# National Report
# Sweden 2002

# Foreword

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The drug policy is part of the national public health and social policy. During 2002 a new National Action Plan on Drugs has been established and a proposal on a new public health policy has been presented. A post as national drug policy coordinator has been set up in order to implement and follow-up the intentions in the action plan.

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# Abbreviations

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| BRÅ | National Council for Crime Prevention<br>Brottsförebyggande rådet |
| CAN | Swedish Council for Information on alcohol and Other Drugs<br>Centralförbundet för alkohol- och narkotikaupplysning |
| MHSA | Ministry of Health and Social Affairs<br>Socialdepartementet |
| MPA | Medical Products Agency<br>Läkemedelsverket |
| MoB | National Drug Policy Coordinator<br>Mobilisering mot narkotika, Narkotikapolitisk samordning |
| NAE | National Agency for Education<br>Skolverket |
| NBHW | National Board of Health and Welfare<br>Socialstyrelsen |
| NCCP | National Council for Prime Prevention<br>Brottsförebyggande rådet, BRÅ |
| NIPH | National Institute for Public Health<br>Statens folkhälsoinstitut (formerly: Folkhälsoinstitutet) |
| SIIDC | Swedish Institute for Infectious Disease Control<br>Smittskyddsinstitutet |
| SiS | National Board of Institutional Care<br>Statens institutionsstyrelse |
| SOU | Swedish official government reports<br>Statens offentliga utredningar |

# Index

# Summary, main trends and developments

During the 1990s there has been reduced funding in this field and at the same time there has been an increase in the availability of drugs with a corresponding increase in lifetime prevalence of drug use among young people. However, the annual school survey in grade 9 made during the spring showed a decrease in use of alcohol, drugs and tobacco. This decrease was the first in more than a decade.

There are indications that the number of problematic abusers has increased in this period and also that the social services are less informed about their whereabouts and conditions than they used to be. There are also fewer specialised agencies involved.

A new national action plan on drugs has been introduced. Its main content is that the drug policy should be target oriented and that resources on national as well as local level are coordinated. There is also a visible political priority behind the plan, as a minister for public health including drug questions has been elected (late in 2002) as well as a post as national drug policy coordinator has been created. This is the response to the verdict of two national inquiries on public health and drug abuse.

The action plan essentially remains unchanged in that the overall visionary aim is to shape a drug-free society. Through better coordination, funding, education and accentuation of evidence based methodology conditions for development has been laid.

# Part I.
# National strategies: institutional & legal frameworks

## 1. Developments in drug Policy and Responses

### 1.1 Political framework in the drug field

Sweden has a restrictive policy on drugs (Proposition 2001/02:91. Nationell narkotikahandlingsplan); This was established already in 1968 when a drug policy bill was agreed upon in the Parliament, a year before a national Committee on the Treatment on Drug Abusers was ready to present its final report and recommendations on co-ordinating measures (SOU1969:52). A year before, 1967, an incident in a project with free prescriptions to drug abusers in Stockholm led to an intense debate in media and the closure of the project. This project was started in 1965. That was also the starting point for a project in the Central House of Detention in Stockholm, where Professor Nils Bejerot, by noting and counting fresh needle marks among new detainees wanted to demonstrate that the free prescription project would cause an increased prevalence of drug abuse in society. His views were much debated. Together with apprehensions of an escalating drug problem and in accordance with a restrictive alcohol policy the course was set.

In 1994, as a consequence of the coming membership in the European Union and its alterations on national policies and regulations, a National Plan of Action for Alcohol and Drugs was decided (Folkhälsoinstitutet 1995).

In preparation for the Special Session on Drugs in the United Nations (UNGASS), June 1998, a concise description of the policy was compiled (National Institute of Public Health 1998). It was based on a text, A Drug Policy Statement, presented by the Government before the Parliament (Regeringens skrivelse 1997/98: 172).

The overriding aim of the policy, that has been redesigned in 2002 (Regeringens skrivelse 2001/02:91), 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.

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, it was stated, calls for a significant augmentation of resources in the form of commitment, direction, competence and funding. The other, it was said, implies a lowering of sights and a considerable acceptance of drug abuse. The commission clearly took stands for the former alternative.

The Government presented a proposition before the Parliament in January 2002. Besides the Drugs Commission the Government also relied 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.

A mentioned, a reformulated National Plan of Action on Drugs has been accepted by the Parliament in January 2002. A corresponding National Plan of Action on Alcohol was accepted in 2001.

Prevention is the overriding principle in the drug policy, and this perspective is said to influence control actions; i.e. police actions taken to hinder young persons from using drugs. It has been emphasised in the before mentioned reports and constructive critic has been formulated by The Drugs Commission and in other contexts on parts of some of the common efforts. Recommendations have been 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). The agency has started a process aimed at a modernization of its preventive measures within schools. NIPH has started an investigatory work to formulate a course in prevention. A first pilot course has started in October 2002.

Treatment is another cornerstone in the drug policy. The Drugs Commission stated 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 was said to be those worst off in this process. The commission also found a need for improving the competence for those who work in the treatment system. NBHW has started an investigatory work to formulate courses in specialist training for those enrolled in care of substance abuse.

The third cornerstone, supply reduction, was said to have fared better. The commission was proper to note that the drug policy must be balanced and hot rely entirely on supply reduction. 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 also 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 Drugs Commission 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 has been presented before the Court of Justice of the European Communities (ECJ). It is not yet closed.

A Drug Co-ordinator ("Drug General") has been appointed by the Government in order to coordinate and activate the actions at different societal levels. In the Action 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 Apri11999. 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 Law has been put forward as a result of the EU project Joint Action on New Synthetic Drugs and the Early Warning System.

The Medical Products Agency specifies which medical products which 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 n -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 a more 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 n. 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

In the Government authorities' directives for the police the fight against drugs has been given high priority. In November 1996, the police authorities in Stockholm County appointed a special group, the Rave commission, to work with at rave parties and similar gatherings. The National Council for Crime Prevention (NCCP) found in an investigation that sixty percent of the persons who were suspected of drug crimes as a result of the work by the Commission were already known by authorities and that the majority of those who were not known were cleared of suspicion, which lent to some criticism from NCCP (Brottsförebyggande rådet 1999a).

The NCCP also 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 were 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.

Slight drug offences are still the most common, which is a response to changes in the law (see above). In 200082 % of all drug offences were of this category. In 1990 the corresponding level was 69% (Brottsförebyggande rådet 2001b,c).

Driving under the influence of drugs is regulated with a zero-tolerance paragraph in the law since July 1999. During 20001600 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. The 2001 figures are not yet available, but it is commonly estimated that 20 % of all cases "driving under the influence" is about drugs, not alcohol.

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) 4 % of the boys and 8 % of the girls says (year 2000) that the have been tempted to try drugs (but without doing it), and about 1/4 say they actually have had a chance to do it. This proportion has been the same since 1992. The proportion of pupils who actually have tried drugs has risen from 4 to 9 % (boys 10% and girls 9 % ) between 1992 and 2001. However, in 2002 this trend seems to be broken, as only 8% of the 9-graders (both boys and girls) have tried drugs (CAN 2002a, Hvitfeldt 2002)

Attitudes towards drugs among young people (16-24 years) are negative. 71 % see the drug problem as one of our most prominent problems. However, those that do not follow that view have risen during the last surveys from 9% in 1996, 12% in 1998 to 17% in 2000. The rest could not decide (CAN 2002b).

A survey among young people (16-24 year) showed that 91 % said no to decriminalisation of cannabis use (CAN 2002b). 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 is 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 (CAN 2002b).

The Drugs Commission presented its report 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 general" or Drug coordinator 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". Since then the Drug Co-ordinator has established an office, "Mobilisering mot narkotika" (Mobilization against drugs) within the Social Ministry.

The National Board of Institutional Care, which is responsible for compulsory institutional care, has sent alarming signals the last years 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 (Statens institutionsstyrelse 2001) 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. A pilot study has shown that clients leave treatment without a place to live in. None of 31 clients who were homeless when the entered treatment had a dwelling when the left treatment (Yohanes 2002). The public perception has also been influenced by a report about treatment shortcomings (SBU 2001). Homelessness among drug abusers has also been illustrated in media as well as teenagers involvement in 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. The agency has after that started a process to bring about this negative helix. This debate about the downsizing of preventive and treatment efforts has dominated the debate in the latest two years or so. Much hope is invested in the new action plan and the resources that the Drug Co-ordinator will mediate.

## 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 (Riksrevisionsverket 1993) and by N Nilsson in 1999 (Nilsson 1999) was presented reflecting societal costs.

In 1998 a state committee (SOU 1998: 18) put the society cost for drugs to be 600 million Euro per year. The Drugs Commission (SOU 2000:126) made a computation resulting in 770 million Euro 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 37 million Euro 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 125 million Euro to combat drugs during 2000. This proportion has been exactly the same for years. In 2000 that corresponded to 70 million Euro (in 1999 69 millions and in 1998

67 millions). 889 persons were involved in drug issues in 2001. The customs, with 2600 employees, had 1 080 persons involved in frontier defence (not only drugs) in 2000. The exact number of persons involved in defence is not published for 2001 but 2 558 persons were employed (Tullverket 2001). 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.

A publication from the National Council for Crime Prevention, "Current Swedish Legislation on Narcotic Drugs and Psychotropic Substances" (Brottsförebyggande rådet 1997, ISBN 91-38-31222-0, www.bra.se) presents the essential laws: The Narcotic Drugs (Punishments) Act, The Smuggling of Goods (Punishments) Act, The Act on the Control of Narcotic Drugs and the Act on the Treatment of Alcoholics and Drug Misusers. The book also contains ordinances and proclamations related to the above acts.

Drugs classified as narcotic drugs are listed by the Medical Products Agency and published in their Statute book, available on www.mpa.se/lagar/ie_lagindex.html.

# 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 has 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 9 % in 2001. 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.

However, the school survey in grade 9 in 2002 points in a new direction. For the first time since 1990 the figures are mowing down. In 2002 8 % of the boys and 8 % of the girls stated that they had tried a drug. The number of smokers has also gone down since last year; for boys from 30 to 25 %, and for girls from 36 to 34 %. This is preliminary data from the 2002 school survey (CAN 2002a), which is made with the same methodology as the ESPAD survey.

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 and scrutinized in a network that has been set up by NIPH to follow the protocol of the Early Warning System.

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 (Olsson, B. 2001). It used the same technique, "capture/re-capture", that was used in the two foregoing national studies made in 1979 (Socialdepartementet 1980) and 1992 (Olsson, 0. 1993). The 1998 study 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. Another problem is the increased rate of simultaneous abuse of illicit drugs and alcohol.

The number of individuals that has underwent hospital care for drug related diagnoses has more than doubled between 1987 and 2000 from 1 800 persons to 4 500 and the number of drug related deaths has also increased. Besides the explanation that this reflects a growing population of advanced drug abusers it may also mirror an aged population as well as risky behaviour and multiple drug use. Restructuring and dismantling of specialised treatment facilities is also a factor in this development.

Emerging trends

When party drugs reached Sweden in the late 1980s and early 1990s it was soon postulated that this could lead to a new generation of drug abusers with a different background pattern (i.e. middleclass). 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, still has only few reports of these drugs outside the affected regions. NIPH has published two reports on this (Folkhälsoinstitutet 2000, 2001a).

A few years ago a growing interest was reported not only in ecstasy but also magic mushrooms and LSD, but this seems to have tapered off.

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 a group has been made in one town (Lalander 2001). It was found that in Norrköping the rise in the number of heroin abusers has been sharp. In 1994 only 4 persons used heroin. In 2000 there were 248 known users. Similar results were found in another town, Malmö, a few years earlier (Tops 1997). The development in Göteborg is the same.

Multiple drug use and the high prevalence of personality disturbances have been frequently discussed in seminars during the 1990s.

The annual school survey in 2002 points to what might be a new direction when prevalence figures went down for boys in grade 9 from 10 to 8 % and from 9 to 8 % for girls. Use of alcohol and tobacco also went down.

Drug trends in a wider social context

The reasons for the growing interest in drugs among youths have been under debate. One reason could 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) aimed for smoking has become more available in later years and comprises about 90 % of the heroin market. Prices are low and stable. White heroin is very uncommon outside the Capital but heroin has got, during the latest years, a wider distribution over the country. Among advanced drug abusers heroin has become more common, even among those who kept to amphetamine for years. Amphetamine is still important; in the first part of 1990s persons sentenced for drug crimes with amphetamine was declining, but in the second part it has again grown. Prices are low and stable.

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. In 2000 1 777 kilos was seized, and in 2001 3 463 kilos. Somalis, especially women, living in Sweden has put attention to the problem and accused the authorities for not taking the problem seriously enough. A daily newspaper (Dagens Nyheter 2002a,b) had two extensive articles about the khat situation in Sweden.

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 years an annual average of 12 kilos has 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 next is planned to take place in 2003. 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), 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. 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 %.

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.

According to the new Action plan on drugs surveys in the general population is supposed to be done among young people 16-24 years old every year and in the population 15-75 years every second year with a start in 2003.

School surveys, students grade nine

School surveys have been carried out annually since 1971. A sample of about 5,400 pupils is enrolled and the non-response rate is 12-14 %. Pupils fill in a formula during school hours 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 was 9 % (10 % for boys and 8 % for girls) in 2001 (Andersson 2000). In 2002 figures went down for the first time in a decade (CAN 2002a). This year 8 % have tried drugs (same proportion for boys and girls). Figures for alcohol and tobacco also went down. Analysis of the measurement is ongoing and an explanation of this eventual break in the trend must wait.

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. The survey in 2002 is not fully analyzed and published.

When the new Action plan on drugs has been implemented it is supposed to encourage the local society to do school surveys and other actions that may give a view of the local drug situation as a means for planning of counteractions and preventive efforts.

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 %. The development follows that from grade 9.

The last reported survey is from 2001 (Guttormsson 2002). Lifetime prevalence was then 18 % (in 2000 17 %). This is in parity with the early 1970s. Of these 90 % had used cannabis and about 60 % had done only so. 16.3 % of all conscripts hade used cannabis, 3.2 % amphetamine, 3.3 % ecstasy, 1.4 % cocaine, 0.5 % heroin, 1.6 % LSD, 2.2 % magic mushrooms, 1.4 % GHB, 3.6 % pharmaceuticals (tranquillizers, sedatives) and 0.9 % other substances.

Last 30 days prevalence had increased from less than 1 % in 1992 to 3 % in 2001. In the early 1970s the proportion was nearly 5 %.

Gender differences

The male dominance is striking. 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, 3/4 of the population are males. This is shown in national case-finding studies and has also been reported from treatment agencies. An extensive research project during the 1980s (SWEDATE) found that 71 % were men (Berglund 1991). In a survey of services and clients in treatment for adults (from 18 years) who misuse alcohol and other drugs in April 2001 69 % were men (Socialstyrelsen 2002).

Attitudes to drugs are also different. In surveys among 16-24 years old young women are marked more negative to drugs. While 76 % agree with "Drugs is one of our biggest problems in society", only 66 % of young men agree with it. 13 % and 21 %, respectively, expressed disapproval to the statement.

Women have the lowest ranks among drug abusers (Lalander 2001) and often show a multi problem 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 considered 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 it was calculated that 80% of the most severe drug abusers (and 60 % of all actually counted) were found in the three metropolitan areas (Stockholm, Göteborg and Malmö). In the study from 1998 this was down to 60 %. 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 and stay there or that drug abusers from the biggest cities move away for one or another reason.

Among military conscripts those who live in the mentioned areas are more experienced with drugs; 25 % of those who live in the metropolitan areas have used drugs but only 11 % of those in other regions (Guttormsson 2002). Surveys in the general population as well as school surveys in grade 9 have shown it to be at least twice as usual to have used drugs among those who live in larger cities.

Other differences

In grade 9 pupils that have tried drugs are more often reported to have felt uncomfortable in school (14 % compared with 6 %), they skip classes several times a month (36 to 12 % for boys and 39 to 12 % for girls) and have various sorts of individual problems (89 to 49 % for boys and 94 to 53 % for girls (Hvitfeldt 2002).

Among military conscripts those who are students very seldom use drugs. Most experienced drug users are those who do not study or work. Among persons with one or two parents born abroad 23 % have used drug compared to 16 % with both parents born in Sweden (Guttormsson 2002).

Among problematic drug users in the 1998 survey every fifth person was born in another country. Practically all problematic users has most of their social relations among other drug users; only 10 % of them had a majority of friends among persons who do not use drugs (Olsson, B. 2001).

## 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 (Socialdepartementet 1979, Olsson, O. 1993). The results have been reported in earlier Reports and are mentioned above. A third study was carried out in 1998 (Olsson, B. 2001). 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. It was shown that the number of severe drug abusers successively has increased.

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, the capital, case-finding studies has been carried on since 1987. Between 1996 and 1998 the number of drug users was about the same; 4800. 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.

Another region with a pronounced drug problem is Scania with its border to Denmark and Copenhagen. In relation to its population Malmö (250 000) is the most stricken town in the country. This is often partly explained by its nearness to Copenhagen and the continent. While it takes 4 _ hours by train to Stockholm it only takes 20 minutes by train to Copenhagen. Therefore there are no connection between the drug market in the capital and Malmö, but distinct links between those in Malmö and Copenhagen, where a district, Christiania, in thirty years has been the market place for cannabis and other drugs. This district has always been a lure for young persons and drug abusers

on the Swedish side of the straight (Öresund). In later years prices on drugs in Malmö and nearby towns has tended to resemble those on the Danish side, indicating that supply is well taken care of. In 1998 it was estimated to be 1 600 drug abusers in Malmö (Olsson, B. 2001). These circumstances is the reason that needle exchange programs was started in Lund 1986 and Malmö 1987; physicians at clinics for infectious diseases adapted this move from a recommendation adopted at a WHO meeting "Aids among drug abusers", held in Stockholm October 1986, as a response to an approaching HIV -epidemic.

A repeated study in Uppsala (north of the capital) 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 for some crucial variables.

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 has 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 (1997). It was shown that the drug abusers way of life makes them very vulnerable and of extreme risk to die (Fugelstad 1998).

An HIV-prevention project among detainees in Stockholm started in the spring 2002. Of the first 265 persons that were contacted 185 were IDU:s. Of these 63 % had shared utensils (but not during the period of detention). Eight persons were HIV -infected (and they were already known). 15 of 68 persons under the age of 25 (22 %, to compare with 9 % for those over 25) had had ten or more sex partners during the last twelve months. Only 5 persons out of 15 young persons used a condom during the last intercourse. Data from the project will be announced during 2003.

# 3. Health Consequences

## 3.1 Drug treatment demand

The National Board of Health and Welfare publish a report based on the situation on a census day, Apri1 2, every second year, the last made in 2001 (Socialstyrelsen 2002a). The report does not separate drugs from alcohol. 20 244 persons (18 years or older) received treatment for abuse. In all, 49 % received treatment for alcohol misuse, 19 % for drugs misuse, and 32 % for both alcohol and drug misuse. 83 % underwent outpatient treatment, 13 % residential treatment, 2 % hospital care and 2 % drug treatment in prisons. 69 % of the clients were men. 10 % of the clientele were under

25 years of age and 13 % born outside Sweden (of them, 8 % in the Nordic countries). A total of 2 800 IDU:s were detected. 44 % of the clients had had treatment before.

A total of 567 units were identified; 48 % outpatient units, 39 % institutions and 13 % combinations of these. Most of them are not specialised for a certain type of misuse. Only 6 % of them (30 units) are restricted to drug abuse and 10 % to alcohol abuse. 34 % report that they have special programs for women.

NBHW also publish a report based on the situation in November 1, the last from 2001 (Socialstyrelsen 2002b). While the first monitor developments in the treatment sector as a whole for persons 18 years or older, the latter has a focus on social services and on persons 21 years or older.

Housing assistance was received by 5 628 persons (4 266 men and 1 362 women), out-patient care by 10 287 (7 223 men and 3 064 women), institutional care by 3 182 (2 388 men and 794 women), and treatment in private homes by 286 (214 men and 72 women). 286 persons (199 men and 87 women) received compulsory institutional care pursuant to The Care of Alcoholics, Drug Abusers and Abusers of Volatile Substances Special Provisions Act ("LVM"), and 16 persons (9 men and 7 women) were in private homes according to the same law.

A regular system for collection of treatment data is under construction. The system, KIM (“Klienter i missbrukarvård”), which adheres to the epidemiological key indicators system ("Treatment Demand Indicator"), will cover all units in 2004/05. A presentation of the introductory phase was made at an Expert Meeting in June 2001 (REITOX Project CT.00.RTX.21). According to preliminary and unpublished data 100 units had a total of 3823 clients during 2001. Primary drug was for 33.4 % alcohol, for 61.3 % drugs and for 5.4 % pharmaceuticals. 26.3 % had heroin (and other opiates) and 22.4 % amphetamine as their primary drug. 33.7 % injected these substances.

The Drugs Commission (SOU 2000: 126) has recommended that all treatment facilities must produce treatment data in accordance with the KIM-system. The Government is researching the legal aspects of registration, and the National Drug Policy Coordinator (www.mobilisera.nu) has stated his intention to support a national information system that continuously can produce information about developments in the drug market. KIM/TDI might be a part of that (Mobilisering mot narkotika 2002).

There already exists another form for collecting treatment data, DOK (“Dokumentation av klient”), which is more extensive than KIM/TDI, but with a limited spreading (in 65 or about 10 % of all treatment units). However, the two systems can go together as all items in KIM/TDI are integrated in DOK.

DOK registered 2 161 clients in the year 2000 in its annual report (IKM-DOK 2001, www.ikmdok.com), 1 127 had drug problems, 523 alcohol problems and 511 were poly-drug users.

Addiction Severity Index, ASI, is also used in parts of the system, and now under introduction in full scale in the prison system. So far it is only KIM/TDI that is reported on a national level. Hospital data (mostly detoxification) is 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) for adults is provided by the National Board of Institutional Care (Statens institutionsstyrelse, SiS, www.stat-inst.se ). In 2001 378 clients was enrolled (1022 men, 74 %, and 356 women, 26 %), which is 16% less than in 1994, when NBIC was established. The number of discharges was 1 405.

Compulsory treatment for young people is also provided by NBIC in accordance with a corresponding law for young persons (LVU). 1 133 persons were enrolled (69 % boys) and 1 140 was discharged during 2000. It must be noted that for young people drug misuse is only one of several reasons for being given involuntary treatment.

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. 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. In 1997 ICD9 was replaced with ICD10, which definitely complicates comparisons over time (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 (6 884). 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 have lead to an "unnatural" increase, wherefore the time series have to be considered disrupted. In 1998 the number of discharged persons was 7 000, in 1999 7 115 and in 2000 7 821.

The single drug contributing the most are heroin and the proportion treated for opiates have increased somewhat during the 1990s while amphetamines remain the same. However, the biggest group is multiple drugs (F19.1-F19.9). Since 1997 about 65 % of all discharges take place in the three metropolitan areas (before that it was about 75 %).

## 3.2 Drug-related mortality

Data on drug-related deaths originates from the Cause of Death Register (NBHW), 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. ICD9 selections are: 304.1-9. Only underlying death causes are included.

The latest mortality figures are from 2000. Then 190 persons died a drug related death; 132 men and 35 women. Mean age was 35 years. In 1999 the number of deaths were 152, in 1998 138 and in 1997 132.

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

A special local register on drug-related mortality has been running since 1985, consisting information from all deaths investigated by the Department of Forensic Medicine in the Stockholm reception area: the counties of Stockholm, Södermanland and Gotland with in all 2 million inhabitants (Narkotikakommissionen 1999b). The trend of the local register has shown 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 and 1988 and followed up 1992 has been carried out (Fugelstad 1997). The annual mortality rate was 2.2 %. The highest mortality, 4.4 %, was found among heroin addicts (not enrolled in methadone treatment). A Nordic meta-study (Tunving 1989) found that opiate abusers had a mortality rate 16 times as high as in the normal population. For amphetamine abusers it was 8 times as high. The annual mortality rate for heroin abusers was about 4 % and for amphetamine abusers 1.5-2 %.

NIPH arranged a conference in Apri12001 regarding the statistics on drug-related deaths in Europe. It was stated that the diagnosis drug-related death constitutes a social construction that lacks clear medical criteria and that there are considerable variations across Europe in reporting cases to the official statistics. Trends in drug-related mortality within national statistics is what can be used at the moment as an indicator for comparisons of the number of drug abusers and the amount of drug-related problems (National Institute of Public Health 2002).

The Drugs Commission (SOU 1999:90) suggested that a surveillance register on drug-related deaths should be constructed as a more detailed and faster complement to the ordinary register. A working-group has been established to plan this register.

## 3.3 Drug-related infectious diseases

Statutory surveillance of communicable diseases is regulated in the Communicable Disease Act. Notifications are submitted to both the County Medical Officer (one in each of the 21 Counties) and the Swedish Institute for Infectious Disease Control, SMI ( www.smittskyddsinstitutet.se. All diseases with the exception of sexually transmitted infections are notified with full patient identity. Diseases are notified both by the treating doctor and the laboratory. The report from the doctor includes information of epidemiological relevance, e.g. suspect source, route of infection, risk group, etc. Statistics is reported in an annual report; Communicable Diseases in Sweden.
The increase of Hepatitis B, HBV, among intravenous drug abusers continued during 2001; 119 cases compared with 110 during 2000. Of 105 notified cases with chronic infection 56 were infected through intravenous drug abuse.

During 2001, 1 970 new cases of Hepatitis C, HCV, were notified (during 2000 1 995 cases were found). The distribution of cases by route of infection did not change much compared to the previous years; 1 269 (64 %) were infected through intravenous drug abuse (in 418 cases the route was not fully known).

Thirty-six intravenous drug abusers (26 men and 10 women) were reported to have contracted HIV during 2001, compared to an average of 19 cases per year reported during the past five years. The majority of these (25 cases) were reported from Stockholm. A total of 840 have been reported to acquire the infection via intravenous drug abuse, or by sex among intravenous drug abusers. Of these, 596 were males and 244 females. 201 have developed AIDS, 5 during 2001, and 150 have died.

The SMI has followed the development of HIV/AIDS, hepatitis and TB in the Baltic republics and in Russia. So far Swedish drug abusers have not contracted diseases that are reported among drug abusers in those countries.

## 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 in 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 is, 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 poly-drug 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 CAN:s periodical journal Alkohol & Narkotika were 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. However, a working group has been formed to develop a surveillance register for drug-related deaths, which supposedly can generate hypothesis that can be researched.

In 1999 the already existing regulations on alcohol and car driving were enlarged with regulations about drugs. In 2000 1 867 persons were tested positive for drugs (most often amphetamine and cannabis) and sentenced in court. According to statements in the media from traffic policemen and others it is difficult to pick up drug offenders in road controls.

# 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 recent data that can describe developments of problems with housing, unemployment and such, for drug users. However, a register study (Svensson 2000) covering the period 1987-1994 found that, in the first year, 25 % of those treated in hospital for drug problems (mostly detoxification) did not have any salary at all. In the last year 49 % were without any salary .Heroin abusers were the most exposed.

A state committee (SOU 2000:4, SOU 2001:95) has presented its report on homelessness. It was found that drug abusers with a dual diagnosis constitute a respectful part of this group. In a study in Stockholm they were 38 % of the homeless population (Finne 2001). 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, and so have the National Action Plan on Drugs (Regeringens proposition 2001/02:91).

## 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 2000 the corresponding figure was 12 545 persons. The hump in the statistics in the early 19 805 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 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 35 % of all persons suspected for drug offences in 2000.

Among the 25-39 year-olds are a rather opposite trend at hand, with an increase up to 1993 (61 %) and thereafter a drop to 44 % in 2000. 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 2 325 in 1975 to 10 144 in 1998 and 10 771 in 1999. In 2000 11 326 (Brottsförebyggande rådet 2001b).

Out of all drug related sentences cannabis was involved in 44 % of the cases in 2000. Corresponding figures for amphetamines and opiates were 43 % and 8 % respectively.

On a census day (April 1) 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 was 37 % that year (Kriminalvårdsstyrelsen 2000a) (A drug user were defined as someone having used drugs at least once during the twelve months preceding the imprisonment). That share was pretty stable between 1986 and 1996 (some 40-42 %) but rose to 49 % in 1998 and dropped slightly to 47 % in 1999, but rose to 51 % in 2000 and 52 % in 2001. 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, 2002).

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). 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.

In 1992, an attempt to calculate societal costs 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 has been made (Nilsson 1999). 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 rarer, but one recent example can be found in a state committee investigating 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.

Estimates of total consumption, demand for drugs, expenditures on drugs, street prices, purity etc do not exist, but the Drugs Commission (SOU 1999:90, SOU 200: 126) suggested that this should be calculated, and the National Action Plan on Drugs refers this to be developed by NIPH and CAN (Regeringens proposition 2001/02:91).

# 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 (Skåne) region via ports in Helsingborg and Malmö. 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, Malmö and Göteborg.

The following information originates from a report on the Swedish drug situation 2001 compiled by the National Criminal Investigation Department (Rikskriminalpolisen/Tullverket 2002).

According to analyses of seizures (police and customs together 19127) made at the National Laboratory of Forensic Science approximately 75 % of all seized cannabis originates from Morocco. The last year it might have been up to 95 %. Distribution routes often go through Spain, the Netherlands and Denmark. Swedish citizens living in Spain and the Netherlands sometimes control the transactions. A trend is that Spain is more important and that other nationalities are involved. Operators from the Baltic States have also been identified. MC-organisations are still involved in the cannabis trade. In 2001 police and customs seized 698 kilo cannabis (5 339 seizures), which is a drop from 1 181 kilo the year before.

The Police have investigated 53 cases of home growing during 1999, 45 during 2000 and 51 during 2001.

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 rising; 5 513 in 2001. The amount of amphetamine was 231 kilo). Ecstasy and methamphetamine is not included.

The main markets for heroin are the Stockholm and Malmö regions, even if there have been increases in heroin use in other regions, especially Göteborg. 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 2001 police and customs seized 32 kilo (1 271 seizures).

Cocaine has not attracted the market in Sweden in any larger extent. The number of seizures is relatively low (in 2001 328), however the quantities might sometimes be surprisingly 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 Göteborg. In 2001 only 39 kilo was sized.

Even though there are signs of new distribution routes arising via Eastern Europe, 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. Figures from the mentioned report show that the numbers of seizures have increased at the same time as the volumes have decreased. Yet the conclusion is that the access to drugs is better than ever.

## 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 as practically all substances are imported. 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. During 2001 19 127 seizures was made, 2 735 by the Customs and 16 392 by the Police.

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 and in 2001 6 935 (1 744 seizures and 259 kilo by the customs and 5 191 seizures and 480 kilo by the police). Almost 1 200 kilo (1191) were seized 1999, which is about twice the normal average for the 1990s as well as the 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 2001 it dropped to 739 (at 6 935 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 38 170 during the second part. In 1999124 kilo was seized at 5073 occasions, and in 2000 108 kilo at 4 978 occasions. In 2001 240 kilo was seized at 5 837 occasions (121 seizures and 89 kilo by the customs and 5 716 seizures and 151 kilo by the police).

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. In 2001 39 kilo was seized at 328 occasions (57 seizures and 28 kilo by the customs and 271 seizures and 11 kilo by the police). 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 2001, 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 1200 in the late 1990s. Comparing the latter part of the 1980s with the latter part of the 1990s reveals that the yearly averages have ten-folded, from 3 kilo to 30. Some possible explanation to this increase might be new routes for the heroin traffic to Norway and improved intelligence work. In 199964 kilo was seized at 1 244 occasions, in 2000 30 kilo at 1 264 occasions and in 2001 32 kilo at 1 271 occasions (32 seizures and 22 kilo by the customs and 1239 seizures and 20 kilo by the police).

Worth mentioning is the fivefold increase in seizures of pharmaceuticals controlled according to the list of drugs (mostly tranquillisers and sedatives). Between 1985 and 2001 the number of seizures rose from about 500 to 3 214 (351 629 tablets). The large majority of those medicines were of benzodiazepine type and the dominating make was Rohypnol (flunitrazepam).
184 161 ecstasy tablets were seized at 544 occasions during 2000 and 89571 tablets and 621 occasions during 2001. The most common compound in the tablets has been MDMA.

LSD is uncommon. During 1999 35 seizures were made, in 2000 64 and in 2001 28 (629 doses).

During 2000 1 777 kilo khat was seized (at 186 occasions). The corresponding figures for 1999 were 3 373 kilo and 304 occasions. In 2001 3 463 kilo was seized at 285 occasions.

Information about GHB is scarce, but it is known to be demanded in Göteborg. During 2000 about 103 seizures was made, in 2001 154. The amount was increased from 17 to 47 litres.

## 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" (CAN:s reporting system on drugs). 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 10 Swedish krona (the rate fluctuates between 9 and 10).

Cannabis prizes have remained pretty stable during the 1990s, at about 9 Euros per gram, both for hash and marihuana. Also cocaine prizes have remained pretty much the same for the last ten years, but have dropped somewhat recently to about 90 Euros per gram. Amphetamine prizes at the other hand have dropped considerably during the 1990s, from 50 to 25 Euros. Also heroin prizes have gone down, from 240 to 150 Euros for white heroin and from 180 to 100 Euros for brown heroin (which is the most common variety).

LSD and ecstasy prizes are available from 1995 onwards. No major prize changes have occurred for any of these drugs. LSD was some 10 Euros a trip and ecstasy about 22 Euros a tablet during the period, and today 12 Euros. Finally, a single tablet of benzodiazepine-type costs around 1-2 Euro on the black 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 a longer perspective. In 2000 and 2001 cannabis seizures were by all means exceptionally high, 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 2001 10 % of grade 9 boys and 9 % of the girls had used drugs (in most cases cannabis) and 18 % 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 in that group.

Surprisingly, the school survey in 2002 (grade 9) showed a decline in alcohol-, tobacco- and drug use. The survey is not yet ready for publication, so it is too early to try to explain this development. 8 % of boys as well as girls had used drugs.

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 recently 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), 4 978 (108 kilo) in 2000 and 5 837 (240 kilo) in 2001. Prices have dropped substantially at the same time as seizures have increased, both in numbers and amounts.

After cannabis, amphetamines have always been the second most common drug experienced by the Swedish population. Approximately 2 % of those 16-64 years old have reported lifetime prevalence. According to various surveys amphetamines also rates second among youths, and is increasing in magnitude. For example, less then 1 % of the military conscripts reported lifetime experience of amphetamines in 1992 and that figure was four folded; 3.5 % in 1999 and 2000 and 3.2 % in 2001.

Intravenous abuse 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 reported in relatively large intervals, indicating that the supply/availability is unstable and that these drugs are not fully established all over the country.

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

Information from hospitals in Härnösand and Göteborg, areas with pronounced GHB-problems, indicated drops in the emergency room visits due to GHB during the 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 (Gamma Butyrolactone). During 2001 154 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 1996) and one in Malmö (Tops 1997) have showed that the proportion of opiates among problematic 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 heroin, at least initially. A recent report from a research project in Norrköping shows 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. Smoking is considered to be less stigmatising than injecting, which partly could explain why heroin-smoking has begun to be common among younger drug users. A few years ago it was practically non-existent. The sharp increase of heroin seizures during the 1990s, both in numbers and kilos, paralleled with a decrease in prizes, suggests that heroin has become more available on the market. Still no spread outside the "traditional" user groups has been traced. Lifetime prevalence in the general population is practically zero and despite of an increase during the 1990s, the lifetime prevalence among the military conscripts is still below one percent.

## 6.4 Cocaine/crack

Cocaine is the 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. Among military conscripts a slight increase in cocaine use has appeared during the latest years, but the level is still very low.

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

Poly-drug 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 when analysing data from the inpatient registry. An example of an increase in multiple drug use among severe users was noticed when results from the national case finding study from 1992 was compared to the earlier one from 1979 (Olsson 1993).

Some sources indicate an upward trend in poly-drug abuse 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 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. The number of drug users in prison have increased, but the proportion of persons with a multiple abuse of alcohol and drug remained the same during the 1990s (Kriminalvårdsstyrelsen 2002).

As already mentioned, there are many signs of an increase in the use of particularly pharmaceuticals 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 (at 2 713 occasions), most of them tranquillisers and sedatives of bensodiazepine-type. In 2001 296 418 tablets were seized (at 3 214 occasions). Rohypnol is the most common benzodiazepine on the black market, and one tablet is sold for about 1 to 2 Euros depending on the amount that is bought.

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 1998).

Among military conscripts, 3.6 % stated illegal use of sedatives or tranquillisers in 2001, which is roughly four times more than a decade ago. 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 poly-drug abuse can actually be found in the literature since the late 1960s. There are however not any known sources indicating an increase or 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 poly-drug abuse among severe users. In the 1992 national 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 2000). Solvents sniffing are more related to younger teenagers. Various surveys reveal that poly-drug abuse often is at hand among younger persons experimenting with drugs (Andersson 2000 and Guttormsson 2002). For example, the ones drinking larger quantities of alcohol is more likely to report experience of tobacco, drugs, solvents and doping substances than the others using smaller quantities of alcohol are.

# 7. Discussion

## 7.1 Consistency between indicators

Throughout the 1990s the seizures of several drugs have increased. Particularly seizures of amphetamines and heroin have gone up significantly during the period, 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, 9 % in 2000 and 2001 (boys 10 % and girls 9 %). 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 school survey in 2002 might point in another direction, as only 8 % (both boys and girls) had used drugs. This drop is accompanied with corresponding drops in use of alcohol and tobacco too.

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 and later 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 used drug is amphetamine, thereafter cocaine among adults, and 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 difficult to find local surveys reflecting divergent developments. However, there are differences between urban settings and the countryside.

Provided data on severe drug use might be more difficult to interpret. The majority of the provided statistical indicators do suggest an increase in the number of severe abusers 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 anyhow 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 "easily" counted.

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 (the exception is the rise in the last figures). Also hepatitis C has declined or at least stabilised during the latter part of the 1990s, but on a very high level, as about 90 % is supposed to be affected.

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. It is probably too early to draw any specific conclusions on the extent of the increase from this kind of information.

The two national case-findings from 1979 and 1992 suggested that there had been a 40 % increase in severe drug use between those 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. The same holds for 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. 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, which in turn might be the result of more efficient production and distribution.

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 1998 was still four-folded compared to 1989. One possible reason for increases in drug use among younger people, 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 as well as in special forms of treatment (walk in clinics, therapeutic communities, etc). This might have had impact both on recruitment of new drug users who fall through the welfare net but also on the possibilities to offer drug users appropriate treatment. Statements from social workers, policemen, hospital staff and others sometimes indicates that the group of severe drug users are worse off nowadays, regarding economic and health aspects.

## 7.2 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 is 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 prices on the black market. 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 2002).

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 their 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 EMCDDA, since these are a prerequisite for cross-national comparisons and research, a topic always of interest.

# Part III.
# Demand reduction interventions

## 8. Strategies in demand Reduction at National Level

### 8.1 Major strategies and activities

The Action Plan on Drugs (Regeringens proposition 2001/02:91) emphasizes a balance between prevention, control and treatment. The vision is a drug-free society. Springing from the sub-goals of the 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.

Demand reduction is defined as actions taken to influence structures and conditions or to implement actions that prevent or counteracts what is not desired. This means that demand reduction actions is part of a general public health perspective, in this case to give children and youths a good upbringing.

Preventive measures, of which education and information campaigns are examples, are used to limit the number of young people experimenting with drugs. These actions are foremost carried out in schools, in the so-called ANT -information programmes (with the abbreviation standing for Alcohol, Narcotics and Tobacco). As the level of drug use is coupled to attitudes it is stated that interventions should take this into consideration. In recent years ANT -programmes has had such a direction.

The Action Plan point out that it is important that drug questions are given high political priority in the local society and that the public opinion is mobilized. Preventive programmes have more potential if they are supported by supply-reducing efforts. That is another reason for all parties to unite.

In order to reduce the number of severe abusers, there are a number of treatment facilities available. An ongoing shift from institutional and compulsory treatment towards outpatient treatment has been noticed for several years, but specialized out-patient centres also tend to be reduced in favour of ordinary social services centres. 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 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.

The Action Plan puts emphasis on co-operation between actors, especially in the local society. NIPH had been given the commission to develop methods that will help local governments in this process. Local authorities are supposed to act together with organizations and other interested parties.

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, as mentioned above, 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) as well as in the Action Plan.

## 8.2 Approaches and New Developments

New and innovative approaches

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 field, some of them offering services answering e-mailed questions. One of these, www.drugsmart.com , is administered by CAN on a public budget.

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. CAN, www.can.se , is only one of them. NIPH, www.fhi.se is another example.

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. However, NIPH, has been committed to develop and disseminate methods, as part of its new role in the public health field (National Institute of Public Health 2002).

Socio-cultural developments relevant to demand reduction

Research in demand reduction has shown that is often is essential to address young persons as personal as possible. That means actors must acquire new competence and enrol new partners. In the Action Plan it has been pointed out that all education and information about drugs must have a starting point in young persons own reality to be meaningful for them. This was also pointed out in an evaluation of ANT -education in schools (Skolverket 2000), and will be further elaborated in a working group that has been set up in the National Agency for Education (Skolverket).

Ethnicity has been observed, but more in the light of treatment and criminality than in prevention. A public health report on children in Stockholm (Hjern 1998) showed that boys with a foreign background more often develop drug abuse. The same tendency was observed for girls with mothers born in Europe but outside the Nordic countries and for adopted foreign-born girls. In general, drug experience was more common among those born in another country. 25 000 Roma people live in Sweden. It has only been known for a short period that drug abuse exists among them. They made this public and have thereafter received help from local and central authorities (Maldaner 1998). Certain immigrant groups have been investigated in local studies, among them Iranians in Umeå (Domeij 1997) and in Uppsala (Danesh 1993). These reports found a hidden consumption of cannabis and heroin among male immigrants. The local authorities responded to their problem with remedial measures.

Overall ethnicity has not been a prominent question regards drug prevention. On the other hand it is often referred to in surveys.

Developments in public opinion

Since long the official policy has been that a national policy on drugs must rest on the public opinion. Therefore it is logical to influence the opinion. This has been more successful with drugs than alcohol. The official discourse describes drugs as more dangerous than alcohol, which in the public opinion results in a strong dissociation from drugs (Hübner 2001). This is heightened in the Action Plan on Drugs; "Today there is a strong support for the restrictive policy within all age categories. If drug abuse is allowed to escalate risk is that it will be more accepted, at least in certain groups." (Regeringens proposition 2001/02:91, p 11)

The drug policy has support even among young people. In a survey 2000 among those 16-24 years 71 % (men 66 % and women 76 %) agreed with a statement saying that Drugs is one of our greatest problems. Identical surveys were made in 1996 and 1998 and they gave the same picture. (CAN 2002b).

New research findings

In 2001 the Swedish Council on Technology Assessment in Health Care (SBU 2001, www.sbu.se ) made a thorough meta-report on evidence based treatment on alcohol- and drug problems. With this survey as an important component the National Board of Health and Welfare has started a process that will end in recommendations for treatment. The SBU-study has shown that not all forms of treatment interventions have effect.

Specific events

Every second year an exhibition on drugs is arranged by central authorities, "Mässan Sverige mot narkotika". In May 2001 this was arranged for the fifth time. It gathers participants from all over the country under two or three days. Participants are professionals. Usually about 70 seminars with various themes are arranged. These fairs are always well-attended. The next fair will take place in November 2003 and after that it will be arranged the next two following years as a response to implementation of the new Action Plan on Drugs.

# 9. Prevention

National strategy

In the new Action Plan on Drugs (Regeringens proposition 2001/02:91) prevention is presented as a part of a public health policy and essentially a means to guarantee children and young people a good upbringing. This is meant to be a long-term investment against drug abuse. Within this frame it is seen as important to mobilize public opinion and resources in the local society, not only among authorities but also among organizations, the entertainment sector, etc. Prevention is consequently perceived as more than information and education. Central authorities under the co-ordination of a National Drug Policy Coordinator ("Drug general") support the efforts.

Organisation and co-ordination within national structures

A National Drug Policy Coordinator was appointed in January 2002. The mandate is for three years. The government has reserved 32 million Euro for this period. Of these 10 million Euros is aimed at reinforcing drug treatment within the prison system. The rest is distributed by the Coordinator and his staff according to a scheme that has been drawn up (www.mobilisera.nu).

The coordinator is ordered to cooperate with ministries, central agencies, municipalities, counties, organizations and youth organizations. The appointment is not equipped with executive power, but the Coordinator is supposed to make his partners aware of which actions has to be done. He is also the Governments official spokesman in drug affairs.

Expenditures on prevention

The coordinator is planning to spend nearly 7 million euros from his budget on prevention during the coming three years. Of these 3 millions is reserved for actions against recreational drug use. Opinion enhancing campaigns as well as knowledge enhancing actions will be initiated. Partners in these are opinion leaders, youth organizations, researchers, parents groups and professionals. Nearly one million Euros is used by the Coordinator to stimulate associations to become active in prevention. Another million Euros is earmarked for a network of youth organizations and their contacts with foreign counterparts. Three million Euros is aimed for parents. This will be done through a new channel; working life. Preventive measures is schools and in universities will get over 5 million Euros. Evaluation of preventive programmes will receive 7 million Euros.

## 9.1 School programmes

Specificities of policies

Schools are a major arena for preventive measures, but so far there is no common model within the school system for drug education or other measures to prevent drug use. Schools are administered in the local community but with a national curriculum. In this curriculum drug education is supposed to be design by local school authorities. This might be somehow altered, as an evaluation of preventive programmes was carried out in 1999 (Skolverket 2000). It pointed to a need of reorganization. This has been further emphasised in the new National Plan of Action on Drugs (Regeringens proposition 2001/02:91). The National Agency for Education has now constituted a working group (together with NIPH) in order to come up with new strategies based on evaluated and renowned operations.

Models of school interventions

The National Agency for Education has stated (Skolverket 2000) that drug education, when given, has been administered without a clear aim and without any follow-up and evaluation. Pupils is said not to have been involved in the programme in any other way than as listeners and no efforts has been directed to engage parents and the surrounding society. The agency has the intention to change this.

Prevention programmes available

The Drugs Commission (SOU 2000:126) criticised the current situation, where any school principal himself is able to decide how drug education shall be accomplished. The Commission, and later the Government (Regeringens skrivelse 2001/02:91), wish to see regular programmes based on evaluated, effective methods. At the present state there is no common strategy. This is not to say that it is all confused, but those who organize drug educational efforts need help to find the best strategies. This is what will be attended to. NIPH has recently published an anthology about preventive actions (Andréasson 2002), which scrutinizes different methods commonly used in drug education.

Evaluation studies and results

As mentioned, an investigation made by the National Agency for Education in 1999 (Skolverket 2000), found that very often drug education was arranged with methods that research has shown has little or no result, while effective methods seldom was in use. Recent research results have not made its way into the educational system. The agency is in a process to carry out recommendations.

Research projects

Where drug education is part of a project that has economic support it is usually evaluated and researched. Results from national and international research in drug education and communication are now collected and will be presented for school leaders within short. It is expected that this effort will stimulate new research projects, and the National Drug Policy Coordinator is but one instance that will support that.

The Drugs Commission went through the research literature (Narkotikakommissionen 2000e), and concluded that it is needed three types of efforts; specialised efforts for those worst off, general efforts to strengthen public health, and broad efforts for weak families. Preventive programmes in school with o focus on drugs instead of social competence were found to have only marginal effect, if at all. The Commission found that most of what is done up to date has not been properly evaluated.

Schools are often in focus for drug prevention programmes, and schools are also a milieu that can curb or create problems. A study in Stockholm County (Öfverberg 2000) identified schools in comparable districts with low, respectively high grade of acting-out problems, which is often related to drug habits. It was found that schools with high levels of protective factors (active leadership, structured, and planned lessons, engaged teachers, open communication etc) had less problems.

## 9.2 Youth programmes outside school

Definitions used

Organisations that arrange activities that counteract drug use are apt to search grants from the National Board of Health and Welfare. The allowance is meant for influencing the public opinion, for information, education and various forms of social work. The County Administrative Board is another fundraiser for local club activities. Prevention has a wide definition in this connection. There is a tendency today to see drug (and alcohol) prevention as part of a wider context; public

health. A new national public health policy has been presented early in 2003 (Regeringens proposition 2002/03:35). Drugs are integrated in it. Together with the implementation of the National Plan of Action on Drugs (Regeringens proposition 2001/02:91) definitions will crystallize.

Types and characteristics of intervention with youth outside school

The main activities take part during school hours. Non-governmental organisations may have some sort of interventions as part of their youth programmes, and if so, be eligible to draw economic help for this. A few organisations have such activities on their regular agenda. Beside organisations there are youth centres arranged for by the municipalities. They offer different forms of activities but are only secondarily involved in drug education, as their main purpose is to offer meaningful activities for youth.

Statistics and evaluation results

There exists a national youth policy coordinated and followed-up by the National Board for Youth Affairs (www.ungdomsstyrelsen.se), but it is not focused on drug misuse. The policy state three objectives and 32 sub-objectives, of which one (no. 17) is about drugs (another one, no 16, is about alcohol): The proportion of young women and men who try drugs shall decrease over the period 2001-2003. The long-term objective is that no young people shall use drugs. Statistics regarding drugs are those that are produced by CAN (www.can.se) and NIPH (www.fhi.se), and these are inserted in the section about health in the policy. An annual report from NBYA presents the latest follow-up (Ungdomsstyrelsen 2002). A summary of this report appears on the web-site (Swedish youth 2002).

Specific training for professionals and peers

NIPH has been appointed to investigate the need and direction of training courses in prevention. A pilot course on academic level for professionals has started during the autumn 2002. It will be evaluated and followed with regular courses. NIPH is also involved in an investigation that will see how training of teachers can integrate courses in prevention (Regeringens proposition 2001/02:91).

## 9.3 Family and childhood

Definitions used

Today there exist no national or local policies for prevention directed to families and early childhood. However, NIPH and other agencies have supported such programmes, for instance in primary care and maternity welfare. The Drugs Commission (SOU 2000:126) also pointed to this need, and said that a good relation between mother and child during the first year of living is the best single protective factor (Narkotikakommissionen 2000e, p.28). The Commission also found evidence that children who had got help in early childhood showed a better prognosis in their teens. The National Plan of Action on Drugs (Regeringens proposition 2001/02:91) has this view as a staring point, and the new Public Health Policy (Regeringens proposition 2002/03:35), has it as one of its eleven objectives.

Types and characteristics of intervention with family and childhood

Social services in municipalities are responsible for interventions in families. This is regulated by law. It is up to the local authority to decide what actions is to be taken. In severe cases it is possible to interfere and take care of the child that is neglected. If, for instance, the father is threatening the rest of the family he can be removed. All this is rare instances. Normally various forms of support is offered; economic, personal, etc.

Research projects and evaluation results

Children with a disadvantaged upbringing have a higher risk to develop problems as drug abuse. Actions taken to strengthen risk-groups is therefore of importance. Trulsson (1998) has made a study about addicted mothers with small children. She found that life with the children became a balance between the children, the man (often addicted himself) and the addiction. It also was some sort of hide-and-seek with authorities and others in order to conceal the drug abuse. Their ideal image was similar to what is common for women in general. The problem was the large gap between the ideal image and the reality. The mothers wanted to put the need of their children before their own, but felt they could not cope with that. Trulsson concluded: The opportunity for mother drug addicts to strengthen their identity through interaction with other women is a unique situation in the women`s lives, connected to their situation of mother-to-be. It marks the way forward and should be used in connection with treatment (p.293).

## 9.4 Other programmes

Description of certain interventions

*Peer-to-peer approaches*

Peer-to-peer approaches are not common, but exist on local initiatives. The normal model use pupils a few years older as mentors and they are not focused on drugs alone. An organization, Hassela Solidarity has, since 1984, set up peer-to-peer networks (“kamratstödjare”) in several municipalities all over the country. Unemployed young persons (in age 18-23) are trained and supervised as mentors for pupils a few years younger. The aim is to counteract mobbing, drug use, violence, criminality and exclusion during the school years.

*Telephone help-lines*

There are no manned telephone help lines for drug issues available, but the Government has given NIPH the assignment to investigate the need for it (Regeringens proposition 2001/02:91). This will be done during 2003.

In case of poisoning accidents, it is possible to contact the 24-hours available Drug and Poisoning Centre, as well as the Medical Service Information Centre. During office-hours it is possible to reach every specialised treatment agency to get advice.

The only telephone help line offering information by a trained staff is the Anti Doping Hotline, free of charge and available weekdays. This service was opened in 1993. Nowadays it also has an Internet-connection, www.dopingjouren.nu .

*Community programmes*

Not being a programme itself, but a centre of resources for the city parts of Stockholm, "Precens" opened during 2000. It is a drug prevention centre run by the social services aimed at stimulating 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.

A similar centre has newly opened in south of Sweden in the Scania region, www.cerum.se . Cerum is supposed to act as consultants for the region and point at evidence based methods. Together with the university it will start an academic course in prevention, arrange seminars, etc.

*Mass media campaigns*

Mass media campaigns are not common. An eventual campaign will probably be directed by the National Drug Policy Coordinator. At the moment no such campaign is planned. There is a view that campaigns only are motivated if they are meant to promote certain other activities aimed at a problem. A local example of this is a campaign on commuter trains, buses and the local newspaper when the social authorities in Stockholm by post distributed a handbook on alcohol- and drug abuse to parents. The campaign wanted to highlight the event and make parents aware of the parcel.

*Internet*

There are several Internet-sites that have a profile on drugs or at least dedicate some of its space for that. One example is www.droginfo.com . This site has a profile on drugs, and part of its content is presented in several languages. Another site is www.drugsmart.com , administered by CAN and with a focus on youths. Drugsmart is an interactive site primarily aimed at pupils in grade 7-9, their teachers and parents. The site has been evaluated and found highly appreciated. On the negative side, according to the evaluation, it was found that only a limited share of the teachers responding to the survey knew of its existence (KAN AB 1999).

The Internet based news agency www.drugnews.nu present articles and extracts from newspapers and journals. Another site, www.hnnsweden.com , presented both in Swedish and English, has an international coverage.

*Research projects and evaluation results*

NIPH has issued a volume about prevention in the alcohol field (Andréasson 2002). In relevant parts it covers also drugs. There, as well as by a memorandum from the Drugs Commission (Narkotikakommisionen 2000e), it is concluded that the base for all preventive efforts is the supply dimension. It is a need, it says, to divert actions from the individual perspective to the structural level. It is also concluded that the field of prevention is missing a research base.

*Specific training*

An academic post-graduate course in prevention for professionals is under construction. A pilot course has started during the autumn 2002. A corresponding course in treatment is under way.

# 10. Reduction of drug related harm

## Role of harm reduction

*Definition and priority*

The National Action Plan on Drugs (Regeringens proposition 2001/02:91) does not use the term "harm reduction". However, the Drugs Commission (SOU 2000:126) clarified the Swedish view: Individual drug abusers can be offered help without demand for an immediate and/or long lasting drug-free living. If this could be interpreted as a harm reduction view, the rest of the policy could not: The drug abuser shall be offered contributions that are built on abstinence, but the choice of treatment shall not be chosen on economic grounds (harm reduction is criticized for being offered for reasons of economy instead of actual needs). The Commission advised against legal prescription of heroin, shooting galleries and other low threshold programmes. As methadone maintenance treatment is administered in a very strict form in Sweden (ad modum Dole – Nyswander) it is not apprehended as a harm reduction action. Buprenorphine (Subutex) has been introduced for treatment of heroin addiction, and it seems it will be regulated in very similar way.

*Recent policy trends*

The Government and the Parliament has decided on a new Action Plan on Drugs (Regeringens proposition 2001/02:91). This was made in 2002. In its opening passage it is stated that the objective still is a drug free society, which means that the restrictive policy is unchanged. In its choice of direction the Drugs Commission (SOU 2000:126) had opened its report in the following way: "Swedish drug policy has come to a crossroads. 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 considerable acceptance of drugs."

*Current public/professional discussion*

A common first reaction on the new Action Plan on Drugs was presented (as a proposition from the Government in January 2002 and as accepted by the Parliament in April) were that it offered to little. This could be argued for from conservative as well as from liberal standpoints. A debate started in daily newspapers. In one of them (Dagens Nyheter 2002-02-26) six researchers said that the proposition lacked any new thoughts and that the emerging problems was supposed to be met by "more of the same" (which they argued has not been effective). A year later another newspaper, Expressen (2003-02-04), accused the Swedish restrictive drug policy for being a religion and that another year has been lost.

## Harm reduction practice

Harm reduction in its usual definition is not in practice. In conflict with the restrictive policy two needle exchange programmes exist. They are situated in Scania (Lund since 1986 and Malmö since 1987) on clinics for infectious diseases as a reaction on an expected HIV-epidemic at that time. The National Drug Coordinator will present a recommendation on the programmes future in February 2003. One alternative is to close them down.

## 10.1 Description of interventions

### Outreach work in recreational settings

Outreach work in recreational settings is not an established work routine for the social services drug teams, but is sporadically formed at special settings as music festivals that gather young people.

### Prevention of infectious diseases

Drug abusers in treatment or in custody or jail are approached regarding infectious diseases and informed, offered testing and vaccination. It is a normal routine in treatment for drug abuse to handle also prevention of infectious diseases. This is of course easier to fulfil in treatment within hospitals (detoxification) and in jails. In out-patient treatment (which dominates the treatment supply) it is not always a remittance for testing will lead to an actual visit at a clinic where it can be done. The custody in Stockholm and in other places has, during 2001, formed special teams that seek out inmates for preventive actions and eventual treatment. This has increased the number of HIV-tests.

### Prevention of drug related overdoses

There are no dedicated actions to counteract overdoses. The needle-exchange program in Malmö tried to start a course for their visitors, including handling of naloxon, and to persuade the police not to arrest those drug abusers that were present when one of their mates waited for an ambulance. This could not be done, but the programme instructs their visitors how to act in case of overdoses. It is believed that experienced IDU:s has some knowledge and that this is spread also to less experienced abusers.

### User rooms

There exist no user rooms in Sweden.

## 10.3 Standards and evaluations

Harm reduction in its classical sense in not used. The only examples of HR are two needle-exchange programmes that were started without official permission in 1986/87. They are now standing before a definitive decision by the Parliament if they are accepted or must close down. The National Drug Policy Coordinator will present his recommendation in February 2003. The programmes have presented yearly statistics and reports and several external evaluations have been made, the latest by NBHW. As it cannot be proven that the lower rate of HIV among IDU:s in the region is due to the programmes it is put in question if the needle exchange should continue.

# 11 Treatments

The financial difficulties of municipalities and county councils are part of the reason for the inadequacy of drug abuser care in many quarters. This is most pronounced when comes to the most

problematic abusers. To a great extent what seems to be involved is a combination of resource constrains and poor utilisation of the resources available, due to, among other things, shortage of detoxification places. An infelicitous combination of economisation targets and division into progressively smaller performance units has thwarted the necessary holistic view of the individual abuser of treatment initiatives. Short-term, isolated decisions often take the place of interaction and examination of the abusers long-term needs (SOU 2000:126).

The latest contribution to the treatment strategies is the introduction in 1999 of buprenorphine (Subutex). In an initial phase it was introduced in a few specialised and hospital-based treatment units within university hospitals. Evaluation of the first pilot-cases was favourable and buprenorphine has thereafter been used under supervision in other specialised units, but still in a low number of cases. The NBHW has let a panel of experts compile a preliminary report on buprenorphine treatment, which is now under discussion. It is very probable that the Swedish methadone maintenance programme will be used as a model. 36 years of experience with MMT will lead to restrictions in the prescription with buprenorphine. Treatment would then be limited to specialised drug units highly structured and with established channels to the social services that has the formal responsibility for the patients.

## 11.1 "Drug-free" treatment and health care at national level

Objectives and definitions

"Drug-free" is not a term in common use. It refers to all types of treatment except detoxification and substitution with methadone and buprenorphine. In reality "drug-free" is not fully correct, as it is not uncommon to prescribe certain pharmaceuticals in residential care or in out-patient contacts. The difference is the period the abuser is supposed to take his medication. There is, however, a common held view that medication should be kept at a minimum level.

Criteria for admission to drug-free treatment

If there are thresholds it is not primarily by criteria that should be fulfilled, but rather a willingness by the social services to stand behind the application for treatment. There might also be a waiting-list. These problems are less manifest in out-patient treatment. During the latest decade reorganisations and discontinuation of specialised treatment has, however, made it a bit harder to get a treatment contact at the very moment you apply for it.

Availability, financing, organisation and delivery of drug-free treatment services

The Drugs Commission put it bluntly: It is the Commissions opinion that treatment supply does not meet the demand, and this is particularly evident for the most problematic abusers (SOU 2000:126, p.149). The National Drug Policy Coordinator has got the task to stimulate developments in this field; resources, methods, etc. It is the economic responsibility of the local social service or the counties (treatment in hospitals) that those in need get adequate treatment.

Evaluation results, statistics, research and training

On national level data are scarce, but the NBHW produce a report, "IKB", that sets out the results of a survey of services and clients in treatment units for adults who misuse alcohol and other drugs. The latest was carried out on a certain day, April 2, 2001 (Socialstyrelsen 2002a).

20 244 people (18 years old or older) were undergoing treatment for their misuse problem. Of these 83 % were undergoing out-patient treatment, 13 % were undergoing residential treatment and 2 % were undergoing in-patient treatment in hospitals. 2 % were undergoing treatment for misuse in prisons. The proportion of women was 30 %. Approximately 10 % of all clients were younger than 25 years old. Almost half (49 %) received treatment for alcohol misuse only, just under a fifth (19 %), for drug misuse only and a third (32 %) for both alcohol and drug misuse.

In total it was reported that those undergoing treatment included 2 800 injecting drug users and 2 900 with serious mental disorders.

The vast majority of the units do not specialise in a particular type of misuse. Of all the 567 units included in the survey, most of them (84 %) address both alcohol and drug misuse. About 10 % treat alcohol misuse but not drug misuse and 6 % treat drug misuse but not alcohol misuse. Out-reach activities occur only at a fifth (21 %) of the units.

## 11.2 Substitution and maintenance programmes

Objectives for substitution treatment

Substitution treatment for heroin addiction is offered only in Methadone Maintenance Treatment programmes or through controlled prescription with buprenorphine (which seems to be regulated more or less in the same way as MMT within short).

Criteria for admission to substitution treatment

The MMT-programme adheres to the Dole–Nyswander formula. The criteria for admission are: a) A history of at least four years documented intravenous opiate abuse, b) earlier attempts at drug-free treatment judged to be of negligible value to the patient, c) age at least 20 years, d) an opiate as the dominating drug, and e) not being in prison at the time of admittance to the programme. During the entire MMT period the patient should have support from the social services.

It is easier to get into buprenorphine treatment, but the availability is limited, and will be further regulated.

Availability, financing, organisation and delivery

MMT is available in four places: Uppsala (which started in 1966), Stockholm, Lund and Malmö. Lund has a branch unit in nearby Helsingborg. Together the four units constitute a national programme with a common admission. The programme is under supervision of the NBHW and the Parliament has decided that the total number of patients may not excess 800.

Counties pay for the treatment of their patients. Patients meet up at the clinics every day in the first six months of treatment (which sometimes is started with a period in a hospital that have a special unit for drug abuse and methadone treatment). The spend most of the day there while they are undergoing various forms of training and education. They are screened for drugs on a regular basis even after this initial period.

Substitution drugs and mode of application

Methadone and buprenorphine are the only drugs used. To get into the MMT-programme you need a remittance from a physician specialist in psychiatry/drug abuse working in a drug treatment unit, and to "qualify" for this remittance you have to be well known. The NBHW decide which applications should be granted.

Psycho-social counselling

MMT is a combination of pharmacological treatment and psycho-social counselling. It is clearly stated that MMT means "methadone assisted treatment". Hence, the first six months means a full time occupation in psycho-social counselling.

Diversion of substitution drugs

As all patients are urine screened on a regular basis that makes it impossible to make it sure that they have taken their daily dose and noting else it is nearly impossible to find any leakage of methadone. Patients are also aware that they will be thrown out of the programme if they do not adhere to the rules.

Buprenorphine is not yet surrounded with the same level of security as methadone, but so far there has not been established a black market for it.

Evaluation results, statistics, research and training

The Swedish experiences with MMT is presented in EMCDDA:s Insights series no 3 in 2000, Reviewing current practice in drug-substitution treatment in the European Union (pp.232-253).

A register study (Socialstyrelsen 1997) included 655 patients (465 men and 190 women) who were treated at some time or other between 1966 and 1993. Of these 257 (195 men and 62 women) had been involuntary discharged and had not returned to methadone treatment, 48 (40 men and 8 women) had at least two methadone treatment periods and 312 patients (203 men and 109 women) had not interrupted their methadone treatment. 38 patients (27 men and 11 women) died while enrolled for a methadone programme.

As part of the evaluation, an interview study was undertaken with a total of 205 methadone patients enrolled in 1993-1994 in the four units. A majority of both male and female patients reported distinct improvements with regard to housing, employment/education, social relations, health, family relations and use of alcohol and drugs. 38 % of the patients showed a significant improvement in six out of the above seven areas. The number of hospital admissions declined markedly, as did the number of indicted offences. Similarly, there was a decline in the number of detentions (arrest or remind in custody).

The patients who had difficulty in adjusting to methadone treatment and were involuntary discharged showed an increase in recorded criminal behaviour but had fewer indicted offences after discharge than before entering treatment. On the other hand, consumption of in-patient care in hospital showed a marked increase following discharge.

The study concluded that MMT leads to a noticeable decline in criminal behaviour, hospital care and mortality and also a clear improvement in many patients` living conditions. Factors such as

being a man, being under 30 years old when entering MMT, having collected at least ten criminal convictions before entering MMT and low Methadone dosage (below 65 mg/day) augment the likelihood of involuntary discharge.

## 11.3 After-care and re-integration

Links with national strategy and legislation

The new national strategy (Regeringens proposition 2001/02:91) wants the treatment offerings to be improved. The objective is: a) To offer every drug abuser treatment, b) that advice and help shall reach those in need early in the drug career, c) that treatment shall result in a life without drugs, d) that treatment shall be of good quality, and e) that all actions shall be persistent. The responsibility to realise this is on the municipalities and the counties.

Objectives, definitions and concepts of reintegration

The NBHW has started an analysis of treatment methods that will end in recommendations of how drug treatment shall be organised. A meta-analysis of international research reports made by The Swedish Council on Technology Assessment in Health Care (SBU 2001) is the ground for this process. This is part of the new national strategy to improve the actions against drug abuse.

Accessibility for different target groups

The new strategy makes a considerate effort to improve drug treatment in prisons. This is part of the new profile to sharpen the attention on those who are worse off. It is believed that the group of older abusers with a long drug career need more active help.

Organisation, financing, managing, availability and delivery of services

It is the duty of the social services in the municipalities to arrange for adequate treatment for those in need of that. The client has a right to treatment. It is also on the social services to guarantee payment for treatment that is administered by other suppliers. Treatment in hospitals is, on the other hand, a task for the counties.

Statistics, research an evaluation results

Statistics relating to adult abusers of alcohol and drugs given by the social services in the municipalities are reported by the NBHW. The last (Socialstyrelsen 2001) refers to the situation in November 1, 2000. In all, 49 % of those receiving care solely used alcohol, 29 % solely used drugs and around 22 % used both alcohol and drugs. Around 80 % were receiving out-patient care.

Until the Treatment Demand Indicator project (part of Epidemiological Key Indicators) has been fully implemented (KIM, Klienter i missbrukarvård) national statistics focused on drugs is not available. Data from KIM is so far not published (but has been presented in a preliminary form in EMCDDA-seminars).

Training

The NBHW has started a process to investigate the needs for training courses for staff in different treatment sectors. It will also outline a programme for training in certain educational schemes; physicians, social workers, etc. The need for this was highlighted by the Drugs Commission (SOU 2000:126) and in the new National Action Plan on Drugs (Regeringens skrivelse 2001/02:91).

# 12. Interventions in the Criminal Justice System

The national Prison and Probation Administration present statistics and other information on its web-site www.kvv.se . The new National Action Plan on Drugs (Regeringens skrivelse 2001/02:91) puts much emphasis on treatment of drug abuse in the prison and probation system because of its intensive and close contact with a large number of experienced drug abusers. It is of importance that time spent in prison and probation is used to motivate abusers for treatment. Therefore the Administration has been granted an extra funding with 10 million Euros for such actions. Methods for planning of enforcement and treatment should be developed. Programme activities, methods development and competence development should be given priority, and activities in motivation and treatment units should be developed so as to permit greater involvement of the outside community.

The Administration has presented an Action Plan on Drugs that works in that direction. The objective is to keep prisons and custodies free from drugs. This is a prerequisite for treatment to have effect. Prisoners will from now on be evaluated by Addiction Severity Index, ASI, and from that treatment for drug abuse or other forms of programmes are offered. Staff will undergo training courses to handle this. The action plan puts more emphasis on reward than punishment.

## 12.1 Assistance to drug users in prisons

Abstinence oriented treatments

Today (Kriminalvårdstyrelsen 2002, referring to October 1, 2001) there are 502 accommodations for drug abusers within prisons, which correspond to 12 % of all places. These are in drug free units (urine samples are taken) demarcated from the ordinary system. Besides special wards certain actions for drug abusers are arranged. Of 1 834 persons with a known drug problem 513 were engaged in such activities on the census day. The newly established programme on drugs will extend these operations.

Substitution treatment

Substitution treatment with methadone is only possible in the MMT-programme. A patient that is placed in prison will lose his methadone.

Harm reduction measures

It is a normal procedure to test new prisoners for HIV. It is also possible to get vaccinations and condoms. Needle exchange is out of the question.

Community links

It is possible to be transferred to treatment for drug abuse in, for instance, therapeutic communities. Prisoners that have not misbehaved can often expect to be released in advance. The normal procedure, also called "the normality principle", is that prisoners have access to the ordinary health system.

## 12.2 Alternatives to prison for drug dependent offenders

Objectives, organisation, funding and professional resources
Accessibility to alternative measures: principles, criteria for admission

If treatment motivation and needs cannot properly be taken care of within the prison system it is possible to be transferred to treatment outside prison. This is regulated by law, and thereby in everyday expression called "§ 34". In case of misconduct the individual can be called back to the prison. Problems can rise when a prisoner in external programmes reaches the end of his sentence and the Prison and Probation Administration no longer have to pay for his treatment. It is not always that the social services automatically take over the responsibility – for instance because it has binding agreement with another treatment enterprise. The Administration will work on that problem in its new programme on drug abuse.

Information strategies

Prisoners are always informed at detention, and later, about study programmes, therapy for drug abuse, testing for HIV, and the special drug free units that are at hand. In the new programme on drug abuse this will be enhanced. All inmates will undergo ASI/MAPS-screening (Addiction Severity Index and Monitoring Area Phase System) at intake to get a clear picture of the certain need of the client. From that a treatment plan will be elaborated together with the client.

Evaluation and training

The Prison and Probation Administration publish an annual report on the drugs situation. The drug abuse treatment scheme that are now under introduction are supported with an assessment programme (ASI/MAPS) that also will result in more detailed evaluation possibilities.

An extensive education programme for staff members has started. It is built upon ASI/MAPS-strategy.

# 13. Quality assurance

Description of new trends and developments

The Drugs Commission (SOU 2000:126) highlighted the need for evidence based methods and evaluations in prevention and treatment. The National Action Plan on Drugs (Regeringens skrivelse 2001/02:91) puts this into action. Different agencies are involved in this. The National Agency for Education has reported (Skolverket 2000) that drug education in schools is not up to date, and will now, together with the National Institute of Public Health (NIPH) analyse what is needed to reinforce the preventive programme in the school system. The school curriculum is supposed to integrate the preventive programme.

NIPH will also investigate the need for training courses for those active in prevention. A telephone help-line will also be investigated. The National Board of Health and Welfare, NBHW, will sketch out a training course for those active in drug treatment and present directions for treatment of alcohol and drug abuse.

NIPH and NBHW has been directed to present methods to follow-up all those activities that now are inaugurated in municipalities, counties, etc.

Formal requirements for quality assurance
Criteria and instruments applied in quality assurance

The new action plan has started a mobilization process based on quality assurance and certain central agencies are in a process to develop quality assessment instruments.

Application of quality assurance procedures and results

Certain agencies, like NIPH, NBHW, and the National Drug Policy Coordinator are involved in the process to develop and administer quality assurance instruments and report on the development.

# Part IV.
# Key Issues

## 14. Demand reduction expenditures on drugs in 1999

Direct expenditures in the field of drug demand reduction
A short introduction

Direct expenditures in demand reduction have never been estimated. A few estimates of the cost of society for drug abuse has been made, but preventive costs were then excluded as they focused on factual costs for abuse. For instance, when the Customs tried to calculate the economic benefit of seizures, cost for prevention was excluded, as drugs that are seized are aimed at existent abusers. Moreover, drugs that might attract novices has a low rank in an index of relative harmfulness of different drugs that has been published by the UNDCP (1997) and the prices on the illegal market seems to follow that very well. The Customs, therefore, set a higher value on seizures of drugs like heroin than on cannabis.

Together this puts emphasis on the established group of problematic users (most often IDUs), which set the agenda not on primary prevention but secondary and tertiary prevention. As it was estimated that in excess of 90 % of all illegal drugs was consumed by this group this was only natural. Drug novices are not a driving force when it comes to costs of drug use. That describes the present situation. We are in a (slow) process to develop some knowledge about the economic stigmata of developed drug abuse, while our efforts and costs of prevention are not even estimated. Today we lack collected information about actions taken, and are unable to calculate what it cost.

The Drugs Commission discussed expenditures, but excluded prevention. NIPH has started a process that might, in a few years time, get a better picture of demand reduction programmes – and expenditures – when the new national agenda on public health has been fully implemented throughout the country.

### 14.1 Concepts and definitions

Demand reduction is a term not easily translated into Swedish even if the meaning of it is clear for those closely involved in it. “Förebyggande arbete” or “prevention” is the terms normally used in Swedish. While preventive means mainly points to counteractive measures before a drug debut, prevention has a wider range including means even after a debut in drug use. It is commonly talked about primary, secondary and tertiary prevention, and this is also terms used in the National Action Plan on Drugs (Regeringens skrivelse 2001/02:91)

The Drugs Commission (SOU 2000:126) has emphasised that “prevention” is more than direct actions aimed to be preventive as actions on a structural level might have effect also on drug behaviour (p.115). The Commission actually suggests that focus is shifted from special and temporary contributions to the structural level whereby more precise measures can ride the wave. “Structures” refers to laws, rules, routines, partnership, political decisions, etc.

It was further stated (p.116) that primary prevention should be considered on different levels; public level, group- and individual level. Primary prevention refers to what happens before a problem arrives. Secondary prevention is early reaction on a problem and tertiary prevention reactions on an established problem.

Prevention is one part of the national drug policy. The others are care and treatment, restriction of supply and international cooperation.

## 14.2 Financial mechanism, responsibility and accountability

Organisation and delivery of drugs demand reduction expenditures during the year

The greatest part of the costs of drug abuse is transferred to the rest of the population and society. In spite of that these costs are hard to calculate. The Drugs Commission (SOU 2000:126 p.179) estimated a daily cost of at least 21 million SEK (about 2.1 million Euros). Prevention has never been estimated, and there is not even a consensus on what comprises prevention. Much of it is paid by tax money, but various associations may have programmes that could be labelled demand reduction without this would be integrated in an analysis of costs.

Through the creation of a national drug policy coordinator and the reorganisation of NIPH (who will follow-up measures on the local level) it will perhaps be possible to estimate the total costs for demand reduction. Until then calculations can only be brief. Demand reduction actions is often made in the form of a project, but as funding comes from the state, counties, municipalities (n=289), insurance companies, organisations etc it is nearly impossible to get a full picture. Actions are also taken by all these parties. Projects or regular actions can also be integrated into the routines whereby costs are hidden and unknown. It is also common that drug demand reduction are integrated in operations that also focuses alcohol, criminality etc which makes it hard to differentiate the costs. The trend makes it hard to believe that drug abuse will be an own entity. In fact, it is recommended it will not. It is known that persons that are apt to develop drug problems also have other problems that need to be taken care of. This can be done, but it is harder to break down the costs to different types of problem.

National bodies finance, initiates and support demand reduction activities on both national and local level. In practical life these activities is done in schools, social services, medical services, youth centres, associations and by families. Customs and police contribute not only by supply reduction, but also through their part in traditional preventive work as information. They are also members in co-operation networks with the social services and other interests.

It is obvious that demand reduction and drug abuse treatment is differently organised in the municipalities. About half of all municipalities (n=289) have a population less than 15 000 and thereby lack the resources to have a full scale operation on drugs in level with those municipalities that are far greater. In most cases the do not need it either, as problems normally is more prominent in towns and cities. Instead they can relay on preventive programmes administered by, for instance, departments of social medicine in universities and hospitals.

For most people prevention is synonymous with drug education in schools, “ANT” (alcohol, narcotics, tobacco), which is arranged everywhere (but irregularly and with different content). In

most cases this is arranged without extra funding, and thereby its costs are unknown. There is no reporting on the amount of time and resources spent.

There is an interaction between public and private expenditures, but only marginally. Examples are when an association arrange an activity on its own, or together with others, and is sponsored by companies. Financial sources are in almost all cases the public sector, either through special funding or as part of the ordinary budget. In the latter case its actual cost is not observable.

## 14.3 Expenditures at national level

*From central level*

The only known estimate on costs for demand reduction expenditures on alcohol and drugs was made by the Customs (Tullverket 2000). The estimate was very rough and made an assumption that the municipalities spent an average three man-year with a total cost of 300 million SEK (30 million Euros), the counties spent five man-year with a cost of 250 million SEK (25 million Euros) and the state spend 50 million SEK (5 million Euros). Non-governmental organisations, foundations and companies were estimated to spent 25 million SEK (2,5 million Euros). With this formula the total cost were 625 million SEK or 62,5 million Euros.

The Customs as well as the Police can make estimates of what resources they direct to combat drugs, but prevention can not be separated from this. Prevention will also be a smaller part of the costs. The Prison and Probation Administration and the National Board of Institutional Care put resources on alcohol and drug problems, but this is not foremost prevention.

In 1999 the National Institute of Public Health distributed 3.8 million SEK (380 000 Euros) to demand reduction projects in counties and municipalities.

*At regional/local level*

There is an array of prevention projects on the regional level, but information of their budgets are notoriously missing. However, many of these projects are financed by funding from NIPH (see above). Some of these activities are not solely preventive and others are only indirectly preventive, as their foundation is to build networks. At regional level it is often the county administrative board that acts as convener.

The main actor is the municipalities. Traditionally it is the social services that co-ordinate the local programme. Contributory actors come from schools, recreational services, drug treatment, the police and other instances, as organizations. Normally such activities are part of the ordinary duties and its direct cost is normally not calculated.

## 14.4 Expenditures of specialised drug treatment centres

Treatment centres put only marginal resources on prevention. However, their patients might receive measures that could be described as prevention, but as this is regarded as part of the treatment it is hard to calculate the amount of preventive actions without detailed studies in the units – and those are missing.

Out-patient treatment centres has more external contacts than in-patient centres, but so far it has not been possible to get information to what degree this means preventive actions. It seems so, but data that could be translated into man-years and costs is missing.

## 14.5 Conclusions

Problems on information and research

While hospitals during the latest decade have developed an extensive cost oriented approach, drug treatment and drug prevention programmes has not - and this not only in local activities but at national level as well.

There is a growing interest in expenditures, but within the drug abuse field it is costs in relation to treatment that attracts most interest. The NBHW is preparing recommendations for drug abuse treatment. The underlying motive is to get individual clients into the kind of treatment that best suits his needs; i.e. is cost-effective.

Publications from the National Board of Education (Skolverket 2000), the Drugs Commission (SOU 2000:126) and the National Institute of Public Health (Andréasson 2002) have triggered the interest to evaluate prevention too. Thereby the costs will be elucidated.

# 15 Drug and alcohol use among young people aged 12-18

There are two main sources of information about prevalence rates of drug and alcohol use among young people in Sweden. These are the annual school surveys and the annual surveys among young men enrolling into army, which both have been conducted since the early 1970s.

Other sources are population surveys, case-finding studies which are aimed at counting the regular and severe users, findings from research projects and official statistics.

## 15.1 Prevalence, trends and patterns of use

General population surveys and special surveys and special surveys on people 12-18

*School surveys*

The school surveys focus on two grades, six and nine, at which the students are 12-13 and 15-16 years old respectively. Additionally, in the late 1990s, a special study was performed by drawing cross-sectional samples in four consecutive grades at school, including the grades six, seven, eight and nine. These studies gave complementary information about the development, within an age cohort, of drug and alcohol habits of students in Sweden.

In grade six (aged 12-13) the prevalence rates of drug use are very low. Just 1 % of the students or less has tried drugs and the prevalence rates have been the same over the years since the beginning of the 1970s (Hvitfeldt 2002). The cohort that constituted the grade six in 1997 were, as mentioned above, surveyed also in consecutive grades. These data shows that it is particularly in grade eight (students aged 14-15) that the big change occurs. In grade seven (in 1998) about 2 % had tried any drug, in grade eight 7 % (1999) and in grade nine 9 % (2000) (Andersson 2002).

In grade nine the lifetime drug use prevalence rates form a U-shaped curve over a 30 year period (Figure 1) (Hvitfeldt 2002). From the high rates in the early 1970s (about 15 %), the proportions stayed at the level of about 7 % over a decade between the mid-70s and the mid-80s. It reached its lowest level in 1989 (3 %). In the beginning of the 1990s the figures begun to rise, but have not as yet reached the top levels of the 1970s. In 2001 the lifetime prevalence among 15-16 years old students was 10 %. No important gender differences are found in this respect in any of the different school surveys.

*Surveys among military conscripts*

The tests that all Swedish men have to pass for enrolment into the army are carried out at the age of 18. On that occasion a small questionnaire about alcohol and drug use is also answered. The development of the prevalence rates is similar to the one in grade nine, but on a higher level (Guttormsson 2002). These data show that in the beginning of the 1970s about 16 % had used illicit drugs and these figures reached their top level in 1980 (19 %). A decline occurred in the 1980s and the lowest prevalence rate was noted at the end of the decade (about 6 %). During the 1990s an increasing trend has resulted in prevalence figures passing the top figures noted in the beginning of the series (18 % in 2001).

*Household surveys*

Of the population surveys that have been performed over the years a majority have focused on alcohol and only a few of them reveal data on young peoples drug use. In 1994 and 1996 surveys were conducted among people aged 15-24 and in 1998 among people aged 16-24 (Lindén-Boström 2000). The lifetime drug use prevalence rates for the entire survey populations these years were 4.9 and 11 %. Only the 1998 data allowed for breakdowns by age group. The proportion of young persons aged 16-17 who had ever used drugs was 3 %.

Thus, there is a discrepancy between these data and the grade nine survey data (around 8 % had ever used drugs in 1998). The difference is most probably a methodological effect. The school surveys were conducted as group administered questionnaires in the classroom, while the population surveys were telephone interviews. The respondent might perceive a higher degree of anonymity in the classroom compared to the interview situation in his/her home, perhaps with other family members around.

*Types of drugs*

Cannabis is the dominant drug among young people who have tried drugs in Sweden. Of those in grade nine in 2001, who ever used any drug, more than a half had used cannabis solely (54 %), a tenth (10 %) had used any drug other than cannabis and a third (30 %) had used both (Hvitfeldt 2002). There is a tendency towards a slow change in this pattern during the last ten years. Thus, in 1991 the corresponding figures were 73.2 and 16 %. Also among the 18 year old military conscripts the main drug still is cannabis with a slight increase in the use of other drugs (Guttormsson 2002).

In 1992 68 % had used only cannabis, 8 % drugs other than cannabis and 24 % had used both. In 2001 the corresponding figures were 55.6 and 37 %.

*Combination with alcohol*

Drug use is often correlated with heavy alcohol use. The series of school surveys has shown that heavy alcohol consumers are more likely to use drugs. Among the grade nine students in 2001 who reported the highest annual alcohol consumption 26 % had ever used illicit drugs compared to 10 % at average. In addition, both the schools surveys in grade nine and the military conscript surveys show that the prevalence rates of intoxication form a similar U-shaped curve as the drug use figures do over a period of about 30 years, i.e. when drug use frequency increases the intoxication frequency does the same (Figure 2) (Hvitfeldt 2002, Guttormsson 2002).

Young people sometimes try different combinations to achieve possible synergetic effects. In grade nine many of the students report that they have combined alcohol with pills in order to get high. In 2001 the proportions of students who reported this were 5 % among boys and 12 % among girls (Hvitfeldt 2002). Thus, this behaviour is particularly common among girls. The results from the ESPAD study show that this is true also in many other European countries (Hibell 2000). In many cases they have used pain killers because this is what is at hand and it is believed to have the desired effect.

*Studies on severe drug abuse*

Case-finding studies were carried out in 1992 and 1998 in order to determine the prevalence of severe drug abuse in Sweden (Olsson, O. 1993, Olsson, B. 2001). “Severe drug abuse” is defined as “any intravenous use of drugs, regardless of substance, or any daily or near-daily use of drugs, regardless of the method of administration”. Cases of known drug abusers were collected from local authorities in a selection of local communities.

The 1992 investigation consisted of 100 local communities (52 % of the total number). Using a capture-recapture technique gave the estimated number of 19 000 severe abusers. The 1998 investigation involved 47 local communities (40 % of the total number). The estimated number of severe drug abusers this time was 26 000.

**Table 1**. Drug use pattern among reported drug users aged 12-18 in 1992 and 1998 (percentage)

| | **1992** n=882 | **1998** n=804 |
|---|---|---|
| Female | 37 | 30 |
| Male | 63 | 70 |
| ***Drugs used*** | | |
| Cannabis | 51 | 93 |
| CS (amphetamines) | 18 | 38 |
| Cocaine | 4 | 1 |
| Opiates | 10 | 12 |
| Hallucinogens (LSD) | 3 | 11 |
| Psychoactive drugs (bensodiazepines) | 21 | 30 |
| Solvents | 12 | 8 |
| Alcohol | 12 | 36 |
| ***Dominant drug*** | | |
| Cannabis | 36 | 70 |
| CS | 4 | 9 |
| Opiates | 2 | 3 |
| Psychoactive drugs | 2 | 3 |
| Solvents | 4 | 1 |
| Alcohol | 8 | 13 |

Table 1 show that 882 persons aged 12-18 were found in 1992, which is 5 % of the total number reported abusers. In 1998, 804 persons were found, 7 % of the total number. The proportion defined as "severe abusers" within these groups was 9 % in 1992 and 12 % in 1998. This might indicate that recruitment of young people into severe abuse of drugs has increased.

*Drugs used*

As can be seen from Table 1, cannabis and amphetamines are the most common substances of abuse. In 1992, 51 % used cannabis and 18 % used amphetamines. In 1998 there was a rise to 93 % for cannabis and 38% for amphetamines. Use of opiates was relatively unchanged (10 and 12 % respectively). Hallucinogens (LSD mainly) have increased from 3 % in 1992 to 11 % in 1998. Table 1 also shows that use of psychoactive drugs (bensodiazepines) has increased in this period from 21 % to 30 %. Alcohol misuse is common among drug abusers, with an increase from 12 % in 1992 to 36 % in 1998. However, use of cocaine and solvents has declined; cocaine from 4 % in 1992 to 1 % in 1998 and solvents from 12 % in 1992 to 8 % in 1998.

*Dominating substances*

Table 1 show that cannabis was the dominating substance among the very young abusers in 1992 as well as in 1998. Cannabis as the dominant drug increased from 36 % to 70 % between 1992 and 1998. Amphetamines increased from 4 % to 9 %, while opiates and psychoactive drugs remained relatively the same. Misuse of solvents declined. Alcohol, however, was the dominating substance of abuse in 13 % of the cases in 1998, compared to 8 % in 1992. A conclusion from the last study was that the reporting authorities seemed to have a better knowledge about young people than the about older abusers.

*Patterns of use*

In 1998 the most common combination was CS-cannabis, followed in order by CS-cannabis-ecstasy, CS-cannabis-LSD-ecstasy, opiates-cannabis, CS-opiates-cannabis-LSD-ecstasy and CS-opiates-cannabis.

*Homeless*

In 1999 the National Board of Health and Welfare counted up to 8 440 homeless people in Sweden (Socialstyrelsen 2000c). Of those had 70 % drug problems (amphetamines, opiates, alcohol and other drugs), 35 % had mental problems and one fourth had both mental problems and drug abuse problems. However, the number of young persons aged 12-18 among them are very few.

Qualitative research

A qualitative study within the MAX 1998 project includes deep interviews with severe drug abusers. However, the absolute majority of the interviewees are 20 years or older (Lander 2002).

Perceptions about risks

There is reason to believe, that increasing drug use prevalence rates would lead to less restrictive attitudes towards drugs among young people. Negative correlations have been found between the proportions who have used any drug and the proportions considering drug taking as a great risk in 26 European countries in 1995 (Morgan 1999). The proportions among Swedish students aged 15-16 who considered taking cannabis once or twice as a "great risk" decreased from 52 % to 44 % between 1995 and 1999, while the lifetime prevalence rates of taking cannabis increased somewhat from 6 to 8 %.

In the annual school surveys the students are asked if they have felt attempted to try any drug and if someone has offered them to try a drug. The proportions among those who actually never tried any drug, but who answer positively to these questions tend to rise at the same time as the prevalence rates arise. This indicates that in times of increasing drug taking there is a parallel change in the attitudes towards drugs, also among those who haven't tried any drug (Hvitfeldt 2002).

Trends in recent years

As described earlier, the long term trends in prevalence rates of drug taking and the frequency of intoxication among young people 15-18 tend to take the form of long waves (Figures 1 and 2). From a period of low prevalence rates in the 1980's, a new upward trend was observed in the 1990's. Figure 1 shows the proportion of boys and girls in their 9$^{th}$ school year with intensive alcohol consumption at least once a month, and military conscripts that gets drunk once a week (1971-2001). Figure 2 shows the lifetime drug use prevalence among students in their 9$^{th}$ school year and among military conscripts.

A slow shift can be observed towards drugs other than the traditional (mainly hashish), that have been predominant over the years. Still, the prevalence rates are low, but an increasing testing, experimenting and mixing of drugs has been observed (Byqvist 2002). Drugs that are mentioned in relation to this are ecstasy, amphetamines, heroin for smoking and new synthetic drugs.

## 15.2 Health and social consequences

Deaths and overdoses

Drug related deaths are recorded in the National Cause of Deaths Registry. The National Board of Health and Welfare are responsible for the publication of the data. In the annual reports, an index of drug related deaths (both underlying and contributory drug related causes) are presented. Overdoses and deaths among drug dependent persons are included, but it should be noted that in some cases it might include poisonings among non-drug addicts. The, opposite, underreporting, ought to be rather unusual in this case since most unexpected deaths among youths are carefully investigated and have high autopsy rates.

According to that index, the number of drug related deaths among persons below 19 years old has been 2 deaths per year at average in the period of 1969-2000 (Socialstyrelsen 2002b). The figures have been fluctuating between 0-7 per year, apart from the latest available year (11 deaths). An age cohort consists of approximately 100 000 persons, which gives an average of 1.6 drug related deaths per 100 000 persons in the age group of 12-18 years old for the year of 2000.

The total upward trend in drug related deaths among all ages might be reflected also in the youngest ages, since the average for the last five year period has been 5 deaths a year. However, since the numbers are low, it is difficult to make any certain statements about any increase among the youngest.

Hospital emergencies

There is no national collection of data on the causes for emergency room visits in Sweden. An attempt to describe the frequency of drug overdoses might be to use the in-patient registry, and extract the ICD codes corresponding to drug poisoning (T40.0-T0.3, T40.5-T40.9 and T43.6). However, in several cases these codes apply on drugs that might have been legally prescribed and overdosed, by mistake or by purpose. In other words, it is not necessary that overdoses with these drugs have to be overdoses among drug addicts. On the other hand, F-codes (F11-F16 and F18-F19) might also be used in some of these cases and are therefore of interest as well. The data on discharges according to the in-patient registry are collected by The Centre for Epidemiology at The National Board of Health and Welfare (Socialstyrelsen 2002c).

During 1997, when the 10th ICD-revision came into use, some 28 drug-related intoxications among 12-18-yearolds can be found in the in-patient registry (T-codes). The figures were the same in 1998, 35 in 1999 and 45 in 2000. In all, 136 intoxication events took place among 133 individuals during the four-year period. Since the period is short and the figures are low, it is not possible to draw any conclusions on trends. Only half of the reported intoxications were due to illegal drugs, almost a third was due to codeine preparations and the rest were due to “other or non specified narcotic drugs”. If one adds the above-mentioned F-codes, the number of discharges was 388 in 1997 and rose to 448 in 2000 among the 12-18-year olds. Counting an individual only once per year of course gives lower figures, and the number of yearly treated unique persons remains more or less the same each year during the period (some 260 individuals per year at average).

One of the major hospitals in Stockholm city runs a local registry on the emergency room admissions. A searchable variable in the registry is heroin intoxications. Between 1996 and 2001

some 550 emergency room visits were caused by heroin overdoses, and in about one percent of those cases the patients were between 12 and 18 years old. Without drawing further conclusions for the country as a whole, this information indicates that at least heroin overdoses appear to be relatively unusual among younger persons. No data is available for other narcotic drugs.

Driving accidents

Persons below 18 are only allowed to drive mopeds and motorcycles with a maximum cylinder volume of 125 cc in Sweden, not cars. Driving under the influence of narcotic drugs has been a criminal offence for a long time. In case of a motor vehicle accident, alcohol or drug tests should be carried out, not as a strict routine but when the police have reasons to believe that the driver was under the influence. However, in 1999 a new law was passed that clarified the circumstances to be punished for driving under the influence of drugs.

Official statistics presents data on the number of motor vehicle drivers (incl. moped drivers) involved in road traffic accidents with personal injury reported by the police where the police suspected that the driver was under the influence of alcohol and/or illegal drugs (SIKA 2001). In 2001 39 persons below 18 years old and 73 persons between 18-19 years old were reported in such accidents. This corresponds to some 6 % of all reported accidents in those age groups. This proportion has been the same since the new legislation came to practice in mid 1999, even though the absolute figures were somewhat lower that year (35 and 47 persons respectively). As stated above, these proportions have to be considered minimum figures (Bicycle drivers are not included in the statistics and are practically never investigated regarding driving under the influence of alcohol or other drugs).

In 2001 3 persons aged 15-17 were found guilty for drunk driving under the influence of narcotic drugs as principal offence.

All body fluid samples that are collected within traffic related settings (accidents or careless driving) are analysed at The National Board of Forensic Medicine. According to their statistics a total number of 84 drug analysis were made among persons 18 and below in the year of 2000 (Rättsmedicinalverket 2002). In 2001, the number of received samples was slightly higher (146). (Roughly 85-90 % of the samples turn out positive.)

Although the sources available are somewhat imprecise, they might suggest an upward trend in driving under the influence among young people. On the other hand, this kind of statistics is to a large extent influenced by police routines, priorities and enforcement.

Demand for treatment

There is no complete national registration of compulsory treatment for young drug abusers. However, most of them are treated in institutions registered at the National Board of Institutional Care, SiS. Their latest report states that in 1999, 1069 young persons were taken to treatment at their institutions (Statens institutionsstyrelse 2002). Below follows a summary of interviews with 425 of them. There is, however, not possible to sort out 12-18 year old persons, as the data is collected from persons 12-20 years. 29 % were girls and 71 % boys.

55 % had used cannabis; 29 % at least twice a month.
30 % had used amphetamine (not injection); 11 % at least twice a month.
9 % had injected amphetamine; 5 % at least twice a month.
11 % had used heroin (not injection); 4 % at least twice a month.
3 % had injected heroin; 2 % at least twice a month.
27 % had used solvents; 4 % at least twice a month.
28 % had used psychoactive drugs; 13 % at least twice a month.
49 % drank alcohol twice a month or more often.
46 % had experienced a black-out.

The older persons in the cohort (18-20) had tried more drugs and use different drugs regularly. 15 % of the youngest (12-15) used cannabis at least twice a month and 6 % used solvents to the same extent. There are no gender differences in the use of drugs.

The tendency, compared to 1998, shows that among the youngest (12-15) there were more who used alcohol in the 1998 study than in the 1999 study. Among the older (16-20) cannabis use has increased from 1998 to 1999 and amphetamine- and heroin use has declined.

The average age has declined from 1997 to 1999. In 1997 the average age was 16.2 years (549 persons interviewed), 1998 16.3 years (573 persons interviewed) and 1999 15.5 years (425 persons interviewed).

## 15.3 Demand and harm reduction responses

Prevention programs and campaigns

There is a very clear objective in the Swedish society to reduce demand and supply as well as the use of illicit drugs. To this end the Swedish government in 2002 established a national coordinating body at the governmental level to initiate and coordinate prevention efforts. In addition a similar committee, The National Alcohol Policy Committee, devoted to alcohol abuse prevention is active since 2001.

The National Drug Policy Coordinator is especially aimed at implementing the national action plan for the mobilisation and coordination of the prevention efforts on a national level. However, based on scientific evidence the Swedish prevention initiatives are aimed at combining different approaches on as well national, regional and local levels, rather than doing large scale isolated national campaigns.

In the national action plan it is stressed that the mobilisation against drugs must involve pupils and their parents, schools, non-governmental organisations including youth organisations, political assemblies, social workers, workplaces, recreational and entertainment areas as well as the mass media (Mobilisering mot narkotika 2002).

Information directed towards parents and the forming of youthful networks are examples of such activities. Also risky environments are targeted, e.g. bars and restaurants which can be altered to make drug use less easy to get around with.

In Sweden, the schools are required to provide information to the students about the risks from using alcohol and other drugs (including tobacco), and this has been the so for decades. In addition

many communities have ongoing prevention programs, including the development of a prevention policy document. Special funds have been allocated to the municipalities, aimed at reinforcing the alcohol and drug prevention work and to appoint local coordinators for the prevention initiatives.

In the year 2000 a specific centre was established in Stockholm, aimed at giving service to the local districts of the city including competence reinforcement, prevention education etc. In three consecutive years an information folder was sent to all teenagers, aged 13-17 as well as to their parents. The first, in 1999, was about alcohol, the second was about illicit drugs and the third (in 2001) dealt with the importance of communication between parents and their children in relation to alcohol and drug use. A simultaneously performed advertisement campaign in the underground helped to draw attention to the folders. According to a later evaluation the campaign had been successful as regards attention (USK 2002).

The Gävleborg county may serve as another example of local and regional action. Around 10 different action groups are engaged, using a variety of strategies such as peer support groups, Prime for Life education groups, Project Charlie programs and drug action teams.

Specific harm reduction intervention

Harm reduction is a description for a wide range of different activities, and it is not always easy to establish a definite distinction between prevention and harm reduction actions. Regarding the "classic" medical individual harm reduction measures as methadone maintenance and syringe exchange, the situation is easy to describe. Methadone treatment is so far only allowed for persons 20 years and above, which is stated in the special admission restrictions.

Another substitution drug used in Sweden is Subutex (Buprenorphine), but no officially adopted criteria are at hand for opiate dependence treatment with that drug today. According to several major drug treatment wards/institutions and practitioners, opiate substitution with Subutex for persons 18 or below would be extremely unusual, even though the drug is allowed to be prescribed to persons 15 and above according to FASS*,* the Swedish Drug Compendium (FASS 2002). Most likely, the methadone treatment criterions are applied also for Subutex in the vast number of cases, even if some exceptions might be at hand.

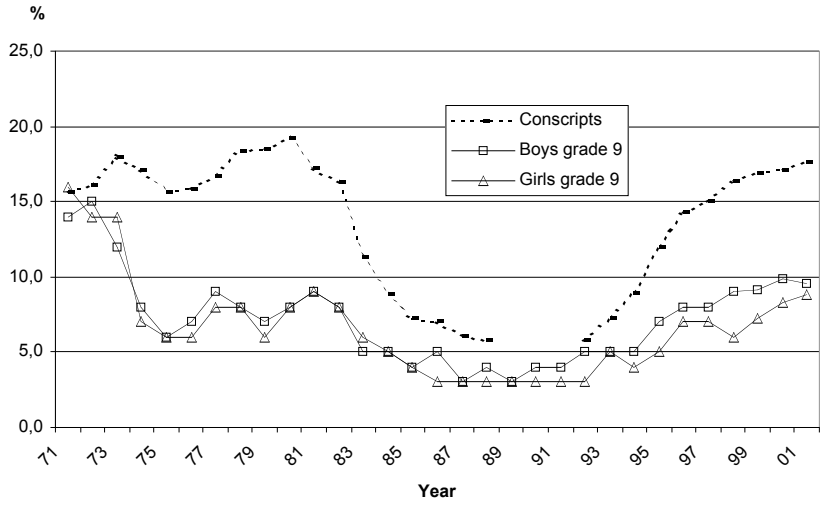
Other demand reduction responses

The two running syringe exchange programmes in the south of Sweden applies a 20-year age rule.

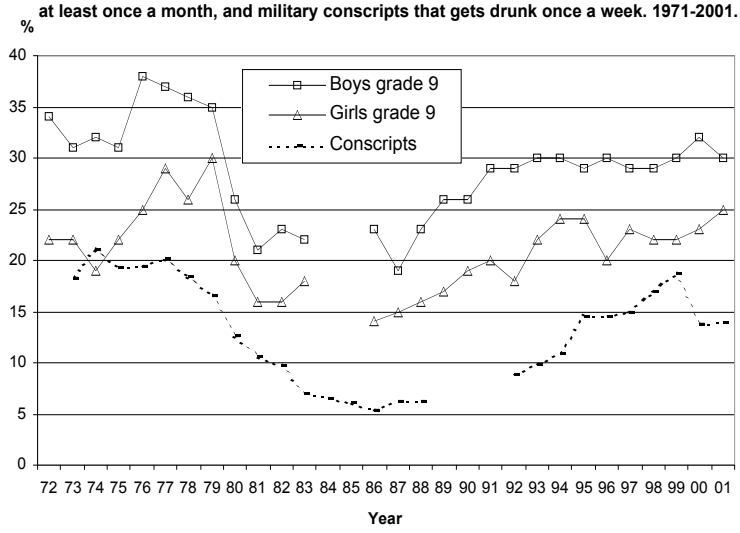
Actions as pill testing are not practised in Sweden. Such activities are regarded to be in conflict with the overall aim of Swedish drug policy, "a drug free society" sending out "double messages". Also the legislation would make this an activity very difficult to perform.

If one regards information on drugs given in selected special settings, like music festivals or gay festivals, as a harm reductive measure, such actions take place. One example might be the mobile information unit "*Ung på väg*" (Youth on their way) which travels around to places where young people meet and party. The staff hands out printed fact sheets as well as condoms, but are also trained to handle specific questions on drugs, among other things. Such projects are normally run at a local level and today no nationally collected information on the number of projects; their profiles, extension, quality etc are at hand.

**Lifetime prevalence of drugs among students in their 9th school year and military conscripts. Percent. 1971-2001.**




**Proportion of boys and girls in their 9th school year with intensive alcohol consumptic at least once a month, and military conscripts that gets drunk once a week. 1971-2001.**




# 16 Social exclusion and reintegration

## 16.1 Definitions and concepts

Concepts and definitions used

Problem use is often referred to as “heavy abuse” (tungt missbruk). The definition used in three national case-finding studies (1979, 1992 and 1998) and in various other contexts is daily or almost

daily use and any use – regardless of frequency – by injection. This is the most excluded group, comprising persons with one or several problems; intravenous use, homeless, double diagnosis, prostitution, social isolation, infectious diseases, a criminal record.

Groups seen as particularly vulnerable regarding drug use

The Drugs Commission (SOU 2000:126) has summarized research and clinical experience on vulnerability and enumerates factors that can lead to drug abuse and social exclusion; genetic vulnerability, family circumstances, impulsivity/aggression/hyperactivity, school related problems, early alcohol debut, smoking, unemployment, socio-economic difficulties, etc. Also structural factors like the amount of drugs that are accessible are of great importance. If several risk-factors are present the vulnerability will increase. On the other hand, there are protective factors, and these can be reinforced.

The introduction of a lifestyle that coupled music with certain drugs (rave and ecstasy) put the explanation above in question. Suddenly young adults and teenagers without obvious risk-profile started to use drugs (mostly ecstasy). It is too early to say how it will end, but there seems to be some reason to believe that parts of these new consumers do not move into the traditional drug career. It is still mostly drug abusers with the traditional background characteristics that enter treatment. For them drugs furnish an escape route and marks signals of acceptance in a marginalised subculture. Most of the social excluded IDU:s have this background. On the other hand, ecstasy is far from removed from the market. In the end this could mean that more young people are recruited into a drug career.

People involved in problematic drug use will increasingly be more socially excluded irrespective of their background. On the other side, socially marginalised people will have a greater risk of developing drug abuse. Immigrants that have not been properly integrated can fare an increased risk to develop problems. In a national case-finding study on problematic drug use ("heavy abuse") in 1992 (Olsson, O. 1993, 1994) it was found that immigrants under 25 years of age were over-represented in relation to their share in the population. Those over 25 were under-represented. It is believed that this difference between the generations is caused by a conflict between values in the family and what schools and life outside the family mediates. Young persons are probably more vulnerable in such conflicts.

It has been found that there is a tendency that drug crimes by immigrants more often are detected by the police (Olsson, O. 1983). In other words, the part of crimes that are committed by immigrants might be exaggerated in the statistics.

A report about drug abuse and marginalisation (Lander 2002) has found tendencies that ethnicity might be a variable worth elaborate on, but the report do also comment that before we seek explanation to drug abuse in ethnicity or cultural differences it is more relevant to look at general conditions on living among these people. It is these conditions that have the strongest impact, not ethnicity per se.

## 16.2 Drug use patterns and consequences observed among socially excluded

Prevalence of drug use and problematic drug use amongst socially excluded

There are very few studies that have ethnicity as its starting-point. On the other side, it is not uncommon to comment on ethnicity in reports. However, the actual information gathered is sparse.

A report on heroin abuse in Malmö (Tops 1997) reported an increase in the share of immigrants among patients at a detoxification unit from 25 % to 40 % between 1993 and 1996. This was interpreted as caused by the greater availability of brown heroin, usually used for smoking. As immigrants is more common in Malmö than in any other town (22 % of the population to be compared with 16 % for the country as a whole), and especially people from regions were opium or heroin smoking occurs, this was not unsuspected. Heroin has continued to be the dominating drug at the unit, but later statistics do not report on the number of immigrants. Heroin smoking, and injecting, is however far from a problem only among immigrants even if the latest wave started among them. The report tracks the cause for the increase in heroin abuse to a pronounced local increase in unemployment, which took its share not least among immigrants.

The development of problematic drug use is presented in an annual report (CAN 2002a). Several indicators show that the development has been less favourable for the most marginalised among drug abusers. The number of individuals that has had in-patient treatment has doubled between 1987 and 2000 from about 1 800 to 4 500. The mortality rate has also increased in this group. The explanation seems to be an ageing population of IDU:s with a growing physical and psychical vulnerability and social marginalisation. Multiple drug use has increased and new drugs or ways to use them has been introduced. This group have obvious and pronounced problems when the economic situation in society is strained. Re-integration is extremely hard to achieve as this group have the most problematic life circumstances of all.

The specific drug pattern in different ethnic groups is not known, if there is one. There is one exception. Immigrants from Somalia are known to chew khat, and this habit is secluded to this group. It is mostly adult men that gathers and chew khat, a traditional way of being together in Somalia. Khat has been classified as a narcotic drug in Sweden since 1989. The social services say that it foremost has economic consequences for the families. During 2001 3 463 kilos were seized at 285 occasions. Roma people have announced, through their associations, that drug abuse is growing among their young people. Heroin abuse is said to prevail. So far there are no reports, only newspaper coverage. Also in these groups there is a link between unemployment and drugs.

Patterns of use

Heroin smoking is believed to have started among immigrants and then spread to a wider public, especially among young persons (Tops 1997, Lalander 2002). According to information gathered at the two needle exchange programmes in Lund and Malmö most of their newer heroin clients has started their heroin habit by smoking heroin.

## 16.3 Relationship between social exclusion and drug use

Indicators of social exclusion amongst specific populations of drug user

A report from NBHW (Socialstyrelsen 2000c) about homeless people found that about 50 % of those who had been in compulsory treatment November 1, 1998 were homeless the year after. The National Board of Institutional Care, SiS, has also (Statens institutionsstyrelse 2001) established that this is still so.

In a clinical pilot study in Stockholm 35 homeless people (22 men and 13 women) were followed. At the time for an ASI-interview 27 had used alcohol and/or drugs the latest 30 days. Cannabis and amphetamine were the most used drugs (13 and 11 persons) together with alcohol. Heroin or analgesic pharmaceuticals were used by 10 persons. Two thirds and used more than one substance. There was no indication that drug use had started after they got homeless.

Data from research on social exclusion and drug use

A report from BRÅ (Solarz 1990) found a significant link between drug use and several social variables ranked in the following order: Use of other drugs, criminality, parent relations, school performance, personality and leisure activities. Another study (Svensson 2000) found that drug abusers, especially heroin users, are hit more than others when the economy is in recession. Reports like these (and others that are at hand) do not regard social exclusion as prerequisite for drug abuse.

## 16.4 Political issues and reintegration programmes

Policies around social exclusion

The Public Health Policy, which is in a process to be extensively revised, has social exclusion as its starting-point. The report from the National Committee for Public Health (SOU 2000:91) talks about “health on equal terms”. The Drugs Commission (SOU 2000:126) has a similar view.

Elements of treatment focusing on reintegration with general drug services

Specialised out-patient treatment facilities and the general social service are at hand to help clients that have spent time in residential treatment and prisons.

Specific reintegration programmes

Treatment in therapeutic communities and prisons are often followed by after-care and after long terms in residential care it is common to arrange special training programmes before discharge. After discharge clients are normally remitted to out-patient treatment and the social service.

Results from outcome evaluation

An extensive follow-up report (Berglund 1991) on residential treatment showed that 50 % of the clients were drug-free at control one year after discharge. If the drug-free criteria should include alcohol it dropped to about 40 %. If the success criteria also included no criminality or renewed treatment it dropped to 20 % and if total social integration were added it dropped to 10 %.

## 16.5 Methodological information

Limits in data available

Research with a starting-point in social exclusion is not prominent. One such way in could be ethnicity. A search in a data base relieves only a few references and they are spread over a long time.

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