National report
Sweden 2001

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Foreword

This report has been prepared and compiled in cooperation with a number of national authorities, e.g. The National Board of Health and Welfare, the National Police Board and the Swedish Customs. The main author of the report is Mr Bengt Andersson.

The main conclusion of the report is that there is reason for some concern about the drug situation. The number of illicit drug users and rate of occasional drug use among young people is increasing.

As a response to the drug situation the Swedish Government will put a bill on drug policy to the Parliament in January 2001. Hopefully this will strengthen the restrictive Swedish policy on illicit drugs.

Stockholm, December 2001

Gunnar Ågren
Director General
National Institute of Public Health
## Abbreviations

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<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>CAN</td>
<td>Swedish Council for Information on Alcohol and other Drugs</td>
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<td>MHSA</td>
<td>Ministry of Health and Social Affairs</td>
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<td>NBHW</td>
<td>National Board of Health and Welfare</td>
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<td>MPA</td>
<td>Medical Products Agency</td>
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<td>NCCP</td>
<td>National Council for Crime Prevention</td>
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Introduction to the Swedish National Report

This National Report has been compiled with the assistance of the EMCDDA document “Guidelines 2001 for National Reports”. The paragraphing of the Guidelines has been followed and the report is hence divided into a summary, four main parts, and ended with a list of references. The focus of the report is on new developments.

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

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

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

In order to avoid unnecessary repeating of names of authorities and organisations frequently referred to, they are abbreviated in the text after being mentioned the first time. In order to evaluate the Swedish drug policy a Commission on Narcotic Drugs was set up by the Government in May 1998, referred to as the Drugs Commission in the text. The commission presented its analysis and recommendations in the turn of the year 2000/2001.
Summary, main trends and developments

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

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

Furthermore, the Swedish drug policy is recognised as a part of the social policy, and should also in the future be an important and well-integrated factor in the general welfare policy. Recently, this view has been established in a proposal from a national committee on public health.

During the 1990s there has been an increase in the availability of drugs, particularly of amphetamine and heroin. This is reflected in multiplied seizures among the Police and Customs and decreases in price. The drug trafficking profile has changed somewhat in recent years with an increased proportion of the drugs entering Sweden having been smuggled in from Eastern Europe. It should however be emphasised that the vast majority of the seizures made by the Customs are still made at the border of a member country of the European Union.

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

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

Most persons having tried drugs, both younger people and adults, have tried cannabis, and the majority has tried cannabis only. The second most commonly experienced drug is amphetamine.

A relatively new drug spreading among (especially) teenagers is GHB. It was classified as a narcotic drug in February 2000. Recently also GBL and Pro-G have become a part of the “GHB-problem”. In most repeated surveys on drug use GHB-questions have recently been included, but prevalence is low.

Illegal medicines, especially benzodiazepines, have been paid a lot of attention recent years and the seizures have increased significantly during the 1990s. The flunitrazepam group has been directed to a higher classification list.

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

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

The Government set up a commission on drugs in May 1998. The task has been to evaluate the drug policy of Sweden and to propose future reinforcements to strengthen the efficiency. A great number of areas such as legislation, research and epidemiology, preventive measures, and various aspects of the treatment system (including treatment in the correctional system) have been investigated. The interplay between different sectors, levels and actors in society are also given attention. A great number of discussion memorandums have been published and the definitive report was ready in December. A Plan of Action regarding drugs will be released next year, likely comprising many of the findings and proposals of the Drugs Commission. It has been declared from the Minister of Social Affairs that a position as drug-tsar will be created.
Part I.
National strategies: institutional & legal frameworks

1. Developments in Drug Policy and Responses

1.1 Political framework in the drug field

Objectives and priorities of national policy


The overriding aim of the policy is stated as “a drug-free society”. This aim is to be seen as a vision reflecting the attitude to narcotic drugs and an indication of the direction of the policy. The overriding aim of a drug-free society is concretised in three sub-targets; reducing the recruitment of new drug abusers, inducing more drug abusers to kick the habit, and reducing the supply of drugs. The drug policy has support from all political parties and surveys have shown that the general population stand behind it. Several interest groups are active in the field.

At the same time as the UNGASS meeting was prepared and the policy statement presented a Drugs Commission was called. The commission was directed to study the development since the middle of the 80s and, within the concept of a restrictive drug policy, identify deficiencies in the existing structure and formulate new strategies. The commission reached the conclusion (SOU 2000:126) that Sweden has reached a crossroad: One direction calls for a significant augmentation of resources in the form of commitment, direction, competence and funding. The other implies a lowering of sights and a considerable acceptance of drug abuse. The commission clearly take stands for the former alternative.

The Government has announced a proposition before the Parliament in January 2001. Besides the Drugs Commission the Government will relay on another investigation, namely The National Committee for Public Health, who has presented a report: Health on equal terms – national goals for public health (SOU 2000:91) that also deals with these questions, if not to the same level of details. During next spring a reformulated National Plan of Action is supposed to be accepted by the Parliament. The former plan was taken when Sweden entered the European Union (1995). The proposition is scheduled to January 2002.

Prevention is the overriding principle in the drug policy. It has been emphasised in the before mentioned reports and constructive critic has been formulated on parts of the efforts. Recom-
mendations are made that all preventive actions shall be relying on evidence-based methods. The same conclusion has been made by an investigation The National Agency for Education has made regarding drug education in the school system (Skolverket 2000).

Treatment is another cornerstone in the drug policy. The Drugs Commission states that care and treatment is a field that has been subject to extensive spending cuts and downgrading. In many communities the continuity of operation has thereby been lost during the 90s. Problematic drug abusers are those who are worst off. The commission also found a need for improving the competence for those in the field.

The third cornerstone, supply reduction, is said to have fared better. The commission is proper to note that the drug policy must be balanced and not rely entirely on supply reduction. All parts must be in full vigour.

Even if the Drug Commission stated that supply reduction has fared better than demand reduction in a period of economic recession and organizational upheaval it is far from saying that police and customs has gained control over the illegal market (which is explicit stated in the annual reports from customs and police). Indicators such as seizures (amounts as well as number of seizures), prices on the street and anecdotal data from users unanimous tell the same story: supply is more generous and prices lower than ever. The variety of drugs has also expanded during the 90s and now follows what happens in the rest of the EU. Clearly, Europe is a common market. Reforms in the police force have influenced the ability to cope with the drug problem when specialised drug squads were dissolved (the problem is similar to what happened to specialists in the social sector). The Drug Commission has called attention to this development.

The Drugs Commission also discussed cultivation of industrial hemp (cannabis) as Sweden follows another line of reasoning than the EU. During 2001 this has developed to a legal affair. A few farmers have started to cultivate cannabis, which has resulted in interference by prosecutors and police. The case seems to end in the Court of Justice of the European Communities (ECJ).

The Government and the Parliament last spring inaugurated a National Action Plan on Alcohol and a chancellery in the Social Ministry co-ordinates the activities. A National Action Plan on Drugs will probably have a similar formula. A special “Narcotics General” (“Drugtsar”) will be appointed by the Government in order to coordinate and activate the actions at different societal levels. In the Alcohol Plan it is stated that the local level is the main platform for activities.

1.2 Policy implementation, legal framework and prosecution

**Laws and regulations**

A law, The Act on the Prohibition of Certain Goods Dangerous to Health, was put into action in April 1999. It supplements The Penal Law on Narcotics (inaugurated 1968). This new act applies to goods that, by reason of their innate characteristics, entail a danger to human life or health and are being used, or can be assumed to be used, for the purpose of intoxication or other influence. The act is not meant to regulate substances that are regulated in other ways: pharmaceutical products or drugs controlled by the Penal Law on Narcotics or The Penal Law
on Doping Substances. However, products classified by this act can, after careful investigation, be transferred to the Penal Law (this has been the case of 4-MTA in Nov 1999).

The Medical Products Agency specifies which medical products that are to be considered as narcotic drugs. The agency presents these products in five lists with regards to their effects. List I register classical illegal drugs without medical use, list II – IV register narcotic substances with medical usage and regulation of its import/export, and list V narcotic substances outside international control. Generally, penalties for drug crimes are influenced by the classification of the drug involved. Heroin generates severe punishment than Rohypnol.

In February 2000 GHB became classified according to the Penal Law on Narcotics and in May 2001 flunitrazepam (Rohypnol etc.) was raised from list IV to II. In February 2001 regulations about import of personal medication for visitors was revised to standards in the EU.

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

The National Council for Crime Prevention has researched the effects of making the use of drugs an offence (Brottsförebyggande rådet 2000c). This regulation is from 1988 and it was sharpened in 1993. It was found that it resulted in a sharp increase in the number of persons arrested for slight drug offences. Many of the arrestees show up to be well known drug abusers, but the police also was able to detect young formerly unknown abusers. One prominent cause for the regulation was to identify young persons in an early phase of a drug career. That was accomplished. The report also discusses its importance on the drug market (which has escalated) and integrity matters (1/3 of those young people that had to present a urine sample could not be bound to a drug offence). Conclusive remarks could not be reached. The Drug Commission discussed similar matters in one of its reports (Narkotikakommissionen 1999a). In that report teenagers present their view on drug policies, the police, the school, rave parties and so on.

Driving under the influence of drugs is regulated with a zero-tolerance paragraph in the law since July 1999. During 2000 1600 persons was caught under influence of a drug (Brottsförebyggande rådet 2001). About 90 per cent was convicted with other serious charges at the same trial. The corresponding figure was only 30 per cent for those convicted with an alcohol offence.

More data on legal framework and prosecution are presented in chapter 4.2.

**1.3 Developments in public attitudes and debates**

**Public perception and public debates**

Public attitudes to drugs are recorded in surveys in schools (level 9), among military conscripts (males, 18 years old), representative samples of the population 16-24 years (“young people”) and among 15-75 years. Surveys are made annually in schools and among military conscripts. Surveys in the general population are made every second year. On and off surveys are made in population samples ordered by newspapers, organisations or authorities.

In grade 9 (at 15 years) 6 % says (2000) the have been tempted to try drugs (but without doing it). This proportion has been the same since 1992. At the same time the proportion of pupils who actually have tried drugs has risen from 4 to 9 %. Attitudes towards drugs among
young people (16-24 years) are negative. 71% see the drug problem as one of societies most prominent problems. However, the proportion that do not follow that view has risen during the last surveys from 9% in 1996, 12% in 1998 to 17% in 2000. The rest could not decide.

The latest, in October 2001 (by Temo), showed that 96% opposes legalization of any drug that today are classified. Earlier surveys have shown the same response pattern (they usually are made every second year). A survey among young people (16–24 year) showed that 91% said no to decriminalisation of cannabis use (by Temo, 2000). In the earlier surveys, 1996 and 1998, only 3 respectively 4% held the view that cannabis should be allowed and 65 and 63% were against “the liberalization of legislation that are taken place in some other countries”. This was not asked for in the latest survey.

The lifetime prevalence of drugs among the population 15-75 years given as running three-year averages is 12% in the 2000 stand. The highest prevalence, 17%, is among those 30-49 years. Among those 15-29 years it is 13%. Last year prevalence has never (since 1988) been over one percent.

The Drugs Commission presented its report late in 2000. During the working process, started in 1988, thirteen discussion memorandums were published and several conferences arranged. Accordingly, it has been possible to follow the process. A “shadow” commission set up by members of popular movements against drugs presented their ideas to the Minister of Social Affairs in June 2000. Their text discussed drug education, working life, harm reduction, economic responsibility for treatment, compulsory treatment, substitution treatment, education, needle exchange and presented proposals in these issues.

The political leadership in the drug field has been called in question. Organisations and the Drugs Commission has proposed the government to install a “drug tsar” to take the lead in a significant augmentation of resources in the form of commitment, direction, competence and funding. The Commission stated (SOU 2000:126) that “the care and treatment of drug abusers is a field which has been subjected to extensive spending cuts and down-grading by the municipalities of Sweden”.

The National Board of Institutional Care, which is responsible for compulsory institutional care, has several times during 2000 sent alarming signals about the situation for those worst off among drug abusers. The clients treated in compulsory care are younger today, they are involved multiple abuse and most of them have serious psychiatric problems. Women are severely exposed. The Board criticize social authorities for intervening too late and in the debate that has taken place in newspapers, in the Parliament and in conferences it is said that considerations over treatment costs has part in this development. Homelessness among drug abusers has also been illustrated in media as well as young peoples alleged interest in various drugs.

Also prevention is believed to have dwindled. The National Agency for Education has published a report (Skolverket 2000) saying that the school do not fulfil the demand in drug education.

This debate about the downsizing of preventive and treatment efforts has dominated the debate, and it has followed into 2001.

1.4 Budget and funding arrangements
Systematic figures reflecting costs for drug policy is missing. In last years National Report an estimate made by the National Audit Office in 1993 and by N Nilsson in 1999 was presented reflecting societal costs.

In 1998 a state committee (SOU 1998:18) put the society cost for drugs to be 6 billion SEK per year. The Drugs Commission (SOU 2000:126) made a computation resulting in 7.7 billion SEK per year. These calculations do not take into account prevention, training and evaluation. No attempt has been made to summarize these costs.

According to the National Board of Health and Welfare treatment costs for alcohol- and drug abuse can be estimated to cost the municipalities 3.7 billion SEK per year (of which 55 % is for institutional care). Costs for alcohol and drugs cannot be separated.

The police, with 22 000 employees of which 16 201 are police officers (17 % women), used 6 % of its total budget of 12.5 billion SEK to combat drugs during 2000. This proportion has been exactly the same for years. In 2000 that corresponded to 702 million SEK (in 1999 689 millions and in 1998 673 millions). 869 persons were involved in drug issues in 2000. The customs, with 2 600 employees, has 1 080 persons involved in frontier defence. The cost of this year is not available.

Notes on Part I

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

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

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

2. Prevalence, Patterns and Developments in Drug Use

2.1 Main developments and emerging trends

Overview of most important characteristics and developments

With start in the early 1990s an increase in lifetime prevalence of drugs have been observed among youths. In grade 9 (15-16 year) this has meant a gradual change from 4% among boys and 3% among girls to 10 and 8%. This upward trend still holds true for the 18 year old male military conscripts. Recent data (2000) from the repeated study among 16-24 years old also indicate an ongoing increase at the national level.

The upward trend is followed by a steady increase in supply, at least for some drugs. This conclusion is made from a background of increases in seizures, stable or falling prices and anecdotal data from the field. Customs and police are aware of the fact that seizures do not reflect the full picture as their interfering routines varies. A rising trend in seizures can also be explained by introduction of new transit routes. This is believed to have happened with cocaine, as this market is relatively small in Sweden.

Amphetamine and heroin seem to be somewhat more available today than a decade ago. The same has happened to ecstasy and other party drugs, but from markedly low levels a decade ago.

For a number of years various types of statistical sources (on morbidity, mortality and criminal statistics and some local epidemiological studies) have suggested a slow but steady increase in the number of severe drug abusers. A national case-finding study was made in 1998 (CAN 2001). It has used the same technique, “capture/re-capture”, that was used in the two foregoing national studies made in 1979 and 1992. The latest study (published in 2001) underwent methodological difficulties that still are under discussion. The first study was carried out in all municipalities (277), the second in one hundred and the latest in forty-seven. It became necessary to save the comparability between the studies through a re-analysis by a new formula. Thereby the original figures in the former studies were adjusted upwards. In 1979 the number of advanced drug abusers were set to 15,000 (formerly 12,000), in 1992 19,000 (formerly 17,000). In 1998 the number is said to be 26,000. The difficulty the staff had to tackle demonstrates how uncertain this indicator is. However, most people in the branch agree that the population of advanced drug abusers has somewhat escalated. The question is how much. One problem is the increased rate of simultaneous abuse of illicit drugs and alcohol. It is very hard to distinguish severe drug abusers from alcohol abusers.
Emerging trends

When party drugs reached Sweden in the early 1990s it was soon postulated that this could lead to a new generation of drug abusers with a different background pattern (i.e. middle-class). Today, there are no obvious signs of any particular new group of teenagers experimenting with drugs. The scene has gone back to “normality”. Since an increasing number of youths try drugs, the number of middle-class youngsters doing so naturally becomes greater. Drug experimentation was proportionately rare in the 1980s. Those who became involved in drugs in that period were more likely to present a multi-problematic background than the ones experimenting with drugs during the latest years. From the field it is reported that those who today escalates into frequent drug use usually has a problematic background.

During the 1990s a new drug, GHB, has been spread among teenagers. It started among bodybuilders because of its alleged power to stimulate production of growth hormone. Later it was sold as a recreational drug. Teenagers found that it could be used together with alcohol. The spread of it has been restricted to two geographical parts of the country. This is comprehensible by the domicile of the sellers. Nearly all intoxications reported by hospitals have taken place in these regions. GHB was classified as a narcotic drug in February 2001. After that GBL and Pro-G have become the new GHB-problem. The regional reporting system for drugs (“CRD”) administered by CAN has only few reports of these drugs outside the affected regions.

A few years ago a growing interest was reported not only in ecstasy but also magic mushrooms and LSD. This has tapered off according to the CRD-system and other sources.

Availability of heroin is rising. Anecdotal data about heroin smoking has circulated in several years and are today verified in several parts of the country. It is supposed that heroin smoking started among certain groups of immigrants and socially excluded groups in the major cities. Field research in such group has been made in one town (Norrköping). It is reported (Lalander 2001). It was found that in that town the rise in the number of heroin abusers has been sharp. In 1994 only 4 persons used heroin. In 2000 there are 248 known users. In Norrköping amphetamine has always been the drug of choice for those with an advanced drug habit. So far most of the new heroin users are smokers, but some are hooked on the needle. In the beginning they could live a relatively normal social life with the habit, some with a blasé attitude, fast cars and fancy clothing. Ordinary life is coupled with criminality and drug selling, and it is obvious that not all of them can put a stop to a gradual decay. Similar results were found in another town, Malmö, a few years earlier (Tops and Silow 1997).

Multiple drug use including alcohol and pharmaceuticals is the most common form of drug abuse. However, a drug of choice usually exists. Experts state that multiple drug use has become more pronounced during the 1990s. But this could be disputed. Already in the 1970s it was more the rule than an exception that different sorts of abusers (cannabis, hallucinogens, heroin, amphetamine) used an array of drugs including pharmaceuticals and risk consumption of alcohol (Andersson et al 1986). At that time it should have been unnoticed if it had not been carefully recorded for research purposes. Today it is common knowledge.

Another theme highlighted during recent years in reports from the psychiatric treatment field is the very high prevalence of personality disturbances among drug abusers and the complications this means for treatment and prognosis (Fridell 1991, SBU 2001). NIPH has arranged an expert meeting about poly-drug use to highlight the phenomena (Folkhälsoinstitutet 1999).
Drug trends in a wider social context

The reasons for the growing interest in drugs among youths have been under debate. One reason might simply be a growing supply of new drugs with special attractions for young people. Drugs are often coupled with music, for instance rave music. Another is influence from overall international youth trends; increased levels of experimental use of the same substances have been observed all over the Western world. New trends are communicated very fast. The anthropological research mentioned above (Lalander 2001) showed with alarming clearness how certain films can influence and rule daily life in the gang.

Heroin (brown heroin) has become more available in later years. This has happened at the same time as youth unemployment rates and signs of social exclusion have risen. This is not an area that has been well researched yet, but media has covered signs of discrimination and segregation in suburbs of the larger cities. On an aggregated level this might be one possible explanation of the increase in heroin use that is reflected in statistical indicators (Lenke and Olsson 1996). Another problem stemming out of higher unemployment rates is that the rehabilitation process becomes more difficult as occupation is a means to get out of drug abuse as well as the target for the rehabilitation process. However, youth unemployment rates has not reached such alarming heights or existed so long that it is believed to explain the growing interest in drugs. At least not in party drugs. In the latest years the economy has developed in a positive direction, which should result in better employment rates. Those who have dropped into drug abuse may nevertheless have difficulties get on the train.

Certain drugs have special cultural connotations. One of these drugs is khat. It was classified as a narcotic drug in 1989. Use of khat is limited to immigrants from the Horn of Africa (East Africa), particularly from Somalia (an unpublished examination of sentences coupled to khat showed a couple of years ago that all cases involved Somalis). Seizures have increased throughout the 1990s and in reached a peak in 1999. In 2000 3,583 kilos was seized by customs and police.

Opium is another example of a drug with a cultural connotation. Opium is used by immigrants from the Middle East and Balkan. The drug has not gained much attention, probably because its use has been kept in close circles and not reached street level. During the last five years an annual average of 12 kilos have been seized. Most cases of smuggling have involved persons from Iran or of Iranian heritage.

Traditionally drugs have entered Sweden in the south and coming from EU member states. This is still so, but the origin of those drugs (synthetic drugs like amphetamine and ecstasy) has to some degree seen a shift to countries in the former Eastern block. However, the traffic has not reached the level that was postulated some years ago. Domestic production of illegal drugs is very rare. A limited number of cannabis cultivators have been detected, though.

2.2 Drug use in the population

General population

Polling institutes have carried out face-to-face interviews on drug use in the general population throughout the years using slightly different methods and intervals. Since 1994 they are conducted every second year, the last in 2000. The figures fluctuate from year to year due to
small samples and a non-response rate around 30%. This is most marked when results is broken down in smaller groups. Anyhow, they still give some rough estimates on prevalence, especially seen together in year series. In the annual report “Drogutvecklingen i Sverige” (issued by CAN and NIPH), that presents a collected view of drug statistics, this fluctuation is compensated for by using running three-year averages.

About 12% of the general population aged 15-64 reports lifetime prevalence for drugs (this was elaborated in the last National Report). Lifetime prevalence is slightly higher in the age group 15-34 compared to the total. This is an indication that people nowadays 40 to 50 years old tried drugs during their adolescence at a time when drugs, mostly cannabis, were spread in wider circles. Broken down to 25-34 and 35-44 years we find those with the greatest lifetime prevalence, namely 17%. Persons over 55 very seldom have tried drugs. The proportion of drug experienced in the 15-24 and the 45-54 year group were 11%.

Special telephone interviews are made among young persons aged 16-24. In the years 1996, 1998 and 2000 it was relieved that 9, 11 and 13% had used drugs. The methodology used differs from that used in the previous surveys, so direct comparisons cannot be done.

Less than 1% of all respondents 15-64 have used drugs during the latest twelve months. In surveys in 1998 and 2000 respondents also were asked if they had used drugs the latest 30 days. Practically none had done that.

School surveys, students grade nine

School surveys have been carried out annually since 1971. A sample of about 5,800 pupils is enrolled and the non-response rate oscillates between 10 and 15%. Pupils fill in a formula during school ours and put it an envelope that are sent to CAN. The procedure guarantees anonymity.

Reported lifetime experience was highest in the early 1970s, about 15%. It thereafter dropped to about 8% and in the late 1980s it reached its lowest level at 4%. From that level it has again raised and is now 9% (10% for boys and 8% for girls) (Andersson et al 2000).

Cannabis is the most commonly used drug, and in about 2/3 of the cases the only drug used. About 1% has experience of amphetamine, ecstasy and LSD.

Last month prevalence was reported by about 3% during the 1970s. After that it has been lower, in 1994 1%. From that point it has increased to 3% among boys and 2% among girls the last two years.

Military conscripts

Surveys have been carried out since 1971. Practically all men aged 18 are called for an examination and this survey are only one of several they are handled. This particular survey is however separated from the rest and with guaranteed anonymity sent to CAN. Non-response rate has normally been about 10% (Guttormsson 2000). The development follows that from grade 9 (illustrated in last years National Report).

The last reported survey is from 1999. Lifetime prevalence was then 17%, which is in parity with the early 1970s. 90% of them had used cannabis and about 2/3 had done only so. 4% of all conscripts hade used amphetamine and pharmaceuticals (tranquillizers, sedatives). 2% had used ecstasy and LSD. 1% had used cocaine and heroin.
Last 30 days prevalence had increased from less than 1% in 1992 to 3% in 1999. In the early 1970s the proportion was about 5%.

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

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

**Gender differences**

In the general population almost twice as many males than females have tried drugs. This difference is also seen among young adults, but in grade 9 the difference is very narrow. There are also marked differences among severe drug users, % of the population are males. This is shown in national case-finding studies and has also been reported from treatment agencies.

Women have the lowest ranks among drug abusers (Lalander 2001) and often show a multi-problematic background with early traumas and a stormy puberty with an early drug debut (Trulsson 1998). They also have a troublesome way in the rehabilitation process (Bergström 1998). In later years this has been highlighted in the treatment arena.

**Geographical differences**

Experience of drugs is more common in larger cities. This is most marked when it comes to hard drugs as amphetamine and heroin. Cannabis is the only drug that can be seen all over the map. In the two first national case-finding studies in 1979 and 1992 80% of the most severe drug abusers were found in the three metropolitan areas (Stockholm, Gothenburg, Malmo), and 60% of all counted. In the 1992 study no direct measure is given, but there are indicators pointing at the same level. In the study from 1998 this was down to 65% for all counted. As the population has added life years and years in drug abuse it is possible that a greater proportion of the population has reached more advanced levels of drug abuse than in the earlier surveys. The explanation for the eventual spread of severe abuse is hard to give. One explanation could be that drug abusers nowadays find it easier to support their habit in smaller or at least middle sized towns or that drug abusers from the biggest cities move away for one or another reason. Among military conscripts are those who live in the mentioned areas more experienced with drugs.

**Other differences**

In grade 9 pupils that have tried drugs are more often reported to have felt uncomfortable in school (15% compared with 5%), their results are below average (41% compared with 16%) and they skip classes several times a month (38 to 9%) (Andersson et al 1999). Those who had left school after 9 years (instead of 12) had tried drugs in a larger extent (34 to 15%). Immigrants with Swedish citizenship and persons with at least one immigrated parent had to a larger extent tried drugs than indigenous Swedes (22 to 15 %).
2.3 Problem drug use

National and local estimates

Nation-wide studies aimed at assessing the number of drug users are not carried out on regular intervals. Studies have been carried out in 1979 and 1992 using the same technique, capture/re-capture. In these studies all drug users known by different authorities were reported (UNO 1979, Olsson et al 1993). The results have been reported in earlier National Reports and are mentioned above. A third study was carried out in 1998. However, this was carried out in only 47 municipalities and it was discovered that the technique used (which tried to emulate the technique used formerly) should be compensated for in an intricate way. Doing so it was shown that the number of severe drug abusers successively has increased. The 1998 study (“MAX”) will be able to publish a report about background characteristics, facts that were not collected in the two other studies.

There are only a few local epidemiological studies covering severe drug abuse, and they are not done with regularity or with a technique that could link them to other studies.

In Stockholm case-finding studies has been carried on since 1987. Between 1996 and 1998 the number of drug users were the same. In 1996 4.6 drug users per 1,000 inhabitants were reported. Corresponding figures for 1997 and 1998 were 4.7 and 4.5 (Finne 2000). This is a result that somehow opposes the MAX-results.

A repeated study in Uppsala 1997 and 1999 (Winfridsson and Dahlman 2000) found no differences in the number of drug abusers: about 1,900. Out of those 491 were classified as severe abusers (2.5 per 1 000 inhabitants aged 15-64) in 1999, which was a decrease with 30%. The research team discusses this decrease and argues that it partly can be explained by missing data (“don´t know”-answers) for some crucial variables. The next survey will probably sort this out.

Risk behaviours

Severe drug abusers lack socio-economic resources. They are often recruited from marginalized groups and after many years of isolation within the drug abuse collective they have extreme difficulties to live up to common peoples expectations and demands. In the latest years this have been more distinct for everyone. After three decades with drug abuse there is more of them and they are more visible not only for the knowing eye but for everyone. In the metropolitan areas they appear on the streets as beggars and homeless people (Beijer 1999, SOU 2000:4).

In Stockholm, social authorities have shown (Finne 1998) that only 40 % of the drug abusers had an apartment of their own. Less than 10 % had working-related incomes. Social allowance was the most common legal support. The mortality among hospitalised users has been studied by Fugelstad et al 1997.
3. Health Consequences

3.1 Drug treatment demand

Data on treatment demand is scarce, but the National Board of Health and Welfare publish a report (in 2000 for the third time) based on the situation on a census day, 1/11 (Socialstyrelsen 2001). The report do not separate drugs from alcohol. 21,018 persons received treatment for abuse. In all, 49% solely misused alcohol, 29% solely drugs and 22% both alcohol and drugs.

Housing assistance was received by 27%, outpatient care by 55%, institutional care by 15%, habituation in private home by 1%, and compulsory institutional care by 1% (one person could receive different types of care at the same time). 29% of the clients were women. 240 persons received compulsory institutional care pursuant to The Care of Alcoholics, Drug Abusers and Abusers of Volatile Substances Special Provisions Act (“LVM”).

A system for collection of treatment data is under construction. The system, which adheres to the epidemiological key indicators (“Treatment Demand Indicator”) system (EMCDDA), will cover all units in 2004. A presentation of the introductory phase was made at an Expert Meeting in June 2001 (REITOX Project CT.00.RTX.21). A questionnaire was sent to all treatment units and 627 (70%) replied. The dominant treatment setting is outpatient treatment, with 302 units. Inpatient treatment has 192 units, special facilities within the criminal justice system 44 units and other forms of treatment 89 units. The number of drug abusing clients was distributed as follows: outpatient care 2 757 (70%), inpatient care 496 (13%) and other forms 714 (18%), which gives a total of 3,967 clients outside the criminal justice system.

The Drugs Commission (SOU 2000:126) has recommended that all treatment facilities must produce treatment data in accordance with the KIM-system (“Klienter I Missbrukarvård”), which is the Swedish version of TDI. The Government is researching the legal aspects of registration. There already exists another form for collecting treatment data (“Dokumentation av Klient”), which is more extensive than KIM/TDI, but with a limited spreading. However, the two systems can go together as all items in KIM/TDI is integrated in DOK. Addiction Severity Index, ASI, is also used in parts of the system. So far it is only KIM/TDI that are reported on a national level. Hospital data are available through the National Hospital Discharge Registry at NBHW.

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

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

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

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

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

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

The trend of first treatment demands is a bit difficult to interpret. One of the obstacles is that there is no linking to the Discharge Registry prior to 1987. This means that it is not possible to control for treatment demands made before 1987, and that the figures, especially at the beginning of the time series, thereby are overestimating the number of first treatment demands made.

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

3.2 Drug-related mortality

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

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

The average age at death increased more or less steadily from 32 years in 1987 to 38 years in 1996. The following year it dropped below 37, and in 1998 to 35 years. The decrease coincides with the change of ICD revision and indicates that we might be looking at a somewhat
different population. On the other hand one could not possibly expect that no changes at all would occur, shifting into a new ICD revision. It seems that the consistency is acceptable under the circumstances and the populations approximately the same.

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

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

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

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

### 3.3 Drug-related infectious diseases

As described previous year, there are hardly any estimates on the prevalence of HIV and hepatitis among drug users. One study resulted in the following: overall seroprevalence were 14% for HIV, 75% for hepatitis B and 92% for hepatitis C. In another study 3% of 195 IDUs gave HIV antibody seropositive saliva samples. A third source determined the proportion IDUs infected with hepatitis C to 90%. In common for those studies is that they are conducted among small samples from metropolitan areas.

The number of reported cases of hepatitis and HIV/AIDS are centrally notified. A total of 5,368 HIV-infected persons had been notified at the end of 2000 and out of those 804 were intravenously infected and classified as IDUs (15%) (Smittskyddsinstitutet 2000).

The trend of incidence is a slightly decreasing one, both for intravenously infected and other transmission routes. In 1999 15 IDUs were reported, the lowest figure ever. The proportion of intravenously infected, compared to all cases reported, has decreased over time. Out of all 804 intravenously infected, a total of 196 persons had developed AIDS by the end of 2000. Out of those, 146 persons were deceased at the same point of time.

Between 1990 and 2000 a total of 1,032 cases of hepatitis B due to IDU have been reported, which comprise some 49% of all HBV-cases reported that period.

During the same period about 29,870 hepatitis C-cases was reported and out of those 19,822 was due to IDU (67%). The 2000 figure (1,341) was the lowest ever reported for HCV (due to IDU) but for HBV the 2000 figure was higher than the ones of the three preceding years.
3.4 Other drug-related morbidity

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

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

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

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

4. Social and Legal Correlates and Consequences

4.1 Social problems

Social exclusion and public nuisance

Apart from what has been said already in paragraph 2.3, there are not much existing data that can describe developments of problems with housing, unemployment and such, for drug users. The MAX project, that made a national case finding study in 1998, will go with a report of marginalized groups.
Nuisance problems cause local concern, and sometimes there are serial stories on this in the media. The normal picture presented is the one of an (older) drug using man, causing disturbances for the neighbors due many late visitors, car speeding, burglaries etc. There exists however no information of an epidemiological nature to describe this phenomena, but a state committee (SOU 2000:4) has presented its view on homelessness and a new report will be published within short. The National Committee for Public Health (SOU 2000:91) and the Drugs Committee (SOU 2000:126) has also paid attention to the situation for the most excluded.

4.2 Drug offences and drug-related crime

The number of persons suspected of offences against the Narcotic Drugs Act and the Goods Smuggling Act (only drugs included) has continuously been increasing since the middle of the 1980s. A total of 6,567 suspected persons were reported during 1985 and in 1999 the corresponding figure was 12,470 persons. The hump in the statistics in the early 1980s is an effect of extra efforts from the police on the street/user level. Due to changes in database routines at the police some data are only available up to 1998.

In 2000 the police registered 32,423 violations to the Narcotic Drugs Act (3 % of all crimes). This has been stable during the last decade. The number of violations to the Goods Smuggling Act was 350. This number has decreased with 85 % since 1980 (2,300 violations).

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

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

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

The number of sentences (including summary convictions) for offences against the Narcotic Drugs Act or the Goods Smuggling Act (only drugs included) has increased, from 2,601 in 1975 to 10,377 in 1998 and 12,470 in 1999, (Brottsförebyggande rådet 2000a).

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

Since 1988 information on imposed sanctions are available and the proportions between different sanctions have been more or less the same. In 1998, about 38% of the sanctions led to fines, 27% to prison, and some 14% to prosecution waivers or probation respectively, and finally, 8% led to other sanctions. The most common length of imprisonment in 1998 was from two to six months.
On a census day (1 April) 1,336 prison inmates were classified as drug users in 1985 (according to information captured at the prison admission). Of all inmates the proportion of drug users were 37% that year (Kriminalvårdsstyrelsen 2000a). A drug user is here defined as someone having used drugs at least once during the twelve months preceding the imprisonment. That share was pretty stable between 1986-1996 (some 40-42%) but rose to 50% in 1998 and dropped slightly to 47% in 1999. In absolute numbers 1,652 inmates out of 3,537 were classified as drug users. Before 1997, the period in question was only two months, which partly explains the higher level. The number actually sentenced for drug crimes is lower, about 1/3 during the latest years (Kriminalvårdsstyrelsen 2001).

In 2000 a total of 9,200 persons were in prison at any time during the year. More than half of them were drug users and out of those 75% were classified as severe drug users (injected drugs at least once during the twelve-month period before imprisonment or daily or almost daily drug use no matter what routes of administration). In 1990 the corresponding number were 14,300.

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

4.3 Social and economic costs of drug consumption

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

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

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

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

5.1 Availability and supply

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

According to analyses of seizures (police and customs together 1181.787 kilo) made at the National Laboratory of Forensic Science approximately 75-90% of all seized cannabis originates from Morocco. Distribution routes often go through Spain, the Netherlands and Denmark. Swedish citizens living in Spain and the Netherlands many times control the transactions. Operators from the Baltic States have also been identified. MC-organisations are still involved in the cannabis trade. In 2000 police and customs seized 1,241 kilo cannabis (6,050 seizures).

The Police have investigated 53 cases of home growing during 1999 and 45 during 2000. Apart from being an increase compared to earlier years it is also stated that the home growers are becoming more professional.

For many years, most of the amphetamines seized in Sweden originated solely from two regions, Belgium/Netherlands and Poland. In 2000 11 laboratories was detected in Poland, and amphetamine manufactured in Poland has dominated the Swedish market in 2000 (50% of the number of seizures). During recent years amphetamines produced in the Czech Republic have been seized in some extent. Seizures from Estonia has also increased, it is however not known where this amphetamine has been produced. It has been detected in Sweden, Finland (95% of all amphetamine) and Norway. During 2000 5 laboratories has been detected in Estonia. The number of seizures in Sweden is slowly raising (4,978 in 2000) but the amount of amphetamine is the smallest in ten years (108 kilo).

The main markets for heroin are the Stockholm and Malmo regions, even if there have been increases in heroin use in other regions, especially Gothenburg. About 90% of the heroin seized is brown, mainly transported through Eastern Europe and seized by Scania customs. White heroin often arrives by air (postal packages or couriers) and the use and seizures of white heroin is concentrated to the Stockholm region. A new scenario arising is white heroin coming from St Petersburg via Finland, not yet of any significance though. During 2000 police and customs seized 30 kilo (1,264 seizures).

Cocaine has not attracted the market in Sweden in any larger extent. The number of seizures is relatively low (in 2000 405), however the quantities might sometimes be very big, 50 kilo in 2000, but 420 kilo in 1999 indicating it was meant for another market (400 kilo was discovered in a container supposed to contain only bananas). Most cocaine seized by the customs is taken in Stockholm and Gothenburg.

Even though there are signs of new distribution routes arising, via Eastern Europe for example, it should be emphasised that the vast majority of the seizures made by the Customs are made at the border of a member country of the European Union.
The best indicators to describe trends in availability of drugs at hand are seizures and price. It can already here be stated that these sources suggest that there has been an increase in availability, at least for some drugs. This seems reasonable considering the increase in demand that has paralleled the increase in availability.

5.2 Seizures

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

A well-known fact is that the Police make the large majority of all seizures but that the Customs seizes the big quantities. Data on seizures are collected from the BAR database at the National Criminal Investigation Department.

The number of cannabis seizures made by the Police and the Customs fluctuated between 4,000-5,000 during 1985-1998. The 1999 figure (5,989 seizures) was all time high. In 2000 the figure was 6,050. Almost 1,200 kilo (1,191) were seized 1999, which is about twice the normal average for the 1990s as well as the 1980s. This figure is only outscored on two earlier occasions during the early 1980s. Apart from the high levels in 1999, cannabis seizures have been fluctuating for quite some time, without any obvious trends. In 2000 it was raised to 1,241 kilo (at 6,050 occasions).

In numbers, seizures of amphetamines have been on a stable increase all since early 1970s. During the 1990s they have gone up from approximately 3,000 to 5,000. The amounts have been fluctuating but a comparison of averages from the three latest five-year periods reveals an increase from 110 kilo a year during the second half of the 1980s, to 140 during the first of the 1990s, and 170 during the second part. In 1999 124 kilo was seized at 5,073 occasions, and in 2000 108 kilo at 4,978 occasions.

The (low) numbers of cocaine seizures have increased between 1985 and 2000 (from 25 to 405) as the size of the seizures have. At average, 12 kilo a year was seized during the 1980s and the corresponding figure for the 1990s were 140 kilo, partly explained by two major seizures in 1991 (226 kilo) and 1999 (420 kilo). In 2000 50 kilo was seized at 405 occasions. There are considerable fluctuations in the quantities seized, and many of the larger seizures have probably been intended for further transportation to markets outside Sweden (Rikskriminalpolisen 2000 and SOU 1998:18). This is perhaps not unique for cocaine, even though it might apply even more for this than other drugs.

Heroin seizures have continuously increased since the mid 1980s, from approximately 160 to 1,200 late 1990s. Comparing the latter part of the 1980s with the latter part of the 1990s reveals that the yearly average for those periods have then-folded, from 3 to 30 kilos. Some possible explanations to this increase might be new routes for the heroin traffic to Norway and improved intelligence work. In 1999 64 kilo was seized at 1,244 occasions, in 2000 30 kilo at 1,264 occasions.

At the beginning of this chapter it was stated that the Police makes the majority of the seizures in numbers but that the Customs makes the majority of the seizures in size. Presented in percentages per drug reported on above, with numbers first and quantities last, the police took 78/33 of the cannabis, 97/58 of the amphetamines, 74/31 of the cocaine and 95/36 of the heroin, at average during the 1990s.
Worth mentioning is the fivefold increase in seizures of pharmaceuticals controlled according to the list of drugs (mostly tranquillisers and sedatives). Between 1985 and 1999 the number of seizures rose from about 500 to 2,600 and 2,700 in 2000. The large majority of those medicines were of benzodiazepine type and the dominating make is “Rohypnol” (flunitrazepam).

184,161 ecstasy tablets were seized at 544 occasions during 2000. The most common compound in the tablets was MDMA. LSD is uncommon. During 1999 35 seizures were made and in 2000 64. According to a youth clinic in Stockholm LSD is not as usual as in the beginning of the 1970s.

During 2000 1,777 kilo khat was seized (at 186 occasions). The corresponding figures for 1999 were 3,373 kilo and 304 occasions.

Information about GHB is scarce, but during 2000 about 100 seizures was made.

5.3 Price and purity

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

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

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

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

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

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

6.1 Cannabis

The availability of cannabis seems to have been quite stable throughout the 1990s, according to seizures and price developments seen in longer perspective. In 1999 and 2000 cannabis seizures were by all means exceptionally big, both in numbers and kilo, but temporary fluctuations have been seen before and one must not jump to conclusions using data from a single year.

It is however a well-established fact that during the 1990s, a growing number of younger people state that they have tried/used cannabis. In 1999 8% of grade 9 students and 16% of 18-year old male military conscript reported this, while some 12% of the total population aged 15-75 reported lifetime prevalence of drugs in 2000. In most cases this is synonymous with cannabis. Whether the severe drug users, of whom many are frequent cannabis consumers, have changed consumption patterns is not known, but to say the least, no information available indicates a decreased demand in cannabis.

An alternative source to smuggling is domestic production. Some signs indicate that both small and medium scale home growing have increased. One example of increased home growing is that the (relatively low) number of military conscripts stating that they grow their own cannabis has doubled during the 1990s. During 2000 the police investigated 45 cases involving home growing. The production has become more professional. This might be explained by the fact that seeds, growing instructions and equipment have become more easily available recent years, not the least with the growth of Internet as a partial explanation.

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

Availability of amphetamines has no doubt increased throughout the 1990s. 4,859 seizures was made in 1998 (135 kilo), 5,073 in 1999 (124 kilo) and 4,978 (108 kilo) in 2000. Prices have dropped substantially at the same time as seizures have increased, both in numbers and amounts. After cannabis, amphetamines have always been the second most common drug experienced by the Swedish population. Approximately 2% of those 16-64 years old have reported lifetime prevalence. According to various surveys amphetamines also rates second among youths, and is increasing in magnitude. For example, less than 1% of the military conscripts reported lifetime experience of amphetamines in 1992 and that figure was four folded in 1999 (3.5%).

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

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

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

Information from Härnösand and Gothenburg hospitals, areas with pronounced GHB-problems, indicated drops in the emergency room visits due to GHB during winter 1999/2000 (Folkhälsoinstitutet 2000). Whether these drops were temporary or not, or whether this drop will be boosted by the new legislation, is too early to tell, just as they can not be generalised to the situation in other cities. A later report (Folkhälsoinstitutet 2001a) has researched GBL. During 2000 132 seizures of GHB were made.

6.3 Heroin/opiates

Several sources indicate an increase in heroin use during the 1990s (for example mortality and morbidity figures as well as criminal statistics). Two local studies, one in Stockholm (Käll et al 1996) and one in Malmö (Tops and Silow 1997) have showed that the proportion of opiates among severe users has increased on the expense of amphetamines, and that opiates nowadays are more common among the younger generations of severe drug users than amphetamines are. Many of the new users smoke the heroin, at least initially. A new report from a research project in Norrköping show a similar situation (Lalander 2001). Sources in the treatment field report that many heroin users change from smoking to injecting and a major reason for this is that heroin prices are still relatively high and that injecting is more cost-effective.

The sharp increase of heroin seizures during the 1990s, both in numbers and kilos, paralleled with a decrease in prizes, suggests that heroin has become more available on the market. According to a source in the police, 4-t tonnes are smuggled into the Nordic countries every year (Svenska Dagbladet 2001-10-02). Still no spread outside the “traditional” user groups has been traced. Lifetime prevalence in the general population is practically zero and despite of an increase during the 1990s, the lifetime prevalence among the military conscripts is still below one percent.

6.4 Cocaine/crack

Cocaine is the third most common drug experienced in the adult population. This drug has never won any popularity among severe drug users. It has rather had the reputation of being an expensive jet set drug for celebrities in the major cities.

Seizures have increased during the 1990s, but with fluctuations that are not that easy to interpret. In 1999 420 kilos was seized, an exceptionally large seizure and just as much as the total of the previous years during the decade. As stated before, at least parts of these seizures must have been intended for other markets than the Swedish one. Cocaine prices have remained more or less the same throughout the 1990s and no significant increase in use have been spotted in surveys or other types of data.
6.5 Multiple use (including alcohol, pharmaceutical products, solvents)

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

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

As already mentioned, there are many signs of an increase in the use of particularly medicines during the 1990s among severe drug users, especially benzodiazepines. The number of medicine seizures five folded in numbers between 1985 and 1999 (from about 500 to 2,500). A total of 175,000 tablets were seized in 1999 and 351,629 in 2000, most of them tranquillisers and sedatives of benzodiazepine-type. About one third of all police seizures and half of the customs seizures in 1998 (of pharmaceuticals) were flunitrazepam tablets of the make “Rohypnol”.

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

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

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

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

7.1 Consistency between indicators

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

A quite obvious trend observed in regular national surveys during the 1990s is the increase in lifetime prevalence of drugs among Swedish teenagers. Among students in grade 9 (15-16 year-olds) the lifetime prevalence of drugs increased from 3% in 1989 to 8% in 1999 and 9% in 2000. During the last three years the lifetime figure has been pretty stable, though. The increase among girls seems to have halted since 1996 while boys still show a small increase.

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

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

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

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

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

A few indicators also show an opposite development. The number of persons intravenously infected by HIV has declined during the latter part of the 1990s, from a yearly incidence of above 30 per year during the first half to below 20 during the second half. Also hepatitis C has declined or at least stabilised during the latter part of the 1990s. The decreases could be due to changed risk behaviour among IDUs due to massive testing and information campaigns. It could partly also be an effect of a stabilised situation after the initial phases of these infectious diseases. These opposite trends have however not been proposed as evidence of a decreased IDU of any researcher in the drug field.
Apart from general statistical indicators also other type of information sources (local studies etc) suggests that the recruitment of severe drug users is on the rise, particularly heroin users. However, it is too early to draw any specific conclusions on the extent of the increase from this information.

The two national case-findings from 1979 and 1992 suggested that there had been a 40% increase in severe drug use between those two years. It is questioned and debated whether the national estimates from 1979 and 1992 are accurate or fully comparable. This is a subject for further analysis and that has also happened to the MAX project in 1998. Most signals point to an increase in drug abuse, but it is felt that the national case-finding studies do not answer the question as accurate as needed.

7.2 Implications for policy and interventions

Possible hypotheses for the main trends

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

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

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

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

The increase in supply that has occurred for several drugs during the 1990s highlights the importance of co-operation across nation borders. A growing global drug problem demands international solutions. The international engagement in drug issues, that Sweden takes part in, is therefore an integrated and important element in the Swedish drug policy (SOU 2000:126).

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

There have not been many careful systematic evaluations done on how research and experience in the field have had impact on policy and interventions. Researchers sometimes accuse politicians of not taking notice of new results and findings, or for doing so in highly selective ways. Public opinion, and how it is formed has been analysed (Hübner 2001).

But there are another side of the coin. It is obvious that politician makes extensive use of material in the Report-series; a compilation of alcohol and drug related statistics produced by the NIPH together with CAN. Many of the motions submitted and newspaper articles penned by politicians are based on the series. Drug policy is part of general welfare policy and, as such, is seen by many as a measure of how well the aims of welfare policy are being met. Comparative figures are therefore often requested. This might be accentuated in the spring 2002 when the reports from the National Committee for Public Health and the Drugs Committee are discussed in the Parliament when a new Action Plan on Drugs is supposed to be decided.

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

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

7.3 Methodological limitations and data quality

Methodological limitations and priorities for future work

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

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

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

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

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

Also the final interpretation might be difficult to make. For instance, it is not that easy to establish in what extent an increase in mortality and morbidity are due to more dangerous drugs (or combinations of them), increased health problems among the ageing group of drug addicts or an increased number of them. As mentioned earlier, reports from professionals dealing with active drug users indicate that they might be physically worse off than before, and therefore more visible. A fact that speaks for a real increase in the number of drug users is that the number of younger persons arrested, treated etc has increased.

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

The Drugs Commission has published a report (SOU 1999:90) specifying needs of improved statistics. The proposals included routine surveys in the general population, a new data collection system to gather information on the Social Services contacts with drug users, as well as the obligation of treatment centres to provide information on the clients to a central register, and a new data register to monitor the developments of drug related deaths. There are also proposals that methods to monitor price and purity on a regular basis should be further investigated. Other tasks of the Drugs Commission are to evaluate the achievements on drug demand reduction and to propose future reinforcements to strengthen the efficiency of the drug policy. Legislation, methods used in the judicial as well as the treatment system and the preventive work will be evaluated and the interplay between different sectors, levels and actors in society will also be given attention.

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

8. Strategies in Demand Reduction at National Level

8.1 Major strategies and activities

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

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

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

Also legislation and the implementation of the legislation are considered important. Prohibiting drug use gives a clear statement that drug use is not accepted by society. However, demand-reducing measures are not confined to information, prevention and treatment. Maybe the most important factor is the general welfare policy. The drug policy, recognised as a part of the social policy, should be combined with a policy preventing unemployment, segregation and social distress to grow. A positive environment to grow up in might be among the most important preventive measure of them all. This is emphasized in a report from the National Committee for Public Health (SOU 2000:91).

8.2 Approaches and New Developments

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

The Internet has also become a powerful tool for information dissemination. Press releases, research results, news articles and books can easily be obtained. The possibility of downloading selected raw data from databases is an interesting feasibility for researchers as well as another in the field of drug prevention. A number of such examples already exist today.
It is difficult to pinpoint recent socio-cultural developments relevant to demand reduction changes, just as it is difficult to spot any substantial changes in public opinion on drugs and the drug policy.

9. Intervention Areas

A selection of recent events, new approaches and programmes, and descriptions on progresses are presented below. This chapter does not give a complete picture of the state of Swedish demand reduction interventions. If some items of certain interest not are described in detail, or at all, more information on the subject still might be available in previous National Reports or at the Focal Point, NIPH. The field of public health as well as its subdivision drug abuse is undergoing a major re-organization that will be put in action during 2002. The new drug policy will have practical implications on national as well as local level.

9.1 Prevention

9.1.1 Infancy and Family

No new information

9.1.2 School programmes

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

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

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

A new preventive school project in 8th grade was launched by a foundation called Mentor in 1999. The project was called “First Aid” and was an attempt to work with information and education on alcohol, drugs and tobacco in a new and creative way and to make the students reflect on the importance of peer pressure, lifestyles and attitudes when it comes to substance use. The project is going on, now called “Re-Act” and is less focused on parental approaches as it was before, but with a new extensive handbook for the teachers with a number of proposals on lessons on drugs that could be held in various subjects. The students has been invited to participate in a contest, recording their own advertising film. The winning class had
their film professionally re-recorded by a famous director of pop-videos (www.re-act.nu). This method is used since it is believed that traditional lectures do not have any significant influence on young people’s behaviour. This is in accordance with an expert report from the National Agency for Education about drug education (Skolverket 2000). This report is discussed under paragraph 10.2, as well as an overview on research on information and education campaigns released this year.

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

9.1.3 Youth programmes outside schools

No new information

9.1.4 Community programmes

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

9.1.5 Telephone help lines

There are no manned telephone help lines for narcotic drug issues available but the Drugs Commission (SOU 2000:126) has recommended that NIPH shall investigate the need for it.

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

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

9.1.6 Mass media campaigns

No new information

9.1.7 Internet

Drugsmart is an interactive Internet site for pupils grade 7-9, their teachers and parents, started by the MHSA late 1998 (www.drugsmart.com) and re-located to CAN in 2000. Drugsmart has been evaluated and found highly appreciated. On the negative side, it was found that only a limited share of the teachers responding to the survey knew the existence of Drugsmart. The final conclusion of the evaluating team was that the project was promising enough for a continuation, but needed better marketing to make more people aware of its existence (KAN AB 1999).

Facts, downloadable reference materials for schoolteachers, answer to FAQ’s, a game, an interactive ”web soap opera”, a chat room and links are available at Drugsmart. An “open for all” discussion board is also frequently visited and the editors answers e-mailed questions.
Maybe the most exciting news about Drugsmart is the educational package called eMediate-ANT (Alcohol, Narcotics and Tobacco). It is a two-hour lesson, held live on the web in the school’s computer room, with openings for a follow-up. The package contains three short introductory films, interactive value related exercises and a direct chat contact with the supervising Drugsmart staff. The chats are summarised by the staff and e-mailed to the responsible teacher together with requested materials and suggestions on how further education could be done. Information on eMediate-ANT has been disseminated to the schools and successful pilots have already been held, and at the present at least one lesson a week is being held.

The Internet based news agency DrugNews, earlier solely run under an NGO called RNS, is now also sponsored by the IOGT-NTO. It is located at web site of its own (www.drugnews.nu). Important news are free, weekly disseminated e-mails containing summaries of the most important recent articles. Another important improvement is that that all articles are stored and easily searched in a database on the web site. A further web site is www.ihanna Sweden.com, which is presented both in Swedish and English and including news coverage. It also has a subscription system.

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

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

It is also a fact that there are an increase of relevant data and material to be found on the Internet and it is not as common as a few years ago to hear warnings about the negative influences that the Internet mediates. Databases on research, library databases etc, makes information access easy and almost instant. The Internet is also a valuable tool to disseminate new information such as press releases. Added to this might also be statistical databases being built up. One example of this is the web site of the NCCP, where one can extract and download statistics on certain types of crimes in certain regions (www.bra.se). Another similar example is the great number of databases held at Statistics Sweden (www.scb.se), providing downloadable raw data on many different issues, general population data as well more specialised information.

9.2 Reduction of drug related harm

9.2.1 Outreach work

Outreach work within the Social Services as well as within the medical treatment sector was far more common some 10-15 years ago, when the massive campaign for drug treatment was launched in the wakes of the arising HIV epidemic (Offensiv narkomanvård, “The Offensive”). About 100 specialised drug treatment units were built up during the mid 1980s in the municipalities and outreach work was one of the priorities. The Governmental funding for the campaign was liquidated early 1990s in a moment of economic recession and the municipalities became fully responsible for the continuation of the campaign. A substantial decrease in the outreach and motivation work has thereafter been noted (Narkotikakommissionen 2000c). Two studies aimed at investigating the present situation on the outreach work is also in progress at the NBHW.
Examples of opposite developments can however be found, one of them the Female Project in Stockholm (Kvinnoprojektet). In January 2000 the Social Services of Stockholm started an outreach project in order to reach homeless women, of whom many have few or no contacts at all with the Social Services. One of the aims is to motivate the women to increase their contacts. Since one of the field workers is an assistant nurse, simple medical help might be an initialising contact. The project is a joint venture between the Social Services, voluntary organisations and the medical treatment sector, since it is believed to be of importance that all responsible authorities are involved. (More information on women and outreach work can also be found under paragraph 9.6.)

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

9.2.2 Low threshold services

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

9.2.3 Prevention of infectious diseases

Needle exchange programmes are operated at clinics for infectious diseases in hospitals in Lund and Malmö as a means to combat Hiv/Aids among IDUs.

During the start of the Hiv/Aids epidemic in the first part of the 1980s, immediate actions were taken. The organisation that was built up at that time has gradually been reduced. Under the pressure of the development in the Baltic area and Russia it is probable that a new start is about. NIPH has arranged an expert meeting to put light on the alarming situation Folkhälsoinstitutet 2001b). In 2000 16 new HIV-cases were detected. Today 804 IDUs are Hiv-positive. Of these 196 have got an Aids-diagnosis (146 are deceased).

9.3 Treatment

9.3.1 Treatments and health care at National level

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

Methadone substitution programmes are operating in Stockholm, Uppsala, Malmo and Lund. In 1993, 430 patients were receiving treatment on a census day (last December). The figure has now passed 600.

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

A number of patients have in limited pilot studies been treated with Subutex (Buprenorphine). So far the outcomes have been regarded as positive and in 2000 a somewhat larger study, including 40 patients, started at Huddinge Hospital, located in Stockholm. During the year Subutex has been used also in outpatient clinics sometimes under supervision from the methadone units or other drug facilities in hospitals. The Government will probably regulate treatment with Subutex.

9.4 After-care and re-integration

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

9.5 Interventions in the Criminal Justice System

During 2000 more than 5,000 drug abusers were placed in prison (but not necessary because of drug crimes). 4,000 of these were severe abusers. That implies that a considerable proportion of all severe drug abusers pass a prison every year.

As an alternative to prison, it is now possible to sentence such offenders to Secure Institutional Treatment in special homes for young people. The treatment is focused on social skills training, the family network, education, cognitive behavioural methods and more. The treatment plan is made up by the Social Services, but a court makes the decision whether Secure Institutional Treatment might be an alternative to prison. The treatment sanction is for a fixed period, determined by the crime committed.

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

About one fourth of all prisons reported in 1999 that drug use occurred “often or almost daily” while 66% stated it was rare or never occurring (Note that this is related to the number of drug abusers in the specific prison and that some prisons are specialised in drug abuse). In order to reduce drug use inside prisons searches and visitations are regularly held. Another important factor is to differentiate non-drug users and drug users trying to kick the habit from other prisoners, and to offer them drug free locations as far as possible (Kriminalvårdsstyrelsen 2000b). Screening tests is often used to detect drug use and keep drugs outside prisons. During 1999 a total of 110,000 urine samples was taken and in 2000 105,000,, making up to an average testing frequency of 2-3 tests a month per prisoner.

Special programmes are offered in order to motivate the drug users to become drug free, both individually and in groups. During 1999, a total of 1,900 inmates participated in programmes devoted to drug demand reduction motivation. That was reduced to 1,300 in 2000. The average time spent in such a programme is about 100 hours and the programmes can be seen as a start for more long-term treatment contacts. A special paragraph in the Prison Law (§ 34 KvaL; “paragraph 34-care”) states that the imprisonment might be served outside prison under certain conditions. The most common reason for such a decision is drug treatment and normally the treatment is carried out in some sort of institution. In 1993, about one third of all prisoners classified as drug users were in some of the above mentioned drug treatment programmes on a census day. This share rose to 45% in 1997 but is now back on the 1993 level again.

It is however not uncommon that a probational sentence, combined with institutional drug treatment, is used as an alternative to prison for drug users (kontraktssvård). During 1999 1,209 persons received such a sentence, and in 2000 1,147. Out of those, approximately one third was sentenced for a drug related crime.

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

At an early stage during the 1980s HIV-testing was implemented within the correctional system. Motivators and persons developing methods for handling the situation were employed. Nowadays this has been implemented in everyday practice. The number of HIV-infected persons in the correctional system on a census day has decreased from about 200 in 1988 to some 66 in 1999 and 73 in 2000, and out of those 19 and 17 was imprisoned.

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

It was concluded that the treatment plans displayed significant defects and the report states that it is of importance that the routines regarding treatment plans and other documentation are overlooked, as the activities within the programmes, especially the crime- and drug related ones. The ones with short sentences and many convictions seemed to be especially vulnerable and hence in need of special attention, despite the fact that this group of prisoners probably belong to the most difficult set of clients. It was also found to be of importance that the pris-
ons became more focused in their work concerning preparations for the release and to use available measurements in that work.

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

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

9.6 Specific targets and settings

Programmes for female sex workers

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

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

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

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

10.1 Quality assurance procedures

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

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

Another tool of the same kind is the Addiction Severity Index. ASI have been translated into Swedish and adjusted to fit characteristics typical for Sweden. It is believed to become an important tool within the Social Services. A recent improvement is a computerised version believed to be important for increased interest and a broad implementation. ASI is used in a varying degree in some 75 municipalities (of 289). The NBHW supports the implementation of ASI and are planning a follow up study on the implementation.

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

The EMCDDA project TDI is into its second year and the project shall be fully implemented in all units in 2004. The legality in a data register has to be solved before that.

10.2 Treatment and prevention evaluation

No developments have been made in the evaluation policy for treatment and prevention or in requirements for evaluation. Some evaluations of interest have however been released 2000, aiming at improving demand reduction activities.

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

A Danish overview of the international literature and research regarding various prevention and information programmes has been updated and translated into Swedish. It provides a pic-
ture of the present knowledge. Even if some approaches seem better than others, it is stated that recommendations on actions more promising than others are difficult to make. Three reasons for this are given; the context of the programme is often of great importance: short term, and especially long term effects, are hard to establish, and many evaluations show considerable methodological limitations (Thorsen and Andersson 2000).

A critical review of the literature on treatment of withdrawal, prolonged withdrawal, and treatment to prevent relapse has been to be released by The Swedish Council on Technology Assessment in Health Care. Recent meta-analyses in the field are assessed and special attention is given to interventions that either currently exist or can be easily introduced into the Swedish healthcare system. Mainly double blind, randomised controlled trials and meta-analyses based on such studies are included. Cohort studies and other naturalistic studies are also included to acquire information concerning long-term and economic analyses (SBU 2001).

10.3 Research

The last major change made was the establishing of SoRAD (Social Research on Alcohol and Drugs) at the Stockholm University in 1999, which has now attracted more researchers.

10.4 Training for professionals

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

This fact leads to a proposal on establishing a special training/education for professionals. The main idea is to educate treatment staff with qualified tasks as and/or being supervisors and instructors in practice, at the same time as they have a close relation to the research sector/universities. The Government is requested to establish such a master’s degree, founded on the preparations of the NBHW and the National Agency for Higher Education. The commission also points to a need to improve preventive work through education. NBHW and NIPH are supposed to investigate this.
Part IV.
Key issues

11. Poly Drug Use: Drug, Set and Setting

11.1 Patterns and user groups

**Combinations and effects sought**

Two patterns behind poly drug use may be seen. On group of users select and combine drugs in a particular and cunning way to get a certain “high”. Another group do not select, but takes what is at hand without thinking of the eventual consequences. The first group may be able to control their consumption, while the other is unable to do that.

It is well known among clinicians that one drug seldom comes alone. Most drug abusers use several drugs or at least a selection of. One of these is probably a drug of choice. When viewing drug abusers it is not always fully recognized that most of them are heavy smokers. A legal drug is not looked upon in the same way. Some of them also drink too much. Often this comes late in their drug career. It is obvious that certain pharmaceuticals play a distinctive role in drug abusers life. This starts early, sometimes before the formal debut in illegal drugs, and follows through the ages. The classical “OD”, or heroin overdose, is more often explained by a combination of drugs (very often including alcohol and pharmaceuticals) than an actual heroin overdose. Drug abusers take drugs, not a certain drug.

Why do they take all this drugs, why do they take them at the same time and how can change freely between them? Availability could be one answer. Prices another. Even beginners do rapidly get used to the drug-set-setting pattern; it is not only the effects of the drug, it is also the life around it. The positive signals are far stronger than the negative. Drugs or the effects of drugs are essential in this and thereby can the drug(s) develop into the central theme.

Perhaps cigarette-smoking is an example that shows that users are not fully aware of the dependent forming characteristics of drugs. They smoke, but not because they are dependent, they say, but because they are dying for a smoke (!!). Those who smoke tobacco usually develop dependence within a short time-span, which is alarming, as tobacco is often the first drug.

Recent biomedical research has studied the poly drug phenomena, and it seems probable that sensitisation has a part in this. The point is that one drug might clear the way for another. If you are used to one drug, especially if you are hooked on it, it seems you have trained your brain for the next drug. With many years experience it does not matter that much what kind of drug you take. The important thing is that you take something.
When rave-music made its progress and rave parties and party drugs were on the agenda many were surprised by these young people who freely used ecstasy but said no to alcohol. They had made a very distinctive selection to get a drug that harmonised with the music (which was the central theme) and even could enhance it. The dance pattern and the drug combined with the music gave an ecstatic experience. Ecstasy was relevant, but alcohol should have spoiled the experience. On the same ground it would be more or less impossible to have a positive evening using ecstasy in a pub. When you are in a position to choose you do that in respect to drug, set and setting either you are aware of it or not. Gradually, with more involvement in the scene, you loose your selective power.

It seem like the pioneering generation of rave-lovers have left the scene. One explanation that has been supposed is that they lost their “ecstasy-ability”, a known phenomenon when it comes to drugs. The honeymoon is over and it is not the drugs that has changed, but the brain. Some respond on this by leaving the drug scene, others change drug.

Some drugs go well with certain other drugs, and some combinations of drugs are very common. GHB often go together with alcohol, and heroin-smokers use tremendous amounts of cigarettes when they smoke. A common reason to use two or more drugs together is, namely, that they enhance or create a new drug effect. If the drugs are very similar they can sometimes, taken together, give the result that the high occur faster or are prolonged. Poly drug use can also be explained as “balancing”. If the drug of choice has hazardous and potent effect another drug could curb it.

New drug abusers learn this through contacts with experienced users and by testing. Knowledge about useful combinations of drugs is highly valued, and rapidly spread in their circles. To some extent poly drug use is more the rule than the exception, both among beginners and among experienced severe abusers, but the motive and knowledge may differ.

Patterns and user groups: historical perspective and new patterns

From the late 1960s to the early 1990s the dominating drugs were traditional drugs like cannabis, amphetamine and heroin. The common user stuck to one of these. As most drug abusers smoke tobacco it was natural that they also smoked cannabis. However, distinctive cannabis users were clearly seen. These groups had their own distinctive “culture”, and in specialised treatment units it was observed that they behaved somewhat different.

A follow-up of 562 patients (Andersson et al 1986) treated at a detoxification unit in a hospital and an outpatient clinic during the 1970s may illustrate the conditions in the early phase of drug abuse in Sweden. It is obvious that the drug market underwent changes during these years. The medical complications become more evident and patients behaved more often aggressive and deviant.

The research team could distinguish three “generations”. The first generation, 1970-1973, comprised of amphetamine abusers and hippies. Heroin in the shape of morphine base (by intravenous route) were also common. The second generation, 1974-1976, implied the introduction of heroin. Prostitution, criminality and internal fights became common. The third generation reinforced the tendencies from the second generation and heroin got a dominating role. Norms eroded and violence and loneliness took over.
It became more difficult to distinguish one group of users from another, as they developed into poly drug users. Analysis resulted in 21 different clusters of drug abusers. Few of these were comprised of patients that used only one drug. It surprised the team that “hippies” had to be separated into two clusters, as some of them (18 out of 55) had injected drugs. It was also surprising to see that a group of very young people (n=19), also from the first generation, clearly were separated out as “poly drug users”.

In the second generation a cluster (n=16) of older poly drug abusers was found. The other twelve clusters between 1970 and 1976 were more distinctive. They had used more than one drug, but to an insignificant extent.

In the third generation the tendencies were confirmed. Those who were new in drug abuse, and then very young, were characterized by personality disturbances and advanced drug habits.

It can be concluded that poly drug use is not something that has been seen only during the latest years. It shall also be noted that there were few patients that kept to only one drug. To be classified as a poly drug user it should imply it was difficult to sort out the preferred drug. Another prerequisite were the time aspect; it should not reflect a career perspective over several years but contemporaneousness.

In the national case-finding studies that were done in 1979, 1992 and 1998 it was registered that the majority of severe drug abusers that were counted also had an alcohol problem. Different combinations of narcotic drugs were also registered, and to an increased grade. Another indication of this is that persons sentenced for drug crimes more often have been arrested with more than one drug. In 1990 their proportion was 16%. In 1999 this was changed to 38%. The figures might be somewhat exaggerated as new detection techniques have been developed and urine sampling legal since 1993. Another signal is that registered diagnosis indicating poly drug use (nowadays ICD-10 codes F19.1 – F19.9) in hospital treatment has increased from 14% in 1987 to 20% in 1996 of all diagnoses related to drug abuse (CAN 2001b). As the classification system has changed there are some uncertainty in the figures. It is also possible that poly drug use is more observed today, and thereby registered more often.

Poly drug use is something that everybody seems to be aware of today but few find enough reason to investigate. An exception is substitution treatment, which adheres to the original entrance requirements put forward by Vincent Dole and Marie Nyswander and that means poly drug users are not accepted in methadone treatment irrespective the seriousness of the heroin problem. The investigation that takes place before the patient is accepted has as one of its targets to make clear the individuals career pattern. The boundary to amphetamine is clear and negative. For most other drugs the unwritten rule is to accept some secondary use (which is not the case ahead when the patient has been accepted in the programme).

Those who enter the methadone programme (today less than 700 patients) always have a very long career (the requisite four years documented heroin abuse is always well surpassed) and cannot be seen as poly drug abusers. It is probable that established heroin abusers who are not in substitution treatment are more involved in multiple drug abuse, but that is not researched.

Cannabis is a drug that practically all drug users are involved in. This has the consequence that it is not counted in this connection. Legal drugs as alcohol and tobacco also fall out, although it is not unusual in outpatient treatment to demand restrictions in alcohol consumption.
Young people that use party drugs may formally use several substances, but they are not aware of it as it is sold as “ecstasy”, and the effects are similar. During a long drug career it is usual that career stages are tread involving a shift in drug preferences. Thereby it has not attracted special attention.

11.2 Health and social consequences

Health consequences and negative effects

There is no systematic collection of data connected with poly drug abuse. However, NIPH has arranged an expert meeting (Folkhälsoinstitutet 1999) with the title “Double- and multiple dependence”. The meeting looked at biomedical, clinical and social aspects. Light was put on the correlation between alcohol and tobacco. Another theme was “sensitisation”, which means that drugs activates and sensitises the mesolimbic system in the brain, a system that is involved in “craving”. This could facilitate poly drug use and speed up the drug career.

Health consequences of poly drug use are foremost observed in detoxification units, as the eventual medical complications has to be taken into consideration. As mentioned, it is also paid attention to in methadone substitution treatment. Causes and manners of deaths have been studied (Fugelstad 1997, Fugelstad and Rajs 1998) and it has been showed that drug abusers who pass away have used more than one drug. In fact, this could have caused their death.

Specific social consequences for poly drug use

No available information.

11.3 Risk assessment and local market

The frequent use of Rohypnol (flunitrazepam) in combination with alcohol and/or other drugs among young people and drug abusers has attracted much attention as a violence-forming drug when it is used together with alcohol. This has lead to a sharpening of the classification for these products. Rohypnol is used together with alcohol or, by severe drug abusers, with heroin as it is said to potentiate the effect of heroin.

Combination of different substances

In a fact sheet about poly drug use that national authorities distribute (through CAN) the following combinations (based on the international literature and clinical experience) are mentioned:

11.4 Specific approaches to the interventions

In the national drug policy there is no difference between “light” and “hard” drugs, so poly drug use cannot be expected to gain special attention as such. It is quite another matter that it gets special attention in acute treatment situations and in planning after care.

11.5 Methodological issues

There are no data sources that put special emphasis on poly drug use, presumably because it has not seemed to be worth it. In most data collections, however, it is possible to see which drugs the respondents have used. This is collected to show the intensity of the drug problem, not to investigate if poly drug use is at hand (which is taken for granted).

Poly drug use is seen upon as a complication in the treatment process, and it is then often coupled to an observation that “double diagnosis” (drug abuse plus psychiatric disturbance) is very common. This is shown to affect the prognosis in a very distinctive way and also interfere with the single treatment episode (Fridell et al 1996).

12. Successful treatment

12.1 The approaches to treatments and the related concepts of success

The concept and criteria for success

The treatment system has been under press during the 1990s. Economic considerations have resulted in re-organisations and reductions. At the same time the results has been in question.

The Swedish Council on Technology Assessment in Health Care, “SBU”, a public authority that evaluate methods used in health care, has made a thorough analysis of methods used in alcohol- and drug treatment and their results. The study is a meta-analysis, i.e. a survey of the scientific literature not only Swedish, but from all over the world.

Relevant databases were systematically searched. Data from, mostly, double blind, randomised trials and meta-analyses based on such studies as well as cohort studies and other naturalistic studies that focus on long-term course (and economic analysis) were selected. The result has been published in two volumes (SBU 2001), and it goes without saying that it will influence political and economic decisions regarding treatment policies.

SBU says that the simplest preventive action that can be taken within a treatment perspective is “mini-intervention”, i.e. identifying risk consumption and then give professional advise and support. This method is not used in the extent it deserves. It is more successful with alcohol-than drug problems. SBU also say that many of the treatment methods often used methods
that have no proven effect and therefore should be replaced by evaluated, effective methods. SBU finally says that what is needed now is information, education and evaluation.

The Drugs Commission (SOU 2000:126) were able to read the manuscript before it was published and could thereby take it into consideration in its own conclusions and recommendations. The commission agreed with SBU. The political process has started and in the spring 2002 it will be known what reforms are at hand.

Drug abuse is less common than alcohol abuse, but it is still a serious problem, asserts in the SBU report. The National Committee for Public Health held the same view. Abuse is often developed into a chronic condition and the individual suffer from physical and psychiatric disorders. Hence, treatment must aim both at the dependency itself and at concurrent disorders, and may need to be repeated to prevent relapse and reduce injury. This goal, say SBU, is similar to the goals applied in treating chronic somatic diseases as diabetes and cardiovascular diseases.

In the SBU report presents a critical review of the scientific literature concerning the treatment of withdrawal, prolonged withdrawal, treatment aimed at preventing relapse, psychological and social therapy to reduce the rate of relapse, the role of institutional care, treatment of substance abuse during pregnancy and mini-interventions in primary care. Particular weight is given to interventions that now exists in Sweden or can easily be introduced.

Topics that not are addressed include: low-dose dependence on bensodiazepines, other sedatives and sleeping medications, effects of treatment aimed primarily at the physical complications of abuse or ways to limit accessibility of drugs.

The examination shows that simple screening interventions to identify hazardous consumption, combined with information and support is a valuable tool. This “mini-intervention” has a substantial effect compared with interventions required for other preventive programs. It was found that in 18 patients treated by medication for four years for an enlarged prostate it is possible to avoid surgery in one individual. In 128 middle-aged patients treated with medication for five years for moderately elevated blood pressure, it is possible to avoid cardiovascular disease in one individual. In 10 persons who are given counselling and motivation to reduce their alcohol consumption, one individual will cease or lower their consumption to a risk-free level. The principal steps in mini-intervention are: information about alcohol/drugs, personal responsibility, advice, menu (presentation of alternatives), empathy and self-efficacy (Bien et al 1993).

Psychosocial treatment can be divided into support, relearning and psychotherapy. Supportive therapies include information/advice, relaxation techniques, acupuncture, milieu therapy, case-management, pharmacological treatment etc. Relearning is based on learning theory and can use conditioning. The 12-step model is based on relearning. Cognitive therapy, family therapy and dynamic therapies are examples of psychotherapeutic methods.

Supportive treatment is often based on attempts to organize a functioning network among patients, caregivers, and family members. The treatment is not based on protocols, and the structure is usually inadequately described in the studies available. Supportive treatment is more effective in alcohol abuse than in drug abuse, and it is not effective in keeping people in treatment.
Relearning (often variations on behavioural therapy) is directed to change the behaviours behind abuse. This approach might require uniform standards for adequate education of the caregiver. Some techniques are based on written protocols and can be administered by individuals without special qualifications. Research has found positive effects for specific treatments and a lack of positive effects for standard, non-specific, supportive treatment.

Dynamic psychotherapies are effective in treating heroin abusers but not cocaine abusers. They are also the only methods shown to have the effect of keeping people in treatment, a primary measure of treatment effectiveness.

It is common to see pharmacological treatment as a complement to other interventions. Perhaps it is the other way around, or, that they are needed together. An indication of this is reports from methadone treatment, were it has been found that those programs that combine medication with psychosocial treatment have the better results.

In heroin abuse supportive actions has a diminutive effect. Relearning and psychotherapy have positive effects. Relearning has effects over a long perspective (12 months), while psychotherapy has its effects only in a short perspective (1-3 months). In cocaine abuse relearning has effect in 1 - 6 months and psychotherapy in 12 months. However, the effects are not radical, just provable. SBU found no report that could show effect on cannabis abuse. Nevertheless, treatment may have result. Time is a factor, and institutional care is better to reach a drug free result. Three months in treatment is an absolute minimum for this. Institutions with a good organised program can expect at least 50% retention grade during the first six months spent in treatment. For those who stay at least six months about 50% can be expect to be drug free one year after discharge. Programs with selected patients reach even better results.

Results can be maximized if the drug problem is focused, the treatment period is at least three (or readily six months) and the interventions are structured and distinct. It is also essential to intervene in all the problems the individual has. For young people family therapy have good effect. If psychotherapies are to have effect the patient has to be drug free. Therefore treatment is more effective if it take place in institutional care. In heroin abuse a combination of psychosocial intervention and pharmacological treatment is essential.

Methadone treatment has significant positive effects: it reduces heroin abuse and gives good compliance with treatment. It also results in lower mortality rates. Methadone treatment is administered in different forms. In Sweden patients in most cases initially undergo a thorough examination within a hospital setting and a personal dose level is set (and this is not known by the patient). Research has shown that the dose level is of importance. Doses exceeding 50 – 60 mg are usually required to achieve favourable results. In Sweden methadone is given as “methadone assisted treatment” over a long perspective, usually for years.

An alternative to methadone is buprenorphine, which shows positive effects I heroin addiction. Buprenorphine is under introduction in Sweden and it is recommended that treatment take place in, or in close supervision from, drug treatment facilities.

Detoxification in heroin abuse can be achieved with some anti-hypertensive drugs or with morphine-like agents.

Drug treatment in amphetamine or cocaine abuse has not demonstrated result.
Political and professional choices and principles

A Drugs committee was formed in 1998 as a reaction to a negative development in funding, prevention, treatment and supply reduction. The report was released in late 2000. Together with the report from the National Committee for Public Health, also released in late 2000, and the SBU-report a platform for an activated drug policy is formed. This will penetrate prevention, treatment and control measures. The political process has started and the Parliament will take the necessary decisions during the spring 2002.

12.3 Methodological issues

Even with an extensive examination like the one that SBU has made (available in Swedish at www.sbu.se) it is hard to find evaluations that satisfy hard scientific criteria. This is a lesson to learn, as drug treatment must apply to the same rules as other treatment areas. The first thing to do is to introduce a standardised reporting system, which is under implementation (KIM/TDI). According to the Drugs Commission functional treatment also has an effect on the overall consumption of drugs in society besides it effect for those who undergo treatment. Shortcomings in the treatment system, especially with regards to severe drug abuse, were been pointed out. Outreach work is all to invisible. The commission want more resources to the drug treatment sector and to education and research. It also pointed to the lack of statistics. Another point for criticism was the tendency for providers to let someone else pay. At a societal level this is a waste of resources (the cost for drug abuse is calculated to be 7.6 billion SEK a year).

The revised action plan on drugs that will be established during spring 2002 is intended to take care of these matters.

13. Drug users in prison

13.1 Epidemiological situation

Drug use before and within prison

The National Prison and Probation Administration present statistics (Kriminalvårdsstyrelsen 2000a, 2000b, 2001). Much of all statistics from the prison system is based on the situation in April 1 and October 1 each year.

The number of prisoners has been relatively stable since 1997 with around 9,300 persons (in 2000 9,178). Before that the number of prisoners were about 14,000. The difference is a result of a changed policy: it has been possible to chose among several alternatives to imprisonment. The number of prisoners a given day were 3,700 in 2000. The highest level was reached in 1994 with 4,350. This means that those who are sentenced to a prison term have made serious crimes. Accordingly they are sentenced to long terms. In general, prisoners spend 63% of their time in an ordinary prison and the rest (the last part) in an “open” prison.
About 30% of all prisoners during the latest five years have a drug problem (which is not the same as using drugs in prison). 38% of those with a drug problem also have an alcohol problem. Those who have used drugs during the last twelve months before imprisonment are labelled “drug abuser” in this connection.

In 2000 those who were convicted with a drug crime were 1,713 (19% of all prisoners). The corresponding numbers for 1999 were 1,759 (and 19%). The number has changed very little the last four years (the reason is given above).

Those with a drug crime as the main crime were lower, in 2000 1,182 persons (13% of all prisoners). This number also has been relatively stable. In 1999 it was 1,130 (12%). This group differs from the former group and other groups of prisoners by their long sentences. 2% of them had a prison time of ten years or longer. Among other prisoners the corresponding proportion were 0.2%. In the other end of the scale, 2 months or less, those with a drug crime as main crime represented 11.6% but among other prisoners this proportion was 30.0%. Serious drug crimes cause long sentences. As a result of this a large proportion of all prisoners have made serious drug crimes (during 2000 nearly every 4th prisoner). 10% in this group were women. Their prison time resembles those for the men in this group. 22% of all women who entered prison in 2000 belong to this group. The figure for men is 12%. Of 1,182 persons in this group 1,062 were men and 129 women. 4% were 18–20 years old, nearly 70% 30 years or older. Median age was 34 years.

Since 1998 the number of drug abusers that have entered prison has been about 5,000 per year, in 2001 5,064 (55% of all prisoners). The total number of prisoners per year is in the 9,300–9,500 interval since 1998, and in 2001 9,178. The number of severe drug abusers has increased from 3,717 in 1998 to 3,942 in 2000, thereby representing 43% of all prisoners.

The total number of drug abusers in the group with a prison term two months or shorter has shifted from 12% ten years ago to 47% in 2000. For those with sentences longer than two months it has shifted from 43 to 59%.

6% of all new prisoners 2001 were women, and of all new prisoners with a drug problem 7% were women. Women have a drug problem that is more serious than for men 51% are severe drug abusers (men: 43%). Of all prisoners 38% of the women have no drug problem. For men that is 45%.

New drug abusers during 2000 were 33 years old in average (men 33 and women 36).

**Health status in prison, social and legal consequences**

The prison administration started an Hiv-project when the epidemic was known in the middle of the 1980s. Prisoners were informed and offered an Hiv-test. A new set of staff specialised in drug abuse was enrolled with the purpose to help those who were infected or afraid of being it. This is now routine. In the early phase it was believed that Hiv/Aids should develop into a serious problem so that inmates with an infection should be isolated from others. This has not been the case. Besides, there are only few with an infection. In 2001 (on a census day) 17 persons were infected. This is the lowest number ever (records are from 1988).

Those with an Hiv-infection are older than other prisoners (40 years in comparison with 34), the youngest 23 years and the oldest 65.
Hiv-positive persons are not treated in any particular way. The idea is that those infected shall participate in the same way as all others.

Drug abuse is a more pronounced problem as it can affect the atmosphere and create antagonism and violence. All prisoners can visit a doctor or a nurse, and pharmaceuticals can be prescribed. Methadone cannot be ordered and other harm-reduction strategies are not in use.

Prisons have treatment programs for drug abuse. 356 beds (2000) are reserved for inmates who want to participate. Upon that that 15 prisons has different forms of intervention to stimulate inmates to give up drugs. A total of about 1,300 inmates were engaged in drug-related programs in 2000. This is a reduction with 30% in comparison with 1999, and it is now reduced to only half of what was accomplished in 1997. This is a really negative development as the number of drug abusers has grown.

In 2000 418 inmates were transferred to drug treatment programs outside prison. That is an reduction with 40-50% in comparison with the early 1990s.

13.2 Availability and supply

Each prison reports every month about the drug situation. This has been done since 1991. Normally, 60% report no occurrence of drugs while 5-7 prisons (of 62) report frequent (daily, or nearly daily) problem.

The most common drug is cannabis. In 1991 1,594 g was seized (the highest figure so far), in 1999 783 g and in 2000 456 g. Cannabis is also the drug that has been captured most times.

Amphetamine is known as a drug that has some popularity among criminals. In 1996 501 g was seized (the highest figure), in 1999 217 g and in 2000 306 g.

Heroin reached its record in 2000 with 119 g. In 1999 102 g was seized.

The total amount of seized drugs in the prison system represents a very little part (a fraction of one percent) of what police and customs get their hands on.

Drugs are seized within the prison and at the entrance. This makes a difference, as what is captured at the entrance cannot be used. Drugs seized within the walls could be only part of what was smuggled into the prison.

Drugs are smuggled into the prison by prisoners returning after leave, by visitors or by letters and parcels. Besides drugs injection utensils, chillums and other paraphernalia is sometimes found in inspections. However intravenous use is very rare.

Meticulous inspections are made with frequency in cells and other localities. Personal belongings are searched as well as the prisoner himself. Urine samples can be ordered. Staff from other prisons is sometimes enrolled for this and trained dogs search for narcotics.

During 2000 61,000 inspections were made. Drugs was found in 234 of 34,938 cells (one cell can be searched several times during a year), corresponding to 0,7%. In other spaces drugs were found in 99 of 26,058 controls (0,4%).
Urine screening is frequent. Every prisoner is screened, in average, every 13th day (the daily risk is then 8%). During 2000 104,766 samples were taken. This is less than in 1999 (109,021) but about 20,000 more than the average for the eight years before.

Late 2000 the National Prison and Probation Administration called an internal committee to look over the drugs situation.
References


