European Monitoring Centre for Drugs and Drug Addiction

Folkhälsomyndigheten
PUBLIC HEALTH AGENCY OF SWEDEN

Sweden

Country Drug Report 2017

THE DRUG PROBLEM IN SWEDEN AT A GLANCE

Drug use

in young adults (16-34 years) in the last year

Cannabis

7.3 %

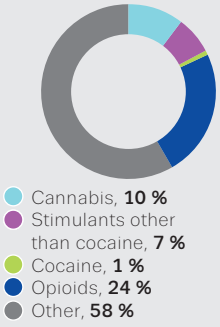
6.2 % 8.4 %

High-risk opioid users

No data

Treatment entrants

by primary drug



Opioid substitution treatment clients

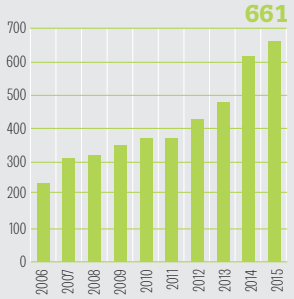
3 679

Syringes distributed

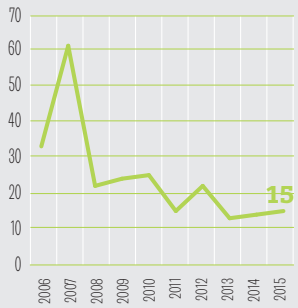
through specialised programmes

281 397

Overdose deaths



HIV diagnoses attributed to injecting



Source: ECDC

Drug law offences

94 035

Top 5 drugs seized

ranked according to quantities measured in kilograms

1. Cannabis resin
2. Herbal cannabis
3. Amphetamines
4. Cocaine
5. MDMA

Population

(15-64 years)

6 152 438

Source: EUROSTAT
Extracted on: 26/03/2017

NB: Data presented here are either national estimates (prevalence of use, opioid drug users) or reported numbers through the EMCDDA indicators (treatment clients, syringes, deaths and HIV diagnosis, drug law offences and seizures). Detailed information on methodology and caveats and comments on the limitations in the information set available can be found in the EMCDDA Statistical Bulletin.

About this report

This report presents the top-level overview of the drug phenomenon in Sweden, covering drug supply, use and public health problems as well as drug policy and responses. The statistical data reported relate to 2015 (or most recent year) and are provided to the EMCDDA by the national focal point, unless stated otherwise.

An interactive version of this publication, containing links to online content, is available in PDF, EPUB and HTML format: www.emcdda.europa.eu/countries

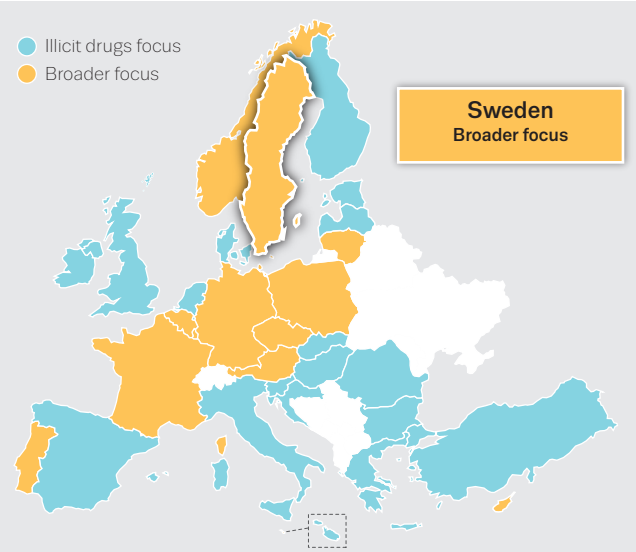
National drug strategy and coordination

National drug strategy

Sweden's national drug strategy, A Comprehensive Strategy for Alcohol, Narcotics, Doping and Tobacco (ANDT), adopted in 2016, covers the period 2016-20 (Figure 1). Its overarching goal is to have a society free from narcotics and doping, reduced medical and social harm from alcohol, and reduced tobacco use. The ANDT strategy represents one of 11 objectives of the national public health policy, and it addresses both licit (alcohol and tobacco) and illicit (narcotics and doping) substances. The ANDT policy takes as its starting point the right of every person to have the best possible physical and mental health. It supports restrictions on personal freedoms in order to protect public health through, for example, the Swedish alcohol monopoly, age limits for the purchase of alcohol and tobacco, and the criminalisation of narcotics and doping. The ANDT strategy is structured around six objectives and it defines fields of action for each objective.

FIGURE 1

Focus of national drug strategy documents: illicit drugs or broader



NB: Year of data 2015. Strategies with broader focus may include, for example, licit drugs and other addictions.

Sweden follows up on and evaluates its drug policy and strategy using routine indicator monitoring aimed at describing developments related to the ANDT strategy's objectives. In 2015, a final evaluation of the Strategy for Alcohol, Narcotics, Doping and Tobacco (2011-15) was completed by the Public Health Agency of Sweden. It considered the implementation of the strategy, its design, and the development of the successor strategy for the period 2016-20.

National coordination mechanisms

At central government level, the Ministry of Health and Social Affairs is responsible for work related to the ANDT strategy. The Public Health Agency of Sweden is responsible for strategic and operation coordination of the implementation of the ANDT strategy. The National ANDT Council is a forum for dialogue on development, commitments and needs for measures between the government and relevant agencies and other organisations that are important for achieving the objectives of the ANDT strategy. At regional level, 21 county administrative boards coordinate and support the implementation of the ANDT strategy in each county.

Sweden's national drug strategy, A Comprehensive Strategy for Alcohol, Narcotics, Doping and Tobacco, covers the period 2016-20

Public expenditure

Understanding the costs of drug-related actions is an important aspect of drug policy. Some of the funds allocated by governments to expenditure on tasks related to drugs are identified as such in the budget ('labelled'). Often, however, the majority of drug-related expenditure is not identified ('unlabelled') and must be estimated using modelling approaches.

In Sweden, the implementation of the previous Cohesive Strategy for Alcohol, Narcotic Drugs, Doping and Tobacco Policy, covering the years 2011-15, was supported by annual action programmes adopted by the government. In line with the principles of the action plans, the Swedish Government also detailed an annual budget for some drug-related activities.

Six estimates of drug-related public expenditures have been made in Sweden so far, but the study for 2002, published in 2006, is the only one to provide information about the methodology used. In 2002, total drug-related expenditure was estimated to represent between 0.2 % and 0.4 % of gross domestic product (GDP), amounting to between EUR 449 million and 1 billion. The majority of total expenditure was spent on law enforcement (70-76 %), followed by treatment (22-28 %) and small proportions on prevention (0.7-1.7 %) and harm reduction (0.1-0.2 %).

As the methods used to estimate drug-related expenditures have changed over time, it is not possible to report on trends in drug-related public expenditure in Sweden.

In 2016, the current government strategy was adopted (see section 'National drug strategy'), and the government earmarked SEK 163 million (EUR 17.2 million) for its implementation in 2016. The proposal for implementation of the strategy indicated annual budget allocations of SEK 213 million for 2017 and 2018 (corresponding to EUR 22.5 million at 2016 prices).

Drug laws and drug law offences

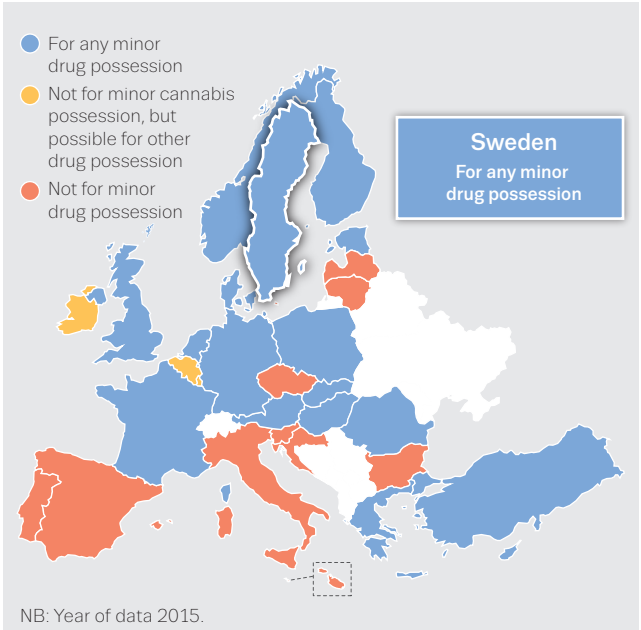
National drug laws

The use and possession of illicit drugs are criminal offences under the Penal Law on Narcotics (SFS 1968:64) (Figure 2). The punishment for possession offences depends on the severity of the offence, which is classified as minor, ordinary or serious. The severity of the offence takes into consideration the nature and quantity of drugs used or possessed as well as other circumstances. Penalties for minor drug offences are fines or up to six months' imprisonment; for ordinary drug offences up to three years' imprisonment; for serious drug offences 2-7 years' imprisonment; and for particularly serious drug offences, 6-10 years' imprisonment.

Sweden also operates a system of classifying substances as 'goods dangerous to health', which may be used to control goods that, by reason of their innate characteristics, entail a danger to human life or health and are being used, or can be assumed to be used, for the purpose of intoxication. Goods covered by the Act on the Prohibition of Certain Goods Dangerous to Health (SFS 1999:42) may not be imported, transferred, produced, acquired with a view to transfer, offered for sale or possessed. Importing such goods is punished in the same way as drugs offences; for other breaches of the provisions, a penalty consisting of a fine or imprisonment for a maximum of one year can be imposed. The Law on Destruction of Certain Substances of Abuse (SFS 2011:111) came into effect in 2011 to enable the confiscation and destruction of new psychoactive substances (NPS) before their official classification as narcotics, with no other penalty for the owner.

FIGURE 2

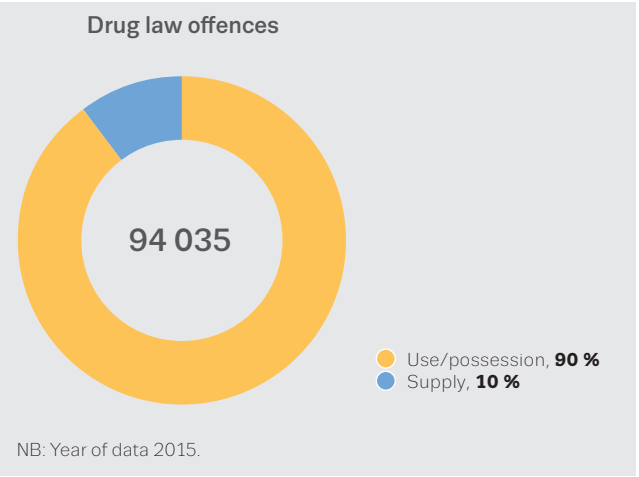
Legal penalties: the possibility of incarceration for possession of drugs for personal use (minor offence)



NB: Year of data 2015.

FIGURE 3

Reported drug law offences in Sweden



NB: Year of data 2015.

Drug law offences

Drug law offences (DLO) data are the foundation for monitoring drug-related crime and are also a measure of law enforcement activity and drug market dynamics; they may be used to inform policies on implementation of drug laws and to improve strategies.

According to the official criminal statistics for Sweden, there was a steady increase in the number of DLOs registered up until 2013 (when 99 175 DLOs were reported), but in the last two years fewer DLOs have been reported. Drug use and possession offences predominate (Figure 3).

Drug use

Prevalence and trends

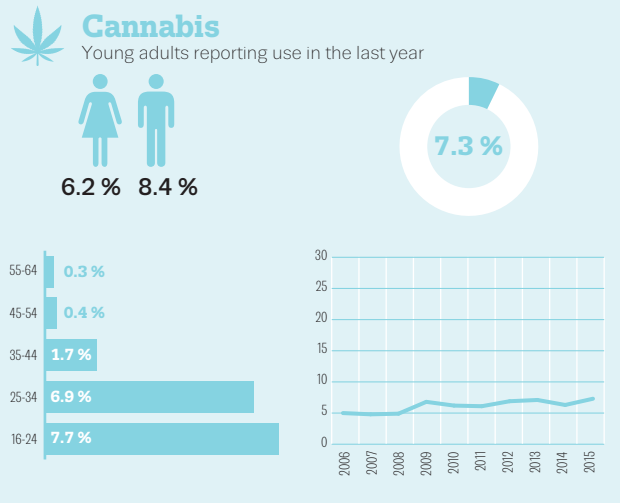
Cannabis remains the illicit substance most commonly used in Sweden, while the lifetime prevalence of cannabis use among the general population aged 16-64 years remains low in comparison with other European countries. The data indicate that cannabis use is concentrated among young adults, in particular those aged 16-24 years, and the data also show a slight increase in last-year cannabis use over the past decade among 16- to 34-years-olds. In general, cannabis use is more common among males than females (Figure 4).

In addition, the available data suggest that the use of cannabis is more common among those living in larger cities and who have a lower personal income. Approximately one third of those who report having ever used cannabis has also used some other illicit substance.

Stockholm participates in the Europe-wide annual wastewater campaigns undertaken by the Sewage Analysis Core Group Europe (SCORE), which provides data on drug use at a community level, based on the levels of different illicit drugs and their metabolites in a source of wastewater. These data complement the results from population surveys; however, wastewater analysis reports on collective consumption of pure substances within a community, and the results are not directly comparable with prevalence estimates from population surveys. The available data on stimulant drugs from Stockholm indicate weekly consumption patterns. The loads of the main cocaine metabolite (benzoylecgonine) and MDMA/ecstasy in wastewater are higher at the weekend than on weekdays, whereas methamphetamine traces are found to be distributed more evenly throughout the week.

FIGURE 4

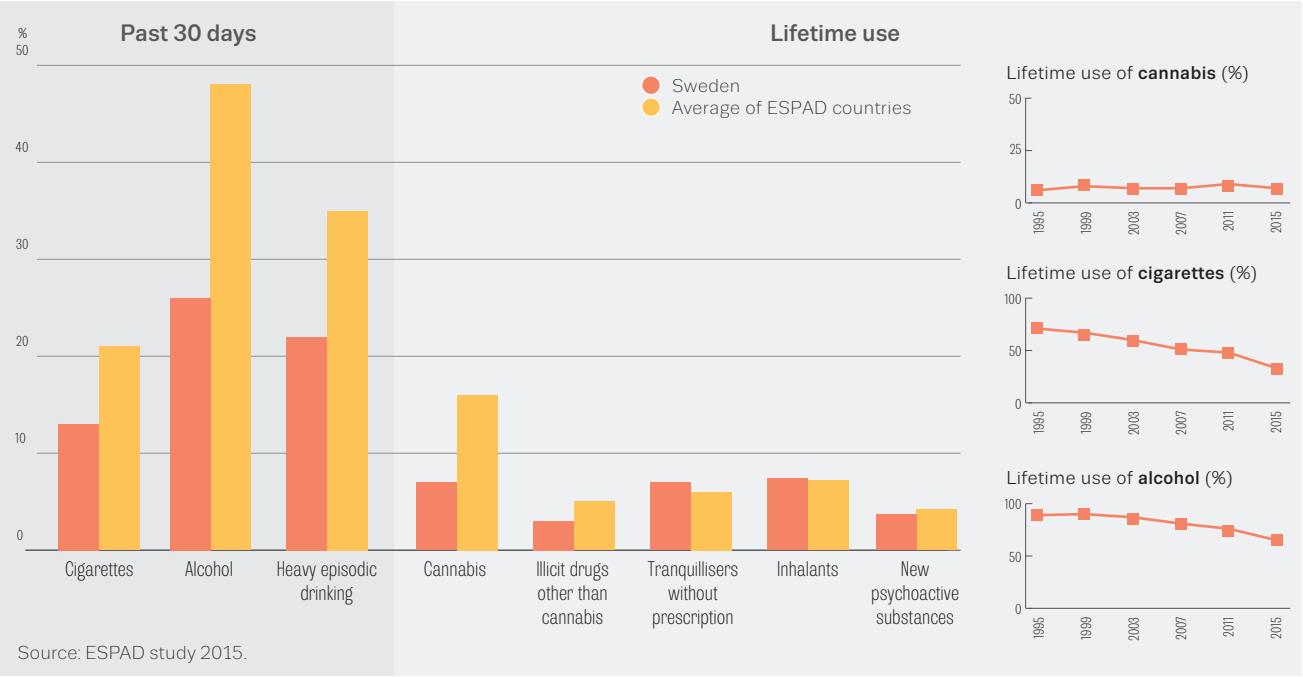
Estimates of last-year cannabis use among young adults (16-34 years) in Sweden



NB: Estimated last-year prevalence of drug use in 2015.

FIGURE 5

Substance use among 15- to 16- year-old school students in Sweden



Source: ESPAD study 2015.

The most recent data on drug use among students come from the 2015 European School Survey Project on Alcohol and Other Drug (ESPAD). Lifetime use of cannabis among school students in Sweden in 2015 was less than half of the European average (based on data from 35 countries). Lifetime use of tranquillisers or sedatives without prescription, lifetime use of inhalants and lifetime use of NPS in Sweden were approximately the same as the ESPAD average whereas alcohol use during the last 30 days and heavy episodic drinking during the same period of time were markedly lower. Swedish students were also less likely to report cigarette use during the last 30 days (Figure 5). The data also point to a slight decrease in NPS use among this group compared with 2011.

High-risk drug use and trends

Studies reporting estimates of high-risk use can help to identify the extent of the more entrenched drug use problems, while data on the first-time entrants to specialised drug treatment centres, when considered alongside other indicators, can inform understanding on the nature and trends in high-risk drug use (Figure 7).

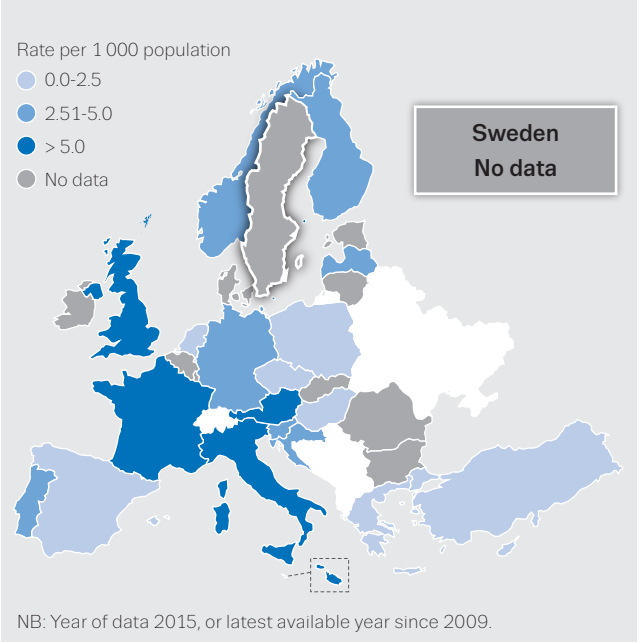
A 2011 study estimated that are approximately 8 000 people who inject drugs (PWID) in Sweden, and most of them use stimulants or opioids. However, no national estimates on high-risk use prevalence by drug type have been reported (Figure 6).

Data from drug treatment providers indicate that opioids and stimulants remained important among first-time clients entering treatment in 2015. Cannabis was the most frequently reported primary drug among the new treatment entrants.

Approximately one out of four treatment clients in Sweden is female; however, the proportion of females in treatment varies by types of primary drug and programme (Figure 7).

FIGURE 6

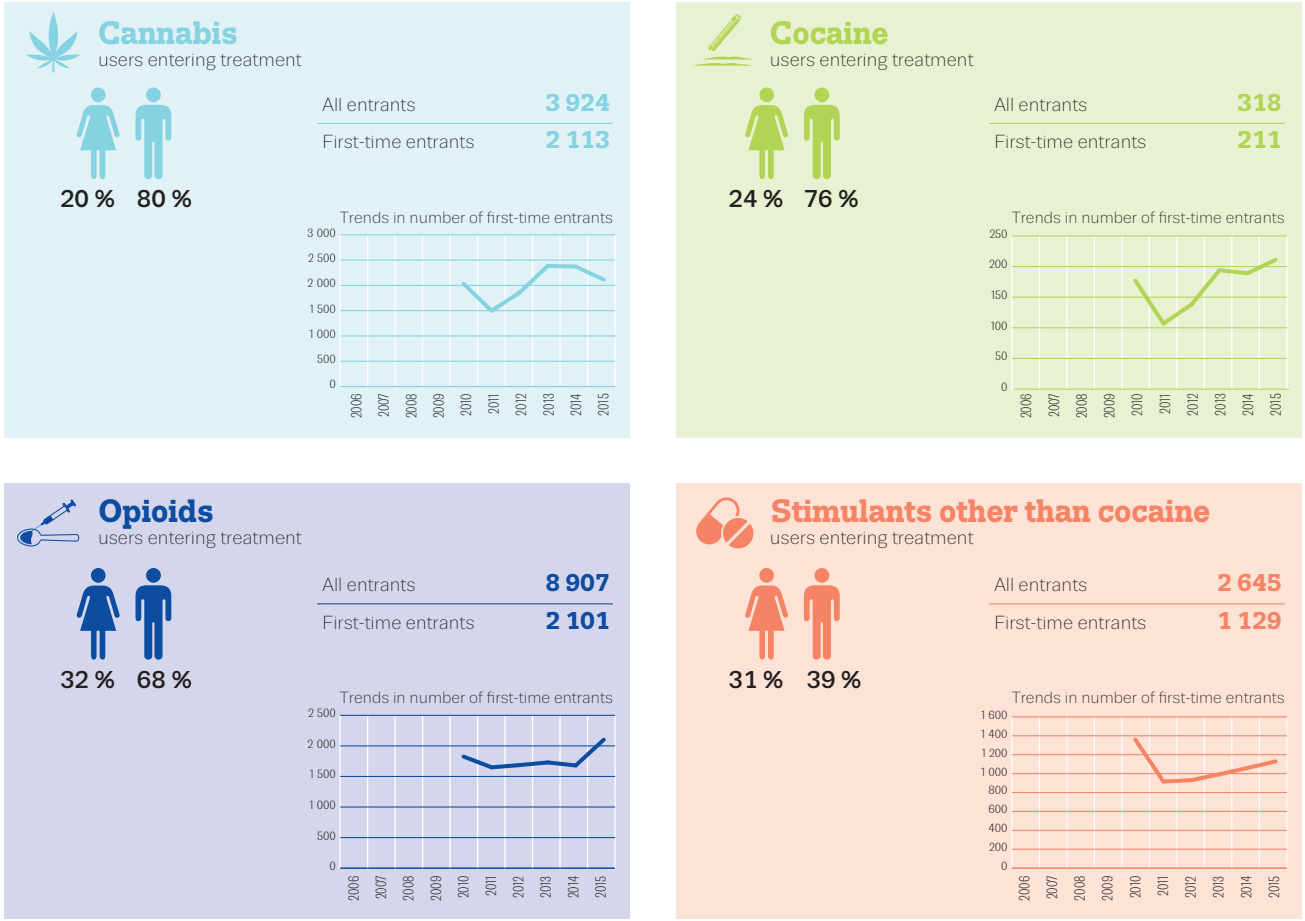
National estimates of last year prevalence of high-risk opioid use



NB: Year of data 2015, or latest available year since 2009.

FIGURE 7

Characteristics and trends of drug users entering specialised drug treatment centres in Sweden



NB: Year of data 2015. Data is for first-time entrants, except for gender which is for all treatment entrants.
First-time and previously treated entrants available only for two of the three data sources available in Sweden and, therefore, not comparable with data for all entrants.

Drug harms

Drug-related infectious diseases

In Sweden, data on drug-related infectious diseases are collected through the statutory surveillance system and notifications are submitted to the County Medical Officer of Communicable Disease Control (one in each of the 21 counties in Sweden) and to the Public Health Agency of Sweden.

Over the past decade, the total number of hepatitis C virus (HCV) infections reported to the national surveillance system has stabilised at around 2 000 cases annually. In 2015, 780 HCV infections were confirmed to be related to injecting drug use. However, in many HCV cases the route of transmission remained unknown. HCV continues to be the most common infection among PWID. Available data suggest that high-risk injection practices remain common among PWID.

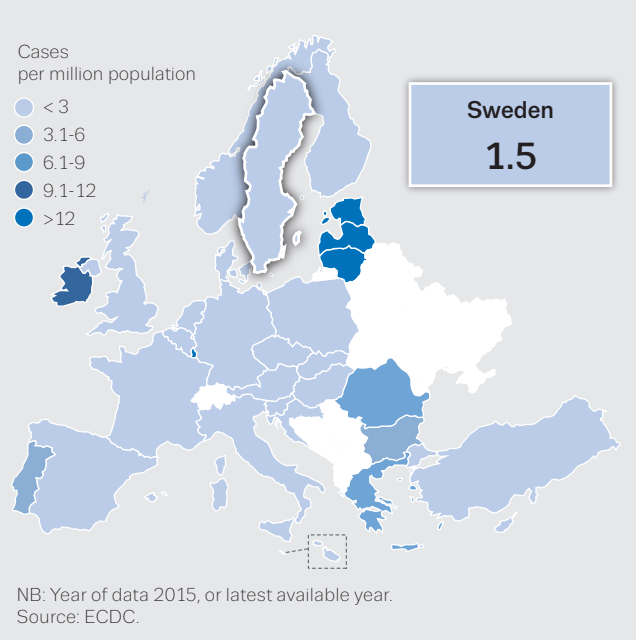
The number of HIV notifications has been stable over the past five years, and only a few cases of new HIV infections notified are linked to injecting drug use. In 2015, out of a total of 15 new cases of HIV infection among PWID, two were linked to domestic infection (Figure 8). In the same year, the number of notified cases of hepatitis B virus (HBV) infection was higher than in previous years; however, the number of cases linked to drug injecting remained stable.

Drug-related emergencies

Information on drug-related acute emergencies is not routinely collected on a national basis in Sweden. Some data on telephone enquiries linked to NPS, which are reported by the Swedish Poisons Information Centre, provide insights into drug-related emergencies. In general, synthetic cannabinoids and synthetic cathinones remain the most commonly mentioned substances; however, in 2015, the number of enquiries involving these substances decreased, while the emergence of requests linked to benzodiazepines or fentanyl analogues was reported.

FIGURE 8

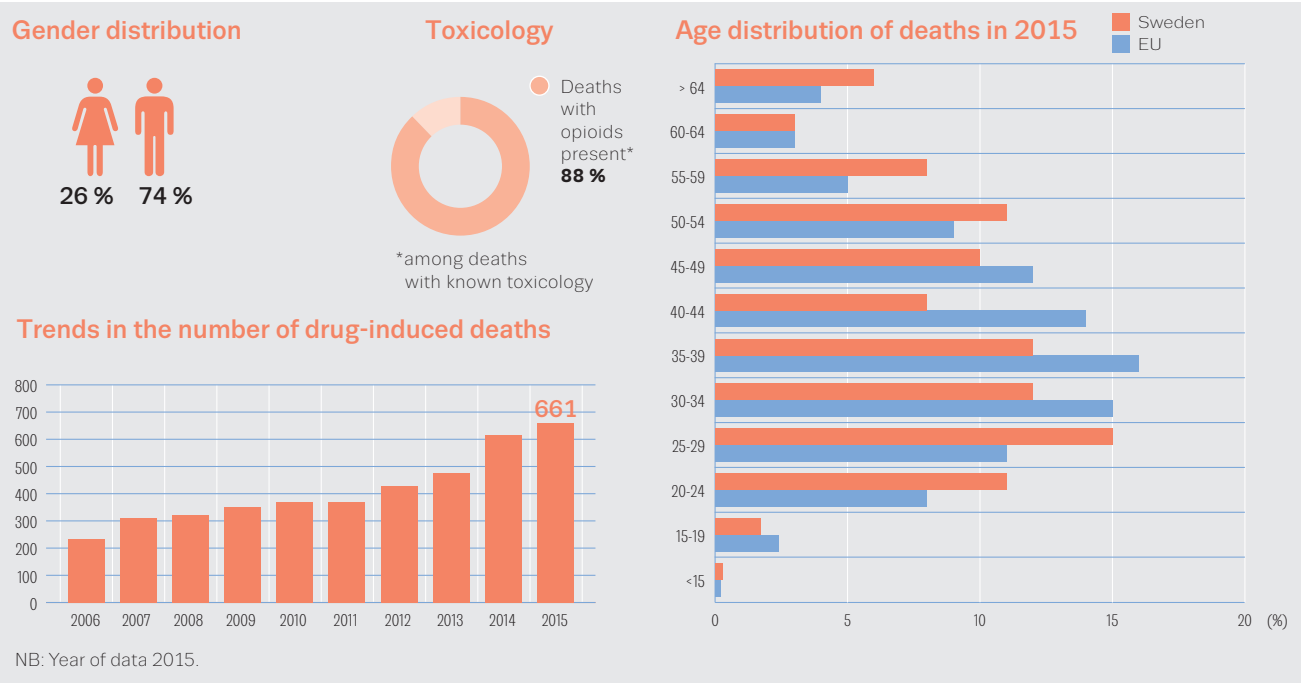
Newly diagnosed HIV cases attributed to injecting drug use



NB: Year of data 2015, or latest available year.
Source: ECDC.

FIGURE 9

Characteristics of and trends in drug-induced deaths in Sweden



NB: Year of data 2015.

Drug-induced deaths and mortality

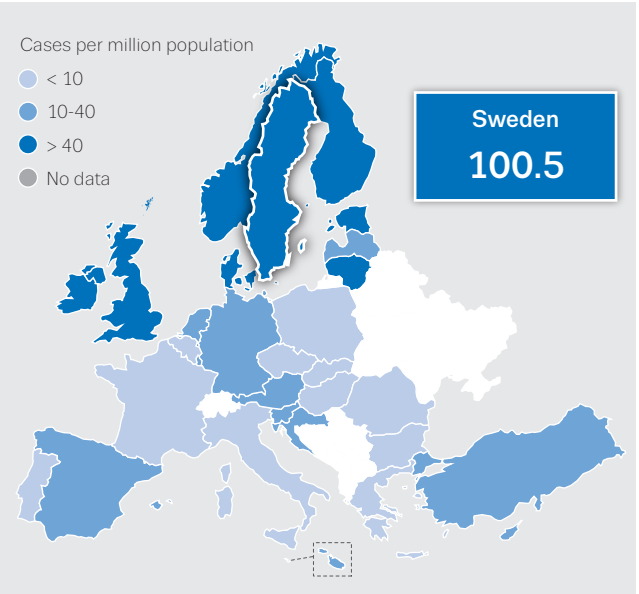
Drug-induced deaths are deaths directly attributable to the use of illicit drugs (i.e. poisonings and overdoses).

In 2015, an increased in drug-induced deaths was reported in Sweden, which continues the trend observed since 2003. The majority of victims were male. The mean age of victims was around 40 years, and has remained stable during the past decade. Toxicology reports indicate the presence of opioids in the majority of deaths (Figure 9). An increased number of toxicology examinations and improvements in analytical confirmation methods for suspected overdose deaths in the recent years have contributed to the increase in the numbers of the deaths reported; however, the increasing trend remains even if all these factors are corrected or controlled.

The latest European average of drug-induced mortality rate among adults (aged 15-64 years) was 20.3 deaths per million. In Sweden, this rate was 100.5 deaths per million in 2014 (Figure 10). Comparison between countries should be undertaken with caution. Reasons include systematic under-reporting in some countries, different reporting systems and case definition and registration processes.

FIGURE 10

Drug-induced mortality rates among adults (15-64 years)



NB: Year of data 2015, or latest available year. Comparison between the countries should be undertaken with caution.

Prevention

Drug prevention activities in Sweden are a key element of the ANDT for 2016-20. The Public Health Agency of Sweden and the National Board of Health and Welfare are central agencies that support the implementation of prevention activities at the local and regional levels, while the regional governments are responsible for drug prevention at the regional level. All 21 counties have a county coordinator to synchronise and promote evidence-based prevention measures at a regional and local level, and in 2015 a total of 16 counties had substance use prevention strategies in place. Municipalities also bear the main responsibility for the implementation of prevention measures. Approximately 88 % of municipalities have now appointed a full-time or part-time drug coordinator for illicit drug prevention work at the community level, and a key component in preventive work is the support of municipality management.

Prevention interventions

Prevention interventions encompass a wide range of approaches, which are complementary. Environmental and universal strategies target entire populations, selective prevention targets vulnerable groups that may be at greater risk of developing drug use problems, and indicated prevention focuses on at-risk individuals.

School-based prevention interventions play an important role in municipalities and schools, and they are mainly implemented in the context of promoting a healthy school environment; they cover both licit and illicit substances. Several interventions focus on the development of children's social and emotional capacity, and many schools also have in place interventions that involve parents (Figure 11).

A number of community-based programmes at the municipal level focus on providing alternative leisure activities and ensuring safe recreational settings, primarily in cooperation with sports organisations, the temperance movement, police and other community-based organisations.

The number of programmes for parents about alcohol and drugs has increased, as has the amount of research done on them. The International Child Development Programme, Komet and COPE have been implemented in approximately one quarter of municipalities. The Örebro programme has been implemented in several versions, among them Effekt, which has also been implemented in Slovenia, Estonia and — in an adapted version — the Netherlands.

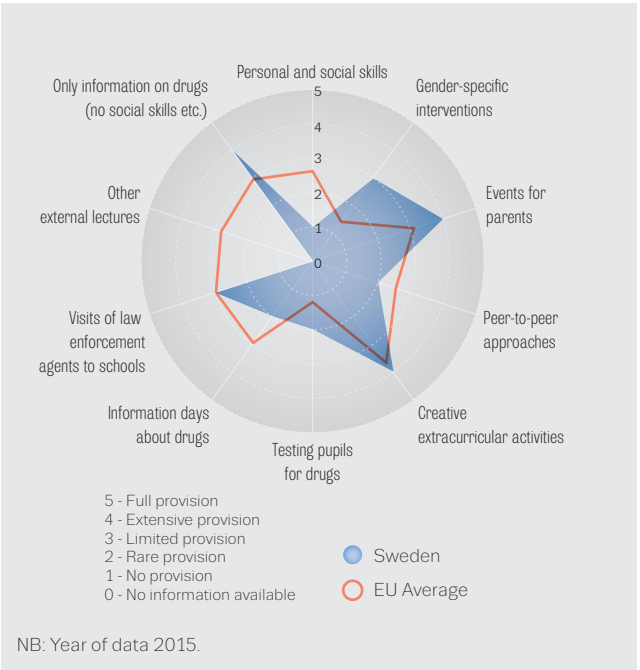
Selective prevention activities mainly include early detection programmes for individuals suspected of drug abuse (young people, drivers and people suspected of minor offences) and programmes for children whose parents are dependent on alcohol or drugs, have mental health problems or are violent. Komet for Parents, a well-researched prevention programme for parents with children aged 3-18 years with externalising behaviour problems, has shown a positive effect on the children's behaviour and the parents' parenting skills.

In recent years, an increasing number of recreational settings, such as clubs and restaurants, have adopted environmental prevention measures, such as norm-setting among staff and the use of controlling approaches that limit drug-intoxicated clients' access to the setting.

Prevention of cannabis use among young people is one of the focuses of the recent national strategy. Between 2012 and 2015, additional funding was allocated to special projects, training and networking in this area.

FIGURE 11

Provision of interventions in schools in Sweden (expert ratings)



NB: Year of data 2015.

Harm reduction

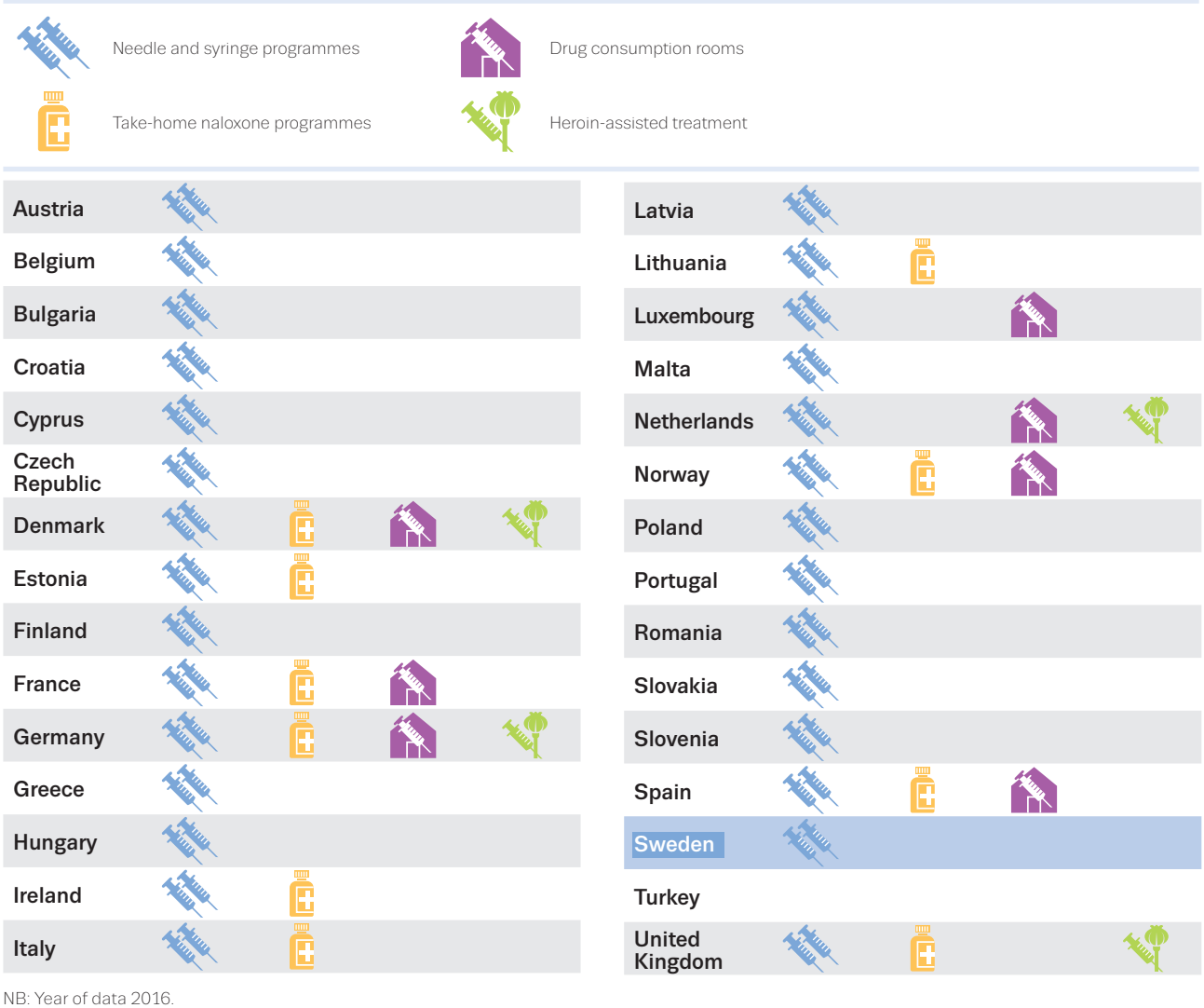
One of the long-term objectives of ANDT is to reduce the harm caused by the use of alcohol, drugs, doping and tobacco. In 2015, the Public Health Agency of Sweden released the first national guidelines for health promotion and prevention of hepatitis and HIV infection among PWID. The recommendations included that county councils should initiate low-threshold services (LTHS), including a needle and syringe exchange programme (NSP). Implementation of LTHS with an aims of preventing drug-related infectious diseases and promoting access to treatment and care services among PWID is within the competence of the county councils. By the end of 2015, three counties — Stockholm, Kalmar and Skåne — operated a total of six LTHS incorporating an NSP.

Harm reduction interventions

Regulations concerning NSPs were drawn up by the National Board of Health and Welfare in February 2007 and define the procedures that county councils should follow. These include a justification of need (e.g. an estimate of the number of potential service users); an assessment of available resources; and a provision plan for complementary and additional care services (e.g. detoxification, drug treatment and aftercare). The regulations also stipulate the obligation for NSPs to inform clients about injecting risks and to offer additional services, including vaccinations and testing for infectious diseases, and they define further quality management rules for the implementation of such services. Drug users are eligible to participate in an NSP when they offer proof of identity and are 20 years of age or older (Figure 12).

FIGURE 12

Availability of selected harm reduction responses



NB: Year of data 2016.

Data from five of the six LTHS show that more than 281 000 syringes were distributed and the service reached approximately 2 590 clients in 2015.

The LTHS also provide their clients with medical and social care and support. They offer free HCV, HIV and HBV testing, and HBV vaccination, monitor and address risk behaviours and link up with other supportive services such as OST programmes and the social services. Pharmacies in Sweden are not allowed to sell needles or syringes to people without a prescription for medical use.

More than 281 000 syringes were distributed in 2015 through the needle and syringe exchange programmes

Treatment

The treatment system

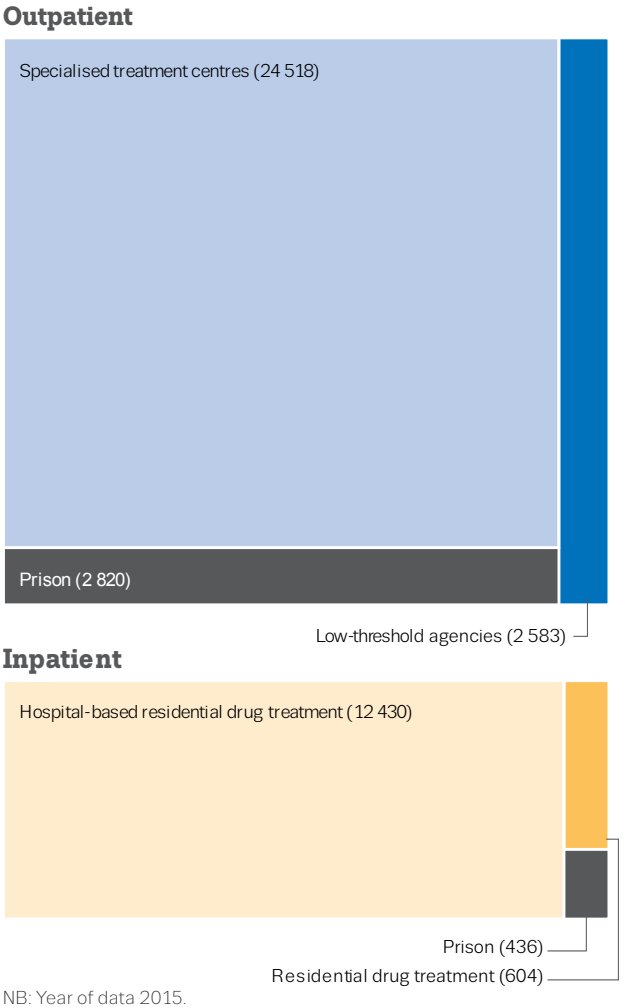
Treatment-related objectives of the ANDT place an emphasis on enhancing the quality of care based on a client-centred approach. In Sweden, drug treatment is organised by the social services in local communities (specialised outpatient clinics), hospitals (providing detoxification) and therapeutic communities. The National Board of Institutional Care provides compulsory treatment (up to a maximum of six months) in special cases.

Approximately 80 % of outpatient services are provided by municipalities, county councils or the state, while 60 % of all inpatient services are provided by municipalities in private and non-governmental organisations (NGOs).

County councils are responsible for the provision of detoxification facilities and OST and for the treatment of psychiatric comorbidities, while municipalities have overall responsibility for long-term rehabilitation through social services, for example in so-called 'homes for care and living' or 'family homes'. Many of these 'homes' are privately operated.

FIGURE 13

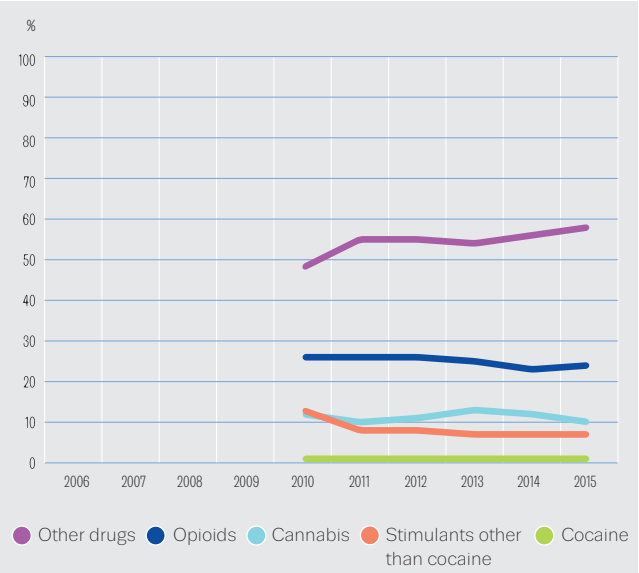
Drug treatment in Sweden: settings and number treated



NB: Year of data 2015.

FIGURE 14

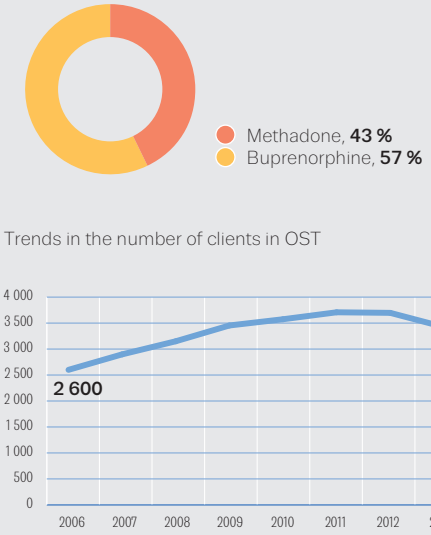
Trends in percentage of clients entering specialised drug treatment, by primary drug in Sweden



NB: Year of data 2015.

FIGURE 15

Opioid substitution treatment in Sweden: proportions of clients in OST by medication and trends of the total number of clients



Trends in the number of clients in OST

NB: Year of data 2015.

OST can be prescribed by a medical doctor. Methadone (introduced in 1967) and buprenorphine-based medications (introduced in 1999) are the only officially recognised pharmaceutical substances used as OST; the national OST guidelines give priority to buprenorphine-based medication in OST treatment.

Treatment provision

The majority of the total of around 38 000 treatment clients in Sweden during 2015, were treated in an outpatient setting (Figure 13). The number of clients treated in different treatment settings should, however, be treated with caution as it may be influenced by the availability of data. In general, the number of people entering treatment has increased in both inpatient and outpatient settings in recent years.

Treatment demand data indicate that a large proportion of people entering drug treatment are polydrug users; opioids and cannabis play an important role among drug treatment demands (Figure 14). It should be noted that in Sweden the treatment demand registration system has gone through several changes, which should be considered when interpreting the data.

The latest available data indicate that in 2015 a total of 3 679 clients were receiving OST in Sweden, of whom the majority received buprenorphine-based medication (Figure 15). OST has always been subject to strict regulation in Sweden. For example, some centres have introduced 'zero tolerance' against lateral illicit drug use. In cases of illicit drug use, clients are frequently referred to a different type of treatment.

Drug use and responses in prison

In 2015, the Swedish Prison and Probation Service, under the authority of the Ministry of Justice, comprised 79 prisons (including remand prisons), with around 7 000 places, of which approximately 10 % were allocated to prisoners who use alcohol or drugs.

According to the latest annual census of prisoners, conducted in 2015, 51 % of males and 43 % of females had used illicit drugs during the year before their imprisonment. Drug use during imprisonment is related mainly to the misuse of prescribed medicines and illicit drugs smuggled into the prisons or used during a period of leave.

On admission, each new prisoner undergoes a medical assessment, which includes assessment of drug use status. Routine tests on drug use are mandatory. Initiatives have recently been undertaken to find new methods of detecting synthetic cannabinoid use, which represents an emerging challenge as these substances are particularly difficult to screen. It is estimated that three out of four prisoners are dependent on alcohol and/or drugs and that around the same proportion have a personality disorder (including antisocial personality disorder). A recent study estimated that up to 40 % of clients sentenced to one year or more in prison, suffer from attention deficit-hyperactivity disorder (ADHD), and that other neuropsychiatric disabilities are also common. Up to one third of the prisoners are infected with HCV but less than 5 % are infected with HIV.

The Swedish Prison and Probation Service provides healthcare in prison. However, the Health and Social Care Inspectorate is responsible for the supervision of prison healthcare services, and the guidelines for such care are issued by the National Board of Health and Welfare. These authorities are governed by the Ministry of Health and Social Affairs.

The guiding principle for the treatment of drug users in prison and during probation is that the prisoner has the same right to social or medical treatment as other people living in Sweden. Prisoners with drug use problems are offered drug treatment programmes; these are mainly abstinence oriented and based on cognitive-behavioural interventions and 12 steps programmes, adapted from Alcoholics Anonymous. The programmes are accredited and evaluated. OST is available in prison and can be either continued or initiated in prison prior to release, following a medical assessment. In Sweden, 14 prison places, distributed among three prisons, have been allocated to permit prisoners to receive OST for opiate dependence, although OST can also be provided in other prisons.

Infectious disease testing and vaccination is also available, and recently the new hepatitis C virus infection treatment has been offered in two regions.

Several specific pre-release measures exist in Sweden: parole, extended parole, halfway house and stay-in care. The last of these is aimed at clients in need of treatment for substance use and takes place on location in treatment centres or as outpatient care.

Routine tests on drug use are mandatory. Initiatives have recently been undertaken to find new methods of detecting synthetic cannabinoid use

Quality assurance

The ANDT emphasises the need for a knowledge base and evidence-based interventions to achieve high-quality drug-related treatment and prevention activities. Several actors, including both independent national agencies and government agencies, work in the field of quality assurance and best practice by evaluating methods used and by providing guidance to treatment providers through guidelines and knowledge provision.

The Swedish Agency for Health Technology Assessment and Assessment of Social Services is an independent national authority tasked by the government with the assessment of healthcare interventions from a broad perspective, covering medical, economic, ethical and social issues. In 2015, it published an evaluation of the scientific evidence for prevention initiatives for the misuse of substances. The National Board of Health and Welfare, a government agency under the Ministry of Health and Social Affairs, publishes guidelines on the treatment of substance use and dependence. An updated version of these guidelines was published in 2015.

In Sweden, there is no general accreditation system in place for drug-related interventions, but service providers or those who implement different projects often have their own accreditation systems to assure the quality and effectiveness of the interventions they provide.

In 2015, to support the health promotion and prevention efforts among PWID implemented at the regional level, the Public Health Agency launched guidelines on the prevention of infectious diseases, based on the EMCDDA and ECDC joint guideline 'Prevention and control of infectious diseases among people who inject drugs' (2011).

The National Board of Health and Welfare, a government agency under the Ministry of Health and Social Affairs, publishes guidelines on the treatment of substance use and dependence. An updated version of these guidelines was published in 2015

Drug-related research

Funding for research comes mainly from governmental sources. The Public Health Agency of Sweden and other agencies have the task of handling project funding related to drug prevention and treatment. The main organisations involved in conducting drug-related research are university departments, although NGOs and governmental organisations are also relevant partners. Several channels for disseminating drug-related research findings are available in Sweden, including scientific journals, dedicated websites, reports, manuals and conferences. Recent drug-related research has mainly focused on demand reduction topics and population-based studies, but studies on supply have also been carried out.

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Drug markets

Most of the drugs seized in Sweden are smuggled into the country via the bridge connection with Denmark or through ports or international airports. Some domestic production of cannabis and amphetamines has been reported in Sweden. This is often small-scale or household based, while large-scale indoor cultivation of cannabis also takes place and is mainly operated by organised criminal networks.

The Swedish illicit drug market is dominated by cannabis and amphetamines. Cannabis remains the most frequently seized illicit drug. Herbal cannabis available on the market is both produced domestically and smuggled from abroad. Cannabis resin originates mainly from Morocco. In general, herbal cannabis seizures have increased both in number and in quantity in the past decade, while seizures of cannabis resin became less common over the same period.

Although amphetamine remains involved in a substantial number of seizures, the data indicate a declining trend in the amphetamine seizures in the last decade (Figure 16).

Heroin seized in Sweden usually originates in Afghanistan and arrives in Sweden through the Balkan route. Seizures are still few in number, and it appears that the downwards trend in heroin seizures over the period 2006-11 has stabilised at a low level.

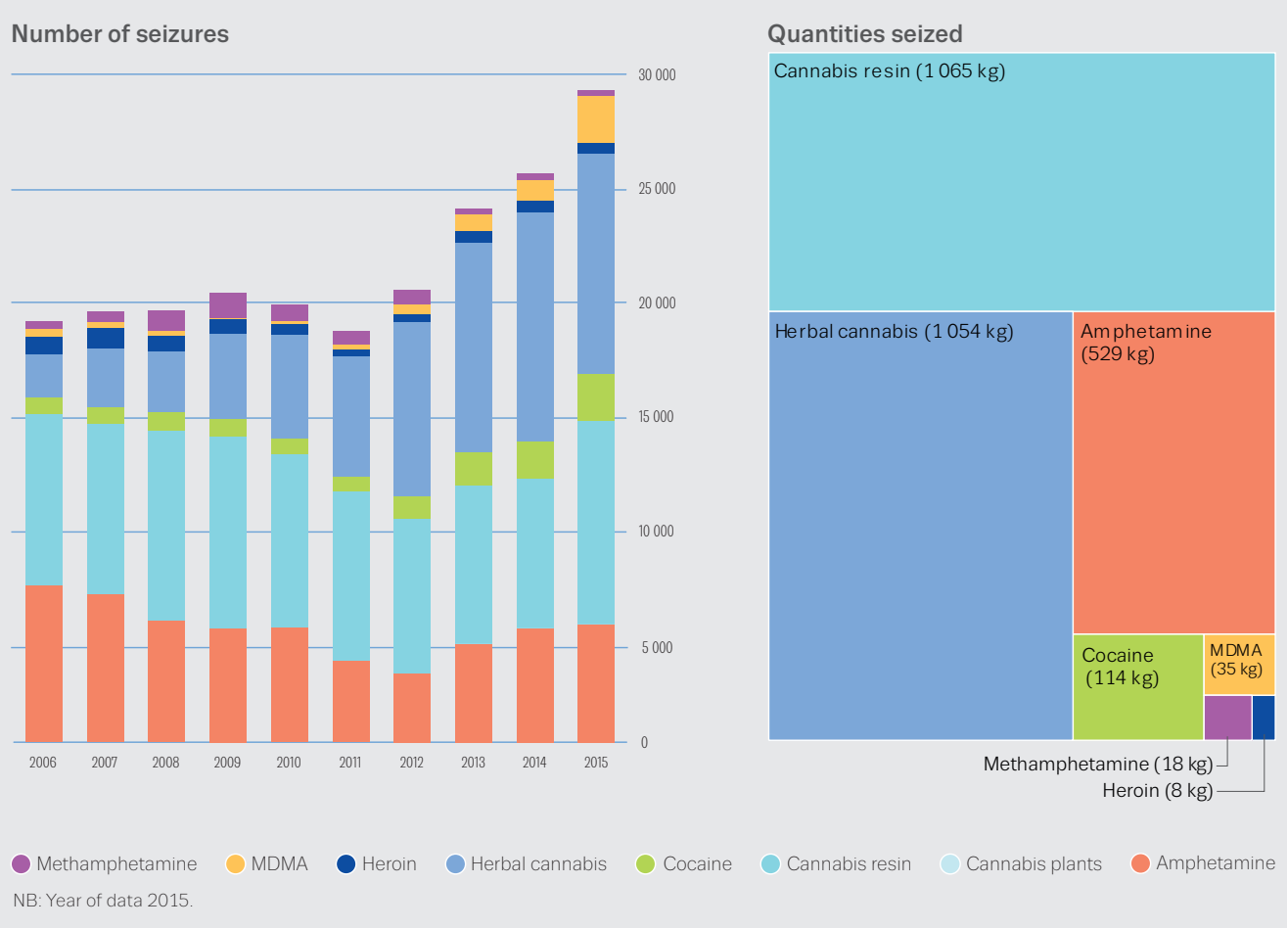
Cocaine seized in Sweden originates from South America and is smuggled in through other European countries. The data indicate large annual variations in cocaine seizures in Sweden. MDMA is smuggled from the Netherlands, and in the past 10 years an increase in seizures has been reported.

NPS retain a strong position in the Swedish drug market, and they usually originate from China. In 2015, a significant decrease in seizures of synthetic cannabinoids was observed; at the same time extremely potent fentanyls were reported. The reduction in synthetic cannabinoid seizures is explained by the introduction of legal control and may be a result of increased awareness among the target groups and the general population.

The retail price and purity of the main illicit substances seized are shown in Figure 17.

FIGURE 16

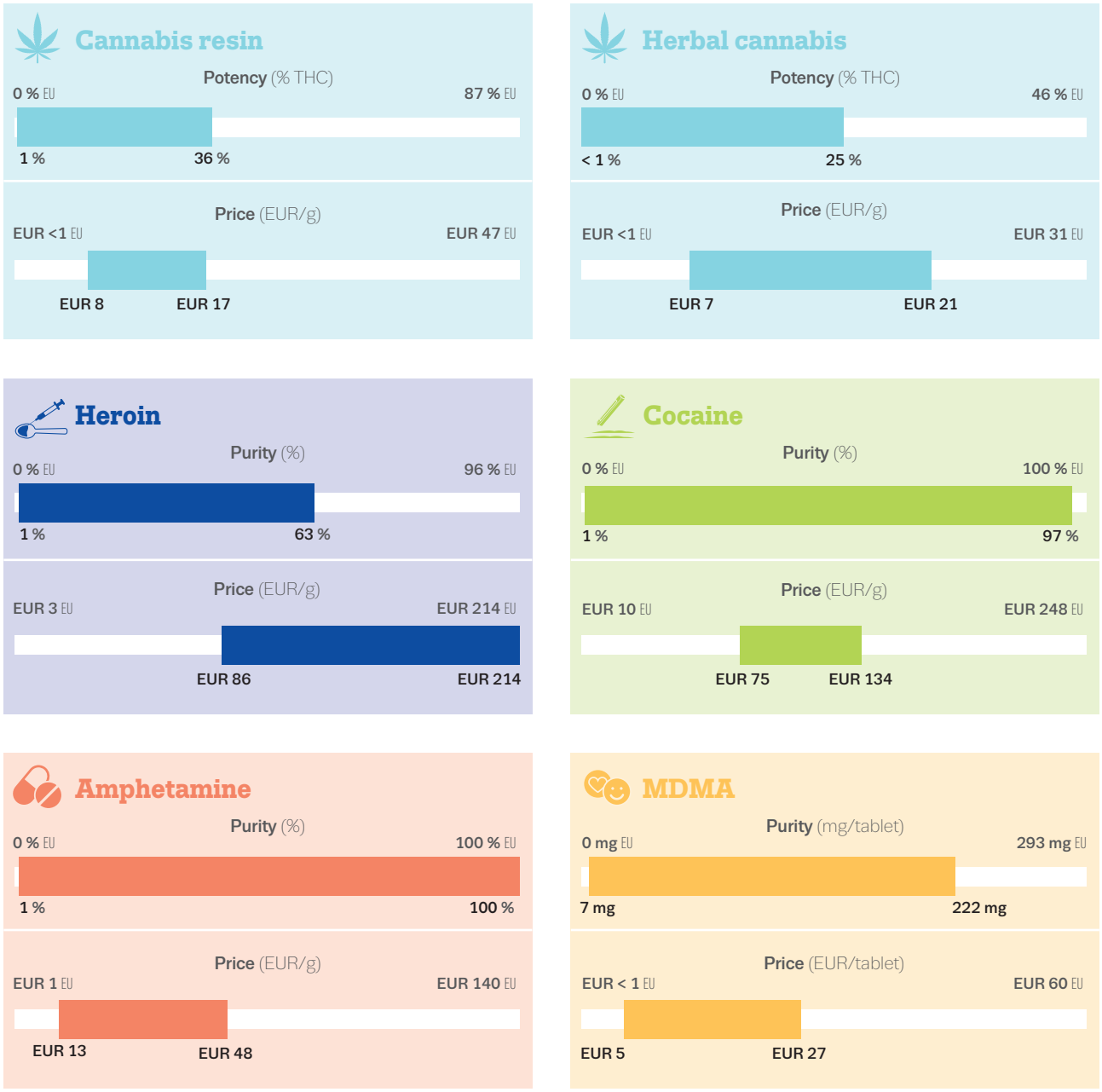
Drug seizures in Sweden: trends in number of seizures (left) and quantities seized (right)



NB: Year of data 2015.

FIGURE 17

Price and potency/purity ranges of illicit drugs reported in Sweden



NB: Price and potency/purity ranges: EU and national mean values: minimum and maximum.
Year of data 2015.

KEY DRUG STATISTICS FOR SWEDEN

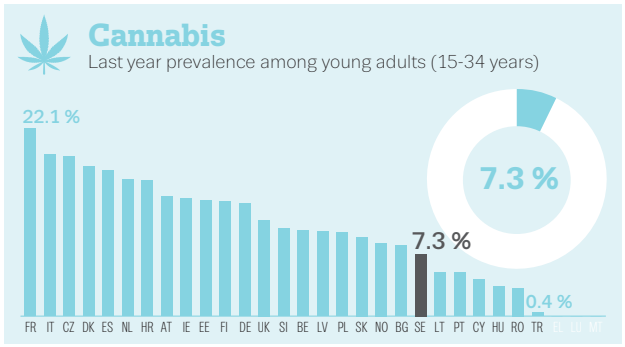
Most recent estimates and data reported

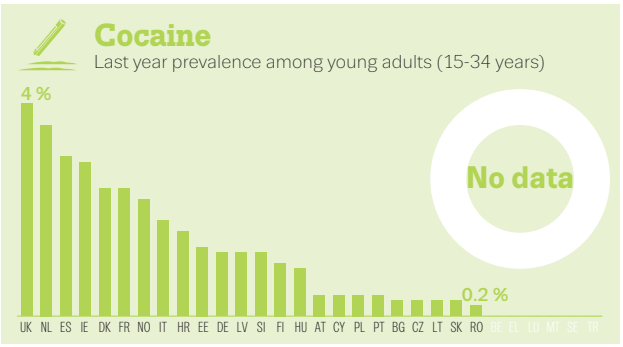
	Year	Country data	EU range	
			Minimum	Maximum
Cannabis				
Lifetime prevalence of use — schools (%, Source: ESPAD)	2015	6.6	6.5	36.8
Last year prevalence of use — young adults (%)	2015	7.3	0.4	22.1
Last year prevalence of drug use — all adults (%)	2015	3.2	0.3	11.1
All treatment entrants (%)	2015	10	3	71
First-time treatment entrants (%)	2015	16	8	79
Quantity of herbal cannabis seized (kg)	2015	1 053.5	4	45 816
Number of herbal cannabis seizures	2015	9 619	106	156 984
Quantity of cannabis resin seized (kg)	2015	1 065.3	1	380 361
Number of cannabis resin seizures	2015	8 897	14	164 760
Potency — herbal (% THC) (minimum and maximum values registered)	2015	0.2-25	0	46
Potency — resin (% THC) (minimum and maximum values registered)	2015	1-36	0	87.4
Price per gram — herbal (EUR) (minimum and maximum values registered)	2015	7-21	0.6	31.1
Price per gram — resin (EUR) (minimum and maximum values registered)	2015	8-17	0.9	46.6
Cocaine				
Lifetime prevalence of use — schools (%, Source: ESPAD)	2015	1.6	0.9	4.9
Last year prevalence of use — young adults (%)	No data	No data	0.2	4
Last year prevalence of drug use — all adults (%)	No data	No data	0.1	2.3
All treatment entrants (%)	2015	1	0	37
First-time treatment entrants (%)	2015	2	0	40
Quantity of cocaine seized (kg)	2015	113.9	2	21 621
Number of cocaine seizures	2015	2 086	16	38 273
Purity (%) (minimum and maximum values registered)	2015	1-97	0	100
Price per gram (EUR) (minimum and maximum values registered)	2015	75-134	10	248.5
Amphetamines				
Lifetime prevalence of use — schools (%, Source: ESPAD)	2015	1.1	0.8	6.5
Last year prevalence of use — young adults (%)	No data	No data	0.1	3.1
Last year prevalence of drug use — all adults (%)	No data	No data	0	1.6
All treatment entrants (%)	2015	7	0	70
First-time treatment entrants (%)	2015	8	0	75
Quantity of amphetamine seized (kg)	2015	529	0	3 796
Number of amphetamine seizures	2015	5 162	1	10 388
Purity — amphetamine (%) (minimum and maximum values registered)	2015	1-100	0	100
Price per gram — amphetamine (EUR) (minimum and maximum values registered)	2015	13-48	1	139.8

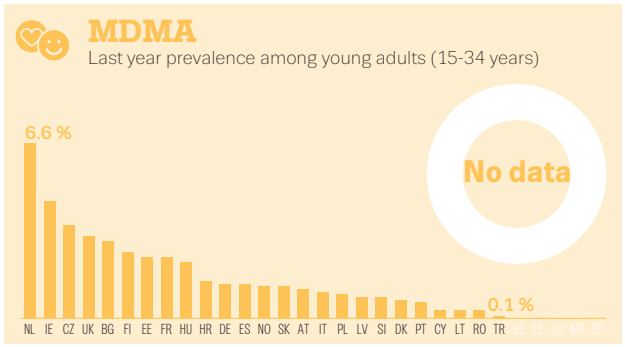
	Year	Country data	EU range Minimum	EU range Maximum
MDMA				
Lifetime prevalence of use — schools (%, Source: ESPAD)	2015	1.2	0.5	5.2
Last year prevalence of use — young adults (%)	No data	No data	0.1	6.6
Last year prevalence of drug use — all adults (%)	No data	No data	0.1	3.4
All treatment entrants (%)	2015	0	0	2
First-time treatment entrants (%)	2015	0	0	2
Quantity of MDMA seized (tablets)	2015	95 421	54	5 673 901
Number of MDMA seizures	2015	2 095	3	5 012
Purity (mg of MDMA base per unit) (minimum and maximum values registered)	2015	7-222	0	293
Price per tablet (EUR) (minimum and maximum values registered)	2015	5-27	0.5	60
Opioids				
High-risk opioid use (rate/1 000)	No data	No data	0.3	8.1
All treatment entrants (%)	2015	24	4	93
First-time treatment entrants (%)	2015	15	2	87
Quantity of heroin seized (kg)	2015	8	0	8 294
Number of heroin seizures	2015	483	2	12 271
Purity — heroin (%) (minimum and maximum values registered)	2015	1-63	0	96
Price per gram — heroin (EUR) (minimum and maximum values registered)	2015	86-214	3.1	214
Drug-related infectious diseases/injecting/deaths				
Newly diagnosed HIV cases related to injecting drug use (cases/million population, Source: ECDC)	2015	1.5	0	44
HIV prevalence among PWID* (%)	No data	No data	0	30.9
HCV prevalence among PWID (%)	No data	No data	15.7	83.5
Injecting drug use (cases rate/1 000 population)	2008/ 2011	1.4	0.2	9.2
Drug-induced deaths — all adults (cases/million population)	2015	100.5	1.6	102.7
Health and social responses				
Syringes distributed through specialised programmes	2015	281 397	164	12 314 781
Clients in substitution treatment	2015	3 679	252	168 840
Treatment demand				
All clients	2015	37 988	282	124 234
First-time clients	2015	13 666	24	40 390
Drug law offences				
Number of reports of offences	2015	94 035	472	411 157
Offences for use/possession	2015	84 494	359	390 843

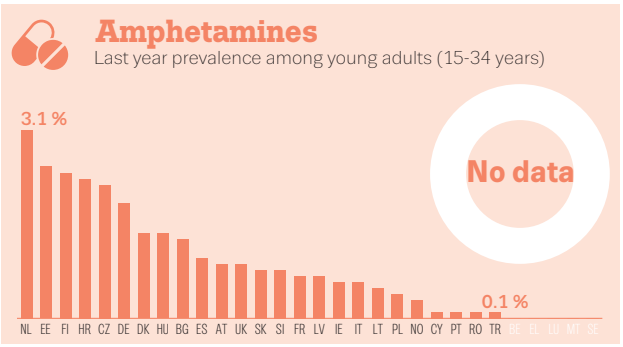
* PWID — People who inject drugs.

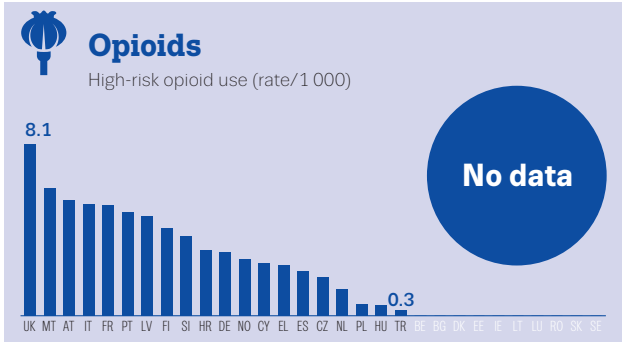
EU Dashboard

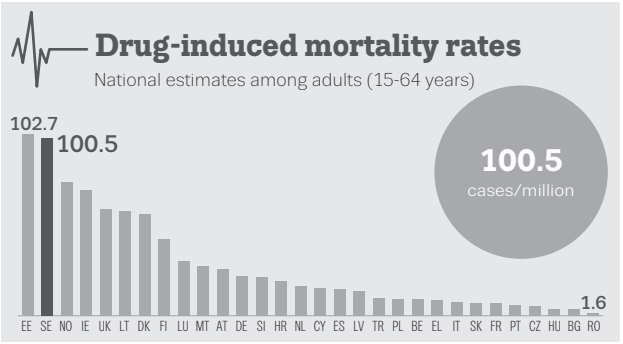


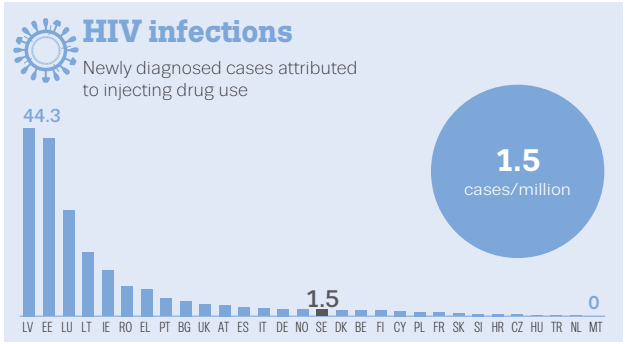


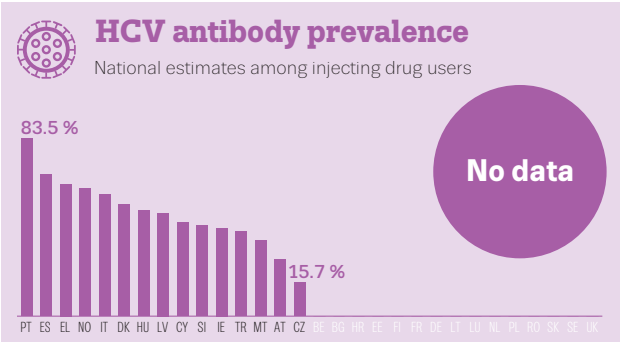












NB: Caution is required in interpreting data when countries are compared using any single measure, as, for example, differences may be due to reporting practices. Detailed information on methodology, qualifications on analysis and comments on the limitations of the information available can be found in the EMCDDA Statistical Bulletin. Countries with no data available are marked in white.

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About the EMCDDA

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is the central source and confirmed authority on drug-related issues in Europe. For over 20 years, it has been collecting, analysing and disseminating scientifically sound information on drugs and drug addiction and their consequences, providing its audiences with an evidence-based picture of the drug phenomenon at European level.

The EMCDDA's publications are a prime source of information for a wide range of audiences including: policymakers and their advisors; professionals and researchers working in the drugs field; and, more broadly, the media and general public. Based in Lisbon, the EMCDDA is one of the decentralised agencies of the European Union.

Folkhälsomyndigheten
PUBLIC HEALTH AGENCY OF SWEDEN

About our partner in Sweden

The Swedish national focal point is located within the Public Health Agency of Sweden, which is responsible for national public health issues. The agency promotes good public health by building and disseminating knowledge to healthcare professionals and others responsible for infectious disease control and public health.

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