number of cases, female	23	33	34	35	42	24	40	36	56	58	63
Number of cases with known toxicology	119	167	188	176	168	134	169	158	223	226	244
Number with opiates	96	127	131	125	107	84	111	119	184	193	213
Number with any drug without opiates	23	40	57	51	61	50	58	39	39	33	31

In 2007 an increase in the number of deaths could be observed (table 6.1 and figure 6.5). There are at the moment no clear explanations for this increase.

Figure 6.5. Number of drug related deaths per year 1999 – 2009. Based on EMCDDA, Selection B 3.1, (T40.4 excluded) and the annual number of deaths of Toxreg (deaths with illicit drugs or methadone present).



Mortality cohort studies)

Sweden has a good infrastructure for performing cohort studies based on linking register information. A number of databases exist such as the population register, the cause-of-death register and the hospital discharge register that covers the whole population. Since 1994 there is also a research register, which covers all forensically

examined deaths, with presence of illicit drugs and methadone. The unique personal identification numbers can be used for linking information in different registers.

On the other hand it is difficult to make regular follow up studies on drug users in outpatient care and in treatment homes outside the health sector. In the social welfare services, the research tradition is much weaker, which makes it difficult to monitor cohorts of treatment populations. There is also a resistance to using personal identification numbers, which is sometimes regarded as infringing on personal integrity. Consequently it is difficult to satisfy the EMCDDA standard – a cohort of 'problem users in treatment settings'.

However, there are a limited number of studies on problematic drug users in treatment settings that have been used for follow-up purposes.

The most common illicit drugs in Sweden are cannabis and amphetamine. Historically the amphetamine has also been the most common intravenous drug in spite of a gradually increased heroin use. Therefore it is possible to study the long-term effects of amphetamine use, which is regarded as a research priority in a comprehensive review by (Singleton et al., 2009).

In 2010 and 2011 the results of two Swedish cohort studies have been published.

Stenbacka et al. (2010) followed up 1,705 drug users (1,288 males and 417 females). People with substance abuse were identified through records collected by various institutions and caregivers in Stockholm in 1967. The subjects were followed in the mortality and hospital discharge registers until 2003. The standardised rate ratio (SRR) for mortality was 3.3 among males and 3.5 among females. Accidents and suicides were the most common causes of death among the youngest subjects and cardiovascular diseases and tumours were most common among the elderly. The cohort was collected before heroin was introduced in Sweden (Stenbacka et al., 2010).

Nyhlén et al (2011) has followed up a cohort of 561 drug users, who were hospitalized between 1970-78 in a detoxification unit in the south of Sweden. The cohort included both amphetamine and opiate users and was followed up until December 31st 2006 (Nyhlén et al., 2011).

More than 60 per cent of the subjects used more than one drug and remained using several drugs during the follow-up period. 204 persons died during the study period. The crude mortality rate was 1.3 per cent and SMR was 5.9. One important conclusion was that the official cause-of-death register underestimates the number of drug-related deaths and suicides.

Fugelstad et al. (1997) have studied a cohort comprising 1,640 individuals, who had undergone in-patient treatment at a clinic specialised in addictive disorders during the period 1981-1988. Mortality was monitored from 1985, when data on HIV status was possible to obtain. Information was also available on the type of drug use. Mortality was observed on two occasions, in 1992 and December 31st 2007 (Fugelstad et al., 1997). The results from the second follow-up have been reported to EMCDDA but not yet been published.

At the second follow-up in 630 deaths had occurred and the crude morality rate was 2.2 per cent, Opiate users had a higher mortality rate than mixed drug and amphetamine users. The mortality rate among males was higher than that among females. However, compared with the general population, females had a higher excess mortality (SMR = 18.3) than males (SMR = 13.8). The two most common causes of death were heroin intoxication and aids-related causes (EMCDDA, 2011).

Fugelstad et al have examined a cohort that comprised 2,986 persons (2,229 males and 757 females), who were in contact with the social services and were problem drug users. The cohort was observed until the end of 2008. The crude mortality rate was 1.6 per cent and higher among opiate users (2.3 per cent) than amphetamine (1.3 per cent) and cannabis users (0.9 per cent). Also this cohort has been reported to EMCDDA but has not yet been published (EMCDDA, 2011).

Previously 6 other cohorts have been described. One includes 151 individuals, who were treated under the law of compulsive treatment of drug abusers (LVM). Another cohort consists of 135 amphetamine users who thoroughly interviewed about risk behaviours. There are three cohorts from treatment settings in the 1960's and 1970', mainly consisting of amphetamine users.

It is a research priority to follow the mortality rates and causes of death among amphetamine users especially with regard to the long-term effects. Therefore a multi-cohort study is planned of persons, who have used amphetamine at several occasions during a long time period.

Since 1965 until 2006 all persons in contact with the remand prison i Stockholm have been screened for injection marks. A data base has been constructed that comprises almost 80,000 individuals, who have been examined and asked about drug use and type of drug at multiple occasions between 1965 and 2006. This register, together with the hospital discharge register and a number of treatment cohorts will be used to construct a cohort of amphetamine users with multiple exposures for the drug during a long time-period. This cohort will be followed up regarding mortality and causes of death.

Specific causes of mortality indirectly related to drug use
No new information available.

7. Responses to health correlates and consequences

Introduction

An evaluation of the last five-year Swedish action plan on drugs (2006-2010) indicates that the national efforts to reach the goals have stagnated in the area of narcotics (Statens folkhälsoinstitut, 2010b). A new national strategy for the period 2011-2015 has been launched and the visionary goal of a society free from narcotics remains. The strategy has seven long-term political objectives, including increased access to health care and support of good quality for individuals with abuse or dependence, as well as a decrease in the number of deaths or harm due to use of alcohol, narcotics, doping and tobacco (Regeringens proposition 2010/11:47).

In January 2010, a preliminary commission report concluded that Swedish health care and social services is of insufficiently quality and not diversified enough in the area of drug use. In the commissions' final report in June 2011 a number of proposals were submitted including increased financial resources, implementation of national guidelines, increased availability to drug treatment including a statutory enhanced health care guarantee, needle exchange and other evidence based interventions. The report also suggest new laws and a new organization where the County Council is given overall responsibility for treatment and municipalities overall responsibility for social support. The commission's proposals are suggested for adoption in January 2013 (SOU 2011:35).

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

Although access to medically drug-assisted therapy has increased significantly in Sweden, long queues still exist in many places. A survey from 2007 showed that only half of the Swedish county councils were able to offer drug-assisted therapy within the timeframes set by the health care guarantee (Sjölander and Johnsson, 2007). Swedish studies indicate that one of the main reasons for illegal use of buprenorphine [15] is that existing programmes do not have capacity for all who require treatment (Antoniusson, 2007, Håkansson et al., 2007).

In recent years, some Swedish drug-assisted programmes introduced a "zero tolerance" against lateral abuse, which means that a patient can be discharged from treatment after a single positive urine test (Heilig and Gunne, 2008), leading to low retention. 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 other mental health care and a reasonable programme size. Small scale programmes create an organizational vulnerability while large scale programmes

[15] The buprenorfin based pill Subutex was approved in Sweden in 1999 and Subutex is of today more common in maintenance treatment in Sweden then methadone (SJÖLANDER, J. & JOHNSSON, B. 2007. Tillgängligheten till läkemedelsassisterad underhållsbehandling i fyra sjukvårdsområden: Västra Götalandsregionen, Jönköpings länslandsting, Kronobergs läns landsting och Västernorrlands läns landsting. Stockholm: Mobilisering mot narkotika [MOB].

increases the risk of neighbourhood problems and therapeutically unfavourable patient compositions (Laanemets, 2007).

The number of deaths with presence of methadone in the blood has tripled in Sweden during the period 2006-2008. In the same period, there has been a rapid expansion of methadone treatment. In 2005, the regulations on medically assisted substitution treatment were changed in Sweden. The previous restrictions on the number of people who were allowed to participate in treatment at the same time were removed. The number of new treatment units increased tenfold when a number of new programmes started throughout the country (Fugelstad et al., 2010). In autumn 2010 there were 64 units that provided pharmaceutically assisted maintenance treatment in Sweden (Swedish National Institute of Public Health, 2010).

A forensic medical examination of the methadone related deaths shows that the majority involved mixed intoxication where the methadone played an important role. As the Swedish prescription register shows that 80 per cent of the deceased persons had not obtained their methadone from any legal sources, methadone programmes or pain relief treatment, leakage from methadone treatment appears to be a possible but minor source (Fugelstad et al., 2010).

Collaboration produces good results in treatment for people with opiate dependence

An evaluation of a drug-assisted programme for opiate dependent patients at the County Hospital in Sundsvall-Härnösand shows very good results; forty per cent of patients have jobs, a high proportion remains in treatment, and no crime occurs in the group. Although the study contains outcome data, the purpose is primarily to illustrate the interaction process between the County Hospital and social services and to highlight treatment from a user perspective.

The drug-assisted programme is carried out by the County Council in cooperation with social services in four municipalities in the region. The evaluation points to the many benefits from collaboration in this area; greater efficiency (faster interventions and transfer of information), increased consistency in the programme and improved knowledge of patients with drug dependency.

In the evaluation patients pointed out how important maintenance treatment was for their lives and psychosocial well-being, but also highlighted the difficulty of the clinics dual role, as a supporting scheme with control functions. Patients also had experiences from poor behaviour at other agencies', and difficulty in gaining access to local drug treatment and rehabilitation.

Both patients and social services had suggestions for improving the maintenance treatment. Among other things more individual psychological therapy was desired together with extended rehabilitation, improved accessibility and a faster route to inpatient care (Augutis and Hillborg, 2011).

In a Swedish review article about the risks and side effects with drug-assisted maintenance treatment is discussed whether the presence of methadone and buprenorphine treatment makes it difficult for drug-free treatment, because heroin addicts who want to stop the abuse prefer replacement therapy. The author argues

that despite the absence of clear evidence of positive effects related to drug-free treatment the competitive claim is worth taking seriously because it will always be patients who prefer treatment aimed at complete abstinence. The article refers to countries where substitution treatment completely dominates the provision of care for heroin addicts and drug-free treatment has largely ceased as an option. Until the mid-1990s it has been relatively easy to access drug-free treatment in Sweden, while it was very difficult to have admission to methadone treatment. The current situation, with an increasing availability of substitution therapy and a reduction in drug-free treatment is, according to the author, primarily due to the fact that Swedish heroin addicts to a greater extent are given the opportunity to influence the choice of treatment (Johnsson, 2010).

Prevention and treatment of drug-related infectious diseases

Today, there are three operational Syringe Exchange Programmes (SEP) in Sweden, all located in the same county council, Skåne, in the south of Sweden. A fourth programme will be set up in Stockholm, and is likely to be operational in 2012 (Swedish National Institute of Public Health, 2010).

As worldwide, SEP in Sweden was 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 intravenous drug users (IDUs) without contact with health care or social services and connecting them with regular drug services. SEPs in Sweden were gradually developed to also include efforts to reduce risky sexual behaviour and somatic, psychological and social interventions (SOU 2011:6).

Several studies from SEP in Malmö show that new infections of HIV in the programme have to a large extent ceased, but especially HCV is still spreading. The programmes provide unique opportunities for relatively regular testing and act as an early warning system for HIV (ibid.).

In 2008 a thesis on IDUs participating in the SEP in Malmö was published (Stenström, 2008)). The study followed 3,660 IDUs over a 15 year period and analysed how the programme is used and developments regarding contagion, HIV and hepatitis testing, vaccinations, and social development. A subset consisting of 495 IDUs who attended the SEP in 1995 were interviewed. These accounted for 74 per cent of all who had contact in 1995 and living in Malmö. Moreover, register data for the years 1989-2003 from a total of 177,000 visits were used together with the Malmö part of an earlier national survey of problematic drug use[16].

The study compared the characteristics of those who participate in SEP with other heavy drug users in Malmö. SEP-users were older and had a longer experience in drug abuse. Amphetamine was the drug of choice among SEP-users, while heroin dominated among the non-SEP users. The majority of SEP-users injected in periods, while the majority of non-SEP users injected regularly.

[16] The MAX Survey 1998 (OLSSON, B., ADAMSSON WAHREN, C. & BYQVIST, S. 2001. *Det tunga narkotikamissbrukets omfattning i Sverige 1998. MAX-projektet, delrapport 3*, Centralförbundet för alkohol- och narkotikaupplysning [CAN]).

The interviewees were divided into four groups according to inclusion in mainstream society and sub cultural involvement. Most interesting perhaps is the difference between the incidence of syringe sharing in the different groups. Last year syringe sharing has occurred in a total of 37 per cent of SEP-users and during the last month in 19 per cent. IDUs integrated into mainstream society, but not in the subculture, have significantly lower numbers than the rest, 29 per cent and 8 per cent respectively. Most IDUs had previously received some form of drug treatment, a total of 75 per cent.

The average visitor participates in the programme for four years, does 50 visits and collects 200 syringes and 400 needles. The variations are however large. About half of the visitors have visited the clinic at any time without changing needles and syringes or using any other regular service. These visits seem to be of an informal social nature.

Syringe and needle coverage was based on interview data on injection patterns during the last year. From the register the number of distributed needles and syringes was then obtained. Ratios of total syringes coverage was estimated at 15 per cent and 30 per cent for needles. Frequent users (> 100 visits) has a ratio for syringes of 21 per cent and for needles 44 per cent. Those who in the last year had not shared injecting equipment with others had a ratio of syringes of 17 per cent and for needles 34 per cent. The corresponding figures for those who had shared equipment with other were 11 per cent and 22 per cent.

Nearly 60 per cent of SEP-users had some form of treatment experience before they joined the exchange programme. More than 40 per cent had received some form of treatment while in the programme, but of those, only 8 per cent had no previous treatment experience. Just over a third had never received treatment for their drug use (Stenström, 2008).

Månsson and colleagues (2000) studied 698 IDUs from the SEP in Malmö registered during 1990-1993. Fifteen individuals (2.8 per cent) were HIV positive at baseline. 74 per cent were followed for an average of 31 months. No new cases of HIV were detected. Initially, 70 per cent were HBV-positive and 91 per cent HCV-positive. Both HBV and HCV continued to spread among the participants in the programme and elevated infection risks were linked to previous imprisonment (OR = 2.2), lack of drug-free periods (OR = 5.5) and frequent use of the SEP (OR = 1.3) (Månsson et al., 2000).

Alanko-Blomé and colleagues (Alanko-Blomé et al., 2011) have since done a follow-up covering the years 1997-2005 of 831 IDUs at the SEP 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 was 38.3 / 100 person-years at risk and for HBV 3.4 / 100 person-years at risk. Using RNA testing showed that 12 per cent already when entering the SEP was affected with hepatitis C virus, but antibodies had not yet developed. This subgroup was therefore already hepatitis C infected before they had access to clean syringes and needles through the SEP. 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[17] (SOU 2011:6).

A recent study of female IDUs social situation, treatment experiences and preferences for help showed that women who inject drugs, in addition to being more marginalized and socially excluded than injecting men, demonstrate significant differences related to their drug of choice. The study included 99 women with heroin as their main drug (mean age 34 years) and 88 women who primarily used amphetamines (average age 42 years), all participants in the SEP in Malmö. Among the amphetamine-using women there are significantly higher percentage women with adequate housing and legal sources of income, while heroin users often have a very unstable housing situation and exclusively live on illegal income from drug dealing, prostitution or theft.

Prior treatment experiences were significantly more common in the heroin group and a much greater proportion of heroin users expressed the continued desire for treatment compared with women in the amphetamine group. According to the authors, the differences between the groups' treatment experiences can be due to the fact that amphetamine users less frequently are offered support and treatment, which may be due to evidence-based treatment for amphetamine users is absent in the current situation (Richert et al., 2011).

Responses to other health correlates among drug users

There are few studies from Sweden on co morbidity. The studies are confirming the high lifetime prevalence, which means that addiction treatment often encounter clients who also have a mental illness and, psychiatric treatment encounter patients who often have a substance abuse or dependence.

The figures on people seeking help for abuse or dependence shows that approximately 30-50 per cent or more also have a lifetime or current prevalence of mental illness, which needs to be identified, assessed and treated by psychiatric professionals. It is necessary for clients with suspected mental illness within the social services to be assessed with structured diagnostic, in accordance with national guidelines for drug treatment, as highlighted in the international literature. Figures based on people seeking treatment for mental illness, shows that about 20-30 per cent have a substance abuse or dependence. The figures are in line with international studies outside the Nordic countries (SOU 2011:6).

Research on compulsory treated female drug users

The study focus is a sample of women with drug dependence admitted to compulsory treatment. From a cohort consecutively admitted to residential treatment between

[17] Over 20 per cent of the visitors at the Syringe Exchange Program in Malmo have received full protection against hepatitis B, generally at least three consecutive vaccinations (STENSTRÖM, N. 2008. *Sprutbyte vid Intravenöst Narkotikamissbruk: En longitudinell studie av deltagarna i sprutbytesprogrammet i Malmö.* Doctoral thesis, Mittuniversitetet [Mid Sweden university]).

1997 and 2000, a sample of 132 women was selected for a five year follow-up. They were evaluated at base-line using a structured assessment procedure including psychiatric diagnoses, personality disorders and tests of symptoms, personality patterns and neuropsychological problems. As much as 70 per cent of the women had personality disorders at admission.

109 of 124 clients (88 per cent), still alive, were interviewed face-to-face five years after the index admission with a triangulation approach including cross-section data, the tests used at base-line and process data like the Timeline-Follow-Back interview.

The psychological and physical health of the sample and the social status of the women five years after discharge were improved in the group with a prolonged abstinence as well as for those having one year or more of abstinence. The levels of abstinence at follow-up were 42-48 per cent for one year, 30-36 per cent for two continuous years and 17 per cent continuously abstinent from discharge up to five years. Psychological improvement was found for all patients with longer periods of abstinence, as was a decrease of criminal sentences and hospital admissions. Conduct disorders and antisocial personality disorder were found to be negative predictors. The author stresses the need for early preventive measures at school when negative trends are first seen (Jansson, 2010).

8: Social correlates and social reintegration

Introduction

One way to understand the concept of social exclusion is to see it as related to social stratification through socio-economic class, education and sex. These characteristics are often included as explanatory variables in statistical analyses of social exclusion. Thus, a definition of social exclusion is that an individual is socially excluded when he or she suffers from several central welfare problems (Bask, 2008).

In recent years the Swedish Governments overarching political aim has been to reduce exclusion through integration on the labour market. The overarching aim of Sweden's national public health policy is to create social conditions that will ensure good health, on equal terms, for the entire population. Universal welfare policy creates the basis on which to prevent poverty and social exclusion and is therefore the foundation on which the Swedish action plan for social inclusion is built. Universal welfare helps to reduce the 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 prioritised in the previous action plan and follow-ups of the initiatives that have been implemented. Thus the Government 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).

In March 2011 the Government adopted a cohesive strategy for alcohol, narcotic drugs, doping and tobacco (ANDT) policy for the period 2011–2015, which specifies the goals, objectives and direction of the Government's ANDT policy and sets out national follow-up and evaluation structures. The aim of the overall strategy is to facilitate state management of public support in the ANDT sphere. The strategy establishes the goals, priorities and direction of public measures.

The common and overall objective of ANDT policy is a society free from illegal drugs and doping, with less alcohol-related medical and social harm, and less tobacco use.

To read more about the cohesive strategy for alcohol, narcotic drugs, doping and tobacco policy see chapter 1.

Statistics and follow-up developed in both the alcohol and narcotics areas during the last year. However, statistics are kept by multiple authorities, are divided and lack overall coordination. No national guidelines have yet been worked out for the follow-

up and evaluation of local and regional efforts in the scope of the implementation of the action plans. Nor has a coordinated national strategy for society's work with alcohol and traffic issues been developed.

Data on social exclusion is not collected and processed in a standardised way for official statistics. From research projects and special investigations information can be gathered, often for a limited cohort. Problem drug abuse and various forms of criminality, unemployment, homelessness, health problems etc. are all closely related and well known to the society. Nevertheless, data from Social Services' care for adults with substance abuse problems is collected on 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.

Organisational framework

The organisation and responsibility of the services for drug users are provided at three levels. At the municipality level, specialised services for problem drug users are provided (the social service system) based on the Social Services Act and the Care of Alcoholics and Drug Abusers Act (handling compulsory care). 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 et al., 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 targeting specific subgroups as: pregnant women, drunk drivers and people dependent on prescribed drugs (op.cit.). Because many drug users end up in the criminal system there are also various treatment facilities in prisons as well as within the parole system. Additionally sentenced drug users can, under certain circumstances, serve their sentences in inpatient drug use treatment.

Substance abuse and dependence care has experienced positive development during the last four years (2006-2009). 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 to a structure for professional support to local authorities and country councils and developing structure for collaboration between local authorities, country councils, local Research and development (R&D) bodies and universities and colleges. The development work is conducted under the name "Knowledge to Practice".

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, large amounts of 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, 2010b).

In a recent conducted open comparison questionnaire to the municipalities, of their abuse and dependency care, some major shortcomings were found when it comes to follow-ups and assessment of the care (Socialstyrelsen, 2011a). For instance only 30 per cent of the municipalities had actually asked the clients about their experiences of the care.

Medication-assisted treatment combined with social-psychological efforts (as motivational interviewing and other brief interventions) is one evidence-based method developed for both opiate- dependent and alcohol-dependent individuals. Although available, good medicines are still under-utilised 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 was stronger in the alcohol area than the narcotics area. Some positive examples include the national guidelines for substance abuse and dependence care, responsible serving of alcohol in licensed premises, and the identification of harmful and hazardous use of alcohol and brief counselling in primary healthcare and occupational health services (The Swedish Risk Drinking Project).

During the last years, the police also increased its involvement in the implementation of the Responsible Beverage Service method. Many efforts were conducted to reduce the availability of alcohol to adolescents. Young people indeed perceived it to be just as easy to get a hold of smuggled alcohol in 2008 as in 2005, but alcohol consumption among children and young people is decreasing, and since 2007 the number of alcoholic poisonings among adolescents has also decreased. Additional incentive is required for greater cooperation between authorities and the non-profit sector in prevention work (op.cit.).

Social exclusion and drug use

- Social exclusion among drug users[18]

Research has shown that a substantial proportion of homeless people are problem drug users. Further, research has shown that drug use is a risk factor for homelessness and homelessness is a risk factor for drug use (Palepu et al., 2010).

[18] See also chapters 2 and 4 for other groups.

The situation in Sweden

A new national mapping of homelessness in Sweden was conducted April 2011 but no data has been presented. In the last inventory of the homelessness situation in Sweden (2005) an estimated number of 17,800 persons were found. Homelessness in Sweden is primarily an urban problem. 42 per cent of the homeless are reported to be from the three largest metropolitan areas in Sweden, but the NBHW surveys also reveal that the problem, although small in scale, is widespread, existing in a large proportion of Swedish municipalities (Olsson, 2008).

Based on recent local mappings, especially in the three larger cities (Stockholm, Gothenburg and Malmö), no explicit decrease in number of homeless persons is seen A similar unofficial mapping of homelessness were done 2011 (Swärd, 2010) and it showed among other things that even though the National institute of Health and Welfare has financed 23 special projects aimed at lowering the number of homeless in Sweden through local development the number of homeless have not significantly decreased.

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 whereas Stockholm is one. 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 the delivery of social services such as housing or social assistance services to especially vulnerable groups. Through their responsibilities as policy-makers and service providers and their engagement in this means that they are in the best position to evaluate what works and what does not and how to prevent social exclusion as homelessness and unemployment.

Sweden also participates as a partner in the Mutual Progress on Homelessness through Advancing and Strengthening Information Systems (MPHASIS), an EU collaboration between approximately 20 countries, with the aim of finding methods to be able to monitor the development of homelessness in Europe and to compare the homelessness situations among the different countries. Further aims with the development of a monitor system is to collect the information needed to improving the provision of interventions and develop strategies for: preventing homelessness, lower the number of homeless people, take action against the causes behind homelessness, lower the harmful effects for homeless people and their families and make 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 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 were 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 organisation. 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 done (Denvall et al., 2011). Main results from the evaluation show that the biggest problem is that neither the projects, the local social services are able to influence the housing provision in the municipalities. Another interesting result is that one of the few evidence-based interventions to help people exit homelessness - Housing-First programmes – have not been implemented in any project (op.cit.). Although, independent of the above mentioned funding in Stockholm and a few other municipalities, the implementation of the Housing First strategy has been initiated.

No new strategy has been presented by the government for future actions to prevent homelessness.

Preventive interventions at the local level

There is a strong connection between eviction and homelessness and people who run a bigger risk for eviction are people with addiction problems and with psychiatric disabilities. During the last five years an estimated 3.500 tenants have been evicted each year and in a recent mapping

Important conditions and measures in order to pursuit an 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.
- The Social Services as well as landlords need to act quickly when a person risks eviction.

Relevant stakeholders need to have knowledge of the legislation associated with eviction – and of the possibility for stakeholders to act.
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).

- Drug use among socially excluded groups

A larger share of socially excluded persons use drugs in Sweden, but most drug users are not socially excluded (Statens folkhälsoinstitut, 2010c). Female regular drug users have less social support and a worse mental health compare to male regular drug users.

Women and substance abuse

Approximately 23 per cent of the adults with substance abuse problems who were receiving housing assistance on 1 November 2010 were women. The proportion of women among those receiving individually means-tested out-patient care was approximately 30 per cent, and among those receiving round-the-clock care it was about 25 per cent. The proportion of women among those receiving compulsory care on 1 November 2010 was 36 per cent (Socialstyrelsen, 2011a).

A recent published study of women injecting heroin (Richert et al., 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 implicates that heroin users, in general, are more socially excluded. They have also to a higher extent 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.).

Khat use

In Sweden khat use has been poorly studied, although the use is fairly well spread among men from specific countries. The khat use has consequences both for the users and their social networks, in particular the family life (De Cal and Söderlind, 2007). During the previous years a few studies on khat use have been conducted in Sweden. One study focused on the population of Somali people in Gothenburg. The results indicated a younger debut age in chewing khat than former studies. However, due to the limited sample further generalisations cannot be made (De Cal and Söderlind, 2007). In another study which among other things focused on estimating prevalence of khat use among Somalis, Ethiopians and Eritreans living in Sweden. The web survey showed that 49 per cent of the respondents answered that they had used khat at least once and the khat users stated the social effects as: the khat use was costly, they were afraid to get caught, they did not have the energy to do anything when using khat and finally they stated that they had difficulties in quitting their use (De Cal and Söderlind, 2007).

In an article from 2009 in Läkartidningen [Swedish medical journal], the problem of “migrating local risk behaviours” is discussed, with focus on the use of khat in Sweden. It is concluded that there are serious social and medical risks coming with the use of khat and its illicit syntheses, and that this problem has not been discussed in the Swedish drug context. Statistics from the customs show that the drug mainly originates from Eastern Africa. There are also easily accessible recipes of metkatinon available on the Internet, and this variant of the drug is mainly injected. The authors conclude that more information about the situation in Sweden is needed, and there is also a need to start discussing this openly (Aquilonius et al., 2009).

GHB and recreational drug use

During the previous years, studies of gamma hydroxybutyrate (GHB) use have pointed out that that the drug gained attention in substance abuse contexts in Sweden. In studies of prevalence, GHB has been found to be somewhat uncommon compared with other drugs. In a drug survey of adolescents, approximately 1 per cent has experience of trying GHB, but it is large regional differences. In Gothenburg i.e. about 6 per cent of the adolescents in upper –secondary school have tried the drug (Statens folkhälsoinstitut, 2011a).

There is strong evidence for that GHB is a dangerous and harmful drug. One study reported twenty-three deaths in western Sweden related to GHB use between 2000–2007 (Knudsen et al., 2008).

Little is known about the risk group but it seems like GHB use often is part of mixed substance abuse and link the abuse with the rave and club scenes and are part of the recreational drug use (Knudsen, 2011).

Social reintegration

Services for drug misusers 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 within the municipalities' social services. Furthermore, the regional healthcare is obliged to offer services to misusers, 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 by 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 achieve a more effective care, and to strengthen the position of the individual which will increase the motivation to participate. Finally, by developing systems for quality assurance, research and dissemination of knowledge and skills provide the foundations for a more knowledge-based care.

- Housing

The primary measures to reintegrated already homeless drug misusers 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 youths.

Recent research has assessed different special collective housing interventions for instance targeting homeless addicts (Blid and Gerdner, 2006). Findings shows that category housing has a positive direct effect on 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 increasing 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 that 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 requirements of abstinence or treatment. It hasn't been assessed yet in Sweden but in a recent review (National Board of Health and Welfare, 2009) of international effect studies of different housing programmes for homeless persons finding showed support for the Housing First model (and the Treatment First model).

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

There is a debate about whom the Housing First programme actually are helping and the programme has been criticized on 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 per cent of the homeless population (Kertesz and Weiner, 2009).

Thus, an uncertainty remains regarding the applicability of Housing First programmes for people with severe and active addiction (Johnsen and Teixeria, 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.).

Regardless, 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 number of municipalities.

- Education, training

Education is one of the most important factors for youth's future possibilities. The earlier the educational sequence breaks the worse future possibilities.

Considering the great importance of education on today's labour market it's not a surprising finding that almost half of those youth never marginalised have tertiary education while only 4 per cent of those how were persistently marginalised have studied on this level. The difference between the groups is striking as it is more than 10 times likely to have tertiary education for those never marginalised. Among those persistently marginalised there are 40 per cent who only have compulsory education; the rate for a comparison group is 7 per cent (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 youth, 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 for psychological ill health (Socialstyrelsen, 2011a). Research has shown that peoples' sense of coherence decrease the longer they are unemployed and at the same time their ill heath increases (Angelin, 2010). Those outside the labour market are missing out on the support by the social insurance system.

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

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 concretised so that measurable goals can be set up. Drug-related crime is among the proposed target areas. The aim of the plan is to enhance local collaboration and communication between the police and local government and to provide a better understanding for the various roles in crime prevention (Rikspolisstyrelsen, 2007)[19].

When it comes to alternatives to prison and the prevention of reoffending after release, the Swedish law (SFS 2006:431)[20] changed on the first of January 2007. The purpose of this change was to ease the transition into society and to offer a structured transition period before release for more inmates and for a longer part of the 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 follow:

- 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 six to 18 month sentences. The conditional discharge can start after half of the sentence (after 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[21] 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 Services (SPPS).

The purpose of the change was for more inmates to end their sentence with measures outside of prison, particularly treatment outside prison for the drug addicts. During 2010, there has been a decreasing number of placements outside prison, which may be related to the close inspection and accounting of cooperative arrangements that subsequently led to cancelled contracts with treatment organisations.[22]

[19] http://www.polisen.se/mediaarchive/4347/3474/Rapport%20Samverkan%20Polis%20och%20kommun.pdf
[20] http://62.95.69.3/SFSDOC/06/060431.PDF
[21] Placement outside prison for treatment.
[22] SPPS: Annual report of 2010

In the opinion of 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 (Ekström and Brottsförebyggande rådet [Brå], 2010, Sundström and Brottsförebyggande rådet [Brå], 2010).

The NCCP gives the following suggestions to the SPPS for how 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 of the law.
- The target group for the halfway houses should be better defined.
- The number of inmates in family or residential treatment should increase, not decrease.
- The application procedures should be simplified to shorten the administrative processing time.
- There should be a uniform practice in judgement and decisions (Sundström and Brottsförebyggande rådet [Brå], 2010).

Many drug users now have the opportunity to receive treatment in prison. The NCCP has conducted an impact study of treatment of drug users in prison that shows a significant decrease in relapses into crime between a treatment group (n=741) and a matched control group. At a 12-month follow-up, 58 per cent in the control group had relapsed compared with 50 per cent in the treatment group. The difference in relapse into crime as measured by new sentences was even larger, 11 per cent 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 per cent) compared with women (3 per cent, non-significant)
- Those that completed treatment had fewer relapses than those that did not (10-12 per cent to 3-10 per cent compared with control).
- The differences were only significant for the group of inmates that were over 29 years old.
- The 12-step oriented programmes had better results (11 per cent) than the non-12-step programmes (5 per cent).
- Longer treatment (>=138 days) had better results (12 per cent) than shorter ((76-137 days = 5 per cent), (<=75 7 per cent))
- Those that could end their sentence with treatment outside prison seemed to have better results (12 per cent) than those that did not (5 per cent, non-significant).

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

Drug-related Crime

Drug law offences

According to the 2010 official criminal statistics of Sweden, about 87,900 offences against the Act on Penal Law on Narcotics were reported in 2010. An increase by almost 10 per cent compared to 2009. The number of convictions with drug violations as the main crime increased by 8 per cent (about 1,500 convictions) compared with 2009. Of the 20,021 convictions with a drug offence as the main crime during 2010, 15 per cent involved women and 26 per cent involved adolescents between the ages of 15 and 20. The offences were considered minor in 83 per cent of the cases (16,952), not minor in 14 per cent (2,701) and serious in 2 per cent (368) as reported in the 2010 Swedish Official Criminal Statistics from the NCCP.

Table 9.1. Number of individuals convicted with drug related offences as the main crime in Sweden 2000 to 2010.

Year	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
n	8,055	8,005	8,992	10,106	10,808	11,862	13,932	15,179	16,817	18,525	20,021

For 2007 and 2008, 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 that breaks down reported drug offences in 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 2000 to 2010.

Table 9.2. Number of drug related offences annually in Sweden 2000-2010[23].

Reported drug offences	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Change between 2009 and 2010, %
Peddling, etc. (1-3a §)	4,012	3,719	3,781	3,766	4,031	3,915	5,539	5,645	6,390	6,440	8,141	26
Drug possession (1-3 §)	11,343	11,588	13,561	14,526	15,249	17,624	22,083	23,150	24,764	25,432	27,368	8
Drug use (1-3 §)	13,936	13,659	16,373	18,583	21,726	26,645	37,544	42,414	46,569	47,847	51,766	8
Possession and use (1-3 §)	2,984	3,305	4,155	3,766	3,876	3,418	1,421	2	-	-	-	-
Production (1-3 §)	148	134	135	219	211	205	270	335	465	537	615	15
Total	**32,423**	**32,405**	**38,005**	**40,860**	**45,093**	**51,807**	**66,857**	**71,546**	**78,188**	**80,256**	**87,890**	**10**

The table above shows that the total number of reported drug offences increased by 10 per cent between 2009 and 2010. The highest increase concerns peddling (26 per cent). Concerning drug possession and drug use, there is a smaller change (8 per cent). The category possession and use has been removed, which is the explanation for the sharp fall in the possession and drug use category (from 3,418 in 2005 to

[23] Statistics available at http://www.bra.se/extra/pod/?action=pod_show&id=21&module_instance=11.

1,412 in 2006 and to 2 in 2007). 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 2009 and 2010 for reported drug offences is similar to the drug offence as the main crime for conviction.

The following narcotic statistics that refer to type of offence and substance are special narcotics statistics that only will be published every third year beginning in 2006. This means that the latest figures are from 2009 (Brottsförebyggande rådet [Brå], 2006). Figures from other areas such as sanctions, age distribution and gender distribution are taken from the official statistic over persons found guilty of criminal offences since 2009.

Table 9.3. Number of individuals found guilty of drug offences annually in Sweden 2000-2009*. By type of offence.

	Year							
Type of offence	**2000****	**2001**	**2002*****	**2003**	**2004**	**2005**	**2006**	**2009**
Court sentence and fine issued by the prosecutor	**11,326**	**12,320**	**13,891**	**14,491**	**14,774**	**15,877**	**17,619**	**21,253**
Drug use	4,460	4,898	5,303	5,816	6,525	7,716	9,397	12,034
Drug possession	3,626	3,771	4,195	4,590	4,531	4,837	5,021	5,619
Possession, use	1,291	1,357	1,544	1,641	1,580	1,522	1,291	1,174
Peddling, peddling and possession	685	749	917	963	948	842	965	1,110
Possession, use and peddling	141	161	143	148	109	102	102	79
Production	15	10	7	6	18	25	17	59
Drug smuggling	770	968	1,495	982	657	556	509	908
Other offence and combinations	338	406	287	345	406	277	317	269
Waivers of prosecution	**1,890**	**1,722**	**2,118**	**2,522**	**2,692**	**2,941**	**4,065**	**6,893**
Total	**13,216**	**14,042**	**16,009**	**17,013**	**17,466**	**18,818**	**21,684**	**28,164**
Minor offences	10,813	11,127	12,596	13,429	13,645	13,774	16,002	21,216
Non-minor offences	2,075	2,548	2,974	3,131	3,336	4,490	5,248	6,472
Serious offences	328	367	440	452	485	435	434	456
Minor offences (%)	82	79	79	79	78	73	74	75

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

** 2000 corrected numbers.

*** 2002 corrected number in waivers of prosecution.

The number of persons convicted of drug offences has increased every year over the past 10 years. The annual increase has varied, but averaged just below 7 per cent until 2006. This means that drug convictions have more than doubled (increased by 110 per cent) over the last 10 years. The following four paragraphs (type of offence → sanctions) are quoted from the 2009 NCCP report referred to above.

Type of offence[24]
At 57 per cent (12,033 convictions) and 26 per cent (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[25] accounted for 4 per cent and 5 per cent of all drug convictions, respectively. The proportion of convictions relating exclusively to personal use increased by 28 per cent, from 9,397 in 2006 to 12,034 in 2009. The proportion relating to possession offences increased by 12 per cent, from 5,021 convictions in 2006 to 5,619 2009.

Offence severity
In 2010, minor offences accounted for approximately 83 per cent of all convictions (just below 17,000 convictions). Non-minor offences accounted for 14 per cent (2,700 convictions) and serious offences for 2 per cent (368 convictions). The proportion of convictions for minor drug offences has increased whereas the proportion of convictions for non-minor drug offences has decreased.

Substances[26]*.*
Amphetamines and cannabis remain the two most common substances in the conviction statistics. In 2009, these accounted for 27 per cent and 42 per cent, 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[27]*.*
The most common sanction issued to those convicted of drug offences is a fine, either in the form of a summary fine issued by the prosecutor or via a court sentence. Those issued fines accounted for 56 per cent of all those convicted of drug offences in 2010. In 2009, 28 per cent of those convicted of drug offences took the form of waivers of prosecution, whereas 8 per cent 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 slightly less than 4,200 persons in 2000 to more than 11,100 in 2010. The number of persons sentenced to a prison term has increased from almost 1,400 in 2000 to more than 1,500 in 2010. The average length of the prison term issued in 2010 was 17 months.

Regional distribution
Relative to the size of the population in the different counties of Sweden, counties in Sweden'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 59 per cent of all drug convictions in Sweden in 2009. Since 2000, this proportion has remained stable at between 59 and 61 per cent of all those convicted in the country as a whole.

[24] Refers to summary fines and court adjudications only, as the offence type cannot be discerned in the case of waivers of prosecution
[25] Distribution and distribution in combination with possession.
[26] Refers to convictions in which the drug offence was the principal offence.
[27] Figures are from the Official Statistics over Persons found guilty of offences from 2010.

Age distribution[28]
In 2010, young persons aged 18–20 had the highest level of drug convictions in relation to their numbers within the population at large, with 911 convictions per 100,000 of population. The groups aged 50 years or over have the lowest number of convictions, with 42 convictions per 100,000 of population. Over the period between 2000 and 2010, the largest increase in the number of drug convictions per 100,000 of population has been noted among those aged 50 years or over. Per capita convictions in this group have more than tripled over the period examined. Similarly for those aged 21–29 years, the convictions per capita have more than doubled since 2000.

Gender distribution[29]
Of the total number of persons convicted of drug offences in 2010, approximately 15 per cent were women. This proportion has remained relatively stable over the past 10 years. The number of women and the number of men convicted of drug offences has more than doubled over the past 10 years. Between 2009 and 2010, the numbers of men convicted increased by 8 per cent and the number of women convicted increased by 7 per cent.

Prevention of drug-related crime

In 2008, the Swedish National Council for Crime Prevention presented a systematic review, including a statistical meta-analysis, of the effects of drug treatment programmes on crime (Holloway et al., 2008). The review was conducted by a number of highly qualified researchers from the United Kingdom. The analysis combines 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 uses the results from these previous evaluations to calculate and produce an overview of the effects that drug treatment programmes do and do not produce. The summary from the study is presented below.

> "The majority of European countries have a drug strategy that aims to reduce drug-related crime. One of the methods commonly used for achieving this is to provide treatment for drug users. In most countries, treatment for drug users is available through conventional medical referral processes. In some countries, treatment is also made available from within the criminal justice system. This can be part of a referral process whereby offenders are diverted at various stages into treatment or treatment can be provided from within the criminal justice system as part of a prison programme. In order for the strategy to be effective, it needs to be demonstrated that treatment for drug misuse can lead to a reduction in crime.
>
> This report presents the results of a systematic review of the literature on the effects of different kinds of intervention for problematic drug use on criminal behaviour. The main selection criteria were that the evaluation should be based on voluntary treatment programmes that aimed to reduce drug use (e.g. methadone maintenance, detoxification, or self-help programmes) or criminal justice programmes that aimed to reduce

[28] Calculations conducted per 100,000 of mean population is from the Official Statistics over Persons found guilty of offences from 2009.
[29] Figures are from the Official Statistics over Persons found guilty of offences from 2009.

drug use and drug-related crime (e.g. drug courts and drug testing programmes).

The main finding of the narrative review was that the majority of treatment programmes (68 per cent) were associated with positive outcomes (the treatment group performed better than the comparison group in terms of subsequent criminal behaviour). In seven of the nine treatment categories investigated, the majority of evaluations produced positive findings. The most successful were psycho-social approaches and therapeutic communities. It was only in relation to other treatment programmes and other criminal justice system programmes that the percentage of positive outcomes fell below 50 per cent.

The main finding of the meta-analysis was that the majority of studies investigated (25 of 37) showed a favourable effect on criminal behaviour. The mean effect size for all studies combined showed that the treatment groups were associated with a 26 per cent reduction in criminal behaviour compared with the comparison groups. Five of the seven programmes investigated generated effect sizes that showed a favourable impact of the programme on crime. The two most effective programmes measured by the meta-analysis were therapeutic communities and supervision.

The report concludes that drug treatment programmes (especially psycho-social programmes and therapeutic communities) are effective in reducing criminal behaviour. However, the moderator analysis showed that there were statistically significant differences among programme types. It is difficult to explain the differences in effectiveness of programmes without a better understanding of the programme content and intensity.

The main research implications of the report are that evaluations need to be of a high quality and to present their findings in a way that can be used in future meta-analyses.

The main implication for policy is that drug treatment can be effective in reducing criminal behaviour and is a useful means of reducing crime.

However, more needs to be known about variations in effectiveness and the influence of programme type, intensity, and context on crime outcomes." (Holloway et al., 2008)[30].

Interventions in the criminal justice system

In 2002, the Government instructed the Swedish Prison and Probation Service (SPPS) to further develop and improve the treatment of inmates with drug problems as part of a major effort in all of the society to improve the treatment and rehabilitation of drug addicts. A report on the SPPS experience of carrying out this

[30]http://www.kriminalvarden.se/upload/Informationsmaterial/Kriminalvardens_sarskilda_narkotikasatsning_2002-2007.pdf

particular effort for the period 2002-2007 was published in 2008 (Göransson, 2008). The report is summarised below.

Finding the addicts

The SPPS objective that all drug addicts in correctional treatment should be identified, "mapped" and motivated to accept treatment was in general fulfilled. It was guaranteed that all inmates wanting help were also offered help. However, in some forms of custody with high turn-over, the outreach activity might miss some detained persons who did not voluntarily come forward since the outreach function is not manned 24 hours a day. In the period of 2002-2007, more than 17,000 people in custody have had in average of three personal motivational interviews aimed at convincing the detainee to participate in treatment (Göransson, 2008).

Drug users in treatment

A general demand was that the number of inmates participating in treatment should increase and that the treatment and rehabilitation efforts should be adapted to the needs. To this end, the SPPS identified and developed several strategic areas where improvements or measures were needed. Among these were:

- the identification and mapping of the inmates' drug problems and treatment needs,
- the introduction of the Addiction Severity Index (ASI) as a mapping method,
- a greater number of prison units/departments earmarked for drug addicts,
- the implementation of Motivational interviews (MI),
- the introduction of evidence-based programmes,
- the testing of medically assisted treatment,
- improved methods to prevent the smuggling of illicit drugs,
- more developed cooperation between the social services and the correctional treatment services and between custody, prison and probation,
- and a major investment in training and competence development of the staff.

Custody units and prisons were given priority at the start and beginning in 2004, non-custodial treatment was also included.

A large number of drug abusers are mapped according to the ASI method as recommended in the guidelines from the Swedish National Board of Health and Welfare. The SPPS has the single largest ASI databank comprising 11,500 cases at the turn of the year 2007/2008 (Göransson, 2008).

Treatment programmes

Implementation and evaluation of the treatment programmes were part of the project. These tasks are on-going and take years since the conditions for the implementation of a programme have to be quality assured before conclusions of the outcome could be drawn. Fifteen programmes at different stages of implementation and evaluation are listed in the report. The programme "Våga välja" (dare to choose) was recently evaluated by SPPS and found to reduce relapses into drug abuse by 13 per cent. According to the evaluators, no other factors could explain the outcome. An investment in MI was deemed to be very important for the creation of a base and platform on which to build the particular drug treatment effort (Göransson, 2008).

Supportive factors for the implementation

According to the report, strong political pressure, interest and demand supported the implementation of the project. In times of cut-backs and organisational difficulties, the project was still given priority and carried out according to plan and the governmental financial support helped in putting the project into practice. The clear position of management at all levels in the SPPS was also of importance since it made the task visible to everyone in the organisation.

As the project concerned the largest target group in correctional treatment, the SPPS decided to include the whole organisation in the project instead of selecting special units for pilot projects. Even though the process was slower, it was the right choice according to the report. Factors, such as the inmate's possibility of maintaining contact with family, the social services, employment offices, etc. in his or her home municipality, were easier to cope with when all of the correctional treatment units participated in the project. It was also judged to be better to establish a commitment to the project among all staff and management rather than forming elite units. This way, conflicts seen to occur between regular operations and special units are avoided and the whole organisation becomes more willing to learn and change (Göransson, 2008).

Limiting factors

The overriding problem in implementing the particular drug treatment effort was the lack of space in the correctional treatment institutions since the SPPS has the task and duty to provide space for all detainees serving their sentence in prison. Consequently, it was not always possible to differentiate the abusers. In the overcrowded departments, there was also a lack of occupational opportunities and workshops which further impaired the motivational climate for the inmates.

Difficulties in getting the municipalities to take financial responsibility for probation treatment or continued treatment after release were further obstacles in carrying out the project. The work done by staff and inmates during the prison period was jeopardised and some municipalities categorically denied all forms of treatment in spite of the fact that the SPPS financed the major part of treatment. Clinics offering medically assisted treatment also commonly refused to accept patients from the SPPS, referring to the fact that they already had long lines of addicts outside the correctional treatment system in acute need of treatment.

The SPPS's choice to include all correctional treatment in the project caused organisational problems. The need to find space and suitable care for an increasing number of convicts at the same time that the project was running meant that trained staff sometimes found it difficult to work with the drug prevention programmes and that staff not yet educated in the new programmes were not available for training and education. The implementation of new programmes was sometimes also hampered by the lack of experienced instructors and teachers.

A huge reorganisation of the SPPS also took part during the project period. From 36 autonomous agencies and one prison and probation board, the organisation became one agency with a head office, several regions, institutions with different and differentiated levels of security, etc. The implementation of an improved and extended treatment system for drug addicts at the same time as a reorganisation of

the prison and probation services often resulted in the treatment drive being impaired (Göransson, 2008).

External evaluators

Parts of the treatment project have been monitored and evaluated by the National Council for Crime Prevention (NCCP). The 2008 National Report reported what the staff perceptions were of how the inmates had benefited from the strategy (Brottsförebyggande rådet [Brå], 2006) and how the inmates themselves judged the strategy (Sundström and Brottsförebyggande rådet [Brå], 2010). The 2008 National Report also had a section on the NCCP studies on the efficacy of treatment in prisons regarding drug use and relapse into crime (Öberg and Holmberg, 2008). In some instances, the treatment was found to significantly decrease the relapse into drug use and crime in the treatment group compared with the control.

Summarised conclusions

According to the report, it was not possible to achieve desirable results regarding reduced relapse into drug use and crime. Quitting drug use, abandoning a criminal lifestyle and forming a life without drugs and crime are difficult and take time. The SPPS handles very problematic drug users. To expect results in terms of directly measurable levels of relapse at the very beginning of the project is not realistic. The SPPS could, however, be expected to initiate rehabilitation and motivation for continued treatment and, according to the report, this was achieved. To create a positive environment for change in a “punishment” system takes a long time and involves many people working towards the same goal.

The prerequisite for implementing major efforts against drug dependence within correctional treatment is that drug treatment is voluntary and that it is simultaneously clear that the efforts take place within the scope of the punishment. The desire to change exists among most inmates, but there is also ambivalence. They do not believe that they are capable of change and they see no alternatives to drugs. Consequently, the special investment in motivational interviews (MI) has been invaluable as a base and platform on which to build the particular drug treatment effort.

Drug treatment initiated within the scope of correctional treatment must not differ from drug treatment given at other treatment institutions in society since treatment commonly continues and is finalised outside the correctional treatment system. Drug treatment within correctional treatment also allows individuals to be reached who never or rarely request treatment. As a consequence of the time in custody, the detainees are detoxified, perhaps for the first time in many years, and have the opportunity to consider and think through their current life situation. If such a person is given the opportunity to meet with a committed and experienced expert in drug treatment who analyses the drug abuser’s needs and presents possible ways for treatment and rehabilitation, it could be an important first step in a process.

Drug use and problem drug use in prisons

The average number of drug addicts in prison is fairly stable over an extended period of time. During 2010, there were on average about 2,600 drug addicts in the prison population. The programmes used for reducing relapse into substance abuse and criminality are VågaVälja [Dare to choose], PRISM (Programme for Reducing

Individual Substance Misuse), 12-steg [12-step-programme], Prime for Life (PFL) and Återfallspreventionsprogrammet [Relapse prevention programme].

The work on various treatment programmes has moved rapidly the past 10 years. In order to ensure effectiveness, the programmes are to be reviewed by a scientific panel and only programmes meeting the requirements will be granted accreditation. To be approved, a programme must include the following, among other aspects:

- 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 limited scope during development. After accreditation, the aim is to offer the programme to all offenders, according to their assessed risk and needs.

An important part of development is to analyse the efficacy of the programmes with regard to reoffending. The 12-step and Dare to Choose programmes have been evaluated. Participation in 12-step programmes was associated with a modest, but significant (16-17 per cent) 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 per cent statistically significant reduction in post-treatment reoffending in the treatment group compared to peer controls after controlling for confounding. The return on invested capital was calculated to be 312 per cent over two years.

PRISM is under evaluation during 2011. 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 per cent lower risk of reoffending compared to those who did not get any treatment.

Important to the implementation of the programmes is the integration with the other activities in prison. 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 surveyed in relation to the sentence planning.

In 2010 a total of 13,668 individuals were at some point in prison, whereof 7,342 prison inmates (of whom 456 are women) started at least one treatment programme. This is 550 more programmes than during 2009. In the probation services, 4,527 (559 women) began in programmes in 2010.

As a part of the prevention activities the SPPS has invested in work with children of inmates. This is based on the idea that a venture on children and parenthood has a twofold crime-prevention advantage. Research has shown that children of drug addicts and criminals tend to follow in their parent's footsteps and becoming drug addicts and/or criminals themselves. By getting the parents to recognise their importance as a role-model, there is an expectation of getting them to abandon the drug use and criminality. To read more about inmates with children in chapter 12.

Responses to drug-related health issues in prisons (and other custodial settings)

Drug treatment (incl. number of prisoners receiving opioid substitution treatment)

Treatment of opiate dependence
In 2007, the Stockholm Addiction Centre and the Swedish Prison and Probation Service started a project called an Integrated Team for Opiate-dependent Clients (ITOK). Clients with opiate dependence were identified at the remand prisons in Stockholm and, following an investigation, were offered the chance to participate in a maintenance programme. An evaluation of the project demonstrated success both from a socio-economical and a co-operational perspective, and the project is now permanent. The model of cooperation is being used in a similar project in southern Sweden (were the project is named SITOK which means South ITOK). A problem there is that the waiting list for maintenance treatment is very long. A socio-economic evaluation conducted in 2010 shows major improvements.

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.

From a gender perspective, this kind of programme appears to be attractive to female clients. Among Swedish inmates, only 5 per cent are women, but in ITOK 12 per cent are women.

Maintenance treatment with methadone and buprenorphine has only been available at the prison in Fosie (Malmö), but other prisons in Region Stockholm and Region West have now opened for such treatment.

ADHD among prisoners – occurrence/diagnosis/treatment/follow-up
The Swedish Prison and Probation Service collaborates with the Karolinska Institutet on two projects for the treatment of inmates with ADHD.

One of the projects is conducted by Ylva Ginsberg, MD, Department of Clinical Neuroscience, Division of Psychiatry, Karolinska Institutet. This project involves inmates with at least 14 months of their sentence remaining who screened positive using the self-reported questionnaires, Wender Utah Rating Scale (WURS) for retrospective symptoms in childhood and the Adult ADHD Self-report Scale (ASRSScreener) for symptoms in adulthood. Following a subsequent assessment, 30 subjects with a confirmed diagnosis of ADHD were randomised to an initial five-week, double-blind placebo-controlled trial in prison, comparing PR OROS Methylphenidate and psychosocial interventions versus placebo. After the five weeks, all participants were treated with methylphenidate.

A scientific evaluation by Ylva Ginsberg in collaboration with Tatja Hirvikoski and Nils Lindefors has been published, but a socio-economical evaluation has not been performed. This study suggested ADHD to be present among 40 per cent of adult male longer-term prison inmates. Further, ADHD and coexisting disorders, such as SUD, ASD, personality disorders, mood and anxiety disorders, severely affected prison inmates with ADHD. Inmates also showed poorer executive functions when controlling for estimated IQ compared with ADHD among psychiatric outpatients and controls. The findings imply a need to consider these severities when designing treatment programmes for prison inmates with ADHD.

The second project is conducted by licensed psychologist Maija Kostenius and takes place at the Storeboda prison outside Stockholm. The study addresses inmates that abuse stimulants and after assessment have been diagnosed with ADHD. Just before parole, half of the population start treatment with PR OROS Methylphenidate and half are given a placebo. Treatment continues at the Stockholm Addiction Centre, where the medication is administered together with individual supportive therapy and medical check-ups. This study is not yet closed, but about 30 per cent are continuing the treatment which may indicate almost 60 per cent retention (if all those continuing are from the methylphenidate group).

Based on these previous positive results, a new collaboration between the Stockholm Addiction Centre and Swedish Prison and Probation Service has started in the treatment of ADHD. Twenty female and 20 male inmates at the prisons in Färingsö and Storeboda are to be included in a treatment programme with psychosocial support and medication with methylphenidate that continues at a probation office in Stockholm during parole. The setting is the same as for those with opiate dependence in the ITOK project.

Prevention, treatment and care of infectious diseases

Infectious diseases related to drug use

As mentioned in Chapter 7, the National Board of Health and Welfare is setting up a sentinel surveillance system. In August 2009, the system covered two out of six potential regions in Sweden. The intention is to roll-out a third region by the end of the year. The project, now re-named the Swedish Prison Programme (SHP), is a joint collaboration between the county councils, the Prison and Probation Service, Karolinska Institutet and NBHW. In 2009, a total of 259 intravenous drug users participated in the programme.

Reintegration of drug users after release from prison

Education and training

The Prison and Probation Service invests heavily in education and vocational training to give the inmates the opportunity to increase their skills and knowledge during the prison sentence and to enhance reintegration. Education and vocational training is an important complement to drug treatment in providing the inmates with skills that will help them to stay drug free after prison, to continue with further education and to get a job.

The education organised in prison is equivalent to municipal adult education. It is based on the same curriculum and syllabi from the Swedish National Agency for Education and is under the supervision of the Swedish Schools Inspectorate. Almost

30 per cent of all inmates (4,297 individuals) were studying something for some time during 2010. That percentage is about the same as in 2009.

During 2010, the number of certificates for completed courses has continued to increase. A total of 2,036 certificates were received by 1,150 inmates, this compared to 1,775 certificates received by 1,060 inmates during 2009.

In total 995 people, 921 men and 74 women, participated in some kind of vocational training in 2010, a slight decrease compared to 2009 when there were 1,050 participants, 989 men and 61 women. A joint venture between the Swedish Public Employment Services and the Prison and Probation Services has been established, ensuring increasing quality and development of vocational training programmes in prison.

10: Drug Markets

Introduction

CAN's reporting system on drugs (CRD)

Since 1988, the Swedish Council for Information on Alcohol and Other Drugs (CAN) has collected information on street-level prices for a number of drugs, such as cannabis resin, marijuana, amphetamines, cocaine and heroin. Since 1993, CAN has also collected information on street-level prices for both white heroin and brown heroin. In terms of more uncommon drugs, such as ecstasy, LSD, GHB and khat, CAN has monitored prices since 2000. Here, the term "street level" refers to small quantities in grams as seen from a consumer perspective. Because information on prices has been collected for several years, the prices have been adjusted for inflation, according to the Consumer Price Index provided by Statistics Sweden (SCB). Since 2010, CAN has also asked for wholesale prices for six narcotic drugs (quantities in kilograms).

CAN's reporting system on drugs is designed for the early detection of new drugs and new ways of using existing drugs, as well as to indicate where in the country changes are taking place in relation to drug use and drug markets (Mietala and Nyström, 2010).

The system is based on roughly 150 respondents from the 15 most populated municipalities (covering almost 30 per cent of the population). These people are mainly found in the social services, health services, police, outpatient care/correctional systems and volunteer organisations. Standardised questionnaires are distributed twice a year, covering changes in the first and second half of the year respectively. The respondents are requested only to submit information based on knowledge obtained from their work place or their region.

Since the municipalities are strategically and not randomly selected, the survey is not representative of the entire country, but provides good possibilities to get information on new drugs and trends relatively quickly, since illicit drug use is more common in areas with a higher population density.

In addition, another questionnaire is distributed at the same time to all 21 county police departments in Sweden. These are only asked to report new drugs in the county, retail drug prices and, from 2010 onwards, wholesale drug prices.

In 2011, there will be an alteration in CAN's reporting system on drugs to only include reports from the 21 county police departments in Sweden (Guttormsson, 2010).

A broader analysis of the availability of various drugs has been developed in Sweden by combining price information with other data, particularly the legal system's seizure statistics and information from drug convictions.

Early detection

Sweden has a well-developed mechanism for the early detection of new substances thanks to interagency co-operation. This means that new substances can be listed for control within a relatively short time-span.

Analysis procedure

At the Swedish National Laboratory of Forensic Science (SKL) the substance identification is performed by qualified personnel exerting a broad spectrum of expertise within different analysis techniques such as GC-MS, GC-IRD, LC-MS, FT-IR etc. The described 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. The competence of the employees as well as the methods has been quality assured for several years.

When a new substance is discovered in a seized sample it is thoroughly evaluated by chemists at SKL. The substance structure is determined and the compound is added to a reference library.

In recent years, the composition, the variety and the number of novel substances 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 an aggressive internet marketing. During 2010 forty novel substances were added to SKL:s reference library. The structure of thirteen of these novel substances were determined by the chemists at SKL while the remaining twenty seven could be purchased as certified references. Most of these substances were synthetic cannabinoids and cathinones (personal communication with Lotta Rapp, Droganalysenheten, SKL, 28 October 2011).
Several of the identified novel analogues to illicit drugs have led to national regulation. A goal for the future is to speed up the process, both on a national plane and within the laboratory, as well as to increase the number of structure determined substances per year (personal communication with Lotta Rapp, Droganalysenheten, SKL, 28 October 2011).

Availability and supply

Price information on drugs is reported by all of Sweden's 21 county policy authorities. Several kinds of drugs are reported less often in northern Sweden, but at the same time prices in northern Sweden may be somewhat higher. This can indicate that illicit drugs are generally less available further north. Prices are often lowest in southern Sweden, but the geographic differences should not be exaggerated. Although some level differences exist between different parts of the country, the trends in the country are often similar.

The number of reports on illicit drug price from the county police authorities covaries with how densely populated a county is: the higher the population density, the more frequently illicit drug prices are reported. This means that various kinds of illicit drugs are more available in big cities, which agrees with what was already known from other sources. LSD, khat and GHB seem to be concentrated to certain regions. For example, it is mainly the police authorities in the counties of Västra Götaland,

Uppsala and Västernorrland that report GHB prices while LSD prices are mainly reported by the police authorities in Stockholm and Uppsala.

The availability of cannabis resin is assessed to have increased for the past 20 years. Both the economic availability and the physical supply have increased. This assessment is made in light of the fact that seizures and court cases involving cannabis have increased sharply, at the same time that prices have fallen. However, data for 2010 indicates that this trend may have been broken in that the prices for cannabis resin rose and seizures decreased somewhat.

This does not mean that availability of cannabis has decreased in general since demand of marijuana has increased. Seizures of marijuana have also increased and virtually all regions in Sweden currently report marijuana prices, which was unusual in 1990s. However, marijuana prices have risen under the past five years, maybe because demand is keeping prices up, despite a larger supply. This could also be due to an effect on prices by increases in quality. Although marijuana has become relatively more common, cannabis resin is still the dominant form of cannabis on the Swedish market.

Central stimulants, such as amphetamines and cocaine, are assessed to be more available now compared with the end of the 1980s; the prices have fallen sharply at the same time that seizures have increased. Like marijuana, relatively few cocaine prices were reported at the beginning of the period, but in recent years, most of the regions in Sweden report cocaine prices. However, amphetamines are still the most common central stimulants in Sweden, although cocaine has become relatively more common compared with 20 years ago. Amphetamine prices have decreased more than other drug prices and today the price is a third of the price of 1988.

Ecstasy, LSD, khat and GHB prices are monitored since 2000 but are all less common in Sweden compared with the other kinds of illicit drugs (with regard to the number of price reports, seizures and court cases). Consequently, the availability trend of these drugs is more difficult to assess. However, data indicates that ecstasy, LSD and GHB are now less common than ten years ago, while khat appears to have become somewhat more common.

Accordingly, the conclusion is that there was an increase in illicit drugs since the 1980's, both in terms of economic availability and physical supply. However, information from recent years indicates a decrease for cannabis resin, heroin and cocaine, but not for cannabis in general, because marijuana has increased.

Drugs origin: national production versus imported

Professional, full-scale illegal indoor cultivation of marijuana, initially concentrated to the southern parts of Sweden, is now observed in other parts of the country as well. These crops are part of transnational, organised crime activities. In addition, the number of cultivations organised 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 crops in Sweden. At the same time, seizures of marijuana are still made at the borders. During the period 2007-2010, marijuana remained the most common drug among Customs seizures.

Trafficking patterns

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 gangs, 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 often are with criminals resident in Sweden who have ethnic ties to the source country of the drug. Within the EU, a large share of 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 over-all 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 organisations, efforts to combat them take place both through international organisations, 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 actually manufactured in just a few places in the world. Because of this, there is a possibility to stop smuggling by focusing on specific routes.

The possibilities of diverting essential precursor chemicals listed in categories I and II by Sweden is 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 two main branch organisations for the national chemical industry. Thanks to this co-operation, most Swedish companies are aware of the threat and have taken proper measures to ensure a 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 large ports of 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.

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

Seizures of pharmaceuticals classified as narcotics (mainly benzodiazepines) are increasing. A growing amount of medicine classified as narcotics are available over the Internet, where drugs are sold without quality assurance or prescription. The large number of seizures is partially due to the fact that these drugs are often used in combination with other drugs.

Table 10.1. Number of seizures analysed according to Police and Customs forensic laboratories 2001-2010 (National Swedish Police, National Bureau of Investigation).

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Narcotics-classed pharmaceuticals	3,223	4,476	4,347	4,715	5,247	6,032	7,443	7,375	7,917	8,374
Cannabis[31]	7,156	8,184	8,243	8,102	8,345	9,365	10,052	10,996	12,108	12,107
Heroin[32]	1,217	1,052	1,057	900	804	800	871	688	671	493
Amphetamine	5,713	6,660	6,657	6,773	6,499	6,842	6,477	5,304	4,986	5,014
Methamphetamine	275	250	301	244	386	359	485	876	1,086	704
Ecstasy	621	631	489	411	381	309	268	231	42	127
Cocaine	328	440	545	524	546	772	725	813	792	724

The majority of cannabis resin (hashish) seized in Sweden originates from Morocco. The number of seizures shows an increase, which together with other observations indicates a substantial supply of cannabis on the drug market. In contrast to cannabis, the geographic spread and the large proportion of seizures of marijuana made by the police (78 per cent in 2008) indicate that most marijuana originates from within Sweden.

Amphetamine seizures have shown a slight decrease since 2006. A possible explanation for this might be the simultaneous increase in availability of other and similar drugs, such as methamphetamine and fluoroamphetamine.

A continuous increase in the number of seizures of cocaine together with other reports of increased use of cocaine indicates that cocaine has become more of a general party drug, in contrast to when cocaine was previously considered to be a more exclusive drug.

For ecstasy, the number of seizures has decreased dramatically since the beginning of the 2000s. This decrease might be due to a decrease in production, mainly in the Netherlands, together with increased competition of other party-related drugs sold over the Internet. Another issue to consider is the decrease of MDMA, used in the ecstasy preparations, in favour of other substances such as mCPP.

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 are produced. A risk is that Sweden is being used as a transit country for the shipping of precursor chemicals to countries where the production of illicit drugs does take place. However, in 2008 and 2009 no serious illegal transactions involving precursors were revealed.

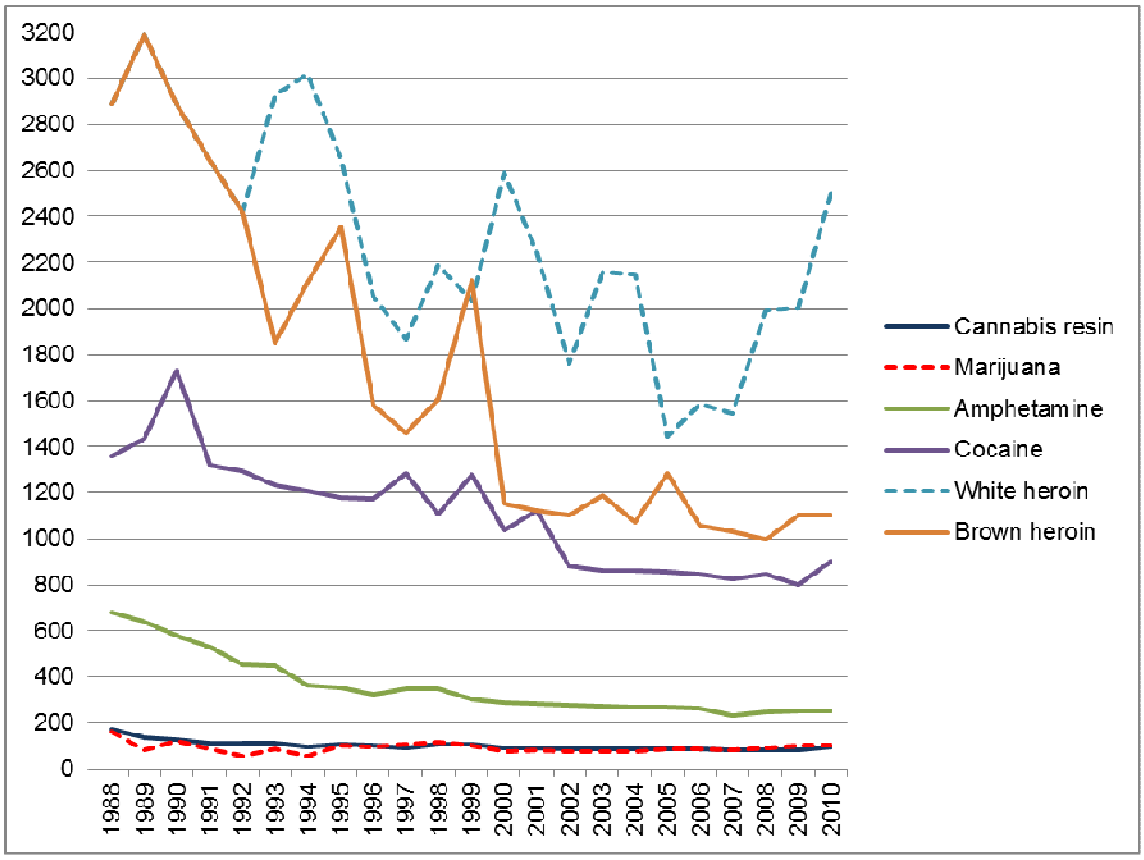
[31] Marijuana and cannabis resin
[32] White and brown heroin

Price

Drug prices have dropped substantially throughout the period. Considering inflation, a rough estimation shows that real prices have been cut in half compared with 1988. Most of the prices dropped during the 1990s, while the situation has been more stable since the turn of the millennium.

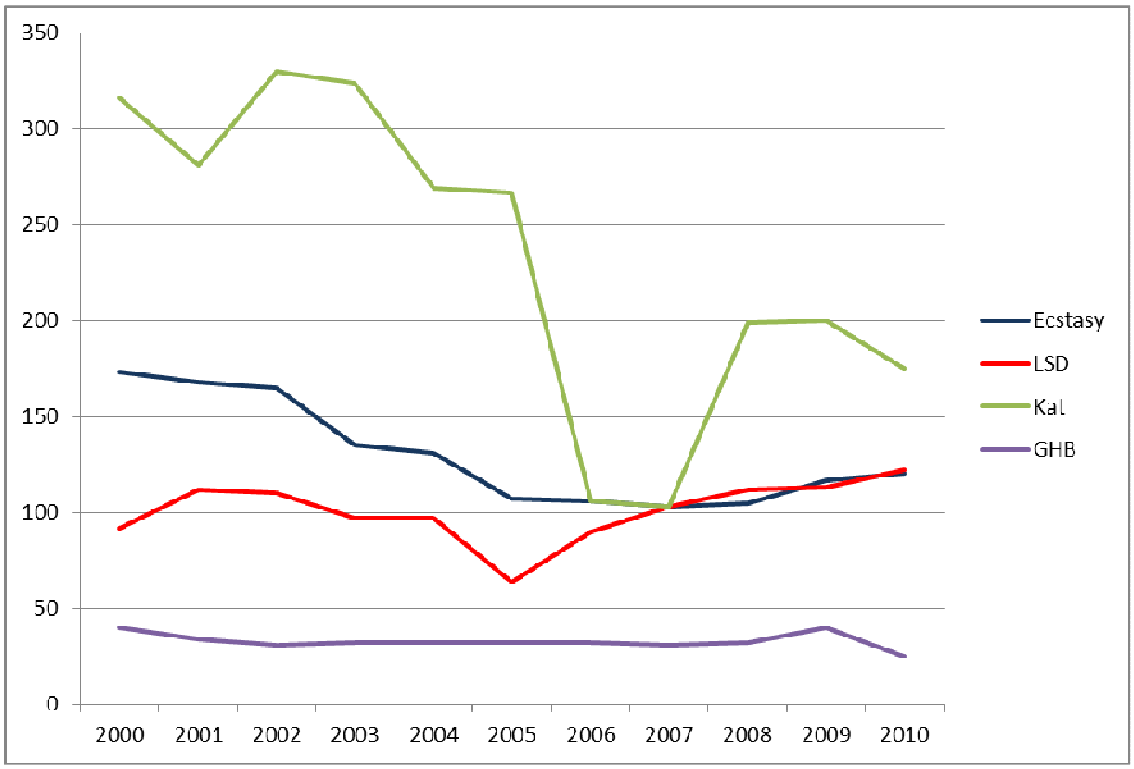
However, from a short-term perspective, prices have increased for marijuana, cocaine and heroin in recent years. The increase is not spectacular, but unique in a long-term perspective because the prices of several illicit drugs have now increased at the same time. Amphetamines are the only drugs with stable prices.

Figure 10.1. CPI-adjusted[33] original median street-level prices, SEK per gram for cannabis resin, marijuana, amphetamine, cocaine and white plus brown heroine 1988-2010.



[33] The Swedish Consumer Price Index, Statistics Sweden.

Figure 10.2. CPI-adjusted[34] original median street-level prices, SEK per gram for ecstasy, LSD, khat and GHB 2000-2010.



In the introduction, it was mentioned that illicit-drug prices were also gathered at a wholesale level beginning in 2010 (quantities in kilograms). A comparison between wholesale prices and street-level prices (quantities in grams) shows that street-level prices are 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 (Guttormsson, 2011).

[34] The Swedish Consumer Price Index, Statistics Sweden.

Part B – Selected Issues

11. Drug-related health policies and services in prison

Introduction

The aim of this report is to describe the population that is in prison with problems related to illicit drug use or a substance use disorder. The report attempts to assess their characteristics and their health and social problems and reviews the interventions aimed at drug use in prison.

This chapter is divided into three sections. Section 1 concentrates on describing the Swedish national prison system and the organisational framework. It also describes the Swedish view of illicit drugs, alcohol, anabolic steroids and tobacco – and the fact that a substance use disorder is not considered to be just a medical problem. The chapter ends with a description of people who commit crimes against the Act on Penal Law on Narcotics, and inmates with a substance use disorder in Swedish prisons.

Section 2 focuses on the organisation of treatment within the Swedish Prison and Probation Service. It also provides an explanation of what an evidence-based programme is, the purpose of accreditation of programmes and the "implementation" concept that covers all procedures used to introduce new methods or new knowledge to an organisation and make sure that methods and knowledge are maintained and applied long enough to produce the expected output. Chapter 2 also provides an explanation of the interventions for inmates with a substance use disorder.

Section 3 describes the actions and interventions pursued to end illicit drug use among inmates. The basis of treatment, an individually designed plan for each inmate, is described. Lastly, a description is provided of the general view of treatment and some results of participation in treatment programmes.

Prison system and prison population: contextual information

National prison system and organisational framework - Swedish Prison and Probation Service

The Swedish Prison and Probation Service is a part of the legal system and a national authority under the Ministry of Justice. The main tasks of the Prison and Probation Service are to implement prison and probation sentences, to supervise conditionally released individuals, to implement community service orders, and to carry out pre-sentence investigations in criminal cases. The Prison and Probation Service is also responsible for activities at remand prisons and the inmate transport service.

The aims of the criminal policy and the Swedish Prison and Probation Service are to reduce criminality and increase safety in society. This work includes engaging in

activities that encourage the inmates to live a life free of criminality and drugs. The Prison and Probation Service implements these responsibilities by:

- Taking actions to prevent offenders from reoffending.
- Maintaining a humane interest in people, providing good care and actively influencing progress while allowing for a high level of security as well as the privacy and legal rights of the individual.

The Prison and Probation Service is organised into one head office, six regional offices and a transport service. Each region has remand prisons, prisons and probation units, which co-operate to help clients adjust to a life free of crime and drugs in the best way possible. In the Prison and Probation Service, there are many different professions, including prison officers, inspectors, transport staff, nurses, kitchen staff, cleaning staff, office workers, etc. The majority are prison officers, who also work as contact persons. Contact persons can, for example, work with planning leave or organising treatment in co-operation with other authorities.

The cost of the Prison and Probation Service is slightly more than SEK 7 billion (€ 63 million) per annum. A prison inmate costs SEK 2,200 (€ 244) per day on average (2010). A non-custodial client costs SEK 200 (€ 22) per day on average (2010). A client in custody in remand prison costs SEK 2,400 (€ 266) per day on average (2010) [35].

In Sweden, remand prisons, which mainly contain people awaiting trial, are often separated from prisons, which only hold those convicted of a crime. Remand prisons are often built or placed at other geographical locations than prisons. Remand prison is a custody facility for persons in pre-trial detention, those who have been apprehended or arrested for a crime, asylum-seekers awaiting deportation and substance abusers or mentally ill persons waiting to be placed in an institution. People arrested for escaping or breaching their probation are also placed in remand prisons. However, most of the people in remand prison are on remand or in pre-trial detention and not yet convicted of a crime.

There are 52 prisons and 31 remand prisons in Sweden (February 2011). Prisons have been allocated security classifications. Closed prisons are divided into classes A-D while open prisons have their own group, class E. Most control is applied to the closed class A prisons. The primary reason for the more distinct security levels is to place the right client in the right prison. Classification is linked to a risk analysis, which is conducted for all clients. Class A prisons are equipped to deal with clients who pose the highest risk, while the rest of the clients do not need to be held at a higher level of security than necessary. Classification of a prison is based on the ability to contain escapes, the ability to resist breakouts and the prison's ability to deal with difficult clients.

Sanctions, legal framework and governing documents

More than one million crimes are reported in Sweden every year. The Swedish Penal Code lists crimes and their sentences. The sentences listed in the Penal Code are

[35] SEK translated into EUR using average currency rates January to September 2011 (Source: Riksbanken [Sweden's central bank]).

fines, imprisonment, conditional sentence, probation and committal for special care. Sanctions implemented by the Prison and Probation Service are prison, intensive supervision with electronic monitoring ('tagging'), conditional release with community service, probation, probation with community service, probation with contract treatment. When deciding on a sanction, the court must take into account whether there are any special factors which would favour a sanction other than imprisonment. Fixed-term prison sentences are seldom longer than ten years and never shorter than two weeks. However, in the event of a re-offence or the sentence pertaining to more than one crime, a fixed-term sentence may be up to 18 years. Life imprisonment is the most severe penalty allowed under Swedish law. Unlike other sentences, life imprisonment is of indeterminate length. A new law applies that stipulates that those serving life prison sentences can apply to the Örebro District Court to have their sentences commuted to a determined sentence. The Court may only commute a life sentence to a determined sentence that is equal to or above the maximum fixed-term sentence allowed in Sweden. In April 2011, 161 prisoners were serving life sentences, 6 of whom were women. The oldest life-term prisoner is 82 years old and the youngest is 23 years old. They are all serving a sentence for murder (including aiding and abetting, attempted murder and solicitation to commit murder).

Intensive supervision with electronic monitoring ('tagging') is an alternative way of serving a prison sentence of a maximum of six months. The convicted person is monitored 24 hours a day with the aid of a transmitter attached to the ankle. Persons sentenced to a maximum of six months can apply for intensive supervision with electronic monitoring. For persons with a drug and/or alcohol abuse problem or a substance use disorder, there is a non-custodial sentence called Probation with a special treatment plan or contract treatment. Contract treatment is primarily for persons with a long-term substance use disorder where there is a link between the substance use disorder and the crimes committed. A contract is drawn up between the court and the client regarding institutional care, which can be in a home or at an open clinic.

In Sweden, the age of criminal responsibility is 15, which means that children under the age of 15 cannot be imposed a criminal penalty. Young people under the age of 18 are only sentenced to imprisonment in exceptional cases. The Penal Code stipulates that persons under 15 years of age cannot be convicted to a sentence executed by the Swedish Prison and Probation Service. There are very few persons under the age of 18 that are sentenced to imprisonment (only one person in 2010). Young adults under the age of 21 cannot be sentenced to life imprisonment. At the beginning of 1999, the sentencing system for young offenders was changed. A new feature that was introduced was closed youth detention. The National Board of Institutional Care (SiS) is responsible for putting this into effect. Young people aged 15-17 who have committed serious crimes can be sentenced to closed youth detention at a special youth detention centre instead of prison. The aim is to reduce the harmful effects of time spent in prison. This sanction is limited with regard to the length of the sentence, during which the time is used for welfare and treatment. It is the crime and not the need for treatment that determines the length of the sentence, which can vary from fourteen days to four years. There is no conditional release. SiS is responsible for putting this into effect, although it is the municipal social services

department that has overall responsibility for young persons placed in special youth detention centres.

In Sweden, people serving fixed-term sentences are conditionally released after having served two thirds of the sentence. However, conditional release is not possible until at least one month of the sentence is served. Likewise, inmates may not be conditionally released (a) if the sanction is not permitted, (b) in cases where the sentence is probation in association with prison or (c) where a sentence is a transformation of fines. Those released on parole are subject to a period of supervision, corresponding to the remaining term of their sentence, although no less than one year.

The Prison Act (Fängelselag 2010:610) stipulates that every prisoner is entitled to special actions before release. This transition is a period at the end of the prisoner's sentence devoted to preparing the inmate for a life outside prison. The aim is to reduce the risk of the inmate reoffending and facilitate reintegration into society. Please note that this is a continuation of the prison sentence where penalty time is still counted. There are four special release actions, depending on the needs of the inmate.

- "Conditional – work and study - release", where the prisoner can be given the possibility to engage in activities such as work or studies outside prison during the daytime.
- "Care service" allows for the prisoner to spend time at a family care home or care and treatment centre for the purpose of participating in various treatments, such as treatment for a substance use disorder.
- "Half-way house" allows the prisoner to interact with an environment that is more exposed than an open prison at the same time that he or she benefits from the support and assistance provided by the Prison and Probation Service and other authorities.
- "Extended – work and study - release" allows the prisoner to serve his/her sentence at home under controlled circumstances (intensive supervision with tagging). The prisoner shall work, attend educational or vocational programmes, receive treatment or participate in organised activities.

In 2010, 1,704 prisoners engaged in such transitional activities. A portion of these, 712 prisoners, underwent Care service. This is an activity aimed for treatment of a substance use disorder.

A number of provisions in the Penal Code and other regulations provide an opportunity to halt proceedings or to provide clemency or care instead of punishment, when people have a substance abuse disorder or have mental health problems. For example, Section 46 of the Act (1988:870) concerning care of substance abusers in some cases (LVM). This Act gives the prosecutor the possibility to determine whether prosecution is appropriate if a person committed crimes and has been under the care of LVM. The crime, though, may not be too severe (maximum of one year in prison).

Once the prosecutor decides to prosecute a person, the court has the possibility (Chapter 29 Section 3 of the Penal Code) to decide that the crime was committed during severe mental health problems or the person had no insight to his actions or

was unable to control his or her actions. This person should be sentenced to mental care instead of imprisonment (Chapter 30 Section 6).

The Swedish view of illicit drugs, alcohol, anabolic steroids and tobacco

The Swedish Prison and Probation Service, unlike that in most other European countries, does not differentiate illicit drug abuse, alcohol abuse or abuse of anabolic steroids (defined by law SFS 1991:1969). In Sweden, even tobacco use is considered a behaviour that indicates an increased risk for using illicit drugs and/or excess use of alcohol. The use of prescription medication without a prescription is considered to be use of illicit drugs.

All prisons and remand prisons are by law Prison Ordinance 2010:2010, Remand Prison Ordinance 2010:2011) non-smoking facilities. This goes for employees as well as inmates. Smoking is only permitted in designated areas.

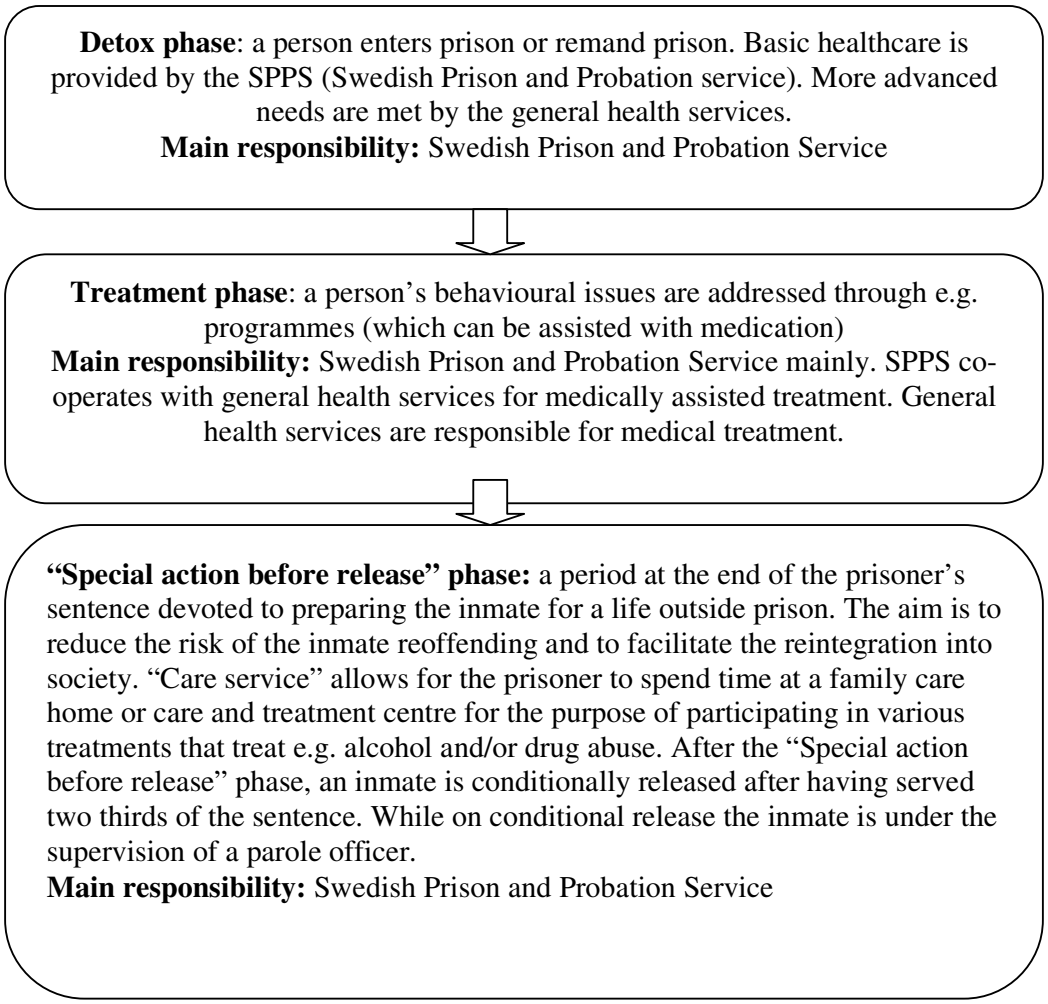
There is a national action plan for working against alcohol misuse, illicit drug use, use of anabolic steroids and the smoking of tobacco. The Swedish Prison and Probation Service strives to reduce the use and misuse of alcohol because there is a strong correlation with criminality, such as drunk driving and crimes with elements of violence. There is also some evidence that the use of tobacco underpins and enhances the effect of other drugs. But the main reason why the Swedish Prison and Probation Service strives to reduce tobacco use is that it has negative effects on a person's general health.

Use of narcotics and anabolic steroids is a crime under the Act on Penal Law on Narcotics, "Narkotikastrafflagen" (1968:64). Use of alcohol and tobacco is not a crime under Swedish law. Section 1 of the Act on Penal Law on Narcotics stipulates that a person cannot use, transmit, produce, acquire, or in any other way handle illicit drugs. A person can be sentenced to prison for these crimes.

Responsibilities regarding treatment for drug addicts

The Prison and Probation Service works in various ways to give clients new skills, knowledge and approaches to life for preventing a return to crime. This is done, for example, through placement services, work, client education and training, treatment programmes and supervision. Health and spiritual care are also provided.

In Sweden, drug and/or alcohol addiction is considered primarily a social problem. It is therefore the social services that are mainly responsible for the care of persons with a substance use disorder. The health care system also has responsibilities for certain parts of the treatment system however, e.g. detoxification, treatment of comorbidity, etc. The model below describes the view of treatment for persons with a substance use disorder in the Swedish Prison and Probation Service.



An important distinction is that general health services in Sweden are responsible for the physical treatment of the inmates, and the Swedish Prison and Probation Service is responsible for cognitive treatment programmes, education or other structured inmate activities while in prison. All of this aims to end a person's misuse of illicit drugs and/or alcohol. This will be explained in detail in the following section.

Health and physical treatment

In accordance to the Health and Medical Services Act and the Prison Act (2010:610), the Swedish Prison and Probation Service has a responsibility for providing basic healthcare for inmates and mediating contacts with the general health services in society. However, there is a "normalisation principle" that is the starting point for all healthcare and social services for inmates (Bill 1982/83:85). This principle means that the general healthcare services are responsible for the health needs of inmates as well as every other citizen. The social services and healthcare services are to serve all citizens based on their individual needs, including those who are in prison or in remand prison. The principle implies that inmates have the same rights to social support, assistance and healthcare as other citizens.

Of course, there can be practical problems when a person is held in prison or in remand prison. He or she may not be able to engage healthcare services in the same

manner as other people in society. The Swedish Prison and Probation Service is therefore responsible for providing basic healthcare and mediating contacts with general healthcare services in society for further care. The Swedish Prison and Probation Service have employed nurses and doctors, but does not conduct more advanced health-care, such as operations.

The formal requirements that are implied for the Swedish Prison and Probation Service are that all inmates are to undergo physical health examinations when entering prison or remand prison. If an inmate has poor health, the person has to be cared for through a standardised approach determined by general healthcare services (doctors and nurses). Transporting every ill prisoner to a hospital off of the prison premises is often not appropriate for security reasons. The Swedish Prison and Probation Service therefore runs healthcare centres. This function is subject to the same legal framework as other social services in society, the Health and Medical Care Services Act (1982:763) and the Dental Services Act (1985:125). Healthcare personnel conduct health examinations for every inmate when they enter prison or remand prison (not only prisoners with a substance use disorder). For every prisoner, an electronic record is created and includes information on any medication the person needs and information on the person's general health status. All healthcare services provided at healthcare centres are to be planned, structured and organised.

Interventions, treatment programmes and other structured activities in prison

There are many inmates who are physically healthy but have evident behavioural disorders. Many also have multiple dependency problems, with physical complications and illnesses as a result. Those who arrive at a prison or remand prison have many kinds of problems. A large portion of the inmates abuse alcohol and/or drugs, and many have injected narcotics. Alongside abuse and dependency, several suffer from psychiatric or personality disorders. Many of the inmates also have physical problems, such as illnesses and disabilities as a result of violence or a hazardous way of life.

Every year, inmates undergo various types of treatment for the purpose of preventing repeat offences. They are provided with new knowledge and skills, as well as insights into their crime and the consequences of it. Treatment is intended to give clients better conditions for being law-abiding citizens once they have served their sentences. The treatment programmes are oriented to different groups of offenders: those with a criminal identity, those convicted of violent crimes, those with substance-abuse problems and those convicted of sexual crimes.

On 1 July 2011, prisons designated for drug and/or alcohol abusers had a capacity to house 1000 inmates. There are treatment and motivational wards36 at prisons to help clients overcome their substance use disorders. The prisons in Högsbo, Gävle, Österåker, Helsingborg, Sagsjön and Färingsö are specially aimed to treat inmates with a drug and/or alcohol addiction. Three prisons, Fosie, Storboda and Täby, have places for opioid substitution treatment. There is also a capacity for 120 inmates who need to be motivated to attend treatment for their drug and/or alcohol addiction. At

[36] On 1 July 2011, there was a change in how capacity is addressed. There are no longer treatment wards (prison cells), only treatment places (treatment capacity on an inmate basis).

almost every prison there are possibilities for motivated prisoners to attend a treatment programme.

In remand prisons, there are special outreach staff who work with identifying and motivating remanded persons to attend treatment using motivational interviewing techniques. Remand prisons are a good place to begin influencing potential prisoners to receive treatment because they may be in an abstinence phase or crisis phase.

Because the level of education among the inmates is low, the Prison and Probation Service also offers various types of education and training in prisons. Inmates can participate in compulsory school studies and upper-secondary school studies, or in vocational training programmes arranged jointly with the Swedish Public Employment Service. Among the Prison and Probation Service's own training programmes are, for example, licensed welding, tiling, soldering, parental training and study circles of various types.

Needs other than the prisoner's physical health are documented and pointed out in a personalised plan that constitutes the basis of the work with each client. An example is if an inmate is a good candidate for cognitive-based programmes or education. Individual needs and risks must be surveyed so as to be addressed with the appropriate measures.

The Prison and Probation Service makes an effort to break criminal behaviour and increase knowledge and understanding in the prison population. In addition to traditional methods, such as education and social rehabilitation, about a dozen national treatment programmes are offered. Five of these are designed for persons with drug and/or alcohol abuse. The programmes are based on the crime committed by the prisoner or if the prisoner has a substance use disorder. The purpose of the programmes is to reduce the risk of the prisoner reoffending and to give the prisoner an insight into the cause of addiction and criminality and the consequences of such addiction and criminality to the prisoner and the surrounding world, such as the victims of crime. The aim of the Swedish Prison and Probation service is only to implement evidence based treatment programmes. In order to ensure effectiveness, the programmes shall be reviewed by a scientific panel and only those meeting the requirements will be granted accreditation. To be approved, a programme must include, among other things, a clear model of change based on scientific evidence, the use of effective methods, site accreditation including monitoring of implementation and staff competence. Before applying for accreditation the programme is usually tried in a limited scope during development. After accreditation the aim is to offer the programme to all offenders, according to assessed risk and needs. In 2010, 5,767 prisoners completed a treatment programme in prison.

Programmes in use (February 2011)

General offending programmes
- Breaking with crime
- One to one
- ETS - Enhanced thinking skills

Violence
- IDAP - Integrated domestic abuse programme
- Violence prevention programme

Substance abuse programmes
- PRISM - Programme for reducing individual substance misuse
- Twelve-step programme
- Relapse prevention programme

Sexual offending programme
- ROS - Relationships and companionship

Motivational programmes
- Behaviour–talk–change
- Win

The Prison and Probation Services provide education and vocational training to give the inmates the opportunity to increase their skills and knowledge during the prison sentence and to enhance reintegration into society. Education and vocational training are important complements to drug treatment, providing the inmates with skills that will help them to not use drugs, to continue with further education and to get a job. The education available to prisoners, usually on a part-time basis, is either theoretical or practical. The Prison and Probation Service is responsible for the education offered to prisoners under the supervision of the Swedish National Board for Education. Around 120 secondary school teachers covering various subjects are employed by the Prison and Probation Service. Educational programmes include basic adult education, vocational training, post-secondary education, labour market training, parental guidance, etc. In 2010, 14,363 inmates had the possibility to engage in studies, while 4,297 inmates, about 30 per cent, chose to do so.

Social skills training is an example of another structured activity that teaches the prisoner to deal with everyday tasks such as cleaning, doing laundry and cooking as well as managing his/her finances. Another example of a structured activity is yoga classes, which are available in some prisons. These activities are not only aimed at those with a substance use disorder, but rather offered to the prison population as a whole to engage in structured activities described above.

General information - the prison population

On 1 October 2010, there were 5,374 people in prisons and 1,472 people in remand prisons arrested for a crime (pre-trial detention). In total, 1,849 people were in remand prisons on 1 October 2010 (this figure is higher than those in pre-trial detention because of the other categories of detainees in remand prisons). Unfortunately Sweden has poor data on individuals arrested for a crime (pre-trial

detention) in remand prison. The following statistics are therefore only on those in prisons (n=5,374).

Table 11.1. The prison population in Sweden, 1 October 2010, by age.

	No. Inmates	%
Age		
15 to 17	0	0
18 to 20	180	3
21 to 24	749	14
25 to 29	917	17
30 to 34	825	15
35 to 44	1,282	24
45 to 54	960	18
55 to 64	373	7
65 or older	88	2
Total	**5,374**	**100**

Table 11.2. The prison population in Sweden, 1 October 2010, by gender.

	No. Inmates	%
Sex		
Women	288	5
Men	5,086	95
Total	**5,374**	**100**

These statistics have been stable over time. For the past decade, there have been around 5,300 inmates in prison on any given day (time of measurement 1 October 2010). Every year, about 10,000 people are admitted or enter prison (excluding remand prison).

Table 11.3. Entries into Swedish prisons 2003-2010.

Year	No. Inmates
2010	9,679
2009	9,805
2008	10,370
2007	9,829
2006	10,428
2005	10,656
2004	11,343
2003	10,721

On any given day, there are approximately 3,200 people in prisons (excluding remand prisons) who are addicted to alcohol and/or drugs. This is about 60 per cent of the prison population on any given day. Including remand prisons and those with probation sanctions, there are between 9,000 and 10,000 people who are addicted to alcohol and/or drugs or have a substance use disorder in Swedish prisons.

Data collection in Sweden – limitations and possibilities

Sweden has three main data sources.

- General criminal register. The national criminal register includes data on convicted inmates, such as gender, age and crimes committed. Upon entering prison, each prisoner is classified as to the severity of their drug abuse. Note that the classification also can be "no drug abuse". Personnel at prisons make this classification. The classification comprises an estimation (a class 1 or 2) if a person is addicted to illicit drugs or alcohol and the severity of the addiction. This estimation is made when the prisoner enters prison. The definition of class 2, a severe addiction, is a person who has injected drugs or taken illicit drugs in any other way in the past 12 months outside prison. The definition of class 1, addiction, is that a person has used illicit drugs the past 12 months in prison, but not in a severe way. The use of prescription medication without prescription is considered use of illicit drugs. Alcohol addiction is estimated in the same way as drugs.
- Addiction severity index (ASI). This is an interview that is used to screen and further investigate the prisoner's substance use disorder. The ASI interview is only conducted if a person is likely to have a drug addiction, which has to be investigated more thoroughly. The ASI interview includes seven areas of questions (a total of 180 questions): physical health/somatic diseases, work and economic support, use of alcohol and/or illicit drugs, legal problems, family/social life, and mental health. The interviewer asks questions about the actual situation as well as the inmate's experiences in a more subjective sense. In the last part of the interview, both the interviewer and the prisoner estimate (on scale of 0-9) the inmate's need for help in various areas, such as physical and mental health.
- PMO, a medical record database. In this database, healthcare personnel (nurses and doctors) at prisons enter information from health examinations conducted when a person enters prison or remand prison. The information in this database is not only related to drug use; the health of every inmate is checked when they arrive in prison. In this database, the Swedish Prison and Probation Service does not consider drug addicts a target population, therefore we do not target the health of drug addicts as a group. This database has been implemented very recently and no data from this database is available yet.

There are methodological problems with using ASI data for knowledge on the prison population as a whole. As mentioned above – not all prisoners get an ASI interview, and not even all inmates who may have a substance use disorder get an ASI interview. There can be inmates with a substance use disorder that do not get an ASI inquiry. Therefore, ASI data can be used as a description of the prison population that has a drug abuse problem or substance use disorder, but ASI data does not describe drug abuse problems in the general prison population. The Swedish Prison and Probation Service uses ASI data to describe the drug addicted prison population, but one must be aware of the limitations. Data from the general criminal register can tell us what proportion of the prison population is addicted to illicit drugs or alcohol. The two data sources are not always equivalent. All data on the prison population is compiled at a national level as well as a prison level. Routine data is collected at prison entry and cross-sectional surveys are also conducted.

As mentioned before, data on those in remand prison is unfortunately very poor. This is an effect of the different legal framework that applies to remanded persons (data must be destroyed within two years) and that remand prisons in Sweden are custody facilities for many different people, such as those who have been apprehended or arrested for a crime, asylum-seekers awaiting deportation and substance abusers or mentally ill persons waiting to be placed in an institution. People arrested for escaping or breaching their probation are also placed in remand prisons.

Drug related crime and drug law offences

In 2009, approximately 1,410,000 offences were reported to the Swedish Police, Swedish Customs or the Swedish Prosecution Authority. A large portion of committed crimes are related to the abuse of drugs and/or alcohol. Offences against the Act on Penal Law on Narcotics are the most common reason for a prison sentence. In the past ten years, the proportion of offences against this Act, in relation to all offences, has increased from 30 to 40 per cent. Other common crimes are those that include violence as well as thefts and drink driving. These crimes are often also connected to drug and/or alcohol abuse. For example, the offenders are under the influence of drug and/or alcohol in eight out of ten assaults (Brottsförebyggande rådet [Brå], 2010).

Drug law offences

In 2010, 87,891 offences against the Act on Penal Law on Narcotics were reported. In 2009, there were 80,256 reported offences. In 2010, 26,771 people were suspected of crimes against the Act. This was an increase of 6 per cent compared to 2009.

Table 11.4. Persons suspected of offences by type of offence, 2010.

Type of offence	Total	Sex		
	Number	Men	Women	Unknown
Crimes against the Narcotics Drugs (Penal) Act	26,771	23,123	3,635	13
Supplying (1–3 a)	2,821	2,495	326	-
Possession (1–3)	12,712	11,204	1,506	2
Personal misuse (1–3)	22,897	19,743	3,141	13
Manufacturing (1–3)	418	376	42	-

In October 2011, the Swedish National Council for Crime Prevention will produce their annual and final statistics over drug law offences. Consequently, the following statistics are up to 2009.

The table below shows that the total number of reported drug offences increased by 3 per cent between 2008 and 2009. The highest increase is for drug production (15 per cent). In terms of drug possession and drug use, there is a smaller change (3 per cent). The category of possession and use has been removed, which is the explanation of the sharp fall in the possession and drug use category (from 3,418 in 2005 to 1,412 in 2006 and to 2 in 2007). A change in practice has occurred and this combined offence is now judged in a different way and, consequently, the cases are accounted for in each category instead. The total change between 2008 and 2009 for reported drug offences is similar to the drug offence as the main crime for conviction.

The table below shows the number of drug related offences annually in Sweden 2000-2009.

Table 11.5. Reported drug offences in Sweden, annually 2000-2009.

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Change 2008 / 2009, %
Peddling, etc. (1-3a §)	4,012	3,719	3,781	3,766	4,031	3,915	5,539	5,645	6,390	6,440	1
Drug possession (1-3 §)	11,343	11,588	13,561	14,526	15,249	17,624	22,083	2,315	24,764	25,432	3
Drug use (1-3 §)	13,936	13,659	16,373	18,583	21,726	26,645	37,544	42,414	46,569	47,847	3
Possession and use (1-3 §)	2,984	3,305	4,155	3,766	3,876	3,418	1,421	2	-	-	-
Production (1-3 §)	148	134	135	219	211	205	270	335	465	537	15
Total	**32,423**	**32,405**	**38,005**	**40,860**	**45,093**	**51,807**	**66,857**	**50,711**	**78,188**	**80,256**	**3**

The table below shows that the number of individuals convicted of drug related offences as the main crime increased significantly from 2000 to 2009. The annual increase has varied, but averages at just under 7 per cent. This means that drug convictions have almost doubled (increased by more than 94 per cent) over the past ten years. The table below presents the number of individuals convicted of drug related offences as a main crime annually in Sweden 2000-2009.

Table 11.6. Number of individuals convicted with drug related offences as a main crime in Sweden, annually 2000-2009.

Year	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
No.	8,055	8,005	8,992	10,106	10,808	11,862	13,932	15,179	16,817	18,525

In 2009, minor offences accounted for approximately 84 per cent of all convictions (just less than 15,500 people). Non-minor offences accounted for 14 per cent (2,700 people) and serious offences for 2 per cent (380 people). The proportion of convictions for minor drug offences increased whereas the proportion of convictions for non-minor drug offences decreased.

Amphetamines and cannabis are the two most common substances in the convictions statistics. In 2006, these accounted for 33 per cent and 36 per cent 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.

The most common sanction issued to those convicted of drug offences is a fine, either in the form of a summary fine issued by the prosecutor or a fine issued through a court sentence. Those issued fines accounted for 53 per cent of all those convicted of drug offences in 2009. That same year, 30 per cent of those convicted of drug offences involved waivers of prosecution, whereas 9 per cent involved prison sentences (Brottsförebyggande rådet [Brå], 2009).

An average of about 46 per cent of those imprisoned for a crime against the drug laws relapsed within three years (Krantz and Lindsten, 2008).

Drug and/or alcohol addicts in Swedish prisons

The Swedish Prison and Probation Service has two main data sources for information about the prison population, the criminal register and ASI enquiries. As mentioned before, ASI data can be used as a description of the prison population that has a drug abuse problem, but it does not describe the drug abuse problem in the general prison population. One must be aware of these limitations. Data from the general criminal register can tell us what proportion of the prison population (how many) is addicted to illicit drugs or alcohol. The two data sources are not always comparable.

This report aims to be a means to benchmark the European countries. Therefore, some of the following tables are the TDI tables requested by the EMCDDA. The TDI tables that are not presented in this chapter should be considered information that is unavailable to the Swedish Prison and Probation Service.

Approximately one-sixth of the clients in the figures presented below are not in prison at the time of the ASI interview. The interview is conducted by a probation officer. This does not mean that the person was not an inmate in a prison before or after the ASI interview was made. For those with a substance use disorder, it is common that they end up in prison after serving a probation sentence. The courts are not willing to impose a probation sentence again if a person continues committing crimes and using illicit drugs.

Proportions of drug addicted inmates

Data described below is collected from the criminal register and it therefore describes the proportions of inmates with drug and/or alcohol abuse problems in Swedish prisons. This register encompasses every person who is convicted to serve a punishment within the Swedish Prison and Probation Service. Every person gets a "classification of drug and alcohol use". The tables below are cross sectional data for 1 October 2010.

On 1 October 2010, 2000 inmates, 39 per cent, have no drug or alcohol addiction according to the personnel conducting interviews when the inmates enter prison. Alcohol addiction affects 11 per cent, 31 per cent abuse illicit drugs and 19 per cent abuse both alcohol and illicit drugs.

Among women, about 40.2 per cent have no problem with drug and/or alcohol use, while 11.4 per cent has an alcohol addiction, 37 per cent has a drug addiction and 11.1 per cent abuse both alcohol and drugs.

Table 11.7. Proportions of inmates with drug and/or alcohol abuse problems in Swedish prisons, 1 October 2010, by gender[37].

No.	No problem	Addicted to alcohol	Addicted to narcotic drugs	Addicted to alcohol+narcotic drugs	Total
Women	113	32	105	31	281
Men	1,887	550	1,520	955	4,912
Total	**2,000**	**582**	**1,625**	**986**	**5,193**

Source criminal register, Swedish Prison and Probation Service, October 1 2010.

Table 11.8. Proportions of inmates with drug and/or alcohol abuse problems in Swedish prisons, 1 October 2010, by age.

No.	No problem	Addicted to alcohol	Addicted to narcotic drugs	Addicted to alcohol+narcotic drugs	Total
18-20	48	16	68	44	176
21-24	206	61	305	179	751
25-29	282	79	308	207	876
30-34	321	66	267	144	798
35-44	544	125	356	212	1,237
45-54	383	154	234	157	928
55-	216	81	87	43	427
Total	**2,000**	**582**	**1,625**	**986**	**5,193**

Source criminal register, Swedish Prison and Probation Service, October 1 2010.

Among prisoners with short-term sentences of up to one year, 7 per cent have no problems with drug and/or alcohol use, 7 per cent have a drug addiction and 5 per cent use both alcohol and drugs. Among those with long-term sentences of 4 years or more, 14 per cent have no problem drug or alcohol use, 3 per cent have an alcohol addiction, 9 per cent abuse illicit drugs and 5 per cent use both alcohol and/or illicit drugs.

[37] For 547 inmates the information is missing. This is partly due to the fact that it takes some time for personnel to conduct interviews with newly arrived prisoners.

Table 11.9. Proportions of inmates with drug and/or alcohol abuse problems in Swedish prisons, 1 October 2010, by sentence length.

Sentence length	No problem	Addicted to alcohol	Addicted to narcotic drugs	Addicted to alcohol + narcotic drugs	Missing	Total
T<=2 months	44	30	47	47	223	391
2 months <**T**<=6 months	108	54	157	82	176	577
6 months <**T**<=1 year	256	83	226	146	75	786
1 year <**T**<=2 years	264	77	271	165	24	801
2 years <**T**<=4 years	506	150	389	238	29	1,312
4 years <**T**<=10 years	538	119	405	198	17	1 277
10 years <=**T**	218	41	104	71	3	437
Lifetime	66	28	26	39	0	159
Total	**2,000**	**582**	**1,625**	**986**	**547**	**5,740**

For those whose main crime is a violation of the Act on Penal Law on Narcotics, 34 per cent have no problem drug use or alcohol misuse, 3 per cent have an alcohol abuse problem, 46 per cent have a drug use problem and 13 per cent misuse both alcohol and drugs. These proportions can be compared to those convicted for sexual offences as a main crime, where only 6 per cent use illicit drugs. Other categories of crimes with a high percentage of persons who use illicit drugs are violent crimes and robbery.

Table 11.10. Proportions of inmates with drug and/or alcohol abuse problems in Swedish prisons, 1 October 2010, by main crime.

Main crime	No problem	Addicted to alcohol	Addicted to narcotic drugs	Addicted to alcohol + narcotic drugs	Missing	Total
Traffic offences	14	6	22	12	10	64
Driving under influence incl. aggravated	19	30	5	16	162	232
Crimes against the narcotics drugs act	591	43	802	218	94	1,748
Assault	440	256	275	381	99	1,451
Sexual offences	239	122	27	42	21	451
Theft and other offences of stealing	124	18	115	77	24	358
Robberies incl. aggravated	124	18	229	146	9	526
Fraud and other acts of dishonesty	208	24	55	23	42	352
Crimes against public and state	64	49	63	54	32	262
Other	177	16	32	17	54	296
Total	**2,000**	**582**	**1,625**	**986**	**547**	**5,740**

In summary, about 60 per cent of the prison population in Sweden had a substance use disorder on 1 October 2010. Substance use disorders primarily focused on illicit drugs affect 31 per cent. Among women, 37 per cent have a substance use disorder (illicit drugs). Among men, 31 per cent have a substance use disorder (illicit drugs).

Adding prisoners who use alcohol and illicit drugs, the numbers are 48 per cent for women and 50 per cent for men.

Unsurprisingly, a large proportion of prisoners whose main crimes are violations of the Act on Penal Law on Narcotics, violent crimes or robberies have a substance use disorder.

Inmates in Swedish prisons with a substance use disorder

In the following, data from ASI interviews is used as a source to further investigate and visualise the characteristics, health and social problems of the inmates who underwent an ASI inquiry in 2010. In short, this provides a more in-depth description of the drug addicted prison population in Sweden. Keep in mind that those found in the ASI data presented in this report are considered prisoners with a substance use disorder (more than three points in the interviewer's estimate).

A majority of the inmates who underwent an ASI inquiry in 2010 were men, 85 per cent, and the average age was 33 years.
A larger proportion of men that get an ASI interview are between the ages of 20-29. Women are more often represented in the age groups 20-29 and 40-49. Older inmates say they are in poor physical health with somatic diseases more often than younger inmates. Females have significantly more long-term somatic diseases or poor physical health than men.

Table 11.11. Number of ASI inquiries conducted within the Swedish Prison and Probation Service 2010, by the inmates' age and gender.

ASI inquiries by age and gender					
Age	**Men**	**Women**	**Total**	**Men %**	**Women %**
15-19	24	4	28	2	2
20-24	256	40	296	24	21
25-29	245	34	279	23	18
30-34	158	11	169	15	6
35-39	113	18	131	10	10
40-44	106	28	134	10	15
45-49	93	23	116	9	12
50-54	54	21	75	5	11
55-59	24	7	31	2	4
60-64	7	3	10	1	2
Total	**1,080**	**189**	**1,269**	**100**	**100**
Mean age	33	36	33		

Most of the inmates say that they are unemployed. Only 33 per cent have an education beyond compulsory school. Nearly half of the inmates provide for themselves through welfare, one quarter says that they make a living through crime.

Table 11.12. The situation for inmates concerning work and providing for oneself, answers in ASI inquiries 2010.

Work & providing for oneself	Men	Women	Total
Employee	304	27	331
Student	27	4	31
Other	278	55	333
Pensioner by age	4	1	5
Unemployed	452	102	554
Missing	15	0	15
Total	**1,080**	**189**	**1,269**

Table 11.13. Inmates current education, answers in ASI inquiries 2010.

Education			
	Men	**Women**	**Total**
No elementary school	175	38	213
Elementary school	547	90	637
Secondary school	324	51	375
University or college	32	10	42
Missing	2	0	2
Total	**1,080**	**189**	**1,269**

Most inmates live alone, 34 per cent, or with a partner, 19 per cent. Of the women, 13 per cent have no stable living situation while the same is true of 11 per cent of the men.

Table 11.14. Inmates current living situation, answers in ASI inquiries 2010.

Living situation						
	Men	**Women**	**Men %**	**Woman %**	**Total**	**Total %**
Live with a partner and a child	95	7	9	4	102	8
Live with a partner only	187	54	17	29	241	19
Live with a child only	10	10	1	5	20	2
Lives with parents	148	16	14	8	164	13
Lives with relatives	33	3	3	2	36	3
Lives with friends	54	11	5	6	65	5
Live alone	376	56	35	30	432	34
Institution	54	7	5	4	61	5
No stable living situation	118	25	11	13	143	11
Missing	5	0	0	0	5	0
Total	**1,080**	**189**	**100**	**100**	**1,269**	**100**

Of the inmates, 70 per cent live in some kind of permanent housing, but 24 per cent have no housing at all. A slightly larger portion of the women do not have a permanent housing.

Table 11.15. Inmates current housing situation, answers in ASI inquiries 2010.

Housing						
	Men	**Women**	**Men %**	**Woman %**	**Total**	**Total %**
Permanent housing	764	124	71	66	888	70
No housing	257	50	24	26	307	24
Institution	16	5	1	3	21	2
Missing	43	10	4	5	53	4
Total	**1,080**	**189**	**100**	**100**	**1,269**	**100**

There are several significant differences between men and women, and between clients in different age groups. Younger inmates show greater problems concerning criminal behaviour and narcotic substances, work/economic support and mental health. Problems regarding physical health/somatic diseases and alcohol grow with age. Men more often show signs of problems concerning criminal behaviour and narcotic substances, while women, on the other hand, need help in areas of family/social life, physical health/somatic diseases and mental health according to the ASI inquiry.

In ASI data from January 2008 to January 2010, 32 per cent of the prisoners' say in the interview that they suffer from hepatitis C. Among the interviewees, 43 per cent say that they have been physically abused and 39 per cent say that they have been psychologically abused. In 2010, about 1 per cent said that their last HIV test was positive.

Main drug and patterns of use

In the ASI interview, the interviewer first asks questions about the inmates' use of drugs and alcohol. Then, the interviewer tries to determine which drug is the main problem.

Interviewer estimates of the respondents' need for help show that illicit and misused prescription drugs and criminal behaviour are by far the greatest problem areas. The chart below presents the answers given by the ASI respondents of main drug use. The predominant drug is amphetamines (24 per cent), followed by cannabis (15 per cent), and 43 per cent use more than one illicit drug.

Table 11.16. Inmates main drug, answers in ASI inquiries 2010.

Main drug	Total	%
Heroine	95	7
Methadone	2	0
Subutex	11	1
Other opiates	20	2
Dampening	35	3
Cocaine	27	2
Amphetamine	309	24
Cannabis	187	15
Solvents	2	0
Other	18	1
More than one illicit drug	546	43
Missing	17	1
Totalt	**1,269**	**100**

The table below presents the main drug of preference in different age groups. In general, amphetamines are the predominant drug in the ages 30-59. For younger inmates (15-30 years of age), it is more common to mainly use cannabis rather than amphetamines. It is most common to use several illicit drugs, which is the case for 43 per cent of the inmates.

Table 11.17. Inmates main drug by age, answers in ASI inquiries 2010.

Main drug	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	Total	Total %
Heroine	0	12	26	19	6	15	14	1	1	1	95	7
Methadone	0	0	0	1	0	0	0	0	1	0	2	0
Subutex	1	6	1	1	2	0	0	0	0	0	11	1
Other opiates	1	8	2	3	0	3	1	1	0	1	20	2
Dampening	1	10	7	8	4	2	2	0	1	0	35	3
Cocaine	0	6	7	5	6	2	1	0	0	0	27	2
Amphetamine	3	30	44	32	45	50	52	38	10	5	309	24
Cannabis	13	79	52	13	9	9	3	7	2	0	187	15
Solvents	0	2	0	0	0	0	0	0	0	0	2	0
Other	0	7	5	5	0	0	0	1	0	0	18	1
More than one illicit drug	9	130	131	82	57	53	41	25	16	2	546	43
Missing	0	6	4	0	2	0	2	2	0	1	17	1
Total	**28**	**296**	**279**	**169**	**131**	**134**	**116**	**75**	**31**	**10**	**1,269**	**100**

The way the prisoners take drugs varies depending on the type of drug, of course. The table below presents the main drug and the way the prisoners take the drug: orally, nasally, smoking or intravenous injection. Amphetamines are the main drug for many of the inmates in Swedish prisons. The most common way to take them is by intravenous injection. For inmates who use several illicit drugs, intravenous injection is also the most common way to take the drugs.

Table 11.18 Inmates drug and way of taking the drug, answers in ASI inquiries 2010.

Main drug & intake	Orally	Nasally	Smoking	Non intravenous injection	Intravenous injection	Missing	Total
Heroine	1	2	44	0	48	0	95
Methadone	1	0	0	0	0	1	2
Subutex	5	3	0	0	3	0	11
Other opiates	13	0	4	0	2	1	20
Dampening	33	0	1	0	1	0	35
Cocaine	2	24	1	0	0	0	27
Amphetamine	57	23	0	4	225	0	309
Cannabis	3	3	180	0	0	1	187
Solvents	0	0	0	0	0	2	2
Other	8	1	2	6	0	1	18
More than one illicit drug	122	33	103	8	229	51	546
Missing	0	0	0	0	0	17	17
Total	**245**	**89**	**335**	**18**	**508**	**74**	**1,269**

In terms of gender, it is more common for women to have recently injected drugs. Almost half of the women, compared to 38 per cent of the men, have recently injected drugs. Also, 39 per cent of the men compared to 24 per cent of the women have never injected any drugs. These figures are presented in the table below.

Table 11.19. Inmates' frequency of injecting drugs, by gender, answers in ASI inquiries 2010.

Frequency of injecting drugs	Men	Women	Men %	Women %	Total
Never been injecting	418	45	39	24	463
Not recently	253	43	23	23	296
Recently	408	101	38	53	509
Missing	1	0	0	0	1
Total	**1,080**	**189**	**100**	**100**	**1,269**

The table below presents the main drug and the frequency of use. Inmates with an amphetamine use disorder often use the drug daily (53 per cent). In total, it is most common to use any drug daily; 43 per cent of the inmates use a drug daily.

Table 11.20. Inmates' main drug and frequency of use, answers in ASI inquiries 2010.

Main drug - frequency of use	Have not used	Maximum once a week	2-6 days a week	Daily	Missing	Total
Heroine	15	5	26	49	0	95
Methadone	0	0	0	1	1	2
Subutex	1	1	5	4	0	11
Other opiates	7	1	2	9	1	20
Dampening	2	3	11	19	0	35
Cocaine	5	6	13	3	0	27
Amphetamine	32	35	78	162	1	308
Cannabis	27	21	44	94	1	187
Solvents	0	0	0	0	2	2
Other	3	2	6	6	1	18
More than one illicit drug	81	54	161	203	47	546
Missing	0	0	0	0	18	18
Total	**173**	**128**	**346**	**550**	**72**	**1,269**

The table below presents the main drug and age at first use. Not surprisingly, most use of illicit drugs starts at quite an early age. Very few of the inmates started using illicit drugs after the age of 30.

Table 11.21. Inmates' main drug and age at first use, answers in ASI inquiries 2010.

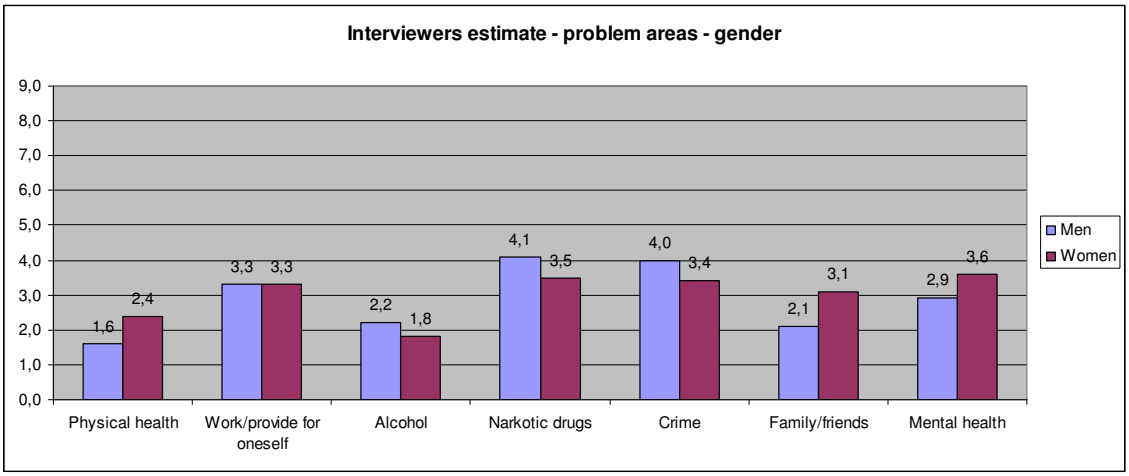
Main drug - age at first use	<15	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	Missing	Total
Heroine	7	30	30	15	5	1	7	0	0	0	95
Methadone	0	0	1	0	0	0	0	0	0	1	2
Subutex	0	5	3	1	2	0	0	0	0	0	11
Other opiates	3	10	1	2	1	0	1	1	0	1	20
Dampening	6	20	3	1	3	0	0	1	0	1	35
Cocaine	1	9	7	8	1	1	0	0	0	0	27
Amphetamine	69	167	44	15	9	1	2	0	1	1	309
Cannabis	98	73	13	2	1	0	0	0	0	0	187
Solvents	0	0	0	0	0	0	0	0	0	2	2
Other	1	8	5	1	2	0	0	0	0	1	18
More than one illicit drug	124	221	91	34	19	7	5	3	0	42	546
Missing	0	0	0	0	0	0	0	0	0	17	17
Total	**309**	**543**	**198**	**79**	**43**	**10**	**15**	**5**	**1**	**66**	**1,269**

Respondents' health and social life

According to the interviews with women, they more often than men live with a partner who also abuses drugs and/or alcohol. Females have also been a victim of violence significantly more often than men and women have psychiatric disorders or poor mental health to a larger extent. Overall, women say their main problem area is family and social life. Men, on the other hand, more often have problems with controlling violent behaviour. The chart below presents the mean of the interviewers'

estimation of the severity of problems in different areas (scale 0-9)[38]. Men have higher interviewer scores in the drug and criminality area, while women have higher scores in physical health/somatic diseases, family/social life and mental health/psychiatric disorders.

Figure 11.1. Interviewers estimate of problems areas sorted by inmates' gender, based on ASI inquiries.



There are a few interesting results that are connected to the prisoner's age when first becoming intoxicated with alcohol. Prisoners who say that they used alcohol at an early age also say significantly more often that they have hepatitis C and have been hospitalized.

There is a correlation between the respondent's first alcohol intoxication and the use of illicit drugs. Respondents who say that they have injected drugs more often had an early alcohol début. Respondents who had been intoxicated with alcohol before 18 years of age are more likely to have experienced severe anxiety, difficulties in understanding, remembering or concentrating. They have more often experienced hallucinations and they have difficulties controlling violent behaviour.

Respondents who say that they use amphetamines also often say that they have long term somatic diseases or physical illnesses. In contrast, respondents who say they use cannabis also say that they have less somatic diseases or physical illnesses. Respondents who use heroin, amphetamines or mix different illicit drugs are more likely have hepatitis C or hepatitis B. Note that this is data from January 2008 to January 2010.

Prisoners with amphetamine use disorder

In a recently published study co-funded by the Swedish Prison and Probation Service, researcher Anders Håkansson studied prisoners with a substance abuse disorder (Håkansson et al., 2009). Håkansson primarily focused on amphetamine addicts and suicides among prisoners with a substance abuse disorder.

[38] Please note that this is data from January 2008 to January 2010.

From an international point of view, Sweden has had unique patterns of drug use for decades because a large portion of Swedish drug addicts have used amphetamines as their main drug. Amphetamines have also been the dominant drug among injecting drug users. Even though heroin use has increased since its introduction to Sweden in the 1970s, amphetamine retained a strong position. Sweden differs from most comparable countries, with one exception, Finland (Kraus et al., 2003) Håkansson's study aims to describe prisoners39 who use amphetamines, and to compare the group with heroin and cocaine addicts (Håkansson et al., 2009).

Amphetamine users differ in several important aspects from the other two groups. Amphetamine users are significantly older, more likely to have been born in Scandinavia, and lived more frequently in big cities. In addition, amphetamine users often have a history of binge drinking or parents with alcohol problems. Psychiatric disorders or poor mental health are common in the three groups. Compared with heroin users, amphetamine users indicated greater cognitive difficulty (difficult to remember, understand or concentrate) and a family history of alcohol problems. The heroin addicts have to a greater extent experienced overdoses, abused other opioids and have been in detoxification treatment in a hospital. Among amphetamine and heroin users, a majority had a history of drug injection, whereas this was rare in the cocaine group. Although the use of other drugs was common, there was little overlap of the abuse of these three drugs.

Håkansson's results indicate an increased risk of suicide and attempted suicide among prisoners with substance abuse disorders, compared with the entire Swedish population.

Many different variables are associated with suicide attempts, although independent of each other. In Håkansson's study, attempted suicide was linked to various psychiatric symptoms, such as depression, anxiety, hallucinations, violent behaviour and eating disorders. As in many other studies, a history of suicide attempts is more common among women. In addition, there was a link between suicide attempts and being victims of physical abuse or assault. Physical, psychological and sexual abuse were linked to suicide attempts, each one individually, and independent of each other and independent of depression. Moreover, there was a connection to alcohol problems and mental health problems among the prisoners' parents. There was a connection between suicide attempts and physical illness, alcohol intoxication, injecting drug use and drug overdose. Alcohol was the only individual drug that showed a positive association with suicide attempts.

This leads to the conclusion that attempted suicide is associated with a very large number of different factors. There is a connection with various negative life events and abuse variables. Increased risk of attempted suicide is therefore associated with many other factors, not just depression. Among prisoners with a substance use disorder, there is a significantly higher risk of attempted suicide. Other studies also indicate that those leaving prison have an elevated suicide risk (Pratt et al., 2006).

At present, there is no approved pharmacotherapy for amphetamine dependence in Sweden. In recent years, however, Naltrexone has been established as a promising

[39] Please note that Håkansson does not only analyse prisoners but also those with different kinds of probation and community service sentences, etc.

treatment of amphetamine dependency in the Swedish research community. Naltrexone has been studied in a recently published study co-funded by the Swedish Prison and Probation Service. The aim of the study was to investigate the effect of an acute dose of Naltrexone on cue-induced craving for amphetamine in dependent persons. The primary hypothesis was that pre-treatment with Naltrexone would attenuate the cue-induced craving for amphetamine. The study was double-blind placebo-controlled within group design and the test sessions took place at the Magnus Huss clinic, Karolinska Institutet and the Kronoberg remand prison. A total of six amphetamine-dependent males underwent testing. Subjective craving was measured using a single-item visual analogue scale, and the physiological craving was measured as a difference in blood pressure and heart rate. This was a pilot study and further studies on this topic should be conducted to validate the results. The results indicated that Naltrexone had a dampening effect on the subjective drug craving. However, there was no difference in the physical drug cravings between the various preparations (Jayaram-Lindström et al., 2010) .

Another measure of the use of illicit drugs

Another measure of the prisoners' use of illicit drugs is urine samples. The Swedish Prison and Probation Service takes urine samples in many different situations, such as the following.

- When the prisoner arrives, such as when returning from 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, such as cannabis, are 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. Consequently, urine tests cannot be considered a measure of drug use inside prison. However, the test may give some knowledge of which drugs are most commonly used by inmates. Urine testing can also detect changes in use that occurs over time. Some prisons in Sweden take a large number of urine tests, while other takes a comparatively small number of urine tests. This may vary based on the client composition and the proportion of inmates with a substance use disorder.

In 2010, the Swedish Prison and Probation Service took 96,319 urine tests. Most of these, 71,378 tests were random testing. Of these, 6,629 tests were taken when the prisoner arrived after a permitted leave. These figures have remained at a similar level since 2001. Only a very small portion of tests were taken because there was a suspicion of drug use outside or inside prison.

Of the tests, 4,965 came back positive for illicit drugs. Cannabis and benzodiazepines were the most common positive tests. A large portion of the positive tests are tests that are taken when the prisoner has been on a permitted leave. This may indicate that urine tests might not be considered a reliable measure of use of illicit drugs inside prison.

Organisation of prison health policies and service delivery

Current status – interventions in the form of evidence-based programmes in prison

The aim of the Swedish Prison and Probation Service is to implement evidence-based treatment programmes to reduce substance use disorders and criminality and, at best, prevent relapses. But, what are evidence-based programmes?

An evidence-based programme in the Swedish Prison and Probation Service is a programme against crime and drugs that is a structured, scheduled activity, aimed at a specified target group of clients and must have a specified evaluation model. The basis of a programme is the client's needs and risk of committing new offences or drug abuse and is aimed at preventing relapse. The purpose is to bring about knowledge and understanding, motivate to change, and alter negative attitudes and behaviour. Since 1999, the Swedish Prison and Probation Service has intensified its work with the aim of identifying and developing a limited number of evidenced-based programmes against crime and drugs, which will be used as National Programmes after being accredited and implementation decisions are made.

The purpose of accreditation

The purpose of accreditation is to develop a number of core programmes for prison and probation, aimed at a majority of client groups, built on research and evidence - the "What Works"-principle. The "accredited programme" concept is defined as a research-based programme expected to reduce recidivism, provided that it is delivered in a correct way. An accredited programme must meet the ten criteria for accreditation, approved by the accreditation board:

- A clear model of change
- Selection of offenders
- Targeting dynamic risk factors
- Effective methods
- Skills oriented
- Sequencing, intensity and duration
- Engagement and motivation
- Continuity of programmes and services
- Programme integrity
- Continuous monitoring and evaluation

Implementation

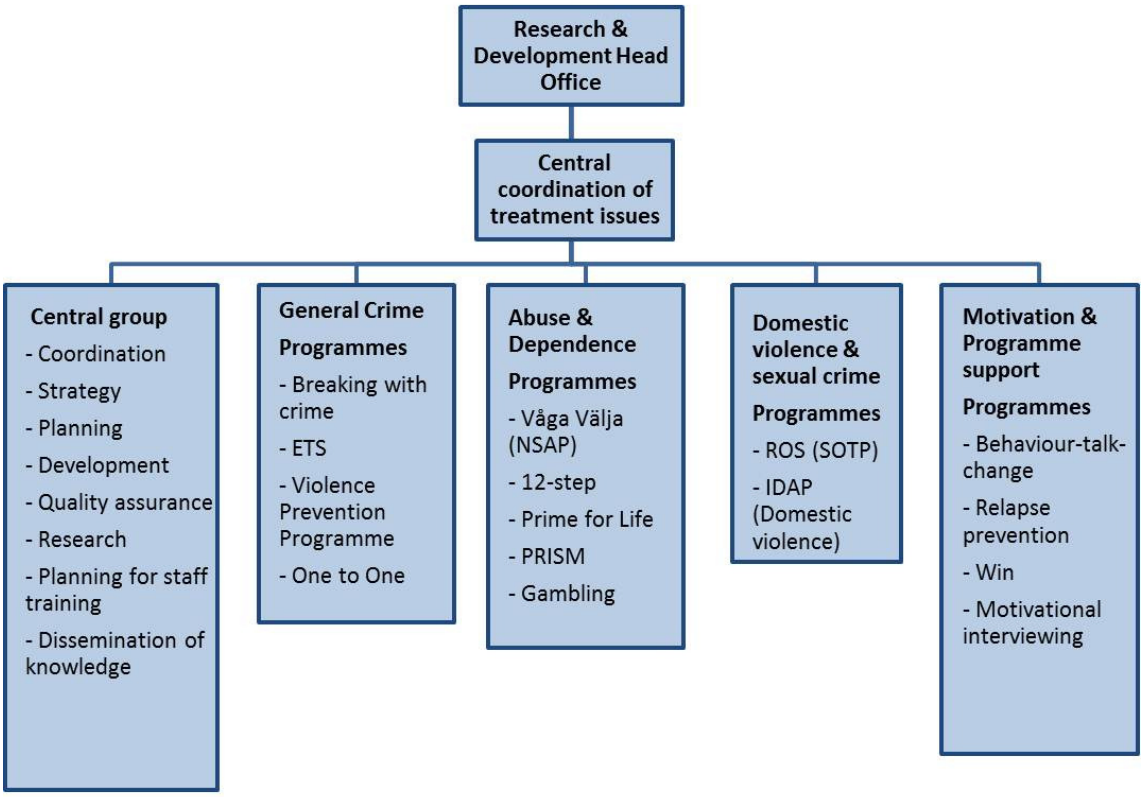
The concept of "implementation" covers all procedures used to introduce new methods or new knowledge in an organisation, and make sure that the methods and knowledge will stay and be used long enough to produce the expected output. Implementation therefore comprises those strategies used to establish and guarantee all efforts from decision to full performance.

Organisation

The organisation for the aforementioned is a part of the Swedish Prison and Probation Service head office. The figure below shows that, in addition to the Central group, there are four groups responsible for different areas, including staff training for programme tutors and development of programmes. According to risk and need

principles, prisoners may participate in programmes in different areas, but a drug problem is often a major issue. The central group also orders the assessments of the programmes (which are carried out by the SPPS research teams) and is responsible for the publishing and handling of results.

Figure 11.2. Organisation and coordination of treatment issues in the Swedish Prison and Probation Service.



Previous investments to improve treatment and rehabilitation interventions

In 2002, the Government instructed the Swedish Prison and Probation Service to further develop and improve the treatment of inmates with drug problems as part of a major effort throughout society to improve the treatment and rehabilitation of drug addicts. A report on the Swedish Prison and Probation Service experience of carrying out this particular effort for the period 2002-2007 was published in 2008 (Göransson, 2008). The report is referred to in some sections below.

Finding the inmates with a substance use disorder

The Swedish Prison and Probation Service's objective is that all drug addicts in correctional facilities should be identified, "mapped" and motivated to get treatment. All prisoners wanting help should be guaranteed help. However, in some forms of custody with high turnover rates, the outreach activity might miss some detainees who have not voluntarily come forward because the outreach function is not manned 24 hours a day. In the period 2002-2007, more than 17,000 people in custody have

had an average of three personal motivational interviews for the purpose of convincing the detainee to participate in treatment (Göransson, 2008).

Efforts made for inmates with a substance use disorder

A general requirement from the Government is that the number of inmates participating in treatment should increase and that the treatment and rehabilitation efforts be adapted to the needs. The Swedish Prison and Probation Service has identified and developed several strategic areas where improvements or actions were needed. Among these were:

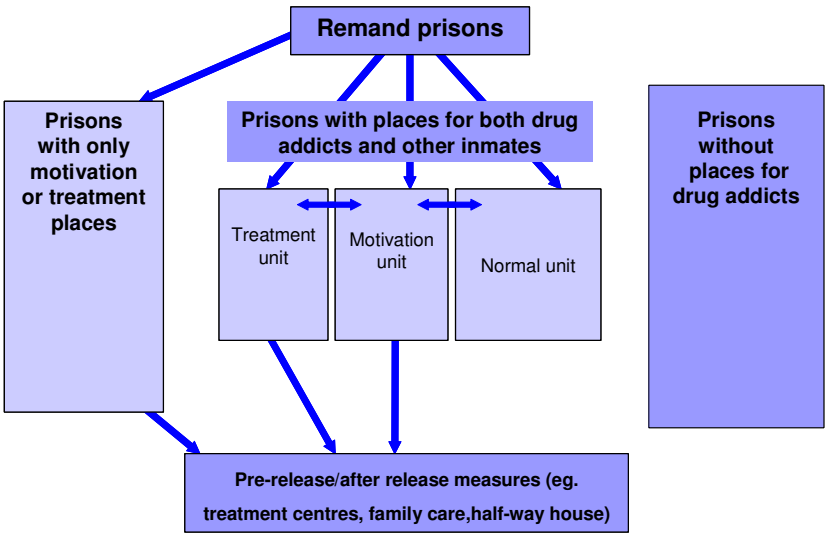
- the identification and mapping of the inmates' drug problems and need for treatment,
- the introduction of the Addiction Severity Index (ASI) as the mapping method,
- increasing the number of prison units/departments earmarked for drug addicts,
- the implementation of motivational interviews (MI) and introduction of evidence-based programmes,
- the testing of medically assisted treatment,
- improved methods to prevent smuggling of illicit drugs,
- developed cooperation between the social services and correctional treatment and between custody, prison and probation, and
- a major investment in training and competence development of the staff.

A large number of inmates with a substance use disorders have been mapped according to the ASI method as recommended in the guidelines from the Swedish National Board of Health and Welfare.

Principles for placement and differentiation of prisoners

One important task is to find a structure for the placement of inmates with a substance use disorder. As shown in the figure below, there are a number of prisons set up only for inmates with a substance use disorder where there are established separate wings for treatment in other prisons.

Figure 11.3. Organisation of prison places for inmates with a substance use disorder.



The number of places and establishments has changed with time. As of 1 July 2011, a capacity of about 1,000 places was designated for inmates with a substance use disorder, out of a total of 5,000 available places for sentenced prisoners.
The principles set up for treatment units were to correspond with those at "Therapeutic Communities":

- separate units
- tolerance and acceptance
- collective responsibility
- open, immediate and direct communication when rules have been broken
- influence from fellow inmates (old timers)
- oppose criminogenic prison culture
- holistic view - focus on relationships and attitudes to crime and morality, outline and practise strategies to prevent relapse

Drug detecting dogs

During the past ten years, many actions have been taken to prevent drugs from being smuggled into prisons – supply reduction. An intelligence service has been established with the mission to obtain 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 urine tests. An important role in this work is played by the drug detecting dogs. Some ten years ago, the Swedish Prison and Probation Service only had a few dogs to search for drugs. As of July 2011, there are 22 specially trained dogs. They cover all prisons and remand prisons. Visitors can also be searched for drugs by dogs. The dogs are owned by the Prison Service, but managed at work and at leisure by a dog officer – a member of the staff. The dog and officer work together as a team.

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

Limiting factors in working with interventions for inmates with a substance use disorder

The main problem in implementing interventions for inmates with a substance use disorder was the lack of space in the correctional treatment institutions. The Swedish Prison and Probation Service has an obligation to provide a place for persons who are sentenced to serve time in prison. A consequence of this is that it was not always possible to differentiate the inmates or offer occupations and work, which impaired the motivational climate for the inmates.

There were also difficulties in getting the municipalities to take financial responsibility for probation treatment or continued treatment after release from prison. Clinics offering medically assisted treatment also commonly refused to take on patients from the Swedish Prison and Probation Service referring to the fact that they already had long lines of addicts outside correctional treatment in acute need of treatment (Göransson, 2008).

Treatment of opiate dependence (ITOK)

In 2007, the Stockholm Addiction Centre and the Swedish Prison and Probation Service started a project called an Integrated Team for Opiate-dependent Clients (ITOK). Clients with opiate dependence were identified at the remand prisons in

Stockholm and after an investigation offered to participate in a maintenance programme. As an evaluation, the project demonstrated success both from a socio-economical and a co-operational perspective and the project is now permanent. The model of co-operation is used in a similar project in southern Sweden.

The integrated teams contain 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 are responsible for cognitive programmes that focus on both criminal behaviour and substance abuse. The social services are involved in each individual case for social support.

From a gender perspective, these kinds of programmes seem attractive to female clients. Among Swedish inmates, only 5 per cent are women, but in ITOK 12 per cent are women.

Maintenance treatment with methadone and buprenorphine was previously only available at the prison in Fosie, but other prisons have also opened up for such treatment.

Evaluation of treatment programmes

Many, but not all, of the treatment programmes have been evaluated with focus on recidivism. This task is on-going and takes years since the conditions for the implementation of a programme have to be quality assured before conclusions could be drawn from the outcome. A fairly large number of inmates must also participate in the programmes that are about to be evaluated. One programme has actually been taken out of service because there were no significant positive results. The other programmes that were evaluated had positive or slightly positive results on recidivism.

Provision of drug related health services in prison

An individually designed plan for each inmate

In Sweden, we have an obligation to make a coherent plan and design of each inmate's time in prison. The plan should be carried out with the purpose of reducing the risk of misconduct and recidivism. A plan should be designed soon after the prison sentence commences. The plan is based on a risk and needs assessment to clarify what efforts will be made for the prisoner. The plan shall include the investigation of the prisoner's relationship to alcohol and drugs, his or her physical and mental health, education, financial situation and of course criminal identification. Every inmate will be medically examined by the institution's nurse and there is access to a consultant doctor. The inmate is examined for infectious diseases, hepatitis, HIV, etc. Prisoners are informed about opportunities for HIV testing and opportunities for vaccination against hepatitis. Specific tools can be used, e.g. Addiction Severity Index (ASI), Alcohol Use Disorders Identification (AUDIT) or Drug Use Disorders Identification Test (DUDIT).

After the investigation, the plan will be compiled and form the basis for the actions to be taken. For drug users, there is the possibility of placement in special sections for those who intend to put an end to their substance use disorder. Acute detoxification

with the support of medication is typically in the initial stages when the prisoner is placed in a remand prison, awaiting investigation and trial.

General view on the provision of treatment

As mainly drug and alcohol abuse are seen as a behavioural problems, treatments are primarily focused on treatment with cognitive behavioural therapy methods. Several prisons offer 12-step programmes according to the Minnesota Model. This self-help programme for recovering addicts is in fact the programme that covers largest number of addicts compared to other programmes. Medication with substitution drugs (e.g. buprenorphine) or other pharmacological treatments may take place, but is usually done close to release and after the prescription of a medical specialist. An example of this is the ITOK project, integrated team for opiate dependence correctional clients. The target group is the heroin-addicted correctional clients who are in prison, in the probation service and patients with maintenance therapy and who have been detained. The project is under evaluation.

Some figures

The table below shows how many inmates completed treatment programmes in prison during the period 2008 – 2010. There has been an increased participation in the programmes year after year. One must bear in mind that not all inmates are suitable for programme participation, not all are motivated and the sentence may be too short to implement a programme It is therefore difficult to give a comparison between the target group's size and how many people actually participate. As comparative figures can be specified, that the prisons in 2010 received about 9,700 new inmates and the average present prison population was about 4,700. An estimate is that at least 60 per cent have drugs and/or alcohol problems. Just over 2,600 inmates participated in programmes directly aimed at abuse. In total there were over 5,300 completers, counting all programmes.

Table 11.22. Number of completed programmes in prison, annually 2008-2010.

	2008		2009		2010	
	Women	Men	Women	Men	Women	Men
Program	Completers	Completers	Completers	Completers	Completers	Completers
12-step extended	10	28	11	71	5	105
12-steg basic	18	308	9	356	11	374
12-steg introduction	10	392	10	488	22	653
Aggression Replacement Training	11	94	13	80	8	85
Aggression Replacement - Prepare	0	156	0	300	0	276
BSF, Behavior-Talk-Change	105	1,039	140	1,359	155	1,487
Breaking with Crime	5	192	5	219	5	185
Enhanced thinking Skills	36	281	26	322	19	343
Integrated Domestic violence progr.	0	56	0	86	0	111
One to One	1	68	9	99	5	148
PRISM	4	69	9	114	12	134
Prime for Life	3	557	5	744	13	785
ROS (SOTP)	0	101	0	114	0	106
ROS-Individual version (SOTP)	0	14	0	30	0	32
ROS follow up					0	41
VPP Medium					0	28
WIN	76	0	67	0	77	0
Våga Välja (Dare to Choose)	22	240	17	248	25	183
Relapse Prevention	6	118	17	183	36	246
Total	**307**	**3,713**	**338**	**4,813**	**393**	**5,322**

Notes:
12-step= Alcohol and drugs program, introduction 63 hours, basic 180 h, extended 360 h (group)
ART= Aggression Replacement Training, violence, 75 h (group)
ART-Prepare = modules of ART which can be combined to a longer programme
BSF= Behaviour - Talk - Change, motivation, 7 h (individual)
Breaking with Crime= general offending, 50 h (group)
ETS= Enhanced thinking skills, general offending, 53 h (group)
IDAP=Integrated domestic abuse programme, 62 h (group)
One to One= general offending, 24 h (individual)
PRISM=Programme for reducing individual substance misuse, 33 h (individual)
Prime for life= Drugs and alcohol, 15 h (group)
ROS=Sexual offender treatment program, 160 h (group)
ROS-Individual version 60 h
WIN = for female offenders, 48 h (group)
VPP= Violence Prevention Program, Medium = 93 h (group)
Våga Välja (Dare to choose) NSAP Drug program, 63 h (group)
Relapse Prevention, alcohol and drugs, 12 h (individual)

In group programs a number of individual hours are added

12: Drug users with children (addicted parents and child-related issues)

Introduction

Not all adults are capable of providing their children the security and care they need. One of the reasons for this may be that one or both parents have problems of substance abuse or addiction. The childhood conditions in a family with substance abuse problems can vary from serious to less serious situations. The parent may display a lack of supervision and care and may not always have the capacity to get involved in the child's needs and activities. Some of the children in these environments exhibit extreme behaviour to get the adults' attention, but there are also children who instead take more responsibility to get the family to function (Socialstyrelsen, 2009). When there is substance abuse in the family, it is also common to be other problems in the family, such as mental illness. In these circumstances comorbidity is often discussed (Statens folkhälsoinstitut, 2011c).

This chapter is divided into the following sections: the first section describes the extent of the problem, the second section presents the laws and national guidelines in place in the area and the final section concerns the preventive measures and treatments provided.

Size of the problem

Studies of the number of children who grow up in substance abuse environments

Children who live in families with substance abuse problems can be found in all classes of society. However, it is not known how many of Sweden's approximately 2 million children and adolescents grow up under these conditions. Various attempts have been made to estimate this (Socialstyrelsen, 2009).

- The Swedish National Institute of Public Health conducts an annual national public health survey "Hälsa på lika villkor" (Health on equal terms). According to this, 1.6 per cent of all men in households with children have said that they used cannabis in the past year. The corresponding figure for women is 0.8 per cent[40] (information prepared by Ann-Sofie Karlsson, Statistician, Department of Analysis and Follow-up, Swedish National Institute of Public Health).
- An analysis from 2004 showed that 1.2 per cent of all children ages 0-17 had at least one guardian who is cared for in inpatient/institutional care due to substance abuse (diagnosed with alcohol or narcotics dependence). This information says nothing about the child's situation or whether or not the child lives with this parent (Socialstyrelsen, 2009). Of those who entered substance abuse treatment in 2008, approximately 21 per cent of the women and 13 per cent of the men lived with children. Half of the women with children were single parents, while the men with children were most often cohabitating (Socialstyrelsen, 2009).

[40] The indicators for narcotics use will be reviewed in conjunction with the Government's new strategy for the alcohol, narcotic drugs, doping and tobacco policy.

- The Swedish Government Official Report (SOU) regarding compulsion and change states that around 100-130 children were born annually to mothers with narcotics abuse. However, the report asserts that the underlying data regarding harms caused by the mother's narcotics abuse is more uncertain compared with the harmful effects of alcohol. The reason for this is that these effects have not been observed during a longer period of time and that many narcotics abusers also consume alcohol, which makes it difficult to isolate various impacting factors (SOU 2004:3).

Damage to the foetus/child caused by the mother's narcotics abuse

The combination of pregnancy and substance abuse entails serious risks, and narcotics abuse entails a considerable burden to the foetus. Different organs are formed at different critical points in time during the first 80 days of pregnancy. The brain of the foetus can be damaged anatomically and functionally if the woman uses narcotics during pregnancy and this is why specific deformities can arise (Socialstyrelsen, 2007b). Children who are exposed to various kinds of narcotic preparations during pregnancy can have different kinds of physical damage, mainly to the brain, with an impact on the reward system. However, it should be emphasized that there is still considerable uncertainty as to how the brain of the foetus is affected by narcotics and a large part of current knowledge comes from animal studies (SOU 2011:35).

Mixed substance abuse is common, particularly in severe narcotics abuse. This means that both the woman and the foetus are exposed to multiple drugs at the same time (such as alcohol and tobacco), which further increases the risk of foetal damage. This makes it difficult in clinical studies to determine the effect on the foetus of the individual drugs (Socialstyrelsen, 2007b).

Most narcotic compounds, such as heroin, amphetamines and cannabis, can result in reduced growth of the child. The risk of premature labour increases with the use of amphetamines and heroin. Abstinence in a woman who abuses heroin also leads to abstinence in the expected child (SOU 2011:35). Studies have shown that children raised in homes in a low socioeconomic class with parents who abuse heroin are at higher risk of having attention-deficit/hyperactivity disorder (ADHD). International studies have also shown that amphetamine exposure during pregnancy leads to lower birth weight and an elevated risk of birth defects in the child. However, there is a lack of Swedish studies in the area (Socialstyrelsen, 2007b). Development is impeded or improved depending on the psychosocial environment the child grows up in. Today, there is a lack of Swedish studies of how psychosocial risk factors can increase alcohol and narcotics consumption during pregnancy. U.S. studies show that many of the pregnant women who use narcotics and alcohol during pregnancy also have psychosocial and medical risk factors, such as violence, mental illness and HIV. However, it is unclear what causes what. Is it the substance abuse that led to the exposure to these psychosocial and medical risk factors situations or the opposite? In order for the treatment of the woman to be effective, a somewhat stable environment is necessary, which can be difficult if she is surrounded by these psychosocial risk factors. The National Board of Health and Welfare's guidelines for substance abuse and dependence care point out that studies of Swedish conditions are needed, as these have been done in the U.S. (Socialstyrelsen, 2007b).

Studies that show the relationshipbetween parental substance abuse and substance abuse in the child later in life

There is a strong relationship between the care capacity of parents and the type of connection the child develops. However, international research shows that more studies are needed that show that it is the parent's substance abuse itself that leads to insufficient care for the child. There are namely several factors that co-vary with the substance abuse, such as mental illness and violence (Statens folkhälsoinstitut, 2011c). According to a Danish study, 10 per cent of the children who live with parents with substance abuse problems are diagnosed with mental disorders and 40 per cent have problems with their physical or mental health. The same Danish study also showed that 30 per cent of the children who grew up with substance-abusing parents had problems with substance abuse themselves later in life (Statens folkhälsoinstitut, 2011c). However, there is a lack of studies done on Swedish conditions that show how large the risk is that children who grow up in substance abuse environments become substance abusers themselves as adults.

Policy and legal framework

A study of policy and practice in Swedish schools

At the end of 2009, Stockholm Prevents Alcohol and Drugs (STAD) conducted a cross-sectional study directed at 443 schools in Sweden. The objective of the study was to investigate what factors affect schools' ability to identify children in substance abuse environments. The results show that an action plan/policy document influences whether school staff participated in further education regarding children in substance abuse environments, which in turn influences the identification of these children (the response frequency was 66 per cent). The training results in the school staff becoming aware of home conditions and how they should act when they discover these substandard circumstances (Elgán and Leifman, 2010).

Government commission: Better interventions in substance abuse and dependence

In 2008, the Swedish Government appointed an investigator to conduct a review of Swedish substance abuse and addiction care. It was an extensive investigation that consisted of a large workgroup of 13 experts, a reference group of 14 researchers and some 30 NGOs (SOU 2011:35). The commission's final report was presented in April 2011. The commission presented some 70 proposals, including clarifying municipal and county council responsibility and measures to strengthen the position of the individual.

One of the commission's proposals is for maternity services to identify pregnant women who exhibit risk alcohol consumption and/or drug consumption based on interviews and screening. When necessary, the maternity service will provide support, such as motivational interviews, to encourage the expectant mother to quit using. The mothers who have serious substance abuse and dependence should be referred to maternity services with special expertise in the substance abuse field (SOU 2011:35).

There are studies that show that damage to the children caused by the mother's substance abuse may first become apparent at school age and that many mothers

tend to relapse into substance abuse after the birth of the child. The commission therefore proposes that the woman and child should be offered voluntary follow-up of the child, at least until the child turns three, but preferably until the child begins school (SOU 2011:35).

Another of the commission's proposals is that the municipalities should develop the psychosocial support efforts for children in families with substance abuse problems. The commission confirms that it is important that these children receive support as early as possible and more public and private organizations should work to identify children in families with substance abuse. The support group activities that currently exist reach only a few of the children affected. There is currently a lack of knowledge about what methods are effective for helping these children and there is a lack of Swedish and Nordic studies in the area (SOU 2011:35).

Government strategy for alcohol, narcotic drugs, doping and tobacco policy

On 30 March 2011, the Swedish Parliament (Riksdag) adopted the cohesive strategy for alcohol, narcotic drugs, doping and tobacco policy (Bill 2010/11:47). The strategy outlines objectives, emphasis and priorities for societal efforts in ANDT for the period 2011-2015. It includes everything from local prevention work, availability-limiting efforts, care and treatment and alcohol and tobacco supervision to international work. The strategy consists of seven long-term objectives, the second of which is that children shall be protected from the harmful effects of alcohol, narcotics, doping and tobacco. The second objective's interim targets are that fewer children should be born with damage caused by alcohol, narcotics, tobacco and doping, and that expectant parents shall be offered information and counselling on the harmful effects of the drugs. Parents with substance abuse should also receive appropriate support or care in order to avoid harm to the child.

Another interim target for the second objective domain is that children in families with substance abuse should be offered appropriate support and that support of children in substance abuse families should be developed during the strategy period. It is also emphasized that collaboration at a local level between stakeholders that work with these children should be developed (Regeringens proposition 2010/11:47).

Objective five in the ANDT strategy concerns people with substance abuse or dependence having greater access to good quality care and support. The interim targets that concern this are to increase accessibility to knowledge-based care and support and for there to be a clearer division of responsibility between the principals for substance abuse and dependence care. The investigators confirmed that it is not uncommon in this area for there to be multiple principals with responsibility under different legislation. There is a risk that the user is sent between different caregivers and none of them take responsibility (Regeringens proposition 2010/11:47).
In order to reach the seven long-term objectives, the Government has also adopted a programme of measures that includes a number of different assignments for authorities and other actors that work in this area (Regeringens proposition 2010/11:47).

New provisions in the Health and Medical Care Act

In order to improve the legal protection of children and adolescents, a number of initiatives have been taken in recent years. In January 2010, new provisions were implemented in the Health and Medical Care Act as well as the Act on Professional Activities in Health and Medical Services, which mean that particular attention shall be paid to children's needs for information, advice and support when the child's parents or another adult abuses alcohol or another addictive substance (Statens folkhälsoinstitut, 2011c).

Care of Alcoholics, Drug Abusers and Abusers of Volatile Solvents Act (LVM)

The Care of Alcoholics, Drug Abusers and Abusers of Volatile Solvents Act (LVM) means that a person with problems of substance abuse who does not want to voluntarily undergo care and treatment for his or her substance abuse may be subject to compulsory care (Statens offentliga utredningar, 2010). However, this law is not applied in a case to protect an unborn child from narcotics. The social services cannot therefore undertake any enforcement action against the woman to protect the expected child. The National Board of Health and Welfare has reviewed a number of LVM court judgements and confirms that the courts most often only take into account the risk that the woman subjects her own health to serious danger or runs a clear risk of ruining her life or is feared to harm herself or a relative. However, it is unclear if the court thereby refers to the foetus.

In a ministerial memo from 2009, there is a proposal that LVM be altered so that a pregnant woman will be able to be compelled to submit to care if, because of her abuse of alcohol or narcotics, exposes her unborn child to a substantial risk of being born with damage caused by the substance abuse. The proposal is currently under preparation in the Government Offices (SOU 2011:35)..

Actors such as the social services, schools, healthcare services and the police are obliged to collaborate in matters that concern children who fare poorly. However, it is the social services that have the utmost responsibility for ensuring that children get support when they fare poorly. However, the obligation to report or provide information to the social welfare board does not cover an unborn child (Socialstyrelsen, 2007a).

Care of Young Persons (Special Provisions) Act (LVU) (1990:870

There is another piece of legislation regarding enforcement action that concerns people with substance abuse and dependence problems that is called the Care of Young Persons (Special Provisions) Act (LVU). Care under LVU can be arranged for anyone under the age of 20 and the law is applied if the young person risks his or her health or is at distinct risk of being harmed through the abuse of addictive compounds, criminal activities or any other socially destructive behaviour. Substance abuse is the most common reason that children are taken into custody under LVU. In 2009, nearly 1500 young people with substance abuse were cared for under LVU (SOU 2011:35).

Reporting obligation for mistreated children

The people who work at an authority or agency the work of which concerns children and young people, and other authorities in healthcare, the social services and correctional care are obliged to immediately file a report with the social welfare board if they become aware in their work that a child is faring poorly or is in danger of doing so. The same obligation also applies to those who conduct private operations that concern children and young people, such as a non-governmental organisation (NGO). Those covered by the reporting obligation also have a disclosure obligation which means an obligation to provide information that may be of significance to an on-going investigation in the matter at hand (Socialstyrelsen, 2009).

National guidelines for pregnant women with substance abuse

Pregnancy is a phase in a woman's life in which she is more motivated than otherwise to change her life situation to protect the child. However, it turns out that many pregnant women with substance abuse enter the healthcare services later than others. Nor is it uncommon for such women to deny being pregnant or to hide their substance abuse for fear of the child being taken from them. There are special resource centres for pregnant women with substance abuse problems in three cities in Sweden: Malmö, Gothenburg and Stockholm. These centres monitor the children until they turn two years of age (Socialstyrelsen, 2007a).

In 2007, the National Board of Health and Welfare was assigned by the Government to investigate efforts for women with substance abuse during pregnancy and provide proposals of continued supportive intervention for the family (Socialstyrelsen, 2007a). The results of this assignment showed that the care offered to these women is not sufficient in Sweden. There is a lack of targeted resources for this target group, a long-term perspective in the work and expertise. Large local discrepancies were discovered in the care offered to the women and it was found that the care efforts offered are late in the pregnancy.

The National Board of Health and Welfare was also assigned to identify how children who live in families with substance abuse problems should be identified and receive support. According to the National Board of Health and Welfare, focus should be on the general activities such as preschools and schools since they meet the large majority of children and have the ability to identify the children who are being mistreated. "The general activities and the social services need to work out procedures for collaboration that are sustainable over time." It is first when the general activities' efforts are not deemed sufficient that the child should receive further support through e.g. the social services and child and youth psychiatric services. Procedures also need to be worked out and collaboration must take place between schools and student health services in order to identify these children (Socialstyrelsen, 2007a).

Children who have a parent in prison

Many prison inmates are parents and every year, several thousand children in Sweden experience their mother or father being in prison. The child can maintain contact with the parent in various ways, such as visits, leaves, by phone and by letter. Inmates with children can also apply for extended contact possibilities. Various kinds of prisons and what kind of security levels apply play a role in what visitation possibilities there are for relatives. The prisons with a lower security level (open

institutions) most often have better visitation possibilities than institutions with a higher level of security (closed institutions). In order to maintain a good relationship between the child and the imprisoned parent, contact during the time in prison is necessary for the vast majority. A prerequisite for a child (under the age of 18) to be able to visit an inmate in prison is that the visit can be assumed to be for the child's best. For visits by children, the child's guardian(s) must consent to the visit. The inmate can choose who visits him or her and some prisons also have special visitation rooms adapted to children (Kriminalvården, 2004).

Every client in the Swedish Prison and Probation Service receives an individual plan for their sentence, meaning the serving of their punishment. The implementation plan will follow the client like a red thread through remand prison, prison and probation. It is the probation service that is responsible for coordinating the implementation plan. From the beginning of the prison sentence, the probation service should already be included in the planning of the sentence implementation and the preparations for the transition from prison. During this planning probation service personnel and personnel at the prison discuss with the client what the contact with the child/children looks like. Does the client have custody of the child/children?

Under the Social Services Act, the personnel of the Swedish Prison and Probation Service must file a report if they suspect that a child is mistreated (anyone who works at an authority is obliged to immediately report it to the social welfare board if they in their work become aware of a risk that a child will be mistreated). For example, a report can be filed if the staff suspects that the client will abuse a substance when he or she is released. After the report is filed, the social service is responsible for following up the matter (personal communication with Birgitta Persson, Operational Developer in charge of child issues at the Swedish Prison and Probation Service, 5 September 2011).

Study conducted at Swedish Prison and Probation Service

The Swedish National Institute of Public Health was assigned by the Government to survey programmes for children and young people in risk situations and one of the sub-studies was in the Swedish Prison and Probation Service. In 2010, a questionnaire was sent to 35 probation service offices/institutions in Sweden. The objective was for all counties and the various security classes of the Swedish Prison and Probation Service to be represented in the selection (response frequency was 66 per cent). There were 87 per cent of the respondents that said that they have procedures to discover at an early stage if a child/adolescent is at risk of receiving insufficient care from his/her guardian. Examples of this can be written procedures for the report to the social welfare board or special child ombudsmen at the prison who are in charge of spreading the child perspective in accordance with the UN Convention on the Rights of the Child. All (100 per cent) of the respondents said that they routinely ask the clients if they have children at home. They also note if there are children in the same household of whom the person is not the parent. A report to the social services is always considered in when substance abuse or other negative conditions are suspected (Statens folkhälsoinstitut, 2011c).

National development work is under way to protect children who witness violence at home. A national action plan has been in place since 2007 that aims to increase the protection and support for women and children who are subjected to violence. The

National Board of Health and Welfare was allocated SEK 108 million, which was to be distributed for this purpose at a local level through the county administrative boards. The National Board of Health and Welfare was assigned to evaluate this effort and the evaluation shall be reported to the Government in 2013 (Statens folkhälsoinstitut, 2011c).

Responses

Preventive measures for children and adolescents in risk situations

The Government has assigned the Swedish National Institute of Public Health to survey the prevention work conducted in the municipalities and directed at children and young people in risk situations, such as children of substance abusers. In 2010, an electronic questionnaire was sent to the social services, maternity services, adult psychiatry services, the Swedish Prison and Probation Service, the police and the women's shelters in 45 of Sweden's total 290 municipalities. Questions were asked about various risk situations that are due to insufficient care from the parent/custodian. The results showed that most actors offered preventive measures in the form of supportive interviews, group activities, home visits and parental support. The social services were the actor that had the most preventive measures to offer children who grow up in substance abuse environments. The majority of actors also said that they had conducted development work in 2010 in the area of children and young people in risk situations, such as work to survey the target group and skills development of personnel (Statens folkhälsoinstitut, 2011c).

Financial contributions for preventive measures

Since 2009, the Swedish National Institute of Public Health has distributed financial grants through the county administrative boards to the municipalities for preventive measures against alcohol and narcotics. At least two thirds of these funds were used for the area of children of parents with substance abuse and mental illness. The focus of the efforts was mainly on educational measures and method development to be able to discover and offer support to this target group. Efforts were also made with regard to parental support and support of relatives (Statens folkhälsoinstitut, 2011c). In 2009 up to and including 2010, just over 600 projects were granted funding from the Swedish National Institute of Public Health. The results show that half of the projects concluded in 2010 resulted in permanent projects.

At the beginning of July 2011, the National Board of Health and Welfare, in consultation with the Swedish National Institute of Public Health and the Swedish Association of Local Authorities and Regions (SKL), was assigned to coordinate and stimulate a national development endeavour to support children and families with substance abuse, mental illness, mental disability and violence problems. The work should be conducted in accordance with the Government strategy for the alcohol, narcotic drugs, doping and tobacco policy. The assignment extends from 2011 to 2014, inclusive. In 2011, the Swedish National Institute of Public Health has the opportunity to distribute funding to support existing activities that address these children (Regeringen, 2011a).

Supportive measures for children and adolescents in substance abuse environments

In 2007, the National Board of Health and Welfare, together with the Institute for Method Development in Social Work (IMS), was assigned by the Government to develop a guide regarding effective methods for children and young people who live in families with substance abuse/dependence problems. In 2009, the report was published and is primarily addressed to the social services that encounter these families in their daily work (Socialstyrelsen, 2009).

In conjunction with the work on the guide, the National Board of Health and Welfare also conducted a knowledge review to compile the scientific base and the effect of efforts for children and young people who live in families with substance abuse. The efforts should be evaluated so that it could be determined if the effect is solely due to the efforts and no other factors. The evaluation was also to encompass children aged 3 to 18, who lived with at least one parent with substance abuse problems. The researchers found two relevant studies that met these criteria, but no study was done on Swedish or Nordic conditions (Socialstyrelsen, 2009).

There is no clear description of what methods should be used with regards to supportive measures for children in families with substance abuse. However, there is research that can provide more general knowledge about child development, relational patterns and risk and protective factors, and it can therefore be relevant to think in terms of reducing risk factors and strengthening protective factors. Risk factors are factors that increase the risk of a negative development and some risk factors can be influenced, while others cannot be influenced (such as gender and age). Protective factors are factors that reduce the risk of developing problems. Some examples of protective factors are qualitatively good preschools and schools as well as the possibility of success in school work, a safe local environment, a high-level social group, good family cohesion, high intelligence and good impulse control (Ljungdahl, 2008). However, research on protective factors is not specifically targeted at children in substance abuse environments. Lessons can, however, be learned from research on protective factors and resilience in general (Socialstyrelsen, 2009).

Evaluation of support group activities

A large number of Sweden's municipalities have support group for children whose parents have problems of substance abuse. The basic idea behind the support group activities is that the children acquire protection towards developing their own problems through learning more about their parents' problems and how they function themselves. This is facilitated by the children sharing their experiences with others in the same situation in the support groups. In spite of this, there are not many scientific evaluations of the activities conducted in Sweden today. Above all, there is a lack of evaluations of the effects (Socialstyrelsen, 2009).

Barngruppsstudien (The child group study) is an on-going Swedish study being conducted by Forum, a research centre for psychosocial health in cooperation with Karolinska Institutet. The purpose of the study is to investigate the effects of support group for children and families with problems, such as substance abuse. The study is expected to answer the question of whether support group activities can improve the children's well-being and if support group activities meet the requirements of evidence-based practices. Parents register their interest on the website, after which a

lottery decides which children will be in the study. The study is planned to continue for three and a half years (from 2009 to 2013). In total, 120 children ages 7 to 13 are participating in the study. The final report is planned to be published in March 2013 (Information on the child group study has been gathered from the project funding application HFÅ 2010/54 Swedish National Institute of Public Health).

Self-help programmem

The Swedish Council for Information on Alcohol and Other Drugs (CAN) is developing a web-based self-help programme www.drugsmart.se for children of substance-abusing parents. The website is expected to be able to open for visitors at the end of 2011. The programme will be evaluated by researchers at Stockholm Prevents Alcohol and Drugs (STAD), which is a part of the Stockholm County Council (Statens folkhälsoinstitut, 2011c).

In 2010, CAN arranged a focus week on the theme of "one out of five children" to direct attention to children with substance-abusing parents (Statens folkhälsoinstitut, 2011c).

Homes for care or housing

If the social services deem that the parents have such large problems that the child needs to be protected, a placement outside the home may be possible. What kind of placement it is depends on the needs of the child. Many children get some form of foster home placement with a close relative. If the child has special needs and needs more extensive care, a home for care or housing (HVB) may come into question. Some of them are under municipal direction and others are privately run. The latter are required to have a permit from the National Board of Health and Welfare and are also subject to the Board's supervision. In November 2010, there were a total of 549 HVB homes, which was an increase compared with 2008 when there were 349. A small portion of these homes are for both parents and their children (Socialstyrelsen, 2011b).

Treatment

Today, there are several actors that work with substance abuse and dependence and there are therefore large differences in approaches with regard to treatment. In 2007, the National Board of Health and Welfare issued national guidelines for addiction treatment. The aim of this was to make treatment more clear and uniform. The guidelines are addressed to both the social services and healthcare services (Socialstyrelsen, 2007b). The National Board of Health and Welfare is currently working on an update of the guidelines and a preliminary version of the revised guidelines is planned for completion in autumn 2013. However, there is no specific treatment method targeted at the group of parents who abuse narcotics. The treatment programmes are focused on the adults' narcotics abuse (personal communication with Ulf Malmström, Coordinator of Substance Abuse Issues, Swedish National Board of Health and Welfare, 2 September 2011).

The Swedish Government Official Report regarding better intervention for substance abuse and dependence 2011 presents a proposal that county councils should be responsible for detoxification operations and abstinence care and treatment. The municipality should in turn be responsible for psychosocial support and help with housing, occupation and making a living. The municipality and county council shall

each have responsibility for examinations, assessment, planning and follow-up. If a person is in need of intervention from both the municipality and the county council, the municipality shall have the overall responsibility for preparing an individual plan (SOU 2011:35).

The following is a brief presentation of some treatment methods for narcotics abuse based on the national guidelines of the National Board of Health and Welfare.

Treatment of withdrawal

Treatment of withdrawal (detoxification) means that the drug is eliminated from the body and the treatment aims to minimise the symptoms that arise in connection with the drug leaving the body. The aim of treatment is also to prepare or motivate the person to continue treatment in other forms of care. There is currently an insufficient knowledge base regarding the long-term effects of treatment, but there is clinical consensus that treatment of withdrawal that is not followed by further treatment has no long term effect. Furthermore, no cost evaluations have been made on treatment of withdrawal as such (Socialstyrelsen, 2007b).

Treatment for cannabis dependence

Psychosocial treatment methods that are effective with other dependence conditions have proven to also be effective in the treatment of cannabis dependence. The arrangement of the treatment varies from brief interventions to a few sessions to more extensive treatments over three months. Studies have also shown positive effects of the treatment also containing supportive measures for family and relatives. There is one study (carried out on adolescents ages 12-18) that addresses cost evaluations of cannabis treatment. The study indicates that the cannabis treatment is cost-effective since the costs for healthcare and the legal system decrease. The National Board of Health and Welfare therefore makes the following assessment: “treatments of cannabis dependence that are directed at immediate abstinence and with regular, supervised urine samples and on disruptions in cognitive functions are financially defensible” (Socialstyrelsen, 2007b).

Treatment for opioid dependence

Methadone and buprenorphine (Subutex) are used as a treatment for opioid dependence.

In recent years, the combination of buprenorphine and naloxone (Suboxone) has also been approved for treatment. Pharmaceutical treatment of conditions of dependence should be combined with psychosocial intervention and it is important that the patient be carefully informed of side-effects and any interactions with other medication. Substitution treatment with methadone and buprenorphine (Subutex) is individually dosed and therefore places high demands on frequent follow-ups.

The National Board of Health and Welfare has published a literature review and general guidelines regarding pharmaceutical treatment of opioid dependence. Methadone is considered to be a compound that provides good effects for the person to remain in treatment, reduced substance abuse and improved social situation. There is also evidence that methadone contributes to decreased mortality. For the compound buprenorphine (Subutex), there is less documentation than for methadone, but it is confirmed that the structure of the compound reduces the risk of

overdose and of developing a pattern of dependence. There are positive effects for both of these medications of combining the medical treatment and psychosocial treatment. There are positive experiences of combining medication and psychosocial treatment, particularly for methadone treatment (Socialstyrelsen, 2007b).

Medically assisted treatment of opioid dependence is surrounded by a number of requirements in Sweden and pharmaceutical treatment for opioid dependence is currently regulated through an authorisation of the National Board of Health and Welfare to issue regulations regarding medically assisted treatment for opioid dependence. In an investigation of substance abuse and dependence from 2011, the investigator believes that pharmaceutical treatment for those with opioid dependence should be used to a greater extent in the future (SOU 2011:35).

Treatment of the abuse of central nervous system stimulants

The Swedish Council on Technology Assessment in Health Care (SBU) conducted a meta-analysis of 25 studies of cocaine abuse and dependence. In the analysis, three different intervention methods were compared, including supportive methods, relearning and behavioural therapy methods and psychotherapeutic methods. The results from the meta-analysis showed that only relearning and behavioural therapy methods showed significant positive effects (especially in the first six months of the treatment). In the pharmaceutical treatment of the abuse of and dependence on central nervous system (CNS) stimulants, there are too few studies to draw any extensive conclusions (Socialstyrelsen, 2007b).

Treatment for pregnant narcotics abusers

The degree of severity of the substance abuse determines what kind of measure is needed. This ranges from brief counselling to more extensive treatment measures. Regardless of what kind of treatment it is, it should contribute to a total abstinence from narcotics. Biological tests such as urine samples are a support in identifying women who use narcotics during pregnancy.

The purpose of the treatment measures is to identify the substance abuse in the expectant mother as early as possible and to be able to offer support that she needs so that the foetus is not harmed. The woman needs to be in good mental and physical shape to be able to take care of the child.

Common treatment methods for substance abusers cannot simply be generalised to also apply to pregnant women since hormonal and metabolic changes can influence the effect of pharmaceuticals and biochemical tests. It has proven important to offer the pregnant woman various kinds of social support as a compliment to treatment efforts. The pregnant woman's partner also has a major influence on the expectant mother's use of narcotics (Socialstyrelsen, 2007b).

If the pregnant woman is treated with pharmaceuticals during pregnancy, it is important to weigh the effectiveness of the medicine against any risks to the child. The starting point is the work is to protect the foetus and the future child. However, there are few studies with a high degree of scientific validity that show how these medications can affect the foetus (Socialstyrelsen, 2007b).

In Sweden, nearly all women have contact with maternity services. This contact provides the possibility of identifying substance abuse, since a number of questions are asked about the woman's state of health and social situation. All pregnant women are also offered HIV and hepatitis testing. However, it is not certain that all pregnant women who use illicit drugs are identified by the maternity services. There are, however, other contacts in the healthcare services where these women could be identified, such as emergency care or outpatient psychiatric care. Another point of contact is with the social services. The woman can either be a candidate for an intervention or sought out by the social services in connection with the pregnancy. The social services also exercise authority and a report may be made by relatives, other authorities or the public (Socialstyrelsen, 2007b).

Open comparisons of substance abuse and dependence care

In 2008, the National Board of Health and Welfare was assigned, together with SKL and the National Board of Institutional Care, to collect data on various aspects of quality and availability in substance abuse and dependence care. The first publication of open comparisons was made in June 2009. The objective of open comparisons is for them to be used as a basis for political decisions and a support for the practitioners in improving their work. Citizens in general shall also be able to use this to obtain information about different activities (Socialstyrelsen, 2007b).

Needle-exchange programmes

Discussions have been under way for several years regarding following up and evaluating needle-exchange programmes in Sweden. There is now a proposal in the SOU report regarding better interventions for substance abuse and dependence that needle-exchange activities for injection misuse should be available nationwide. Needle-exchange programmes are presented in more detail in chapter 7.

Part C - Bibliography

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.

ANGELIN, A. 2010. *Den dubbla vanmaktens logik: En studie om långvarig arbetslöshet och socialbidragstagande bland unga vuxna.* Doctoral thesis, Socialhögskolan, Lunds universitet.

ANTONIUSSON, E.-M. 2007. *Illegal subutexanvändning: en undersökning av missbruket utanför behandlingsprogrammen,* Stockholm, Mobilisering mot narkotika [MOB].

AQUILONIUS, S.-M., BERGQUIST, J. & DAHLLÖF, T. Å. 2009. Droger och desperation i skilda världar: Missbruk av katinon och metkatinon hotar hälsa och social utveckling. *Läkartidningen,* 106.

AUGUTIS, M. & HILLBORG, H. 2011. *En utvärdering av Beroendemedicinska enheten (BME),* Härnösand, FoU Västernorrland.

BASK, M. 2008. *A longitudinal approach to social exclusion*, Umeå university.

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.

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.

BODIN, M. & LEIFMAN, H. 2011. A randomized effectiveness trial of an adult-to-youth mentoring program in Sweden. *Addiction Research and Theory,* 19**,** 438-447.

BROTTSFÖREBYGGANDE RÅDET [BRÅ]. 2006. *Personalens erfarenheter av den fortsatta narkotikasatsningen i kriminalvården* [Online]. Brottförebyggande rådet [Brå]. Available: http://www.bra.se/extra/measurepoint/?module_instance=4&name=Kriminalv%E5rdens%20narkotikasatsning.pdf&url=/dynamaster/file_archive/061215/bfc10612f40b9a5762c11c49fb332c99/Narkotikasatsningen061214.pdf [Accessed 2011-10-20].

BROTTSFÖREBYGGANDE RÅDET [BRÅ] 2009. Narkotikastatsitik 2009: Rapport 2010:16. Stockholm: Brottsförebyggande rådet [Brå].

BROTTSFÖREBYGGANDE RÅDET [BRÅ] 2010. Kriminalstatistik 2010: Rapport 2011:11. Stockholm: Brottsförebyggande rådet [Brå].

DE CAL, E. & SÖDERLIND, L. 2007. *What one can't see, Doesn't exist: A survey of Khat use among the Somali population in Gothenburg.*

Student essay, Folkhälsovetenskapligt program, Sahlgrenska akademin, Göteborgs universitet.
DENVALL, V., GRANLÖF, S., KNUTAGÅRD, M., NORDFELDT, M. & SWÄRD, H. 2011. *Utvärdering av "Hemlöshet - många ansikten, mångas ansvar" Slutrapport.,* Lund, Lunds universitet.
DIR. 2010:82. *Kommittédirektiv: Sveriges internationella engagemang på narkotikaområdet* [Online]. Stockholm: Socialdepartementet. Available: http://www.regeringen.se/content/1/c6/15/11/82/66380f9e.pdf [Accessed 2011-10-20].
EKSTRÖM, E. & BROTTSFÖREBYGGANDE RÅDET [BRÅ] 2010. *Utökad frigång och återfall: Slutrapport om 2007 års reform av utslussning i Kriminalvården.,* Stockholm, Brottsförebyggande rådet [Brå].
ELGÁN, T. & LEIFMAN, H. 2010. Barn i missbruksmiljö: En studie kring policy och praktik på svenska skolor. *Rapport nr 43.* Stockholm: Stockholm förebygger alkohol- och drogproblem [STAD].
EMCDDA. 2009a. *Table INF-1. Prevalence of HIV infection among injecting drug users in the EU* [Online]. Available: http://www.emcdda.europa.eu/stats09/inftab1 [Accessed].
EMCDDA. 2009b. *Table INF-111. Prevalence of hepatitis C infection among injecting drug users* [Online]. Available: http://www.emcdda.europa.eu/stats09/inftab111 [Accessed].
EMCDDA 2011. 2010 National report (2009 data) to the EMCDDA by the Reitox national focal point: Sweden: New development, trends and in-depth information on selected issue. Lisbon: EMCDDA.
FALHKE, C. 2006. Drogvanor och psykisk hälsa hos ungdomar. *Vad är det som gör att unga testar narkotika och vad gör att vissa fastnar? Rapport 15, 2006.* Stockholm: Mobilisering mot narkotika [MOB].
FORSTER, M., SUNDELL, K., MELIN, L., MORRIS, J. R. & KARLBERG, M. 2005. *CHARLIE och KOMET: Utvärdering av två lärarprogram för barn med beteendeproblem,* Stockholm, Socialtjänstförvaltningen: Forsknings- och Utvecklingsenheten.
FUGELSTAD, A., ANNELL, A., RAJS, J. & AGREN, G. 1997. Mortality and causes and manner of death among drug addicts in Stockholm during the period 1981-1992. *Acta Psychiatrica Scandinavia,* 96**,** 169-75.
FUGELSTAD, A., JOHANSSON, L. A. & THIBLIN, I. 2010. Allt fler dör av metadon. "Läckage" från dagens mer liberala behandlingsprogram kan vara en orsak. Läkartidningen 107(18) , 1225-1228. *Läkartidningen,* 107**,** 1225-1228.
GOVERNMENT OFFICES OF SWEDEN. 2007. Homelessness: multiple faces, multiple responsibilities: a strategy to combat homelessness and exclusion from the housing market. Available: 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.

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

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**,** 1997-2004.

GRIPENBERG, J. 2008. *Narkotika på Stockholms krogar: En jämförelse mellan 2001 och 2007/08.* [Online]. Available: http://www.stad.org/upload/resultat_STAD_%2009.pdf [Accessed 2010-10-15].

GRIPENBERG, J., WALLIN, E. & ANDRÉASSON, S. 2007. Effects of a community-based drug use prevention program targeting licensed premises. *Substance Use & Misuse,* 42**,** 1883-1898.

GUTTORMSSON, U. 2010. Narkotikatillgängligheten i Sverige 1988–2009: En analys av priser och beslag: CAN rapport 121. Stockholm: Centralförbundet för alkohol- och narkotikaupplysning [CAN].

GUTTORMSSON, U. 2011. Narkotikatillgängligheten i Sverige 1988-2010: En analys av priser och beslag: CAN rapport 128. Stockholm: Centralförbundet för alkohol och narkotikaupplysning [CAN].

GÖRANSSON, B. 2008. Kriminalvårdens särskilda narkotikasatsning 2002-2007: Slutredovisning 2008-03-15. Norrköping: Kriminalvården.

HEILIG, M. & GUNNE, L. 2008. Nya riktlinjer behövs mot övergrepp i narkomanvården. *Läkartidningen,* 105**,** 3093-3094.

HELLSTRÖM, A. & TORELL, L. B. 2006. *COPE Föräldrautbildning. Rapport från utvärderingen av kurser i Uppsala län och Tyresö kommun,* Uppsala, Uppsala universitet.

HENSING, G. 2008. Bruk av narkotika – är det maskulint? Könsskillnader och konstruktion av genus i narkotikabruk *In:* ANDRÉASSON, S. (ed.) *Narkotikan i Sverige: Metoder för förebyggande arbete: En kunskapsöversikt.* Östersund: Statens folkhälsoinstitut.

HILLGREN, K. & BRITTON, S. 2009. Summary of Sweden's first baseline study on Blood borne Infections among Injecting Drug Users (Stockholm County July 2007 to September 2008). Available: http://www.sll.se/upload/baslinjestudie_summary.pdf.

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].

HVITFELDT, T. & GRIPE, I. 2010. Skolelevers drogvanor 2010. CAN rapport 124. . Stockholm: Centralförbundet för alkohol- och narkotikaupplysning [CAN].

HÅKANSSON, A., MEDVEDEO, A., ANDERSSON, M. & BERGLUND, M. 2007. Buprenorphine Misuse among Heroin and Amphetamine Users in Malmö, Sweden: Purpose of Misuse and Route of Administration. *European Addiction Research,* 13**,** 207-215.

HÅKANSSON, A., SCHLYTER, F. & BERGLUND, M. 2009. Characteristics of primary amphetamine users in Sweden: a criminal justice population examined with the Addiction Severity Index. *European addiction research,* 15**,** 10-18.
JANSSON, I. 2010. *Femårsuppföljning för tvångsvårdade kvinnor: Inverkan av psykiska problem på utfallet.* Doctoral thesis, Lunds universitet.
JAYARAM-LINDSTRÖM, N., KHEMIRI, L. & FRANCK, J. 2010. *Effect of Naltrexone on Cue-induced Craving for Amphetamine in Amphetamine Dependent Individuals,* Stockholm, Department of Clinical Neuroscience, Section Psychiatry Research, Karolinska Institutet.
JOHNSEN, S. & TEIXERIA, 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.
JOHNSSON, B. 2010. Risker och sidoeffekter i läkemedelsassisterad rehabilitering av opioidberoende - en forskningsöversikt. *Socialvetenskaplig tidskrift***,** 46-66.
KAKKO, J. 2011. *Heroinberoende,* Stockholm, Liber.
KERTESZ, S. G. & WEINER, S. J. 2009. Housing the chronically homeless: High hopes, complex realities,. *JAMA,* 301**,** 1822-1824.
KIMBER, B., SANDELL, R. & BREMBERG, S. 2008. Social and emotional training in Swedish schools for the promotion of mental health: an effectiveness study of 5 years of intervention. *Health Education Research,* 23**,** 931-940.
KLING, Å., SUNDELL, K., MELIN, L. & FORSTER, M. 2006. Komet för föräldrar: En randomiserad effektutvärdering av ett föräldraprogram för barns beteendeproblem. Stockholm: Forsknings- och Utvecklingsenheten.
KNUDSEN, K. 2011. Partydroger ger farliga förgiftningar: Risk för allvarliga komplikationer och död. *Läkartidningen,* 108**,** 207-211.
KNUDSEN, K., GRETER, J. & VERDICCHIO, M. 2008. High mortality rates among GHB abusers in Western Sweden. *Clinical toxicology (Philadelphia, Pa.),* 46**,** 187-92.
KRANTZ, L. & LINDSTEN, K. 2008. Kriminalvårdens redovisning om återfall. Norrköping: Kriminalvården.
KRAUS, L., AUGUSTIN, R., FRISCHER, M., KÜMMLER, P., UHL, A. & WIESSING, L. 2003. Estimating prevalence of problem drug use at national level in countries of the European Union and Norway. *Addiction,* 98**,** 471-85.
KRIMINALVÅRDEN. 2004. *Informationshäfte om barn som har mamma eller pappa i fängelse* [Online]. Available: http://www.kvv.se/upload/Informationsmaterial/KVS-0166-Barnbesok.pdf [Accessed 2011-10-20].
LAANEMETS, L. 2007. *Navet Om kvinnor, prostitution, metadon- och Subutexbehandling,* Stockholm, Mobilisering mot narkotika [MOB].
LJUNGDAHL, S. 2008. *Barn i familjer med alkohol- och narkotikaproblem. Omfattning och analys,* Östersund, Statens folkhälsoinstitut.

LVFS 1997:12 *Läkemedelsverkets föreskrifter (LVFS 1997:12) om förteckningar över narkotika*, Läkemedelsverket.
LÖFSTRAND 2010. Reforming the Work to Combat Long-Term Homelessness in Sweden. *Acta Sociologica,* 53:19.
MIETALA, J. & NYSTRÖM, S. 2010. CANs rapporteringssystem om droger (CRD): Tendenser första halvåret 2010: CAN Rapport 123. Stockholm: Centralförbundet för alkohol- och narkotikaupplysning [CAN].
MÅNSSON, A., MOESTRUP, T., NORDENFELT, E. & WIDELL, A. 2000. Continued transmission of hepatitis B and C viruses, but no transmission of human immunodeficiency virus among intravenous drug users participating in a syringe/needle exchange program. *Scandinavian journal of infectious diseases,* 32**,** 253-258.
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].
NYHLÉN, A., FRIDELL, M., HESSE, M. & KRANTZ, P. 2011. Causes of premature mortality in Swedish drug abusers: a prospective longitudinal study 1970-2006. *Journal of forensic and legal medicine,* 18**,** 66-72.
OLSSON, B., ADAMSSON WAHREN, C. & BYQVIST, S. 2001. *Det tunga narkotikamissbrukets omfattning i Sverige 1998. MAX-projektet, delrapport 3*, Centralförbundet för alkohol- och narkotikaupplysning [CAN].
OLSSON, L.-E., & NORDFELDT, M 2008. Homelessness and the Tertiary Welfare System in Sweden - The Role of the Welfare State and Non-profit Sector. *European Journal of Homelessness,* 2.
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.
PRATT, D., PIPER, M., APPLEBY, L., WEBB, R. & SHAW, J. 2006. Suicide in recently released prisoners: a population-based cohort study. *Lancet,* 8;368**,** 119-23.
REGERINGEN. 2010. *Regeringens åtgärdsprogram för alkohol-, narkotika-, dopnings- och tobakspolitiken 2010* [Online]. Stockholm: Regeringen. Available: http://www.regeringen.se/content/1/c6/13/93/20/dd0fcf29.pdf [Accessed 2011-10-20].
REGERINGEN. 2011a. *A cohesive strategy for alcohol, narcotic drugs, doping and tobacco (ANDT) policy* [Online]. Available: http://www.sweden.gov.se/content/1/c6/17/26/95/0603f592.pdf [Accessed 2011-07-15].
REGERINGEN. 2011b. *Regeringens åtgärdsprogram för alkohol-, narkotika-, dopnings- och tobakspolitiken 2011* [Online]. Stockholm: Regeringen. Available: http://www.regeringen.se/content/1/c6/16/98/09/09c75b01.pdf [Accessed 2011-10-20].
REGERINGENS PROPOSITION 2005/06:30 *Nationella alkohol- och narkotikahandlingsplaner,* Stockholm, Regeringen.

REGERINGENS PROPOSITION 2010/11:1 *Budgetpropositionen för 2011: Hälsovård, sjukvård och social omsorg,* Stockholm, Regeringen.
REGERINGENS PROPOSITION 2010/11:47 *En samlad startegi för alkohol-, narkotika-, dopning- och tobakspolitiken,* Stockholm, Regeringen.
REGERINGSBESLUT S 2010/6855/FH & S2010/8869/FH. *Uppdrag angående genomförande av en pilotundersökning inför kommande baslinjemätning av problematiskt missbruk i Sverige av alkohol, narkotika, dopning och tobak* [Online]. Stockholm: Regeringen. Available: http://www.regeringen.se/content/1/c6/15/79/57/8220d7ee.pdf [Accessed 2011-09-30].
RFHL & SVENONIUS, C. 2008. Dina rättigheter och möjligheter i beroendevården Available: http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/8706/2008-124-8_20081248.pdf [Accessed 2011-10-05].
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**,** 144-163.
RIKSPOLISSTYRELSEN. 2007. *Samverkan Polis och kommun - för en lokalt förankrad polisverksamhet i hela landet* [Online]. Available: http://www.polisen.se/Global/www%20och%20Intrapolis/Rapporter-utredningar/01%20Polisen%20nationellt/Brottsforebyggande/Rapport_Samverkan_Polis_och_kommun_08.pdf [Accessed 2011-10-20].
RIKSPOLISSTYRELSEN. 2011. *Årsredovisning 2010* [Online]. Available: http://polisen.se/Global/www%20och%20Intrapolis/Arsredovisningar/01%20Polisen%20nationellt/Arsredov10_digital.pdf [Accessed 2011-10-20].
SAHLIN, I. 2005. The Staircaser of transition. Survival through failure. *Innovation,* 18**,** 115-135.
SFS 1968:64 *Narkotikastrafflag*.
SFS 1988:870 *Lag om vård av missbrukare i vissa fall*.
SFS 1990:52 *Lag med särskilda bestämmelser om vård av unga*.
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 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 2001:453 *Socialtjänstlag,* Stockholm, Riksdagen.
SFS 2006:323 *Lag om utbyte av sprutor och kanyler*.
SFS 2006:431 *Lag om ändring i brottsbalken,* Stockholm, Riksdagen.
SFS 2011:111 *Lag om förstörande av vissa hälsofarliga missbrukssubstanser,* Stockholm, Riksdagen.
SINGLETON, J., DEGENHARDT, L., HALL, W. & ZABRANSKY, T. 2009. Mortality among amphetamine users: a systematic review of cohort studies. *Drug and alcohol dependence,* 1**,** 1-8.

SJÖLANDER, J. & JOHNSSON, B. 2007. Tillgängligheten till läkemedelsassisterad underhållsbehandling i fyra sjukvårdsområden: Västra Götalandsregionen, Jönköpings länslandsting, Kronobergs läns landsting och Västernorrlands läns landsting. Stockholm: Mobilisering mot narkotika [MOB].
SOCIALSTYRELSEN 2007a. Gravida kvinnor med missbruk och barn som lever i familjer med missbruksproblem. *Avrapportering av regeringsuppdrag.* Stockholm: Socialstyrelsen.
SOCIALSTYRELSEN 2007b. *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 2009. *Barn och unga i familjer med missbruk. Vägledning för socialtjänsten och andra aktörer,* Stockholm, Socialstyrelsen.
SOCIALSTYRELSEN. 2010. Hemlöshet - många ansikten, mångas ansvar: Genomförande av regeringens strategi för att motverka hemlöshet och utestängning från bostadsmarknaden 2007-2009 Slutrapport. Available: http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/18089/2010-6-33.pdf.
SOCIALSTYRELSEN 2011a. *Insatser år 2010 för vuxna personer med missbruks- och beroendeproblem och för övriga vuxna,* Stockholm, Socialstyrelsen.
SOCIALSTYRELSEN 2011b. *Tillsynsrapport 2011: Hälso- och sjukvård och socialtjänst,* Stockholm, Socialstyrelsen.
SOU 2004:3 *Tvång och förändring. Rättssäkerhet, vårdens innehåll och eftervård: Betänkande av LVM-utredning,* Stockholm, Fritzes.
SOU 2008:04. *Missbruksutredningen* [Online]. Stockholm: Socialdepartementet. Available: http://www.sou.gov.se/missbruk/ [Accessed 12/12 2010].
SOU 2011:6 *Missbruket, kunskapen, vården: Missbruksutredningens forskningsbilaga,* Stockholm, Fritzes.
SOU 2011:35 *Bättre insatser vid missbruk och beroende: Individen, kunskapen och ansvaret: Slutbetänkande av Missbruksutredningen,* Stockholm, Fritzes.
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 2009. Det drogförebyggande arbetet i Sverige 2008: Rapport om det förebyggande arbetet mot alkohol-, narkotika-, tobaks- och dopningsproblem. Östersund: Statens folkhälsoinstitut.

STATENS FOLKHÄLSOINSTITUT 2010a. Kartläggning av insatser för barn och ungdomar i risksituationer 2010 Östersund: Statens folkhälsoinstitut.
STATENS FOLKHÄLSOINSTITUT 2010b. Minskade skador av alkoholkonsumtion och ett narkotikafritt samhälle: Uppföljning av de nationella handlingsplanerna för alkohol och narkotika 2006-2010. Östersund: Statens folkhälsoinstitut.
STATENS FOLKHÄLSOINSTITUT 2010c. *Narkotikabruket i Sverige,* Östersund, Statens folkhälsoinstitut.
STATENS FOLKHÄLSOINSTITUT 2011a. Balansering på medvetandets gräns: Riskbruk, missbruk och beroende av GHB och närbesläktade preparat: en kunskapsinventering. Östersund: Statens folkhälsoinstitut.
STATENS FOLKHÄLSOINSTITUT. 2011b. En samlad återredovisning av regeringens ANDT-uppdrag till Statens folkhälsoinstitut 2010. Available: http://www.fhi.se/Documents/Om-oss/redovisade-uppdrag/2011/En-samlad-aterraportering-ANTD-20110331.pdf.
STATENS FOLKHÄLSOINSTITUT 2011c. *Kartläggning av insatser för barn och ungdomar i risksituationer. en pilotundersökning av 45 kommuner och sex statsdelar.,* Östersund, Statens folkhälsoinstitut.
STATENS FOLKHÄLSOINSTITUT Unpublished-a. *Länsrapport 2009,* Östersund, Statens folkhälsoinstitut.
STATENS FOLKHÄLSOINSTITUT Unpublished-b. Länsrapport 2010. Östersund: Statens folkhälsoinstitut.
STATENS OFFENTLIGA UTREDNINGAR 2010. *Bättre vård och stöd för individen: Om ansvar och tvång i den svenska missbruks och beroendevården: Diskussionspromemoria av Missbruksutredningen,* Stockholm, Statens offentliga utredningar.
STENBACKA, M., LEIFMAN, A. & ROMELSJO, A. 2010. Mortality and cause of death among 1705 illicit drug users: a 37 year follow up. *Drug and Alcohol Review,* 29**,** 21-7.
STENSTRÖM, N. 2008. *Sprutbyte vid Intravenöst Narkotikamissbruk: En longitudinell studie av deltagarna i sprutbytesprogrammet i Malmö.* Doctoral thesis, Mittuniversitetet [Mid Sweden university].
SUNDSTRÖM, E. & BROTTSFÖREBYGGANDE RÅDET [BRÅ] 2010. *2007 års reform av utslussning i kriminalvården: Delrapport 2,* Stockholm, Brottsförebyggande rådet [Brå].
SWEDISH NATIONAL INSTITUTE OF PUBLIC HEALTH 2010. 2010 National Report (2009 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.
SVENSSON, D. & ARVIDSSON, O. 2009. *Skattning av problematiskt narkotikamissbruk 2007*.
SWÄRD, H. 2010. *Hemlös 2010 - En statusrapport om det offentligas stöd till människor som lever i hemlöshet.,* Stockholm, Stockholm City Mission.

TENGSTRÖM, A. 2006. Ung och oberoende: en studie av Maria Ungdoms klienter. *Vet vet vi om narkotikaanvändarna i Sverige? Rapport 14, 2006.* Stockholm: Mobilisering mot narkotika [MOB].
ÖBERG, J. & HOLMBERG, S. 2008. Behandling av narkotikamissbrukare i fängelse: En effektstudie. *2008:18.* Stockholm: Brottsförebyggandet rådet [Brå].

Annexes

Annex 1 List of tables appearing in the report

Annex 2 List of figures appearing in the report

Annex 3 List of full references of laws in original language

(1968) SFS 1968:64 *Narkotikastrafflag*.Stockholm, Riksdagen
(1982) SFS 1982:763 *Hälso- och sjukvårdslag,* Stockholm, Riksdagen.
(1988) SFS 1988:870 *Lag om vård av missbrukare i vissa fall*. Stockholm, Riksdagen
(1990) SFS 1990:52 *Lag med särskilda bestämmelser om vård av unga*. Stockholm, Riksdagen
(1991) SFS 1991:1969 *Lag om förbud mot vissa dopningsmedel*. Stockholm, Riksdagen
(1992) SFS 1992:860 *Lag om kontroll av narkotika*. Stockholm, Riksdagen
(1992) SFS 1992:1554 *Förordning om kontroll av narkotika*. Stockholm, Riksdagen
(1999) SFS 1999:42 *Lag om förbud mot vissa hälsofarliga varor*. Stockholm, Riksdagen
(1999) SFS 1999:58 *Förordning om förbud mot vissa hälsofarliga varor*. Stockholm, Riksdagen
(2000) SFS 2000:1225 *Lag om straff för smuggling*. Stockholm, Riksdagen
(2001) SFS 2001:453 *Socialtjänstlag*. Stockholm, Riksdagen
(2004) SFS 2004:168 *Smittskyddslag*, Stockholm, Riksdagen
(2004) SFS 2004:255 *Smittskyddsförordning;* Stockholm, Riksdagen
(2006) SFS 2006:323 *Lag om utbyte av sprutor och kanyler*. Stockholm, Riksdagen
(2006) SFS 2006:431 *Lag om ändring i brottsbalken*, Stockholm, Riksdagen
(2011) SFS 2011:11 *Lag om förstörande av vissa hälsofarliga missbrukssubstanser*, Stockholm, Riksdagen

Annex 4 List of abbreviations

ADHD	Attention Deficit Hyperactivity Disorder
ANDT	Alcohol-, Narcotics-, Doping- and Tobacco
ASI	Addiction Severity Index
BRÅ	Brottsförebyggande Rådet [Eng. National Council for Crime Prevention, NCCP]
CAN	Swedish Council for Information on Alcohol and Other Drugs
CMR	Crude Mortality Rate
COPE	Community Parent Education
CRA	Community Reinforcement Approach
CRD	CAN Reporting system on Drugs
CS	Central Stimulants
DRD	Drug Related Death
DUID	Drivers Under Influence of Drugs
ES	Electronic Monitoring
EU	European Union
GIR	Göteborgs Implementering av Riktlinjer [Eng. Gothenburg's Implementation of Guidelines]
GMR	General Mortality Register
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HSL	Health and Medical Services Act
ICD	International Classification of Diseases
IDU	Injection Drug User
ITOK	Integrated Team for Opiate-dependent Clients
IV	Intravenous
KIM	Klienter i Missbruksbehandling [Eng. Clients in Substance Misuse Treatment]
LVFS	Läkemedelsverkets Föreskrifter [Eng. Medical Products Agency's provisions and guidelines]
LVM	Care of Alcoholics, Drug Abusers and Abusers of Volatile Solvents Act
MARP	Most At Risk Population
MI	Motivational Interviewing
MMTP	Methadone Maintenance Treatment Programme
MPA	Medical Products Agency's
MPHASIS	Mutual Progress on Homelessness Through Advancing and Strengthening Information Systems
MUMIN	Maria Ungdom Motiverande Intervention
NBL	Swedish National Bacteriological Laboratory
NBHW	National Board of Health and Welfare
NCCP	National Council for Crime Prevention
NGO	Non-Governmental Organisation
NICE	National Institute for Clinical Excellence

NLAO	Network of Local Authority Observatories on Active Inclusion
NR	National Report
NSEP	Needle and Syringe Exchange Programme
PAR	In-Patient Registry
PDU	Problem Drug Use
PFL	Prime for Life
PR OROS	Prolonged Release OROS
PRISM	Programme for Reducing Individual Substance Misuse
PTN	Nordic Police and Customs Cooperation
R&D	Research & Development
RCT	Randomised Controlled Trial
RFHL	Riksförbundet för hjälp åt narkotika- och läkemedelsberoende [Eng. National Association for Aid to Drug Abusers
RIS	Riktlinjer i Samverkan [Eng. Guidelines In Collaboration]
SAMANT	Workgroup for coordination Alcohol-, Narcotics-, Doping- and Tobacco Politics
SALAR	Swedish Association of Local Authorities and Regions
SBR	Swedish Dependency Register
SBU	Swedish Council on Technology Assessment in Health Care
SEK	Swedish Krona
SEP	Syringe Exchange Programmes
SET	Social and Emotional Training
SFS	Svensk Författningssamling [Eng. Swedish Code of Statutes]
SHP	Swedish Prison Programme
SITOK	South ITOK
SKL	Swedish National Laboratory of Forensic Science
SMI	Swedish Institute for Infectious Disease Control
SMR	Standard Mortality Ratio
SNBYA	Swedish National Board for Youth Affairs
SNIPH	The Swedish National Institute of Public Health
SoRAD	Centre for Social Research on Alcohol and Drugs
SOSFS	Socialstyrelsens Författningssamling [Eng. National Board of Health and Welfare Code of Statues]
SOU	Swedish Government Official Reports
SPPS	Swedish Prison and Probation Services
SRR	Standardised Rate Ratio
ST	Standard Table
STAD	Stockholm Prevents Alcohol and Drug Problems
STI	Sexually Transmitted Infection
TDI	Treatment Demand Index
UNODC	United Nations Office of Drugs and Crime
UN-UNGASS	United Nations General Assembly Special Session
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
WURS	Wender Utah Rating Scale