European Monitoring Centre
for Drugs and Drug Addiction

Swedish National Institute
of **Public Health**

2012 NATIONAL REPORT (2011 data) TO THE EMCDDA
by the Reitox National Focal Point

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

REITOX

Contents

Foreword

The 2012 National Report on the Drug Situation in Sweden has been produced for the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

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

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In part B, the section on “Residential treatment for drug users in Europe” is written by Mr Ulf Malmström, Swedish National Institute of Public Health. The section on “Drug Policies of large European cities” is written by Anders Ericsson, City of Stockholm and staff at Swedish National Institute of Public Health.

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

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Summary

Chapter 1: Drug policy: legislation, strategies and economic analysis
The national ANDT (alcohol, narcotics, doping, tobacco) strategy covering the years 2011 to 2015 from 2011 is a central document in Swedish drug policy. The main objectives include a society free from narcotics and doping, decreased medical and social harm from alcohol and a decrease in the use of tobacco. The strategy contains seven long-term objectives with associated priority goals. Measures are detailed in annual action plans and a total of SEK 257 million per year is allocated to the work in the areas of alcohol, illicit drugs, doping and tobacco.

The new legislation (effective since 2011) aiming to deal with the increased use of hazardous substances not yet regulated is used in an increasing number of cases. Statements have been issued regarding 48 substances and more than 300 destruction decisions have been made by prosecutors.

Chapter 2: Drug use in the general population.
Cannabis is the most common narcotic substance in Sweden and amphetamines is the second most common substance among both men and women. An analysis of the prevalence of cannabis use (2004-2011) in Sweden shows that the trend is stable for both sexes, both in terms of experimental use and more regular use. However, higher prevalence was found in the beginning and end of the period.

An increase can be confirmed among women (16-64 years of age) in 2010 relative to 2008. There was also an increase among the younger women (16-34 years of age) between 2008 and 2011. At the last measurement, the lifetime prevalence for women (16-34 years) was 18.6%.

No major change could be found regarding lifetime and last month prevalence in school surveys, when comparing results for 2010 and 2011.

Chapter 3: Prevention
In 2011 important areas for the work against the use of illicit drugs includes parent support, school-based activities and interventions for children with addicted parents. In 2011, the Swedish National Institute of Public Health was commissioned by the Government to implement a national effort targeting cannabis use. About SEK 11 million was distributed to ten projects that aimed at increasing knowledge about cannabis. Also a joint effort (Trestad 2) to address cannabis problems began involving the state and the three largest cities in Sweden.

Chapter 4: Problem Drug Use
The estimated problem drug use population amounts to almost 30,000 in Sweden. National efforts are being conducted to establish suitable methods for regular estimations of this population.

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

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

Chapter 6: Health correlates and consequences
In 2011, only 14 cases of HIV were reported among injecting drug users (IDU), compared to 24 cases in 2010.

By the end of 2011, IDUs accounted for 7% of all people living with a known HIV infection in Sweden, equivalent to about 400 IDUs (or former IDUs). In May 2012, an outbreak of HIV (5 cases) was detected among IDUs in Kalmar. After this event, a needle-syringe exchange programme has been launched in Kalmar to prevent new cases.

About 100-200 cases of acute hepatitis B are reported annually in Sweden. In 2011, 89 cases of acute hepatitis B were reported, compared to 125 in 2010. In 2011, a total of 2,086 cases of hepatitis C were reported, which can be compared to 1,944 cases reported in 2010.

Data on drug-related deaths in Sweden is acquired from the national Cause of Death Register and from a special mortality register on forensically examined deaths. In 2011, data from the Cause of Death register indicate a decrease in the number of deaths compared to 2010, whereas the special mortality register indicate an increase.

Chapter 7: Responses to health correlates and consequences
Today, there are four operational needle and syringe exchange programmes in Sweden. A fifth programme is planned to be operational in Stockholm during 2013.

Chapter 8: Social correlates and social reintegration
The national strategy for counteracting homelessness and exclusion from the housing market has been evaluated. Main results from the evaluation show that the largest problem is that neither the projects nor the local social services are able to influence the housing provision in the municipalities. Another result is that one of the few evidence-based interventions to help people exit homelessness - Housing-First programmes – have not been implemented in any project.

Chapter 9: Drug-related crime, prevention of drug related crime and, prison
In 2011, an increase of about 2% was reported for offences against the Act on Penal Law on Narcotics and the number of convictions with drug violations as the main crime increased by 7%. Of the 21,500 convictions with a drug offence as the main crime during 2011, 14% involved women and 26% involved adolescents between the ages of 15 and 20.

The average number of drug addicts in prison is fairly stable over an extended period of time. Among the prison population in 2011, 59% of the women and 63% of the men were reported to be drug addicts. According to the National Council for Crime Prevention, persons with long prison sentences are at considerable risk of reoffending and using drugs in the period immediately after release.
The Swedish Prison and Probation Service aim only to implement evidence based treatment programs. In order to secure effectiveness the programs are reviewed by a scientific panel and only programs fulfilling the requirements will be granted accreditation. In the year of 2011, 5787 prisoners completed a treatment program in prison.

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

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

Chapter 11: Residential treatment for drug users in Europe
Except for the information that could be gathered from registries, the epidemiological knowledge in the area is inadequate. Consequently, we know little about the extent of substance abuse and dependence in various groups. However, for healthcare, the patient and pharmaceutical registries can provide a relatively good view of the use of inpatient care. Otherwise, the information is limited.

Substance abuse and dependence care in Sweden is to a relatively limited extent an operation guided by well-developed quality standards. A national regulation exists regarding quality systems, but how it is applied at a local or regional level is unknown. The quality of this area has repeatedly been questioned. National guidelines and quality comparisons may possibly play an important role in improving quality.

It is estimated that approximately 50,000 people have received some form of inpatient care in 2010 as a direct or indirect result of alcohol and drug-related problems.

Chapter 12: Drug Policies of large European cities
About 70% of the municipalities in Sweden had one or more political programmes that included the ANDT prevention work. All programmes included alcohol and over 90% dealt with tobacco and narcotics.

Most city districts in Stockholm, Gothenburg and Malmö had an action plan, an operational plan or equivalent that included the ANDT prevention work. All plans included alcohol, narcotics and tobacco.

The city of Stockholm has a written drug policy/strategy called the STAN programme (Stockholm's Tobacco, Alcohol and Narcotics programme). Concrete action plans are to a great extent a matter for the city's 14 districts which carry out most of the practical, everyday work. The most common measures conducted in the districts are arranging drug-free activities, upholding age limits for purchasing tobacco and alcohol, parent meetings and anti-bootlegging campaigns. Almost all districts have or are processing action plans with measurable targets and plans for follow-ups.

Part A – New developments and Trends

1. Drug Policy: Legislation, strategies and economic analysis

1.1 Introduction

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

The ANDT work in Sweden is cross-sector and comprises several authorities' areas of responsibility, regulations and legislation. The work is coordinated by the ANDT secretariat (Ministry of Health and Social Affairs) which is supported by an ANDT council. The Swedish Prison and Probation Service, the Police, the Swedish National Institute of Public Health, the Swedish Institute for Infectious Disease Control, the Swedish National Board of Health and Welfare and Swedish Customs are the main authorities that play a central role in the narcotics field.

1.2 Legal Framework

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

The aim of this legislation is to legally regulate illicit drugs and other products that, due to their intrinsic properties entail harm to people's lives or health and that are, or can be assumed to be, used for the purpose of inducing intoxication or other effects. Narcotics may only be used for medical, scientific or other purposes useful to society that are particularly important (SFS 1968:64). All other possession or use is punishable.

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

- minor, the penalty is a fine or imprisonment for a maximum of six months

- serious, the penalty for a serious narcotics offence shall be imprisonment for a minimum of two and a maximum of ten years.

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

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

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

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

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

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

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

All illicit drugs/narcotics are included in the Medical Products Agency's (MPA) register of Illicit Drugs (LVFS 1997:12). Hence, only substances that are on this list are considered to be narcotics in the eyes of the law. In total, the list of illicit drugs contains about 300 substances and, indirectly, a number of mushrooms that contain psilocybin or psilocin. In practice, however, only around 30 illicit drugs are abused to a greater extent in Sweden.

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

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

Goods covered by the Act (SFS 1999:42) may not be: imported, transferred, produced, acquired with a view to transfer, offered for sale, or possessed. A penalty consisting of a fine or imprisonment for a maximum of one year can be imposed on

individuals that violate the provisions stated in the Act. However, unlawful importation shall be punished in accordance with the provisions of the Act on Penalties for Smuggling (SFS 2000:1225).

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

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

A regulation in the Act on the Control of Narcotic Drugs (1992:860) enables narcotics to be handled for industrial purposes. The purpose of this was to allow regulation of GBL and 1.4-BD as narcotics during 2011.

The Act on the Destruction of Certain Substances of Abuse Dangerous to Health (SFS 2011:111)
New legislation regulating the destruction of certain substances of abuse hazardous to health entered into effect on 1 April 2011 in Sweden (SFS 2011:111). The new law aims to prevent the use and distribution of hazardous substances that are not yet regulated or are in the process of being regulated as narcotic drugs under the Narcotic Drugs Control Act (SFS 1992:860) or as substances hazardous to health under the Act on the Prohibition of Certain Goods Dangerous to Health (SFS 1999:42).

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

The substances covered by the Act are substances which:

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

A statement is required from the Swedish National Institute of Public Health (SNIPH) or Medical Product Agency (MPA) confirming that the substance can be assumed to be classified as a narcotic or hazardous to health.

All matters are handled according to the (SFS 1986:223) and are not viewed as criminal offences. Certain protocols must be used and the decision can be appealed to court.

In order to facilitate the prosecutors' work and to inform the general public, all statements from the (SNIPH) are published on a public website (www.fhi.se).

Since the new law came into effect, statements have been issued regarding 48 substances. More than 300 destruction decisions have been made by prosecutors.

Laws implementation

In 2011, eight substances were controlled as narcotics according to the Act on the Control of Narcotic Drugs (SFS 1992:860) and the Act on Penal Law on Narcotics (SFS 1968:64) and were thereby listed in the amendment to the Ordinance on the Control of Narcotic Substances, (SFS 1992:1554). JWH-210 and JWH-122 were previously listed as Goods Dangerous to Health and have been reclassified as narcotics in 2011.

Laws concerning harm reduction

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

Other laws

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

1.3 National action plan, strategy, evaluation and coordination

A five-year strategy covering the years 2011 to 2015 was adopted in March 2011 by the Swedish Parliament (Government Offices of Sweden, 2011).

The strategy is similar to previous years, as the main objectives include a society free from narcotics and doping and decreased medical and social harm from alcohol as well as a decrease in the use of tobacco. The new five-year strategy also states that the overarching goals from previous national action plans remain.

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

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

In politics, Ms Maria Larsson has national responsibility for alcohol, narcotics, doping and tobacco issues. She was given responsibility for these issues in 2006 as Minister for Elderly Care and Public Health. In the general election of 2010, the incumbent Government's mandate was renewed and Ms Larsson continued in her post. Her present title is Minister for Children and the Elderly, still under the Ministry of Health and Social Affairs

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

1. Curtailing the supply of illegal drugs, doping substances, alcohol and tobacco
    - Effective and coordinated supervision of alcohol and tobacco
    - Effective measures to combat illicit trading
    - Effective measures to combat illicit sales via digital media
    - Effective local and regional collaboration and coordination of ANDT prevention and crime prevention efforts

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

3. Gradually reducing the number of children and young people who initiate the use of tobacco, illicit drugs or doping substances or begin drinking alcohol early
    - Reduced initiation of illicit drugs and doping abuse
    - Development of methods for deterring children and young people from starting to use tobacco products
    - Wider use of available, effective means of postponing alcohol debuts and reducing alcohol consumption
    - Emphasis on health promotion in schools
    - Greater participation by parents, non-governmental organisations and the business community in preventive work

4. Gradually reducing the number of people who become involved in harmful use, abuse or dependence on alcohol, illicit drugs, doping substances or tobacco
    - Intensified efforts by the healthcare service to prevent ANDT-related ill-health (brief intervention and screening)

- Reduced risk use and less intensive alcohol consumption among students and young adults with mental health problems
- More scope for the dental care service to focus on tobacco prevention
- Improved opportunities for the early detection and prevention of ANDT problems in working life

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

6. Reducing the number of people who die or suffer injuries or damage to their health as a result of their own or others' use of alcohol, illicit drugs, doping substances or tobacco
- Fewer deaths and injuries in road accidents due to alcohol or other drugs
- Fewer deaths and injuries due to alcohol-related, drug-related or doping-related violence
- Lower mortality rate among teenagers and young adults due to alcohol poisoning or drug experimentation
- Greater awareness among the population of the health impact of ANDT use

7. Promoting a public health based, restrictive approach to ANDT in the EU and internationally
- Active efforts to ensure compliance with UN conventions in the illicit drugs field
- Active efforts to ensure implementation of the EU and WHO strategies on alcohol and health
- Active efforts to ensure compliance with the WHO framework convention on tobacco control
- Active efforts to ensure compliance with UN conventions in the illicit drugs field
- More effective coordination and increased prioritisation of Nordic cooperation in the ANDT sphere

Annual action programme

The 2012 action programme is based on the 2011-2015 strategy. The one-year action programme covers all of ANDT and describes the priorities for the coming year in more detail than the full action plan/strategy.

2012

The action programme for 2012 includes a number of efforts to achieve the goals set forth in the 2011-2015 strategy (Regeringen, 2012a). Many of the actions stated in the 2012 action programme are on-going. Examples of actions are:
- Efforts to reduce the illicit drug supply are a high priority among customs and police forces.

- The Swedish National Institute of Public Health shall continue to support maternity care and child welfare services to inform about risks during pregnancy and to develop the drug preventive work.
- Continued focus on cannabis prevention by the three largest cities (Stockholm, Gothenburg and Malmö)
- Further development of a monitoring system on drug-related death
- Active participation in the development of the new EU drug strategy and increased coordination at the Government office on international drug issues

Implementation and evaluation of national action plans and/or strategy

Evaluation of the 2011-2015 strategy

In addition to providing a framework for policy goals and priorities, the ANDT strategy is to establish a structure for monitoring developments in the areas of consumption and abuse, medical and social harm, and interventions and measures (Government Offices of Sweden, 2011).

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

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

The Government intends to continue developing and coordinating these statistics and data collection activities. The aim is to track developments in such areas as ANDT consumption and harm, abuse, care consumption the effects of different types of public input on the individuals concerned and their families. A further aim is to facilitate economic evaluations within a comprehensive, integrated perspective.
The Government plans to propose a limited number of key indicators for follow-up and evaluation of the ANDT strategy. An initial baseline measurement to gauge the extent of the ANDT problem will be conducted in 2011 in accordance with a follow-up and evaluation structure developed by a working group composed of representatives of relevant agencies and the research community (Government Offices of Sweden, 2011).

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

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

In light of the above, specific indicators have been identified (Regeringen, 2012b) in order to monitor the long term goals in the 2011-2015 drug strategy. The specific indicators are likely to be set in 2012. For example, as a measure of the overall disease burden, DALY (Disability Adjusted Life Years) is suggested.

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

The plan established that the overall objective of the drug policy in Sweden, i.e. a society free from illicit drugs, will remain unchanged and that political initiatives will be aimed towards the supply and demand on drugs in order to:

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

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

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

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

Evaluation of the 2006-2010 strategy
SNIPH was given the task of evaluating the strategy for the period 2006-2010 and a final report was published in autumn 2010 (Statens folkhälsoinstitut, 2010b). In summary, a more negative development was observed for narcotics than for alcohol, with increasing harm in the form of ill-health, mortality and crime. While efforts to attain the goals in the area of alcohol have intensified, efforts in the area of narcotics have stagnated.

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

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

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

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

National coordination

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

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

The ANDT Council consists of representatives from central authorities and organisations as well as researchers with the main function of advising and informing the Government on issues, new research and inquiries of relevance to the design of

policy in the ANDT area. The Council is chaired by Ms Ragnwi Marcelind, State Secretary at the Ministry of Health and Social Affairs.

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

Ministry of Health and Social Affairs

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

Ministry of Justice

- Correctional treatment
- Penal law
- Police work

Ministry of Finance

- Customs issues
- Legislation on smuggling

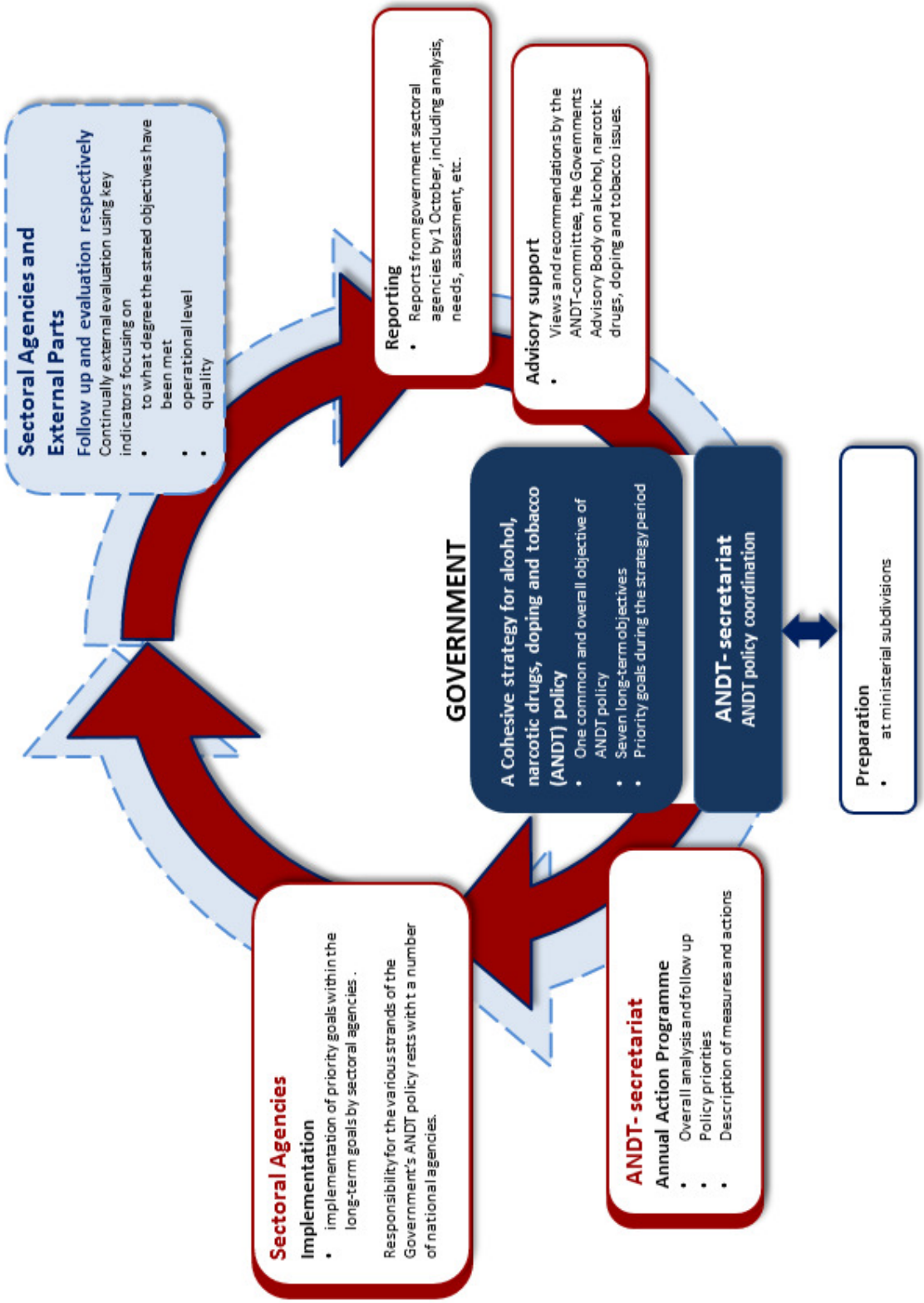
Ministry for Foreign Affairs

- Foreign affairs and drugs-related development assistance

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

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

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

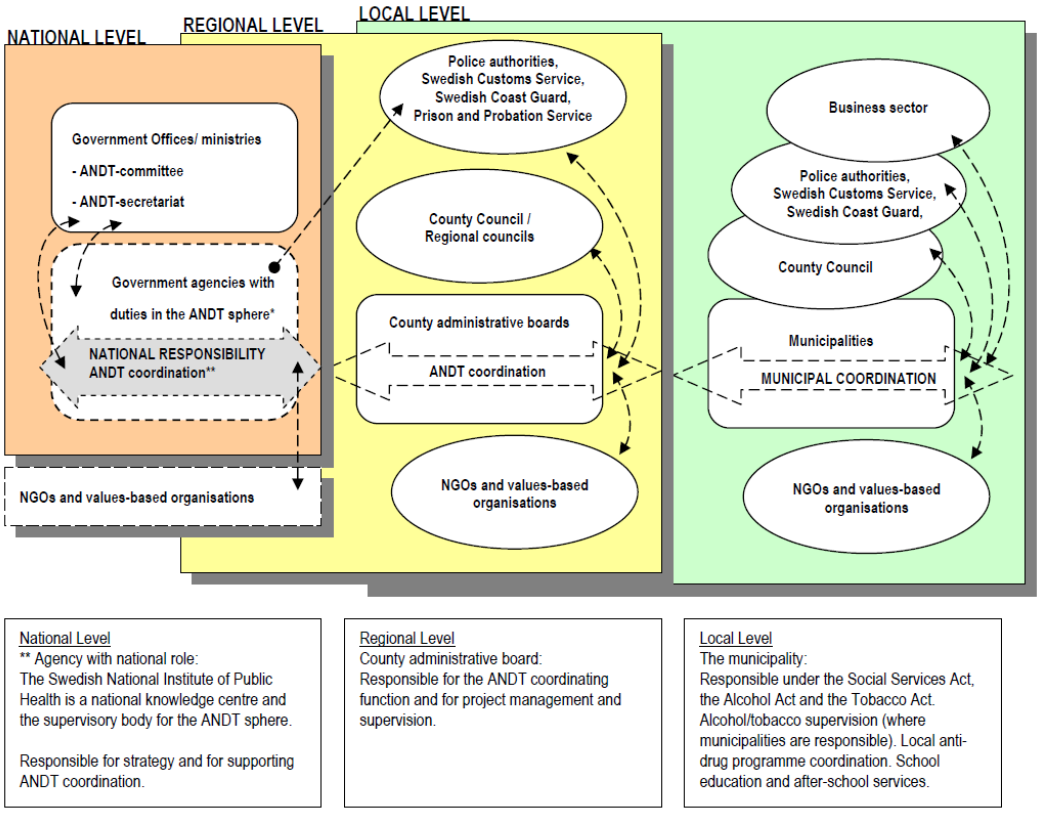


As the national knowledge centre for methods and strategies in the public health sphere, the Swedish National Institute of Public Health (SNIPH) plays a central role in implementing the Swedish national drug strategy covering the period 2011-2015 as well as subsequent action plans. SNIPH's tasks include supporting the ANDT coordinators at the county administrative boards. SNIPH has also been given the task of supporting the health-promoting and preventive work carried out at institutions of higher education in the ANDT area. SNIPH also has a duty to implement information campaigns to ensure that the objectives for the lifestyle issues of alcohol, illicit drugs, doping and tobacco are met.

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

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

Figure 1.2: Overall organisation to reach the national ANDT goals (Government Offices of Sweden, 2011).



Other drug policy developments

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

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

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

In its summary, the Committee of Inquiry states for instance that it "urges an active approach, both at the negotiating table and in the public debate. Non-binding political declarations are also of strategic importance. It is through such declarations that changes in drug policy positions are negotiated. The agreements are adopted by consensus, which confers legitimacy on the measures recommended therein, and can serve as a springboard for drug policy changes and for amending national and international regulations."

Due to the limited resources available, the inquiry further proposes that political and strategic cooperation should be focused on cooperation in the UN and EU.

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

In the 2011-2015 ANDT strategy, the need for greater coordination and prioritisation of Nordic cooperation on ANDT is emphasised. The Committee thus states that, "With regard to general cooperation on drug policy, the former committee of senior officials in the Nordic Council of Ministers has been replaced by an informal annual meeting denominated the Nordic Drug Forum. Although the Nordic countries are bound by strong cultural and language ties, there is no automatic consensus on drug policy. We have differing views on a number of major drug policy issues. It is nevertheless essential that Nordic cooperation, particularly on operational matters, be maintained, whereas the form taken by the general dialogue should always be open to discussion."

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

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

The inquiry had the task of reviewing the regulations in the Social Services Act (SFS 2001:453), the Care of Alcoholics, Drug Abusers and Abusers of Volatile Solvents Act (SFS 1988:870), the Health and Medical Care Act (SFS 1982:763) and the

Compulsory Mental Care Act (SFS 1991:1128). The assignment included considering how the responsibilities of county councils and municipalities can be clarified to ensure that individuals with substance abuse and dependence receive adequate help. The Government Offices of Sweden will compile the parliamentary report in 2012.

The investigator made some 70 proposals. Those that directly concern substance abuse and dependence care aim to clarify municipal and county council responsibility, strengthen the position of the individual, develop the content of care, improve quality, knowledge and expertise and develop compulsory care. In addition, the inquiry makes proposals on the role of the police and correctional care with the aim of improving the care of those committed under the Act on Police Interventions against Intoxicated Persons on disposal of intoxicated people (SFS 1976:511), and efforts within correctional care to prevent relapses into substance abuse and criminality. The investigator also makes some proposals that concern employers, labour market policy and social insurance with the aim of improving the opportunities for occupational rehabilitation.

Work of Schools with Vulnerable Children (SOU 2010:95)
The commission reviewed the right for equal education. The final report was submitted to the Government Offices (Ministry of Education and Research) in December 2010 (SOU 2010:95).

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

National health and welfare commission (S 2011:01)
This commission will review how the state, through its authorities, should work for an effective and long-term sustainable health and welfare system, with a focus on health-promotion and disease-prevention efforts with an aim to promote health and reduce illness and future demand for care and to achieve equal healthcare nationwide. The final report was submitted to the Government Offices (Ministry of Health and Social Affairs) in May 2012 (SOU 2012:33, 2012).

National coordination commission to combat criminality in connection with sporting events (Ku 2011:03)
This commission will contribute to improved coordination between involved authorities and organisations at the national, regional and local levels. The assignment includes analysing and, when necessary, making proposals on what is needed for sporting events to be able to be conducted in a safe and pleasant way and the significance of the use of alcohol, narcotics and doping agents in connection with sporting events. The final report will be submitted to the Government Offices (Ministry of Culture) no later than 31 March 2013 (Regeringen, 2011a).

Patient empowerment commission (S 2011:03)
This commission will propose how the patient's position in and influence over health and medical care can be strengthened. The commission's task includes investigating

the possibilities and structures for providing an electronic health diary on the Internet and the legal prerequisites for the patient to be able to share his or her documentation with the caregiver in a structured manner. The final report will be submitted to the Government Offices (Ministry of Health and Social Affairs) no later than 1 January 2013 (Regeringen, 2011b).

1.4 Economic analysis

Public expenditures

Over the years, a number of different projects have tried to estimate the cost of the drug problem in Sweden. The results are shown in Table 1.1. As shown, the estimates have varied between EUR 330 million in 1991 up to a highest level of € 2,618 million in 2011. Different estimates can largely be explained by different methodology and assumptions.

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

Year of the estimate	Sectors included	Estimate	Reference
1991	health care, treatment, probation care, social service, the correctional system, the judiciary system, the social welfare system	€330 million	The Swedish National Audit Office 1993
1996	treatment, probation care, social service, the correctional system, the judiciary system, the social welfare system, police, customs	€660 million	Fölster and Säfsbeck 1999
1999	not clear	€847 million	The Swedish Commission on Narcotic Drugs 2000
2002	"All institutions dealing with drug users"	€495-1,385 million	Ramstedt, 2006
2007	"All institutions dealing with drug users"	€528-1,474 million	Update of the 2002 estimate using the consumer price index
2011	“All institutions dealing with drug users”	€ 2,618 million	(SOU 2011:6)

Funding for prevention
The Swedish National Institute of Public Health (SNIPH) has been commissioned by the Government to allocate funding in the alcohol, drug, tobacco and doping prevention area. The aim is that these funds will contribute to the implementation of national action plans in the ANDT area.

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

SNIPH has also been instructed by the Government to fund specific projects to support efforts for local activities. Projects carried out in cooperation with NGOs are prioritised. Basic research and data collection aimed at mapping and monitoring developments in this area can also be granted funds.

An equal distribution of funds to the different substance areas within the ANDT field is the aim, although the number and quality of the applications received play an important role.

In 2011, SNIPH allocated a total of SEK 40 million. Priority was given to areas of supply reduction, information, children of substance abusers, efforts in health and medical care, and efforts to support local projects in cooperation with NGOs. All funded projects will submit their reports on activities conducted during the year in December. For projects within NGOs, evaluation cooperation has been established with Örebro University.

From this SEK 40 million, a total of 103 projects received funding for ANDT preventive efforts in 2011.

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

Type of applicant organisation	**Approved grants (103 grants)**			
	Quantity	SEK (thousands)	% of number of granted applications	% of granted total amount
NGOs	79	24,694	76	61
Municipalities	4	1,546	4	4
County council/ administrative board	9	6,653	9	17
University	11	7,107	11	18
Total	103	40,000	100	100

Budget

The Government annually allocates funds during the mandate period for work within the scope of the ANDT strategy, on condition that the Swedish Parliament makes funding available. For 2012, the Government allocated nearly SEK 260 million for this work.

Funding from other policy areas that may be relevant to the ANDT area is in addition to this figure. For example, SEK 109 million are allocated to the area of female victims of violence, child witnesses of violence and violent perpetrators, SEK 70 million to the municipalities for performance-oriented efforts and SEK 20 million to NGOs. Some of the funds are intended to stimulate the incorporation of existing knowledge into efforts and to support long-term method development in the field.

Social costs

Care and treatment for drug users are considered by many to be costly and resources are often not enough. But the real waste is to refrain from treatment claim Swedish economists Ingvar Nilsson and Anders Wadeskog, who in particular have made analyses of the methadone programme in Stockholm (Nilsson and Wadeskog, 2008). With the help of experts and clients they carved out a number of courses that can be described as typical careers in addiction. They identified and priced around 150 different consequences that a life in alienation brings. Many of these effects are more or less invisible and difficult to detect. Their analysis indicates that an active heroin user on average costs society 2.1 to 2.3 million SEK per year. A large portion of these costs ceases or is reduced when the person stops or reduce their drug use.

The cost of a place in the methadone programme is about SEK 100,000. The analysis shows that each invested krona gives 17 times the money back, which according to the researchers is equivalent to an annual return of 1778%.

Drug users who are long-term drug-free without relapses give a return of between 50 and 150 times the money. But even those who have not been as successful generate a financial gain. One of the most important lessons according to Nilsson and Wadeskog is that everyone involved in the maintenance treatment - except those who very quickly leave treatment and return to drug use - contributes to the socio-economic gain. So it is important to nuance the view of what counts as success in treatment.

The study identified a number of mechanisms that contribute to and reinforce marginalization. One of these is short-termism in decision making, where the financial year controls decisions. Another is the so-called “downpipes effect”, meaning that all instances only see their small part of the problem and no one tends to see and take responsibility for the big picture. It also means that most of the economic effects of marginalization are invisible to the individual decision-maker since they affect mainly budgets and sectors other than their own (Nilsson and Wadeskog, 2008).

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

2.1 Introduction

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

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

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

In 2010, the Swedish National Institute of Public Health published a report (Statens folkhälsoinstitut, 2010c) that presents results from a number of studies conducted in 2005 on behalf of the anti-narcotics coordination body of the time called Mobilisation against Narcotics. Among these were four questionnaire studies, the largest of which was a population study. The other questionnaire studies targeted students, restaurant personnel and festival participants. Various methods were tried to reach people with problem drug use, including a technique called respondent-driven sampling (RDS). In addition, register methodology was used to estimate the number of problem drug users in Sweden. More information on the register methodology is provided in Chapter 4.

2.2 Drug use in the general population

Cannabis

The Swedish National Institute of Public Health annually conducts a national public health survey in the form of a questionnaire study that is sent to a random selection of approximately 20,000 people. The national public health survey targets people

between the ages of 16 and 84. Statistics Sweden is commissioned to conduct the questionnaire survey. The objective of the study is to show how the population is doing and to monitor changes in health over time as a part of the follow-up of the public health policy. One question in the survey concerns cannabis use and is intended to indicate prevalence and potential change over time. This question makes it possible to describe the cannabis use trend in Sweden, rather than measuring differences from year to year. The response frequency in the surveys has been around 50% in recent years.

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

Lifetime prevalence (%) - sometime in life									
		2004	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
16-64	Men	17.6	15.5	15.6	16.4	14.6	18.5	18	17.2
	Women	9.9	9.7	8.9	9	8.4	9.2	10.4	11
16-34	Men	25.5	22.1	23.7	22.3	19.7	26.8	24.3	24.2
	Women	16.3	16	15.4	13.8	13.5	14.9	16.5	18.6
16-24	Men	23.3	18.7	16.2	15.5	11.8	20.6	17	18.6
	Women	14.7	13.3	15.4	13.3	12.3	11.4	13.2	16.1
Annual prevalence (%) - the last year									
		2004	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
16-64	Men	3	2.8	2.6	2.8	2.6	4.3	3.7	3.6
	Women	1.5	1	1.4	1.3	1.4	1.5	1.8	1.6
16-34	Men	6.6	6.6	6.7	6.3	5.8	9.8	7.8	8.3
	Women	3.8	2.5	3.6	3.3	3.6	3.8	4.6	3.9
16-24	Men	9.7	10.2	6.2	5.9	4.8	11.1	8.6	8.5
	Women	4.8	3.9	6.2	4.7	5	5.5	5.8	5.9
Monthly prevalence (%) - the last month									
		2004	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
16-64	Men	1.2	1.2	0.9	0.8	0.7	1.5	1.4	1.2
	Women	0.3	0.4	0.3	0.3	0.3	0.3	0.5	0.6
16-34	Men	2.5	2.7	2.3	1.8	1.5	3.1	3	2.5
	Women	0.7	0.8	0.9	0.7	0.7	0.9	1.2	1.5
16-24	Men	4	4.7	1.8	2.3	1.5	3.8	3.3	3.1
	Women	1	1.4	1.8	0.7	0.9	1.2	1.1	2.2

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

An analysis of the entire time series shows that the trend is stable for both sexes, both in terms of experimental use and more regular use. The prevalence for men was

higher at the beginning (2004) and at the end (2009-2011) of the time series. Among women, the prevalence was higher at the end of the time series.

During the time period that the studies were under way, some changes[1] can be statistically confirmed. Among others, an increase can be confirmed among women (16-64 years of age) in 2010 relative to 2008. There was also an increase among the younger women (16-34 years of age) between 2008 and 2011. At the last measurement, the lifetime prevalence for women in the 16-34 age group was 18.6%, see Table 2.1.

The development of the prevalence among men varies more than among women. The prevalence is also significantly higher among the men. The lifetime prevalence is the highest among men aged 16-34, see Table 2.1. The lifetime prevalence for men in this age group was 24.2% at the latest measurement. The annual prevalence and monthly prevalence are also highest among young men. An increase in the annual prevalence for men in all age groups was confirmed in 2009 relative to 2008. The annual prevalence for men between 16-24 years was 11.1% that year. Monthly prevalence for men in the same age group also increased between 2008 and 2009. According to the latest measurement, the monthly prevalence for this group was 3.1%.

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

Comparisons between the national public health surveys and CAN's school surveys are not recommended because the surveys are aimed at entirely different target groups and are structured accordingly. Recurring general surveys among young

[1] **Change in lifetime prevalence for men, women and various age groups, CI (95%)**
Men 16-64 [2004 (16.4 – 18.7), 2008 (13.4 – 15.7), 2009 (15.9 – 18.6)]
Women 16-64 [2008 (7.6 – 9.2), 2010 (7.6 – 9.2)]
Men 16-34 [2004 (23.1 – 27.9), 2008 (17.3 – 22), 2009 (24 – 29.7)]
Women 16-34 [2008 (11.8 – 15.3), 2011 (16.4 – 20.8)]
Men 16-24 [2004 (19.7 – 27), 2008 (9 – 14.6), 2009 (16.8 – 24.4)]

Change in annual prevalence for men in various age groups, CI (95%)
Men 16-64 [2008 (2 – 3.1), 2009 (3.7 – 5)]
Men 16-34 [2008 (4.4 – 7.2), 2009 (7.9 – 11.7)]
Men 16-24 [2004 (7.1 – 12.2), 2008 (2.9 – 6.7), 2009 (8.2 – 14.1)]

Change in monthly prevalence for men (16-24 years of age), CI (95%)
Men 16-64 [2008 (0.4 – 1), 2009 (1.1 – 1.9)]

people (16-24 years of age) are needed to be able to study the entire group more closely, where cannabis use tends to be the highest.

Cannabis use in Sweden does not exhibit declining tendencies. The fact that the time series tends to have a higher prevalence at the end is interpreted here as a risk that cannabis use is increasing. Annual prevalence and monthly prevalence varies less than lifetime prevalence. Approximately 4% of the men and 2% of the women used cannabis in the past year. In 2011, 1.3% said that they had used cannabis in the past month. Slightly more than 0.5% of the women and just over 1% of the men used cannabis. Illicit drug use is uncommon in the population, but it nonetheless appears likely that those that use cannabis more frequently are more difficult to reach in a questionnaire survey. Those who use illicit drugs can generally be described as a stigmatised group and few who use or are dependent on illicit drugs openly announce it (Statens folkhälsoinstitut, 2010c).

Other drugs

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

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

1,000 of those who did not respond to the questionnaire were selected and contacted by phone to participate in an interview with an abbreviated version of the questionnaire. Nearly half (47%) did not agree to be interviewed. After the supplemental drop-out analysis among those who did not respond, the response frequency was calculated to be 52% after weighting. Some of the results from the study are presented below.

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

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

Cannabis was the most common narcotic substance that 23% of the men and 11% of the women said they had used at some time in life, see Diagram 2.1. Amphetamines (6.8%) were the second most common substance among men, followed by cocaine (3.8%), hallucinogens (3.5%), opiates (2.3%) and ecstasy (2.2%). Nearly 1% of the men said they had used another drug. Among women, amphetamines (3%) were also the second most common drug. They were closely followed by cocaine (2.5%), hallucinogens (2.3%) and ecstasy (1.8%). Approximately 2% of the women said they had used another drug. Opiate use (1.3%) occurs more rarely among women.

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

2.3 Drug use in the school and youth population

School population
The Swedish Council for Information on Alcohol and Other Drugs (CAN) annually conducts national studies of the alcohol and drug habits of school children. In 2011, the national school survey was also carried out among students turning 16 and 18, which means that a majority were 15 and 17 years old, respectively, since data was collected in March. The methods and results are presented in Standard Table 2.

The lifetime prevalence (2011) of any drug for 15- and 16-year-old boys and girls were 9 and 6% respectively, which for boys is the same percentage as the year before and for girls is 1% less. The past-30-day prevalence was 2% for boys and 1% for girls. Cannabis was by far the most common drug in the surveys among 15- and 16-year-olds, irrespective of sex.

Lifetime prevalence (2011) of ever having used an illicit drug among the 17- and 18-year-old students was 20% for boys and 14% for girls, which for boys was 1% lower than in 2010, but 2% points higher than in 2009. The past-30-day prevalence was 6% and 2%, respectively. Among those who had used an illicit drug, the most common drug of choice was cannabis, but benzodiazepines, cocaine and amphetamines were also reported.

According to CAN's 2011 school population survey (Centralförbundet för alkohol- och narkotikaupplysning, 2011), very few students used drugs before the age of 14; 2% of the boys and 1% of the girls. The percentage of students who reported drug use before the age of 14 has been stable over the last 20 years.

The percentage of students (15-16 years of age) who had an opportunity to try drugs (for the first time) increased at the end of the 1990s and the increase continued until 2000 when 27% reported in the survey that they had had the opportunity to try drugs. From then on, the percentage decreased again and in 2011 it was 18%. The percentage of older students (17-18 years of age) who had an opportunity to try

drugs is somewhat larger, approximately 32% (Centralförbundet för alkohol- och narkotikaupplysning, 2011).

The results from the same school population survey show that there is a strong correlation between the experience of drug use and extensive alcohol consumption. Among students aged 15-16, approximately 40% of those who had used drugs were also consuming large quantities of alcohol, compared with students with no reported drug use where the proportion was 8%. In addition, among students ages 17-18, there was a large difference between students with and without experience of drug use with regards to extensive alcohol consumption, though the difference was not as large as for students aged 15-16 (Centralförbundet för alkohol- och narkotikaupplysning, 2011).

There is also a correlation between reported drug use and binge drinking. Among students who reported drug use, almost 57% of 15- and 16-year-olds and 74% of 17- and 18-year-olds report monthly binge drinking. This is a considerably higher percentage than what could be found among students with no drug experience. Use of tobacco was also more common among students with experience of drug use, compared with students with no drug experience (Hvitfeldt and Gripe, 2010).

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

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

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

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

Students

In the student study, the aim was to survey illicit drug use among full-time university students (Statens folkhälsoinstitut, 2010c). Students aged 18-34 were included in the analyses. The results indicated that 35% of the men and 33% of the women had used illicit drugs some time in their lives. The results from the student survey do not support a more extensive illicit drug use among university students than others in the same age groups in the population. In the population study, no major difference was found between illicit drug use among students and the gainfully employed. In both cases, 19% said that they had used narcotics at some time in life. However, it was more common among university students (1.5%) to use illicit drugs more regularly, in the past 30 days, compared with the gainfully employed (0.9%).

3. Prevention

3.1 Introduction

Organisational framework of prevention
In 2010, the Swedish National Institute of Public Health (SNIPH) published an evaluation of the action plans to prevent the harmful effects of alcohol and narcotics during the period 2006-2010. The result of the evaluation is presented in chapter 1. A five-year strategy covering the years 2011 to 2015, “A Cohesive Strategy for Alcohol, Narcotic Drugs, Doping and Tobacco Policy” (ANDT strategy), was adopted by the Riksdag (Swedish Parliament) in March 2011(Government Offices of Sweden, 2011). To read more about the strategy, please see chapter 1.

Besides the national efforts, there was a “county coordinator” in each of the 21 counties in Sweden in 2011, who had the role of supporting the preventive work with alcohol, narcotics, doping and tobacco (ANDT) at the county level. In 2011, the county administrative boards were commissioned to: work for the implementation of the national ANDT strategy in the county, to contribute to the development of long-term and knowledge-based prevention efforts at the regional and local level and to stimulate the development of coordinated efforts in cooperation with relevant actors (Swedish Council for Working Life and Social Research, 2012).

According to the *Länsrapport 2011* [Eng. the County Report 2011], almost half of the counties had a regional strategy for the preventive ANDT work in 2011 and seven of them had also adopted an action plan for prevention work in the county (Statens folkhälsoinstitut, 2012c). National responsibility for county coordination is placed at the SNIPH. In 2011, this involved an obligation to allocate SEK 30 million to the coordination of the prevention work in the counties, as well as the financing of the employment of the county coordinators. During 2011, the county coordinators began the work of implementing the 2011-2015 ANDT strategy.

In Sweden, the implementation of prevention is generally the responsibility of the municipality, where the preventive efforts are often coordinated by “drug coordinators”. According to the County Report 2011, about three quarters of the 290 municipalities were able to appoint local drug coordinators for the work on narcotics prevention with national support. The same person often coordinates prevention efforts against different addictive substances (Statens folkhälsoinstitut, 2012c).

On a local level, prevention efforts are normally summarised in a municipal policy for alcohol and drugs. In 2011, about 70% of the municipalities had such a political programme. About 60% of the programmes had measurable objectives and half of the programmes had a follow-up plan. In 65% of the programmes, there was an implementation plan with appointed responsible actors and in nearly a third of the cases funds were allocated for the implementation of activities according to the plan (Statens folkhälsoinstitut, 2012c).

Monitoring tools
The SNIPH annually collects information from the local and regional drug coordinators on illicit drugs and the prevention work at the local level and reports the information in the County Report. The support of municipal management is a key component of the prevention work (Allebeck et al., 2012). Indicators of the priority of drug prevention include the adaptation of a drug policy, the appointment of a drug coordinator and the allocation of funds for prevention work. The recent changes in the Alcohol Act and the onset of the ANDT strategy called for extensive adaptations in the 2011 questionnaire.

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

3.2 Environmental prevention

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

Alcohol policies
Alcohol consumption in Sweden reached a peak in 2004 after steadily increasing since the mid-1990s. Due to revised methodological considerations of handling respondent data on unregistered consumption, new figures have been published covering 2009-2011. This revision does not appear to affect the overall trend that earlier estimates indicated, and only seems to marginally affect the estimate of total consumption of alcohol. Sweden has seen a decrease of the total alcohol consumption since the mid-2000s. This decrease is, however, not as substantial as the increase prior to it that culminated in 2004. Revised figures indicate that the total consumption of alcohol in Sweden amounted to 9.4 litres of pure alcohol per inhabitant 15 years of age and older in 2011 (Projektgruppen som ingår i arbetet med uppföljning och utvärdering av ANDT-strategin i samarbete med Centrum för socialvetenskaplig alkohol- och drogforskning, 2012).

On 1 January 2011, a new Alcohol Act came into effect. The new Alcohol Act (SFS 2010:1622) replaced the former Alcohol Act (SFS 1994:1738) and the Act on the Sale of Technical Spirit and Substances Containing Alcohol (SFS 1961:181). Associated provisions pertaining to the new Alcohol Act are found in the Alcohol Ordinance (SFS 2010:1636). The new legislation includes changes of the regulations relating to e.g. serving licences, production, marketing, supervision and handling of alcoholic beverages. The new alcohol act permits catering companies to require permanent serving licences, enables hotels that have serving licences along with restaurant services to serve alcohol through room service, permits serving licence holders to use a mutual serving area, and contains changes in the requirements pertaining to kitchen equipment and food preparation. Applicants of serving licences

are required to pass a test relating to the regulations connected to the serving of alcohol. The new Alcohol Act also enables holders of permanent serving licences to the general public and wholesalers the possibility to arrange trade fairs or similar activities that offer product sampling to the general public. The right to offer product sampling is also extended to farm producers of alcoholic beverages. Municipalities are required to provide guidelines relating to the regulations surrounding serving licences, as well as to establish plans for supervision that are to be reported to the county administrative boards. Municipalities have been given the possibility of sending out reminders to serving licence holders that have violated the regulations, prior to potentially sending warnings. Both a reminder and a warning should normally precede a possible revocation of a serving licence. In conjunction with severe violations, it is possible to revoke licences without any prior reminder or warning, however.

In order to limit inebriation and alcohol-related nuisances, there are strict regulations surrounding the serving of alcoholic beverages. If the municipality has not decided otherwise, the serving of alcoholic beverages, other than beer containing less than 3.5% alcohol by volume (ABV) may not begin earlier than 11 a.m. or ended later than 1 a.m. All on-premise establishments are required by law to supervise their sales during the entire serving period, to be done by either the serving licence holder him-/herself or a person assigned for the task. Staff responsible for the serving of alcoholic beverages is required to exercise moderation and make sure disturbances relating to intoxication are avoided. On-premise establishments are required to be able to provide a varied menu of food until 11 p.m. and thereafter a simpler assortment, which helps limit inebriation. No one may bring spirits, wine, strong beer or other fermented alcoholic beverages purchased in an on-premise establishment out of the serving area. On-premise sales are also regulated with regard to sales hours, locations of sales and specific events (e.g. sports events or concerts). There are no national regulations regarding restrictions on alcohol consumption in public spaces, but each municipality may apply local provisions regarding alcohol consumption in public places.

The Alcohol Act (SFS 2010:1622) prohibits retail sales of alcoholic beverages to minors under the age of 20, other than beer containing less than 3.5% alcohol by volume which may not be sold to individuals under the age of 18. The serving of alcoholic beverages is also not permitted to individuals under the age of 18. Alcoholic beverages may not be handed over as gifts, loans or offers to individuals that are under the age of 20, except for beer containing less than 3.5% alcohol by volume (ABV) in which case the age-limit 18 applies. The regulations pertaining to age-limits are well enforced.

Systembolaget AB has a monopoly on all retail trade of alcoholic beverages, other than beer containing less than 3.5% alcohol by volume (ABV) which may be sold by grocery stores. Systembolaget's sales take place in part in retail shops and in part through delivery points in most villages or small towns that have no retail shops. In 2011, there were 418 retail shops and 548 delivery points in Sweden. The delivery points do not keep products in stock, but order them upon request by customers. Systembolaget's mandate from the Swedish state is to help limit the medical and social harm caused by alcohol. This includes restricting availability through e.g. the number of stores, opening hours and following the regulations regarding retail trade

(such as conducting ID checks, refusing to sell alcoholic beverages upon suspicion of illegal resale or refusing to sell to intoxicated individuals). Opening hours for a retail shop are chosen with regards to local customer needs, within the permitted opening hours decided upon by the Swedish Parliament. Generally, this means opening hours between 10 a.m. and 6 p.m. Monday to Friday and 10 a.m. to 1 p.m. on Saturdays.

The Swedish Government has approved a trial project in which home delivery of alcoholic beverages from Systembolaget will be available in a limited number of Swedish municipalities starting autumn 2012. The service will only be available by internet to private consumers. Products will be delivered no earlier than three days after ordering and the deliveries will be conducted between 10 a.m. and 8 p.m. Monday-Friday. The home delivery will be conditioned upon strict age-controls and consumers are obliged to pay an additional charge for shipping. The trial project will be evaluated by external researchers (Systembolaget, 2012).

Apart from VAT of 25% on the sales price (excluding taxes), most alcoholic beverages (defined as beverages with an alcohol content of more than 2.25% by volume) are also subject to specific excise duties. Beer with alcohol content up to and including 2.8% ABV is not subject to any specific excise duty, but beer with an ABV of more than 2.8% is levied with SEK 1.66 for each litre and percentage ABV. Wine and other fermented beverages (that are not classified as wine or beer) are taxed as followed: 1.2% < ABV ≤ 2.25% → SEK 0.00 per litre, 2.25% < ABV ≤ 4.5% → SEK 7.58 per litre, 4.5% < ABV ≤ 7% → SEK 11.20 per litre, 7% < ABV ≤ 8.5% → SEK 15.41 per litre, 8.5% < ABV ≤ 15 → SEK 21.58 per litre, 15 < ABV ≤ 18 → SEK 45.17 per litre. Mid-range products relating to CN-numbers 2204, 2205 and 2206 containing more than 1.2% ABV but no more than 15% ABV are levied with an excise tax of SEK 27.20 per litre and mid-range products (with the same CN-numbers) containing more than 15% ABV but no more than 22% ABV are levied with an excise tax of SEK 45.17 per litre. Beverages with an ethyl alcohol content of more than 1.2% ABV derived to CN-number 2208 as well as beverages with an ethyl alcohol content of more than 22% ABV derived to CN-numbers 2204, 2205 and 2206 are levied with an excise tax of SEK 501.41 per litre pure alcohol. The aforementioned tax-rates have been applied since 1 January 2008. Excise taxes on alcoholic beverages are currently not adjusted for inflation. Excise on alcoholic beverages is regulated by the Act (SFS 1994:1564) on Excise Duty on Alcohol.

In Sweden, it is not permitted to operate a vehicle with a blood alcohol concentration (BAC) of 0.02% or more. This is equivalent to 0.1 mg alcohol or more per litre exhaled air. Means of identifying drunk drivers include blood or urine analysis of individuals suspected of drink driving, random breath testing and sobriety checkpoints, observational assessments and blood or breath tests of crash-involved drivers in some but not all cases. Penalties include fines, suspension or revocation of driving licence, imprisonment, community service and mandatory ignition interlocks. A clear majority, about 90%, of all cases of drink driving relates to young or middle-aged men. Blood alcohol concentration of 0.1% or more, equal to 0.5 mg alcohol or more per litre exhaled air, constitutes aggravated drink driving in Sweden. The regulations pertaining to drink driving are strict and well enforced (Swedish Transport Administration, 2010).

Tobacco policies

Smoking has decreased in Sweden since the mid-1980s, and in 2011, the proportion of daily smokers in Sweden was 12% among women and 10% among men. The proportion of daily moist snuff (snus) users is 3% among women and 18% among men. Today, smoking is most common among people with a low level of education or low income, and some immigrant groups (Statens folkhälsoinstitut, 2012d).

The Tobacco Act was implemented in 1993 and a number of amendments tightening the law have since been introduced (SFS 1993:581). Sweden ratified the WHO Framework Convention on Tobacco Control in 2005 (Framework Convention Alliance).

The Framework Convention on Tobacco Control consists of evidence-based measures to decrease tobacco use. One of the most effective measures is higher taxation (World Health Organisation, 2003). In recent years, the Government of Sweden has prioritised tax increases on tobacco products (Socialdepartementet, 2012). The prices on tobacco products are, however, still low compared with some other EU member states and Norway (European Commission, 2012).

All indoor public places in Sweden are non-smoking areas since the implementation of the Tobacco Act in 1993 and school grounds were included in 1994. There is protection from exposure to tobacco smoke in all indoor workplaces and it is prohibited to smoke in public transportation (SFS 1993:581). Sweden implemented non-smoking restaurants and pubs in 2005 (designated smoking rooms are allowed under special exceptions) and there is a high level of compliance and satisfaction with the regulation. Smoke-free school grounds are an exception, were the surveillance does not work. Four out of five students reported that students smoked on the school grounds in 2009. An effort to accomplish smoke-free school hours has been introduced to the municipalities (Statens folkhälsoinstitut, 2010e). Exposure to second-hand smoke decreased after 2005 when smoke-free restaurants and pubs were implemented (Statens folkhälsoinstitut, 2012d).

In recent years, almost all county councils and more than half of the municipalities have voluntarily adopted policies for smoke-free working hours for their employees. A regulation is in place that prohibits smoking during working hours and contributes to the protection from exposure to tobacco smoke for the non-smoking employees. A few of the county councils and municipalities also include snus (snuff) in their regulations (Statens folkhälsoinstitut, 2010d, Tobaksfakta, 2012). Sweden does not have legal restrictions on outdoor areas such as those of restaurants, bars, beaches, parks and bus stops etc., but the Goverment has assigne the Swedish National Institute of Public Health the task of investigating possible areas to make smoke-free in the future through December 2013.

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

Sweden has a comprehensive ban on all tobacco advertising, promotion and sponsorship, but tobacco products are still displayed and visible at points of sale (SFS 1993:581). There is an ongoing investigation about the marketing of tobacco and alcohol in digital media in Sweden.

The National Board of Health and Welfare has developed and disseminated appropriate, comprehensive and integrated guidelines for tobacco cessation based on scientific evidence (Socialstyrelsen, 2011c). Sweden has a national "quit smoking" helpline to help dependent smokers stop. Local healthcare centres offer tobacco cessation treatment, although still at a low intensity. Tobacco cessation is severely inadequate since 300,000 people are estimated to want to quit using tobacco in Sweden (Statens folkhälsoinstitut, 2010d).

There has been a decrease in the number of cigarette smokers in the adult population, (Statens folkhälsoinstitut, 2012d) but there is no such development among adolescents. The proportion of adolescent smokers is nearly the same level as 10 years ago, although there has been a small decrease the past two years, especially among girls (Henriksson and Leifman, 2011). Even if Sweden is a country with few daily smokers, we still have a high total number of tobacco users due to snus (Statens folkhälsoinstitut, 2012d).

Increases in excise duties on tobacco and the introduction of smoking bans in bars and restaurants in 2005 are two efforts in particular that have had an impact on reducing tobacco use in recent years (Statens folkhälsoinstitut, 2011c). However, from an international perspective, Sweden is lagging behind with regard to tobacco prevention measures. Unlike other countries in the EU, Sweden has not adopted certain tobacco policies in recent years, including bans on advertising exposure of tobacco products at sales outlets and the introduction of pictorial warnings on cigarette packs (Joossens and Raw, 2011).

3.3 Universal prevention

Drug prevention activities in Sweden have increased in many areas for a number of years. An effective structure was built for prevention work within the national action plan on drugs 2006-2010. National efforts focused on research, development and the dissemination of preventive methods, regional coordination and local activities (Statens folkhälsoinstitut, 2010b).

In June 2011, the SNIPH was commissioned by the Government to implement a national effort targeting cannabis use. About SEK 11 million was distributed to ten projects that aimed at increasing knowledge about cannabis and, in some cases, served as models for counties and organisations interested in implementing cannabis preventive measures. The projects will be followed-up in 2012/2013. The SNIPH also conducted workshops with the aim of sharing knowledge about the projects and providing participants the opportunity to discuss the information activities that were being planned or implemented (Statens folkhälsoinstitut, 2012e).

In spring 2012, the Government replaced the commission with a new commission focused on compiling research and evaluations of implemented actions related to drug use and cannabis use, in particular. The new commission has been allocated

SEK 4 million per year and the final report is to be submitted by 31 March 2015. When the SNIPH received this new assignment, a joint effort to address cannabis problems began involving the state and the three largest cities in Sweden: Stockholm, Gothenburg and Malmö. The project, Trestad 2, is part of an annual effort that extends to 2014 and has a total budget of SEK 12 million, focused on raising awareness of cannabis among young people and parents. The goal is to reduce the use of cannabis among young people under the age of 25. To achieve this, the cities work on three parallel levels: prevention, early intervention and treatment services.

In 2011, a 12-month review of Swedish research from the period 2005-2010 concerning, above all, alcohol, narcotics, doping and tobacco was conducted by an evaluation group of international ANDT research experts (Swedish Council for Working Life and Social Research, 2012). The purpose of the review was to evaluate scientific quality of the research and to identify gaps, weaknesses and strengths of Swedish ANDT research in an international perspective. The results show that Sweden has maintained a somewhat unique and perhaps more restrictive national policy concerning illicit drugs compared with many other members of the EU.

The report concludes that Sweden could develop the research concerning the effects of Swedish national drug policy, and regards this as a significant opportunity. Also, Sweden has a well-organised structure for prevention work, thus creating a special resource for experimental prevention research. One of the barriers faced by prevention researchers is that testing interventions are seen as less significant because this research is applied.

Another aspect highlighted in the report was the structural changes implemented in conjunction with Swedish EU membership. A number of historical national policies were eliminated or modified and as a result much of the responsibility for local alcohol licensing and regulation and local abuse prevention has been transferred to municipalities. Since this transfer, prevention and policy research has declined and, with a few exceptions, there have been few Swedish quantitative effect studies on local prevention of health and safety problems associated with alcohol or drugs. Finally, the report concluded that there is a need for investment to regain a leading position in addiction research. The report also makes a number of strategic and specific recommendations concerning, among other things, the funding and the focus of ANDT research (Swedish Council for Working Life and Social Research, 2012).

School

Swedish schools have a long tradition of offering education about alcohol, narcotics and tobacco. Research has shown that school-based drug education only has transient preventive effects (Bremberg, 2008), and an increasing number of schools consequently now focus on health-promoting school development, which also constitutes one of the objectives of the national ANDT strategy. The Swedish National Agency for Education emphasizes four key areas of importance for ANDT use based on research: social and emotional learning, cooperation between school and parents, student health and school-extracurricular activities. As a result of a Government commission in 2011 to improve ANDT education, the Swedish National Agency for Education reported that the educational activities will have two main objectives: 1) to provide participants with assistance in developing high quality education about alcohol, narcotics, doping and tobacco, and 2) to provide

participants with knowledge on how issues related to school achievement, school satisfaction and parental cooperation can affect students' use of ANDT (Regeringen, 2011a).

The Social and Emotional Training (SET) is a school based method for promoting social and emotional learning in the municipalities. The method, which aims to develop children's social and emotional capacity and thereby promote psychological health and prevent drug use, was carried out in about half the municipalities in 2010[2] (Statens folkhälsoinstitut, Unpublished). A Swedish study conducted with a control group[3] showed positive effects on the promotion of aspects of self-image, including well-being and the hindering of aggressiveness, bullying, attention-seeking and alcohol use (Kimber et al., 2008).

In recent years, the causal link between alcohol, tobacco and illegal drugs, and its importance for prevention, has increasingly been raised (Statens folkhälsoinstitut, 2012a). Research shows that drug use in adolescents usually develops gradually and that smoking or alcohol is usually the first step. The risk of commencing cannabis use also increases as age at the onset of tobacco use decreases. With this knowledge in mind, the tobacco prevention efforts in schools are also of importance to the prevention of illegal drugs. In 2011, more than half of the municipalities undertook measures to promote smoke-free school grounds and about one third of the local authorities had structured programs to prevent tobacco debut in primary school, according to the County Report (Statens folkhälsoinstitut, 2012c).

Family

In recent years, there has been an increase in the number of municipalities that report on activities for parents in drug prevention work (Statens folkhälsoinstitut, 2012c). In 2009, the Government set up a national strategy for developing parental support. The aim of the strategy is to encourage local collaboration on support and assistance to parents in their parenting. Focus is on universal preventive parenting, namely that all parents are offered the same opportunities for support and help. The SNIPH has, in the context of the strategy, distributed nearly SEK 200 million in support to over 25 local development projects. Even within the national ANDT strategy, the SNIPH has assignments regarding parental support. One is about support for at-risk children in families with substance abuse problems, mental illness or mental disability. Another involves support to child and maternal healthcare (Statens folkhälsoinstitut, 2012b).

Community Parent Education (COPE) is one of several prevention methods focused on parents, and the method was applied in about a third of the municipalities in 2011 according to the SNIPH County Report (Statens folkhälsoinstitut, 2012c). The COPE method aims at giving parents of children of ages 3-12 years tools to understand and handle their children's behaviour, strengthen the parents in their parenthood, improve the interplay in families and create supportive networks. The programme is built on

[2] The question about the Social and Emotional Training (SET) method was excluded from the SNIPH annual questionnaires to the regional and local drug coordinators in 2011.

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

empowerment and intends to inspire parents to find their own solutions to everyday situations. An evaluation of the method showed significant effects on the children's problematic behaviour as well as the parents' ability to handle the child, their experienced level of stress and their feeling of control in parenthood (Hellström and Torell, 2006).

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

Community

As national body responsible for county coordination, the SNIPH receives yearly reports from the county administrative boards about their work. The report compiled for 2011 shows that the cooperation between the coordinator of the prevention work and the officer responsible for the supervision of alcohol and tobacco, both located at the county administrative board, has increased. The report also shows an increased focus on collaboration between the municipalities and crime prevention efforts (Statens folkhälsoinstitut, 2012c).

Collaboration and coordination between crime prevention and drug prevention are highlighted clearly in the national ANDT strategy, which is natural because a lot of the handling of various substances is illegal, especially narcotics and doping. In addition, supply reduction is an essential measure for successful drug prevention. Results from the SNIPH annual questionnaires sent to the 290 local authorities indicate that virtually all municipalities cooperate with the police. Many municipalities and local police authorities also have written arrangements for this work. The share of local authorities cooperating with the business sector, such as restaurants and grocery stores has decreased since 2008 and the same is true for cooperation with NGOs (Statens folkhälsoinstitut, 2012c).

An important part of the work to prevent illicit drug use is to create and supply positive recreational settings. In Sweden, these activities usually take place in the non-profit sector. According to the SNIPH County Report, many municipalities cooperate with sports organisations, the temperance movement and various churches in alcohol and drug prevention work. Sports organisations are the most common type of non-profit organisation that municipalities cooperate with.
Most of the Swedish municipalities conduct activities to establish a drug-free upbringing for children and adolescents and, according to the County Report, more than 80% reported organising drug-free activities in 2011 (Statens folkhälsoinstitut, Unpublished). In 2011, about 70% of the municipalities conduct local alcohol- and/or drug-use surveys and about 60% of the municipalities send out information about drugs to parents (Statens folkhälsoinstitut, 2012c).

In late 2010, a Swedish study on neighbourhood economic context as a determinant of youth drug use or abuse was published. A cohort of 76,693 adolescents ages 13-

15 from 586 urban neighbourhoods in Sweden were monitored for 12 years, from age 16 to age 28. Multilevel modelling was used to analyse neighbourhood variations in hospital admissions due to illicit drug use or abuse. The authors found a variation of 8% by neighbourhood economic status and the risk of being admitted to hospital increased 73% in low-income compared to high-income neighbourhoods. According to the authors, the results suggest that the neighbourhood of residence in adolescence plays a significant role in predicting future health-related behaviours and that the need for drug abuse interventions at a neighbourhood level is compelling (Sellström, 2011).

3.4 Selective prevention in at-risk groups and settings

At-risk groups
The Swedish Police Authority is an important participant in the establishment of a drug-free environment and a common partner of municipalities together with the social services. In many districts, the police work according to a method called the "Linköping Model" that focuses on controlling drug use among young people. At the slightest suspicion of a young person's drug use, the parents are contacted and the district-level narcotics police make a visit to the young person's home (usually together with a representative from the social services) (Statens folkhälsoinstitut, 2009b). Over 80% of the Swedish municipalities were cooperating with the police in matters of illicit drugs in 2011, according to the County Report, and 67% of the municipalities conduct measures related to early detection of drug use among adolescents that are based on cooperation between the police, primary care, social services and parents (Statens folkhälsoinstitut, 2012c).

Several projects are running in different parts of the country with the aim of early intervention when individuals are suspected of drug abuse. The "Maria Ungdom Motiverande Intervention" (MUMIN) [Maria Youth Motivating Intervention] project, which started in Stockholm in 2004, has led other cities to conduct similar activities. In many districts, the police also work with the "Linköping Model", mentioned above.

Another method directed at at-risk groups is "Samverkan mot alkohol och droger i trafiken" (SMADIT), [Cooperation against alcohol and drugs in traffic], also referred to as the "Skellefteå Model". This method is based on cooperation between the police, the social services and addiction treatment services, in connection with the apprehension of intoxicated drivers. The basic idea is that Drivers under the Influence of Drugs (DUID) are most open to receiving support immediately after being apprehended. Hence the DUID – directly after interrogation and the taking of samples – will be referred to an initial contact with the social services or healthcare services for addicts – preferably within 24 hours. In 2011, all police authorities worked according to the method. Örebro County applies an extended version of SMADIT, which, among a few other factors, differ from SMADIT by including persons suspected of minor drug offences (Rikspolisstyrelsen, 2011).

In 2011, the SNIPH has been commissioned to support maternal- and child health care in prevention work as part of the ANDT strategy's goal that fewer children should be born with harmful or disabling conditions caused by exposure to alcohol, narcotic drugs, doping substances or tobacco. The work is focused on informing all

parents of and, if necessary, providing counseling on the damage that alcohol, drugs, doping and tobacco can cause fetal and young children. The work has been based on both evidence and experience from past government assignments (Statens folkhälsoinstitut, 2012b).

At-risk families

Interventions are offered to children living in families where one or both parents are addicted to either alcohol or narcotics in Swedish municipalities in different settings, often in cooperation with NGOs. In about 65% of the municipalities, some group-based activities for these children were offered in 2011 according to the County Report (Statens folkhälsoinstitut, 2012c).

In 2009, the Government gave the SNIPH a three-year commission to map the prevention for children and young people in different risk situations. In the national survey carried out in 2010, local authorities in the municipalities were asked to report on various interventions to support children in vulnerable families. About 80% reported interventions for families with addicted parents, about 65% reported interventions for families where violence occurs and about 55% reported interventions for families with parents with mental disorders (Statens folkhälsoinstitut, 2010a). A new survey which addressed this issue in more depth was carried out among 45 municipalities in the beginning of 2011. Within the framework of the commission, the SNIPH also compiles information and supports local development projects. The development projects extend over several years and are related to the development of new knowledge and evaluation, which means that over the next few years scientific papers on this topic will be published.

In recent years, there has been an increase in activities directed at children with addicted parents among regional and local actors in cooperation with the county coordinators. The number of Swedish municipalities that report offering programmes for children at risk (preschool) has also increased (Statens folkhälsoinstitut, 2012c). One example of a preventive method used is the “Komet för föräldrar” [Comet for parents] for parents with children and adolescents between the ages of 3 to 18. This method aims specifically at those who have children that exhibit externalising behaviour problems and have additional difficulties establishing positive peer relationships. A Swedish randomised controlled trial among children 3-10 years of age showed significant effects of the method on the children’s problematic behaviour as well as the parents’ ability to handle the child (Kling et al., 2006).

Another randomised controlled trial for assessing the effects of Komet för föräldrar, which targets parents of adolescents with antisocial/externalising behaviour, is conducted by STAD (Stockholm Prevents Alcohol and Drug Problems). Komet has been spread nationally by the School Project and about a third of the municipalities report having offered the method to parents in 2011 (Statens folkhälsoinstitut, 2012c). Some of the preventive methods that generally focus on all parents are also possible to implement with parents of children at risk, such as the COPE method mentioned above.

The importance of detecting children at risk has recently been emphasized in different contexts, including the SNIPH’s surveys from 2010 and 2011. Because every child attends school, this setting is an important arena for identifying and

supporting children at risk and their parents. In order to examine policy and practice in Swedish school settings pertaining to children of substance abusing parents/caregivers, a cross-sectional survey involving 443 randomised schools was recently carried out (Elgán and Leifman, 2010). The authors conclude that it appears as if a policy document does not directly predict whether schools identify students having substance abusing parents. However, it does influence whether respondents have participated in further training, which subsequently predicts the identification of students having substance abusing parents.

Recreational settings

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

A study published in 2007 showed that it has become more difficult for drug-impaired patrons to enter those nightclubs/restaurants that are involved in the project in Stockholm (Gripenberg et al., 2007b). In 2007, the National Drug Policy Coordinator also initiated a national venture in spreading this method and supported 11 municipalities in Sweden in efforts to prevent illicit drug use in recreational settings. The focus lay on mapping the illicit drug situation in restaurants, policy work and training of restaurant staff. Since 2008, the network has continued its work with financial support from the SNIPH. In 2011, the network received SEK 900,000 to e.g. encompass additional municipalities to the network, initiate more cooperation between municipalities that are geographically located in the same region, implement training programmes for police officers, and proceed with educational programmes for member municipalities. A web page containing information about current activities and local studies and evaluations (www.krogarmotknark.se) has also been set up.

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

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

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

In a recently published paper, results regarding long-term effects of “Clubs against Drugs” are presented. The indicator chosen for the study was the frequency of doormen intervention towards obviously drug-intoxicated guests at licensed

premises. Professional male actors (i.e., pseudo patrons) were trained to act impaired by cocaine/amphetamines while trying to enter licensed premises with doormen. An expert panel standardised the scene of drug-intoxication and each attempt was monitored by two male observers. At the follow-up study in 2008, the doormen intervened in 65.5% of the attempts (n = 55), a significant improvement compared to 27.0% (n = 48) at the first follow-up in 2004 and to 7.5% (n = 40) at baseline in 2003 (Gripenberg Abdon et al., 2011b).

In order to limit violence and harm relating to alcohol consumption in restaurants, bars and nightclubs, a method titled “Ansvarsfull alkoholservering” [Eng. Responsible Beverage Service] was introduced by an organisation called STAD in Stockholm County in 2003. After spreading to municipalities outside Stockholm, the SNIPH was given the assignment of disseminating the method to all municipalities in the country in 2004. Responsible Beverage Service aims to create a culture surrounding the serving of alcoholic beverages where minors or noticeably intoxicated individuals are not to be served alcohol and potential risk situations are more easily identified and tackled. The method has three basic components: education about Responsible Beverage Service to primarily serving staff (but also restaurateurs, security personal and other staff), coordination of stakeholders (primarily municipalities, police and restaurateurs) and supervision conducted by both municipalities and police (primarily during evenings and nights). Results show that municipalities adopting the method have had fewer violent crimes reported to the police, than municipalities that did not adopt it. Municipalities using all three components showed a decrease in the number of reported violent crimes by approximately 9%. The observed positive effect was especially noticeable in smaller municipalities (i.e. municipalities with 20 serving licences or less) (Trolldal, 2012).

3.5 Indicated prevention

3.6 National and local media campaigns

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

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

4. Problem Drug Use

4.1 Introduction

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

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

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

In the 2011-2015 ANDT-strategy it was stated that an initial baseline measurement to gauge the extent of the ANDT problem were to be conducted in 2011. This baseline measurement has been delayed an recently the commissioned project group finished a pilot survey comparing three different sampling methods – diagnostic telephone interviews, web/postal surveys and standardised telephone interviews (Tengström, 2012).

The results from the pilot study shown that in general, diagnostic telephone interviews performed by trained personnel, had the highest response rate, good distribution of respondents (age, gender) when compared to the general population, and reasonable prevalence numbers. However, the research group also states that diagnostic telephone interviews are quite expensive and require special competence available only in few places in Sweden (Tengström, 2012).

Thus, considering economic and usefulness issues, the most appropriate method to perform regular measurements of the ANDT problem is judged to be web/postal surveys according to the researchers. With some adjustments of the survey method, a response rate of 65% can be expected, suggesting that the baseline measurement is to contain 20 000 answering respondents, out of an overall sample of 30 000 individuals (Tengström, 2012).

In an attempt to further investigate the extent of illicit drug use in Sweden a project with varied data collection methods were carried out in 2010 (Statens folkhälsoinstitut, 2010c). The results indicate that there is a group of illicit drug users who experience severe problems but who do not seek treatment. The results are further discussed in a scientific article where the author emphasizes the stigma attached to drug use as a result for not seeking treatment (Andreasson, 2011). Drug users who do seek treatment for various complications to drug use, e.g. depression and infections, tend not to provide information about their drug use and in the majority of cases are not asked about illicit drug use. In most of these treatment episodes, drug use or diagnoses of harmful use or dependence are not recorded. According to the author the findings raise a number of methodological difficulties with important policy implications, for instance whether there is an epidemiological paradox within the illicit drugs field of the same nature as within the alcohol field, where most problems and costs arise within the larger group of heavy drinkers who do not belong to the most severe group.

4.2 Prevalence and incidence estimates of PDU

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

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

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

A somewhat artificial way to meet the first assumption is to study a delimited time period. The second assumption is met through a stratification of the study population into strata where individuals are thought to be more alike. The assumption hardest to meet in this particular study is the third, regarding the probability of being included in

the sample. Since prison records are part of the sample[4], the probability of being included varies since being imprisoned during the inclusion time frame has a profound effect on the probability of entering the record more than once.

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

Results

Data is stratified regionally, which is a way to meet one of the model's assumptions mentioned earlier: Not only is this a means of approximating a more homogenous population, it is also the geographic boundary for the county council administrations. The county councils are in fact responsible for the treatment system in each region[5], and as such a seemingly obvious stratification variable. Another advantage is that a regional estimate is obtained in the process, not uncommonly sought by various actors.

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

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

* Please note that the figure refers to all ages in the denominator, see Standard table 7 and 8 for further information. The estimate for the ages 15-64 is 4.9 per 1,000. Data after 2007 on estimated PDU is not yet available.

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

In total, the number of problematic drug users in Sweden was estimated at a rounded of figure of 29,500. This number is not directly comparable to the figures previously derived in Sweden due to differences in both the data sources and the methods used. The national estimate relating to population was 3.2 with the "all ages" denominator and 4.9 with the 15-64 years of age denominator (see Standard table 7 and 8 for details).

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

A clear disadvantage, on the other hand, is the fact that other relevant data may be non-existent due to the design and content of the registry or registries. In a case-finding study, sought-after information can be made more readily available, such as housing and occupational status, administration routes, drug markets, risk behaviour etc. The above approach is not without interesting possibilities though. A lot of additional information can be made available through personal identity numbers, such as mortality, socioeconomic data, or health (in terms of registered illness). This would require a more rigorous study, including an approval by an ethical committee, among other matters, and cannot be done on a regular basis (Svensson and Arvidsson, 2009).

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

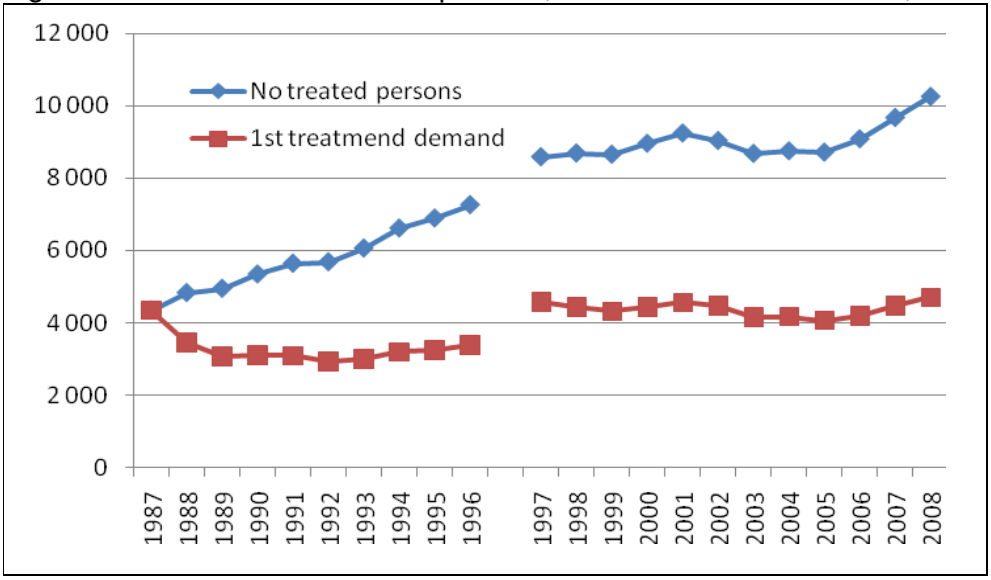
For a period of time, data on drug related diagnoses has been gathered from specialised out-patient treatment[6], and collected in a national registry at the National Board of Health and Welfare. This data can be described as an extension of the in-patient data used in the prevalence estimations described above, in the sense that it is not uncommon for individuals to move between treatment modalities, such as in-patient and out-patient. Thus, it seems reasonable to believe that this additional data can be used to acquire a more adequate picture of the frequency distribution of treatment episodes. It is only in the most recent years that this data is considered to be of reasonable quality (from the year 2008). In future studies of PDU prevalence, this is a path that should be explored. This also distinctly shows the constant evolution of the "audit explosion"[7] and the increase of new data with potential bearing on the PDU issue.

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

Estimates of incidence of PDU

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

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



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

The lower timeline (in red) is a description of people who registered for in-patient treatment for the first time since 1987 (defined in the same way as the cases in the PDU sample 2007, see Standard table 7 and 8 for details). What can be seen is that we are dealing with two periods with rather similar levels in terms of incidence rates. What should be noted, however, is the increasing trend that has been present in the last three years in the figure timeline and that the level of first treatment demand cases is at its all-time high in 2008 (4,700). During the same period, the population grew in number, and the 1990[8] rate of first treatment demand was 0.36/1,000. In 2008, the corresponding figure rose to 0.51/1,000.

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

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

5.1 Introduction

Drug treatment is arranged by the social services in the local community (in ordinary healthcare services or at specialized units such as outpatient clinics), hospitals (detoxification or treatment for certain complications from drug abuse such as infectious diseases, e.g. hepatitis, HIV/aids, psychiatric symptoms, etc.) or therapeutic communities. In severe cases, drug users might be committed to an institution for compulsory treatment. Such treatment is arranged by the National Board of Institutional Care and it is regulated in the Care of Alcoholics, Drug Abusers and Abusers of Volatile Solvents Act, LVM. Yet another treatment environment is the prison and probation system. As roughly half of all prisoners have drug problems, treatment for drug abuse is now offered during prison terms. Persons in detention often have symptoms of acute abstinence, so all custody units have access to a physician to help with a detoxification procedure. After-care following a period in hospital, a therapeutic community or prison is arranged by the social services.

5.2 General description, availability & quality assurance

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

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

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

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

1. to develop a qualified support for municipalities and county councils / regions by providing training and information for practitioners, managers and policy

makers about the methods and procedures that have the best effect and to support local governments in the change process.
2. to develop and organisational structure for the exchange of experiences and cooperation between municipalities, counties, local research and development units, colleges and universities.

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

Responsibilities
The following information on society’s responsibilities regarding treatment for drug abuse can be retrieved from the aforementioned booklet:

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

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

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

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

One data-source is KIM (“Clients in Substance Misuse Treatment”), which is directly tailored from the TDI guidelines with the exception of including alcohol as a drug. KIM

only collects epidemiological information from as many treatment units as possible that do not already belong to another information system. All known units (about 600) were asked to participate. Today, KIM covers about 25% of existing units of inpatient and outpatient centre type from all regions of the country.

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

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

A third source is a newly established "quality register", called SBR ("Swedish Dependency Register"), specifically for substance-dependence treatment units – both inpatient and outpatient – in the healthcare sector. This system is also integrated with KIM/TDI. A few inpatient units began to register patient data in this system in 2009 and also provided some data for 2010.

Lastly, some data is obtained from units that conduct ASI (Addiction Severity Index)-interviews with their clients, mainly prison units. Today ASI is not fully integrated with KIM/TDI. To read more about the Addiction Severity Index see chapter 11.

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

5.2.1 Strategy/policy

In the autumn of 2008, a comprehensive government investigation of substance misuse treatment was started and, due to a recently postponed deadline, is to publish its final report by 15 April 2011 (SOU 2008:04). The objective is to prepare an overview of the whole of the Swedish treatment system – all services that are provided by the municipalities, the counties or the state, and includes both its content, availability, responsibilities, and organization – and to make suggestions for improvements (and possibly also re-organization of the treatment system). The goal is to establish a knowledge-based system for the all treatment of persons with substance misuse and dependence, based on the needs of these individuals.

TDI as a base for national quality registers

One of the areas in the investigation being finalized for political decisions by the end of 2011 is called "Better quality, knowledge and skills" with the overall goal to develop systems for quality assurance, research and dissemination of knowledge and skills to provide the foundations for a more knowledge-based care (SOU 2008:04). This further emphasizes the need for documentation, which opens up a possibility to use the TDI more at a national level.

There is a concrete proposal that SBR (Svenskt Beroenderegister) shall be an obligatory documentation in the dependency care within the medical treatment centres (SOU 2008:04). The documentation in SBR is, as have been stated above, today totally compatible with the TDI –protocol.

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

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

Characteristics of treated clients and trends in number of clients in treatment
Data on treatment for problematic or heavy drug use is reported in TDI (ST 34). For 2010, data is available from a higher number of reporting treatment centres than in previous years. In 2009 the reporting system covered 51% of all inpatient and 31% of all outpatient treatment centres. In 2010 the distribution should be similar even if the exact figures are not known.

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

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

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

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

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

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

6. Health correlates and consequences

6.1 Introduction

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

Behavioural surveillance data is collected through KAB (Knowledge, Attitude and Behavior) surveys. To monitor trends in risk behaviours in Injection Drug Users (IDU), a second generation surveillance programme, Svenska häktesprogrammet, has been conducted in remand prisons in Sweden's two largest cities, Stockholm and Gothenburg (since 2011 only in Stockholm). In this programme, nurses systematically test and vaccinate IDUs held on remand, as well as providing risk reduction counselling. In addition, the nurses conduct behaviourally oriented interviews targeting the IDUs' knowledge, attitudes and practices. As 80% of all IDUs are estimated to pass through remand prisons over a three-year period, this setting has been chosen for regular data collection regarding IDUs and risk behaviours. Preliminary data shows that approximately 2,500 IDUs have participated in the programme and 31 new HIV infections were diagnosed between 2002 and 2011. The data currently collected in this programme is not representative of IDUs in Sweden. However, the programme will be promoted with the aim of involving more remand prisons in order to obtain more representative data. Since the late 1980s, needle-syringe programmes have only been run in one county in Sweden (Skåne). In May 2012, another county, Kalmar, started a needle-syringe programme. A programme is also planned to be operational in Stockholm in 2013.

6.2 Drug-related infectious diseases

HIV/AIDS and viral hepatitis

HIV

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

Fewer cases of HIV were reported among injecting drug users (IDU) in 2010-2011 compared to 2008-2009, with 24 cases in 2010 and only 14 in 2011. By the end of 2011, IDUs accounted for 7% of all people living with a known HIV infection in Sweden, equivalent to about 400 IDUs (or former IDUs). In May 2012, an outbreak of HIV was detected among IDUs in Kalmar comprising 5 cases. The new needle-syringe exchange programme in Kalmar can hopefully prevent new cases.

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

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

Hepatitis B
Between 100 and 200 cases of acute hepatitis B are reported in Sweden annually. However, fewer cases of acute hepatitis B (89) were reported in 2011 due to fewer cases being reported among injecting drug users. Of all acute hepatitis B cases, 18 were among IDUs (compared with 51 cases in 2010), 17 of whom were infected in Sweden. The median age of IDUs diagnosed with acute hepatitis B in 2011 was 32 (range 18-61).

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

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

Altogether, 2,086 cases of hepatitis C were reported in 2011. Intravenous drug use is the dominant transmission route and most cases are domestic. Viewed in a longer perspective, the total number of reported cases is decreasing. However, when viewed by age group, no falling trend can be seen in 15-29 year-olds over the last 10 years. In 2011, 724 cases were reported in this age group and 48 cases were reported among those under the age of 20. This indicates that there is on-going recruitment to injecting drug use among young people and an on-going transmission of the disease among young intravenous drug users in Sweden. Hepatitis C among IDUs remains a challenge and future intervention efforts are prioritised. The trend analysis is aggravated by the fact that it is not possible to differentiate between acute cases and chronic cases of hepatitis C in the surveillance data.

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

6.3 Other drug-related health correlates and consequences

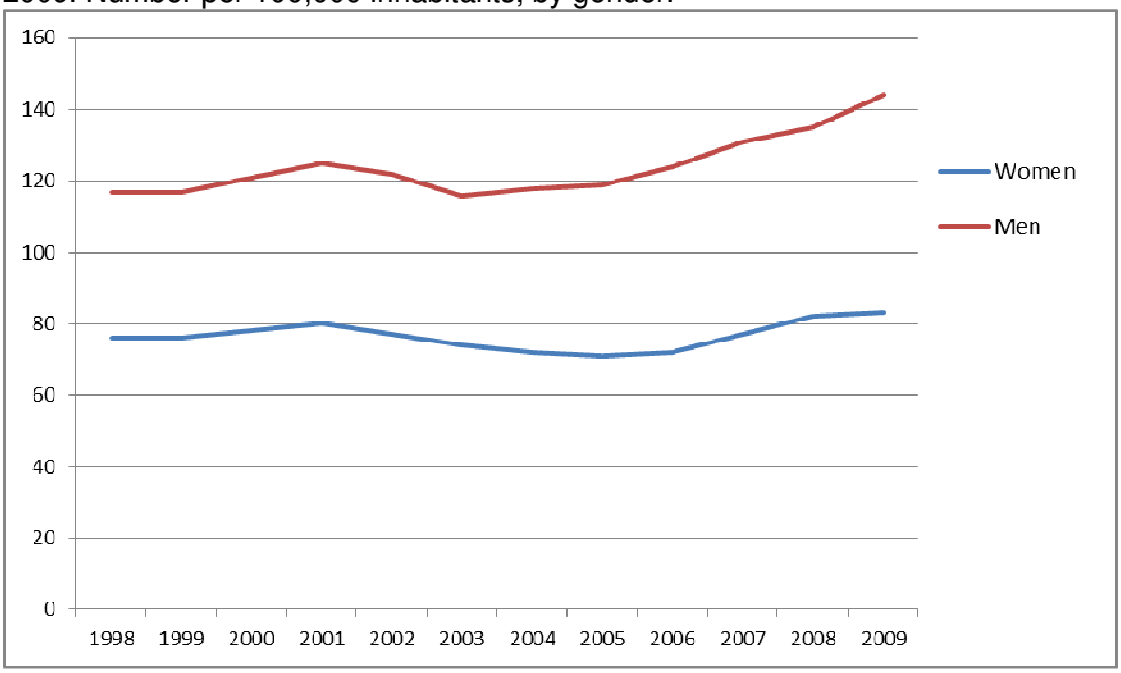
Other topics of interest

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

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

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

Figure 6.1: Men and women treated in healthcare for drug related diagnoses[9]. 1998 - 2009. Number per 100,000 inhabitants, by gender.



Psychiatric co-morbidity

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

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

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

the women and antisocial personality disorder together with conduct disorder were most common among the boys and the men (Tengström, 2006).

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

6.4 Drug-related deaths and mortality of drug users

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

Table 6.1: Total number of forensic autopsies (including extended forensic examination) and the total number of cases analysed at the forensic chemistry department from forensic examinations (Rättsmedicinalverket, 2012).

	2009	**2010**	**2011**
Forensic autopsy	5,122	5,220	5,182
Cases from forensic examinations	5,244	5,228	5,000

Sweden currently has two registers with national coverage where data on drug-related deaths are collected: the official national Cause of Death Register and a Special Mortality Register. The two registers differ somewhat in their aim and classification of drug-related deaths and consequently the type of deaths that are registered. However, the data in both registers originate from the National Board of Forensic Medicine's databases.

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

The CDR includes all deaths among Swedish residents (n = 90,000 in 2010), whether the deceased was a Swedish citizen or not and whether the death occurred in Sweden or abroad. However, a death certificate was missing in about 1.8% of the deaths in 2011, an increase of about 60% compared to 2009 (Socialstyrelsen, 2012). Information on these deaths is included in the CDR but without any medical information. Non-residents who die in Sweden are not included in the CDR.

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

Special Mortality Register (SMR)
There is a national research register called Toxreg, comprising all deaths where illicit drugs are found at the forensic examination. The registry was launched in 2004 and is managed by the Karolinska Institutet and funded by the SNIPH.

In Toxreg, cases are listed according to the substance most likely to be relevant to the cause of death. When several illicit substances are present, the death is listed in the highest ranked substance category. In table 6.3, the ranking order and number of cases is listed.

Over the years, this special mortality register has developed and substances have been added. Recently, both methadone and buprenorphine have been included. These changes have consequences for both the total number of deaths and for deaths in other substance categories several years backwards. To try to avoid cases that might be attributed to suicide with legally prescribed morphine among the elderly, the number of cases with presence of morphine include only cases between 11 and 60 years of age.

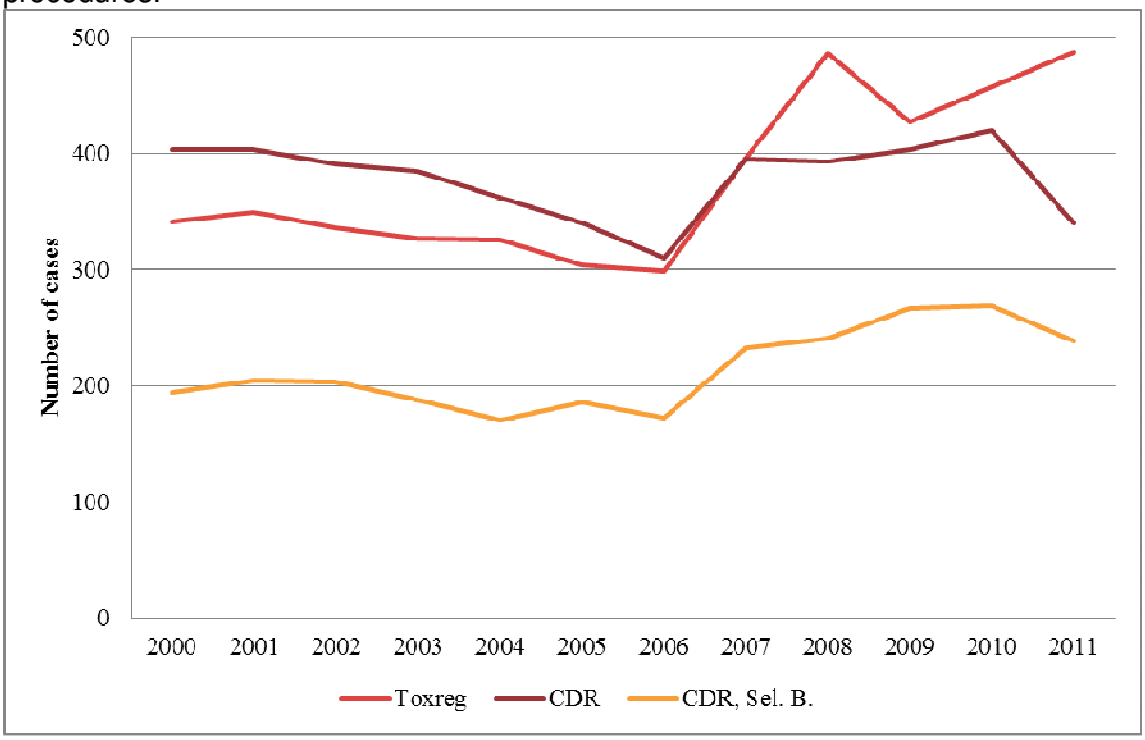
Data from Toxreg show that cases were methadone is present at death remain at a high level, and that cases with presence of buprenorphine and fentanyl (reported under the category “other”) are increasing. In 2011, fentanyl was present in 38 cases compared to 21 cases in 2010.

Table 6.3: Number of cases registered in Toxreg for each substance category.

Year/Substance	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
Heroin/Morphine	198	147	134	128	138	110	142	144	135	120	143
Methadone	17	28	29	26	25	22	48	74	76	94	86
Buprenorphine	0	1	2	7	16	15	22	52	37	59	66
Amphetamine	78	107	98	98	72	97	109	107	83	92	79
Cocaine	1	6	18	10	9	6	9	13	7	9	5
Other	13	10	14	10	16	8	22	33	26	27	48
THC	43	37	32	47	28	41	44	63	63	56	60
Total	350	336	327	326	304	299	396	486	427	457	487

Note: the presence of an illegal drug in forensic analyses does not imply causation.

Figure 6.2: Number of deaths according to national registers and case selection procedures.



According to the CDR, there was a decrease in the number of drug related deaths in 2011, from 269 cases in 2010 to 239 cases (Selection B). In contrast, an increase was noted in Toxreg for the same period, 487 cases in 2011 compared to 457 in 2010.

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

In a recent report of Swedish ANDT research, the evaluators mention the use of registries and the possibility of conducting cohort studies as a strong area for Swedish research However, the report also suggests that the use of cohort studies could be developed even further (Swedish Council for Working Life and Social Research, 2012). When discussing epidemiology and the consequences of illicit drugs, the report states: “Of special note are studies of alcohol and drug use mortality and morbidity at different ages, cannabis and risk psychosis, and social determinants of alcohol-related problems including school performance as well as long term effects of cannabis and other drugs and long term effects of amphetamine use.”

However, a number of caveats exist when studying both living and deceased drug users. It is often unknown when a substance was used, how much of the substance was used and also if, when and what other substances were used simultaneously. Also, a number of other factors may have an impact on the results, e.g. co-morbidity, socioeconomic status.

Nyhlén and colleagues (Nyhlen et al., 2011b) analysed the mortality rate and causes of death among the 561 drug users that were admitted to a detoxification and short-term rehabilitation unit between 1970 and 1978. The cohort was followed until the end of 2006 when results showed that 204 individuals had died (36.4%).

One important analysis done by Nyhlén et al was the comparison of the cohort with the Swedish CDR. Findings from the study showed that only 63% (n=76) of the 120 drug-related deaths were recorded as being drug related in the CDR. In the remaining 44 cases, ICD-codes were missing in the database that the CDR collects its information from.

Nyhlén et al (Nyhlen et al., 2011a) did additional analyses of risk factors for drug-related death from the above cohort of 561 drug abusers. The conclusion was that premature drug related death was linked to the male gender, the use of opiates/barbiturates and depression and anxiety disorders at first admission to detoxification. Stimulant abuse could not be shown to have impact on a premature death.

In 2010, Stenbacka and colleagues (Stenbacka et al., 2010) analysed registry data for mortality, causes of death and inpatient care at hospitals, among 1,705 drug abusers between 1967 and 2003. At the end of the follow-up period, about 50% of the subjects' had died. According to the ICD codes, only 62 cases out of the 860 subjects that had died were directly attributed to drug abuse, whereas other causes of death were cardiovascular diseases and, especially among younger subjects (15-24 years), accidents and suicide. The standardised mortality ratio (SMR) was calculated to 3.3 and 3.5 for males and females, respectively.

For previously reported mortality cohort studies, please see the National report 2010 and 2011 (Swedish National Institute of Public Health, 2011) (Swedish National Institute of Public Health, 2010).

7. Responses to health correlates and consequences

7.1 Introduction

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

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

Although access to medically drug-assisted therapy has increased significantly in Sweden, long queues still exist in many places. A survey from 2007 showed that only half of the Swedish county councils were able to offer drug-assisted therapy within the timeframes set by the health care guarantee (Sjölander and Johnsson, 2007). Swedish studies indicate that one of the main reasons for illegal use of buprenorphine [10] is that existing programmes do not have capacity for all who require treatment (Antoniusson, 2007, Håkansson et al., 2007).

In recent years, some Swedish drug-assisted programmes have introduced "zero tolerance" against lateral abuse, which means that a patient can be discharged from treatment after a single positive urine test (Heilig and Gunne, 2008), leading to low retention. Recent Swedish research has shown good results in clinical trials with highly structured treatment based on positive reinforcement of desired behaviours (Kakko, 2011). In an evaluation of a drug-assisted programme for female prostitutes in Malmö, two success factors are mentioned: effective liaison with social services and mental health care and a reasonable programme size. Small-scale programmes create an organizational vulnerability while large-scale programmes increase the risk of neighbourhood problems and therapeutically unfavourable patient compositions (Laanemets, 2007).

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

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

Service providers' views on maintenance treatment in Sweden
In Sweden, OST has long been ideologically controversial, even if it has become more accepted and prevalent over the past decade. It is widely acknowledged that the social meaning of OST with methadone is context-dependent and that different discourses influence how this approach to opiate addiction problems is practised. OST may thus be seen as a discursive field where science and principles are intertwined and impact on practice jointly, which emphasizes the importance of analysing how OST is attributed with meaning.

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

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

In a Swedish review article about the risks and side effects with drug-assisted maintenance treatment is discussed whether the presence of methadone and buprenorphine treatment makes it difficult for drug-free treatment, because heroin addicts who want to stop the abuse prefer replacement therapy. The author argues that despite the absence of clear evidence of positive effects related to drug-free treatment the competitive claim is worth taking seriously because it will always be patients who prefer treatment aimed at complete abstinence. The article refers to countries where substitution treatment completely dominates the provision of care for heroin addicts and drug-free treatment has largely ceased as an option. Until the mid-1990s it has been relatively easy to access drug-free treatment in Sweden, while it was very difficult to have admission to methadone treatment. The current situation, with an increasing availability of substitution therapy and a reduction in drug-free treatment is, according to the author, primarily due to the fact that Swedish heroin

addicts to a greater extent are given the opportunity to influence the choice of treatment (Johnsson, 2010).

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

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

7.3 Prevention and treatment of drug-related infectious diseases

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

The decision to start an NSP in Sweden rests therefore with politicians and not infectious disease doctors. A recent Swedish study examined infectious disease physicians' perception of needle exchange programmes and how they perceive the regulatory framework surrounding NSPs. In the study, 18 medical doctors were interviewed. The results showed that the majority of respondents were in favour of NSP as a preventative measure, but they also felt frustration at not fully possessing the issue. It was also revealed that most counties lack knowledge of how great the actual need for needle exchange programmes is. The author concludes that infectious disease doctors' motivation to take more initiatives on the issue needs to be strengthened by giving them an extended mandate when it comes to starting new needle exchange programmes (Leandersson, 2011). The Government Report "Better response to abuse and dependence" suggests that county councils should be able to independently apply for authorization to implement needle exchange programmes (SOU 2011:35).

Today, there are four operational needle/syringe exchange programmes (NSP) in Sweden, three located in Skåne county and one in Kalmar. A fifth programme will be set up in Stockholm, and is likely to be operational in 2013.

In recent years, as many as one in five IDUs disappeared from the Malmö NSP according to Magnus Andersson, counsellor at NSP in Malmö. The main reason for this trend is probably an expansion of OST says Andersson. The NSP has also observed a general increase in the abuse of tablets while injecting drug use has declined.

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

.Alanko-Blomé and colleagues (Alanko-Blomé et al., 2011) have done a follow-up covering the years 1997-2005 of 831 IDUs at the NSP in Malmö. In view of the low HIV prevalence among IDUs in Malmö the study focuses on the incidence of surrogate markers of HIV - particularly hepatitis C, because the risk of HBV infection is affected by the introduction of hepatitis B vaccination. HIV incidence remained very low. However, the corresponding incidence rates for HCV was 38.3 / 100 person-years at risk and for HBV 3.4 / 100 person-years at risk. RNA testing (Ribonucleic acid) showed that 12% already when entering the NSP was affected with hepatitis C virus, but antibodies had not yet developed. This subgroup was therefore already hepatitis C infected before they had access to clean syringes and needles through the NSP. If one corrects for those already infected, the HCV incidence rate decreases to approximately 30 per 100 / person-years at risk, which is still a high level of blood contamination. When the study period was divided into three periods, there was no trend of improvement in recent years. Risk factors for anti-HCV seroconversion were injection of both amphetamine and heroin and imprisonment. The strong improvement for hepatitis B may be entirely attributed to the introduction of hepatitis B vaccination[11] (SOU 2011:6).

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

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

7.4 Responses to other health correlates among drug users

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

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

8. Social correlates and social reintegration

8.1 Introduction

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

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

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

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

Statistics are kept by multiple authorities, are divided and lack overall coordination. No national guidelines have yet been worked out for the follow-up and evaluation of local and regional efforts in the scope of the implementation of the action plans. Nor has a coordinated national strategy for society's work with alcohol and traffic issues been developed.

Data on social exclusion is not collected and processed in a standardised way for official statistics. From research projects and special investigations information can be gathered, often for a limited cohort. Problem drug abuse and various forms of criminality, unemployment, homelessness, health problems etc. are all closely related and well known to the society. Nevertheless, data from Social Services' care for adults with substance abuse problems is collected on regular basis by the National Board of Health and Welfare but local drug services are divided between many actors and the collection of statistics differs between various authorities.

Organisational framework

The organisation and responsibility of the services for drug users are provided at three levels. At the municipality level, specialised services for problem drug users are provided (the social service system) based on the Social Services Act and the Care of Alcoholics and Drug Abusers Act (handling compulsory care). The Social Services Act states that the municipal social services should provide users with the help and care they need to get away from their problem substance use (Blomqvist et al., 2009). The social services have a special responsibility for people with problematic drug use including both preventive and individual interventions.

The county councils (the regional health care system) are obliged to provide services in accordance with the Health and Medical Services Act. For alcohol and drug users, this means providing detoxification and other emergency services, medical and psychiatric care for alcohol- and drug-related disorders and pharmacological treatment as methadone and Suboxone (op.cit.). In some counties the healthcare system also targeting specific subgroups as: pregnant women, drunk drivers and people dependent on prescribed drugs (op.cit.). Because many drug users end up in the criminal system there are also various treatment facilities in prisons as well as within the parole system. Additionally sentenced drug users can, under certain circumstances, serve their sentences in inpatient drug use treatment.

Substance abuse and dependence care has experienced positive development during the last four years (2006-2009). In April 2008 The Swedish Association of Local Authorities and Regions (SALAR) entered into an agreement with the government on support for the implementation of the national guidelines for the care of those suffering from substance abuse and addiction. The central idea in the agreement is that the local authorities and country councils will assume a joint responsibility for development. SALAR under takes to uphold the know-how and expertise that exists locally and regionally and to build up a long-term structure for knowledge acquisition and development. This entails, in collaboration with the principals at the county level, building up to a structure for professional support to local authorities and country councils and developing structure for collaboration between local authorities, country councils, local Research and development (R&D) bodies and universities and colleges. The development work is conducted under the name “Knowledge to Practice”.

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

In a recent conducted open comparison questionnaire to the municipalities, of their abuse and dependency care, some major shortcomings were found when it comes to follow-ups and assessment of the care (Socialstyrelsen, 2011b). For instance only

30% of the municipalities had actually asked the clients about their experiences of the care.

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

Knowledge of effective prevention methods has been distributed to the regional and local levels, and this support from the national level to the regional level is generally perceived as functional. However, the development of knowledge and method support was stronger in the alcohol area than the narcotics area. Some positive examples include the national guidelines for substance abuse and dependence care, responsible serving of alcohol in licensed premises, and the identification of harmful and hazardous use of alcohol and brief counselling in primary healthcare and occupational health services (The Swedish Risk Drinking Project).

During the last years, the police also increased its involvement in the implementation of the Responsible Beverage Service method. Many efforts were conducted to reduce the availability of alcohol to adolescents. Young people indeed perceived it to be just as easy to get a hold of smuggled alcohol in 2008 as in 2005, but alcohol consumption among children and young people is decreasing. However, the number of alcohol poisonings among adolescents has increased. This unexpected development has been described in research as a polarisation effect, where consumption is increasing in a disadvantaged minority (Hallgren et al., 2012), and since 2007 the number of alcoholic poisonings among adolescents has also decreased. Additional incentive is required for greater cooperation between authorities and the non-profit sector in prevention work (op.cit.).

8.2 Social exclusion and drug use

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

A new national mapping of homelessness[12] in Sweden was conducted in April 2011 and the results show an increase in the number of homeless persons – from approximately 18 000 in 2005 to 34 000 in 2011(Socialstyrelsen, 2011a). The large increase of reported homeless people mainly concerns persons who live in relatively long-term housing solutions, such as training flats and apartments with social contracts.

About 13% (n = 4 500) of the reported homeless persons were judged to be in acute homelessness, where 280 individuals slept outside or in public places. About 16% (n=5 600) received institutional care or lived in different forms of category housing. About 40% (n=13 900) lived in long-term housing solutions and another 20%

[12] According to the definition formulated by the National Board of Health and Welfare in 2011.

(n=6 800) lived in short-term housing solutions organized by themselves (Socialstyrelsen, 2011a).

For the first time, the National Board of Health and Welfare also made an attempt to identify homelessness among children and young people who are “in the grey area” between the family and community care. In total, about 400 children and adolescents under 18 years were reported. Family problems were presented as being the main reason behind their homelessness. A small proportion was reported to have addiction problems (Socialstyrelsen, 2011a).

Homelessness in Sweden is primarily an urban problem. 42% of the homeless are reported to be from the three largest metropolitan areas in Sweden, but the NBHW surveys also reveal that the problem, although small in scale, is widespread, existing in a large proportion of Swedish municipalities (Olsson, 2008).

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

Preventive interventions at the national/international level
Sweden is involved in different actions at European level aiming at preventing social exclusion.

The “Active inclusion” strategy is an integrated approach designed to tackle poverty and social exclusion in five European cities whereas Stockholm is one. A special project The EUROCITIES Network of Local Authority Observatories on Active Inclusion (NLAO) observes and analyses how this strategy is implemented at local level, in particular regarding access to social services and social and supported housing for people at risk of social exclusion. The municipalities are key actors the delivery of social services such as housing or social assistance services to especially vulnerable groups. Through their responsibilities as policy-makers and service providers and their engagement in this means that they are in the best position to evaluate what works and what does not and how to prevent social exclusion as homelessness and unemployment.

Sweden also participates as a partner in the Mutual Progress on Homelessness through Advancing and Strengthening Information Systems (MPHASIS), an EU collaboration between approximately 20 countries, with the aim of finding methods to be able to monitor the development of homelessness in Europe and to compare the homelessness situations among the different countries. Further aims with the development of a monitor system is to collect the information needed to improving the provision of interventions and develop strategies for: preventing homelessness, lower the number of homeless people, take action against the causes behind homelessness, lower the harmful effects for homeless people and their families and make sure former homeless people can maintain stable housing.

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

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

The National Board of Health and Welfare has been commissioned by the government to work together with the National Board of Housing, Building and Planning, the Swedish Enforcement Authority and the Swedish Prison and Probation Service to co-ordinate the implementation of the strategy. In order to assess the effects of measures taken a plan for a monitoring system on a continuous basis were presented (National Board of Health and Welfare, 2009). The main activity within each objective has been to support local development in relation to work methods and organisation. SEK 46 million (5 million Euro) has been distributed to 23 different projects (Socialstyrelsen, 2010). An evaluation of the implementation of the strategy has been done (Denvall et al., 2011). Main results from the evaluation show that the biggest problem is that neither the projects, the local social services are able to influence the housing provision in the municipalities. Another interesting result is that one of the few evidence-based interventions to help people exit homelessness - Housing-First programmes – have not been implemented in any project (op.cit.). Although, independent of the above mentioned funding in Stockholm and a few other municipalities, the implementation of the Housing First strategy has been initiated.

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

Preventive interventions at the local level

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

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

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

Relevant stakeholders need to have knowledge of the legislation associated with eviction – and of the possibility for stakeholders to act.
The Social Services should be able to offer different kinds of support to persons threatened by eviction, such as:

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

Drug use among socially excluded groups

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

Women and substance abuse

Approximately 23% of the adults with substance abuse problems who were receiving housing assistance on 1 November 2010 were women. The proportion of women among those receiving outpatient care was approximately 30%, and among those receiving in-patient care it was about 25%. The proportion of women among those receiving compulsory care on 1 November 2010 was 36% (Socialstyrelsen, 2011b).

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

Khat use

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

when using khat and finally they stated that they had difficulties in quitting their use (De Cal and Söderlind, 2007).

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

GHB and recreational drug use

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

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

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

8.3 Social reintegration

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

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

Housing

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

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

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

A different theoretical model is at present widely discussed in efforts to decrease homelessness and increasing stable housing, the Housing First approach. The idea behind the model is based on every ones right to housing and is the opposite to the staircase model in that sense that it reverses the "ladder" and starts with a normal housing, usually in combination with some type of case management. The Housing First approach offers stable housing to chronically homeless, alcohol-dependent individuals without requirements of abstinence or treatment. It hasn't been assessed yet in Sweden but in a recent review (National Board of Health and Welfare, 2009) of international effect studies of different housing programmes for homeless persons finding showed support for the Housing First model (and the Treatment First model).

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

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

Thus, an uncertainty remains regarding the applicability of Housing First programmes for people with severe and active addiction (Johnsen and Teixeria, 2010) The majority of Housing First studies have involved evaluations of projects catering for

chronically homeless people with severe mental illnesses, and existing literature provides compelling evidence as to the effectiveness of Housing First with this group, especially as regards housing retention (op.cit.).

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

Education, training

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

Considering the great importance of education on today's labour market it's not a surprising finding that almost half of those youth never marginalised have tertiary education while only 4% of those how were persistently marginalised have studied on this level. The difference between the groups is striking as it is more than 10 times likely to have tertiary education for those never marginalised. Among those persistently marginalised there are 40% who only have compulsory education; the rate for a comparison group is 7% (Angelin, 2010).

Employment

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

Weak connection to the labour market will have great impact on living conditions, e.g. an increasing risk for psychological ill health (Socialstyrelsen, 2011b). Research has shown that peoples' sense of coherence decrease the longer they are unemployed and at the same time their ill heath increases (Angelin, 2010). Those outside the labour market are missing out on the support by the social insurance system.

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

9.1 Introduction

A national plan has been in place since 2007 to strengthen the collaboration between the police and the local municipalities. The plan involves the police and the municipalities signing a contract regulating collaboration towards one or more target areas to promote security and to fight crime. In this contract, the target area will be concretised so that measurable goals can be set. Drug-related crime is one of the proposed target areas. The aim of the plan is to enhance local collaboration and communication between the police and local government and provide a better understanding for the various roles in crime prevention (Rikspolisstyrelsen, 2007)[13].

When it comes to alternatives to prison and the prevention of reoffending after release, the Swedish law (SFS 2006:431)[14] was amended on the 1 January 2007. The aim was to ease transition into society and offer a structured transition period before release for more inmates and for a longer part of their sentence. Already existing transitional measures like family or residential treatment and electronic surveillance were to be complemented with halfway houses.

The changes in the law are as follows:

- Intensive supervision with electronic monitoring is changed to conditional discharge with the flexibility of removing the electronic monitoring (ES) at the end of the sentence. The target group for ES is extended to include those with six to 18 month sentences. The conditional discharge can start after half the sentence (after three months at the earliest). Long-term sentences can be permitted to have conditional discharge up to one year.
- Transition through halfway houses is introduced for those who have long sentences but do not meet the prerequisites for conditional discharge, but have no need for residential treatment.
- The earlier paragraph 34-placement[15] is replaced with “residential care” and the requirements are lowered. The decision is also transferred from the probation committee to the Swedish Prison and Probation Service (SPPS).

The purpose of the change was for more inmates to end their sentence with measures outside prison, in particular treatment outside prison for drug addicts. During 2010, the number of placements outside prison has decreased, which may be related to the close inspection and accounting of cooperative arrangements that subsequently led to cancelled contracts with treatment organisations.[16]

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

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

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

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

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

The best results were for:

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

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

9.2 Drug-related Crime

No new information available

9.3 Drug law offences

According to the 2011 official criminal statistics of Sweden, about 89,400 offences against the Act on Penal Law on Narcotics were reported in 2011, an increase of almost 2% compared to 2010. The number of convictions with drug violations as the main crime increased by 7% (about 1,460 convictions) compared with 2010. Of the 21,500 convictions with a drug offence as the main crime during 2011, 14 involved women and 26% adolescents between the ages of 15 and 20. The offences were considered minor in 87% of cases (18,623), not minor in 12% (2,545) and serious in 1% (314) as reported in the 2011 Swedish Official Crime Statistics from the NCCP.

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

Year	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
n	8,005	8,992	10,106	10,808	11,862	13,932	15,179	16,817	18,525	20,021	21,482

For 2007, 2008, 2010 and 2011, there are no published statistics that further break down drug offences with regard to convictions. The NCCP has published tables of reported offences on their website, which break down reported drug offences in the subcategories of peddling etc., drug possession, drug use, possession and use and production. The table below shows the trend in reported drug offences for those categories for the years 2001 to 2011.

Table 9.2: Number of drug-related offences annually in Sweden. 2001-2011[17].

Reported drug offences	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**Change between 2010 and 2011, %**
Peddling, etc. (1-3a §)	3,719	3,781	3,766	4,031	3,915	5,539	5,645	6,39	6,44	8,141	7,862	-3
Drug possession (1-3 §)	11,588	13,561	14,526	15,249	17,624	22,083	23,15	24,764	25,432	27,368	28,785	5
Drug use (1-3 §)	13,659	16,373	18,583	21,726	26,645	37,544	42,414	46,569	47,847	51,766	52,134	1
Possession and use (1-3 §)	3,305	4,155	3,766	3,876	3,418	1,421	2	-	-	-		-
Production (1-3 §)	134	135	219	211	205	270	335	465	537	615	655	7
Total	32,405	38,005	40,86	45,093	51,807	66,857	71,546	78,188	80,256	87,89	89,436	2

The table above shows that the total number of reported drug offences increased by 7% between 2010 and 2011. The highest increase concerns possession (5%).

[17] http://www.bra.se/bra/bra-in-english/home/crime-and-statistics/crime-statistics/statistical-tables.html

Concerning drug use, there is a smaller change (1%). The reported cases of peddling decreased 3% between 2010 and 2011. The category possession and use has been removed, which is the explanation for the sharp fall in the possession and drug use category (from 3,418 in 2005 to 1,412 in 2006 and to 2 in 2007). A change in practice has occurred and this combined offence is now judged in a different way and thereby the cases are accounted for in each category instead. The total change between 2010 and 2011 for reported drug offences is similar to the drug offence as the main crime for conviction.

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

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

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

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

** Corrected figures.

*** Corrected number of waivers of prosecution.

The number of persons convicted of drug offences has increased every year over the past decade. The annual increase has varied, but averaged just below 7% until 2006. This means that drug convictions have more than doubled (increased by 136%) over the last 10 years. Two of the following paragraphs (type of offence and substances) are quoted from the 2009 NCCP report referred to above.

Types of offence[18]
At 57% (12,033 convictions) and 26% (5,619 convictions) respectively, drug use and drug possession were the two most common offences committed by persons convicted of drug offences in 2009. Drug smuggling and distribution[19] accounted for 4% and 5% of all drug convictions, respectively. The proportion of convictions relating exclusively to personal use increased by 28% between 2006 and 2009 (from 9,397 to 12,034 convictions). The proportion relating to possession offences increased by 12% under the same period (from 5,021 convictions in 2006 to 5,619 in 2009).

Offence severity
In 2011, minor offences accounted for approximately 87% of all convictions (approximately 18,600 convictions). Non-minor offences accounted for 12% (2,550 convictions) and serious offences for 1% (314 convictions). The proportion of convictions for minor drug offences has increased whereas the proportion of convictions for non-minor drug offences has decreased.

Substances[20]
Amphetamines and cannabis remain the two most common substances in the conviction statistics. In 2009, these accounted for 27% and 42%, respectively, of all substances mentioned in criminal convictions. Over the past 10 years, there has been a shift in the proportions accounted for by cannabis and amphetamines, respectively, with cannabis now being the most common substance in criminal convictions.

Sanctions[21]
The most common sanction issued to those convicted of drug offences is a fine, either in the form of a summary fine issued by the prosecutor or via a court sentence. Those issued fines accounted for 57% of all those convicted of drug offences in 2011. In 2011, 29% of those convicted of drug offences took the form of waivers of prosecution, whereas 6% involved prison sentences.

The increase in the total number of persons being convicted of drug offences is also mirrored as an increase in virtually all of the different sanctions. The number of fines has more than doubled over the period examined, from slightly less than 4,200 persons in 2001 to more than 12,100 in 2011. The number of persons sentenced to a prison term has decreased from 1,460 in 2001 to fewer than 1,360 in 2011. The average length of the prison term issued in 2011 was 16 months.

Regional distribution
Relative to the size of the population in the different counties in Sweden, counties in the country's metropolitan areas have a higher proportion of drug convictions than the others. The metropolitan counties, which are home to half of the national population, account for 57% of all drug convictions in Sweden in 2011. Since 2001,

[18] Refers to summary fines and court adjudications only, as the offence type cannot be discerned in the case of waivers of prosecution.
[19] Distribution and distribution in combination with possession.
[20] Refers to convictions in which the drug offence was the principal offence.
[21] Figures are from the 2011 official statistics of persons found guilty of offences.

this proportion has remained stable at between 57 and 62% of all those convicted in the country as a whole.

Age distribution[22]

In 2011, young persons aged 18–20 had the highest level of drug convictions in relation to their numbers within the population at large, with 1,050 convictions per 100,000 of population. The groups aged 50 or over have the lowest number of convictions, with 43 convictions per 100,000 of population. Over the period between 2001 and 2011, the largest increase in the number of drug convictions per 100,000 of population has been noted among those aged 50 or over. Per capita convictions in this group have more than tripled over the period examined.

Gender distribution[23]

Of the total number of persons convicted of drug offences in 2011, approximately 14% were women. This proportion has remained relatively stable over the past 10 years. The number of women and the number of men convicted of drug offences has more than doubled over the same period. Between 2010 and 2011, the number of men convicted increased by 8% and the number of women convicted increased by 2%.

9.5 Prevention of drug-related crime

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

"The majority of European countries have a drug strategy that aims to reduce drug-related crime. One of the methods commonly used for achieving this is to provide treatment for drug users. In most countries, treatment for drug users is available through conventional medical referral processes. In some countries, treatment is also made available from within the criminal justice system. This can be part of a referral process whereby offenders are diverted at various stages into treatment or treatment can be provided from within the criminal justice system as part of a prison programme. In order for the strategy to be effective, it needs to be demonstrated that treatment for drug misuse can lead to a reduction in crime.

This report presents the results of a systematic review of the literature on the effects of different kinds of intervention for problematic drug use on criminal behaviour. The main selection criteria were that the evaluation should be based on voluntary

[22] Calculations conducted per 100,000 of mean population is from the 2011 official statistics of persons found guilty of offences.
[23] Figures are from the 2011 official statistics of persons found guilty of offences.

treatment programmes that aimed to reduce drug use (e.g. methadone maintenance, detoxification, or self-help programmes) or criminal justice programmes that aimed to reduce drug use and drug-related crime (e.g. drug courts and drug testing programmes).

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

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

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

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

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

However, more needs to be known about variations in effectiveness and the influence of programme type, intensity, and context on crime outcomes." (Holloway et al., 2008)[24].

9.6 Interventions in the criminal justice system

Alternatives to prison

The Swedish penal code lists crimes and their sentences. The sentences listed in the penal code are fines, imprisonment, conditional sentence, probation and committal

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

for special care. Sanctions implemented by the Prison and Probation Service are Prison, Intensive supervision with electronic monitoring ('tagging'), Conditional sentence with community service, Probation, Probation with community service and Probation with contract treatment. In deciding the sanction, the court must take into account whether there are any particular factors which would favour a sanction other than imprisonment.

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

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

In 2011, 1,466 prisoners engaged in ”utsluss” activities. Some of them, 531, underwent care service. This is an activity aimed at treatment of a substance use disorder.

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

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

Finding the addicts
The SPPS objective that all drug addicts in correctional treatment should be identified, “mapped” and motivated to accept treatment is in general fulfilled. It should be guaranteed that all inmates wanting help are also offered help. However, in 2011 fewer inmates than earlier have been identified since there have been problems with manning of the outreach function, renovation, and the opening of three new remand prisons. Between 2009 and 2011 more than 22,000 people in custody had an average of three personal motivational interviews aimed at persuading the detainee to participate in treatment.

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

To be approved, a programme must among other things include

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

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

An important part of development is to analyse the effectiveness of the programmes with regard to reoffending. The 12-step and Dare to Choose programmes have been evaluated. Participation in 12-step programmes was associated with a modest but significant (16-17%) reduction in post-treatment reoffending after controlling for confounding variables. This applied to the full treatment group as well as completers only compared with non-treated peer controls. Dare to Choose was found to yield a 14% statistically significant reduction in post-treatment reoffending in the treatment group compared to peer controls after controlling for confounding variables. The return on invested capital was calculated to be 312% over two years.

PRISM is being evaluated during 2012. The programme is individually provided to clients with criminality associated with substance abuse. The evaluation showed that those who had completed the programme had a 30% lower risk of reoffending compared to those who did not receive any treatment.

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

Programmes in use for general offending:

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

Substance abuse programmes:
- Dare to Choose
- PRISM - Programme for Reducing Individual Substance Misuse
- Twelve-step programme
- Relapse prevention programme

Supportive factors for implementation
The Prison and Probation Service makes an effort to reduce recidivism by increasing knowledge and understanding among the prison population. In addition to traditional methods, for example education, vocational training and social rehabilitation, there are a number of national treatment programmes that specialize in various types of behaviour related to offending. Some of them are group work programmes, others are individual programmes. Most of the programmes are based on Cognitive Behavioural Theory. Four of these are aimed at offenders with drug and/or alcohol abuse/dependency. There is today also a gambling programme, which is being run as a trial project during 2012.

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

The Swedish Prison and Probation Service aims to implement only evidence-based treatment programmes. In order to secure effectiveness, the programmes are reviewed by a scientific panel and only programmes fulfilling the requirements will be granted accreditation. To be approved, a programme must among other things include a clear model for change based on scientific evidence, the use of effective methods, and site accreditation including monitoring of implementation and staff competencies. Before accreditation is applied for, the programme is usually tried out on a small scale during its development. After accreditation, the aim is to offer the programme to all offenders who, according to assessed risk, are in need of such intervention. In 2011, 5,787 prisoners completed a treatment programme in prison.

9.7 Drug use and problem drug use in prisons

The average number of drug addicts in prison has been fairly stable over an extended period of time. On 1 October 2011, 59% of the women and 63% of the men in prison were drug addicts.

One measure of an inmate's use of illicit drugs is a urine test. The Swedish Prison and Probation Service take urine samples in many different situations, for example;
- When the prisoner arrives, for example when he/she been on a permitted leave
- When there is a suspicion of drug use

- When there is a suspicion of drugs present inside prison
- After an unsupervised visit from a relative or friend
- After being tested positive for illicit drugs
- Random testing

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

In 2011, the Swedish Prison and Probation Service took 91,931 drug tests. This has to be compared to the fact that 14,803 inmates have to some extent been placed in prison. Most of these, 84,430, were urine tests while 26 were blood tests and 4,972 expiration tests.

In 2010, 96,319 drug tests were taken. 4,965 of these came back positive for illicit drugs. Cannabis and benzodiazepines were the most common positive tests. A large proportion of the positive tests are tests that are taken when the prisoner has been on a permitted leave. Urine tests can therefore not be considered measure of use of illicit drugs inside prison.

Over the past few years, the SPPS has greatly expanded its use of random testing. Twice a year a nationwide test is conducted at all our prison establishments. Five dates in a month are selected, e.g. everybody who was born on day 1-5. On a Monday morning, the prisoners comprised in the selected criteria give a urine sample without prior notification. This means that approximately 15-18% of the whole Swedish prison population is involved. The samples are analysed for the 6 most common drugs - cannabis, heroin, amphetamines, etc. Additional tests are performed on some of the samples to detect so-called research chemicals or internet drugs in prisons where there is reason to believe there may be some such drugs.

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

Drug detection dogs

Many measures have been taken over the past ten years to prevent drugs from being smuggling into prisons – supply reduction. An intelligence service has been established with the aim of obtaining information about, among other things, how drugs are smuggled into and distributed inside prisons. Other control measures are searches of visitors, searches of cells and premises, and drug monitoring by means of urine tests. Drug detection dogs play an important role in this work. Some ten years ago, the Swedish Prison and Probation Service had only a few dogs for searching for drugs. As of July 2011, there are 21 specially trained dogs. They cover all prisons and remand prisons and can also be used to search visitors for drugs. The dogs are owned by the Prison Service but managed at work and at leisure by a dog handler, who is a member of the staff. Dog and handler work together as a team.

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

9.8 Responses to drug-related health issues in prisons

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

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

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

Maintenance treatment with methadone and buprenorphine is available at the prisons in Fosie (Malmö), Storboda and Täby in Region Stockholm and Högsbo in Region West.

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

One of the projects is conducted by Ylva Ginsberg, MD, and Nils Lindefors, MD, PhD, of the Department of Clinical Neuroscience, Division of Psychiatry, Karolinska Institutet. An article has been published in the British Journal of Psychiatry, which states that Attention-Deficit Hyperactivity Disorder (ADHD) is highly prevalent among prison inmates, but pharmacological treatment has not yet been evaluated in this group.

Considering ADHD, investigations are on-going in 8 (soon to be 11) prisons. They are carried out in youth departments and with special resources. In the Stockholm region, there is cooperation with the Swedish Institute for Communicable Disease Control in the prisons in Storboda, Färingsö and, in the very near future, also Täby.

9.9 Reintegration of drug users after release from prison

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

The education available for prisoners includes basic formal adult education, vocational training and post-secondary education. The Prison and Probation Service is responsible for general education, under the supervision of the Swedish Schools Inspectorate. Around 120 qualified, special subject teachers, covering a wide range of subjects at different levels (basic, secondary and upper secondary), are employed by the Prison and Probation Service. A Learning Centre has been established at each prison to make the education available to as many inmates as possible. Vocational training is mainly offered in co-operation with the Swedish Public Employment Service, thanks to a special agreement between the two organizations. In 2011, there were 13,974 inmates serving their sentence in prison. 4,277 participated in some kind of education/training at some time during the year.

10. Drug Markets

10.1 Introduction

Swedish Customs has the highest priority to stop and prevent drugs entering Sweden. This priority is given to Swedish Customs by the Swedish government. To stop or prevent the smuggling of drugs, Swedish Customs cooperates with other domestic authorities such as the Swedish Police and the Coast Guard. There are also cooperation with law enforcement authorities in other countries, both within the EU community and in the rest of the world. Swedish Customs has liaison officers placed in some countries, for example Germany, Russia and, from 2012, China.

To find drugs, the Swedish Customs uses technical equipment such as portable and stationary X-ray machines that can detect drugs in luggage, vehicles and containers, and fiber optic instruments, and of course drug detection dogs.

Reporting system on drugs

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

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

Since 2011, there has been an alteration in CAN’s reporting system on drugs to only include reports from the 21 county police departments in Sweden (Guttormsson, 2010). Previously, the system also included roughly 150 respondents from the 15 most populated municipalities (covering almost 30% of the population).

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

Early detection

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

Analysis procedure
At the Swedish National Laboratory of Forensic Science (SKL) the substance identification is performed by qualified personnel with a broad spectrum of expertise in different analysis techniques. The described standard method for identification has been accredited according to ISO 17025 and allows new substances to be added to existing methods in a controlled way within a flexible scope. The competence of the employees as well as the methods has been quality assured for several years.

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

In recent years, the composition, variety and number of novel substances seized by the Swedish police has increased. This is due to a more scattered drug market and a widely spread knowledge of designer drug synthesis, in combination with a more hidden drug scene and aggressive internet marketing. During 2010 forty novel substances were added to SKL's reference library. The structure of thirteen of these novel substances were determined by the chemists at SKL while the remaining twenty-seven could be purchased as certified references. Most of these substances were synthetic cannabinoids and cathinones. Several of the identified novel analogues to illicit drugs have led to national regulation. A goal for the future is to speed up the process, both on a national plane and in the laboratory, and increase the number of structure-determined substances per year (personal communication with Lotta Rapp, Droganalysenheten, SKL, 28 October 2011).

10.2 Availability and supply

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

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

The most rapidly increasing way to smuggle drugs to Sweden is by mail. More than half the number of drug seizures are made in postal consignments. There are only two places in Sweden were postal consignments arrive from abroad; Arlanda Airport in Stockholm and the postal terminal in Toftanäs, Malmö.

Analysis of the availability
Price information on drugs is reported by all of Sweden's 21 county policy authorities. Several kinds of drugs are reported less often in northern Sweden, but at the same time prices in northern Sweden may be somewhat higher. This may indicate that illicit

drugs are generally less available further north. Prices are often lowest in southern Sweden, but the geographic differences should not be exaggerated. Although some differences in level exist between different parts of the country, the overall trends are often similar.

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

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

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

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

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

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

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

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

Most kinds of illicit drugs are smuggled into Sweden, but marijuana is an exception here, since cannabis cultivation also occurs in Sweden. In recent years, the police have discovered several large plantations in Sweden. At the same time, seizures of marijuana are still being made at the borders. During the period from 2007 to 2010, marijuana remained the most common drug among customs seizures.

Trafficking patterns

Organised crime
Drug-related organised crime that supplies the Swedish addict market can in general be divided into three kinds based on where they act geographically:

- Criminals who deal in illicit substances are mainly active domestically and are often related to gangs, such as motorcycle and ethnic gangs, and other criminal individuals and networks. These categories of criminals are members of, or have contact with, networks with international connections in order to obtain the drugs needed. Either the drugs are for personal use or for further distribution to customers. In order to combat domestically active criminals, the Swedish National Bureau of Investigation co-operates closely with the police authorities in the different parts of the country.

- Drugs produced in neighbouring countries and some EU member states are smuggled into Sweden by regionally active criminal organisations and networks. These criminals mainly act from their home countries, but often use criminals resident in Sweden for distribution of the drugs to Swedish users. In the case of countries in the Baltic Sea Region, such contacts are often with criminals residents in Sweden who have ethnic ties to the source country of the drug. Within the EU, a large share of law enforcement co-operation takes place via Europol and regionally through the Task Force on Organised Crime in the Baltic Sea Region and the Nordic Police and Customs Co-operation (PTN).

Drugs originating in countries outside the EU are produced and smuggled by globally active criminal organisations or networks. In this scenario, Sweden is of less

importance to the overall criminal activity and finances. However, domestically active criminals rely on the supply of such drugs for their income and criminal activities within Sweden. Since Sweden is only of marginal importance to the globally active criminal organisations, efforts to combat them take place both through international organisations, such as Europol and Interpol, and domestic efforts targeted at exposing criminals who distribute such drugs within Sweden. On some occasions, Sweden also co-operates bilaterally with important transit or producing countries when feasible and necessary.

Precursor chemicals used in the manufacture of illicit drugs

The manufacture of illicit drugs requires so called precursor chemicals (except for the drugs used in their natural form, such as khat or cannabis). Precursor chemicals are chemicals used both legally and illegally and are usually manufactured under rigorous security measures. The most important chemicals for producing illicit drugs, mainly piperonyl methyl ketone (PMK), benzyl methyl ketone (BMK, the most important chemical in the production of amphetamines) and ephedra (ephedrine in its natural form), are actually manufactured in just a few places in the world. For this reason, there is a possibility to stop smuggling by focusing on specific routes.

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

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

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

10.3 Seizures

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

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

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

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Narcotics-classed pharmaceuticals	3,214	4,511	4,317	4,715	5,347	6,032	7,443	7,375	7,917	8,374	7,987
Cannabis[25]	6,929	7,351	8,243	8,102	8,345	9,365	10,052	10,996	12,108	12,107	12,737
Heroin[26]	1,271	1,052	1,057	900	804	800	871	688	671	493	314
Amphetamine	5,513	6,660	6,657	6,773	6,501	6,842	6,477	5,304	4,986	5,014	3,542
Methamphetamine	275	250	301	244	386	359	485	846	1,086	704	608
Ecstasy	621	631	489	411	381	309	268	231	42	127	189
Cocaine	328	440	545	524	546	772	725	813	792	724	618

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

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

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

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

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

In Sweden, cross-border smuggling of precursor chemicals is limited as Sweden is mainly a recipient country for drugs, and where only a small amount of drugs requiring chemicals is produced. There is a risk that Sweden is being used as a

[25] Marijuana and cannabis resin
[26] White and brown heroin

transit country for the shipping of precursor chemicals to countries where production of illicit drugs does take place. However, in 2008 and 2009 no serious illegal transactions involving precursors were detected.

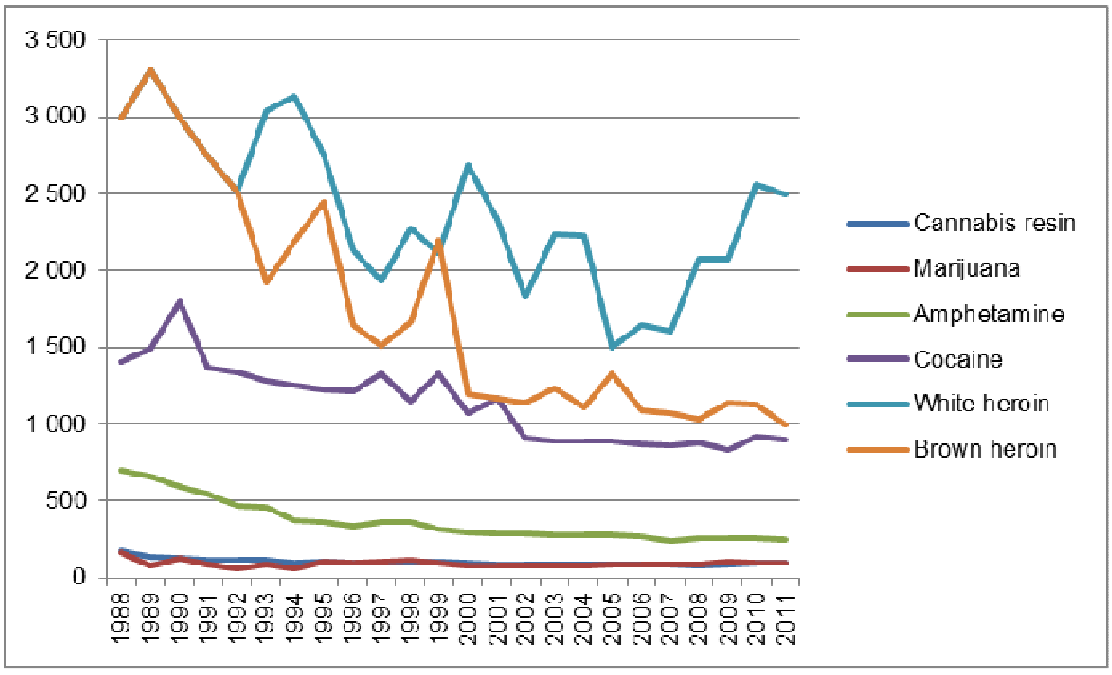
Precursors
Only small quantities of precursors (only ephedrine) are seized by Swedish Customs.

10.4 Price

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

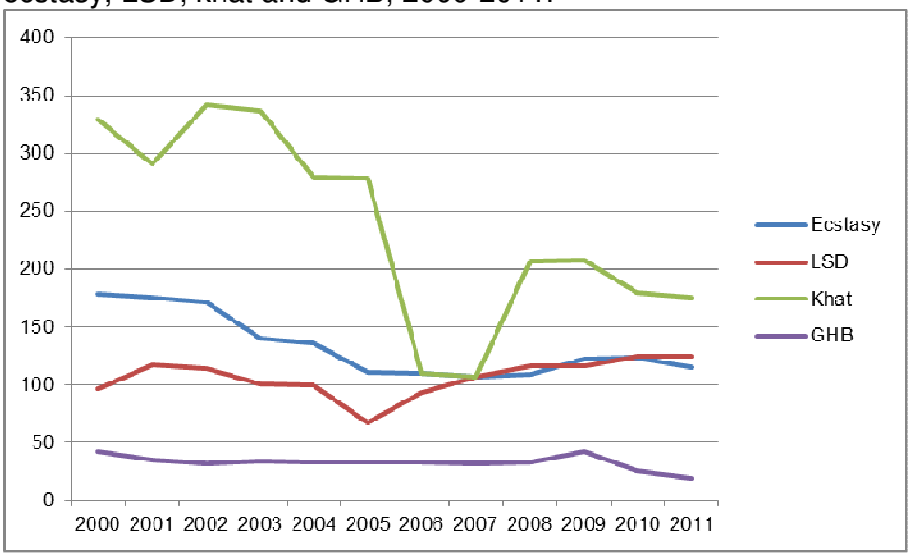
However, from a short-term perspective, prices have increased for marijuana, cocaine and heroin in recent years. The increase is not spectacular, but unique in a long-term perspective because the prices of several illicit drugs have now increased at the same time. Amphetamines are the only drugs with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

Figure 10.1: CPI-adjusted[27] original median street-level prices, SEK per gram for cannabis resin, marijuana, amphetamine, cocaine, and white brown heroin, 1988-2011.



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

Figure 10.2: CPI-adjusted[28] original median street-level prices, SEK per gram for ecstasy, LSD, khat and GHB, 2000-2011.



In the introduction, it was mentioned that illicit-drug prices were also gathered at a wholesale level beginning in 2010 (quantities in kilograms). A comparison between wholesale prices and street-level prices (quantities in grams) shows that street-level prices are three times higher than wholesale prices. This applies to both narcotic substances that are not cut with dilution agents, such as cannabis resin, marijuana and ecstasy, as well as illicit drugs like amphetamines, heroin and cocaine that are diluted with relatively inexpensive, inactive substances (Guttormsson, 2011).

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

Part B – Selected Issues

11. Residential treatment for drug users in Europe

11.1. History and policy framework

A description of institutional inpatient care for substance abuse-related problems can be based on several, more-or-less limiting perspectives. The objective of this report is to describe Swedish narcotics-related inpatient care based on the guidelines provided by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Such an approach can, at best, provide good insight into the situation of the most vulnerable substance-abusers. This report touches upon all forms of institutional care targeted at those with narcotics abuse and dependence, regardless of principal.

An assumption in the survey is that the target group (adults from 20 years of age), especially the problematic substance abusers, move between different treatment systems as their living situation and misuse leads to serious problems of various kinds. The way in is problematic, however, since there is currently no personal data that makes it possible to identify a single individual in the various systems, which makes it difficult to count the number of individuals who have received inpatient care over a year. There is a risk that the number of individuals is overestimated. Another problem is the hidden statistics that all surveys of substance abuse and dependence struggle with, i.e. that the number of people who received care is underestimated due to the number of unreported cases through e.g. under diagnosis or as the need for inpatient care in society.

Another complication is the number of "pure" illicit drug abusers, i.e. people who only use narcotics tend to decrease over time. Depending on availability and price, increasing numbers of substance abusers combine different substances of abuse. In several contexts, the concept of a "primary drug" is used, but this concept can lose its meaning if the preference for the drug is increasingly an issue of accessibility. In reference to the wide-spread mixed substance abuse, some data regarding pharmaceutical dependence has been included.

Since 1997, patients have been categorised in the patient register in terms of International Statistical Classification of Diseases and Related Health Problems (ICD) codes, and thereby substance types (alcohol, narcotics and pharmaceuticals), which likely improves the conditions of extracting care data.

There is no corresponding categorisation in the statistics that comprise the social services' clients, which is why a division into different substance groups is more difficult (exceptions are clients from the age of 20 who are covered by care under the Care of Alcoholics, Drug Abusers and Abusers of Volatile Solvents Act - LVM). Consequently, the social services do not register what substances of abuse are involved, which means that people with problems of substance abuse and

dependence are lumped together and reported as a collective. The studies available for illustrating what substances of abuse those in inpatient care use are also beginning to become out of date.

In Sweden, the social services are an important actor in institutional care. Consequently, social services' clients are included in this survey with the reservation that the substance of abuse has not been possible to fully survey. The increased mixed substance abuse naturally begs the question as to whether the diagnosis systems match real social, psychological or other differences in the individual, and if it is reasonable on the long term to attribute the substance in itself a more subordinate significance. The registers that are currently of interest and are largely administered by the National Board of Health and Welfare are based on data from various sources with partially different aims and contents, which makes the overview more difficult. Another problem is the lack of personal data in parts of institutional care.

In brief, the above means that the possibilities of coordination of registers in the area are limited and that there are also no possibilities of tracing individuals in the various care systems (an exception is, however, the data concerning those in compulsory care under LVM). This also impedes or makes it impossible to tie various care and treatment activities that are current at the same time or closely related to one another in time to a single individual. Studies of the consumption of care of individuals and over time can therefore only be conducted at a local level. In one such more limited study, it came forth for instance that those in compulsory care had been subject to medical care to a very high degree[i29]. The lack of coherent national data is a strong incentive for more in-depth studies of the area.

11.1.1 History of residential treatment

Alcoholic care and drug addict care had previously come to represent two different socio-political fields. The differences were primarily manifested in various areas of policy; alcohol and narcotics policy have included different legislation and means of incentive. The care of drug addicts has its origins in the pilot programmes with the prescription of narcotics and methadone maintenance treatment that began in 1965 and 1966, respectively. The first investigative committee, the Drug Addict Treatment Committee (SOU 1969:53), initiated its work in 1966 and led to proposals regarding the development of drug-free treatment centres. From the care and treatment perspective, the efforts culminated in the effort called Aggressive Drug Addict Care. It was based on the Government bill 1984/85:19 "Aggressive care of addicts", which aimed for a rapid build-up of both outpatient and inpatient care in light of a feared HIV epidemic. The expansion came to become temporary, in part due to a questioning of how public care should be organised, but also due to a budgetary crisis at the end of the 1980s. At the beginning of the 1990s, these specialised addict care units gradually began decreasing in number or developing into other forms of activities and

[29] Status report 2006 and 2007 (pages 48 and 44, respectively), Individual and family care, National Board of Health and Welfare 2006 and 2007.

caregivers began to turn to both the client categories. The Minnesota model began to rapidly expand in this period (Blomqvist and Olsson, 2011).

Institutional care with the consent of the individual is a form of care intervention that essentially coincides with the establishment of the Temperance Act in the mid-1950s. Prior to this, it was solely compulsory care, psychiatric or somatic care that was dominant in the treatment of substance abuse.

The development of institutional care can be seen as a result of the abolition of the alcohol ration book at the same time and a gradual increase in alcohol-related harms. During the so-called "alcohol ration book period" (1917-1955) when purchases of alcohol were rationed, Sweden had a decreasing and low frequency of alcohol-related harms and disease, also compared with other countries. Institutional care was then conducted for individuals within psychiatric or internal medicine clinics, primarily as compulsory care. The care institutions that conducted compulsory care were supplemented by municipally operated care institutions or treatment centres for voluntary care. Several of these had NGOs as a base.

Since the 1960s, the narcotics issue has been subject to several investigations and socio-political discussions. Care and control efforts have been two parallel lines in the narcotics policy that is presumed to lead to a drug-free society. The starting point has been to not distinguish between narcotics use and narcotics abuse (Blomqvist and Olsson, 2011).

From a care and treatment perspective, the large number of investigations and efforts related to narcotics policy in recent decades essentially played a minor role in relation to addict care as a whole. The individual substance abuser has been relegated to the same "care apparatus" and regulations regardless of their substance of abuse. The care legislation and care structure presented in the following section are therefore relevant to the care and treatment of both alcohol and drug abusers.

The latest local study that covers addict treatment was conducted in the Stockholm County Council[30]. The county accounts for around one fifth (approx. 2.1 million people) of Sweden's population. The study was based on information in a database over all registered care consumption concerning alcohol- and narcotics-related diagnoses over an 11-year period. (1998-2008). What attracts interest here are the changes that have occurred in the consumption of inpatient care in a large number of alcohol- and narcotics-related diagnoses and are probably representative for Sweden as a whole. Data shows that the number of people treated for *alcohol-related* diseases has increased by 10% per 100,000 residents and by 20% in absolute figures. The increase is particularly tangible in the younger age groups, 15-24 years – among both men and women, at around 100 and 150%, respectively. Alcohol poisoning is the most prominent diagnosis. The number of people treated for *narcotics-related* diseases is, however, largely unchanged, except for women in the 15-24 year age group and men in the 50-64 year age group. In these groups, the increases per 100,000 residents are 18 and 60%, respectively.

[30] Alcohol- and narcotics-related care consumption and mortality in various age groups in Stockholm County 1998-2008, Karolinska Institutet School of Public Health, 2010:7

In this context, it should be added that a high proportion of correctional treatment clients have alcohol and/or drug problems. Like somatic care, correctional care has not previously had the express aim of treating or caring for this group. In recent decades and particularly in the 2000s, special programmes including pilot programmes with pharmaceutically assisted treatment have done so, however.

Care without consent

The care and treatment of substance abusers arose as a concept in connection with the adoption of the first social care act by the Swedish Parliament in 1913 (see inter alia *The Substance abusers, social services and compulsory care,* report by the Social Committee, SOU 1987:22, *Care of alcohol abusers*, National Board of Health and Welfare reports 1978:4).

The Act on the Treatment of Alcoholics became a reality when Sweden's first state care institution (Venngarn) opened in 1916. This law was replaced by the Act on the Treatment of Alcoholics (1931:233) with a somewhat stronger emphasis on the care of the individual. However, it only pertained to severe cases and was still focused on confinement.

In the 1930s, socio-political reform efforts began in Sweden, which encompassed labour market and housing policy measures, the creation of a system of social insurance and the development of health and medical care. A certain shift in the view of the individual substance abuser occurred towards a somewhat less moralising attitude. It allowed for the possibility of connections between social deviations and the social environment. The explanatory model of the alcoholic as a *social ne'er-do-well* gave way to some extent to a more liberal view. Substance abuse increasingly came to be seen as a disease that required both medical and social treatment.

In 1954, a new law entered into effect, the Temperance Care Act (1954:579), with a greater emphasis on preventive measures. Compulsory care would be resorted to only when it was established that voluntary care efforts were inadequate. The previous concept of reversion was complemented by the concept of substance abuse and the possibilities of opting for both helping intervention and monitoring. If these were insufficient, there was a possibility of resorting to compulsion and admission to a public care institution.

The Social Commission, which was appointed in 1967, issued a report in principle in 1974 (1974:39), which established the principle that the care and treatment of individuals with problems of substance abuse and dependence should take place in voluntary forms to the furthest possible extent. A discussion was conducted as to whether compulsory intervention could take place within the Act on Institutional Psychiatric Care (LSPV), but it was believed, however, that care in the framework of the healthcare system would provide an excessively medical orientation and not address the need for solutions to social problems. The conclusion was that compulsory measures had to take place within the scope of a separate law.

In the Social Commission's final report (SOU 1977:40), it was agreed to repeal the Temperance Care Act and that the substance abusers not covered by compulsory psychiatric care would instead receive voluntary care under the proposed Social Services Act. This proposal was subject to several reviews, however. One took place

in connection with an inspection by the National Board of Health and Welfare of the psychiatric compulsory care legislation, where a joint law was again proposed to be included (Psychiatric Care Act), in which substance abusers in dire need of detoxification and psychiatric care would be included. In a later bill (1979/80:1), a model with compulsory psychiatric care was proposed (largely in accordance with the inspection's proposal), but the Social Committee asserted that it was necessary for the issue of the compulsion of adult substance abusers to be decided with broad political unity. A special parliamentary committee (the Social Drafting Committee) hereby came to be appointed to again review the issue of compulsion. The committee issued its interim report (SOU 1981:7) proposing the Care of Alcoholics, Drug Abusers and Abusers of Volatile Solvents Act (LVM), which came to be a compulsory law within the scope of the social services. The main principle of the law is that the abusers of alcohol and narcotics that cannot be enticed to participate in voluntary efforts under the Social Services Act shall be provided care under LVM.

This exposé over society's position on care without consent and individual substance abusers with severe problems is of particular principle interest. Is severe, occasionally life-threatening substance abuse to be considered a psychiatric matter, i.e. can it be viewed, at least temporarily, as a mental illness? Or should substance abuse primarily be seen as a social and psychological problem? The issue has again come to the fore with the Substance Abuse Commission, a government commission with the task of conducting a review of the care and treatment of people with problems of substance abuse and dependence. In a discussion memorandum *Better care and support for the individual* (S 2008:04), the commission proposed that LVM should be repealed and regulations regarding compulsion should be integrated into the current Compulsory Psychiatric Care Act (LPT). In the ensuing request for comment process, a division again came forth in the responses to the proposal. However, the Substance Abuse Commission proposed in its final report (Better interventions for substance abuse and dependence, SOU 2011:34) that LVM should be integrated into LPT. The issue is still controversial and does well in reflecting a watershed in Swedish social policy as to how social discrepancies should be interpreted and handled. A bill will probably be presented during the 2012 parliamentary year.

Narcotics treatment has been developed to meet the needs of internees for rehabilitation. In the assessments and estimates made by correctional care of its operations, it is believed that around 60-70% of the internees have problems with narcotics or other drugs. In total, it involves approximately 10,000 people within correctional care (both non-institutional care and institutional care) who are assessed to abuse or be dependent on narcotics.

11.2 Availability and characteristics of residential treatment

In Sweden, different terms are used to describe such care that takes place after admission and a 24-hour stay at a special care and treatment unit. In health and medical care, the term of inpatient care is regularly used. For such care where the social services have decided on assistance in the form of inpatient care, the term of institutional care is more common. In the statistics over the social services' efforts, this care is called full-time care. However, the term inpatient care is used in continuation for all forms of "round-the-clock" care, regardless of caregiver.

Inpatient care in substance abuse and dependence care is primarily financed by taxes with a number of different providers. The most important providers are county councils, municipalities, the state, private actors, foundations and NGOs. Providers alongside of the municipal, county council municipal and state sphere (care and treatment under public management) as a rule have been procured and contracted in free competition. According to surveys by the National Board of Health and Welfare, private companies and NGOs accounted for around 60% of inpatient care (42 and 18%, respectively), while the publicly operated care accounted for the remaining 40%[31].

Inpatient care in county councils

County councils finance all substance abuse and dependence care, where medical complications or psychiatric problems are in the foreground. The care is primarily conducted at special clinics, often within psychiatric services, to treat severe abstinence problems and co-morbidity (substance abuse or dependence and simultaneous mental and/or somatic problems). Specialised treatment for substance abuse and dependence is also conducted in the special clinics. This is also the case with regard to the operations that conduct needle exchanges. In some cases, people with substance abuse and dependence problems are subject to compulsory care under the Compulsory Psychiatric Care Act (LPT) or the Forensic Mental Care Act (LRV).

The detailed costs of the county councils' inpatient care are unknown, since a large number of care episodes are not budgeted or are reported as alcohol or drug-related. However, the estimates show that they amount to approximately SEK 2.8 billion[32].

Inpatient care in the social services

Homes for care and living

Inpatient care in the social services is in principle conducted at three different institutions. *Homes for care and living* (HVB) constitute the dominant component. In accordance with available register data, there are currently around 300 homes[33] that receive individuals with problems of substance abuse and dependence. The homes have been entered in a special register (the HVB register at the National Board of Health and Welfare). A high proportion of these homes are operated under private management. According to a previous study (JKB, 2003), around 65% of these are run by private actors or organisations. Municipalities and county councils operate 25% while around 6% are operated by the state.

[31] In outpatient care, publicly operated operations are dominant. Around 80% of them are operated by municipalities, county councils and the state.

[32] See the inquiry, Better interventions in substance abuse and dependence (SOU 2011:35), volume 2, page 591. According to a study by the National Board of Health and Welfare *Cost of alcohol and narcotics, estimate of society's direct costs 2003*, National Board of Health and Welfare 2010, the cost amounted to nearly SEK 2 billion.

[33] In total, a survey in spring 2006 was able to identify around 680 units in both outpatient and inpatient care.

Family homes
The other form of inpatient care is carried out in so-called *family homes*[34]. Like HVB, these operations are regulated by the Social Services Ordinance (Chapter 3, Section 2). Among others, the family homes accept adults for care and nursing. Family homes are not normally operated as professional operations. A so-called reinforced family home care can, however, include supplementary support in the form of guidance, special round-the-clock support, training and relief. In a few cases, LVM care (see below) has converted into family home stays under Section 27 of LVM. There is a large uncertainty as to the number of family homes and the number of people who receive such support. One is related to the fact that the family homes are sometimes recruited directly by municipalities, sometimes through special private stakeholders. The latter can sometimes arrange more family homes. How many homes they have at their disposal is unknown, however. The other is related to correctional care procuring a relatively large number of placements that are not registered as assistance under the Social Services Act. This care is financed by correctional care. Except for the homes recruited directly by the municipalities, the operations are conducted under private management or by NGOs.

Compulsory care
Compulsory care (LVM) lastly constitutes the third form of inpatient care. The social services petition for such care with the administrative court if the individual does not consent to voluntary care. The statistics are relatively extensive and consist of applications for LVM care, decisions on LVM care, immediate custody and discharges from LVM care. Today, there are 11 homes that conduct care under LVM[35].

Compulsory care has undergone relatively large changes in recent decades. In the beginning of the 1980s, the number of people in compulsory care was at around the same level as today. As a result of legislative changes, which entailed a changed responsibility for investigations, the number of people in compulsory care more than tripled at the end of the 1980s and the beginning of the 1990s. A gradual decrease has since occurred with the changes this has entailed. The number of LVM homes declined by nearly half during this period[36]. In this context, it can be mentioned that the women's proportion of the number of internees increased from around 14% to 36%. At the same time, a significant change in the substance abuse patterns of internees occurred. The proportion with only alcohol abuse decreased from 93% to 46%. Narcotics abuse increased from 2% to 34% and mixed substance abuse increased from 5% to 19%.

[34] In legislation, a family home is understood as ”a private home that, on behalf of the social welfare board, takes in … adults for care and nursing and the operations of which are not conducted professionally” (Chapter 3 Section 2 of the Social Services Ordinance (SoF)). Family home care can be provided in the form of support, work or occupational training, either pursuant to Chapter 4 Section 1 of the Social Services Act as voluntary care or as compulsory care pursuant to Section 27 of LVM for adults with substance abuse and dependence problems.

[35] http://www.stat-inst.se/
[36] The changes are discussed in depth in Compulsion and change, content of care and after-care, Interim report by the LVM Commission, SOU 2004:3.

In 2010, a total of 952 people were subject to a decision on an LVM care intervention from the administrative court. Around one fourth of them (235) were only subject to immediate custody, while the others (717) had decisions of immediate custody and preparation of care or only preparation of care. The total number of care days amounted to nearly 160,000.

The costs of the social services' total and direct interventions for substance abuse and dependence care amounted to approx. SEK 5.8 billion in 2010, of which nearly half, nearly SEK 2.7 billion pertains to inpatient care . The costs of LVM care are borne by the municipalities, which pay a special daily fee. How large a proportion of the municipalities' costs for inpatient care that can be linked to LVM care is unclear, however.

The Swedish National Board of Institutional Care, administrator of LVM, has delivered TDI-data to EMCDDA for many years by the use of the assessment instrument DOK being compatible with the TDI-protocol.

11.2.1 National (overall) availability

In accordance with the narcotics index[37] used by the National Board of Health and Welfare to monitor the primary trend with regard to hospital care, the number of patients amounted to 7,792 people in 2010, of which 5,092 were men and 2,700 women. For women, the trend has been relatively stable since 1998 (approx. 57 people/100,000 residents). The number of men in hospital care during the same period increased from around 89 to 109 people per 100,000 residents, or an increase of approx. 18%.

Table 11.1: The number of patients according to the narcotics index and existing compound-specific diagnoses as per DSM IV.

Diagnosis and index	Compound	Code as per DSM IV	Number of patients 2011
Narcotics index		Some 20 diagnoses	7,792
Mental disorder/ behavioural disorder	Opiates	F11	1,247
” –	Cannabis	F12	511
” –	Sedatives/soporifics	F13	1,308
” –	Cocaine	F14	30
” –	Other stimulants	F15	740
” –	Hallucinogens	F16	90
” –	Several drugs combined	F19	3,994

Number of people in care and care episodes
Considering all people in care with narcotics-related sub- or primary diagnosis, the number is higher, however. In 2010, nearly 11,200 people received inpatient care, of which nearly half, around 4,900, were in first-time care - an increase of approx. 20%

[37] The index constitutes a summary of some 20 narcotics-related diagnoses in inpatient care. Consequently, it does not comprise all narcotics-related diagnoses.

since 2005. According to the statistics, women accounted for one third of the inpatient care instances, which in absolute figures would mean 370 people.
Since 1997, when a new classification (ICD 10) was introduced, the total number of people in care increased by approx. 30%.

The trend among young people (defined here as the age group 0-24) exhibits a somewhat dramatic tendency. According to the narcotics index, the number of patients in this age group increased from 1,351 in 1998 to 2,225 in 2010, or nearly 65%. This increase is remarkable even considering the population increase. The most important explanation should be the increased use of cannabis (F12) and other stimulants (F15). Cannabis-related illnesses have increased by more than 100% since 1998.

The number of clinically reported cases of *hepatitis C* with an intravenous infection pathway amounted to a total of 2,086 cases in 2011, according to the Swedish Institute for Infectious Disease Control.

Lastly, the number of cases of intravenous *HIV infection* should be mentioned. According to the Swedish Institute for Infectious Disease Control, 24 people were reported as being infected by HIV in 2010 and only 14 people in 2011.
The total number of people treated for alcohol and narcotics diagnoses in the county councils' inpatient care amounted to around 26,800 and 11,200, respectively, in 2010 Accordingly, there were a total of around 38,000 patients who received care one or more times as a result of their alcohol- or drug-related diseases or damage.

Social services' inpatient care
The social services' reporting and the statistics kept by the National Board of Health and Welfare do not differentiate between type of substance abuse. This means that it is impossible to distinguish different groups that receive inpatient care for problems of substance abuse and dependence from each other. However, according to assessments, more than half of the clients have a so-called mixed substance abuse. According to IKB 2003[38], approx. 33% of those treated in various forms of outpatient and inpatient care had mixed substance abuse. A larger proportion of those cared for in inpatient care than those in outpatient care were mixed substance abusers, however. The study showed that, depending on the type of the inpatient care unit, between 13% and 60% of the clients/patients only abused narcotics and between 25% and 59% abused both alcohol and narcotics.

The statistics for inpatient care in municipal social services are not based on personal ID numbers or another identity system except for compulsory care, which means that certain statistics cannot report the number of unique individuals. As previously emphasized, this means significant difficulties of coordinating data from different registries and obtaining a more complete picture of the care consumption.

The total number of admissions in the form of care pertaining to *Homes for care and living* (HVB) amounted to 10,688 in 2011, according to the official statistics. The number of unique individuals that spent time in HVB (or family homes) in 2011 was a

[38] Interventions for clients in treatment units in substance abuse care on 1 April 2003, National Board of Health and Welfare 2004.

total of 7,345, of which 5,516 men and 1,829 women. The total number of care days amounted to nearly 800,000 with an average care period of 108 days.

The total number of admissions to *family homes* amounted to 543 in 2010, of which 132 were women and 411 men. On 21 November 2011, 213 clients were in family homes, of which 58 were women and 155 men. The total number of unique individuals that received such care during one year is unknown, however. An assessment is that it is around 300-500 clients, including the clients of corrective care. The total number of granted care days with assistance under the Social Services Act amounted to nearly 75,000, with an average number of care days per admission/person of 137 days.

The number of people who were admitted to compulsory care (LVM) on 1 November 2011 was 276, of which 106 women and 170 men. Seen over the entire year, 931 people spent time in compulsory care pursuant to LVM at some time during 2011, of which 619 men and 312 women.

Table 11.2: Overall inpatient statistics in healthcare and the social services for 2010, or also for 2011 insofar as data is available, are summarised in the table below.

Forms of inpatient care	**Healthcare**	**Social services**[39]
Men cared for alcohol related diagnoses	19,578	
Women cared for alcohol related diagnoses	6,879	
Men with narcotic related diagnoses	7,500	
Women with narcotic related diagnoses	3,700	
Men in voluntary inpatient care[40]		5,516
Women in voluntary inpatient care		1,829
Men in compulsory care		619
Women in compulsory care		312
Women cared for pharmaceutical dependence[41]	1,940	
Men cared for pharmaceutical dependence	2,982	
Total number of patients/clients	42,579	8,276

In total, about 50,000 individuals can be assumed to have received inpatient care in some form in 2010. However, one reservation is that a single individual can be presented at more than one care provider.

With the hidden statistics that are discussed in the estimates that were previously done by the National Board of Health and Welfare regarding the heavy narcotics and alcohol abuse, the figures in the table appear reasonable. The hidden statistics may primarily be comprised of those who do not receive an adequate diagnosis (under-diagnosis) in contacts with primary care or who seek assistance from the social services as a result of financial problems and do not receive attention for their problems with substance abuse. Another group could be those who have sporadic

[39] Statistics pertain to 2011

[40] All who voluntarily spent time in institutional care are presented here, except for correctional care's placements in family homes.

[41] All information regarding inpatient care for pharmaceutical dependence is estimated information that may also comprise outpatient care.

and recurring contacts with care providers (e.g. primary care) as a result of their substance abuse problems, but who for various reasons do not receive the perhaps more adequate treatment effort in inpatient care. Those who receive care at private clinics are another and probably somewhat small group. Lastly, we can assume that there are individuals in the population with very large needs for care who never or very rarely come into contact with inpatient care. Some of these people would probably be "captured" if one chose longer periods of observation of five years or more with the support of individual-based information.

Other information concerns the number of people who are deemed to have a serious problem of dependence in correctional care (approximately 8,000 people). Correctional care's clients are interned to serve sentences, not to undergo treatment (with the exception of the special locations mentioned above). This group can therefore be seen as a care-demanding group and a potential target group for inpatient care otherwise.

Mortality of Narcotics and Pharmaceuticals
The death rate is an important indicator for reading changes, particularly in the groups subject to more extensive care interventions and perhaps especially for inpatient care efforts. This can, among other things, involve which compound triggered the death, age and gender distribution and the development over the time. One could possibly also draw conclusions on the care systems and their ability or inability to provide adequate interventions to prevent death.

In Sweden, a discussion is being held about the deaths in which methadone/buprenorphine were indicated in a forensic examination. Some claim that the deaths are due to a relatively extensive leak from substitution treatment or from irresponsible prescriptions by private doctors, while others believe that these substances are smuggled into the country. According to statistics, a total of 77 people (63 men and 14 women) died as a result of methadone poisoning in 2010. Nearly half of them are between the ages of 20 and 34. According to the Swedish Cause of death register, 420 deaths were related to use of narcotics in 2010.

Mortality as a result of pharmaceuticals coincides to some extent with the narcotics-related causes of death, particularly opioids. In connection with this survey, information on deaths was gathered for the following diagnoses F11 and, respectively, T400-T404 (Analgesics), F55 (which can include pharmaceuticals involved), T42 (Hypnotics) and F13 (Sedatives). According to the Swedish Cause of Death Register, a total of 605 people (207 women and 398 men) died as a result of the pharmaceuticals in question in 2010.

The total known and registered mortality as a result of substance abuse-related causes in 2010 encompassed a total of 1,025 people. It can be assumed that a significant proportion of those who die received inpatient care in some form and close to death and should therefore be included in the inpatient care statistics presented above.

11.2.2 Types and characteristics of residential treatment units

The care and treatment currently provided in inpatient care can roughly be categorised into three specific groups: *psychosocial treatment*, *medical treatment* and *psychosocial supportive measures*. This categorisation is based on the information gathered from publications previously issued by the National Board of Health and Welfare and the division that was applied in the national guidelines for problems of substance abuse and dependence (National Board of Health and Welfare 2007). The information sources primarily comprise *Outpatient care in substance abuse and dependence care (ÖKART)* 2008, *Organisation, resources and efforts within public addict care (ORION)* and Interventions for *Clients in Treatment* (IKB) as well as *Clients in substance abuse treatment*,(KIM), 2003. ÖKART indeed concerns outpatient care, but the content of the activities exhibited considerable similarities in the comparisons made with the inpatient care units registered in IKB.

At the beginning of an admission or stay in inpatient care, some form of investigation or diagnosis of the problems, the social situation and mental health is now regularly performed. However, the scope of this is unknown. In IKB 2003, it came forth that a large proportion of the studied treatment units, 73-100%, conducted investigations or assessments of substance abuse problems. A smaller proportion (47-80%) investigated the social situation and between 8-80% investigated mental illness. According to Open Comparisons[42], an annual comparison between municipalities and county councils with regard to quality indicators since 2008, the proportion that uses more extensive assessment instruments (e.g. ASI, DOK, MAPS) has, however, gradually increased. In 2011, an average of two thirds of the municipalities and county councils used such instruments, mainly in outpatient care. In 2003, approx. 50% of the large municipalities used these instruments. At the individual level however, it is not known what proportion of patients/clients that are assessed through these instruments. It is our perception that the responses also reflect inpatient care's use of assessment instruments, particularly since the National Board of Health and Welfare has issued national guidelines that also cover them.

11.2.2.1 Common approaches

Psychosocial treatment

In the Swedish national guidelines for substance abuse and dependence care (National Board of Health and Welfare 2007), psychosocial treatment was defined using four criteria: the evidence criteria, intention criteria, competence criteria and therapeutic context criteria. This definition has not yet found general acceptance. However, if there is reason to believe that the core of the definition has broad support, i.e. that psychosocial treatment is a systematic and theoretically based method or technique supported by research, with a particular emphasis on the substance abuse and dependence, and which is practised by individuals with specific expertise.

With this starting point, a total of eight methods were identified that were assessed to have a high level of evidence and relevance for alcohol and narcotics problems. In

[42] http://www.socialstyrelsen.se/oppnajamforelser/missbrukochberoende

the screening of outpatient and inpatient care units done in IKB 2003, it was confirmed that a total of 22 different methods were practised. Most of them were without a scientific foundation and orientation towards alcohol or drug problems. A similar picture came forth in the survey conducted in ÖKART in 2008. Several of the methods/techniques also lacked support in the activities by being practised by trained or certified personnel.

The number of evidence-based methods that are practised is limited. Less than one third of the activities use psychosocial treatment methods with strong evidence.

Medical treatment
Various medical treatment measures occur in a number of different operations, particularly in inpatient care and regardless of the form of ownership. The medical efforts are often procured by county councils or private actors. This may involve medical examinations, testing, detoxification and abstinence treatment, smoking cessation treatment or health information, which are most often conducted in outpatient contexts.

The purely medical measures that as a rule also comprise nursing mainly take place, however, at inpatient care wards at hospitals, outpatient care clinics, combinations of these and private clinics. It is then often a matter of more invasive efforts such as continuous medical monitoring, care and nursing during relatively limited care episodes. A typical example is detoxification and abstinence treatment, where the initial medical intervention often takes place in inpatient care to then convert to outpatient activities. Treatment of many different somatic, occasionally acute conditions (pancreatitis, liver failure, esophageal varices with bleeding, etc.) that are related to substance abuse and dependence is begun, for example, at intensive care, surgical or medical clinics with follow-up and after-controls in outpatient care. The medical measures can vary depending on illnesses.

Pharmaceutically assisted treatment
Pharmaceutically assisted treatment is provided upon the indication of opiate abuse (LARO), which in Sweden is subject to special regulations (SOSFS 2009:27) or alcohol abuse/dependence. Pharmaceutically assisted treatment for opiate abuse presupposes that it is conducted at a medical care facility and that such treatment is prescribed by a physician with specialist expertise in psychiatry. Treatment is normally provided in outpatient care, but can be provided in inpatient care as long as the patient is not subject to compulsory care under LVM. As a pilot project, correctional care has started programmes (ITOK) in which internees assessed to be suitable are contacted by a special team - a collaboration between the county council, correctional care and the social services - which conducts an examination and begins treatment - if deemed appropriate - in special departments. According to the most recent estimate by the National Board of Health and Welfare, the number of people who receive LARO in Sweden amounts to nearly 4,000. Pharmaceutical treatment for alcohol dependence concerns approximately 28,000 people (see table below).

Table 11.3: Pharmaceutically assisted treatment 2011. Type of pharmaceutical and number of people by gender.

Type of compound	Men	Women	Total
Narcotics dependence			
Methadone	1,332	539	1,871
Subutex/Suboxone	1,472	593	2,065
Alcohol dependence			
Disulfiram	10,180	3,911	14,091
Akamprosat	4,970	2,502	7,472
Naltrexon	4,103	2,142	6,245

Needle exchange

Needle exchange activities for intravenous drug abuser are currently conducted in Sweden in Malmö/Lund and Helsingborg. Planning is under way in Stockholm County Council to open another clinic in Stockholm. These activities were conducted in an outpatient format in close connection with infectious disease clinics. In the beginning of the 2000s, just over 1,500 injection abusers have regular contact with the two operations. The objective of the operations is primarily to prevent blood-borne infections, but also comprises various medical care efforts: treatment of infections, vaccinations against hepatitis B, etc. and social welfare efforts. The target group for the needle exchange is largely included in the group of heavy substance abusers with recurring needs for various inpatient care efforts.

Psychosocial supportive measures

Uncertainty has existed and does exist with regard to what is or what characterises psychosocial supportive measures. Most would likely agree that substance abuse and dependence care is highly characterised by various forms of supportive measures that either complement treatment efforts or are prerequisites to them. In the aforementioned national guidelines, an attempt was made to define psychosocial support compared with psychosocial treatment (see above). Psychosocial support was then defined as supportive measures both in regard to the individual's *social situation* (work, housing, etc.) and *living situation* otherwise (relationships, self-esteem) and which are not based on a specific, often evidence-based method or technique.

In the revision of the national guidelines for the area now under way, the recommendations being prepared for prevention and assessment instruments will be supplemented with a special guide or decision support concerning psychosocial support. In the preliminary working report prepared for this purpose, a distinction is made between the psychosocial support's organisational form and its contents. Sometimes, these aspects or parts of them can be streamlined. The organisation of the psychosocial support is occasionally attributed the nature of a method and vice versa. Here, organisation refers to issues concerning the choice between outpatient and inpatient care, coordination in various forms, specialisation, case-management, peer and self help (AA, NA, etc.). In terms of content, in Sweden, this most often means:

- Counselling
- Motivation
- Housing assistance/sheltered living/housing

- Financial assistance
- Occupational rehabilitation/sheltered employment
- Public support effort (e.g. contact person)
- Family/relative support
- General curative efforts

Many of these efforts are a result of decisions made pursuant to the Social Services Act and are regularly carried out under the auspices of the social services/municipality. However, psychosocial supportive measures in a broad sense are carried out in virtually all of the aforementioned activities with an emphasis on problems of substance abuse and dependence, sometimes with the support and cooperation of the social services under the Social Services Act.

11.2.2.2 Typical mix/integration of services

In the survey done by the National Board of Health and Welfare in 2003 (Interventions for clients in treatment units, IKB), a number of efforts came forth under the heading "other efforts", such as school education, vocational guidance, contact persons, legal advice, residential training, etc. Such supportive efforts were conducted in the roughly 300 units designated as inpatient care and were relatively common. Between 40% and 80% of the units had such a range of efforts.

The dominant element, according to ÖKART (National Board of Health and Welfare, 2008), appears to be various kinds of counselling and motivational interviewing, regardless of the type of unit. Looking at various combinations of efforts, which appear to be natural in all supportive and treatment activities, the combination of *counselling and motivational interviewing* is the most frequent combination of efforts (87%) followed by *psychosocial support* (62%), *psychosocial treatment, psychotherapy and environmental therapy* (55%), *testing* (55%), relapse prevention (55%) and various *healthcare efforts* (54%). This study largely confirms the findings that came forth in a previous, more limited study by the National Board of Health and Welfare (Organisation, resources and efforts within public addict care, ORION, National Board of Health and Welfare 2003).

The studies that have more closely surveyed the treatment units' offerings of support tend to present an extensive and diversified arsenal of efforts, probably to appear as competent, resourceful and attractive operations in competition with other units. A general impression from questionnaire studies of treatment units is the wide-spread desire to meet all kinds of needs. Whether this is possible without compromising on specialisation is unclear, however.

Types of drug misuse in general and in the population of residential care

In Sweden, personal use or misuse of narcotics is criminalised, which is why opinion is divided as to how to study the extent of the misuse in the population. This applies primarily to experimental, risk or recreational misuse, which pertains to temporary or spontaneous use or use that cannot be classified as abuse or dependence under DSM IV (Diagnostic and Statistical Manual of Mental Disorders, version four). The selection of naming and approach to this kind of use/misuse is particularly reflected in studies of school adolescents, where the less stigmatising expression of use was

chosen. Criminalisation probably is of significance to the inclination to report one's use related to both experimental and heavy drug misuse. An overview is provided in the following section on what we know about both of these forms of misuse and its potential connections to care and treatment.

Experimental and regular drug use among adolescents
School student studies and earlier military conscript studies (until 2006) constitute the main information about narcotics use among school students. The school student studies are targeted in part on students in year 9 of compulsory school (15-16 years of age) and in part on students in the second year of upper secondary school (17-18 years of age). Among the compulsory school students, 3% of the boys and 2% of the girls had experience of narcotics in the past month (2010). Among the upper-secondary students, 5% of the boys used narcotics in the past month, while the girls were on the same level as those in year 9 (2%).

The dominant drug is cannabis. Approximately two-thirds of all respondents only have experience of cannabis. A small group uses amphetamines and benzodiazepines (see The Drug trend in Sweden, 2011, CAN report 130). Data on the adult relationship to regular drug use is largely lacking[43].

Problematic drug use
According to the most recent estimate (Statens folkhälsoinstitut, 2010c), which is based on a mathematical model with the support of various care data/indicators, the number amounted to approx. 29,500.

According to a report recently made by the National Board of Health and Welfare to the Swedish National Institute of Public Health[44] based on the annual survey Clients in substance abuse care (KIM), drug misuse for those under treatment is distributed over the following main types: Cannabis, opiates, central nervous system stimulants (mainly amphetamines) and sedatives (barbiturates and benzodiazepine). This picture agrees well with the information prepared by the Swedish Council for Information on Alcohol and Other Drugs (CAN) which is mainly built on population studies. Through the patient register, it is possible to derive what the dominant drugs are, at least for those cared in inpatient care (also see the previous section). Here, the picture is somewhat different, probably as a result of various means of admission, drug culture patterns and differences in the harm trend. Various drugs in combination dominate the inpatient care pattern, followed by opiates, sedatives and barbiturates, cannabis and other stimulants. A reasonable assumption is, however, that opiates, cannabis and compounds such as GHB, etc. play an important role, as treatment comes up as a result of the use of several different drugs.

[43] According to a population study by the Swedish National Institute of Public Health STATENS FOLKHÄLSOINSTITUT 2010c. *Narkotikabruket i Sverige,* Östersund, Statens folkhälsoinstitut., approx. 23% of the men and 12% of the women had used narcotics at some time. Of them, 60% had only used cannabis and between 5-10% had only used another drug.
[44] Concerning Annual Report Questionnaire (ARQ), drafted by the United Nation, Commission on Narcotic Drugs. Statistics pertain to 2011.

Pharmaceuticals
In a few places, including Stockholm, Gothenburg and Malmö, there is specialised care and care programmes for people with pharmaceuticals dependence. The TUB clinic (Therapy and Evaluation of Addictive Substances) is perhaps the most well-known of these specialised clinics started in 1984 as a three-year pilot project targeted at patients with pharmaceutical dependence. Today, TUB is a permanent operation with an outpatient unit and a care ward with inpatient care primarily targeted at individuals who misuse or are dependent on hypnotics and sedatives (primarily benzodiazepines or analgesics).

The Substance Abuse Commission makes the judgement, with support of a 2010 survey by the Swedish National Institute of Public Health, that approximately 65,000 people are dependent on narcotics-classed pharmaceuticals. In international studies, this dependence is considered to be the largest misuse problem second only to alcohol dependence. At the same time, it can be confirmed that the misuse of pharmaceuticals is often combined with alcohol. The knowledge of the problem is, however, limited in Sweden. Pharmaceuticals dependence has not yet been subject to a more extensive knowledge review in Sweden, often with the motivation that there is an insufficient knowledge base.

The majority of the problems can be considered to be a result of doctor prescriptions or over prescription. According to the commission's analysis, the basic education of physicians is inadequate with regard to competence in substance abuse and dependence.

According to one analysis (SOU 2011:35), 13,000 unique individuals in Sweden are estimated to receive care for misuse/harmful use or dependence on pharmaceuticals. This applies primarily to pain relievers (analgesics of the opiate type), soporifics and sedatives (sedatives and hypnotics, including benzodiazepines). The analysis is based on patient data from Stockholm County Council and includes both outpatient and inpatient care and has been scaled up to a national level. Whether or not the number of people in care in Stockholm can be considered to be representative for Sweden as a whole is unclear, however.

Another study utilised the National Board of Health and Welfare registrations in the pharmaceutical register (pharmaceutical withdrawals) and coordinated them with information concerning care for harmful use or dependence on hypnotics/sedatives and opiates in the patient register during the years 2006-2008. During these years, just over 85,000 people made at least four withdrawals of the aforementioned compounds, which corresponds to two or more normal daily doses on average per day and during one year. Of them, a total of 5,480 people received inpatient care during the same period.

Another approach was to study how many patients received care according to the National Board of Health and Welfare patient register for misuse or dependence of these compounds. The results are presented in the table below. The opioid group includes pharmaceutically assisted treatment for opiate abuse.

Table 11.4: Persons treated for the misuse of or dependence on sedatives, hypnotics and opioids 2006-*2008* (ICD 10: F13.1, F13.2)

Year	Hypnotics/Sedatives	Opioids
2006	2,422	3,463
2007	2,720	3,954
2008	2,971	4,539
2009	3,202	5,179
2010	3,260	5,598

As presented, the number of people treated in the two groups increased in the period 2006-2010 by nearly 26% and 38%, respectively. Somewhat more men than women were treated as a result of the misuse of or dependence on hypnotics/sedatives, while the men clearly dominated the opioid group. Excluding those who receive pharmaceutical treatment against opiate abuse leaves around 1,600 people (of a total 5,598) in the opioid group. In total, the number of people treated for pharmaceutical misuse or dependence (except for pharmaceutically assisted treatment) was around 4,860 people in 2010.

11.3 Quality management

Legal prerequisites
Inpatient care in Sweden is mainly covered by the National Board of Health and Welfare regulations and general guidelines on management systems for systematic quality work (SOSFS 2011:9). Chapter 3, Section 1 states that a management system for the operations shall be in place at the care provider to be used to systematically and continuously develop and secure the quality of the operations. This includes planning, managing, controlling, following up, evaluating and improving the operations. The regulations are relatively new and how it is applied is unclear. Government supervision exercised by the National Board of Health and Welfare shows how the adaptation to and compliance with the regulations looks. However, it can be noted that there is now a structure set forth in the legislation for how the quality work shall be structured.

As noted above (see Chapter 11.2.2.2), in terms of the content and quality of treatment, there is a lack of real opportunities to steer the emphasis towards e.g. evidence-based methods or techniques. Many operations use non-evidence-based methods or develop their own solutions with theoretical or practical elements from different treatment models that have not been subject to follow-ups or evaluations. Many have previously claimed that the treatment sector is generally governed or influenced by strong trends or fashion trends. This is particularly true of the 12-step model or cognitive behavioural therapy (CBT), which have had a major breakthrough in Sweden in recent years at the same time that other less serious methods or techniques are practised to a large extent.

11.3.1 Availability of guidelines and service standards for residential treatment

National guidelines
However, many are convinced that the treatment sector will on the long term be influenced by the national guidelines drafted for substance abuse and dependence care. They primarily pertain to treatment methods for substance abuse and dependence and in co-morbidity and pregnancy, primarily substance abuse and psychiatric morbidity. In the guidelines, there is also a presentation of tests and assessment methods. A revision of these guidelines is currently under way, which will also comprise adolescents and young adults. It is scheduled for completion in 2014.

National guidelines have no legal content, i.e. there are no possibilities to hold the treatment operations responsible if they do not follow them. However, there are reasons to assume that they have a strong corrective effect when an independent and authoritative agency evaluates the methods' scientific foundation. In the supervision exercised by the National Board of Health and Welfare, it can also be perceived as embarrassing or troubling if one states that methods are used without scientific legitimacy.

Research
The inquiry, Better interventions in substance abuse and dependence (SOU 2011:35), reported a relatively extensive review of the research in the substance abuse field. It shows that state-financed research (through the national research councils) in terms of clinical research, particularly the evaluation of treatment, is relatively modest. The Swedish Parliament also noted in a report that little research is conducted that concerns the Social Services Act and the field of substance abuse care. In the summary of the Substance Abuse Commission, it is confirmed that the research is divided over many financiers, universities and research bodies and that it appears to be fragmented. It points out particular areas of inadequacy, including interdisciplinary treatment research, clinical treatment research and forms of treatment for the special needs of women. It is believed to be necessary to organise the research and knowledge distribution in a more effective manner.

The conclusions are also largely confirmed by an evaluation of Swedish research in the area (Swedish Council for Working Life and Social Research, 2012). Proposals included a greater concentration of research resources and cooperation between institutions, as well as increased efforts in the research field of psychotherapy and pharmaceutical treatment.

Altogether, the pure treatment research in terms of systematic evaluations of programmes in inpatient care environments appears underutilised in Sweden. Quality development with the support of research results is virtually non-existent, except for the national guidelines' potential impact.

Open comparisons
Open comparisons[45] is a recurring publication of an amount of data, primarily questionnaire data, but also health and mortality data, on the municipal and county

[45] http://www.socialstyrelsen.se/oppnajamforelser/missbrukochberoende

council substance abuse and dependence care. In total, some 30 indicators are assessed to represent the quality of the operations. This is true, for example, of the use of evidence-based methods and assessment instruments, the occurrence of user surveys, operational follow-up, etc. The data collection targets the care providers - municipalities and county councils - substance abuse and dependence treatment operations and not units that conduct 24-hour care. The reporting shall also be viewed as an aggregation and assessment of the municipalities' and county councils' operations in the field and therefore provide no detailed knowledge.

The intent of open comparisons is to achieve processes (through annual comparisons) at the care providers to develop quality. Whether or not these processes reach out to the inpatient care units is unclear. However, one assumption is that individual municipalities' and county councils' procurement of 24-hour care is indirectly affected by the published comparisons.

Local standards and guidelines
Many municipalities, county councils and even regional confederations have established guidelines for their substance abuse and dependence care. They often have the nature of policies or goals of emphasis that have sought to increase or limit one type of resources. One of the more noted of these is the limits on placement in inpatient care, preferring outpatient or so-called "home field" solutions. The reasons have occasionally been a mistrust of the rehabilitation potential of inpatient care, although they have often been financial. The costs of the efforts for those most in need of care have been able to be reduced in the short-term perspective.
Today, there is no collective overview of local standards and guidelines, but several of the larger municipalities with more extensive operations have probably adopted such standards and guidelines.

11.4 Discussion and outlook

Except for the information that could be gathered from registries, the epidemiological knowledge in the area is inadequate. Consequently, we know little about the extent of substance abuse and dependence in various groups. However, for healthcare, the patient and pharmaceutical registries can provide a relatively good view of the use of inpatient care. Otherwise, the information is limited.

A mapping of the use of inpatient care would be substantially simplified if there were access to personal ID number-based data and the potential for coordination of the relevant registries. In Sweden, there is a number of registries that are useful, but cannot be used in part because of ethical regulations and legislative provisions.

Today, there is data from the TDI-compatible assessment instrument DOK used both in compulsory and in voluntary care – the latter administered by the Linnaeus University with a total of 55,000 treatment episodes. Also, more than 54,000 ASI interviews have been conducted in treatment contexts in Sweden in recent years. These constitute an example of data that can be used and linked with information from the patient register, among others. It should also be possible to conduct a nationwide study with a random selection to examine the connections between various forms of inpatient care utilisation.

This more overall survey shows that inpatient care utilisation is extensive. This applies to care related to alcohol, narcotics and narcotics-classed pharmaceuticals. The majority of people with alcohol and drug problems do not seek treatment however and constitute hidden populations. This applies especially to alcohol problems. Furthermore, many individuals receive treatment without their alcohol or drug problems being recognised or acknowledged. This form of underreporting, which probably is most extensive for alcohol-related harms and conditions, can be assumed to be significant. This primarily involves somatic care, where alcohol has played a role, but for various reasons has not been indicated on the physician certificate and thereby not been noted in the patient register. However, it has not been possible in this survey to estimate the extent of this underreporting.

For natural reasons, the medical and psychiatric inpatient care account for the most extensive effort counted in number of people. The available data indicates that more than 40,000 received care for alcohol and drug-related reasons in 2010. Medical and psychiatric harms and complications in substance abuse and dependence forces close contacts with healthcare services, even if it involves shorter care episodes and, to a large extent, short-term somatic efforts. In this context, detoxification and abstinence treatment can be seen to be a typical or characteristic measure and a measure more limited in time.

The care efforts of the social services are at roughly the same level as those of the healthcare services in terms of costs, but comprise substantially fewer people and significantly longer periods of care. In 2010, more than 8,000 people received services in the institutions run or procured by the social services. Of them, more than 900 people received compulsory care. These efforts are by nature more long-term and often have the goal of fundamentally changing the individual's living situation. This often also includes health and medical care in a broad sense and, alongside the therapeutic elements, even social welfare or psychosocial supportive measures. One issue that has not been possible to clarify is whether the healthcare efforts that take place in this part of inpatient care – occasionally through agreements with a medical care facility, primary care or contracts with private operations – are registered in the patient register.

Corrective care also accounts for extensive inpatient care that is often brought about by narcotics crimes and personal misuse. A large proportion of the interns have alcohol and/or drug problems. The operations in correctional care are not explicitly designed for the care and treatment of substance abuse and dependence, except for the special, professional programmes worked out for the clients who are motivated.

The three named care providers are fundamentally independent systems with somewhat underdeveloped cooperation. Where such cooperation has developed, it is generally in geographically limited projects. For the future, compulsory cooperation will be important, where criminality, illness and social problems are seen as parts of the very same living situation.

In total, nearly 50,000 people are assumed to have received some form of inpatient care in 2010 as a direct or indirect result of alcohol and drug-related problems. This group should also include a large part of the registered deaths, just over 2,300,

where the cause was long-term and extensive substance abuse and where the deaths occurred after one or more inpatient care episodes. However, in this survey, it has not been possible to establish if those who died in 2010 were also consumers of inpatient care or other care during the same period. For this, a coordination of patient registers is necessary.

Substance abuse and dependence care in Sweden is to a relatively limited extent an operation guided by well-developed quality standards. A national regulation exists regarding quality systems, but how it is applied at a local or regional level is unknown. The quality of this area has repeatedly been questioned. National guidelines and quality comparisons may possibly play an important role in improving quality.

12. Drug Policies of large European cities

At the national level, the Swedish people are represented by the Riksdag (Swedish parliament) which has legislative powers. Proposals for new laws are presented by the Government which also implements decisions taken by the Riksdag.

Sweden is divided into 21 counties. Political tasks at this level are undertaken on the one hand by the county councils, whose decision-makers are directly elected by the people of the county, and on the other by the county administrative boards which are government bodies in the counties. Some public authorities also operate at regional and local levels, for example through county administrative boards.

Sweden has 290 municipalities, each of which has an elected assembly, the municipal council, which takes decisions on municipal matters. The municipal council appoints the municipal executive board, which leads and coordinates municipal work.

12.1 Large cities

Kommunallagen [Eng. Local Government Act] stipulates that municipalities are responsible for social care, childcare and preschools, elderly care, support for the physically and intellectually disabled, primary and secondary education, planning and building issues, health and environmental protection, refuse collection and waste management, emergency services and emergency preparedness and water and sewage (SFS 1991:900).

According to the Local Government Act, the main task of the county councils and regions is to provide health care and promote regional development. This assignment includes ensuring that the same high level of health care is delivered across the country. However, the principle of local self-government (designing and structuring activities according to local conditions) means that patient fees vary. In general, the municipalities, county councils and regions exercise a great deal of freedom within their assignments. This is partly regulated through the Local Government Act and other laws and ordinances that cover more specific areas. Examples are the Social Services Act, the Planning and Building Act, the Education Act and the Health and Medical Services Act. Decisions taken by the European Union obviously affect the role and responsibilities of local and regional self-government.

The Swedish primary health care structure consists of more than one thousand local medical centres, surgeries and district nurse clinics across the country. Preventative health work is carried out, for example, at maternity and child healthcare centres.

Ultimately, the supreme political decision-making body is the Swedish Parliament.

Municipal governance structure

In 2011 there was a so-called county coordinator in each of Sweden's 21 counties, with the role of supporting the preventive work on alcohol, narcotics, doping and

tobacco (ANDT) by the local coordinators in the region. In 2011 the county administrative boards were commissioned to work for the implementation of the national ANDT-strategy in the county, to contribute to the evolvement of a long-term and knowledge-based preventive work on regional and local level and to stimulate the development of coordinated efforts in cooperation between relevant players.

According to the Länsrapport 2011 [Eng. County Report 2011], almost half the counties had a regional strategy for the preventive ANDT work in 2011 and seven of them had also adopted an action plan for preventive work in the county (Statens folkhälsoinstitut, 2012c). National responsibility for county coordination lies with the Swedish National Institute of Public Health (SNIPH). In 2011, this involved an obligation to allocate SEK 30 million to the coordination of the prevention work in the counties, as well as the financing of the employment of the county coordinator. In Sweden, the implementation of prevention is generally the responsibility of the municipality, where the preventive efforts are often coordinated by “drug coordinators”. According to the County Report 2011, about 75% of the 290 municipalities had a local drug coordinator for the work on narcotics prevention with governmental support. The same person often coordinates prevention efforts against different addictive substances, i.e. alcohol, narcotics, doping and tobacco. How the ANDT prevention work is organised differs between municipalities and in the major cities of Stockholm, Gothenburg and Malmö much of the work is done in the city districts. Stockholm is divided into 14 districts, whereas Malmö and Gothenburg are divided into 10 districts. In many cases these have a larger population than many of the country's municipalities.

In 2011 all major cities had a central coordinator with responsibility for the whole municipality as regards alcohol, tobacco and narcotics and Gothenburg and Malmö also had one for doping. Stockholm and Malmö had a coordinator for alcohol, narcotics and tobacco in most city districts while Gothenburg had such a coordinator in only two (Statens folkhälsoinstitut, 2012c).

The Local Government Act (SFS 1991:900) allows great scope for autonomy. This means that the municipalities have extensive rights to decide themselves on how to carry out their tasks and how to distribute their resources. However, this autonomy is limited by several other laws, for example the Alcohol Act (SFS 2010:1622) and the Tobacco Act (SFS 1993:581).

One central law that applies to large parts of the municipalities’ operations is the Social Services Act (SFS 2001:453), which is also linked to the Government’s ANDT strategy and the prevention work. Section 1 of Chapter 3 states, among other things, that it is the duty of the social welfare board to make itself well acquainted with living conditions in the municipality and in cooperation with other societal bodies, organisations, associations and individuals promote good environments. Section 7 of Chapter 3 states that the social welfare board shall work to prevent and counteract abuse of alcohol and other addictive substances.

Parliament, the Government and regional authorities can influence municipalities’ operations by means of state grants to efforts that meet certain requirements. Municipalities can apply for and receive grants for ANDT prevention work and the ANDT strategy is a central steering document in this process.

Steering

Steering groups

About half of Sweden's municipalities had a steering group for their ANDT prevention work in 2011. Some city districts also had steering groups, mainly in Malmö where all except one of the districts had one. It is not clear from the material whether the steering group deals exclusively with the ANDT prevention work or if steering is coordinated in a group that for example also represents crime-prevention work or security-creating work (Statens folkhälsoinstitut, 2012c).

Political programmes, action plans and operation plans

About 70% of the municipalities had one or more political programmes that included the ANDT prevention work. All programmes included alcohol and over 90% dealt with tobacco and narcotics while doping was taken up in about 60% of the programmes (Statens folkhälsoinstitut, 2012c).

Most city districts in Stockholm, Gothenburg and Malmö had an action plan, an operational plan or equivalent that included the ANDT prevention work. A few city districts were working to develop one. All plans included both alcohol, narcotics and tobacco while doping was only included in two of Stockholm's city districts' plans, six of Malmö's and none of Gothenburg's (Statens folkhälsoinstitut, 2012c).

The city of Stockholm has a written drug policy/strategy called the STAN programme[46] (Stockholm's Tobacco, Alcohol and Narcotics programme). Concrete action plans are to a great extent a matter for the city's 14 districts which carry out most of the practical, everyday work. Gothenburg has an overarching political strategy[47] as well as time-limited and concrete plans for the alcohol, narcotic, doping and tobacco area. The action plan for 2012-2015[48] has been approved by the municipal executive committee. The city of Gothenburg's overarching strategy and plans shadow the national alcohol, narcotic, doping and tobacco strategy. The city's plan focuses on some additional areas that are more specific to Gothenburg.

Follow-up and evaluation

About half the municipalities followed up or evaluated all or part of their ANDT prevention work during 2011. The city districts also conducted follow-ups or evaluations to a greater or lesser extent. In three of Malmö's city districts and one of Stockholm's this applied to all the work while it was most common to follow up or evaluate parts of their ANDT prevention work. Six city districts in Gothenburg and four in Stockholm made no follow-up or evaluation in 2011 (Statens folkhälsoinstitut, 2012c).

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[46] http://www.stockholm.se/Fristaende-webbplatser/Fackforvaltningssajter/Socialtjanstforvaltningen/Utvecklingsenheten/In-English1/

[47] Gothenburg's strategy is available in Swedish at the following link: http://prevu.goteborg.se/prod/SocialResurs/dalisprevu.nsf/vyFilArkiv/Alstratsammanf.pdf/$file/Alstratsammanf.pdf

[48] http://www5.goteborg.se/prod/Intraservice/Namndhandlingar/SamrumPortal.nsf/59A31DC43EF3825CC12579E90042994E/$File/1.2_20120502.pdf?OpenElement

Financing

A third of the municipalities financed their ANDT prevention work wholly with municipal funds and about the same number financed most of the work with municipal funds. Most of the city districts financed the work entirely with municipal funds. The proportion was somewhat larger in Gothenburg and Malmö compared to Stockholm where approximately half of the city districts financed the work exclusively with municipal funds (Statens folkhälsoinstitut, 2012c).

In Gothenburg, the municipality finances and runs three local medical centres specifically focusing on drug addiction. In addition to these medical centres, the municipality delivers a drug addiction service together with the health care services and the correctional establishment. The city also runs and finances a wide range of services catering for the housing needs of this group (Statens folkhälsoinstitut, 2012c).

Gothenburg is a segregated city as the majority of the population in some districts are of foreign descent. There are no unique services directed towards ethnic minorities. However, specialist and cultural qualifications have been developed for a large proportion of staff in order to meet the needs of ethnic minorities. Individual and couple treatments are used and the best results have been achieved when staff has been able to involve clients' networks (Lundgren, 2012).

Cooperation

Networks

The city districts' ANDT coordinators participated in networks for coordinators in the major cities but it is unclear who organised this. Participation was greatest in Stockholm where 12 city district coordinators participated extensively, followed by Malmö where the corresponding figure was seven. None of Gothenburg's coordinators participated to any great extent but five did so to some extent.

Both Stockholm and Gothenburg are involved in several networks, including

- National network against cannabis. The aim of the network is to spread knowledge about treatment and to work for prevention initiatives aimed at minimizing the use of cannabis.
- ECAD Sweden. A network of 50 Swedish municipalities that are members of ECAD (European Cities Against Drugs). The network's aim is to spread knowledge and facilitate exchanges of best practices in the drug field with regard to prevention, treatment and defending a restrictive and humane drug policy (based on the UN's drug conventions).

Collaboration between different players

In all of Malmö's city districts, there was collaboration on ANDT and crime prevention work and at least in 1 of Stockholm's. In Gothenburg, half the city districts had collaboration between ANDT and crime prevention work (Statens folkhälsoinstitut, 2012c).

The police were the most common collaborating partner and almost 90% of the 290 municipalities collaborated with them in alcohol prevention work and almost as many in narcotics prevention work. The police were also the most common collaborating partner of all authorities is city districts. Half the municipalities had written collaboration agreements for the ANDT prevention work that included the municipality and one or more named authorities. Such written agreements also existed at city district level, to the greatest extent in Stockholm and Malmö where over half of the city districts had drawn up written agreements with one or more authorities (Statens folkhälsoinstitut, 2012c).

12.2 Case study: Stockholm

Key features of Stockholm city's drug policy
The city of Stockholm has a written drug policy/strategy called the STAN programme[49] (Stockholm's Tobacco, Alcohol and Narcotics programme). Concrete action plans are to a great extent a matter for the city's 14 districts which carry out most of the practical, everyday work. The most common measures conducted in the districts are arranging drug-free activities, upholding age limits for purchasing tobacco and alcohol, parent meetings and anti-bootlegging campaigns. Almost all districts have or are processing action plans with measurable targets and plans for follow-ups.

The overall objectives of the STAN programme are:

1. Childhood and adolescence must be free from the use of tobacco, alcohol and illegal drugs.
2. A Stockholm free from illegal drugs.
3. The inhabitants of Stockholm should have moderate drinking habits.
4. The inhabitants of Stockholm who abuse alcohol or other drugs must be offered treatment.

These objectives relate to the overarching goal of the 2011-2015 national ANDT (alcohol, narcotic drugs, doping, tobacco) strategy which is "A society free from illegal drugs and doping, with reduced alcohol-related medical and social harm, and reduced tobacco use" - where everyone may grow up, live and work without risking harm through their own or others' use/misuse of ANDT. The STAN programme also relates to a regional drug policy (available in Swedish only).

The main content of Stockholm's STAN programme is a framework for the practical work on three levels: primary prevention, early intervention and care/treatment. Locally based measures and interventions are important since the city's 14 districts differ significantly in many aspects. Therefore, the city's overall STAN programme does not go into details. The programme also connects to other important steering documents, such as the Crime Prevention Programme.

[49] http://www.stockholm.se/Fristaende-webbplatser/Fackforvaltningssajter/Socialtjanstforvaltningen/Utvecklingsenheten/In-English1/

The STAN programme is connected to the city's budget, which is a very important aspect. The budget highlights the programme and mirrors some of the indicators set out in the programme, which ensures better annual follow-ups.

Coordination at city level
The City of Stockholm has a unit within its Social Affairs Administration, the Social Development Unit, which deals with drug prevention. This unit serves as a resource centre for the local drug prevention coordinators who work in all of the city's districts. Both formal and informal networks have been developed between players in the city and other stakeholders such as the police, the county council, and the county administrative board. A majority of the districts have written agreements on cooperation in local crime and drug prevention work.

The Social Affairs Administration does the coordinating policy work in the field of social affairs. The district administrations have key roles and close contact is held with the political level. However, depending on the nature of the policy, several internal and external actors can be involved in both planning and implementation.

Local level drug monitoring
Stockholm has access to several systems for monitoring different aspects of drug use. One very important monitoring system for the city is the biannual Stockholm Survey[50] among young people. The County Council also monitors, for example, drug treatment and health care. The police and other authorities monitor crime statistics.

Results from the most recent survey[51] indicate reduced life time prevalence of illicit drugs among boys in 9th grade. In other groups the levels are unchanged or somewhat lower than in the 2010 survey.

Drug policy agreements
Stockholm is a signatory of the ECAD (European Cities Against Drugs) declaration, which is based on the UN Conventions on Drugs and has 251 Signatory Municipalities in 30 countries.

12.2.1 Four areas of drug policy in Stockholm

Local policing strategies against drug scenes/drug trafficking
The police force is responsible for the city's response to public nuisance and open drug scenes. The police force conducts a number of projects and established activities in socially oriented areas. The city, especially the local districts, has established cooperation with the police in these matters.

[50] http://www.stockholm.se/Fristaende-webbplatser/Fackforvaltningssajter/Socialtjanstforvaltningen/Utvecklingsenheten/In-English1/
[51] http://www.stockholm.se/Fristaende-webbplatser/Fackforvaltningssajter/Socialtjanstforvaltningen/Utvecklingsenheten/Prevention/Stockholmsenkaten1/

Interventions in recreational nightlife settings
STAD (Stockholm Prevents Alcohol and Drug Problems), Karolinska Institute and Stockholm County Council is developing and conducting a number of evidence-based methods in this field[52]. One example is "Krogar mot knark" (Restaurants against drugs)[53]

Another example is the training of bar staff in responsible beverage service programmes and stricter enforcement of existing alcohol licensing and drug laws. The evaluation of the method found a decrease in alcohol-related problems, increased refusal to serve minors and a 29% reduction in assaults (Gripenberg et al., 2007a).

Low threshold services for problem drug users
The social welfare services in Stockholm can provide variety of services for homeless people depending on the individual's problems and needs. In addition to housing, a person who is homeless may need help with substance abuse and mental health treatment, job training programmes, financial aid, etc. The county council is responsible for substance abuse and mental health treatment services. Collaboration between social welfare services and the county council is absolutely necessary in order to provide the comprehensive services that many homeless people require.

Non-governmental organizations (NGO), private entrepreneurs and other organizations work in close collaboration with the social welfare office to provide services to homeless people in Stockholm. Stockholm is currently developing a new homelessness strategy which will be implemented in 2013.

The county councils are responsible for treatment. The Stockholm County Council is preparing a three-year needle/syringe exchange programme. A venue for this has been designated and staff employed. The role of the City of Stockholm is to connect an out-reach worker to the programme.

Responses to head/smart shops
Regulation of head/smart shops is a matter of national strategy/legislation, not on city level. Stockholm/Sweden do not have physical head/smart shops. The regulation of new synthetic drugs/legal highs is also an issue on national level. Stockholm is following the trends and can, when necessary, call attention to new drugs in existing prevention/treatment work

[52] http://stad.org/en/om-stad/
[53] http://www.krogarmotknark.se/site/

12.2.2 Current issues in Stockholm

Policy concerns
Stockholm has a number of key social policy issues which concern the drug area.

- Prevention priority: Youth under 25.
  One specific drug-related issue is the priority to prevent drug use among youth under 25 years of age. Stockholm is at present following the national priority of highlighting cannabis.

- Family support programmes
  Family is seen as the most important protective factor, and the role of parents is therefore prioritised.

- Quality development – knowledge based work
  There is a strong ambition in Stockholm that social (including drug) work should be knowledge-based using high quality methods. The term "knowledge-based" is developed from "evidence-based" and relates to a broader perspective including not only research findings but also the perspective of the client and the competence/experience of the professional delivering the work.

- Internet
  The internet has in many ways changed our societies. Stockholm's social services are developing ways to be accessible through the internet to its inhabitants. In addition, Stockholm is following work on the national level concerning efforts targeting the internet as an easy access marketplace for drugs.

Part C - Bibliography

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