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Foreword

This National Report on drug policy and the drug development in Sweden during 1999/2000 has been compiled for the European Monitoring Centre for Drugs and Drug Addiction, a European Union agency. EMCDDA, in its turn, produces an annual report for all Member States.

The report has been made in co-operation with several national bodies and a steering group was appointed to assist in the work, consisting of representatives from the Ministry of Health and Social Affairs, the National Board of Health and Welfare, the Governmental Swedish Commission on Narcotic Drugs, the National Police Board, the Customs, the National Board of Institutional Care and the Swedish Council for Information on Alcohol and other Drugs.

The National Institute of Public Health was convenor of the steering group and overall responsible for the production of the National Report. Ulf Guttormsson at the Swedish Council for Information on Alcohol and Other drugs (CAN) was responsible for the compilation of the report. Chapter 14 was written in co-operation with Daniel Svensson (of the NIPH).

Stockholm, December 2000

Gunnar Ågren
Director General
National Institute of Public Health

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Graphs and Tables

Introduction of the Swedish National Report

This National Report has been compiled with the assistance of the EMCDDA document "Guidelines 2000 for National Reports". The paragraphing of the Guidelines has been followed and the report is hence divided into a summary, four main parts, and ended with a list of references. The focus of the report is on new developments.

Part I deals with National policies and part II with the epidemiological situation. The second part contains not only required data from the (most) recent year, but also some historical information. This is many times necessary, not only to illustrate trends and developments but also to give relevant backgrounds and comments on other events that might have influenced the trends in data. If various circumstances that might have affected the figures are not taken into consideration, like changes in legislature or of ways registering statistics, the figures might not make any sense at all. If specific types of epidemiological data have been asked for but however not being available, this is indicated (which is relevant for other parts as well).

A small number of graphs have been added to the epidemiological chapter, in order to illustrate certain developments, where it has been motivated and possible to do so. Attempts have also been made, as far as possible, to link the text with the Standardised Epidemiological tables already delivered.

In Part III follows a short overview of recent (1999/2000) developments in the Demand Reduction field. This compilation of demand reduction activities and events are compiled with assistance of the checklist in the GL. The three chapters on key issues requested follows in Part IV.

To obtain a more complete picture than this report is able to give, it might prove remunerative to consult previous NRs, especially the one of 1997, which was quite extensive and contained a lot of background information, not only on historical developments regarding Swedish drug policy but also in describing various authorities and organisations, their responsibilities and how they operate. In this regard, Information Map is also an important document.

In order to avoid unnecessary repeating of names of authorities and organisations frequently referred to, they are abbreviated in the text after being mentioned the first time. A list of frequently used abbreviations follows below. In order to evaluate the Swedish drug policy a Commission on Narcotic Drugs was set up by the Government in May 1998, referred to as the Drug Commission in the text.

List of frequently used abbreviations

CAN	Swedish Council for Information on Alcohol and other Drugs
MHSA	Ministry of Health and Social Affairs
NBHW	National Board of Health and Welfare
NCCP	National Council for Crime Prevention
NIPH	National Institute of Public Health
PLN	Penal Law on Narcotics
SIIDC	Swedish Institute for Infectious Disease Control
ST	EMCDDA Standard Table

Summary, main trends and developments

The Swedish drug policy remains unchanged and the overall visionary aim is, as before, to shape a drug-free society. This objective was set up already during the early 1980s. During the 1990s three limited, finite and measurable sub-objectives were set up, in order to concretise the overall visionary aim. One of the goals is to reduce experimental use and the recruitment of new drug users, another to induce more drug users to give up their habit and the third goal is to reduce the supply of drugs.

Preventive measures are used in order to stop young people from experimenting with drugs, care and treatment helps active users to kick the habit and, finally, various control measures reduces supply, and also strengthens the restrictive policy at the whole. These three parts of the policy are dependently integrated and each other's pre-requisites, in order to reduce both demand and supply. Public opinion strongly supports the policy operated in Sweden.

Furthermore, the Swedish drug policy is recognised as a part of the social policy, and should also in the future be an important and well-integrated factor in the general welfare policy.

Some minor legislative changes have taken place during the recent year. In accordance with a decision of the Council of Europe, 4-MTA is now regulated under the Penal Law on Narcotics instead of the recently adopted Act on the Prohibition of Certain Goods Dangerous to Health. Since February 2000, also GHB (Gamma Hydroxybutyric Acid) is regulated under the Penal Law on Narcotics.

During the 1990s there has been an obvious increase in the availability of drugs, particularly of amphetamines and heroin. This is reflected in multiplied seizures among the Police and Customs and decreases in price. Also the availability of LSD and ecstasy has increased during the 1990s, at much lower levels though, while the market situation for cannabis and cocaine seems to be relatively unchanged. Illegal medicines, and especially Benzodiazepines, have been paid a lot of attention recent years and the seizures have increased significantly during the 1990s.

The drug trafficking profile has changed somewhat in recent years with an increased proportion of the drugs entering Sweden having been smuggled in from Eastern Europe. It should however be emphasised that the vast majority of the seizures made by the Customs are still made at the border of a member country of the European Union. Domestic production of drugs is rare, but some signs indicate an increase in the relatively limited number of cannabis home growers.

A quite obvious trend observed in national surveys during the 1990s is the increase in lifetime prevalence of drugs among Swedish teenagers. Among younger teenagers, especially young girls, these increases have come to a halt during the most recent years. The upward trend continues among older teenagers however.

Also recent use (last year, last 30 days prevalence) has increased among teenagers and younger adults during the 1990s, even though the figures have not reached the magnitude of the early 1970s.

Most persons having tried drugs, both younger people and adults, have tried cannabis, and the majority has tried cannabis only. The second most commonly experienced drug is amphetamines. Thereafter comes ecstasy and LSD among youths but cocaine among older people.

A relatively new drug spreading among (especially) teenagers is GHB. It is primarily used as a recreational drug because of its alcohol-like intoxicating effects. The use has been concentrated mostly to two regions so far. Four deaths were GHB was considered being the trigger drug (other drugs were also present) has taken place. Recently also GBL and Pro-G have become a part of the "GHB-problem". In most repeated surveys on drug use GHB-questions have recently been included.

During the latter part of the 1990s there have been indications that the recruitment to severe drug use is on the rise, particularly heroin use. Several statistical indicators have on the aggregated national level given such signals, as well as information from various local clinics, institutions and professionals has. The information indicates that the number of younger severe users has increased while the number of older users not has decreased.

A report on a 1998 case finding study of severe drug use is in progress and soon to be released. No figures have so far been made available but preliminary information support the interpretation of the above given indicators.

In order to reduce the number of severe abusers, there are a great number of care and treatment facilities available. An ongoing shift from compulsory treatment and institutional treatment towards outpatient treatment has been noticed for several years. There are also some indications that treatment might be less easily available nowadays, at least compared to the situation 10-15 years ago when there was a massive build up of institutional treatment facilities in the wakes of the arising HIV epidemic. There has also been a shift towards increased local/municipality responsibilities for treatment, as well as for other demand reduction activities like prevention campaigns and such.

The Government set up a Drug Commission in May 1998. The task is to evaluate the drug policy of Sweden and to propose future reinforcements to strengthen the efficiency. A great number of areas such as legislation, research and epidemiology, preventive measures, and various aspects of the treatment system (including treatment in the correctional system) are investigated. The interplay between different sectors, levels and actors in society are also given attention. A great number of discussion memorandums have been published, but the final analysis and conclusions are still ahead (January 2001). A Plan of Action regarding drugs will be released in next year, likely comprising many of the findings and proposals of the Drug Commission.

The ongoing governmental investigation called MAX, ordered by the Ministry of Health and Social Affairs, is focused on drug use and social exclusion and aims at exploring drug use in socially excluded groups as well as to study how marginalisation may lead to drug use and to achieve a more detailed picture of the living conditions among severe drug users. Apart from a case-finding study, other reports are ahead.

One example in the demand reduction field worth highlighting is the growing importance of the Internet. It is becoming a valuable tool for interactive drug education, for disseminating of various types of new information, for providing databases on articles, books and scientific reports, and not the least, in providing downloadable epidemiological data.

Part I.
National strategies: institutional & legal frameworks

1. Developments in Drug Policy and Responses

1.1 Political framework in the drug field

Objectives and priorities of national police

Since one of the Key Issues concern national policies and strategies only a brief description are presented in the following. More details are provided in chapter 12.

The Swedish drug policy remains unchanged and the overall visionary aim is, as before, to shape a drug-free society. This objective was set up already during the early 1980s. During the 1990s three limited, finite and measurable sub-objectives were identified, in order to concretise the overall visionary aim. One of the goals is to reduce the recruitment of new drug users, another to induce more drug users to give up their habit and the third to reduce the supply of drugs. Preventive measures are used to stop young people from experimenting with drugs, care and treatment helps active users to kick the habit and, finally, various control measures reduces supply. These three parts of the policy are dependently integrated and each other's pre-requisites, in order to reduce both demand and supply.

Descriptions on this can be found throughout many official documents. One example, in English, is the publication called "A Preventive Strategy –Swedish Drug Policy in the 1990s", prepared by the National Institute of Public Health (NIPH) ahead of the UNGASS-meeting in June 1998 (National Institute of Public Health 1998).

In the above-mentioned document it is also stated that the drug policy also in the future should be an important and well-integrated factor in social policy and that prevention can be seen as a scarlet thread in Swedish drug policy.

Basic elements at national, regional and local level

The Swedish national drug policy is well implemented throughout the system, also at the local level. There are several important and easily identified parts of the policy, all equally necessary.

Prevention is the overriding principle of Swedish drug policy. A lot of efforts are directed at limiting experimental and occasional use as far as possible. Information campaigns and local preventive activities are carried out in order to withhold the resistance against narcotic drugs. The main aim of prevention is to reduce the supply of drugs.

Care and treatment is another basic element of the Swedish drug policy. In order to induce drug users to give up their habit various types of support is being offered. Rehabilitation of

former drug users must also help to reduce the negative consequences of drug abuse to the individual, to his or her family and to society as a whole.

Both prevention and treatment are carried out on the local, municipality level, however in accordance with the national policy. The third major basic element is the legal framework and law enforcement. Reducing the supply of drugs and preventing them from spreading is important objectives for the Customs and the Police, at the same time as various control measures also strengthens the restrictive policy. Of course, this is handled on a national, Governmental level, just as the shaping and implementation of the national policy is.

As already mentioned, these elements are considered being supplementary and equally necessary, and actually each other's prerequisites, forming the unity that the drug policy is. It is however important to emphasise that drug policy cannot be considered as a freestanding part from the social policy or general welfare policy in general. The restrictive drug policy is a necessary and important part of this.

1.2 Policy implementation, legal framework and prosecution

Laws and regulations

Drugs are defined as those substances that Swedish law classifies as such. They are specified in five lists issued by the Medical Products Agency. These lists include preparations specified in the international conventions that Sweden is party to as well as preparations fulfilling certain conditions, which the Swedish Government has decided to classify as drugs.

At several occasions a need for measures to make fast interventions on new substances has been at hand, and the Penal Law on Narcotics (PLN) has sometimes proved to be inappropriate for such fast actions. Therefore, the Act on the Prohibition of Certain Goods Dangerous to Health was put in to action April 1, 1999 (SFS 1999:42 and 1999:58), as a complement to the PLN (SFS 1968:44). This new act "applies to goods that, by reason of their innate characteristics, entail a danger to human life or health and are being used, or can be assumed to be used, for the purpose of intoxication or other influence".

The Swedish Government prescribes the goods to which the Act shall be applicable. After careful investigations the substance later on might be transferred to the lists of drugs, which was the case with 4-MTA in November 1999, now being controlled under the PLN in accordance with the decision of the Council of the European Union of September 13. No other drug have so far been removed or transferred from the "interim-list".

During February 2000 GHB became controlled within the PLN. Worth mentioning in the GHB case is that an attempt to control the substance under the Penal law on Doping Substances was made, however rejected by a District Court in November 1999 not considering GHB to apply under the Penal law on Doping Substances. Other substances recently added to the lists of narcotic drugs are Karisoprodol (January 1999), mushrooms containing the substances psilocin or psilocybin and Remifentanil (August 1999), and finally Modafinil (September 2000).

As reported in previous NR, a change was made in the Motor Traffic Crime Act in July 1999, prohibiting driving under the influence of drugs (SFS 1999:217). During the first half of 2000, some 1,700 drug impaired drivers had been detected by the police, most of them receiving fines for the violation. Amphetamines were present in more than 50% of the cases and cannabis in some 30%.

Prosecution policy, priorities and objectives in relation to drug addicts, occasional users and drug related crime

In previous NR a key issue on law enforcement, diversion to treatment and alternatives to prison was included, giving a detailed picture of prosecution routines in at least some cases. This information remains unchanged and might serve as an illustration of the complexity in such issues. In the following a very brief overview is given.

Naturally trafficking and supplying drugs in large quantities belong to the gravest offences. Supplying/selling drugs are practically never rated as minor offences. However, not only, trafficking, pushing and possession is prohibited, also drug use is a crime.

According to police tactics, the drug users themselves might be seen as the "weakest link" in the chain of drug trafficking, and therefore often approached. An important goal of this tactics is to prevent open drug scenes to establish and thereby keeping the drugs market a less visible one, in order to prevent easy contacts between sellers and buyers/users. The sanctions are naturally depending on the amount and what type of drugs possessed. One example of user orientated police tactics are the Stockholm situated special police force called the "Rave Commission", intervening not only on rave parties and dance events but also at sports events, restaurants and in the nightlife at the whole.

The efforts made in order to expose occasional users are considered important as preventive measure not the least, clarifying that also experimenting/temporary use is not tolerated by society. Persons caught only for drug use are never imprisoned, even if a maximum of six months imprisonment is theoretically possible. Fines or a prosecution weaver is the normal sanction in such cases. A report is sent to the Social Services to investigate if there is a need for social support or drug treatment.

The National Council for Crime Prevention (NCCP) is investigating the effects of making the consumption of drugs an offence and a report on this is expected soon.

1.3 Developments in public attitudes and debates

Public perception and public debates

The drug policy operated by the Swedish Government and the Parliament has a strong support in the public opinion. There is hardly any opposition of magnitude, and the support has been quite massive for a long time. In recent years several opinion polls asking about people's social concerns have found that drug use is one of the main worries, equivalent to fears about violence, unemployment or environmental pollution.

Some indications during the 1990s of a slight change towards less harsh attitudes to drugs have been noticed among younger persons, especially males. This is evident not the least regarding the increases in lifetime and last month prevalence of drugs. The proportion of teenagers having tried drugs is still rather small however and the vast majority also of younger persons still express negative attitudes towards drugs and drug use.

An interview study with some hundred persons 15-25 years old was presented in a discussion memorandum by the Drug Commission and one of the issues were attitudes (Narkotikakommissionen 1999a). One of the findings being mentioned was that the younger adolescents had more restrictive views upon drugs while the older ones more often said that drug use was a personal issue for each individual to decide upon and to be responsible for. The respondents very much agreed upon that the popular culture was important in establishing attitudes. Films were important, music in a lesser extent, while the Internet not was considered having any

particular influence. The influences are however adopted indirect and in a subtle way. Lifestyles, or sub-cultures, were mentioned as very important in shaping younger persons ideals, attitudes and beliefs, but very complex processes precede adopting a lifestyle and it is very difficult to tell what factors are most important.

There is always an ongoing debate whether the drug policy is too restrictive or has to be even more so. Many debate articles from spring 2000 accuses the new Minister for Health and Social Affairs for not attending the restrictive model well enough and for not being active enough in advocating the Swedish drug policy abroad. There are also fears expressed that Sweden in the future will be forced to take part in a harmonized European drug policy.

One particular issue that has caused concern is the needle exchange programme in the Scania region, running on experimental status since some 14 years. A voting in the parliament led to the urgent need to finalize the evaluation of the experiment. The future of the provisional syringe exchange programme is subject to an investigation by the NBHW.

Since drug use is prohibited with a maximum of six months imprisonment, the police are allowed to conduct drug tests (blood or urine) if there is reasonable cause to believe that a person is under the influence of drugs, however not on persons younger than 15 years old. The conservatives have however suggested a change in the legislation so that also these persons could be tested, in order to detect and stop drug use among young teenagers at an early stage. Not only the conservative former Minister of Justice and the present Social Welfare City Commissioner of Stockholm are advocating this for example, but also representatives from other parties as well. A response to criticism on the proposal is that the health of the children is more important than their integrity.

No recent relevant research has been conducted on the media presentation and imaging of drug use, wherefore nothing specific can be said about this matter at this moment.

1.4 Budget and funding arrangements

Very little is known about funding figures for drug policy. Early 1990s the Swedish National Audit Office made an attempt to calculate societal costs due to drug use (Riksrevisionsverket 1993). This study was partly updated in late 1990s (Nilsson 1999). Funding figures accounted below are given in Euros at the exchange rate of 1 Euro to 8,38 Swedish krona.

Law enforcement costs due to drugs for 1998 were estimated at 328 million Euros. This sum includes expenditures for the Police (113 millions), the Correctional system (162 millions), courts and public prosecutors (23 millions) and the Customs (30 millions). Since some of these figures were not updated to the 1998 level, this is likely an underestimate for that year.

Drug treatment costs are actually partly included in the above costs, since many drug users receive treatment in some form within the correctional system. Costs for institutional treatment (therapeutic communities etc) was estimated to 64 millions in 1991, while hospital care and outpatient treatment amounted to 41 millions for the same year. It must however be emphasised that the accounted figures only are rough estimates and very much depending on the type of expenses included and various definitions made.

It is very difficult to determine how much is spent on prevention since this field is hard to define and mark off. Research funds are granted via, and to, a great number of authorities, institutions and organisations, at least partly a contributory factor explaining why there does not exist a figure on drug research. Unfortunately, there are not any figures on expenditures for evaluation, quality and training as well, partly for the same reasons.

Notes on Part I

All Swedish laws are published in full text in a database called RixLex, available on the Internet. This is the official database on all Laws decided upon by the Parliament and all Statues decided upon by the Government. Also the preparatory works are available. Unfortunately the database is not available in English.

RixLex can be found on the following URL: www.riksdagen.se/debatt/Index.asp. One key for searching in the database is the SFS-numbers, included in the text for each law mentioned.

Drugs classified as narcotic drugs are listed by the Medical Products Agency and published in their Statute book, available on the following URL www.mpa.se/lagar/ie_lagindex.html. The basic document LVFS 1997:12, has been updated with the following ones: LVFS 1997:15, LVFS 1998:3, LVFS 1998:12, and LVFS 1999:6. So far, no Statues on GHB and Modafinil have been published.

Part II.
Epidemiological situation

2. Prevalence, Patterns and Developments in Drug Use

2.1 Main developments and emerging trends

Overview of most important characteristics and developments

During the 1990s an increase in lifetime prevalence of drugs have been observed among youths. This upward trend still holds true for the 18-year-old (male) military conscripts. Most recent data (2000) from the repeated study among 16-24 year-olds also indicate an ongoing increase at the national level. The only repeated study showing a partly different pattern are the one among grade 9 students (15-16 year-olds). The lifetime prevalence among the girls has hovered for the last four years and among the boys for two years. Some degree of "saturation" seems to have been attained, at least among younger teenagers.

No doubt, there has been a steady increase in supply, at least for some drugs. This conclusion can be drawn when analysing data on seizures and prices, combined with other types of sources. The cannabis situation can be described as relatively stable during the 1990s, and also the cocaine situation, even if there have been some major cocaine seizures made.

Both heroin and amphetamines however seem to be more easily available now, than some five or ten years ago. Increased availability also holds true for ecstasy and LSD, however at much lower levels, considering that these drugs hardly could be found on the Swedish market at all, some ten years ago.

For a number of years, various types of statistical sources have suggested an increase in the number of severe drug users. Examples of such data are registers on morbidity, mortality as well as criminal statistics and various local studies. A report on a case finding study from 1998, aiming at comparing the present situation with the ones of 1979 and 1992, is in progress and soon about to be released. No data has so far been made available but preliminary findings support the interpretation of the above given indicators; there has been an increase in the number of severe drug users in Sweden during the 1990s.

Emerging trends

There are no recent obvious signs of any particularly "new" groups of teenagers experimenting with drugs. Since an increasing number of youths try drugs, the number of "normal" or "middle class kids" doing so naturally becomes greater. During the late 1980s, drug experimenting was quite uncommon among teenagers. Such behaviour was even more deviant than today, and the persons experimenting with drugs at that time were at the same time more likely to present a multi-problematic background than the ones experimenting with drugs nowadays. Still, there are obvious background differences between teenagers experimenting with drugs and the ones who don't, particularly when it comes to frequent use.

A relatively new drug spreading among (especially) teenagers is GHB (Gamma Hydroxybutyric Acid). It is primarily used as a recreational drug because of its alcohol-like intoxicating effects. The use has been concentrated mostly to two regions so far; the Gothenburg area and mid-Norrland, but seizures and use have been reported from other regions as well. Four deaths were GHB was considered being the trigger drug (other drugs were also present) has taken place. In February GHB was classified as a narcotic drug. Recently also GBL and Pro-G have become a part of the "GHB-problem". In most repeated surveys on drug use GHB-questions have been included but there are no data available so far.

The growing interest in hallucinogens (LSD, ecstasy, magic mushrooms) that became apparent some years ago however seem to have tapered of according to various sources of information.

Several sources have pointed out the fact that heroin now is more common among younger cohorts of severe drug users than amphetamines are. According to available indicators heroin is still becoming more frequent among severe drug users. During the 1990s, heroin smoking seem to have increased among certain groups of immigrants, as well as other groups, preferably socially excluded groups in some suburbs of the major cities. Also signs of older amphetamine users switching to heroin have been noticed among treatment staffs, social workers etc.

Polydrug use (including alcohol and sedatives) is the most common type of drug use, even if there may be a drug of choice. Many experts in the field state that the polydrug use has become even more pronounced during the 1990s. Another theme highlighted during recent years in reports from the psychiatric drug treatment field is the very high prevalence of personality disturbances in populations of (treated) drug users and the complications this causes for treatment. These two themes (polydrug use and personality disturbance) have together been frequently discussed regarding organisation of treatment in voluntary as well as compulsory settings.

Drug trends in a wider social context

The reasons for the growing interest in drugs among youths have been under debate. One reason might simply be a growing supply of new drugs with special attractions for young people. Another is influence from overall international youth trends picked up also by Swedish youths; increased levels of experimental use have been observed in other parts of the Western world.

Heroin has become more available in Sweden during the 1990s, at the same time as youth unemployment rates has reached relatively high levels and signs of social exclusion processes are at hand in some groups. On an aggregated level this might be one possible explanation of the increase in heroin use that several statistical indicators suggest has taken place (see Lenke and Olsson 1996). It is at least a future prospect that has caused some concern. Another problem stemming out of higher unemployment rates is that the rehabilitation process become more difficult since work has proved to be rather important to maintain positive treatment results. It is however not very likely that youth unemployment has influenced the number of teenagers experimenting with drugs.

Some drugs have, more or less, typical cultural connections. One type of drug with such connotations is khat (classified as a drug in Sweden since 1989). The use of khat is still practically solely limited to immigrants from East Africa, and has been so since the drug arrived to Sweden some decade ago. Khat seizures have increased throughout the 1990s and in 1999 the Police and the Customs seized close to three and a half ton.

Opium is another example of a drug with a typical cultural context, at least in Sweden, since the use of opium is relatively limited to immigrants from the Middle East. The drug perhaps has been somewhat overlooked, in the shade of heroin, and has not gained much attention. However, during the last five years and annual average of 12 kilos have been seized by Swedish Police and Customs. According to police information, in practically every smuggling episode revealed, persons of Iranian heritage have been involved.

The drug trafficking profile has changed somewhat in recent years with an increased proportion of the drugs entering Sweden having been smuggled in from Eastern Europe. It should however be emphasised that the vast majority of the seizures made by the Customs are still made at the border of a member country of the European Union. Domestic production of drugs is rare, but some signs indicate an increase in the relatively limited number of cannabis home growers.

2.2 Drug use in the population

General population

Various polling institutes have carried out face to face interviews on drug use in the general population throughout the years, with slightly different methods and intervals. Since 1994 they are conducted every second year and the last one was carried out in 2000. Due to relatively small samples and non-response rates around 30%, the figures might fluctuate from one year to another, especially when broken down in smaller groups. Still they give some rough estimates on drugs prevalence in the general population, especially when several of these studies are compared and analysed together. (One way to compensate for this is to use running three-year averages, as done in CAN and Folkhälsoinstitutet 2000).

According to the three most recent studies presented in Table 1, about 12% of the general population aged 15-64 reports lifetime prevalence of drugs. The trend seems upward during the 1990s, however this is a bit difficult to establish for a fact since the figures fluctuates, due to the above mentioned reasons. Cannabis is the most experienced drug in the population, and in most cases this is the only drug reported. Second comes amphetamines, and in third place is cocaine.

The lifetime prevalence is slightly higher in the age group 15-34 compared to the total. Still, the differences are not larger than a few percent units. This points out that many Swedes now in their 40s and 50s tried drugs during their adolescence, some decades ago.

Table 1. Lifetime prevalence and last year prevalence of narcotic drugs, by sex and age. Percent. 1992-2000.

	Lifetime Prevalence						**Last Year Prevalence**					
	15-64			15-34			15-64			15-34		
	M	F	Tot	M	F	Tot	M	F	Tot	M	F	Tot
1992	13	7	10	13	10	12	1	0	1	2	1	1
1993	15	9	12	20	11	16	2	1	2	5	2	3
1994	8	7	7	11	9	10	0	0	0	1	1	1
1996	13	8	10	15	9	12	1	0	1	2	0	1
1998	18	10	14	19	12	16	1	0	1	3	0	2
2000	17	8	13	19	10	15	1	0	1	2	1	2

A more detailed look at different age groups, as presented in ST 1, using data from the last three surveys, reveals that it is the age groups 25-34 and 35-44 that report the greatest lifetime prevalence. The shares are relatively equal between them and a three-year average for those groups is 17%. Drug experiences among those older than 55 are quite uncommon while they are reported of practically equal shares among those aged 15-24 and 45-54 respectively (roughly 11% using a three-year average).

The results for the youngest age group was about the same in the special telephone surveys conducted among youths aged 16-24, carried out in 1996, 1998 and 2000 respectively (9, 11 and 13% LTP respectively). In comparison with the two following youth surveys, the lifetime experience reported by those 16-24 years old might seem a bit low. One obvious explanation to this is the different research methods used.

Up to 1% of all respondents 15-64 stated that they had used drugs during the last twelve months. Young males primarily report this. Some 2% of the males aged 15-34 states last year prevalence according to Table 1. In the studies from 1998 and 2000 the respondents were also asked about last 30 days prevalence and practically no one reported this.

School surveys, students grade nine

National schools surveys have been carried out since 1971 among 15-16 year old students (grade 9). A normal year around 5,800 students participates and the non-response rate is about 10-15%. The survey questionnaire deals mostly with alcohol but other drugs, as narcotic drugs and doping substances, is also covered (Andersson et al 2000).

The reported lifetime experience of drugs was rather high during the early 1970s (about 15%), dropped to about 8% during the latter part and to 4% during the second half of the 1980s. During the 1990s the lifetime prevalence of drugs has doubled (to approximately 8%), however the upward trend has been weakening during the most recent years. In 1999 the figures were 9% for the boys and 7% for the girls (ST 02 and Graph 1). Unfortunately, results from the survey of spring 2000 are not yet available, due to technical problems in the data capture (scanning) procedure.

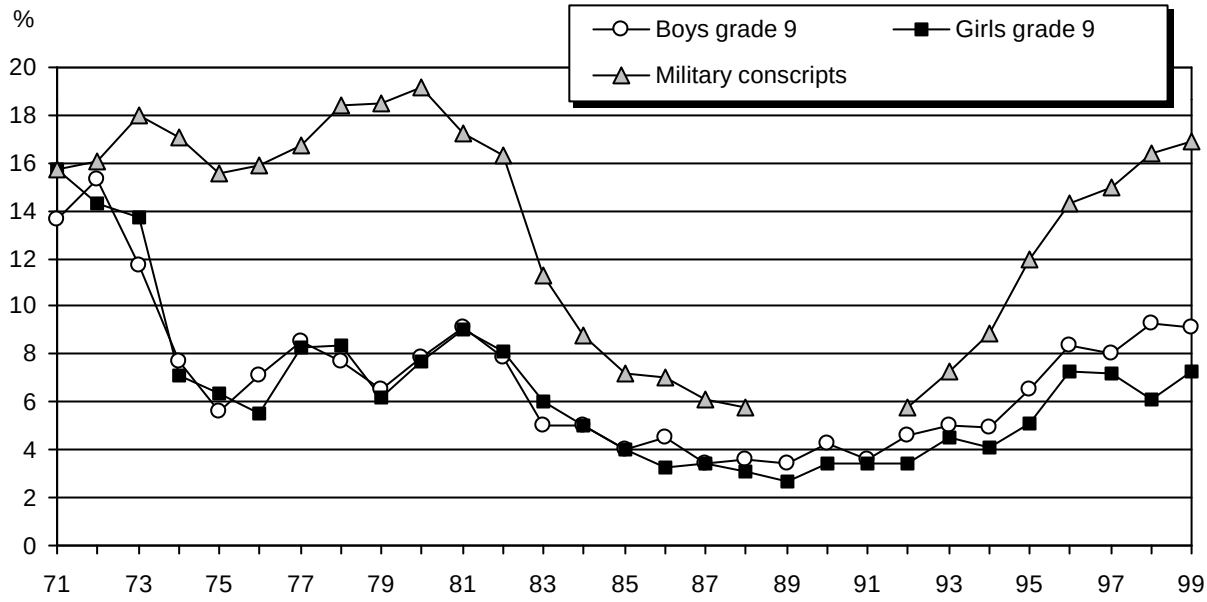
Cannabis was the most commonly drug experienced, and in about two thirds of the cases the only drug used. Approximately 1% reported experience of amphetamines, ecstasy, and LSD respectively. Other drugs were reported at lower levels.

During the 1970s some 3% of the students reported last month prevalence of drugs. This share decreased during the 1980s and amounted to 1% up to 1994. Thereafter this figure has increased and came up to 3% among the boys and 2% among the girls in the two most recent years.

Military conscripts

Drug use among military conscripts/draftees has been surveyed with similar methods and questionnaires since 1971. With the exception of disabled or mentally disturbed persons, practically all 18-year-old males with a Swedish citizenship runs certain tests to get a future military training. When those enrolment tests are made, at special military offices, the conscripts also fill out anonymous group administrated questionnaires on alcohol and drugs. Due to technical reasons the response rates has varied somewhat throughout the years, but in general approximately 90% of the conscripts answers the questionnaire (Guttormsson 2000).

With some exceptions, the conscripts report a quite similar historical pattern of drug experiences as the students in the school surveys do (Graph 1). During the 1990s, the lifetime prevalence has been rising, and the figure of 1999 (17%) is in level with those of the 1970s.



Graph 1. Lifetime prevalence of drugs among grade 9 students and military conscripts. Percent. 1971-1999.

A little more than 90% of the conscripts reporting lifetime experience had used cannabis and about two thirds had done so only. In the study from 1999 some 4% of all conscripts had used amphetamines and just as many had used illegally obtained tranquillisers or sedatives. Thereafter came LSD and ecstasy respectively (2% each). Cocaine and heroin was reported by around 1% respectively.

Last 30 days prevalence of drugs has increased from less than 1% in 1992 to 3% in 1999. This is not of the magnitude of the early 1970s though, when about 5% reported recent use.

Gender differences

A very basic factor related to drug use is gender. Among the general population, almost twice as many males as females have tried drugs at some occasion (Table 1). This overrepresentation is also true for younger adults. Among 9th graders, the differences are relatively small, but older male teenagers and grown up males report LTP rates up to twice as high as women do (see Table 1) and those are differences that increase when it comes to more recent use. According to various sources not more than approximately one fourth of the severe drug users are females.

Geographical differences

Regional analysis of drugs prevalence in the general population reveal that the experience of drugs is more common in larger cities and other districts with a high population density and less common in smaller cities and at the countryside.

The same pattern is found in studies of teenagers, indicating that there are no obvious tendencies that the uneven distribution in drug experiences between rural and metropolitan areas are levelling out. For example some 26% of the draftees from the three largest cities (Stockholm, Gothenburg and Malmoe) reported lifetime experiences of drugs and 5% reported last month use, compared to 15 and 3% among the draftees from the rest of Sweden (Guttormsson 2000).

Other differences

From the school surveys in grade 9 some simple associations (no causality established) between drug use and other factors have been noticed. For instance, students that have tried drugs state that they feel uncomfortable in school in a higher degree than other students do (15 and 5% respectively), that their grades are below average (41 and 16% respectively) and that they skip classes several times a month (38 and 9% respectively). Only half of those having tried drugs lived in a "traditional" nuclear family (both biological parents), compared to 72% among the others (Andersson et al 1999).

Some simple associations among the 18-year-old conscripts in the conscript surveys have also been found. For example, those who had not continued schooling after compulsory school had tried drugs in a larger extent than others had (34 an 15% respectively) and that 35% of those who neither worked or studied the period before the conscription tests had tried drugs. Immigrants (with a Swedish citizenship) and persons with at least one immigrated parent had in a larger extent tried drugs than indigenous Swedes had (22 and 15% respectively).

Since an increasing number of youths try drugs, the above-mentioned co-variations have diminished somewhat through the 1990s, quite naturally. These differences are however (even) more pronounced when it comes to recent drug use (last month drug use). This means that the ones continuing with their drug use have a rather different background compared to those who quit their drug experiments and (in particular) to those who never try drugs.

2.3 Problem drug use

Nation-wide studies aimed at assessing the number of drug users are not carried out on regular intervals. Only two major case-finding studies have been carried out and published so far. The first was a total investigation of all Swedish municipalities carried out in 1979 (UNO 1977) and in the second one some 100 out of approximately 290 municipalities participated (Olsson et al 1993). In these studies all drug users known by authorities (Police, Social Services, Correctional System and various treatment institutions) were reported and a capture-recapture method was applied to estimate the proportion of unknown drug users.

Only the number of "severe drug users" was calculated and severe drug use was defined as having injected drugs at least once during the twelve-month period before the study or to have used drugs daily or almost daily the four weeks prior to the study (no matter what routes of administration).

According to the comprehensive study carried out in 1979, the number of severe drug users was between 10,000 and 14,000, with an average age of 27 years. Using the point estimate (12,000), the rate per 1,000 inhabitants 15-64 was 2.3 in 1979. In the 1992 study, it was estimated that there were between 14,000 and 20,000 severe drug users (approx. 3.1 per 1,000 inhabitants 15-64). The average age was 32 in 1992 and amphetamines were still the most common type of drug used, even though an increase in polydrug use was noted.

Within the ongoing MAX-project, another case-finding study was conducted during April-October 1998 in 47 municipalities. The methods applied were very much similar to those applied in the earlier studies and all municipalities investigated had participated in the 1992 study, however not selected randomly. No estimates or other results have however been published yet, but a report is expected before the end of this year.

Preliminary information however reveals that if all 47 municipalities are analysed together and are being compared to the 1992 situation, it is obvious that there has been an increase in severe drug use in those municipalities participating. In what extent conclusions can be drawn

from this on a national level is not easy to determine. There is however no doubt that these results point out that the there has been an increase in severe drug use also on the national level, however not yet determined in what extent.

Unlike earlier case-finding studies, the one of 1998 also asked for some background information on social characteristics. Those results will be reported later on during the year of 2001.

A local case-finding study in the County of Uppsala (fourth biggest city in Sweden) was carried out in 1997 using the same methods as the studies mentioned above, except no capture-recapture procedure was exercised (Olsson 1998). This study suggested an increase in severe drug use in the County during the 1990s. In 1992 the number of known severe drug users reported were 455 and in 1997 730 (3.8 per 1,000 inhabitants 15-64 in 1997). One part of the explanation to the increased number delivered by the researcher is that the 1997 study in a high degree was locally orientated/supported and that the participants therefore were more willing to participate in the reporting process.

The study in Uppsala County was repeated in 1999 (Winfridsson and Dahlman 2000). The total number of known drug users reported was practically the same as 1997 (some 1,900) but out of those only 491 were classified as severe abusers (2.5 per 1,000 inhabitants aged 15-64). This is a 30% decrease compared to 1997. The researchers points out that due to an increase in "don't know"-answers for some crucial variables, the actual decrease might be much smaller. Another reason for the lower figure is that many older users reported by the police turned out to be ex users, had moved etc. In the 1997, there were no thorough checks for "routine-like" reporting of users not actually fulfilling the reporting criteria. This contributes to the drop, at the same time as it suggests why the proportion of older users was lower in 1999 compared to 1997 (see also ST 8).

Since 1996, a similar case-finding study is being carried out in the municipality of Stockholm. Reporting units are the Social Services, Hospitals and other institutions or organisations working with homeless, drug users and mentally disturbed persons (Finne 2000). Reporting period is in October each year, and the reporting time is varying a bit, depending on what type of institution that is reporting, but never exceeding one month.

Sampling only those persons reported for drug use with opiates, amphetamines cannabis or hallucinogens as main drug, one gets a definition of "drug user". Between 1996 and 1998, there seems to have been hardly any change in the number of such users. In 1996, 4.6 drug users per 1000 inhabitants were reported (only persons domiciled in Stockholm are included). Corresponding figures for 1997 and 1998 were 4.7 and 4.5 respectively.

One explanation to the hovering level suggested is that the Social Services has reached its upper limit when it comes to offer special measures for drug users, and therefore only attends the "worst cases" as such. It also deserves to be pointed out that the reporting period is relatively short compared to the other case-finding studies, and that nor the Police or the Correctional system is included in the reporting system.

Regional differences in severe drug use are apparent. In the 1979 case-finding study, 60% of all severe drug users came from the three metropolitan areas and more than 80% of the daily IDU (intravenous drug use) were reported from those regions. No regional estimations are given in the 1992 study, but there are no data indicating any dramatic changes in the regional distribution of severe drug use. Other indicators suggest similar geographical distributions.

Characteristics and Risk factors

Some 23% of the severe drug users in the case finding studies from 1979 and 1992 were women. The female share is not above 15% in statistics regarding drug-related criminality but closer to 20% in statistics on mortality and 30% in statistics on morbidity (CAN and Folkhälsoinstitutet 2000). The gender proportions seem to be quite stable over time.

Several studies concerning background factors of severe drug users have been carried out and together they show that severe drug users in a very high extent are recruited among persons with rather unusual characteristics of their upbringing (Goldberg 2000). Negative home conditions, early problems in school and, later on, a low attachment to the labour market are not unusual. Before the drug use starts off, the person often has showed one or several psychosomatic symptoms like depressions, stomach problems, anxiety etc. The problematic childhood is many times manifested with numerous contacts with different authorities.

A recent study from a female drug treatment ward in Stockholm on 132 treated women during 1994 and 1995 also gave a picture of a multi problematic background (Thorberg 1999). The study also revealed that someone within the family or close to the family had sexually abused 29% of the women during their childhood. The abused women had had an earlier drug debut, were using benzodiazepines in a higher extent and had also more psychiatric problems than the ones declaring not being abused.

It is common knowledge that active drug users often lack socio-economic resources. Severe drug users are often recruited from marginalised groups and the social exclusion many times accelerates along with the drug career. The route to recovery is long and for some very difficult. To many drug users a subcultural gang life is perceived both as the norm and the best way of living at hand. Ex-addicts are not seldom hampered by economical problems, lack of education, work experience and not the least the lack of drug free friends wherefore "complete rehabilitation" sometimes is a difficult goal to achieve.

According to information from the Social Services in Stockholm not more than 40% of the 1,800 drug users who had been in contact with them during 1997 had an apartment of their own. Less than 10% of them had had any elements of working-related incomes. The most common legal source of economic support was (not surprisingly) social allowance, but also temporary disability pension and early retirement pension was at hand (Finne 1998).

The ongoing governmental investigation MAX is focused on drug use and social exclusion and aims at exploring drug use in marginalised groups as well as to study how social exclusion may lead to drug use. The case-finding study carried out within the MAX-project asks for information not only on drug use but also on the drug users attachment to the labour market, housing situation, how the drugs are financed and in what extent the drug user has any social interaction with non drug users.

Some studies have already been carried out dealing with analyses of already existing information in various registers (Guttormsson et al 1999 and Svensson 2000), while others consisting of interviews with key personnel and professionals on the field as well as drug users still are under progress.

Selecting persons treated for drug dependence (ICD 302.A-X) from the Social Database run at the Epidemiological Centre at the National Board of Health and Welfare (NBHW), Svensson (2000) analysed the social and economical development for this group and made comparisons with the total population. Distinctive features of the group, especially compared to the total population, was an unstable housing situation, a bad financial position, high morbidity and mortality rates, and a high degree of criminal experiences.

The working related incomes decreased during the period analysed. When unemployment rose, this group seemed to be struck at an early stage. The income loss was compensated with various social allowances and pensions. The disposable income actually increased during the period, but in a lesser extent than it did among the total population. The proportion with a high level of social problems (simultaneous economic, employment and housing problems) increased from 3% in 1987 to 8% in 1996 and it was concluded that the drug using population had become more marginalised during the period investigated.

Risk behaviours

Practically no detailed research has been done the recent decade on drug using patterns among regular/severe drug users (i.e. amounts, frequency etc). Amphetamine users are still dominating in numbers. Periods of amphetamine use are followed by periods of rest, when there can be substantial elements of use of sedatives as well as alcohol. Intravenous heroin users at the other hand inject on a more regular basis and therefore more frequently.

The number of drug users reported to be intravenously infected by HIV has declined during the latter part of the 1990s, from an average of approximately 30 persons during the first half to below 20 during the second half. Also incidence of hepatitis B and C has declined or at least stabilised during the latter part of the 1990s. The decreases could partly be an effect of a stabilised situation after the initial phases, but also due to changed risk behaviour. Information campaigns on these infectious diseases have increased awareness about them in the general and massive testing ought to have had impact as well, both for the users and to other persons in their environment.

3. Health Consequences

3.1 Drug treatment demand

Data on treatment for narcotic drugs within the Social Service are quite scarce. One indicator presented by the NBHW is the number of persons (voluntarily) treated for problems related to alcohol, drugs, pharmaceutical products and/or solvents. On a census day (1 November), some 3,700 persons were receiving treatment in institutions or foster homes according to the Social Services Act (SoL) in 1983. This figure rose to 4,300 in 1989 but has declined during the 1990s and amounted to 3,200 persons in 1999 (Socialstyrelsen 2000a).

Compulsory institutional treatment according to the Care of Alcoholics, Drug Abusers and Abusers of Volatile Substances (Special Provisions) Act (LVM) has followed the same trend. In 1983 the number of treated persons were 229 on a census day. In 1989 there was a peak (748) but in 1999 the number was down in 257.

The Social Service do not only offer institutional treatment to persons with problems related to alcohol, drugs, pharmaceutical products and/or solvents but also outpatient care and housing allowance. If one includes all Social Services treatment measures for substance and alcohol abuse, some 20,000 persons received treatment on a census day in 1999. Since no distinguishes are made between alcohol, narcotic drugs or other type of drugs in the statistical presentations from the NBHW, this statistical source will not be used any further.

It could be mentioned that a limited share of the therapeutic communities produce formalised data on treated drug users. (The Governmental Drug Commission proposed in 1999 that this

should be an obligation for such units.) One exception to the lack of data from treatment facilities for drug use is the units offering compulsory treatment. Reported statistics from this type of treatment does however not separate compulsory treated drug users from other persons treated in such facilities and are only available for three years, and will not be used in this report. One should also bear in mind that drug users put in compulsory treatment is a very special group and that this treatment type has been used in a varying degree over the years. The number of compulsory treated drug users of narcotic drugs on a census day rose from 16 in 1983 to 316 in the peak year of 1994 and has declined to 145 in 1999. The usefulness is therefore quite limited for this source as well.

In line with the Treatment Demand Indicator work by the NBHW all treatment units running programmes for alcohol and substance abusers conducted a study on a census day in 1999, including residential treatment, counselling, detoxification and prison and probation services Aggregated data for each unit were collected and some 24,000 persons (18 years and above) receiving some form of treatment for misuse problems were found in the study. Most of them, 86%, were undergoing outpatient treatment. Almost half of them (48%) were receiving treatment for alcohol misuse only, 19% for drugs only (including medicines) and 33% for both alcohol and drugs. This study will be repeated every second year (Socialstyrelsen 2000b).

To compensate the lack of time series regarding treatment on narcotic drugs within the Social Services, one can use hospital data from the National Hospital Discharge Registry, run by the Epidemiological Centre at the NBHW. It is worth emphasising however that many drug users treated in therapeutic communities/residential care and similar type of facilities have passed a detoxification clinic and is therefore present in this statistical source.

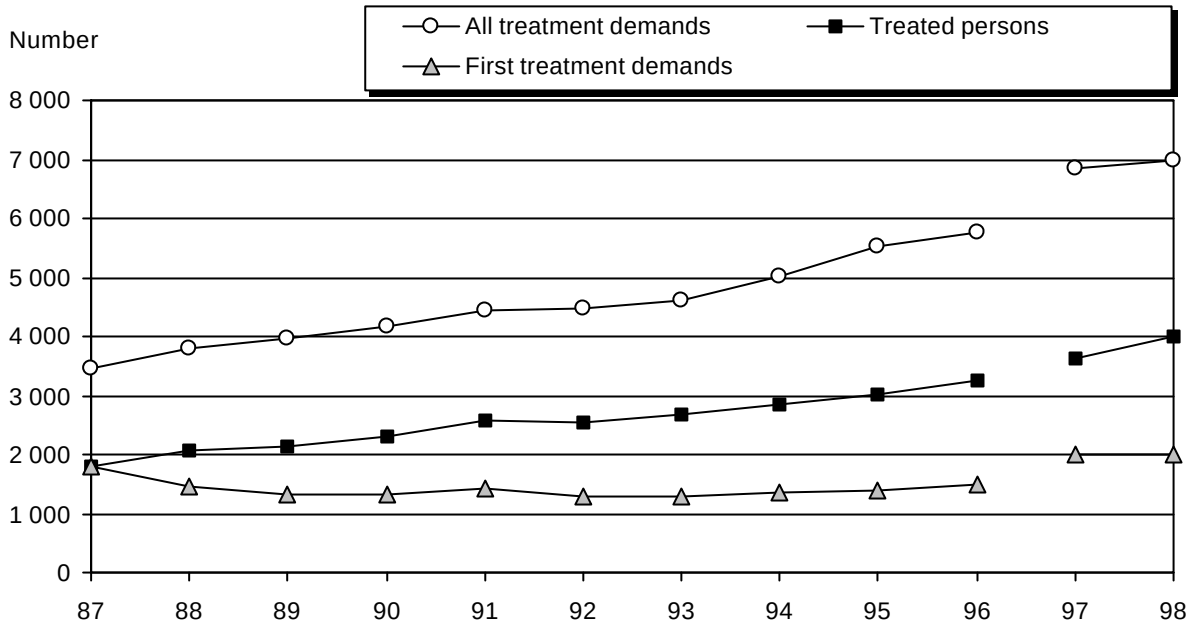
The registry covers all inpatient somatic and psychiatric care and is based on discharges. Information is accessible electronically from 1987 to 1998. In 1997 ICD9 was replaced with ICD10, which definitely complicates comparisons over time (the 304 was used before 1997 and currently the following codes are being used: F11.1-F11.9, F12.1-F12.9, F14.1-F14.9, F15.1-F15.9, F16.1-F16.9, and F19.1-F19.9).

Between 1987 and 1996 the total number of all hospital discharges due to drug addiction (ICD 304, primary diagnosis) increased with 67%, or from 3,455 to 5,769 in absolute numbers (Graph 2 and ST 4). During the same period the mean age increased from 30 to 33. The same average age was found in 1997, but the number of treated persons had increased with some 1,000 persons that year. Also the sex distribution (72/28) remained unchanged. This indicates that the same type of population still might be covered, in spite of the ICD-change. The yearly average increase of discharges was 6% between 1987 and 1996. The increase was 19% in 1997, which ought to indicate that applying the new ICD 10-codes has lead to an "unnatural" increase, wherefore the time series have to be considered disrupted.

The single drug category contributing the most are opiates and the proportion treated for opiates have increased somewhat 1990-1998 while stimulants remain the same and cannabis has dropped somewhat. The biggest group is multiple drugs (F19.1-F19.9) however, contributing with 43% of all discharges in 1998. Diagnosis with cocaine and hallucinogens contributes with less than 1% of all discharges respectively.

The numbers of treated individuals on an annual basis obviously takes a position between all treatment episodes and first treatment demand. The figure is the same as for first treatment demand in 1987 and the trend does not deviate from that of all treatment demand or first treatment demand.

The trend of first treatment demands is a bit difficult to interpret. One of the obstacles is that there is no linking to the Discharge Registry prior to 1987. This means that it is not possible



Graph 2. The number of all hospital discharges resulting from drug addiction; all treatment demands, treated persons and first treatment demands since 1987. 1987–1998.

to control for treatment demands made before 1987, and that the figures, especially at the beginning of the time series, thereby are overestimating the number of first treatment demands made.

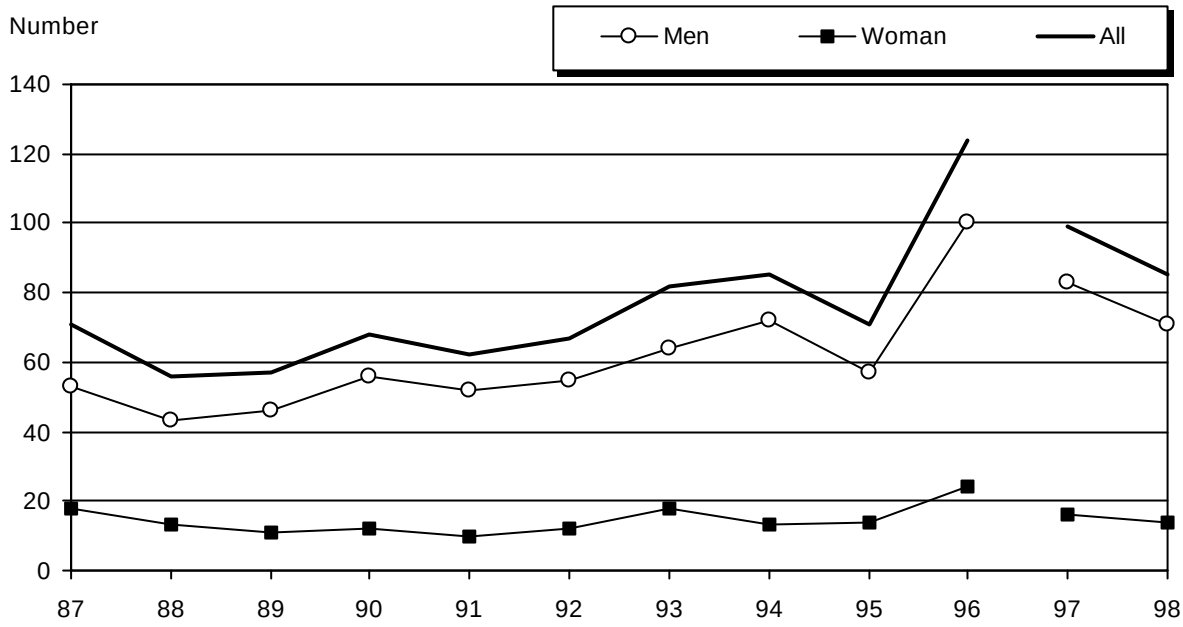
In 1987 there were 1,798 first treatment demands made and in 1992 the numbers had decreased to 1,283. It is likely that the decrease to a great part is fictitious and caused by the non-existing linking possibilities for the years before 1987. In 1996 the figure had increased to 1,492 (a 16% increase since 1992). The figures for 1997-1998 (about 2,000) cannot be compared to the earlier period, again because of the ICD-change.

3.2 Drug-related mortality

Data on drug-related deaths originates from the Cause of Death Register, which has national coverage and is more than 99.5% complete. In 1997 ICD10 was introduced and the codes selected are: F11.1-F11.9; F12.1-F12.9; F14.1-F14.9; F15.1-F15.9; F16.1-F16.9; F18.1-F18.9; F19.1-F19.9. The ICD9 selections are: 304.1-9. Only underlying death causes are included.

Since 1987 there has been a slight increase with a peak in 1996 when 124 deaths were recorded (Graph 3). It is not clear what the classification change in 1997 meant for the drug-related deaths–actually, the question is whether the drop in the two subsequent years following the introduction of ICD10 was an actual trend or the result of the new classification. Additionally, the share of females was somewhat lower 1997 and 1998 (16%) compared to the average share of 20% between 1987-1996.

The average age at death increased more or less steadily from 32 years in 1987 to 38 years in 1996. The following year it dropped below 37, and in 1998 to 35 years. The decrease coincides with the change of ICD revision and indicates that we might be looking at a somewhat different population. On the other hand one could not possibly expect that no changes at all



Graph 3. The number of drug related deaths. 1987–1998.

would occur, shifting into a new ICD revision. It seems that the consistency is acceptable under the circumstances and the populations approximately the same.

It cannot be established to what extent the increase in drug related deaths is due to more dangerous drugs or combinations of drugs (like poly abuse), increased morbidity and decreased life expectancy among drug addicts, or if it is an increased population of drug users. Obviously, some or all these factors can have had a simultaneous effect on the number of deaths.

A local register on drug-related mortality has been running since 1985 and consists of information from all deaths investigated by the Department of Forensic Medicine in Stockholm (catchment area: the counties of Stockholm, Södermanland and Gotland with in all 2 million inhabitants) (Narkotikakommissionen 1999b). The trend of the local register shows a more linear increase compared to that of the Cause of Death Register but the direction of the development is basically the same. Unfortunately, this register offers no data after 1996.

Some studies on mortality among drug users have been carried out. In one study hospitalised drug users in Stockholm County during 1971–1972 were followed through to 1984 (Adamsson-Wahren 1997). The excess mortality in the cohort was 5.3 compared to the general population. Opiate users, particularly males, were at an extremely high risk. Also the central stimulant users (amphetamines), mostly intravenous, were at a high risk. An average of 2.3% of the patients died annually, while the opiate users reached 3.1%.

A similar study among 1,640 drug addicts treated at a Stockholm hospital between 1981-1988 and followed up 1992 has been carried out (Fugelstad 1997). The annual mortality was 2.2%. The highest mortality, 4.4%, was found among heroin addicts (not enrolled in methadone treatment).

It should be noted that the mentioned studies were made on selected groups in a particular city. Other studies in other regions or smaller and even more selected groups might show different mortality rates. For example, persons excluded from the Stockholm methadone treatment programme reached an annual mortality above 10% (ibid.).

In a later study, using the national hospital discharge register, the annual mortality was 3.3% among opiate users, expressed as the average for the years 1987-1994. Among amphetamine users the average mortality during the period was 1.4%, and among multiple (poly) abusers 2.3%. When comparing the separate years no particular trend was discernible (Svensson 2000).

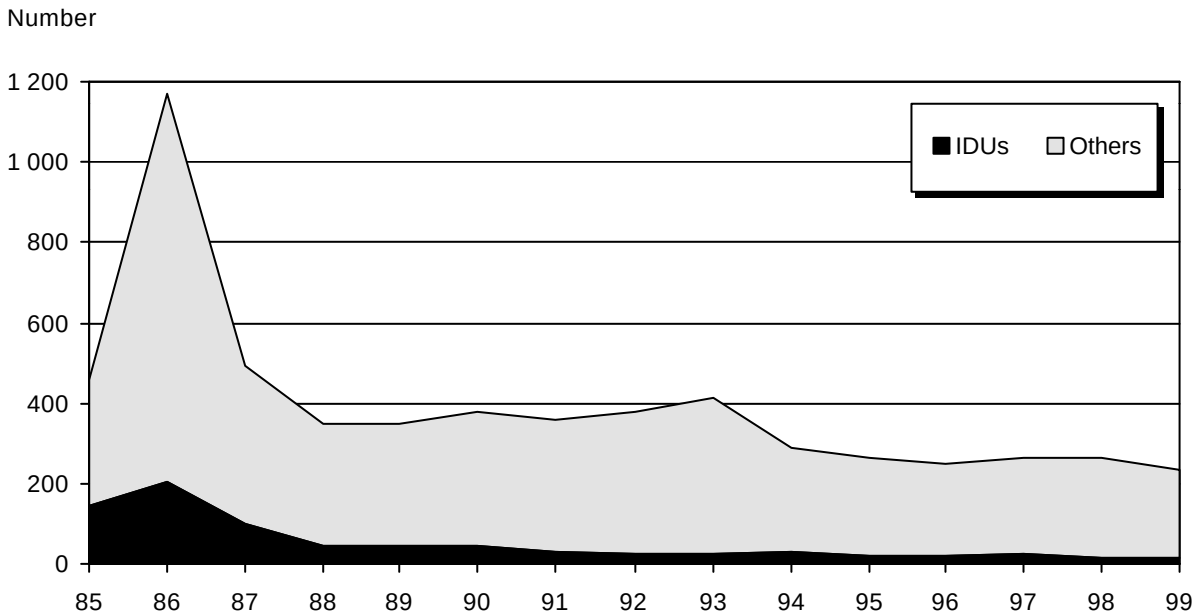
3.3 Drug-related infectious diseases

Since this years National Report includes a comprehensive Key Issue-chapter on infectious diseases (paragraph 14) only a brief overview are presented in the following. As described previous year, there are hardly any estimates on the prevalence of HIV and hepatitis among drug users. One study resulted in the following: overall seroprevalence were 14% for HIV, 75% for hepatitis B and 92% for hepatitis C. In another study 3% of 195 IDUs gave HIV antibody seropositive saliva samples. A third source determined the proportion IDUs infected with hepatitis C to 90%.

In common for those studies, apart from being closer described with references in chapter 14, is that they are conducted among small samples from metropolitan recruited among certain institutions.

The number of reported cases of hepatitis and HIV/AIDS are centrally notified. A total of 5,132 HIV-infected persons had been notified at the end of 1999 and out of those 788 were intravenously infected and classified as IDUs (15%) (Smittskyddsinstitutet 2000).

The trend of incidence is a slightly decreasing one, both for intravenously infected and other transmission routes (Graph 4). In 1999 15 IDUs were reported, the lowest figure ever. The proportion of intravenously infected, compared to all cases reported, has decreased over time. Out of all 788 intravenously infected, a total of 193 persons had developed AIDS by the end of 1999. Out of those, 144 persons were deceased at the same point of time.



Graph 4. The number of clinically reported HIV-positive persons per year due to IDU and other ways of transmission respectively. 1985-1999.

Between 1990-1999 a total of 921 cases of hepatitis B due to IDU have been reported, which comprise some 42% of all HBV-cases reported that period.

During the same period about 27,875 hepatitis C-cases was reported and out of those 18,481 was due to IDU (66%). The 1999 figure (1,495) was the lowest ever reported for HCV (due to IDU) but for HBV the 1999 figure was higher than the ones of the three preceding years.

3.4 Other drug-related morbidity

It is common knowledge that the use of drugs for various reasons is associated with health risks of varying extent. It is also well established that mortality and morbidity among severe drug users, especially heroin users, are many times greater compared to the same age groups among the total population. There are several reasons for this and they could schematically be divided in three categories.

One is complications due to pharmacological effects of the drug (of which heroin overdoses could be an example). There are however no information on non-fatal drug emergencies available from emergency rooms, ambulance rescues or similar sources. Secondly, the administration route is of importance, infections are easily obtained via intravenous use, but also diseases as endocarditis. It is not possible to detect drug users within the in patient registry, apart from the drug-related diagnosis's themselves, and therefore there is difficult to obtain information reflecting this problem. The already given information on hepatitis and HIV are of course an exception, and obtainable due to the Communicable Disease Act. The third and maybe even the most important reason for health problems are negative conditions in the way of living that many severe drug users have. A wide spread multiple use of drugs, medicines and alcohol, criminal lifestyles, difficult living conditions in general, and great risks of being exposed for violence as well as accidents is of course negative for the health.

During the 1990s the phenomena of double diagnosis, both drug problems and a psychiatric diagnosis, has been given attention (number 6 1999 of CANs periodical journal *Alkohol&Narkotika* was devoted to the subject for example). Many drug users are attended at psychiatric wards at hospitals and according to an inventory by the NBHW, there were 413 drug users treated at in-patient psychiatric units on a census day in 1997, either for drug dependence or drug psychosis. This figure corresponds to 5% of all patients in psychiatric care on the same occasion (CAN and Folkhälsoinstitutet 2000). Due to changed statistical routines it is difficult to make comparisons with previous years but unquestionable the 1997 figure rates all time high.

To conclude, there are practically no sources apart from the ones already put in use in previous paragraphs that systematically can provide information on the development of the health status among drug users. It is actually difficult to find even smaller studies following or describing morbidity among drug users.

4. Social and Legal Correlates and Consequences

4.1 Social problems

Social exclusion and public nuisance

Apart from what has been said already in paragraph 2.3, there are not much existing data that can describe developments of problems with housing, unemployment and such, for drug users. The ongoing MAX investigation, and other research projects, will partly change this.

Nuisance problems cause local concern, and sometimes there are serial stories on this in the media. The normal picture presented is the one of an (older) drug using man, causing disturbances for the neighbors due many late visitors, car speeding, burglaries etc. There exists however no information of an epidemiological nature to describe this phenomena.

4.2 Drug offences and drug-related crime

The number of persons suspected of offences against the Narcotic Drugs Act and the Goods Smuggling Act (only drugs included) has continuously been increasing since the middle of the 1980s. A total of 6,567 suspected persons were reported during 1985 and in 1998 (last year available due to changes in statistical and database routines at the police), the corresponding figure was 11,490 persons, a 75% increase (Brottsförebyggande rådet 1998, updated with data base on www.bra.se). The hump in the statistics early 1980s is an effect of extra efforts from the police on the street/user level (Graph 5 and ST 11).

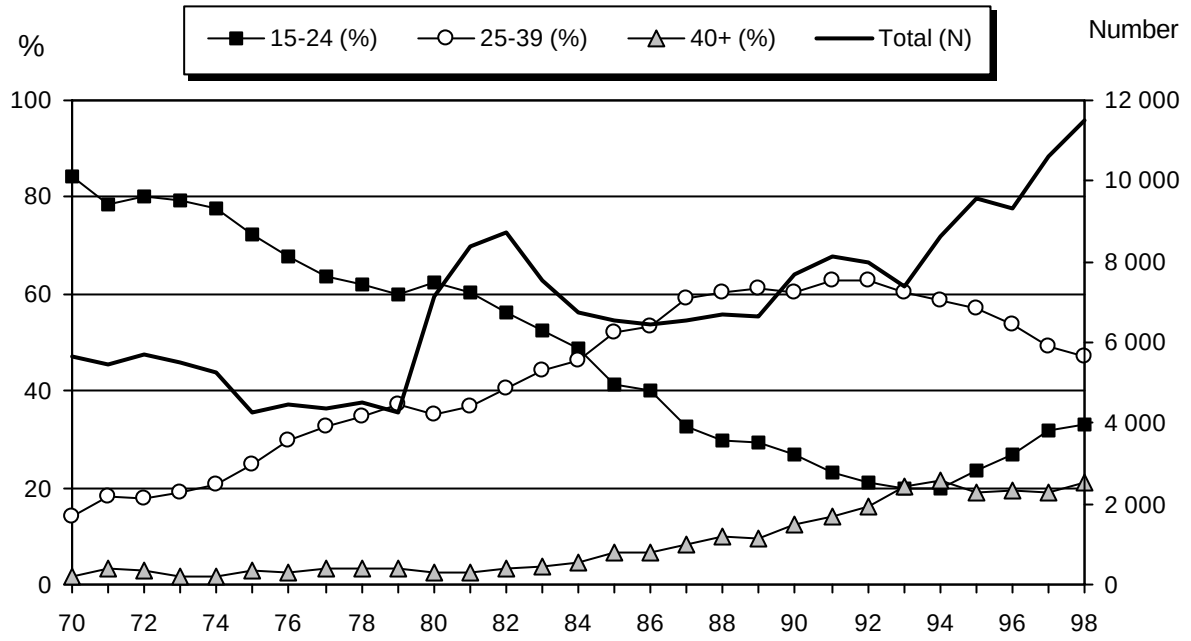
Only a smaller share of all persons suspected for drug crimes were suspected for drugs smuggling. This share decreased from some 15% in the 1980s to 4% in 1998, a decrease also in absolute figures and the 1998 figure (441 persons suspected) was one of the lowest since 1970.

The vast majority was suspected (at least) for use or possession, and this share has increased from 76% in 1975 to 92% in 1998. The share suspected for pushing/selling or manufacturing drugs has dropped from 40 to 19 % between 1975 and 1998. (Since one person can be suspected for several crimes the percentages exceed 100.)

Early 1970s, 85% of the drug crime suspects were less than 25 years old. That share dropped continuously until it reached 20% in 1993. However, the share of suspects younger than 25 years old have increased during the latest years and made up to 33% of all persons suspected for drug offences in 1998. The trends of the 25-39 year-olds are a rather opposite one, with an increase up to 1993 and thereafter a drop. The proportion of persons 40 years and above seems to have stabilised during the second half of the 1990s, on a 20%-level.

The increase among 15-24 year-olds during the 1990s suggests an increase in drug use among younger persons. It is however not easy to determine in what extent, since police activities seems to have been directed towards youngsters in a higher degree than before.

The number of sentences (including summary convictions) for offences against the Narcotic Drug Act or the Goods Smuggling Act (only drugs included) have according to Graph 6 and ST 11 increased, from 2,601 in 1975 to 10,377 in 1998, a 300% increase (Brottsförebyggande rådet 2000a).



Graph 5. The number of persons suspected of offences against the Narcotic Drugs Act or the Goods Smuggling Act (for drugs smuggling) and the age proportions among them. 1970–1998.

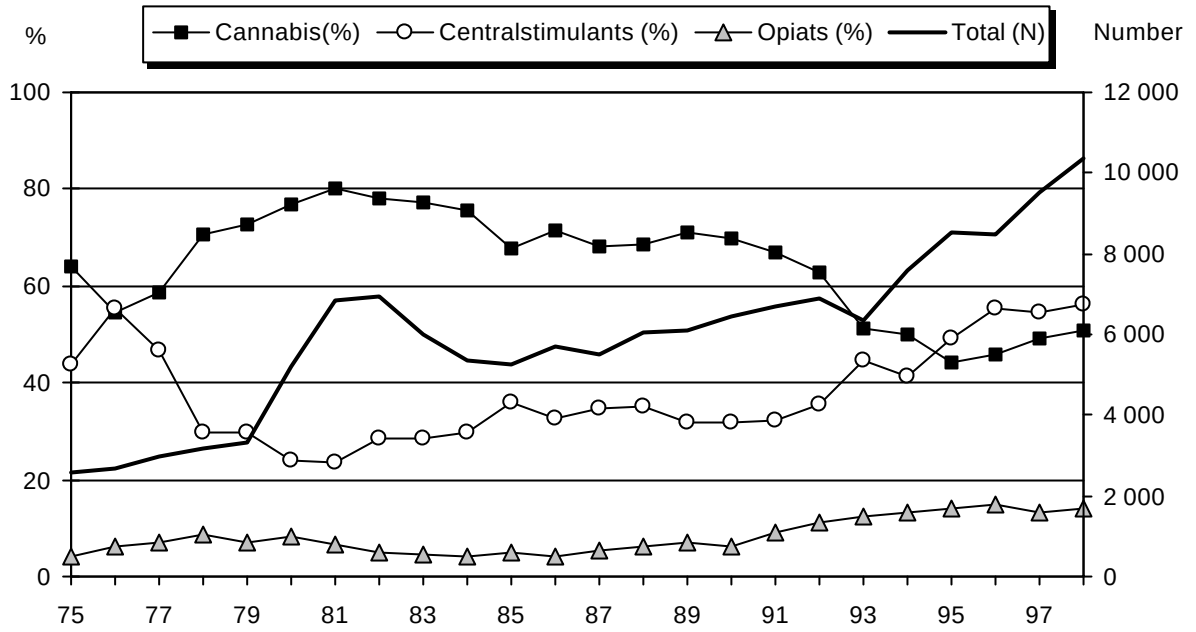
Out of all drug related sentences cannabis was involved in 51% of the cases in 1998. Corresponding figures for amphetamines and opiates were 56 and 14% respectively (totals to more than 100% because several drugs might be present in one sentence). Since 1990 there has been a drop for cannabis but an increase for opiates and amphetamines.

Since 1988 information on imposed sanctions are available and the proportions between different sanctions have been more or less the same. In 1998, about 38% of the sanctions led to fines, 27% to prison, and some 14% to prosecution waivers or probation respectively, and finally, 8% led to other sanctions. The most common length of imprisonment in 1998 was from two to six months (ibid.).

On a census day (1 April) 1,336 prison inmates were classified as drug users in 1985 (according to information captured at the prison admission). Of all inmates the proportion of drug users were 37% that year (Kriminalvårdsstyrelsen 2000a). A drug user is here defined as someone having used drugs at least once during the twelve months preceding the imprisonment. That share was pretty stable between 1986-1996 (some 40-42%) but rose to 50% in 1998 and dropped slightly to 47% in 1999. In absolute numbers 1,652 inmates out of 3,537 were classified as drug users. Before 1997, the period in question was only two months, which partly explains the higher level (please also see ST 2).

However, the total number of inmates peaked in 1994 (4,581 persons). The explanation for the drop is that electronic intensive surveillance of convicts outside prisons was fully and nationally implemented during 1997. That type of sanction seems to be less commonly used among drug users since their share of the prison population has increased.

In 1999 a total of 9,300 persons were in prison at any time during the year. More than half of them were drug users and out of those 75% were classified as severe drug users (injected drugs at least once during the twelve-month period before imprisonment or daily or almost daily drug use no matter what routes of administration).



Graph 6. The number of sentences for offences against the Narcotic Drugs Act or the Goods Smuggling Act (for drugs smuggling) and the proportions between different drugs involved. 1975–1998.

No known estimates are at hand giving information on what proportions of thefts, criminal violence, etc that are drug-related or not.

4.3 Social and economic costs of drug consumption

Estimates of the societal costs due to use of alcohol and other drugs are very difficult to calculate, illustrated by that almost no research has been done, and that the few attempts made have attended criticism. One problem is to determine what expenses that should be included in the calculation and another to determine the size of them. One of the attempts to calculate the societal costs of alcohol problems in Sweden was published by Johnson (2000). A final comparison in his book was between alcohol and narcotic drugs. The costs for fall in production, treatment and property losses were estimated at 10 and 3.5 billion Euros respectively. Unfortunately, only the calculations for the alcohol costs were accounted.

In 1992, an attempt to calculate societal costs (Governmental and Municipalital) from drug use was made by the Swedish National Audit Office (Riksrevisionsverket 1993). The cost of a typical severe drug user career was estimated at between 0.2 and 0.5 million Euros in 1991. The interval is due to varying costs depending on the length of the drug career and the type of drug abused. The total sum for that year due to drug use, including costs for care, treatment, the Correctional System, the Judicial System and the Social Services, was estimated at 0.4 billion Euros.

An attempt to update this estimate to the 1998 situation was published by Nilsson in 1999. If possible, the 1991 expenditures were updated and drug-related costs for the Customs and for property losses stemming from both companies and private persons were added as well. The total sum for drug-related costs during 1998, both public and private, was estimated to a minimum of 0.7 billion Euros.

It must again be emphasized that the figures given above are only rough estimates and very much depending on what posts that are entered in the calculations. Maybe the most fundamental problem is to determine whether it is actually the drug abuse, or some other problems, that is the real cause for the costs that drug users generate.

Estimates on the total drug consumption and expenditures related to this are even more rare. One recent example can however be found in a Report of the Governmental Inquiry Commissions i. e. SOU-series (SOU 1998:18). The NIPH was asked to calculate the total consumption/demand on drugs, among other things. Estimates were given for amphetamines, heroin and cannabis and the figures refer to the 1996 situation. Using different scenarios the amount of amphetamines consumed during 1996 was calculated at between 600-1,500 kilos. Corresponding intervals for heroin and cannabis were 250-500 kilos and 2,500-3,250 kilos respectively. The Commission used the upper levels of the intervals and calculated that the street value of those drugs amounted to some 0.1 billion Euros.

5. Drug Markets

5.1 Availability and supply

Practically all drugs used in Sweden are imported, often via the south of Sweden, i. e. the Scania region. This is not surprising given the fact that Scania's ports are the gateway to the continent. The drug market in this region is also more or less regarded much as a part of the Danish one. Many cannabis users in Scania have always been, and still are, tourist traffickers to Denmark. The main drug markets are in the three major metropolitan areas of Stockholm, Malmoe (located in the Scania region) and Gothenburg. The following information originates from a report on the Swedish drug situation 1999 compiled by the National Criminal Investigation Department (Rikskriminalpolisen 2000).

According to analyses of seizures made at the National Laboratory of Forensic Science approximately 85-90% of all seized cannabis originate from Morocco. Distribution routes often go through Spain, the Netherlands and Denmark. Swedish citizens living in Spain and the Netherlands many times control the transactions. Operators from the Baltic States have also been identified during 1999. MC-organisations are still involved in the cannabis trade.

The Police have investigated fifty-three cases of home growing during 1999. Apart from being an increase compared to earlier years it is also stated that the home growers are becoming more professional.

For many years, most of the amphetamines seized in Sweden originated solely from two regions, Belgium/Netherlands and Poland. During recent years amphetamines produced in the Czech Republic have been seized in some extent. Seizures from Estonia has also increased, it is however not known where this amphetamine has been produced.

The main markets for heroin still are the Stockholm and Malmoe regions, even if there have been increases in heroin use in other regions, especially Gothenburg. About 90% of the heroin seized is brown, mainly transported through Eastern Europe and seized by Scania customs. White heroin often arrives by air (postal packages or couriers) and the use and seizures of white heroin is concentrated to the Stockholm region. A new scenario arising is white heroin coming from St Petersburg via Finland, not yet of any significance though.

Cocaine has not attracted the market in Sweden in any larger extent. The number of seizures is relatively low, however the quantities might sometimes be very big. Most cocaine seized by the customs is taken in Stockholm and Gothenburg.

Even though there are signs of new distribution routes arising, via Eastern Europe for example, it should be emphasised that the vast majority of the seizures made by the Customs are made at the border of a member country of the European Union.

The best indicators to describe trends in availability of drugs at hand are seizures and price. It can already here be stated that these sources suggest that there has been an increase in availability, at least for some drugs. This seems reasonable considering the increase in demand that has paralleled the increase in availability.

5.2 Seizures

The development of seizures is not only an indicator of supply of drugs but it might also be a result of changes in priorities and resources within the Police and Customs. The Swedish drug scene is intimately linked with developments in the surroundings. A number of external factors such as developments in Eastern Europe and in the European Union have effects on the priorities within the Police and the Customs.

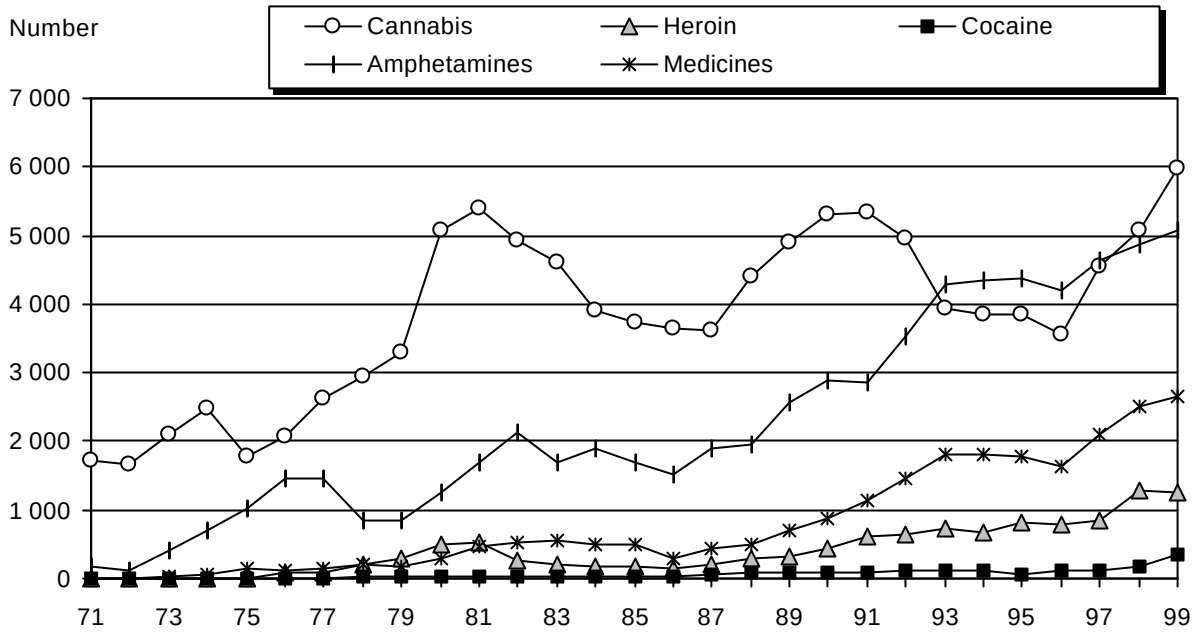
A well-known fact is that the Police make the large majority of all seizures but that the Customs seizes the big quantities. This is evident in ST 13, providing both a total as well as separable data for the Police and the Customs. In Graph 7 the numbers of seizures are presented for a selection of those drugs accounted for in ST 13. Data on seizures are collected from the BAR database at the National Criminal Investigation Department.

The number of cannabis seizures made by the Police and the Customs fluctuated between 4,000-5,000 during 1985-1998. The 1999 figure (6,000 seizures) was all time high. Almost 1,200 kilos were seized 1999, which is about twice the normal average for the 1990s as well as the 1980s. This figure is only outscored on two earlier occasions during the early 1980s. Apart from the high levels in 1999, cannabis seizures have been fluctuating for quite some time, without any obvious trends.

In numbers, seizures of amphetamines have been on a stable increase all since early 1970s. During the 1990s they have gone up from approximately 3,000 to 5,000. The amounts have been fluctuating but a comparison of averages from the three latest five-year periods reveals an increase from 110 kilos a year during the second half of the 1980s, to 140 during the first of the 1990s, and 170 during the second part.

The (low) numbers of cocaine seizures have increased between 1985 and 1999 (from 25 to 346) as the size of the seizures have. At average, 12 kilos a year was seized during the 1980s and the corresponding figure for the 1990s were 140 kilos, partly explained by two major seizures in 1991 (226 kilos) and 1999 (420 kilos). There are considerable fluctuations in the quantities seized, and many of the larger seizures have probably been intended for further transportation to markets outside Sweden (Rikskriminalpolisen 2000 and SOU 1998:18). This is not unique for cocaine, even though it might apply even more for this than other drugs.

Heroin seizures have continuously increased since the mid 1980s, from approximately 160 to 1,200 late 1990s. Comparing the latter part of the 1980s with the latter part of the 1990s reveals that the yearly average for those periods have then-folded, from 3 to 30 kilos. Some possible explanations to this increase might be new routes for the heroin traffic to Norway and improved intelligence work.



Graph 7. The number of seizures of cannabis, cocaine, heroin, amphetamines and medicines made by the Police and the Customs. 1971-1999.

At the beginning of this chapter it was stated that the Police makes the majority of the seizures in numbers but that the Customs makes the majority of the seizures in size. Presented in percentages per drug reported on above, with numbers first and quantities last, the police took 78/33 of the cannabis, 97/58 of the amphetamines, 74/31 of the cocaine and 95/36 of the heroin, at average during the 1990s.

LSD seizures increased from 10 in 1991 to 86 in 1997, but dropped to 37 in 1999. At average some 1,700 doses has been seized annually during the five last years. Also the number of ecstasy seizures shows a low but upward trend: from 10 in 1993 to 160 in 1999. The number of tablets/trips rose from 171 to 73,250 during those years.

Worth mentioning, and also included in Graph 7, is the fivefold increase in seizures of medicines controlled according to the list of drugs (mostly tranquillisers and sedatives). Between 1985 and 1999 the number of seizures rose from about 500 to 2,600. The large majority of those medicines were of benzodiazepine type and the dominating make is ”Rohypnol” (flunitrazepam).

5.3 Price and purity

Unfortunately, information on purity is not systematically collected, even if the purity of larger seizures are analysed at the National Laboratory of Forensic Science. A project on developing a database for routine collection of this information, as well as ad-hoc studies for smaller amounts, is however being planned with the NIPH as co-ordinator.

Information on drug prices reported below is gathered from CANs regional drug-reporting system. For some of the drugs and some of the years the number of persons reporting prizes have been low, which makes the information a bit unreliable. Comparing a number of years reveals no apparent errors in the average prices however, and information obtained from the annual reports from the National Criminal Investigation Department supports the CAN data.

The prices are based on average consumer's prizes for smaller quantities. It should be noted that the drug prices vary quite a lot. They are lower in metropolitan areas and in the south of Sweden and higher in areas with lower population density, especially in the north of Sweden. All prices are calculated with the exchange rate of 1 Euro equal to 8.38 Swedish krona.

Cannabis prizes have remained pretty stable during the 1990s, at about 10 Euros per gram, both for hash and marihuana (please see ST 16). Also cocaine prizes have remained pretty much the same for the last ten years, at some 110-120 Euros per gram. Amphetamine prizes at the other hand have dropped considerably during the 1990s, from 50 to 30 Euros. Also heroin prizes have gone down, from 240 to 200 Euros for white heroin and from 180 to 120 Euros for brown heroin.

LSD and ecstasy prizes are available from 1995 onwards. No major prize changes have occurred for any of these drugs. LSD was some 12 Euros a trip and ecstasy about 22 Euros a tablet during the period. Finally, a single tablet of benzodiazepine-type costs around 1-2 Euro on the illegal Swedish market.

If prices reflect the availability of drugs, the above information indicates that the availability for cannabis and cocaine has been relatively stable during the 1990s, while heroin and, especially, amphetamines have increased in availability.

6. Trends per Drug

6.1 Cannabis

The availability of cannabis seems to have been quite stable throughout the 1990s, according to seizures and price developments seen in longer perspective. The 1999 cannabis seizures were by all means exceptionally big, both in numbers and kilos, but temporary fluctuations have been seen before and one must not jump to conclusions using data from a single year.

It is however a well-established fact that during the 1990s, a growing number of younger people state that they have tried/used cannabis. In 1999 8% of grade 9 students and 16% of 18-year old male military conscript reported this, while some 13% of the total population aged 15-64 reported lifetime prevalence of cannabis in 1999. Whether the severe drug users, of whom many are frequent cannabis consumers, have changed consumption patterns is not known, but to say the least, no information available indicates a decreased demand in cannabis.

An alternative source to smuggling is domestic production. Some signs indicate that both small and medium scale home growing have increased. One example of increased home growing is that the (relatively low) number of military conscripts stating that they grow their own cannabis has doubled between 1992 and 1999. During 1999 the police investigated 53 cases involving home growing, which is more than previous years and according to information from the Police, the production has become more professional. This might be explained by the fact that seeds, growing instructions and equipment have become more easily available recent years, not the least with the growth of Internet as a partial explanation.

6.2 Synthetic drugs (amphetamines, ecstasy, LSD, other/new synthetics)

Availability of amphetamines has no doubt increased throughout the 1990s. Prices have dropped substantially at the same time as seizures have increased, both in numbers and amounts. After cannabis, amphetamines have always been the second most common drug experienced by the Swedish population. Approximately 2% of those 16-64 years old have reported lifetime prevalence. According to various surveys amphetamines also rates second among youths, and is increasing in magnitude. For example, less then 1% of the military conscripts reported lifetime experience of amphetamines in 1992 and that figure was four folded in 1999 (3.5%).

IDU in Sweden has traditionally primarily involved amphetamines but various sources indicate that opiates might be more common than amphetamines among younger IDUs, at least in some regions. Still, amphetamines dominate the IDU. It is however not known whether the low prices have lead to an increased frequency of consumption within the group.

Especially younger persons interested in modern dance music have (together with amphetamines) used ecstasy and LSD, as so-called party drugs during the 1990s. Among younger age groups, experience of LSD and ecstasy is more common than of cocaine (in contrast to older generations). The upward trends for those drugs seem however to have tapered off during the most recent year according to surveys. Data on seizures still show upward trends, however at relatively low levels. Prices reported show no specific trends during the second part of the 1990s. The prices are however reported in relatively large intervals, indicating that the supply/availability is unstable and that these drugs are not fully established all over Sweden.

A relatively new synthetic drug in Sweden is GHB (Gamma Hydroxybutyric Acid). GHB was at first used among body builders but the use has spread among (especially) teenagers, used primarily as a recreational drug because of its alcohol-like intoxicating effects. There is hardly any systematic information on the trends in use, seizures, prices etc. This is due to the recent spread and the fact that GHB did not became classified as a narcotic drug until February 2000, an action that at least makes it a drug that there will be more research made upon.

Information from Härnösand and Gothenburg hospitals, areas with pronounced GHB-problems, indicated drops in the emergency room visits due to GHB during winter 1999/2000 (Folkhälsoinstitutet 2000). Whether these drops were temporary or not, or whether this drop will be boosted by the new legislation, is to early to tell, just as they can not be generalised to the situation in other cities.

6.3 Heroin/opiates

Several sources indicate an increase in heroin use during the 1990s (for example mortality and morbidity figures as well as criminal statistics). Two local studies, one in Stockholm (Käll et al 1996) and one in Malmoe (Tops and Silow 1997) have showed that the proportion of opiates among severe users has increased on the expense of amphetamines, and that opiates nowadays are more common among the younger generations of severe drug users than amphetamines are. Many of the new users smoke the heroin, at least initially. Numerous sources in the treatment field report that many heroin users change from smoking to injecting and a major reason for this is that heroin prices are still relatively high and that injecting is more cost-effective.

The sharp increase of heroin seizures during the 1990s, both in numbers and kilos, paralleled with a decrease in prizes, suggests that heroin has become more available on the market. Still no spread outside the “traditional” user groups has been traced. Lifetime prevalence in the

general population is practically zero and despite of an increase during the 1990s, the lifetime prevalence among the military conscripts is still below one percent.

6.4 Cocaine/crack

Cocaine is the thirdly most common drug experienced among the adult population. This drug has never won any popularity among severe drug users. It has rather had the reputation of being an expensive jet set drug for celebrities and mostly used by people taking part of the life of pleasure in the major cities.

Seizures have increased during the 1990s, but with fluctuations that are not that easy to interpret. In 1999 420 kilos was seized, an exceptionally large seizure and just as much as the total of the previous years during the decade. As stated before, at least parts of these seizures must have been intended for other markets than the Swedish one. Cocaine prices have remained more or less the same throughout the 1990s and no significant increase in use have been spotted in surveys or other types of data. For more details on the cocaine situation, please consult chapter 13.

6.5 Multiple use (including alcohol, pharmaceutical products, solvents)

Polydrug use (including alcohol and sedatives) is the most common type of drug use among severe drug users, even if there is a drug of choice. This is evident analysing data from the inpatient registry for instance. An example of an increase in multiple drug use among severe users was for noted when results from the national case finding study from 1992 was compared to the earlier one from 1979 (Olsson et al 1993).

Some sources indicate an upward trend in multiple use during the 1990s. Crime statistics regarding sentenced persons reveal that the proportion of persons sentenced for drug crimes with a single substance have decreased from 85% in 1990 to 61% in 1998 (CAN and Folkhälsoinstitutet 2000). The proportion of blood and urine analyses from persons suspected of drug use that included more than one drug increased from 50 to 60% between 1994 and 1998. While the proportion of the drug users in prison have increased the proportion of persons with both alcohol and drugs problems have however remained the same during the 1990s (Kriminalvårdsstyrelsen 2000a).

As already mentioned, there are many signs of an increase in the use of particularly medicines during the 1990s among severe drug users, especially benzodiazepines. The number of medicine seizures five folded in numbers between 1985 and 1999 (from about 500 to 2,500). A total of 175,000 tablets were seized in 1999, most of them tranquillisers and sedatives of benzodiazepine-type. About one third of all police seizures and half of the customs seizures in 1998 (of medicines) were flunitrazepam tablets of the make “Rohypnol”.

There are no reliable sources that can describe the developments of illegal medicine consumption among severe drug users. There are many “field-reports” though, stating that there has been an increase in use. Among heroin users benzodiazepines might replace or strengthen heroin effects and among amphetamine users these types of substances are popular as “downers”, when a period of amphetamine use is at end. According to several reports Rohypnol are also injected and smoked. Rohypnol smoking has been given attention in a Swedish Medical Journal where the authors presented some cases where patients had suffered from severe coughing related to such drug intake (Greitz et al 1998).

Among the military conscripts 4% stated illegal use of sedatives or tranquillisers in 1999, which is four times more than in 1992. Not much is known of the illegal use in the general population.

It is not easy to determine whether the sources and examples mentioned above give a correct picture of the trends or not. Reports on increases in multiple use can actually be found in the literature since the late 1960s. There are however not any known sources indicating a decrease in multiple use during the 1990s. Considering the increased availability of a number of drugs, alcohol, and other substances as well, the statistical indicators might very well give a correct picture of a continuos increase in multiple use and mixing of various drugs.

Solvents use is not normally a component of multiple use among severe users. In the 1992 case finding study the frequency of sniffing was less than 1% among the severe users. Approximately one percent of all persons undergoing compulsory treatment had volatile solvents as at least one component in their drug use leading to treatment (CAN and Folkhälsoinstitutet 2000). Solvents sniffing are more related to younger teenagers. Various surveys reveal that multiple use often is at hand among younger persons experimenting with drugs (Andersson et al 2000 and Guttormsson 2000). For example, the ones drinking larger quantities of alcohol is more likely to report experience of tobacco, drugs, inhalants and doping substances than the others using smaller quantities of alcohol are.

7. Discussion

7.1 Consistency between indicators

Throughout the 1990s the seizures of several drugs have increased. Particularly seizures of amphetamines and heroin have gone up significantly during the period, especially in numbers but also in kilos. Increase in seizures holds true also for LSD, ecstasy and cocaine, but at much lower and more fluctuating levels. Heroin and amphetamine prices have decreased significantly during the decade. Ecstasy and LSD prices fluctuate and the price intervals reported are considerable, probably due to limited availability. Cocaine and cannabis prices remain relatively unchanged and also the cannabis seizures have more or less hovered during the 1990s, both in numbers and size (apart from the very high figures of 1999). To sum it up, availability of particularly heroin and amphetamines seem to have increased during the 1990s and there are no signs of this these trends to taper off.

A quite obvious trend observed in regular national surveys during the 1990s is the increase in lifetime prevalence of drugs among Swedish teenagers. Among students in grade 9 (15-16 year-olds) the lifetime prevalence of drugs increased from 3% in 1989 to 8% in 1999. During last three years the lifetime figure has been pretty stable though. The increase among the girls seems to have halted since 1996 while the boys still show a small increase.

The upward trend continues among older teenagers however. In the early 1990s, 6% of the 18-year-old male military conscripts had tried drugs at any occasion and the corresponding figure for 1999 was 17%. Similar increases among older teenagers have also been noted in studies done by various polling institutes as well as in repeated local studies.

Also recent use (last year, last 30 days prevalence) have increased among teenagers during the 1990s, even though the figures have not yet reached the levels of the first half of the 1970s.

Most persons having tried drugs, both younger people and adults, have tried cannabis, and the majority have tried cannabis only. The second most commonly experienced drug is amphetamine. Thereafter comes cocaine among older people, but ecstasy and LSD among youths.

To conclude, survey data on drug use show a quite coherent picture of the developments of the 1990s. It is actually difficult finding even local surveys reflecting divergent developments.

Provided data on severe drug use in this report might be more difficult to interpret however. The majority of the provided statistical indicators do however suggest an increase in the number of severe users during the past ten years. This holds true for the national criminal statistics as well as the mortality and morbidity (treatment) data, and is also indicated in some local studies or other more limited sources. It is however not easy to establish exactly in what extent these increases are a sign of an increased number of drug users or the traces of an ageing, and to the authorities well known, group of drug users.

A few indicators also show an opposite development. The number of persons intravenously infected by HIV has declined during the latter part of the 1990s, from a yearly incidence of above 30 per year during the first half to below 20 during the second half. Also hepatitis C has declined or at least stabilised during the latter part of the 1990s. The decreases could be due to changed risk behaviour among IDUs due to massive testing and information campaigns. It could partly also be an effect of a stabilised situation after the initial phases of these infectious diseases. These opposite trends have however not been proposed as evidence of a decreased IDU of any researcher in the drug field.

Apart from general statistical indicators also other type of information sources (local studies etc) suggests that the recruitment of severe drug users is on the rise, particularly heroin users. However, it is too early to draw any specific conclusions on the extent of the increase from this information.

The two national case-findings from 1979 and 1992 suggested that there had a been a 40% increase in severe drug use between those two years. It is questioned and debated whether the national estimates from 1979 and 1992 are accurate or fully comparable. This is a subject for further analysis within the awaited report from the ongoing MAX-project regarding the 1998 case-finding study. No data have yet been released but preliminary results however reveals that if all 47 participating municipalities are analysed together and are being compared to the 1992 situation, it is obvious that there has been an increase in severe drug use in those municipalities. In what extent conclusions can be drawn from this on a national level is not easy to determine. There is however no doubt that these results point out that there has been an increase in severe drug use also on the national level as well, however not yet determined in what extent.

7.2 Implications for policy and interventions

Possible hypotheses for the main trends

Increases in drug seizures might be the result of changed priorities within the police and customs. Another reason might be new distribution routes. The increases in seizures of heroin and amphetamines during the 1990s however ought to be regarded as a reflection of increased availability, especially since the prices have dropped. Apart from an increased production and supply of drugs on the world market, which naturally affects also Sweden, the “opening” of Eastern Europe might have had some impact on the drug seizure figures.

Somewhat less negative attitudes towards drugs have been witnessed among youths during the 1990s, along with an increase in use. Maybe the most common explanation for this change is the adopting of international youth trends. The health oriented lifestyles and drug negative trends of the 1980s have no longer the same impact, instead the reverse might be the case. Both in the USA and in several western European countries similar developments on drug use have taken place. Such trends have a tendency to travel fast, especially in modern post-industrial societies based on information and communication. Sometimes increased access to alternative information, less negative than the official Swedish one, is proposed to have influenced the drug experimenting behaviour. Another explanation to increased drug experimenting among teenagers could simply be the increase in supply/availability.

The Swedish unemployment rates were rather low during the 1970s and the 1980s. During the first half of the 1990s unemployment rates reached relatively high levels, especially among youths (16-24 years). During the late half of the 1990s the figures have decreased, but the unemployment rates in 1998 was still four folded compered to 1989. One possible reason for increases in the severe drug use among younger people that has been proposed, apart from an increased supply, is problems connected to social exclusion and high levels of youth unemployment. Negative future prospects, at least for certain groups of youths, might be a reason for not giving up experimentation with drugs, which in turn might lead to a long lasting severe drug use.

During the 1990s there has been financial cut downs within the general welfare systems, as well as in special forms of treatment (therapeutic communities etc). This might have had impact both on recruitment of new drug users, falling through the welfare net of social protecting, but also on the possibilities to offer drug users appropriate treatment. Statements from social workers, policemen, hospital staff sometimes indicates that the group of severe drug users are worse off nowadays, regarding economic and health aspects, then some ten years ago.

Relevance to policy makers

The increase in supply that has occurred for several drugs during the 1990s highlights the importance of co-operation across nation borders. A growing global drug problem demands international solutions. The international engagement in drug issues, that Sweden takes part in, is therefore an integrated and important element in Swedish drug policy.

New trends always arouse interest, not the least when these involve drugs and young people. Research findings are often referred to in the public debate and initialise public discussions, which in turn affect policy makers. On a local level, school surveys and similar studies might be the starting points and catalysts for special preventive campaigns and interventions carried out.

It is however more difficult to say in what extent overall policy decisions are based on research findings. There have not been any careful systematic evaluations done on how such findings have had impact on policy and interventions. Researchers sometimes accuse politicians of not taking notice of new results and findings, or for doing so in highly selective ways.

It is however obvious that politician makes extensive use of material in the Report-series; a compilation of alcohol and drug related statistics produced by the NIPH together with CAN. Many of the motions submitted and newspaper articles penned by politicians are based on the series. There is considerable political interest in Sweden's position compared to other European countries when it comes to drugs. Drug policy is part of general welfare policy and, as such, is seen by many as a measure of how well the aims of welfare policy are being met. Comparative figures are therefore often requested.

During 1998 the Government set up a Drug Commission. The first report of the Drug Commission was published in August 1999, a inventory report of present drug statistics with suggestions on how to develop it further (SOU 1999:90), which might serve as an illustration of how important the investigators find relevant statistics for the decision making. The Commission has released another eight discussion memorandums, and a final analysis will follow by the turn of 2000.

At the other hand, a problem for policy makers is that science seldom produces pre-packed solutions or suggestions on how to act. Research findings many times must be interpreted before turned into action. Another problem might be pressure from NGOs, the mass media or a political opposition to act fast and solve an emerged problem hastily. Therefore, there is not always time enough to await scientifical findings.

7.3 Methodological limitations and data quality

Methodological limitations and priorities for future work

As already mentioned, increases in drug seizures might be due to changed distribution routes where Sweden not always are the final country on the route. Cocaine might be an example of this. Increases in heroin and amphetamine seizures might partly be due to changed priorities within the Customs. It does not seem likely though that the increase is explained solely by such changes, especially since prices have dropped significantly. Another reason for the price drops might however be weakening world market prices.

If information on seizures and prices are combined with analyses of purity, both on the street level and the trafficking level, a more detailed picture of the drug market and its mechanisms might be obtained. As mentioned before, a project on developing a database for routine collection of purity of larger seizures, as well as ad-hoc studies for smaller amounts is being planned with the NIPH as co-ordinator.

CANs regional reporting system on the local drugs situation obtain information on drug prices. With funding help from the NIPH, the system was enlarged (more informants) and modernised (automatic data capture of fax-surveys), which ought to improve the reliability on prices for instance. Its function as an early warning system is thereby also improved. After a pilot study using the new routines this spring, the improved reporting system is now running on regular basis (Byqvist 2000).

New and experimental users are hard to trace. We have to rely on what is reported in anonymous interviews and questionnaires. Most of these studies provide a picture of the respondents' experiences of drugs, but not in any detail. For that we have to use other type of information, official registers and data from various authorities they might be in contact with. However, only a limited number of such users are known to the authorities. This means that there is an information gap on the experimental/recreational drug use.

Severe drug users are more easily detected by the society through contacts with different authorities and institutions. Still, there are many problems interpreting official records and statistics describing such groups. Data on severe drug use is not complete or totally accurate. This is due to many factors. Statistical trends are often distorted by new routes of registration, changes in legislation, changes in enforcement, variations in resources allotted to different measures etc.

Also the final interpretation might be difficult to make. For instance, it is not that easy to establish in what extent an increase in mortality and morbidity are due to more dangerous drugs

(or combinations of them), increased health problems among the ageing group of drug addicts or an increased number of them. As mentioned earlier, reports from professionals dealing with active drug users indicate that they might be physically worse off than before, and therefore more visible. A fact that speaks for a real increase in the number of drug users is that the number of younger persons arrested, treated etc has increased.

Even though much research has been carried out throughout the years, there are obviously still information gaps that need to be covered. Most parties agree that prevention and demand reduction is fundamental and that there is a need of research in this particular field. Researchers, practitioners and administrators need valid statistics, which have to be developed further. Longitudinal studies of drug careers as well as of life cycles are of interest too. Little is also known about the drug use that is not only casual, but also nevertheless not defined as severe.

There is always a political and administrative demand for estimates of the number of severe drug users. Meeting that demand is one of the aims for the ongoing MAX-project ordered by the Ministry of Health and Social Affairs (MHSA). Other goals of the project are to investigate relationships between social exclusion and drug use and to give a more detailed picture of the living conditions of severe drug users.

The Governmental Drug Commission has published a report specifying needs of improved statistics. The proposals included routine surveys in the general population, a new data collection system to gather information on the Social Services contacts with drug users, as well as the obligation of treatment centres to provide information on the clients to a central register, and a new data register to monitor the developments of drug related deaths. There are also proposals that methods to monitor price and purity on a regular basis should be further investigated. Other tasks of the Drug Commission are to evaluate the achievements on drug demand reduction and to propose future reinforcements to strengthen the efficiency of the drug policy. Legislation, methods used in the judicial as well as the treatment system and the preventive work will be evaluated and the interplay between different sectors, levels and actors in society will also be given attention. Already mentioned, a great number of discussion memorandums have been published but the final analysis and conclusions are still ahead (January 2001).

Finally, there is also an ongoing work in developing the key indicators identified by the EMCDDA, since these are a prerequisite for cross-national comparisons and research, a topic always of interest.

Part III.
Demand reduction interventions

8. Strategies in Demand Reduction at National Level

8.1 Major strategies and activities

The Swedish model of drug policy is a balance between prevention, control and treatment, with an overall aim of a drug free society. Springing from the sub-goals of the Swedish drug policy, reducing experimental drug use and inducing more drug users to give up their habit can be considered the two main aims of the Swedish demand reduction strategy.

Preventive measures, of which education and information campaigns are examples, are used to limit the number of young people experimenting with drugs. This work is to a great deal carried out in schools, in the so-called ANT-information programmes (with the abbreviation standing for Alcohol, Narcotics and Tobacco).

In order to reduce the number of severe abusers, there are a great number of care and treatment facilities available. An ongoing shift from compulsory treatment and institutional treatment towards outpatient treatment has been noticed for several years. There are also some indications on that treatment might be less easily available nowadays, at least compared to the situation 10-15 years ago when there was a massive build up of institutional treatment facilities in the wakes of the arising HIV epidemic. There has also been a shift towards increased local/municipality responsibilities for treatment, as well as for other demand reduction activities.

Also legislation and the implementation of the legislation are considered important. Prohibiting drug use gives a clear statement that drug use is not accepted by society. However, demand-reducing measures are not confined to information, prevention and treatment. Maybe the most important factor is the general welfare policy. The drug policy, recognised as a part of the social policy, should be combined with a policy preventing unemployment, segregation and social distress to grow. A positive environment to grow up in might be among the most important preventive measure of them all.

8.2 Approaches and New Developments

One new approach that deserves mentioning is the rapid growth of the use of the Internet. A number of sites, some of them with a high degree of interactive facilities, are present in the drug information filed, some of them offering services answering e-mailed questions.

The Internet has also become a powerful tool for information dissemination. Press releases, research results, news articles and books can easily be obtained. The possibility of downloading selected raw data from databases is an interesting feasibility for researchers as well as another in the field of drug prevention. A number of such examples already exist today.

It is difficult to pinpoint recent socio-cultural developments relevant to demand reduction changes, just as it is difficult to spot any substantial changes in public opinion on drugs and the drug policy.

9. Intervention Areas

Only a selection of recent events, new approaches and programmes, and descriptions on progresses are presented below. Worth emphasising as well is that several sub paragraphs are indicated "no new information". This should however not be interpreted as that there are no actions at all for a particular item. In fact, a massive number of actions might be carried out since many years, however not recently changed or being in any particular progress. To conclude, this chapter does not give a complete picture of the state of Swedish demand reduction interventions. If some items of certain interest not are described in detail, or at all, more information on the subject still might be available in previous National Reports or at the Focal Point.

9.1 Primary prevention

9.1.1 Infancy and Family

No new information

9.1.2 School programmes

Schools can be seen as an arena for public health work. Since 1997, the NIPH is involved in a long-term project in supporting, stimulating and inspiring the schools throughout the country. The project is called "A Health Promoting School" and is aiming at developing the every day life in schools towards a more supportive and promotive physical and psychosocial environment for health and for learning.

The work is targeted at disseminating know-how on new methods, experiences and scientifical findings in health work in a network of schools. At the moment, close to 600 schools are participating in the network. Regional contact persons are offered training, supervision and meetings for exchange of experience.

The American drug prevention programme DARE (*VÅGA*) was adopted in 1993. The projected was evaluated by the NCCP and gained some criticism (Brottsförebyggande Rådet 1999a) reported on in previous NR. The VÅGA programme nationally targeting grade 7 students is nowadays run by the temperance organisation IOGT-NTO, still in co-operation with the Police, but modified to be more flexible and locally orientated and to pay special attention to discussions on values and attitudes. It was also broadened in the sense that the focus was shifted from drugs to an approach that also include alcohol and tobacco as well as other substances (www.vaga.nu).

A new preventive school project in 8th grade was launched by a foundation called Mentor in 1999. The project was called "First Aid" and was an attempt to work with information and education on alcohol, drugs and tobacco in a new and creative way and to make the students reflect on the importance of peer pressure, lifestyles and attitudes when it comes to substance use. The project is running also this year, now called "Re-Act" and is less focused on parental approaches as it was before, but with a new extensive handbook for the teachers with a num-

ber of proposals on lessons on drugs that could be held in various subjects. The students are also invited to participate in a contest, recording their own advertising films, trying to make positive propaganda for healthy life styles. The winning class will have their film professionally re-recorded and a trip abroad is also at stake (www.re-act.nu). This method is used since it is believed that traditional lectures do not have any significant influence on young people's behaviour.

An information programme run primarily for schools is the website called Drugsmart (www.drugsmart.com), providing information for both teachers and students of grades 7-9. Information and news about this site is found under paragraph 9.1.7.

During 2000 an inspection report from the National Agency for Education regarding the education in schools on tobacco, alcohol and other drugs was released. This report is discussed under paragraph 10.2, as well as an overview on research on information and education campaigns released this year.

9.1.3 Youth programmes outside schools

No new information

9.1.4 Community programmes

Not being a programme itself, but a centre of resources for the city parts of the Stockholm municipality, PRECENS opened during the autumn 2000. It is a drug prevention centre run by the Social Services aimed at stimulating and activating alcohol and drug prevention in the city parts, as well as to initiate co-operation between them. The centre provides education and disseminates research results and good examples. Interesting is the approach with tight links to youth organisations, voluntary organisations and private companies.

9.1.5 Telephone help lines

There are no manned telephone help lines for narcotic drug issues available in Sweden. A free phone number however exists, opened late 1998, giving automated information on alcohol and drugs. Information is obtained by making use of a press-button-phone but there are no possibilities to get in contact with any help staff, apart from using provided information where one can search "traditional" help. The phone service is run and updated by the NIPH.

In case of poisoning accidents, it is possible to contact the 24-hours available Swedish Drug and Poisoning Centre, as well as the Medical Service Information Centre.

The only telephone help offering substance information by a trained staff is the Anti Doping Hotline, free of charge and available weekdays. This information service was opened already late 1993, with funding from the NIPH. In 1997 a medical products enterprise offered to support the help line but since January 2000 funding is allocated from the MHSA.

9.1.6 Mass media campaigns

No new information

9.1.7 Internet

Drugsmart is an interactive Internet site for pupils grade 7-9, their teachers and parents, started by the MHSA late 1998 (www.drugsmart.com) and re-located to CAN in 2000. As described previous year, Drugsmart was evaluated and found to be highly appreciated. On the negative side, it was found that only a limited share of the teachers responding to the survey

knew the existence of Drugsmart. The final conclusion of the evaluating team was that the project was promising enough for a continuation, but needed better marketing to make more people aware of its existence (KAN AB 1999).

Facts, downloadable reference materials for schoolteachers, answer to FAQ's, a game, an interactive "web soap opera", a chat room and links are available at Drugsmart. An "open for all" discussion board is also frequently visited and the editors answers e-mailed questions. Recent news are a Drugsmart club to create more relation-like contacts with the visitors and co-operation with a number of commercial sponsors providing game prices, contacts with celebrities being guests in live chats etc.

Maybe the most exciting news about Drugsmart this year is the educational package called eMediate-ANT (Alcohol, Narcotics and Tobacco). It is a two-hour lesson, held live on the web in the school's computer room, with openings for a follow-up. The package contains three short introductory films, interactive value related exercises and a direct chat contact with the supervising Drugsmart staff. The chats are summarised by the staff and e-mailed to the responsible teacher together with requested materials and suggestions on how further education could be done. Information on eMediate-ANT has been disseminated to the schools during this autumn and successful pilots have already been held, and at the present at least one lesson a weak is being held.

The Internet based news agency DrugNews, earlier solely run under an NGO called RNS, is now also sponsored by the IOGT-NTO and is located at web site of its own (www.drugnews.nu). Important news for 2000 are free, weekly disseminated e-mails containing summaries of the most important recent articles. Another important improvement is that that all articles are stored and easily searched in a database on the web site.

More updated news is also easy accessible on the Internet. CAN offers last week summarises of drug related editorial articles, news and debate articles obtained from 35 major national and regional news papers on its home page (www.can.se). These can also be daily subscribed, however only for members and co-workers of CAN at the present.

In general, there is a strong development of Internet sites regarding drug issues in Sweden, primarily because of the rapid interactive IT-development in society as a whole, and to some extent also as a reaction to anti-prohibitionist sites put up on an earlier stage.

It is also a fact that there are an increase of relevant data and material to be found on the Internet. Databases on research, library databases etc, makes information access easy and almost instant. The Internet is also a valuable tool to disseminate new information such as press releases and such. Added to this might also be statistical databases being built up. One example of this is the web site of the NCCP, where one can extract and download statistics on certain types of crimes in certain regions (www.bra.se). Another similar example is the great number of databases held at Statistics Sweden (www.scb.se), providing downloadable raw data on many different issues, general population data as well more specialised information.

9.2 Reduction of drug related harm

9.2.1 Outreach work

Outreach work within the Social Services as well as within the medical treatment sector was far more common some 10-15 years ago, when the massive campaign for drug treatment was launched in the wakes of the arising HIV epidemic (*Offensiv narkomanvård*). About 100 specialised drug treatment units were built up during the mid 1980s in the municipalities and out-

reach work was one of the priorities. The Governmental founding for the campaign was liquidated early 1990s and the municipalities became fully responsible for the continuation of the campaign. A substantial decrease in the outreach and motivation work has thereafter been noted (Narkotikakommissionen 2000c). Two studies aimed at investigating the present situation on the outreach work is also in progress at the NBHW.

Examples of opposite developments can however be found, one of them the Female Project in Stockholm (*Kvinnoprojektet*). In January 2000 the Social Services of Stockholm started an outreach project in order to reach homeless women, of whom many have few or no contacts at all with the Social Services. One of the aims is to motivate the women to increase their contacts. Since one of the field workers is an assistant nurse, simple medical help might be an initialising contact. The project is a joint venture between the Social Services, voluntary organisations and the medical treatment sector, since it is believed to be of importance that all responsible authorities are involved. (More information on women and outreach work can also be found under paragraph 9.6.)

Mainly in the major metropolitan areas, it has become more frequent during the 1990s that voluntary organisations are present in the community. Examples of such organisations are the "Non-Fighting Generation" and various parental groups working towards younger persons hanging out late at night. The municipalities normally provide some economic support for premises, materials and such to those projects/organisations. Also more traditional voluntary organisations, like the Salvation Army, are of course contributing to the outreach work.

9.2.2 Low threshold services

Low threshold services are relatively uncommon in Sweden but do exist in metropolitan areas, usually staffed not by official bodies but by voluntary organisations. These may however have official financial support, at least partly. They help with shelter, food, personal hygiene, contacts with the authorities and basic health care but do not offer money or prescriptions. Examples of organisations running low threshold services in Sweden are *Stadsmissionen*, *DKSN*, *Convictus* and the Salvation Army.

9.2.3 Prevention of infectious diseases

All new and relevant information on prevention of infectious diseases is provided in chapter 14 and in the questionnaire in ST 10, wherefore no information is provided under this paragraph.

9.3 Treatment

9.3.1 Treatments and health care at National level

As reported in previous NRs there is an ongoing shift within the Social Services in giving alcohol and drug treatment. The use of institutional treatment has decreased and instead non-institutional treatment programmes and out patient treatment have been put to use in a greater extent. The compulsory part of the institutional treatment has decreased, particularly for alcohol bot also for drugs. Also the average time spent in institutional treatment has dropped. In what extent this is due to weakening budgets, lack of positive outcomes of the institutional treatment, or other reasons have not been established. No special events or changes regarding the hospital/in-patient care have occurred.

9.3.2 Substitution and maintenance programmes

Practically the only drug substitution programmes run in Sweden are the methadone maintenance programmes, located in Stockholm, Uppsala, Malmoe and Lund. In 1993, 430 patients were receiving treatment on a census day (last December). The figure has continuously increased and amounted to 601 in 1999.

A small number of patients have in limited pilot studies been treated with Subutex (Buprenorphine). So far the outcomes have been regarded as positive and in 2000 a somewhat larger study, including 40 patients, started at Huddinge Hospital, located in Stockholm.

In accordance with the decision of the NBHW, there are a maximum number of patients that may be in methadone treatment at the same time. This number was raised from 600 to 800 in October 1999. The maximum number of patients is, among other things, regulated in official instructions on methadone treatment issued by the NBHW. A revision of those instructions are at hand, not the least in order to fit the arisen situation with new types of medicines used in maintenance treatment, and a revised version are expected during the first half of 2001. For a detailed description of admission criteria's etc of the Swedish methadone programmes, please consult chapter 18 in NR 1999.

In November 1999 the Government asked the NBHW to conduct an evaluation study of the methadone maintenance programme. The ongoing study comprises 261 persons who entered the programme during 1989-1991 and these persons are followed up mainly regarding mortality, morbidity and criminality. The results will be presented to the MHSA late 2000.

9.4 After-care and re-integration

To some extent, drug treatment services are offered within the correctional system. A report released by the NCCP in 2000 examined how the correctional treatment system prepared the inmates for their parole. This study is briefly described under paragraph 9.5. No information on new improvements or programmes are available, however it is often emphasised among the professionals that the after-care and re-integration is a very important aspect of the drug treatment and that improvements in this field would be positive and welcome.

9.5 Interventions in the Criminal Justice System

A description of interventions in the criminal justice system hereby follows, not that there has been any major recent changes made, but the issue is important enough, not the least since more information on this was requested in the evaluation of the previous Swedish NR and that there are not many societal institutions meeting as many drug users as the correctional system does. For example, on a census day in 1999, some 1,700 drug users were in prison and 4,400 under probation (please see paragraph 4.2 for the definition of drug user used).

Already mentioned in previous report but worth repeating is the recent law (SFS 1998:603 and SFS 1998:641) on sanctions for young offenders aiming at decreasing the use of imprisonment for persons 15-17 years old. As an alternative to prison, it is now possible to sentence such offenders to Secure Institutional Treatment in special homes for young people. The treatment is focused on social skills training, the family network, education, cognitive behavioural methods and more. The treatment plan is made up by the Social Services, but a court makes the decision whether Secure Institutional Treatment might be an alternative to prison. The treatment sanction is for a fixed period, determined by the crime committed.

Another recent sanction related change was the implementation of intensive supervision with electronic monitoring, as an alternative to shorter prison terms. In an evaluation made by the NCCP it was stated that a consequence of this new sanction might be an increased concentration of habitual criminals in prison (Brottsförebyggande rådet 1999b). This new type of sanction seems to have been used in a lesser extent for drug users than for others, since the proportion of persons classified as such at the admission has increased from about 40 to 50% during the second half of the 1990s.

About one fourth of all prisons reported in 1999 that drug use occurred "often or almost daily" while 66% stated it was rare or never occurring. In order to reduce drug use inside prisons searches and visitations are regularly held. Another important factor is to differentiate non-drug users and drug users trying to kick the habit from other prisoners, and to offer them drug free locations as far as possible (Kriminalvårdsstyrelsen 2000b). Screening tests is often used to detect drug use and keep drugs outside prisons. During 1999 a total of 110,000 urine samples was taken, making up to an average testing frequency of 2-3 tests a month per prisoner.

Special programmes are offered in order to motivate the drug users to become drug free, both individually and in groups. During 1999, a total of 1,900 inmates participated in programmes devoted to drug demand reduction motivation. The average time spent in such a programme is about 100 hours and the programmes can be seen as a start for more long-term treatment contacts. A special paragraph in the Prison Law (§ 34 KvaL; "paragraph 34-care") states that the imprisonment might be served outside prison under certain conditions. The most common reason for such a decision is drug treatment and normally the treatment is carried out in some sort of institution. In 1993, about one third of all prisoners classified as drug users were in some of the above mentioned drug treatment programmes on a census day. This share rose to 45% in 1997 but is now back on the 1993 level again (ibid.).

It is however not uncommon that a probational sentence, combined with institutional drug treatment, is used as an alternative to prison for drug users (*kontraktsvård*). During 1999 a total of some 1,200 persons received such a sentence. Out of those, approximately one third was sentenced for a drug related crime.

There are no services offering syringes in prisons and there is neither any substitution treatment. Information on injecting and infectious diseases is held, but there is no national programme for this, so it is up to each prison to decide upon how, and in what extent this should be done.

At an early stage during the 1980s HIV-testing was implemented within the correctional system. Motivators and persons developing methods for handling the situation were employed. Nowadays this has been implemented in everyday practice. The number of HIV-infected persons in the correctional system on a census day has decreased from about 200 in 1988 to some 60 in 1999, and out of those 19 was imprisoned (ibid.).

A report released by the NCCP in 2000 examined how the correctional treatment system prepared the inmates for their parole (Brottsförebyggande rådet 2000b). A group of 95 inmates with prison terms over six months, and the prison guards with special responsibilities for those prisoners, were interviewed. The housing situation was poor for most paroled inmates and the educational status was generally low. Social welfare was the most likely source of income after being released. About one fifth reported problems with the psychical health and over two thirds had problems with alcohol or other drugs. The physical health was however quite well and some reported a considerable improvement during imprisonment.

It was concluded that the treatment plans displayed significant defects and the report states that it is of importance that the routines regarding treatment plans and other documentation

are overlooked, as the activities within the programmes, especially the crime- and drug related ones. The ones with short sentences and many convictions seemed to be especially vulnerable and hence in need of special attention, despite the fact that this group of prisoners probably belong to the most difficult set of clients. It was also found to be of importance that the prisons became more focused in their work concerning preparations for the release and to use available measurements in that work.

The Governmental Drug Commission released a discussion memorandum on how the correctional system should be able to improve the work on drug demand reduction among prisoners during October 2000 (Narkotikakommissionen 2000d). Both drug treatment programmes as well as measures for keeping drugs outside the prisons were discussed. It was stated that the time spent in the correctional system by drug users should be even more focused on motivating them for treatment and that the possibility of letting prisoners undergo treatment while imprisoned should be more thoroughly examined. It was also stated that more efforts on offering treatment and various types of support to prisoners ought to be made by the Social Services.

Funding arrangements are problematic when it comes to the “paragraph 34-care”, mentioned earlier, due to that the costs are to be split between several authorities, and it is suggested that the correctional system should take full economic responsibilities if problems arise (ibid.). An increased budget would also improve the possibilities of developing the methods and programmes. To prevent drugs from entering prisons, the Drug Commission advocates more far-reaching methods of body searches on visitors and personnel, among other things.

9.6 Specific targets and settings

Programmes for female sex workers

In Stockholm, the "*Spiral-projektet*" is active since the late 1970s, focusing on reaching female prostitutes. The soft, low threshold contact facilitates STD-and HIV-prevention is part of a motivation work, leading to treatment for the drug problems. In Malmoe, a similar programme is active since several years.

A low threshold female project is presently set up in Malmoe, recruiting women from the needle exchange program, however not solely female sex workers.

In the larger cities (Stockholm, Gothenburg, Malmoe and Norrköping) specialised groups of social workers are active in outreach activities directed to prostitutes, many of them drug misusing women. The task is to come into contact, establish a trustful relation and, later, be supportive in all the needs a prostitute might have to get off addiction and prostitution.

In Stockholm, an outreach initiative from the voluntary organisation *DKSN/Hela Människan* has been running for several years. It is called "*Bullgerillan*" (Sweet Bun Guerrilla). A bus is located in the prostitution and drugs areas at night, inviting prostitutes and other people in for a cup of coffee and sweet buns. The contacts established might later function as an opening to various forms of help. DKSN runs shelters for homeless people, out patient treatment programs for alcohol and drug users, as well as therapeutic communities.

10. Quality Assurance

10.1 Quality assurance procedures

There have not been any recent developments in the formal requirements of quality assurance, however progress has been made in developing instruments for criteria and instruments applied. A lot of efforts are put in the work of developing methods and tools for increasing the quality of the drug demand reduction related work carried out, and a few will be mentioned below.

As described already in NR 1997, a documentation and assessment system for quality assurance and evaluating of the institutional drug treatment (*DOK*) was constructed in co-operation between The Institute for Development of Knowledge about Treatment of Alcohol and Drug Misusers (IKM) and the Research Department at the National Board of Institutional Care. Today the implementation of the DOK-system has improved, with some 80 treatment units, many of them offering compulsory treatment, participating. The aim of the system is to provide knowledge of particular interest not only to practitioners in the field, but also to decision makers and researchers. Treatment units use the information for self-assessment and to enhance competence of the treatment staff.

Another tool of the same kind is the Addiction Severity Index. ASI have been translated into Swedish and adjusted to fit characteristics typical for Sweden. It is believed to become an important tool within the Social Services. A recent improvement is a computerised version developed, believed to be important for increased interest and a broad implementation. ASI is used in a varying degree in some 75 municipalities (of close to 300). The NBHW supports the implementation of ASI and are planning a follow up study on the implementation next year.

The ASI has also been tested in pilots within the Correctional System. Added was also a special module on criminality. An evaluation report on its usefulness within the correctional system is soon to be released, and thereafter a decision will be made regarding the full implementation.

10.2 Treatment and prevention evaluation

No developments have been made in the evaluation policy for treatment and prevention or in requirements for evaluation. Some evaluations of interest have however been released 2000, aiming at improving demand reduction activities. None of these have been mentioned earlier in the report and will therefore be shortly highlighted in the following, as examples of quality assurance related research.

During 2000 an inspection report from the National Agency for Education regarding the education in schools on tobacco, alcohol and other drugs was released. Some of the findings were that the information and prevention campaigns often lacked proper follow-ups. Concrete goals needed to be drawn up and central decrees on this would be useful. It can also be mentioned that the education was found to be mostly devoted to facts and risk information on drugs, in spite of the fact that prevention research gives little support for such actions (Skolverket 2000).

Worth mentioning in this context is an overview of international literature and research on existing knowledge regarding various prevention and information programmes. The report is a Swedish update of a ten-year-old Danish work, and provides a picture of the present knowl-

edge. Even if some approaches seem better than others, it is stated that recommendations on actions more promising than others are difficult to make. Three reasons for this are given; the context of the programme is often of great importance, short term, and especially long term effects are hard to establish, and many evaluations show considerable methodological limitations (Thorsen and Andersson 2000).

A critical review of the literature on treatment of withdrawal, prolonged withdrawal, and treatment to prevent relapse is soon to be released by The Swedish Council on Technology Assessment in Health care. Recent meta-analyses in the field are assessed and special attention is given to interventions that either currently exist or can be easily introduced into the Swedish healthcare system. Mainly double blind, randomised controlled trials and meta-analyses based on such studies are included. Cohort studies and other naturalistic studies are also included to acquire information concerning long-term and economic analyses.

10.3 Research

There is nothing particularly new to report on regarding the structure and organisation of demand reduction regarding research, funding or training. The last major change made was the establishing of SoRAD (Social Research on Alcohol and Drugs) at the Stockholm University in spring 1999, however reported on in previous NR.

10.4 Training for professionals

A discussion memorandum from the Drug Commission highlights the importance of competence among the staff working within the treatment system, not the least due to the highly set objectives of the Swedish drug policy (Narkotikakommissionen 2000a). It is stated that education and training is present in many ways within the drug treatment sector today, but there is however no deepened expert training that in a long-term perspective can lead to a drug user treatment based on "scientific knowledge and tried and tested experience".

This fact leads to a proposal on establishing a special training/education for professionals. The main idea is to educate treatment staff with qualified tasks as and/or being supervisors and instructors in practice, at the same time as they have a close relation to the research sector/universities. The Government is requested to establish such a master's degree, founded on the preparations of the NBHW and the National agency for Higher Education.

11. Conclusions: future trends

Prevention and drug treatment will remain very important aspects of the demand reduction interventions for the future, not the least since they are recognised as two important parts of the national drug policy. An ongoing shift towards increased responsibilities on the local level for such actions has been apparent for some years, and there are no signs of this development to reverse. This development is at the whole recognised as a positive one.

Reports from various sources agree that teenagers are experimenting with drugs in a higher extent than some 5-10 years ago and that the attitudes towards narcotic drugs have become somewhat less negative. Also severe drug use seems to be on the rise. This calls for countermeasures, and re-enforcement of the demand reduction interventions might be one of those.

The Governmental Drug Commission have in its ongoing work of evaluating the drug policy investigated several areas and aspects of the policy, in order to suggest future reinforcements or further analyse. Among those areas are prevention and treatment. A great number of discussion memorandums have been released already, and a final document with summaries, conclusions, and recommendations is to be released in January 2001. There is no source more relevant for speculations and hints on future re-enforcement of demand reduction activities than the works of the Commission. Even if many of those memorandums have been mentioned earlier, in this and previous NR, some findings will be highlighted below.

Even if policy documents often mention prevention as something important, prevention often lack both status and resources. The Drug Commission also made the observation that there were a lot of expectations on prevention campaigns, at the same time as research has started to indicate its limitations. In the future work of developing a national strategy the Commission will highlight; co-ordination, control and responsibilities; methods for general and special campaigns; development of methods within different drug preventive arenas; competence strengthening means and methods for effective spread of knowledge (Narkotikakommissionen 2000b).

Extra funding for the drug treatment sector was given by the Government as a response to the HIV-epidemic in the 1980s. This temporary support was liquidated early 1990s. At the same time the economy of the municipalities were weak in many cases, due to economic recession. An investigation of three municipalities showed that the expenses for drug treatment decreased up to mid 1990s, but has then increased somewhat again. The turn could at least partly be explained by a better economic situation, and changes in the environment, such as an increase in drug use and a National Plan of Action released 1995 (Narkotikakommissionen 2000d). Whether the description of the developments is nationally coherent is not established, however likely.

It is important to have a high degree of competence off the staffs working within the institutional treatment system, not the least due to the highly set objectives of the Swedish drug policy. The Drug Commission found that education and training was present in many ways within the drug treatment sector today, but there were no deepened expert training that in a long-term perspective can lead to a drug user treatment based on “scientific knowledge and tried and tested experience”. A proposal of establishing a special training/education for professionals leading to a master degree was therefore made (Narkotikakommissionen 2000a).

Some proposals on how the correctional system should be able to improve the work on drug demand reduction among prisoners have been made, since it was found that the time spent in the correctional system by drug users could be even more focused on motivating them for treatment and that the possibility of letting prisoners undergo treatment while imprisoned could be more thoroughly examined. Also the Social Services, together with the correctional system had a part in those efforts, in providing various types of support, treatment and assistance at the release. Funding arrangements was found to be problematic when treatment costs was to be split between authorities, and it was suggested that the correctional system should take full economic responsibilities if problems arise (ibid.). An increased budget would also improve the possibilities of developing the methods and programmes. To prevent drugs from entering prisons, the Drug Commission advocated more far-reaching methods of body searches on visitors and personnel (Narkotikakommissionen 2000c).

As stated before, the Internet has proved to be a valuable tool for interactive drug education, for disseminating of various types of information, for providing databases on articles, books and scientific reports, and not the least, in providing data. To state that this development will continue for many years is not saying too much.

Part IV.
Key issues

12. Drug Strategies in European Union Member States

12.1 National policies and strategies

The global national drug policy in Sweden remains unchanged. The overall long-term visionary aim is, as since the late 1970s, to shape a drug-free society. The high level of ambition clearly expresses that narcotic drugs not are tolerated in the Swedish society. This information can be found in various official documents. One example of such a document is the official letter "A Report on Drug Policy", sent from the MHSA to the Swedish Parliament in 1998 (Regeringens skrivelse 1997/98:172).

Another example, but in a more popularised version, can be found in the publication "A Preventive Strategy –Swedish Drug Policy in the 1990s" (1998), prepared by the NIPH ahead of the UNGASS-meeting in June 1998. A forerunner for this pamphlet was a policy report entitled "Drug policy - the Swedish experience" (Folkhälsoinstitutet 1995).

These documents describe how the visionary aim can be concretised in three limited, finite and measurable sub-objectives. One goal is to reduce the recruitment of new drug users, another to induce more drug users to give up their habit and the third to reduce the supply of drugs. Preventive measures are used to stop young people from experimenting with drugs, care and treatment helps active users to kick the habit and, finally, various control measures reduces supply. These three parts of the policy are dependently integrated and each other's prerequisites, in order to reduce both demand and supply.

It is also pointed out that drug policy is a part of the social policy. A restrictive drug policy must go hand in hand with a policy that does not allow unemployment, segregation and social distress to grow. Measures to cope with such problems could therefore be seen as prerequisites of a successful drug policy.

The status of the overall policy can be described as well accepted at most levels. In the political system, or among the political parties rather, there are only small divergences and these do not concern the overall goals. In the justice system, the policy status can only be described as well implemented, even if procedures on adopting new legislation sometimes might be criticised for appearing somewhat slow.

During the 1970s and 1980s some difficulties in co-operation between the Police and The Social Services could be noticed. There was suspiciousness on both sides, emanating from different perspectives on how drug problems arise and how to tackle them and not the least on how to tackle the individual drug user. These difficulties seem to have diminished more or less during the 1990s and information exchanges between the two are now everyday practice. Examples of joint ventures between the Police and the Social Services manifested in local campaigns against open drug scenes have for instance been seen during the 1990s.

The treatment sector might be the one field were divergences between the official policy and the implementation, as in "daily work", might become visible. The debate on needle exchange programmes might be one example and the debate on substitution programmes another, neither of those being officially fully approved components in the Swedish drug policy. Another illustration of this might be various statements from treatment personnel, expressing that on a client basis, the attitude in practice sometimes ought to be more "caring" and less focused on treatment expecting an immediate drug-free living.

12.2 Application of national strategies and policies

Leading principles for priorities and measures taken by authorities under the Government are the three sub-goals. Responsible for drug policy issues are the Minister for Health and Social Affairs. The issues do however in a high degree concern also the Ministry of Justice, responsible for the legislation and for the authorities working within the judicial system and also the Ministry of Finance, head of the Customs. Regarding international commitments, also the Ministry for Foreign Affairs might be involved.

A working group called *SAMNARK* is working within the Government in order to improve co-ordination between the Ministries and continuously suggest measures and improvements in order to make the drug policy more efficient.

Drug policy matters are present in many sectors of society. The Government is responsible for legislation, being a normative factor and for allocating resources. When it comes to prevention, care and rehabilitation it is the Counties and the Municipalities that are the key actors. A condition for a successful implementation of the policy is local commitment among political groups, organisations, community groups, schools etc. In these matters, actors on the local level, such as the Municipalities, play a key role.

The Government does not have full influence on the Municipalities; the right of self-determination is relatively high, even though the Municipalities have certain obligations to fulfil some Governmental tasks regulated by legislation. It is however expected that the Municipalities, as well as the treatment sector, The Police and Customs are co-operative in a relatively high degree. A shift towards increased local responsibilities for prevention measures have been noticed during 1990s (Narkotikakommissionen 2000b). Another finding within the Drug Commission (see below) is however that the responsibilities of each actor could be even more clearly specified and that the local responsibilities for contacts with prisons, institutions etc, could be increased.

It is a fact that drug issues are still highly prioritised and there are no indications that this would change in the near future. The Swedish drug policy can only be described as well implemented among all responsible authorities and organisations, both on the central and the regional/local level. Local activities are permeated of the national policy and divergences seldom occur. This is maybe not surprising since the policy is very clear, well founded in the public and has been the same for many years.

12.3 Evaluation of national strategies

In order to evaluate the Swedish drug policy the Swedish Commission on Narcotic Drugs (the "Drug Commission") was set up by the Government in May 1998. The overall task of the Drug Commission is to evaluate the Swedish drug policy carried out since the middle of the 1980s and to propose future reinforcements to strengthen the efficiency of the policy. The evaluation will cover legislation, prevention, rehabilitation of drug abusers and measures to

limit the supply of narcotic drugs. A web site is put up where one can find a presentation of the Commission, its tasks, downloadable reports etc (www.sou.gov.se/narkotikakom).

The instructions given stated that the Drug Commission should take its point of departure from the balanced and restrictive approach of the current Swedish drug policy and that the overall aim of a drug-free society is fundamental. The Commission shall complete its work by the end of the year 2000 and a final proposition is expected in January 2001.

The terms of reference specify seven important areas. The Commission shall

- propose improvements of methods and systems to assess the drug situation and to evaluate the goal of a drug-free society,
- evaluate and propose measures to strengthen and streamline drug prevention measures,
- analyse the development of treatment programmes, including those in the prison and probation system, and propose measures to improve treatment and rehabilitation of drug abusers,
- evaluate the extent and focus of national funds for the development of treatment and of measures to prevent drug related crime,
- analyse the need for changes in the working methods in the judicial system and in penal and criminal procedural legislation,
- review existing research, propose how research can be stimulated, strengthened and organised and identify important but neglected areas for research in the drug field,
- frame strategies for targeted information measures and for the formation of opinion.

So far, nine discussion memorandums have been released, already at this point offering some proposals on improvements.

It is for example considered a disadvantage that no authority today has the responsibility to keep an overall perspective on the drug situation and to be responsible in developing new data gathering methods. It is advocated that the NIPH should have the overall responsibility for compiling and analysing national data, not the least since the NIPH already are responsible for the communication with the EMCDDA (SOU 1999:90). Another proposal within the same report is that the National Police Board should be in charge of finding methods of keeping routine statistics on price and purity and to regularly report such data.

Another memorandum, on competence within drug treatment system, pinpoints the fact that high demands must be put upon competence among the people working in the treatment system (Narkotikakommissionen 2000a). This fact leads to proposals on a special training/education for professionals (please see 10.4 for more information on this). Certain demands must also be made upon the system itself, competence among the employees must be utilised and developed, and in order to develop methods and competence it is necessary to keep a continuity in the structures of the system.

Also the drug prevention situation has been investigated by the Commission (Narkotikakommissionen 2000b). Even if policy documents often mention prevention as something important, prevention often lack both status and resources. It is also observed that there are a lot of expectations on prevention campaigns at the same time as research has started to indicate its limitations. In the future work of developing a national strategy the Commission will highlight; co-ordination, control and responsibilities; methods for general and special campaigns; development of methods within different drug preventive arenas; competence strengthening means and methods for effective spread of knowledge.

A national Plan of Action for prevention of alcohol and drug related harm in Sweden was released in 1995. This autumn an updated version will be released, but only regarding alcohol. During spring 2001, a Plan of Action regarding drugs will be released as well. The reason for keeping the two apart was simply to await the results of the Drug Commission, in order to have a possibility to comprise some of the findings in the Plan of Action.

13. Cocaine and base/crack cocaine

13.1 Different patterns and users groups

Crack is hardly ever seized in Sweden. A quick search in CANs database of press cuttings, containing summaries of drug related articles from newspapers from 1995 onwards, gives 235 hits for cocaine and 14 for crack. This gives an, unscientifically, picture of its rarity, especially since only a few articles describes episodes where crack actually was seized/used in Sweden. According to officers at the National Police Board crack is hardly ever smuggled into Sweden, instead smaller amounts sometimes might be manufactured for instant personal use.

The only major survey asking for lifetime prevalence of crack is the one among military conscripts. Since 1994, when the question was introduced, the proportion stating having tried crack has hovered around 0,2%. Such a low figure could almost be considered as "noise"; some respondents joke, misunderstand the question, misplace their marks, as well as errors occur in the scanning procedure, wherefore this figure is negligible, and not possible to use to determine if any crack experiences exists among the military conscripts.

According to the above, crack will not be dealt with any further in this paragraph.

The practically only use pattern for cocaine in Sweden is to inhale it. This is likely due to the groups that are using it. Cocaine is a rather expensive drug by Swedish standards, especially compared to amphetamines, and not a "street drug". An IV user/regular user that prefers stimulants in favour of opiates uses the much cheaper amphetamines.

Two smaller historic cocaine waves occurred in Sweden during late 19th century and the 1920s respectively (Emblad et al 1990). During the 1980s, the developments in the US caused some concern for a possible cocaine wave to appear also in Sweden, and it became evident that cocaine also was present in the country. An investigation from 1991 (Helling et al), based on available statistics, interviews with key persons and analysis of personal files from cocaine convictions, concluded that cocaine use was rather rare in Sweden, both in comparison with other drugs as well as the cocaine situation in many other European countries. One could argue that the situation is pretty much the same, ten years later on.

According to ST 01, about 1% of the population 15-64 years declared lifetime prevalence of cocaine in a survey from 2000, which makes it the third most commonly experience narcotic drug among the population (after cannabis and amphetamines). This situation has been the same during all the 1990s. The study among military conscripts reveals that cocaine was the fifth experienced drug among 18-year-old boys, with higher rates for cannabis, amphetamines, LSD and ecstasy (Guttormsson 2000). Other smaller surveys among teenagers (also including girls) point to the fact that these results can be generalised for younger age groups.

Drug use/experience of drugs is concentrated to metropolitan areas in Sweden. This is even truer for cocaine, with its connotations to outgoing people in the major cities, especially ce-

lebrities, artists, actors and such (Helling et al 1991). Cocaine has a reputation of being an upper class recreational drug, anyway not a working class drug, maybe with some exceptions for restaurant/night club staff, but still socially well-established people. Cocaine is nor a street drug or an average persons drug in Sweden.

13.2 Problems and needs for services

Even though some persons may need medical attention and a few cocaine related deaths might have occurred, this drug has, by Swedish standards, not any particularly negative connotations when it comes to health problems. This is likely due to that the users are well established in society, uses smaller amounts on a non-frequent basis and, not the least, they seem to be quite few.

There is no need for special services regarding cocaine; the problem is handled within the regular drug treatment system. The consequences of cocaine use for society are rather limited, in line with what was mentioned above.

13.3 Market

The cocaine market is primarily concentrated to the three major cities in Sweden, even if a number of smaller seizures outside the major cities indicate a spread to some other cities/regions as well.

According to ST 16, the gram price at user level has remained stable on circa 120 Euros 1995-1999. This is true also for the year of 2000 as well as the first half of the 1990s. Unfortunately, information on purity is not systematically collected, even if most seizures above five grams are analysed at the National Laboratory of Forensic Science.

A stable prize level suggests that there have been no major changes when it comes to availability. The fact that the number of seizures increased 1990-1999, from 80 to 346, might then be somewhat contradictory (ST 13). This is however likely explained by the fact that the police work has become more user-orientated, and that it is the Police that answer for the increase in numbers.

It is more difficult to analyse the trends in quantities. Even if 1999 rates all time high (420 kilos) there is no large and obvious increase in quantity for the last 10 years, rather a fluctuating situation, and the vast majority is seized by the Customs. The Gothenburg Customs took almost 400 kilos of the 1999 seizures on three occasions. At all occasions the cocaine was found in banana containers in the harbour. None of those seizures was believed to have been targeted for the Gothenburg market or even the Swedish market. The Gothenburg police as well as the National Police Board concludes that the shippings likely were supposed for other European countries and that Sweden in those cases was the transit country (Rikskriminalpolisen 2000).

A recent phenomena worth mentioning is the two larger seizures made in the port of Stockholm during the summer 2000. The seizures were made on large international cruise liners, and similar incidents have also been reported from other Nordic cities.

In practically all police cocaine investigations people living in Latin America or with Latin American heritage are being involved. The number of people with a Middle East background has increased in the cocaine investigations, and just recently persons with contacts to Russia and the Baltic States also have been involved (Rikskriminalpolisen 2000). During 1999, some

10 couriers have been arrested arriving from South or Latin America with cocaine hidden in the luggage or swallowed down.

There are no special open cocaine/drug scenes in Sweden, even though places notoriously known for drug selling exist in the major cities. Cannabis, amphetamines, heroin and benzodiazepines ought to be the most common substances on those scenes, even if it might be possible to obtain contact with cocaine dealers via those places. As already mentioned, the cocaine market ought to be rather small and considering the user groups, cocaine is to a higher extent distributed via networks of users. In the 1991 cocaine investigation (Helling et al) it actually proved rather difficult to get in contact with users, due to quite closed networks consisting of people not willing to do interviews with the researchers, leaving the snow-ball method out.

13.4 Intervention projects

There are no new approaches aimed specifically at cocaine use to report on. An old example is a brochure disseminated to musicians by the Musicians association. This was due to the fact that many musicians had been involved in cocaine seizures made (Emblad et al 1990). Discussions with the restaurant business were also held at that point of time, however leading nowhere since the restaurant business did not want to be identified as a problem group, at the same time as they believed that the problem was negligible.

When it comes to policy, cocaine is not differentiated from other narcotic substances. This holds true for information and prevention campaigns as well as for treatment services as well as for research. This is maybe not surprising since there are other drugs that are used on a broader basis and causing more concern.

14. Infectious diseases

14.1 Prevalence and incidence of HCV, HBV and HIV among drug users

Cases of hepatitis and HIV/AIDS are centrally notified at the Swedish Institute for Infectious Disease Control (SIIDC) by the 21 County Medical Officers of Communicable Disease Control.

A total of 5,132 persons had been notified HIV-positive at the end of 1999. Out of those 25% were female (Smittskyddsinstitutet 2000). The trend has been downward since the middle of the 1980s, with the lowest number ever reported in 1999 (217 persons). (Pleas also see Graph 4 in paragraph 3.3)

The number of intravenously HIV-infected persons, classified as drug users, was 788 by the end of 1999, i. e. 15% of all cases reported. The corresponding figure for 1995-1999 was significantly lower (8%). For persons intravenously infected the 1999 figure was the lowest ever (15 persons) however only slightly below the average for the last five years (19 persons). It is obvious that the number of intravenously HIV-infected persons has decreased though, with an average of 108 persons reported 1985-1989 and an average of 31 persons during 1990-1995. Out of all 788 intravenously infected, 226 were woman. The proportion of females, 29%, is slightly higher than for all HIV-infected persons reported.

Since 1995, the average age has been around 38 years for those intravenously infected. The average age has increased compared to the latter part of the 1980s, when it was around 33 years. The combination of low incidence rates and an increased average age among those infected indicates a positive situation when it comes to HIV-infections among drug users, not the least among the younger users.

Out of all 788 intravenously infected, a total of 193 persons had developed AIDS by the end of 1999. Out of those, 144 persons were deceased at the same point of time.

The vast majority (73%) of all intravenously HIV-infected persons have been reported from the County of Stockholm. Three percent was reported from the County of Gothenburg, 7% from the County of Malmoe and the remaining 17% from other Counties. (Both the County of Malmoe and Gothenburg were merged with surrounding counties in 1997 and 1998 respectively. The previous County borders are however still used in the statistics regarding infectious disease delivered by the SIIDC).

It seems quite obvious that the drug users in Stockholm are over represented in the HIV-statistics. No other information sources indicates that as many as 73% of the IV-users should be living in Stockholm County. The contribution from Stockholm County of in-patient treated drug users was 49% during 1987-1998, for example (CAN and Folkhälsoinstitutet 2000). The same source reveals that about one third of all persons suspected for drug crimes lived in Stockholm County during the 1990s. This might be explained, at least partly, with the fact that a great number of the Swedish heroin users live in Stockholm and that HIV was spread early in the Stockholm region.

Between 1990-1999 a total of 2,176 persons were notified HBV-infected. Out of those, 921 were intravenously infected (42%). Between 1995 and 1998 the number of infected IV-users fell from 151 to 48. A small increase was noticed 1999, when 90 IV-users were reported, a more “normal” figure considering the annual average for the 10-year period. Some fluctuations could be considered normal due to temporarily intensified screening. This was the case around 1993-1995, due to a HAV-epidemic.

During the same period 18,481 hepatitis-C cases due to intravenous drug use were reported. The figures have dropped from 3,200 in 1992 to 1,495 in 1999. All cases reported during the period amounts to 27,875 and the downward trend holds true for the total as well. In 1992, a total of 4,028 persons were reported and the corresponding figure for 1999 was 2,330 persons. The proportion intravenously infected, around two thirds, has remained relatively stable throughout the period and is obviously higher than the one for HBV.

There are hardly any estimates on the prevalence of HIV and hepatitis among drug users. One study was carried out among 913 IDUs from Stockholm in 1994. The participants were recruited from the remand prison in Stockholm and from the Departments of Infectious Disease and Psychiatry at Huddinge Hospital (Krook et al 1997). The overall seroprevalence were 14% for HIV, 75% for hepatitis B and 92% for hepatitis C.

Another study was conducted on imprisoned IDUs in 9 local medium security prisons in and around Stockholm (170 kilometres from Stockholm at the most) (Käll Thorstensson 1998). A total of 195 IDUs participated and out of those 3% gave HIV antibody seropositive saliva samples.

Andersson (1998) also gives a figure on hepatitis-C prevalence. He states that about 90% of the IV-users in the Malmoe needle exchange programme are infected by hepatitis-C virus. Most of them are infected already when entering the programme, while others gets infected while participating in the programme.

All studies mentioned have a regional bias (Stockholm or Malmoe) and a population sampling bias (treatment system or prisons). It is therefore impossible to draw any certain conclusions on infectious diseases for the total population of Swedish IDUs from these studies. The figures given could be an over estimate.

14.2 Determinants and consequences

One obvious type of risk behaviour is the sharing of syringes among IDUs. For somewhat unclear reasons heroin users seem to share needles to a larger extent than amphetamine users do. One possible explanation is that heroin users less often inject on their own, in a way adopting to the potential health hazards connected with the drug (i.e. risk of overdose). Another reason could be the fact that they are injecting more frequently, thus having a greater demand for needles and syringes. Since heroin is much more expensive than amphetamines another reason could be that the heroin users are more likely to share what they have managed to get hold on for the moment. Sometimes also withdrawal symptoms might have a negative effect on the users discernment in injecting situations.

One risk factor that possibly can contribute to increasing sharing habits among IDUs is a greater concentration of drug users within the prison environment. The numbers of drug abusers in prison have increased somewhat during the 1990s. At the same time the numbers of non-users has decreased, mainly due to the implementations of new forms of sanctions (i.e. electronic surveillance). Together, these two factors are behind the fact that nearly every second inmate is classified as a drug abuser. It seems reasonable to draw the conclusion that since drugs as well as syringes of course are prohibited, this in turn makes sharing more common.

There is no routine testing for hepatitis in prison. The development of HIV is monitored more closely however, and all clients are offered a HIV-test at intake. The worst fears in the late 1980s of an epidemic spread of the disease did however not come true. The average number of HIV-infected in prison on a census day (April 1) between 1988 and 1998 was 26. In 1999 the number of HIV infected persons in prison amounted to 19.

The social impact of infectious diseases among IDUs is unclear. No recent research is available and the issue does not have high priority. The situation should be seen in the light of the HIV "panic" in the late 1980s, IDUs being one of the major risk groups. Today, when HIV is under control there is less concern with other infectious diseases. This also seems to be the view among drug users - hepatitis (A, B or C) is largely looked upon "as something that comes with the trade".

There is substitution treatment available, and the same goes for needle exchange programmes, though limited. In the semantic tradition, they are usually referred to as "pilot programmes", and as such there are restrictions in accessibility. In addition there are free access to testing and vaccination for hepatitis A and B at infection clinics and at the needle exchange program. To conclude, there are harm-reduction activities available and they are recognised in research and evaluations to be of good practice. At the same time the subject can be considered politically hot, and there is no political recognition of harm reduction activities at the national level.

14.3 New developments and uptake of prevention, harm reduction and care

Testing for infectious diseases is of course available nationally on all infection wards, as vaccination for hepatitis B. Local campaigns do also exist outside the hospital system. One example of this might be the remand prison in Stockholm, were all drug users are offered tests

and vaccination. Even if there is no official decree from the National Prison and Probation Administration, local information initiatives at the prisons can also be found. One example is the Täby prison, where information campaigns are held every sixth months on virus diseases such as hepatitis.

A general trend is that in-patient treatment is decreasing, on behalf of outpatient treatment in the treatment centres around the country. This pattern is valid for different kinds of abuse (alcohol, illicit drugs, pharmaceuticals and volatile solvents). Drug abusers and multiple abusers (alcohol and illicit drugs) were increasing their share over the second half of the 1990s.

The reasons for the changes mentioned above are probably structural more than having anything to do with the characteristics of the clients, or patterns of abuse. One important factor has to do with a more market oriented economical regime being implemented, thus decreasing the client-capacity from around 7,700 in 1990 to 5,500 in 1998 (including all kinds of treatment regardless of substance). The development is similar for compulsory treatment and the capacity went down from 1,100 to 350 between 1990 and 1998. Following from this the clients in this latter type of treatment had poorer health status than previously, only the most acute cases being subjected to such measures.

A remark is that knowledge of this kind of treatment (non-hospital treatment), in terms of content, quality and outcomes are poor. In the future it is likely that the development of the treatment demand key-indicator will provide information in the areas mentioned.

With regard to hospital treatment (typically detoxification), of which proper registration exists, there is no discernible decrease during the 1990s. Treatment demand increased at a rather stable pace, while at the same time average treatment duration decreased slightly (please also see ST 03 and 04).

Methadone is the normal medicine used in maintenance programmes. The methadone programmes have an upper limit of patients allowed to participate at the same time, this upper limit have been raised at several occasions during the 1990s and amounted to 800 in 1999. A small number of patients have in limited pilot studies been treated with Subutex (Buprenorphine). So far the outcomes have been regarded as positive and in 2000 a somewhat lager clinical trial, including 40 patients, started at Huddinge Hospital, located in Stockholm.

A strategy document on Hepatitis C was recently released, springing from a joint venture between the NBHW, SIIDC and the Organisation of County Medical Officers of Communicable Disease Control (Socialstyrelsen, Smittskyddsinstitutet and Smittskyddsläkarföreningen 1999). In the report it is established that IDUs are massively exposed for HCV infections and that intravenous drug use is dominating the spread of HCV. The most important measure to stop the spread pointed out by the authors is to stop the recruitment of new IDUs, by the use of prevention campaigns among youths. It is stated that other effective measures but stopping the substance abuse at hand are hard to find. Information to already infected users is mentioned as very important but difficult carry out in reality. Findings from the needle exchange programmes have highlighted that some IDUs underestimates the risks of sharing vessels where the drugs are being prepared, and sharing injecting tools with a drug using sex partner (ibid.).

One issue that has been up for discussions, at least in the media, is whether the ongoing experiment with needle exchange programs should be permanent or not. The reason for the arisen debate is a report in progress from The NBHW where all relevant literature and data on the Swedish programmes have been collected and analysed. This investigation was started out due to a request from the standing committee on social questions of the Swedish Parliament, in its turn the result of a Parliament bill on closing the programmes was rejected spring 2000.

For over 13 years, the needle exchange programmes have been running on experimental status, and the committee wanted to see some final conclusions of the experiment.

Long before the investigation was completed, information on its existence leaked to media, and it was believed that the investigators were about to suggest a determination of the experiment and that the programmes, found to be of good practice from several aspects, accordingly was to be made permanent. This caused for concern since it is often advocated that such programmes might induce recruitment to injection use and that such a practice is not possible to combine with the Swedish policy of a drug free society. This matter will be settled, in one way or another, during this autumn.

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