European Monitoring Centre
for Drugs and Drug Addiction

2007 NATIONAL REPORT (2006 data) TO THE EMCDDA by the Reitox National Focal Point

SWEDEN

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

REITOX

Foreword

The 2007 National Report on the Drug Situation in Sweden has been produced for the European Monitoring Centre for Drugs and Drug Addiction. With the exception of part B the report is mainly an update of previously delivered data in areas where new information has developed or where the guidelines has been changed. The report has been prepared in cooperation with national agencies, institutions and experts. Main authors are Ms Anna Bessö, Ms Erica Brostedt, Mr Stig Helling, Mr Anders Persson, Mr Bertil Pettersson and Mr Matt Richardson, all permanently or temporary employed at the Swedish National Institute of Public Health (SNIPH). Ms Monica Nordvik, University of Stockholm, and Mr Teymur Noori at the National Board of Health and Welfare (NBHW) have contributed in the DRID issues, Mr Roger Holmberg at the NBHW in the TDI issues and Mr Björn Hibell at CAN in the issues on drug use in the school population and among conscripts.

For the sections “Public expenditure” and “Vulnerable groups of young people” in part B, external experts were requested to write these sections but the manuscripts have not yet been delivered to the SNIPH.

You are welcome to contact the Swedish NFP for possible need of clarification of the various reports and publications in Swedish referred to in the NR.

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Summary

Most of the indicators used to monitor the drug situation in Sweden indicate that the problem with illicit drugs is serious but also that positive changes are observed in some areas. The annual report 2006 of the NDPCo[1] shows that for the major objectives set out in the action plan improvements are achieved. Fewer have tried illegal drugs, the drug related mortality and morbidity remain on a plateau or decrease, the local and regional preventive work is improved and mobilised to a large extent. In order to overcome a period of downsizing in the treatment sector particular efforts, substantial funding and new regulations shows promising results. The public opinion supporting the present drug policy remains very strong and the attitudes to drug use are clearly negative even in the younger population.

A second action plan on drugs for the period 2006–2010 was adopted by the Parliament in 2006. It is a straight forward continuation of the previous action plan and the role of the special national drug policy coordinator (NDPCo) was prolonged to 2007.

New legislations on substitution treatment and needle exchange have come into force with the explicit purpose to improve the situation for problem drug users and promote the possibilities for care and rehabilitation.

The introduction of a permission procedure for all handling of GBL and 1,4-BD in order to prevent the use of GHB has run smoothly. The permission procedure is a consequence of the change in the Act on the Prohibition of certain Goods Dangerous to Health that made it possible to control chemicals used for commercial purposes, *inter alia* GBL and 1,4-butandiol. It is to early to judge if the control of GBL and 1,4-butandiol has decreased the abuse. As shown in this report an increased use of GHB was reported from certain regions and in certain connections.

Drug experience as measured by various school surveys is stable or levelling of as shown in this and previous reports. The marked difference in life time prevalence between the grade 9 and grade 11 age groups is not seen in the last 30 days prevalence figures. In grad 11 the last 30 days prevalence in 2006 was 5% for boys and 2% for girls and grade 9 figures for the same year was 4% for boys and 3% for girls. Cannabis is by far the major drug of experience. In the adult population the figures for cannabis experience are stable over the period 2004–2006 as measured in the annual public health surveys.

It is still difficult to get reliable estimates for the problematic drug abuse defined as IDUs or persons using drugs daily or almost daily, independent of drug. According to the 2006 report of the NDPCo[1] the latest figure (2003) was 26 000 abusers, showing large geographical differences and with the three major cities of Sweden in the top. On the issue of cocaine some reporters claim that use as well as availability is increasing. The consequences are however not yet seen as an increased demand for treatment according to TDI figures.

An alarming increase of HIV among IDUs was reported for the first six month of 2007. The majority were infected in the Stockholm area by a new variant of the virus, previously also seen in Finland.

A marked increase in drug prevention activities related to the implementation of the action plan on drugs is noted. By governmental support the majority of the 290 Swedish local authorities have been able to appoint local drug co-ordinators for the

[1] http://www.mobilisera.nu/upload/slutlig_2006.pdf

alcohol and drug preventive work. The co-ordinators are also the key players in the training and education programs as well as in the local prevention programmes initiated by the committees for the implementation of the alcohol- and drug action plans or other actors on the alcohol and drug prevention arena.

Schools are very often in focus for the preventive work and in a project running over several years the SNIPH is supporting schools and municipalities with tested and scientifically evaluated methods and supportive materials on how to apply the methods in the local work. The NDPCo has also initiated a number of activities for the early detection and intervention of at risk groups and persons.

The national action plan on drugs (2002–2005, 2006–2010) has led to an increased support for drug related research. In the period 2002–2006 the government has supported just over 100 different research projects in the drugs at a cost of 9.6 million €.

National guidelines for the treatment of alcohol and drug abuse came into force in 2007. The guidelines are directed towards both the social service and the health- and medical sector with the aim to develop a higher clearness and uniformity in the care- and treatment sector. Issues covered by the guidelines are *inter alia* detection and early intervention, instruments for judgement and documentation, psychosocial treatment and medically assisted treatment, pregnant women, dual diagnosis.

Deaths in the presence of illegal drugs are stable or slightly decreasing over the latter years. The trend is the same when monitored by the National Cause of Death Registry and the recently introduced Forensic Toxicity Register.

Efforts for early intervention to promote drug addicts to start treatment are promoted by the government. Interventions similar to the MUMIN project (Maria Ungdom Motivational Intervention) previously reported on are running in several cities to help and support young abusers to stop.

Drug offences continue to increase and over the last ten years an average annual increase of close to 7% is noted. Drug use (53%) and drug possession (28%) were the two most common offences committed by persons convicted of drug offences in 2006.

The availability and supply of drugs appears to be god as judged by stable or even dropping prices and a continuously high number of seizures by police and customs. According to the police in Stockholm, medicines classified as narcotics are increasing on the illegal market. There are also reports on an increased use of cocaine.

1. National policies and context

Overview/summary on legal, policy and institutional framework, strategies and social context

No new information available.

Legal framework.

Laws, regulations, directives or guidelines in the field of drug issues (demand and supply,)

In October 2007 twenty-four substances are controlled under the Act on the Prohibition of certain Goods Dangerous to Health (SFS 1999:42). The list of goods dangerous to health is published as an appendix to the Ordinance on the Prohibition of certain Goods Dangerous to Health (SFS 1999:58)[2]. The list consists of MBDB, BDB, 1-benzylpiperazine, DOC, 5-MeO-DMT, 5-MeO-DIPT, 5-MeO-AMT, AMT, 2C-C, 2C-D, 2C-E, 4-AcO-DIPT, 4 HO-DIPT, GBL, 1,4-butandiol, 4-AcO-DET, 4-HO-DET, 4-AcO-MIPT, 4-HO-MIPT, methylone, TFMPP, salvinorin A, Bromodragonfly and 2C-T-4.

In May 2007 DOC and DOI were listed as narcotic substances, list I. The regulation is an amendment to the Ordinance on Control of Narcotic Substances (SFS 1992: 1554). Also in May 2006 a new crime on illegal conducts with precursors entered into force. This crime criminalizes most intentional conducts, for instance production or possession, of precursors which are intended for illegal manufacture of narcotics. The punishment for such a crime may be decided from a fine for the pettiest cases up to imprisonment for six years for the most serious cases. Before the new crime entered into force most of the conducts concerned were criminalized as preparation to commit a drugs-offence.

Section 3 b in the Swedish narcotics punishment act (SFS 1968:64) states as amended (SFS 2006:46): Any person who intentionally:
1. Transfers, manufactures, acquires, procures, processes, packages, transports or in some other similar way handles narcotic drugs which are intended for illegal manufacture of narcotic drugs, or
2. Keeps, possesses or otherwise handles such narcotic precursors
shall be sentenced for a illegal handling with narcotic precursors to imprisonment for not more than two years.
If, having regard to the nature and the quantity of narcotic precursors involved and other circumstances, an offence is judged to be petty, a fine or imprisonment for most six months shall be imposed.
If the offence is judged to be grave, the sentence shall be imprisonment for at least six months and at most six years. In judging whether an offence is grave, particular consideration shall be given to whether it has been part of large-scale or professional activities, has involved especially large quantities of narcotic precursors or has in any other way been of a particularly dangerous or unscrupulous nature.

Laws implementation

The government has decided on a review of the acts and regulations on illegal drugs (Dir 2006:97[3]) as previously reported. A special investigator is appointed and among the tasks for the committee to consider and respond to are:

- To analyse how the present regulations to control drugs, doping substances, precursors, solvents and other goods used to get high relates to one another

[2] http://www.riksdagen.se/webbnav/index.aspx?nid=3911&bet=1999:58
[3] http://www.riksdagen.se/Webbnav/index.aspx?nid=10&dok_id=DIR2006:97&rm=2006&bet=2006:97

- To investigate the possibilities to make the system more clear i.e. by reducing the number of statutes.
- To investigate the possibility to limit the access to goods that is not regulated by the statutes but used for intoxication.
- Map how the different regulations are used in practice, in particular what goods is covered by which regulation.
- To analyse the efficiency of the system, inter alia consider if the present regulation of doping substances observe the hazards of these preparations enough, compared to drugs and goods hazardous to health.
- To propose improvements of the present system and give suggestions to statute changes.

With reference to the third task above the police and customs have for quite some time complained over a situation where they have to give back seizures of goods that obviously are intended for getting high but not yet controlled by the legislation. The problem seems to have increased as the Internet market for designer drugs, plants, seeds and fungus grow. As a response to the presented problems the government has presented additional directives[4] on the issue. The investigator should consider the implementation of a procedure not based on criminalisation that prohibits the handling of goods that could be expected to be classified as an illegal drug or health hazardous goods. Both assignments should be reported at the latest 31 December 2008.

Institutional framework, strategies and policies.

Coordination arrangements

In June 2006 the government gave the NDPCo the task to coordinate the work against the illegal use of doping agents. The NDPCo should within the scope of his tasks give notice to the problem and initiate actions to limit the demand and supply. The NDPCo should strengthen the efforts to improve the cooperation between different agencies and between agencies and organisations. The NDPCo should actively cooperate with ministries, agencies, municipalities, NGOs and the experiences from the doping hot line should be considered in the work. In December 2006 the NDPCo presented an action plan on the abuse of hormone preparations[5].

National plan and/or strategies

No new information available

Implementation of policies and strategies

Numerous examples of the implementation of the national action plan are found on the NDPCo website[6]. One is the 323 000 € grant for the development of preventive work against drugs and damages from alcohol consumption in 21 smaller municipalities in two counties in Sweden[7]. The effort aims at developing strategies to limit the supply of drugs and illegal alcohol and to develop a systematic support for parents. Small municipalities have different financial and staffing conditions than larger when implementing drug and alcohol preventive work. It takes cooperation over the municipal borders and exchange of experiences for an effective work.

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4 http://www.riksdagen.se/Webbnav/index.aspx?nid=10&dok_id=DIR2007:26&rm=2007&bet=2007:26

5 http://www.mobilisera.nu/upload/Aktionsplan%20mot%20missbruk%20av%20hormonpreparat_webb.pdf

6 www.mobilisera.nu

7 http://www.mobilisera.nu/templates/GeneralPage.asp?id=4623&pageName=1

One other example of the implementation of the national action plan is the 215 000 € grant for preventive efforts in nine municipalities in three different counties[8]. The chosen municipalities are of different sizes and should intensify their work with the implementation of the goals of the action plan, in particular supply reduction but also the cooperation with recreational settings. A possible "size-factor" of the municipalities should be considered in the evaluation of the outcome of the work.

Impact of policies and strategies
Impact of the first phase of the action plan on drugs (02-05) was presented in the previous NR. Simultaneously the conclusions from a report from UNODC on the Swedish drug policy were presented. In 2007 the mission of the NDPCo will cease and the different tasks be taken over by relevant agencies. The NDPCo will present an overview for the period 02-07 and the SNIPH has the task to evaluate the implementation of the national action plan on drugs for the latter period (2006–2010) and present a report late 2009.

Budget and public expenditure.
Development work financed with central-government funds is being carried out in Sweden's municipalities. About 21 million € of central-government development funds has been allocated among municipalities by county administrative boards in 2006[9].Of these funds, around:

- SEK 23 million (22 million in 2005) has been allocated to outpatient projects targeting young people or adults with addiction problems;
- SEK 93 million (74 million in 2005) has been allocated to alcohol and drug prevention, of which:
  - SEK 55 million to preventive work (53 million in 2005);
  - SEK 34.5 million to early interventions for children in families where substance abuse and violence between adults occur (18 million in 2005);
  - SEK 3.5 million to interventions for women with addiction problems who are victims of violence (3 million in 2005);
  - SEK 93 million (40 million in 2005) has been allocated to supporting the development of services for heavy addicts.

86 projects relating to outpatient care have received development funding (92 projects in 2005), of which 34 have adults as their main target group and 52 target young people. Both categories focus on treatment programmes and method development. Their main partners have been health-care services as regards adults; schools and youth centres as regards young people. Projects targeting young people have received the larger share of development funds.

A total of 403 programmes have received funds to develop alcohol and drug prevention (335 programmes in 2005). Of these:

- 263 programmes have received support for preventive work. These funds have been used mainly for training efforts and coordinator positions. The most frequent partners are schools, youth centres, youth councils and pupils' councils (226 programmes in 2005);
- 130 programmes have received support for early interventions for children. Of these, 66 target children of parents with addiction problems and the same number target children in families where violence occurs. Slightly fewer (48) relate to programmes which will reach the children of parents with poor mental health. Each of these programmes may have several parallel target groups. The

[8] http://www.mobilisera.nu/templates/GeneralPage.asp?id=4707
[9] http://www.socialstyrelsen.se/Publicerat/2007/9475/Sammanfattning.htm

main partners are schools, pre-schools and youth centres (96 programmes in 2005);
- 10 programmes have received support to work with women who have addiction problems and are victims of violence (10 programmes in 2005). One area of interest in these programmes has been the development of methods. Almost all programmes cooperate with health-care services and half of them work with other municipal programmes.

165 programmes (104 programmes in the care chain in 2005) have received support in the framework of the efforts to improve services for heavy addicts. These programmes have focused mainly on strengthening the care chain and on providing training in the use of client-assessment instruments. The most common focus of municipal programmes is the introduction of a local treatment guarantee; 19 municipalities or parts of municipalities have received funds for this purpose. The most common partners are the psychiatric addiction services of county councils.

One persistent difficulty associated with the efforts to enhance both outpatient services and prevention is the fact that it is uncertain whether such stimulus funds will be allocated in the future and, if so, what the amounts will be. It also emerges that the various county administrative boards have differing conditions and needs. Another type of comment made is that certain central-government efforts are difficult to keep apart; for instance, several county administrative boards mention that actions in favour of women who are victims of violence receive support in the framework of other efforts as well. In some cases, county administrative boards have deemed local needs to be large and allocated resources from one area, such as alcohol and drug prevention, to others based on their knowledge and on the needs of individual municipalities.

The opinion of the Swedish National Board of Health and Welfare (NBHW) is that the allocation of funds should be less fragmented and have a more explicit long-term perspective.

The county administrative boards send general information to all municipalities in their respective county about opportunities to apply for central-government grants. In 2006, a total of 751 applications for development funds were received, and 654 of them were given support (678 applications were received in 2005). Most of the applications were related to alcohol and drug prevention. A survey carried out among the municipalities receiving grants showed that the number of municipalities which make use of the opportunity to receive help in the form of scientific support is still rather small.

County administrative boards follow up programmes either by having municipalities submit written half-year reports (around 66 %) or by means of other follow-up methods (one-third). Just over half of the county administrative boards organise conferences or workshops to disseminate experiences from programmes which have previously received development funds. It is important to ensure that knowledge and experience from programmes which have received funds are exploited to help develop drug and addiction services. One way to do this may be to continue encouraging the use of scientific support from regional R&D units, universities, university colleges or internal staff in the design and/or evaluation of programmes which have received funds.
In line with the task given by the Government, this report indicates for whom and for what the funds have been used. Many programmes have started recently or are in the process of implementation, which makes it difficult to measure their impact. This also applies to the projects generally. Another type of in-depth evaluation of fund use

is required to determine whether, and if so how, the funds have contributed to the long-term development of drug and addiction services.

This year's report – care chain becomes Care Agreement.
In January 2006, the Government entrusted the county administrative boards with the task of supporting the development of services for heavy addicts in line with the directives previously given. The county administrative boards are to allocate 9.7 million € in 2006 and 27 million € in 2007. The Swedish National Board of Health and Welfare will submit a final report on this effort in December 2009. As a result, in this year's report the 'Care Chain' heading has been replaced by 'Care Agreement on the development of services for heavy addicts'.

In the annual report for 2006[10] the NDPCo established that 4.7 million € was used for carrying through the national action plan in 2006. The budget was distributed as follows.

- Coordination	80 645 €
- Media activities	26 880 €
- Communication and opinion forming	1194 000 €
- Prevention activities	715 000 €
- Care and treatment	511 000 €
- Prison and probation treatment	317 000 €
- Supply reduction	333,300 €
- Research	1274 200 €
- Other	199 000 €

Additional 4.3 million € was assigned to the special effort in the prison and probation system previously presented.

Law enforcement
(2007) No new information available

Social and health care
(2007) No new information available

Research, international actions, coordination, national strategies
In 2006 the NDPCo allocated approximately 1 million € for drug related research[11].
From a total of 52 applications 26 projects were given support. Areas of priority were:

- Demand reduction
- Experimental and regular abuse
- Implementation research
- Ethnical groups and illegal drugs
- The importance of genetic and neurobiology factors for the development of dependence and dependence deceases
- Evaluation of treatment methods
- Opinion formation to reduce the demand

During the first national action plan on drugs (02–05) the NDPCo supported 77 different drug related research projects with 8.6 million €. In 2006 nine research reports were published and are now available at the website of the NDPCo, www.mobilisera.nu.

Social and cultural context.

[10] http://www.mobilisera.nu/upload/slutlig_2006.pdf
[11] http://www.mobilisera.nu/templates/GeneralPage.asp?id=4816

Public opinions of drug issues
No new information available

Attitudes to drugs and drug users
Youths attitudes to illegal drugs have been studied by Rytterbro & Tham at the University of Stockholm. Simultaneously the youth's assessments of the risks and their judgment of the official information on drugs from the society were investigated. 28 girls and 13 boys, aged 15-24, were interviewed according to a semi structured questionnaire. Preliminary results presented in a report from the NDPCo[12] shows that most of the youth have strongly negative attitudes to illegal drugs, that some of them are rather sceptical to the information on drugs from the society and in the media but that simultaneously, the information on the health hazards of drugs is positive. The Swedish vision of a drug free society was regarded unrealistic. The report concludes that the recently presented fear about young Swedes becoming drug liberal lacks support with the possible exception of cannabis, where the view deviate from the official Swedish drug policy. Many of the youths in the study regard cannabis as less hazardous and harmful than other illegal drugs, even if few wishes to see cannabis legalized.

With the main purpose to investigate youths positive and negative expectations of drug use a study was performed among last year pupils in the upper secondary school. The study was performed by Bergman & Karlsson at the University of Stockholm and preliminary results were presented in a report from the NDPCo[10]. The overriding aim of the work is to improve the drug prevention efforts in school by increasing the understanding of the youths view on drug issues. In an enquiry responded to by 2104 pupils in grade 12 (age 18-19) in the Stockholm area clear differences were seen between males and females and between pupils with or without experience of drug use. The young men found it less likely that negative consequences should occur and more likely that positive consequences should occur as a consequence of drug use than what was the case for the young women. Those with experience of drug use stated also as less likely that negative consequences should occur and more likely that the consequences should be positive than was the case in the group with no experience of drug use.

Debates and initiatives in parliament and civil society
No new information available

Mass Media Campaigns
The Action Plan emphasises that children and young people themselves should be involved in and exert influence over preventive work, and that they should be offered opportunities to discuss issues of drug policy in dialogue with adults. The overall objective of the work carried out in this field by the NDPCo has been to strengthen negative attitudes to illegal drugs among young people. A campaign entitled 'There are many reasons not to try drugs' (*Det finns många anledningar att inte testa knark*), was conducted in 2006 and 2007, has been adapted to 16–18-year-olds – a younger and wider target group than previously. The new campaign has been designed on the basis of an analysis of attitudes prevailing in the target group. Information has been collected from focus groups, from a survey on Lunarstorm[13] about the target group's attitudes to drug information, from the relevant segment of the Citybarometern survey on lifestyles and trends (information purchased by the NDPCo) and from a workshop organised jointly with the Interactive Institute.

[12] http://www.mobilisera.nu/upload/slutlig_15.pdf
[13] A leading social-networking website for teenagers in Sweden.

The analysis shows that the target group would like to (1) receive information about drugs when they are at upper-secondary school age; (2) receive such information from an expert on drug issues; (3) have opportunities to discuss drug issues; and (4) be able to do this anonymously.

Cooperation with MTV.
The NDPCo started working with the MTV television network in the spring of 2006. The reasons for choosing MTV as a partner are its strong credibility with the target group, its work on issues of social awareness and its programming format, which is well suited to the needs of the NDPCo. The Internet survey of the campaign which was conducted in September 2006 among 16–20-year-olds living in Sweden's three largest cities (Stockholm, Göteborg and Malmö) found that 88 % of the respondents thought that it was very good or rather good that the campaign was being carried out jointly with MTV.

Four films about 'drugs and stuff'.
The Coordinator's Office has given a number of film directors the task of freely interpreting the campaign messages in short films of 3–5 minutes' duration. These films have been shown as part of MTV's regular programming in July–September 2006 and in Stockholm, Göteborg and Malmö cinemas. The films were promoted on billboards in the three cities and through advertising spots on MTV. At the end of August 2006, 1.4 million unique viewers had seen the films on MTV. The Internet survey (see the section 'Cooperation with MTV' above) shows that the films and messages have had a positive reception, with around one-third of the target group saying that the films have given them arguments not to try drugs.

Internet.
The campaign has been broad and nationwide in nature. Its main channel has been a website, www.knarkärbajs.nu ('drugsarepoo'), where visitors could watch the films and background material about the directors' choice of messages as well as vote on the films and fill out surveys about them. The website also included open forums and an ask-an-expert function for which the experts have been provided in 2006 by the CAN. There was also always an ongoing competition on the website. In September 2006, five winners were selected among around 4,000 participants in a competition to design a T-shirt with the best anti-drug message. An evaluation of the activities which have taken place in the discussion forums of the website was carried out in the autumn of 2006. The website has had 123,000 visitors between its launch on 7 July and 31 December 2006.

Debates.
One important component of the campaign was ensuring that its arguments and messages were discussed by members of the target group. For this purpose, the Coordinator's Office organised two discussion sessions based on the films, one in connection with the Almedalen Week[14] in July 2006 and one which was broadcast on MTV on three occasions in September 2006. In the Internet survey (see the section 'Cooperation with MTV' above), 92 % of the target group stated that it is very good or rather good for a government agency to initiate an open discussion about drugs.

Overall results.
There is strong support among young people and young adults for anti-drug efforts to shape public opinion. This is clear both from the most recent Internet survey (see the section 'Cooperation with MTV' above) and from measurements made earlier in the

[14] An annual event in Sweden where representatives of all political parties and others gather to discuss politics for a week.

period of activities. Nine out of ten young people living in Sweden's three largest cities consider it important for government agencies to conduct anti-drug campaigns. The overall objective of the campaign is to strengthen negative attitudes to illegal drugs among young people. 79% of the target group think that the campaign can strengthen the resolve of those who have a negative attitude. 45% say that they have talked to somebody about the campaign, and 56% have heard somebody repeat the campaign message, 'drugs are poo'.

2. Drug Use in the Population

Overview / summary on drug use and attitudes to drugs. Prevalence and incidence of use, characteristics of users (gender, social characteristics, age at first use)

Cannabis has been the only illegal drug studied in the general population over the last years (2004-2006) and the figures for life time, last year and last month prevalence appears stable as reported in last years NR containing the figures for 2006.

Sometimes overlooked is the fact that youth also use medicines classified as narcotics without prescription. In the conscript survey the experience of "illegally" consumed sedatives has for many years ranked second after cannabis (although the gap in prevalence is more than fivefold) and higher than amphetamine and ecstasy, to which the difference in prevalence on the other hand is very small.

A socially integrated group of drug users that have been of interest to study over the last years are visitors in clubs and restaurants. Resent findings indicate that drug abused visitors are common, but also that the club/restaurant employees have high experience of personal drug use.

Drug Use in the general population.
No new information available

Drug Use in the school and youth population.
School population
In 2006, national school surveys regarding drug use were carried out among pupils turning 16 and those turning 18[15]. The methods and results are presented in the EMCDDA Standard Table 02. The lifetime prevalence's for 16 year-old boys and girls were 7 and 5%, respectively and the last month prevalence was 4% for boys and 3% for girls, which is the same as the previous year. Cannabis was by far the most common substance in the surveys among 16 year olds, irrespective of sex.

The lifetime prevalence (2006) of ever having used an illegal drug among the 18 year old students was 16% for the boys (-1% from 2005) and 14% for the girls (+ 1% from 2005). The last month prevalence was 5% for the boys and 2% for the girls, which is about the same as in previous years. Among those who had used an illegal drug, the choice of drug was cannabis. Ecstasy was the second most common substance, closely followed by amphetamine.

Drug Use among specific groups.
Conscripts
Lifetime prevalence in the conscript population has decreased in the last three years - from approximately 18% in the early years of the millennium to 12.6 % in 2006[16]. The most common substance used was cannabis (lifetime prevalence 11.8 % in 2006), followed by sedatives (1.8%) and the third place was shared between ecstasy and amphetamine (1.5%). The last 30 days prevalence of having used an illegal drug has also decreased from 3.1% in 2000 to 1.9% in 2006. The most commonly used drug by far was cannabis.

[15] http://www.can.se/documents/CAN/Rapporter/rapportserie/CAN-rapportserie-103-skolelevers-drogvanor-2006.pdf
[16] http://www.can.se/documents/CAN/Rapporter/rapportserie/CAN-rapportserie-105-monstrandes-drogvanor-2006.pdf

Drug use among socially integrated drug users

As many as 16% of the employees of clubs/restaurants and places of entertainment see guests each week who are under the influence of illegal drugs. This is one of the findings from a questionnaire survey conducted by the Office of the Swedish National Drug Policy Coordinator in eleven Swedish municipalities[17]. In Helsingborg in the south west of Sweden, one in four such employees sees such guests each week. The survey is part of a 'National Nightclub and Restaurant Project' where municipalities receive support from the Coordinator's Office to develop cooperation among nightclub and restaurant owners, the police and local authorities. As part of this project, all nightclub and restaurant employees will be given training in how to detect that a guest is under the influence of illegal drugs and how to stop such guests from entering the premises (see section 3).

The survey shows that illegal drugs are common not only among guests – of the nightclub and restaurant employees asked, 28 % have used hashish or marijuana on at least one occasion. Full survey findings and more information about the 'National Nightclub and Restaurant Project' (*Den nationella krogsatsningen*) can be downloaded from the website of the NDPCo[18] .

[17] http://www.mobilisera.nu/upload/Kartläggning_sammanställning%20samtliga.pdf
[18] http://www.mobilisera.nu/templates/GeneralPage____5030.asp

3. Prevention

Overview / summary of framework, strategies and interventions in relation to universal and selective prevention (incl. National definitions)

The increased drug prevention efforts following the implementation of the action plan as reported previously are ongoing. The efforts cover a wide area of activities, from Internet communication and campaigns at specific arenas and in specific groups to selective/indicated prevention, in schools as well as in the society as a whole, where increasing efforts and promotions are manifested. Reports on follow-up or evaluations are emerging as shown below. A majority of the activities supported or initiated by the NDPCo or other agencies is governed by the principle of evidence or research based methods and the aim is that the activities should be evaluated or followed up.

By governmental support the majority of the 290 Swedish local authorities have been able to appoint local drug co-ordinators for the alcohol and drug preventive work as reported in the EMCDDA structured questionnaires 25 & 26 in 2007. The co-ordinators are also the key players in the training and education programs as well as local prevention programmes initiated by the NDPCo, the National Alcohol Commission (NAC) or other actors on the alcohol and drug prevention arena. Schools are very often in focus for the preventive work.

The carrying through of prevention is generally the responsibility of the municipality as reported on previously and in the 2007 upgraded SQ 25 & 26. National funding for this work is channelled through the NBHW/County Administrative Boards and to some extent via the NDPCo. Methods and availability of prevention efforts could vary between municipalities due to the relevance of the problem. The local prevention efforts, priorities, methods, costs, results, evaluations e t c in the 290 municipalities in Sweden are not followed systematically with the aim to mirror the prevention work in a national perspective. Annual questionnaires to the local and regional drug co-ordinators developed to mirror the supervision of the alcohol- and tobacco legislation simultaneously give some information on illegal drugs.

Universal prevention.

School

No new information available

Family

Preliminary results from the Iowa Strengthening Family Programme reported on last year (19 schools in Stockholm) show no significant difference in alcohol use between the intervention group and the control group, two and three years following intervention[19]. Additional analyses will be performed and the results will be presented at the SPR conference in San Francisco in May 2008 and in peer reviewed articles. According to the developer of the Swedish version of the Iowa Strengthening Family Programme (STAD) 40 municipalities in Sweden are now using the programme.

Community

To facilitate young people's commitment at local level, the NDPCo initiated in 2003 a network for young people engaged in drug prevention (*ung-nätverket*). It consists mainly of youth organisations active in the prevention of drug abuse. One of the objectives is to make young people participate in projects and to stimulate the dissemination of new, creative methods for preventive work. This was presented in

[19] Skärstrand, personal communication

NR 2005. The NDPCo has now published a number of booklets with ideas for youth groups wishing to work with drug prevention. Topics for the booklets are i.e. ”digital media”, ”drama”, ”gal-groups” ”young to young”. All the booklets could be downloaded from the website of the NDPCo, www.mobilisera.nu.

Selective/indicated prevention.

Recreational settings

Restaurants, bars and clubs are as previously reported considered important settings for the fight against drugs. The NDPCo has thus decided to support 11 municipalities in Sweden in the work to prevent illegal drugs in recreational settings[20]. It is known that staffs in the “restaurant trade” are more frequent drug users than most other categories of staff and that restaurants, bars and clubs are places where many young people get in contact with drugs (Andersson et al[21], Gripenberg[22]). The work starts in 2007 by the setting up of a working party with participants from the local police, local restaurant keepers and the community in each of the municipalities. The municipalities should also present a plan on how to limit the availability of drugs in the local community. The NDPCo supports the project financially with 5400 € per municipality as a starting contribution and is also financing the evaluation of the project. The municipalities are also offered assistance from persons experienced in the work against drugs in recreational settings from Stockholm, Göteborg and Malmö where the NDPCo have supported similar projects as reported on in NRs previously. Experiences from the “Three City Project” has been collected in a publication[23] “Att arbeta mot narkotika på krogen” (To Work Against Illegal Drugs at the Restaurant[24]) aimed for training of staff at all levels in recreational settings.

Results from the previously reported Stockholm project "Restaurants against Drugs" (NR 03) are to be published in the Journal of Substance Use & Misuse. In brief, this community-based drug use prevention program had an effect on the frequency with which doormen intervened in cases of obviously drug-impaired patrons[25]. Professional actors were trained to act as if they were obviously drug use-impaired (cocaine/amphetamines) while attempting to enter nightclubs. Data were collected at pre-test (baseline) when 40 entry attempts were made (2003), and post-test (2004) when 48 attempts were made. At follow-up, the doormen intervened in 27% of the attempts, a significant improvement compared to 7.5% at baseline. It could be concluded that this intervention including changes in the physical environment, policy work, staff training, enforcement and media advocacy has had effects on doormen's behaviour.

At-risk groups

In 2006 the government allocated 377 000 € to interventions for women with addiction problems who are victims of violence as shown in section 1. This is a 16 % increase compared to 2005. A report from the previously reported MUMIN-project (Motivating young abusers to treatment) is now published in English[26].

[20] http://www.mobilisera.nu/templates/GeneralPage.asp?id=4845
[21] http://www.rus-gbg.nu/customFiles/Rapport%205%20Kartläggning%20Narkotika%20på%20krogen.pdf
[22] http://www.stad.org/upload/Rapporter%20mm/rapport_22.pdf
[23] http://www.mobilisera.nu/upload/20058_MOB%20korr.pdf
[24] restaurant = recreational setting such as Pubs’, bars, clubs etc. See this and previous NRs
[25] personal communication Johanna Gripenberg
[26] http://www.mobilisera.nu/upload/NyaMuminengelsk.pdf

At-risk families
As reported in section 1 the government allocated 3.7 million € in 2006 to early interventions for children in families where substance abuse and violence between adults occur. This is close to a doubling compared to 2005.

Indicated prevention.
No new information available.

4. Problem Drug Use

Overview / summary on prevalence and characteristics of problem drug use.
It is difficult to get hold of the PDU. Different estimates have been calculated over the years on the number of persons injecting drugs or use drugs daily or almost daily, independently of drug as previously reported. The latest estimate from 2003 is 26 000 PDUs and imply a decrease compared to 2000–2002. It should be noted that the used method (Chao's estimator) imply a "conservative" estimate, built on treatment register that could be affected by structural changes in the treatment sector. The judgement is however that the trend is falling since year 2000 based on figures from an official investigation (SoU 2005:82[27]) with the purpose to propose a treatment agreement between the state and the municipalities as previously reported. PDU exists all over the country but geographical differences are huge. The three major city counties are in the top. In 2003 it was estimated to be 6 600 PDUs in the Stockholm county, 5000 in the Västra Götaland region and 3 800 in Skåne. Over the last years an increased interest to map the local and regional PDU situation is noted.

Prevalence and incidence estimates of PDU.
By substance used
No new information available

By injecting drug use (ever and current)
No new information available

Profiles of clients in treatment (TDI).
The overall picture
Data on treatments begun in 2006 that are fully TDI-compatible have, on a voluntary basis, been reported from 188 treatment units of the 525 that are known to treat drug misuses and have been asked to participate in reporting. The reporting systems used KIM and DOK (presented in previous NRs) and cover both alcohol and drug misuse. Alcohol is the primary drug in 62% of the cases reported. About 15% of the alcohol clients also use drugs of some kind.

Data that are not fully TDI-compatible have also been reported from 32 of 58 treatment/motivational units in prisons. From 2007 the number of treatment units in prisons will be reduced to 20.

By substance used
Amphetamine is still the most commonly used drug (34%) among the reported drug clients in treatment outside prisons, followed by heroin (22%), cannabis (20%) and benzodiazepines (10%). Cocaine misuse is rare (2%) among treated clients, and less common than "other opiates" (5%) and buprenorphine (3%), and about as common as GHB (1, 6%). Amphetamine also dominates among clients treated in prisons (36%), while heroin is the primary drug in 11% of the cases.

By centre types
The big differences between the centre types are that the proportion of heroin clients is much higher (30%) in inpatient units than in outpatient units (11%), and that the proportion of cannabis clients is much higher (32%) in outpatient units than in inpatient units (11%).

[27] http://www.regeringen.se/sb/d/108/a/51024

By gender
There are some marked gender differences to note. Among men in treatment 23% have a primary cannabis misuse, while only 12% of women primarily use this drug. Among women 40% have a primary amphetamine misuse while 31% of the men primarily use this drug. Heroin is somewhat more common among the treated men (25%) than among the treated women (18%). Other differences are that women more frequently are treated for benzodiazepines (14%) than men (9%) and "other opiates" (painkillers) (8%) than men (3%).

PDUs use from non-treatment sources.
The overall picture
There is no systematic collection of information from non treatment sources available. In the latest report (winter 06-07) from the biannually CRD[28] enquiry to a number of local and regional experts 69% of the reporters say that the situation is unchanged regarding problematic drug use compared to the previous enquiry[29]. 16 % answer that they don't know, 13% claim that the problem has increased and 2% see a decrease. The outcome of the enquiry is very similar to the previous one, covering the summer period 06.

By substance used
Except for the injection of amphetamine and heroin it is not feasible to discriminate the substances related to PDU in the above reported CRD enquiry. 20% of the reporters note an increase in amphetamine not injected and 35% of the reporters note an increase in cocaine. 25% of the reporters also note an increase in the use of sedatives & tranquilisers. On the issue of cocaine and other drugs reflected in the CRD enquiry see section 10.

Injecting drug-users
In the CRD enquiry referred to above 6% of the reporters see an increase in the number of persons injecting amphetamine and 8% of the reporters see an increase in the number of persons injecting heroin.

Other specific sub-populations
No new information available.

[28] the CRD (CAN reporting system on drugs) method is presented in previous NRs
[29] http://www.can.se/documents/CAN/Rapporter/rapportserie/CAN-rapportserie-104-CANs-rapporteringssystem-om-droger-CRD-tendenser-vinterhalvaret-2006-2007.pdf

5. Drug-Related Treatment

Overview / summary of framework, strategies and interventions in relation to drug related treatment (incl. national definitions)

The National Board of Health and Welfare (NBHW) issued an inspection-report in 2007 on how medically assisted maintenance treatment for opiate abusers is implemented in the health care system[30]. The regulation from January 1st 2005 states that all abusers who want to stop abuse should be offered treatment[31]. The Board found that treatment for this group of patients was not given priority in several counties, which leads to unequal treatment opportunities in different parts of the country – a circumstance that is contrary to the health care law.

The NDPCo has put forward a detailed proposal for the improvement of the treatment of abusers of heroin and other opiates[32] – among other things the possibility of economic sanctions against counties that do not offer treatment. The NDPCo also propose the establishment of an "ombudsman" to care for opiate abusers rights to treatment.

Treatment system.

The NBHW has published evidence-based national guidelines[33] for the treatment of persons with substance abuse and dependence problems. The section on narcotic drugs deals with topics such as: abstinence treatment, specific treatments for misuse of cannabis, hallucinogens, stimulants, opiates, and also social support issues and ethical aspects of treatment. Other sections present evidence-based methods for
- prevention, detection and early/brief intervention,
- assessment and documentation
- pregnancy and substance misuse
- psychiatric co-morbidity.

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

In order to improve outreach work generally, and specifically towards street drug addicts with heavy problems and little motivation for treatment, the NDPCo has initiated and/or sponsored various activities:
- a national conference for outreach workers, that resulted in the establishment of an "Outreach network". Meetings for this network have been sponsored.
- "Lots för livet" (Life guide project) with the aim to develop locally adapted models that will guarantee treatment for drug addicts with severe problems. The pilot phase was presented in section 7.4 NR 2006 and the project has now been made permanent. It runs in Stockholm and involves the county police authorities, the county health-care and the municipality social services agencies.

[30] http://www.socialstyrelsen.se/Publicerat/2007/9720/2007-109-26.htm
[31] http://www.sos.se/sosfs/2004_8/2004_8.pdf
[32] http://www.mobilisera.nu/templates/GeneralPage.asp?id=5012
[33] http://www.socialstyrelsen.se/Publicerat/2007/9468/Summary.htm

Other sponsored treatment projects are:
- “Navet” (The Hub), an outpatient treatment centre for prostituted, drug addicted women in Malmö. The centre enables rapid and easy access to health-care, social support and treatment for this group of women, which they otherwise would not have (See below).
- The “MUMIN-method”, a project where the police and a treatment agency work closely together with intoxicated described in section 3 of the 2006 NR. 52% of all adolescents accepted to have a first consultation with the treatment unit in connection to their arrest for minor drug offences. 55% of this group later engaged in treatment for their drug misuse at the unit. An English version of Mumin – motivating young abusers to treatment, discussing methods, results and experiences is now available as a pdf-file[34].

Drug free treatment.
Inpatient treatments
No new information

Outpatient treatments
In 2007 the NDPCo presented a report titled (in translation) “Young abusers in Stockholm, Göteborg and Malmö – a descriptive and comparative study of six outpatient centres and their visitors” written by Torkel Richert. The report[35] is a follow up of the support and treatment interventions for young alcohol and drug users in Sweden’s three largest cities – Stockholm, Göteborg and Malmö – during the period 2000–2005. The aim of the report is to describe and compare these six outpatient centres (two in Stockholm, three in Göteborg, one in Malmö), to make an inventory of the characteristics of the young people and young adults who come to the centres, and to present the outcome of the exchange of experience which has taken place among the centres.

To characterise the young people and young adults who come to the centres a common interview questionnaire was developed and used over a 13-months period, 2005-06-01 – 2006 -06-30. The ambition was that all first visitors should be interviewed in all the centres except for the major centre in Stockholm where a randomised selection making up approximately 10% of the first visitors should be interviewed as an adaption to the large number of clients. The response rate was 80 %. An analysis of the drop of has not been feasible to perform but according to the interviewers it is not likely that the drop out population differs significantly from the participants. 395 visitors who have come to the different centres are included in the study. The report presents *inter alia* figures on age, sex, ethnicity, primary drug, frequency, first dug used and age at first drug use, mental health, previous abuse problems, criminality and education level. The report also present figures on the type of intervention during the first two months, the number of meetings in that period and the state of the cases after the first two months.

The qualitative part of the report presents data from the exchange of experiences and development of work. A number of factors considered important for the quality of the centres are ranked, documentation and documentation systems discussed as well as evaluation and quality development.

The “summary and discussion” chapter of the report is translated to English and presented with the exception of some references in full below.

[34] http://www.mobilisera.nu/upload/NyaMuminengelsk.pdf
[35] http://www.mobilisera.nu/upload/Unga%20missbrukare.pdf

Summary and discussion from the report "Young abusers in Stockholm, Göteborg and Malmö…"

Background

The NDPCo and the county administrative boards concerned have together invested resources in the development of new support and treatment interventions for young drug users in Sweden's three largest cities – Stockholm, Göteborg and Malmö – during the 2000–2005 period. As part of this effort, new outpatient centres for young people with drug problems have started and existing centres have been able to start projects and to work on method development. Today there are specialised outpatient centres for young people with drug problems in all three of Sweden's largest cities. Since these centres represent a relatively new phenomenon in drug services, there is still rather limited knowledge about their interventions, their methods and their visitors. There are at present no comprehensive national data. Against this background, and given that several of the recently started centres had expressed a need for guidance in the development of their programmes, it was decided by representatives of centres in the three cities to carry out a comparative study and an exchange of experience among their centres. The exchange of experience has been carried out as a 'quality circle' where representatives of the six centres concerned have met on a continual basis to discuss quality problems and possible strategies for operational development. Using a jointly developed interview questionnaire, data on visitors to the centres have been collected during a year. These data have constituted, together with descriptions of programmes, an important basis for comparison among the centres and their interventions, methods and visitors.
The comparative study and the exchange of experience were financed by the NDPCo and implemented in 2005–2007. The study was carried out by representatives of the centres under the guidance of Torkel Richert, Lecturer at Malmö University.

A total of six outpatient centres for young people with drug problems participated in the study. Two of them are located in Stockholm: Maria Ungdom Stockholm, which is the oldest centre in Sweden and has served as a model for many centres which have been created more recently, and PUMAN (the Swedish acronym stands for 'Programme for young people at risk of developing alcohol/drug addiction'). Three of them are located in Göteborg: Ungdomsteamet Mini-Maria Nordost, Ungdomsteamet Väster and Ungdomsteamet Hisingen (the word ungdomsteam means 'youth team'). And one of them is located in Malmö: Maria Malmö, the only specialised centre for young people with drug problems in the city as well as the only centre which serves all of the city districts.

The aim of the present report is to describe and compare these six outpatient centres, to make an inventory of the characteristics of the young people and young adults who come to the centres, and to present the outcome of the exchange of experience which has taken place among the centres.

The centres

The six centres have much in common. They all offer advice, support and outpatient treatment which is easily accessible to visitors. In their sessions with young people, most of the centres use above all cognitively oriented methods. All of them also work on the basis of systems theory since the resources of the young person's family and social network are seen as a natural and important component of the work done. To visitors who are heavy cannabis users, the centres are able to offer a structured and manual-based programme building on the treatment model for cannabis users in outpatient care.

One aspect considered important by all centres is the ability to offer simple medical services as well, such as medical assessment, health counselling, hepatitis and HIV testing, tests of liver status, drug analysis and administration of medications. This makes it important to have access to health-care staff. The centres have taken different approaches when it comes to offering medical services. Several of them started out as co-operation projects between municipal services (i.e. social welfare) and county services (i.e. health care). Their staff then consisted of graduate social workers as well as nurses and physicians. However, because of various problems associated with such co-operation, today only Maria Malmö uses integrated co-operation between municipal and county services. The other centres have resolved their need for staff with health-care training through co-location or co-operation projects with other services employing health-care professionals, by engaging the services of physicians on a consultancy basis, or by employing a nurse as part of their regular staff.

Co-operation or co-location with other services has proved to give many benefits. Maria Malmö, which co-operates with the South West Scania Regional Health Care District, the Sub-Regional Addiction Centre and the Regional Child and Youth Psychiatry Unit, has access to human resources representing a broad spectrum of skills and is thus able to offer a wide range of interventions. Maria Malmö's close co-operation with the Child and Youth Psychiatry Unit involves consultation between the two services in cases where expertise in both drug use and psychiatry is needed. Through its co-operation with the Regional Health Care District and the Addiction Centre, Maria Malmö is able to offer its visitors health counselling, drug analysis, administration of medications and withdrawal treatment.

However, it is rare for the effects of co-operation and/or co-location to be exclusively positive. Practical co-operation is often time-consuming, and differences between work cultures and professions may sometimes lead to differences of opinion as well as slow decision-making. Indeed, the fact that several of the centres which are independent municipal programmes today actually started out as co-operation projects between municipal and county services shows that the difficulties involved in such co-operation may sometimes outweigh the benefits.

At present there are differences between the six centres in the extent to which they are able to offer medical interventions. There are also certain differences in working methods and in prioritised work and interventions. Some centres place a great deal of emphasis on their own outreach work while others devote more efforts to advertising and marketing in the media or to co-operation with other actors in order to reach a broad target group. Some centres focus more on investigation, assessment and short-term conversational therapy while others rather emphasise longer-term treatment interventions with a more explicit therapeutic component.

The fact that the centres differ from one another in certain respects can be seen both as an advantage and as a problem. The use of different approaches may appear to confirm the lack of clear evidence-based practices or methods in their work. According to the Swedish National Board of Health and Welfare, there are still few compilations of knowledge about the effects of short-term psychosocial anti-drug interventions which are of acceptable quality. The differences in the range of interventions offered by the various centres can be seen as a problem from the perspective of citizens' rights since this means that the service provided will differ depending on where in Sweden a person lives. On the other hand, the differences between the centres may also be seen as positive to the extent that they are a reflection of differentiated target groups and/or variation in the problems and needs of visitors.

In Göteborg, there have recently been discussions among representatives of various city districts about the four outpatient centres which operate in the city and the differences among them. The outcome of these discussions was a decision to the effect that the future development of the four centres will move in the same direction. The objective is for all of them to be able to offer, from 2008 onwards, more or less the same types of interventions and services. The idea is that all inhabitants should have access to the same treatment and services regardless of where in the city they live.

The extent to which it is also a good idea to ensure at the national level that all outpatient centres for young people with drug problems offer the same services and use the same methods is an interesting issue for further discussion. On the one hand, it is appropriate to consider the right of all citizens to have access to the same service regardless of where in Sweden they live; on the other hand, a degree of flexibility whereby centres adapt their offering to local needs may lead to citizens being given a better service. As knowledge and evidence in the field accumulate, it is reasonable for the centres to move closer to each other. At the same time, however, it is important to emphasise in this context that differences in respects such as specific methods account only for a limited part of treatment outcomes in the case of drug problems. Other factors such as the therapeutic alliance and organisational circumstances may be of critical importance.

One explicit objective is for the centres to reach young people at risk: those who are not established drug users and who are not socially excluded or marginalised. A key area of work for the centres, therefore, is to engage in various types of outreach efforts. This takes place, for example, through field work carried out by staff of the centres to meet young people and tell them about the work they do. All of the centres have also built working relationships with authorities and various actors which come into contact with many young people, such as social-welfare services, schools, the police, health-care services, health-care guidance centres for young people and the criminal-justice system.

Besides this, several centres have started co-operation projects to recruit young people who would not normally come to them. The MUMIN Project at Maria Ungdom in Stockholm (presented in NR 06) was started as an attempt to improve the care chain between the police and the social services. As a result of this project, many of the young people arrested for minor drug offences have quickly been passed on to treatment providers. Ungdomsteamet Hisingen and Ungdomsteamet Väster in Göteborg have also carried out a co-operation project with the police and the social services in order quickly to take care of young people who are convicted of minor drug offences. At Ungdomsteamet Mini-Maria Nordost, also in Göteborg, the ‘Boys Project’ (Killprojektet) – a co-operation project between the centre and the local health-care guidance centre for young people – has led to a number of the young people who come to the guidance centre also establishing a contact with Ungdomsteamet Mini-Maria Nordost.

Through these recently started co-operation projects, and through the outreach work carried out, the objective of reaching young people at an early stage has been partially fulfilled. It is a moot point, however, whether the explicit target group is actually being reached to an adequate extent. Staff at several of the centres are of the opinion that they do not carry out a sufficient amount of outreach work in the arenas where members of the target group are to be found and thus that they do not fully reach the group of ‘young people at risk’. The material collected about the visitors to the centres also indicates that only a small share of the young people

visiting them can be said to fit the description of 'young people at risk' who are not established drug users. According to this material, the vast majority of the visitors are fairly heavy and established drug users.

An important question in this respect is what group of young people should constitute the top priority of the centres. Should they prioritise outreach work to identify young people who are not established drug users, or should they devote most of their resources to treating those who are already established?

Visitors to the centres
Who are the young people and young adults who come to the centres today? During the period from 1 June 2005 to 30 June 2006, data were collected on people visiting the centres by means of structured interviews. In all, 395 young people or young adults coming to the different centres during this period were included in the study.

Among the visitors to the six centres, 37 % were females. This is slightly more than the share of females recorded for all drug treatment services in Sweden. The larger share of females at these outpatient centres can probably be explained by reference to the fact that they mainly target young people with emerging drug problems. In this group, the differences between men and women in the prevalence of drug use are smaller than in the group of older, established drug users.

The share of the visitors to the centres who were born outside Sweden is slightly lower than the overall share of foreign-born young people/young adults in the three cities. The share of young people with a foreign background (i.e. either born outside Sweden themselves or having both of their parents born outside Sweden) at the centres in Göteborg and Malmö is higher than the respective overall share of young people with a foreign background in these cities. At the two Stockholm centres, the share of visitors with a foreign background is on a par with the overall share of young people with a foreign background in Stockholm.

The age distribution of the visitors was very wide. The youngest visitor was 12 years old and the oldest was 28. Just over half (53%) of the visitors were 18 or older, and slightly less than half (47%) were under 18.

The vast majority of the visitors to the centres had used both alcohol and illegal drugs. One-fifth of them did not mention any illegal drug when asked about their drug use. However, most of these visitors said that they came to the centres because of extensive alcohol use. Almost all visitors stated that they had been drunk at least once, and more than 90% of them had had their first such experience before the age of 16. One-fifth of all visitors claimed to have used alcohol 2–3 days a week or more during the past six months. The share of females reporting such more frequent alcohol consumption over the past six months was slightly larger than that of males. The share of females reporting periodic abuse of alcohol was also larger. This finding differs from those of previous studies, which have shown young men in general both to consume substantially larger quantities of alcohol than young women and to use alcohol more frequently.

Almost 70% of the young people who came to the outpatient centres used illegal drugs for the first time before the age of 16. This means that their age at first use, in general, was low both compared with the entire group of young people who have used illegal drugs at least once and compared with the group of young people who use illegal drugs on a more or less regular basis. Cannabis was the clearly most common illegal drug in all three cities. Three-quarters (75%) of all visitors reported

previous or present use of cannabis. Older studies have also shown cannabis to be the most common illegal drug both among experimental and occasional drug users and among heavy drug users. Cannabis was also the most common primary drug (principal drug of abuse) among the visitors. Of those who had ever used illegal drugs, 75% reported cannabis as their primary drug. Smaller shares reported amphetamines, cocaine or heroin as their primary drug. Differences between men and women emerged in this respect as well: males were more likely to report cannabis as their primary drug while females were more likely to mention amphetamines, cocaine or heroin.

Besides cannabis, a number of other illegal drugs were also fairly common. Among all visitors, 30% had used amphetamines, 25% had used ecstasy, 20% had used benzodiazepines and 20% had used cocaine. Compared with the entire group of young people with experience of illegal drugs, visitors to the centres were much more likely to have used heroin, amphetamines, cocaine and ecstasy. Smaller shares of the visitors reported having used LSD (10%), heroin (7%) or GHB (5%).

A majority of the visitors had been using drugs frequently – at least 2–3 days a week – in the past six months. Of those whose primary drug was cannabis, moreover, just over one-quarter had been using it on a daily basis in the past six months.
There emerged three clear differences in drug use among the three cities. First, visitors to the two Stockholm centres were substantially less likely to report use of illegal drugs. Two possible explanations are that Maria Ungdom Stockholm has a large share of very young visitors and that a large share of those visiting PUMAN come because of their alcohol abuse. The second clear difference identified was that heroin use was reported by a larger share of visitors in Malmö than in Stockholm and Göteborg. Given the long tradition of heroin use in Malmö and given its geographical location close to Copenhagen and continental Europe, this finding was not entirely unexpected. However, it is difficult to tell whether this finding reflects a real difference in drug use among the young populations of the three cities. The third clear difference relates to use of GHB. Use of this drug was substantially more common among visitors to the three Göteborg centres than among those visiting the Stockholm and Malmö centres. This finding is consistent with those of previous studies. Göteborg and the rest of western Sweden has been a GHB stronghold ever since the mid-1990s, also reported in previous NRs. What is more, a recent study indicates that the use of GHB has increased in Göteborg compared with the rest of Sweden as reported by CAN[36].

In general, the prevalence of psychological problems among the visitors was high. Over half of the females and more than one-third of the males reported having problems with their mental health at the time of the interview. One-fifth of the visitors had had medical drugs prescribed to them for psychological problems, and over one-quarter had undergone psychiatric treatment. Problems experienced at least once for a lengthy period of time by a majority of the visitors include sleep disturbances, severe anxiety and serious tension disorders as well as comprehension, memory and concentration difficulties. Almost half of the visitors had experienced at least one lengthy period of severe depression. A worryingly large share of the visitors, above all of the young women, stated that they had engaged in self-injury (43%) and had had serious suicidal thoughts (40%). One-quarter of the young women who participated in the study reported having tried at least once to commit suicide.
Some of the above-mentioned problems seem to be clearly linked to drug use. Almost half of those who had been severely depressed had been so only in

[36] http://www.can.se/documents/CAN/Rapporter/rapportserie/CAN-rapportserie-106-CANs-rapporteringssystem-om-droger-CRD-tendenser-i-Goteborg-vinterhalvaret-2006-2007.pdf

connection with drug use, and over one-third of those who had experienced comprehension, memory and concentration difficulties had done so only in connection with drug use.

To paint a broader picture of the young people and young adults who visit the six centres, this group was compared in a number of respects with the same age group of the general Swedish population as well as with the group of young people placed at 'specially approved homes' run by the Swedish National Board of Institutional Care[37]. Comparison with the same age group of the general population showed that the visitors to the six centres, in addition to having more extensive drug use, had generally grown up in less secure conditions, had experienced greater problems with their mental health, had a lower educational level and were less likely to be financially self-supporting.

When a comparison was made between the visitors to the outpatient centres and young people placed at specially approved homes, several similarities emerged. There were large similarities in the illegal drugs used by the young people and in their frequency of alcohol use. Furthermore, about one-third of both groups had previously received drug treatment, and a significant share had committed criminal acts. There were also certain differences between the groups. Frequent use of illegal drugs (more than one day a week) was reported by a larger share of the young people visiting the outpatient centres than of the young people placed at homes. The young people at the homes, in general, had been younger the first time they used alcohol and illegal drugs, were more likely to have grown up in separated families and were more likely to have interrupted their studies at compulsory school (age range 6–16) or to have left compulsory school permanently without finishing it.

To sum up, it can be concluded that the group of visitors to the six centres is a very broad one in terms of both age, backgrounds, problems and needs. The young people who come to the centres range from 13–14-year-olds having had their first 'drinking binge' who arrive with their parents to young people and young adults who are established users of illegal drugs, have an extensive criminal record and/or suffer from severe psychological problems. Even though there is a degree of variation among the centres, the same broad group of visitors is represented at all six of them. One question which arises is whether it is possible for a single service to meet such a broad group of visitors with so widely differing problems and needs. Is there a limit to the skills and expertise of the centres? Meeting such a diverse group requires access to highly qualified staff with skills and expertise in a wide range of fields as well as the preparedness and ability to either consult with experts or refer cases to other services when necessary. In the vast majority of cases, the staffs of the centres feel capable of helping their visitors. The breadth of skills and expertise and the wide range of interventions available to most of the centres make them confident that they can meet a very diverse target group. However, representatives of all centres said that a small share of the young people they meet have problems of such magnitude that the resources of their centre are inadequate. Some of these young people have very extensive psychiatric problems, others suffer from very heavy and advanced

[37] Under the Swedish Care of Young Persons Act (SFS 1990:52), young people (aged below 18 or, in some cases, 20 years) can be placed at a specially approved home by virtue of a care order issued by a local administrative court (i) if they expose their health or development to a palpable risk of injury through the abuse of addictive substances, criminal activity or some other socially degrading behaviour; or (ii) if they have been sentenced to closed institutional care under the Penal Code and are considered to be in manifest need of continued care so as not to run the risks referred to in (i).

drug use and/or have extensive criminal records. In some cases, staff feels that other types of interventions may be necessary:

'We deal to some extent with young people who should perhaps be placed in institutional care, young people who are such heavy drug users and criminals that ten years ago they would have already spent quite some time at an institution. One problem is that the city districts are very restrictive when it comes to placing young people at institutions; they always send them to us first. Whether this is always the right way to go is debatable.'

This quotation illustrates a clear shift which has taken place in drug treatment over the past fifteen years. During this period, the treatment of people with abuse or addiction problems has progressively moved from inpatient to outpatient care. It is increasingly rare for applications for institutional treatment to be approved, and people with drug problems are often referred to outpatient care in their own municipality, regardless of their actual care needs.

The new guidelines for abuse and addiction care issued by the Swedish National Board of Health and Welfare[38] present three fundamental questions which should be asked whenever a choice is to be made between outpatient and inpatient care:
- On what basis should either type of care be chosen?
- Is there evidence in favour of either alternative?
- For whom, or for what groups, should either alternative be chosen?

There are at present no unequivocal answers to these questions. It is therefore most probable that some of the young people who receive outpatient care today would benefit from inpatient care while some of those who are today treated in inpatient/institutional care would receive adequate or better help in outpatient care. Better and more uniform documentation of outpatient centres, as regards both target groups, interventions and outcomes, would facilitate comparison between outpatient and inpatient treatment. This would also increase opportunities to provide the right individuals with the right type of treatment at an early stage.

The objective of the present study was to provide an outline view of six outpatient centres and their interventions, methods and visitors. This is a first small step towards building a more extensive base of knowledge about the outpatient treatment of young drug users. In order for this treatment form to gain greater legitimacy and stronger scientific support, there is a need for continuous internal development at the individual centres as well as for larger and more comprehensive evaluations and studies of the impact of the work done by the centres.

Exchange of experience
The working party in charge of conducting the comparative study has also exchanged experience and worked on issues of operational development. This work has been carried out in the framework of a 'quality circle' where issues of mutual interest have been presented and discussed. The exchange of experience has shown, among other things, what the representatives consider to be important factors for outpatient centres targeting young people with drug problems, what works well at the various centres today and what is in need of improvement.
The most important factor was considered to be that visitors should feel that they are seen and listened to and that they should have an opportunity to express their needs, expectations and wishes. Another very important factor was for staff to be up to date

[38] http://www.socialstyrelsen.se/NR/rdonlyres/A50309C4-BAB3-4EB9-A407-E5C684469D90/7076/20071021_rev.pdf

about drugs, drug use and recent research in this field. A third very important factor was for the centres to be easily accessible and to have a welcoming atmosphere. The representatives considered that, at present, all of these requirements were well met at their respective centres.

The shortcomings identified mainly concern documentation, quality development and evaluation. As a consequence, these issues were given particular attention in the quality circle where the exchange of experience was carried out.
Two lectures on the theme of evaluation and quality development were organised in order to enhance the knowledge of the group about possible models and strategies. Both external evaluation, self-evaluation and peer-review models were presented, and their advantages and disadvantages were discussed.

The working party wished to have an easy-to-use instrument or method capable of yielding information about the outcome of their work with visitors. Two rating scales – SRS (Session Rating Scale) and ORS (Outcome Rating Scale) – were presented as possible such instruments. Both of these scales have been developed by Scott D. Millers at the Institute for the Study of Therapeutic Change. They are intended to enable clients to provide treatment staff, in a quick and easy way, with feedback on their mutual relationship, on the relevance of the content of sessions and on the importance of these sessions for the clients' development.

A small-scale pilot project was carried out as part of the exchange of experience, with staff from all six centres testing these rating scales in their work and then discussing their experiences in the quality circle. Overall, their experience from using the scales was positive. Among other things, the scales were felt to provide very helpful guidance as to appropriate areas of focus in treatment work and to give insight into the development of the relationship between the person providing treatment and the client. Other positive experiences included the fact that the scales yielded new information about the home conditions, relationships and needs of the young people. Following this pilot project, several of the centres have now started using ORS and SRS as tools and simple evaluation instruments in their everyday work. The degree of motivation to use the scales, however, varies among the employees of the different centres. One possible way of increasing the penetration of ORS and SRS at the centres might be to organise workshops or training days on these instruments for all staff.

One of the key issues dealt with in the exchange of experience was documentation and documentation systems. It was concluded at a very early stage that this was one of the areas where the centres were experiencing major problems. At present they use different questionnaires/systems for documentation purposes. The three Göteborg centres all use an established documentation system called 'DOK' (the Swedish acronym stands for 'Documentation of clients') while Maria Ungdom Stockholm, PUMAN and Maria Malmö use questionnaires of their own creation as the basis for their documentation. None of the centres is fully satisfied with the questionnaire or system which it uses today. Discussions in the quality circle have dealt both with the current documentation systems and with other possible ones such as ASI, ADAD and EURO-ADAD. However, none of them was found to be optimal for the outpatient centres.

Three main problems have been identified:
- The questions are not adapted to the needs of young people coming to outpatient care;
- Certain questions may be perceived as sensitive or offensive;
- The systems are too extensive and time-consuming.

A view to which all participating representatives subscribe is that detailed and systematic documentation is absolutely crucial. Such documentation may form the basis of statistics and descriptions of programmes, it may provide material for making inventories of the problems and social evils existing in a certain geographical area, and it may give important information about the problems, resources and needs of individual visitors – information which may be directly useful in treatment. Furthermore, a well-designed documentation system can also be used for purposes of monitoring, follow-up and less advanced types of evaluation of the interventions made by a centre. At the same time, the participants in the quality circle agreed that a documentation system which is too extensive and time-consuming or which focuses on the wrong issues may have a negative impact on the relationship with the visitor and thus on treatment.

Many of the young people visiting the outpatient centres come there only a few times. There is thus a need to make the best possible use of the time available. If the short period of time spent by a young person at a centre is devoted to filling out an extensive questionnaire, there is a high risk that the issues of interest to the young person will not be focused on. Another important aspect is the young people's experience of the questions. They do not come to the centres to be assessed or investigated – they come because they want advice, support and help. Many of them have an extremely fragile motivation and many are ambivalent about their contact with the centre even though they have come there voluntarily. The therapeutic alliance may be negatively affected by a questionnaire containing questions which do not feel meaningful, which are felt to be offensive or menacing, which take up a lot of time or which the young person does not understand. In the worst-case scenario, this might make the young person break off his or her contact with the centre.

The issue of documentation can be said to pose a dilemma to the centres. On the one hand, documentation is a prerequisite for high-quality work; on the other, it risks having a negative impact on their work with visitors. Since none of the existing documentation systems discussed by the working party was deemed suitable to the needs of the centres, its members have initiated work to create a new system as part of their exchange of experience. The common interview questionnaire developed to collect data for the comparative study was felt to be easy to use and to provide valuable information. It will therefore serve as the basis for the documentation system which is now being developed.

To enable further work on creating a documentation system adapted to the needs of the outpatient centres, the working party has applied for funds from the respective county administrative boards concerned. Co-operation in the field of scientific guidance has been initiated with the Institute for Evidence-Based Social Work Practice (IMS). It is hoped that, over time, the system will become widespread among outpatient centres for young people with drug problems. This could lead to the creation of a larger knowledge base and yield national data on the group of young drug users in outpatient treatment.

Pharmacologically assisted treatment.

Withdrawal treatment

No new information available.

Substitution treatment

Substitution/maintenance treatment is offered at about 60 specialised units in Sweden. During 2006 a total of 2739 persons have been in substitution treatment – 1270 with methadone and 1469 with buprenorphine according to the National Board

of Health and Welfare. It is considered a problem that this type of treatment is not equally available in all parts of the country.

An activity (The Hub) to help prostituted women was started in the city of Malmö in 2005 and was initially financed by support from the NDPCo. It was part of the municipality strategy to help prostituted women and included a substitution treatment project for heroin using prostituted women. In the funding of the project a reservation for evaluation was granted and the evaluation report was presented in Mars 2007[39]. In the autumn 2006 just over 20 women were participating in the activities at The Hub, most of them in substitution treatment. The report shows that women were able to cut the abuse and to stop the prostitution and several women have got the care of their children back. One conclusion is that The Hub represents a successful treatment alternative for persons used to fail, with a strong distrust to authorities and tiredness of treatment. The evaluation is based on interviews, participation, official documents regarding The Hub and unidentifiable ASI interviews with clients at The Hub. In 2007 the responsibility to run the service is taken over by the municipality and the region of Skåne.

Other medically assisted treatment
No new information available.

[39] http://www.mobilisera.nu/upload/Navet.pdf

6. Health Correlates and Consequences

Overview / summary on health correlates and consequences

A marked increase of HIV among IDUs was observed during the first six months of 2007. 29 cases were reported compared to an average of 12 per 6 months over the last 5 years. The majority of the cases were infected by a for this population new variant of the HIV virus, a variant which also was seen in Helsinki, Finland, in an outbreak around year 2000. 24 of the 29 HIV infections among IDUs 2007 originate from the Stockholm area. It is also clear that the number of HIV infections has increased in all categories in the Stockholm area and that Sweden now is the most common place for infection for this geographical group in stead of abroad as previously.

Drug related deaths and mortality of drug users.

Direct overdoses (substances involved) and (differentiated) indirect drug related deaths

Data on drug-related deaths in Sweden are collected either from the National Cause of Death Registry (NCDR) or from forensic data on "deaths with illegal drugs present" (DIDP). Forensic investigations are performed routinely in Sweden at fatal accidents or when there is a suspicion of unnatural death, suicide or crime.

Data from the National Cause of Death Registry (NCDR).

The cases of death in the NCDR have to be correctly coded strictly according to the ICD-10 system. It is a complex and time-consuming task, which causes delays in the possibility of investigating current trends. The most recent data is from 2004, when 348 persons died according to the EMCDDA DRD-Standard selection B, code T40.4 (dextropropoxyphen) excluded. A 10 year trend is presented in figure 6.1.

Data from the forensic toxicity register.

The 1994–2006 DIDP data (Table 6.1 and Figure 6.1) are divided into five mutually exclusive categories. If several illegal substances were present simultaneously, the death was placed in the highest ranked substance category. For instance, if both cocaine and amphetamine was detected, the death was placed in the amphetamine category.

Categories of substances analyzed in drug-related cases of death based on forensic data:

1. Verified heroin: 6-monoacetylmorphine (6-MAM) present. After intake, heroin is rapidly transformed into (6-MAM), which can only originate from heroin. If 6-MAM is present, it can be assumed that death occurred close to the intake of heroin.

2. *Heroin/morphine:* Deaths with morphine but no 6-MAM present, where morphine levels are equal to or higher than codeine levels. After ingestion, heroin is transformed into codeine and 6-MAM. The 6-MAM is further transformed into morphine, which can also originate from legally prescribed medicine. In this manner, the simultaneous presence of both codeine and morphine strongly suggest death caused by heroin. To further ensure deaths caused by legal medicine were not included, deaths occurring among persons older than 50 were excluded from this specific category. In this manner, suicides with legally prescribed medicine among elderly people were excluded.

3. Amphetamine

4. Other illegal drugs: Cocaine, ecstasy-type substances, GHB, LSD, DOB, methamphetamine, 4-methylthioamphetamine

5. *Cannabis only:* Deaths were only attributed to this category if no other illegal drugs were present.

Table 6.1. Characteristics and number of deaths with illegal drugs present in body fluids based on forensic data, in total and for respective substance category, 1994-2006.

No of deaths per year						
	Verified Heroin	Heroin/ morphine*	Amphetamine	Other illegal drugs	Cannabis only	Total
1994	39	58	62	0	22	181
1995	37	67	51	2	20	177
1996	40	70	80	4	23	217
1997	62	74	68	6	26	236
1998	55	74	74	3	38	244
1999	55	86	98	9	29	277
2000	67	120	77	22	45	331
2001	69	119	85	11	46	330
2002	48	88	114	15	41	306
2003	57	67	104	25	40	293
2004	45	69	104	15	59	292
2005	65	63	86	17	36	267
2006	34	64	113	13	48	272

*Deaths among persons over 50 years of age excluded from this category.

In 2006, the number of verified heroin related deaths (6-MAM) were notably lower than the previous year (34 in 2006 compared to 65 in 2004), reaching almost the same level as in 1994. By contrast to the trend for the verified heroin related deaths, the heroin/morphine related deaths remained on the same level as in 2003 and onward.

Deaths with amphetamine present in body fluids have also increased in numbers since 1994, peaking in 2002 and since then the numbers have fluctuated.
The annual number of deaths where cannabis was detected in body fluids increased dramatically between 1994 and 2001. Since then the numbers have varied annually but no trend is seen. After that a fairly stable level has been maintained. Since cannabis has no known acute toxic effect and does not cause organ damage (at least not in the short-term perspective), these deaths may be related to a number of causes, including the effect on psychological functions increasing the risk of accidents, suicide or murder. Many of these deaths are possibly also related to alcohol.

The annual number of direct drug related deaths 1994 – 2004 based on the NCDR, EMCDDA DRD-Standard selection B, code T40.4 (dextropropoxyphene) excluded, is shown in Figure 6.1 together with DIDP data.

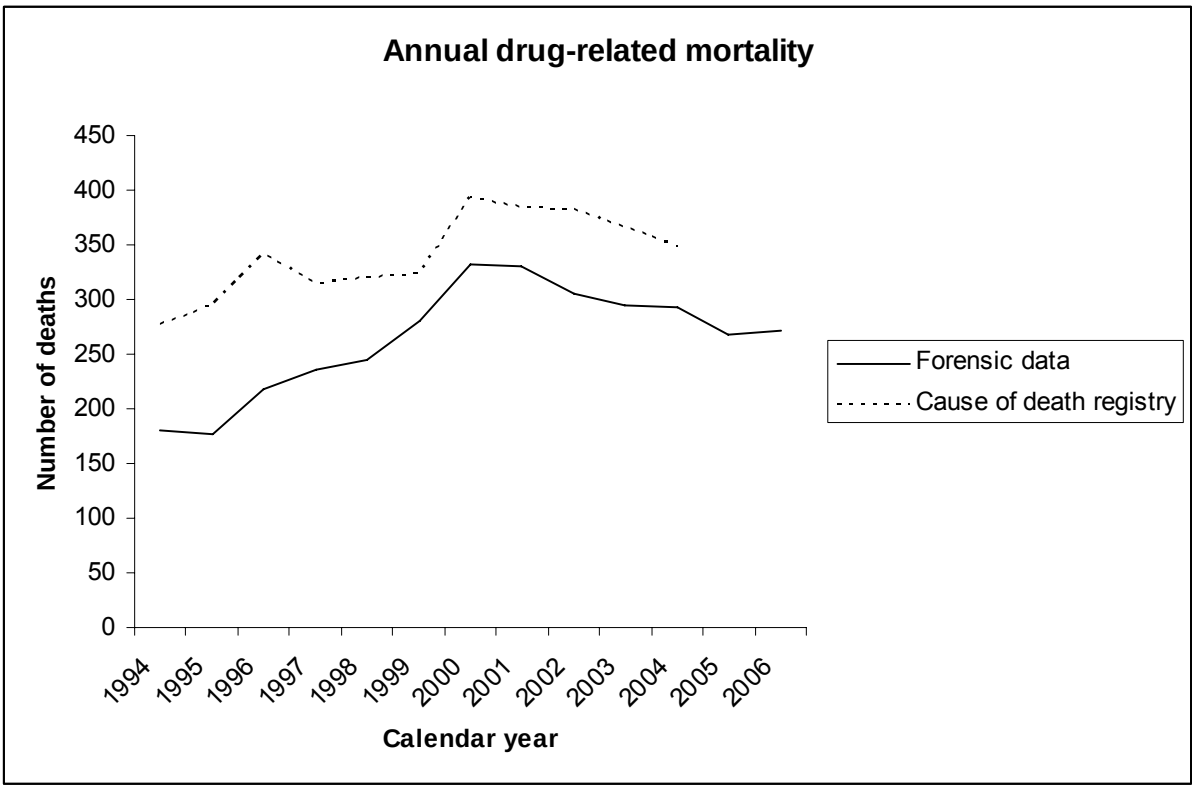

Figure 6.1. Number of direct drug related deaths per year 1994 – 2004 based on the NCDR (EMCDDA DRD-Standard selection B, code T40.4, dextropropoxyphene, excluded) and the annual number of deaths of DIDP based on forensic data 1994 – 2006.

As the NCDR includes all deaths with drugs as an underlying (=main) cause in accordance with the EMCDDA Standard B selection, the DIDP numbers are lower since they only represents the cases were an illegal drug was found in a dead person. However, and in the long-term perspective, they both seem to follow the same general trend.

The short delay in data availability makes the forensic data a very useful tool when looking at DIDP trends, though somewhat costly. It must be kept in mind that the mere presence of an illegal drug in forensic analyses does not imply causation. Additionally, the chain of causation (of drug-related deaths) also varies for different substances.

Mortality and causes of deaths among drug users
No new information available

Drug related infectious diseases.
(HIV)
During 2006 a total of 390 cases of HIV were notified in Sweden (151 women, 236 men, 3 unknown). Out of these 390 cases 35 have been identified as being IDUs (7 women and 28 men). During the second half of 2006 an increase in reported HIV-cases among IDUs was observed. Preliminary results from DNA sub typing of these

newly diagnosed cases suggest that the increase in reported cases is due to an outbreak with a genetic variant called CRF01-AE. This specific genetic variant has also been observed among newly notified heterosexual cases which can suggest that the virus has spread from IDUs to their sexual partners. During 2006 a total of 25 people have been infected with this genetic variant. This cluster of newly diagnosed cases is probably due to a so-called ”founder-effect”, where the virus has been introduced and thereafter spread, through needle-sharing, among IDUs in the Stockholm area.

During the first six months of 2007 a total of 29 cases of HIV among IDUs have been notified. During the last five years an average of 12 cases have been reported every six months in this group. 25 of the reported cases were infected in Sweden.

Hepatitis C
During 2006 a total of 1 648 HCV cases were reported. The number of reported cases continues to decrease year by year (4 % decrease compared to 2005).The share of intravenous drug users has also decreased: in 1995 they made up 92% of the new cases with a known transmission route, compared to 83% in 2004, 64% in 2005 and 57% in 2006.

69% of those infected through intravenous drug use were men. The same dispersion between men and women could be observed in most age groups except in the age group 15–19, where more women than men were infected. The mean age for those infected through IDU was 33 (14–64) for women and 36 (14–73) for men.

Hepatitis B
During 2006 a total of 162 notified cases of acute HBV were reported in Sweden, 57 women and 105 men. 40% of the cases were attributed to IDU. 18 women, mean age 32 (18-49) and 45 men, mean age 30.5 (17-48) were infected through IDU. Of those infected through intravenous drug use 32 had also a known HCV infection. Molecular typing of acute HBV cases in Stockholm showed that approximately 50% could be attributed to a known drug associated strain, suggesting that sexual transmission is now just as important factor in the spread of acute HBV as is intravenous drug use.

Psychiatric co-morbidity (dual diagnosis).
No new information available.

Other drug related health correlates and consequences.
Experience of violence among female drug addicts
No new information available

Driving and other accidents
An official national register over drug related health correlates as a consequence of driving or other accidents is not at hand. Please consult last years selected issue on drugs and driving for some information on the item.

Pregnancies and children born to drug users
No new information available

Problematic consumption of medicines classified as narcotic drugs.
Please consult section 10 in this report.

7. Responses to Health Correlates and Consequences

Overview / summary of framework, strategies and interventions in relation to prevention of health consequences

The national action plans on drugs (2002–2005, 2006–2010) has vitalised the fight against drugs markedly. The action plans has promoted the test and implementation of new methods and strategies, improved the quality, increased the resources and introduced new and specialised projects. Examples on responses to health correlates and consequences are presented in previous NRs. Early detection and early intervention are key issues in the efforts to reduce the consequences of drug abuse and the primary aim to end the abuse.

Prevention of drug related deaths

Overdose prevention

No new information available

Prevention and treatment of drug-related infectious diseases

Prevention

No new information available

Counselling and testing

No new information available

Infectious disease treatment

No new information available

Interventions related to psychiatric co-morbidity

No new information available

Interventions related to other health correlates and consequences

Somatic co-morbidity

No new information available

Non-fatal emergencies and general health-related treatment

No new information available

Prevention and reduction of driving accidents related to drug use

No new information available

Other health consequences reduction activities

No new information available

Interventions concerning pregnancies and children born to drug users

No new information available

8. Social Correlates and Consequences.

Overview / summary on social correlates and consequences.

Data on social exclusion is not collected and processed in a standardised way for official statistics. From research projects and special investigations information can be gathered, often for a limited cohort. Problem drug abuse and various forms of criminality, unemployment, homelessness, health problems etc. are closely related and well known to the society. The NDPCo has pointed to the need to see the health- and social problems related to drug abuse not as separate phenomena, but as a unified problem that must be solved in its entirety. With that view the NDPCo is supporting local/regional cooperation networks and research projects. The social costs of drug abuse are also part of the mapping of the problems and the efforts to solve them.

Social exclusion.

Homelessness

According to a report from the NBHW[40] 17800 persons (75% men and 25% women) were homeless in a specific week in 2005 (week 17). The mapping of the homelessness situation is based on data from all agencies, authorities, institutions and organisations that are in contact with these persons. 12% of the homeless persons were during the study week living in some kind of acute housing and 5% slept outdoors. Homelessness was reported in 86% of the 290 municipalities in Sweden. The highest figures per 10 000 inhabitants were reported from Göteborg and Stockholm. Abuse problems were at approximately the same level when major cities were compared to the rest of the country. More people are reported as homeless 2005 than 1999, mostly reported from the social services. The number of persons reported to have abuse problems had increased since 1999 but simultaneously their share of the total homeless population had decreased. The same situation was found for persons with mental problems. Fewer persons in 2005 had participated in compulsory contributions due to abuse or mental problems.

Persons considered as homeless were divided in four different situations.

- Situation 1 is the most acute, people sleeping outdoors or referred to acute housing or shelter. Close to 3 600 persons (20%) were in this situation at the time of the mapping.
- Situation 2 is valid for persons lacking home and within short are released from any form of institution or supportive housing. 11%, close to 2000 persons were in this situation at the time of the mapping.
- Situation 3 concerns people lacking home, living according to situation 2 but not considered to be released within short. This was the largest group with 6 400 persons (37%). The investigators claim that there is a risk of underestimate in this group since they traditionally have not been considered homeless and the reporters could have missed that these persons should be part of the investigation.
- Situation 4 finally include persons that involuntary are referred to staying with family or friends. This group consisted of 4 700 persons (26%).

Very few of the homeless had employment or salary, many are dependent on support from the society. 62% are judged to have abuse problems and 40% to have mental problems. Slightly over 30% of the homeless population was reported as parents to children under 18.

[40] http://www.socialstyrelsen.se/Publicerat/2006/9162/Sammanfattning.htm

Persons in the homeless category had received several supportive contributions over the last year, 75% on housing, close to 50% on abuse problems and little more than 33% on mental problems. 35% of the homeless category had been in non voluntary situations, like prison or different forms of compulsory treatment.

Women were in general younger and had been homeless for a shorter period than the men. Women were more often said to have children under 18 and also to live together with their children more frequently. The problems of the female population were more often related to family, like divorce and violence in the family. Women were also more often than men said to have mental problems while men more often had abuse problems. The large majority of homeless persons were born in Sweden but there was an over representation of people born outside Sweden in relation to their proportion in the general population.

Persons having been homeless for a longer period had more often a specific problem for which they needed help and support. Most frequent as function of the time as homeless were somatic problems, mouth and teeth problems and mental health problems. In contrast, financial problems, family problems and lack of employment seemed to decrease as experienced problems after a longer time as homeless. The investigators interpret the results as if the reporters mainly have focused on the more acute and obvious problems of the homeless while other problems were judged less important the longer the homeless situation had lasted.

Drug related crime

Drug offences

According to the 2006 BRÅ-report[41], 66 850 offences against the drug punishment act were reported in 2006. An increase by 24% compared to 2005. Almost 22 000 persons were convicted of drug offences in 2006 as shown in table 8.1 from BRÅ[42], an increase of around 13% compared to the previous year.

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http://www.bra.se/extra/measurepoint/?module_instance=4&name=Narkotikastatistik%202006.pdf&url=/dynamaster/file_archive/071031/e921dc9d58f20a07a9a0290cfbfad3ff/53090%255flow.pdf

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http://www.bra.se/extra/measurepoint/?module_instance=4&name=Narkotikastatistik%202006.pdf&url=/dynamaster/file_archive/071031/e921dc9d58f20a07a9a0290cfbfad3ff/53090%255flow.pdf

Table 8.1. Persons found guilty of drug offences by type of offence, 1997 - 2006

Type of offence	Year									
	1997	1998	1999	2000 [1]	2001	2002 [2]	2003	2004	2005	2006
Court sentence and fine issued by the prosecutor	**9 448**	**10 144**	**10 771**	**11 326**	**12 320**	**13 891**	**14 491**	**14 774**	**15 877**	**17 619**
Drug use	3 290	3 707	4 077	4 460	4 898	5 303	5 816	6 525	7 716	9 397
Drug possession	3 545	3 772	3 636	3 626	3 771	4 195	4 590	4 531	4 837	5 021
Possession, use	1 052	1 156	1 279	1 291	1 357	1 544	1 641	1 580	1 522	1 291
Peddling, peddling and possession	558	599	701	685	749	917	963	948	842	965
Possession, use and peddling	116	133	150	141	161	143	148	109	102	102
Production	20	9	29	15	10	7	6	18	25	17
Drug smuggling	590	560	639	770	968	1 495	982	657	556	509
Other offence and combinations	277	208	260	338	406	287	345	406	277	317
Waivers of prosecution	**1 847**	**1 798**	**1 569**	**1 890**	**1 722**	**2 118**	**2 522**	**2 692**	**2 941**	**4 065**
Total	**11 295**	**11 942**	**12 340**	**13 216**	**14 042**	**16 009**	**17 013**	**17 466**	**18 818**	**21 684**
minor offences	9 000	9 551	9 843	10 813	11 127	12 596	13 429	13 645	13 774	16 002
non-minor offences	2 219	2 127	2 210	2 075	2 548	2 974	3 131	3 336	4 490	5 248
serious offences	282	264	287	328	367	440	452	485	435	434
minor offences (%)	80	80	80	82	79	79	79	78	73	74

[1] 2000 corrected numbers.

[2] 2002 corrected numbers in waivers of prosecution.

The number of persons convicted of drug offences has increased every year over the past 10 years. The annual increase has varied but averages at just under 7%. This means that- drug convictions have almost doubled (increased by more than 94%) over the last ten years. The following four paragraphs (*type of offence →sanctions*) are quoted from the BRÅ-report 2006 referred to above.

Type of offence[43].
At 53% (9 397 persons) and 28% (5 021 persons) respectively, drug use and drug possession were the two most common offences committed by persons convicted of drug offences in 2006. Drug smuggling and distribution[44] accounted for 5% and 3% of all drug convictions respectively. The proportion of convictions relating exclusively to personal use has increased with 4%, from 7 716 in 2005 to 9 397 in 2006.
The proportion relating to possession offences has increased with 2%, from 4 837 persons in 2005 to 5 021 2006.

Persons convicted for crime against the Act on Prohibition of Certain Goods Dangerous to Health has increased more than six-fold between 2005 and 2006. 37 men, 3 women and 6 young persons were convicted 2006. An explanation to this marked increase is not at hand. One possibility could be that many persons were involved in the same crime.

Offence severity.
In 2006, minor offences accounted for approximately 74% of all convictions (just fewer than 16 000 persons). Non-minor offences accounted for 24% (5 250 persons) and serious offences for just over 2% (430 persons).The proportion of convictions for minor drug offences has decreased, primarily in 2005, whereas the proportion of convictions for non-minor drug offences has increased.

Substances[45].
Amphetamines and cannabis remain the two most common substances in the convictions statistics. In 2006 these accounted for 33% and 36% respectively of all substances mentioned in criminal convictions. Over the past 10 years there has been

[43] Refers to summary fines and court adjudications only, as the offence type cannot be discerned in the case of waivers of prosecution
[44] Distribution and distribution in combination with possession.
[45] Refers to convictions in which the drug offence was the principal offence.

a shift in the proportions accounted for by cannabis and amphetamines respectively, with cannabis now being the most common substance in criminal convictions.

Sanctions[46].
The most common sanction awarded to persons convicted of drug offences is a fine, either in the form of a summary fine issued by the prosecutor or via a court sentence. Persons awarded fines accounted for 55% of all those convicted of drug offences in 2006. 22% of those convicted of drug offences in 2006 took the form of waivers of prosecution, whereas 14% involved prison sentences.

The increase in the total number of persons being convicted of drug offences is also mirrored as an increase in virtually all of the different sanctions. The number of fines has more than doubled over the period examined, from slightly over 3 700 persons in 1997 to 8 000 in 2006. The number of persons sentenced to a prison term has increased from 1 300 in 1997 to 2 000 in 2006. The most common length of the prison term awarded in 2006 was between two and six months. Almost one-third of prison sentences fell within this range. The average prison term has gradually increased from 16 months in 1997 to 19 months in 2006.

Regional distribution
Relative to the size of the population in the different counties of Sweden, counties in the country's metropolitan areas have a higher proportion of drug convictions than the remainder. The metropolitan counties, which are home to half of the national population, account for 59% of all drug convictions in Sweden in 2006. Since 1997 this proportion has remained stable at between 59 and 64% of all those convicted in the country as a whole.

Age distribution[47].
In 2006, young persons aged 18–20 had the highest level of drug convictions in relation to their numbers within the population at large, with 860 convictions per 100 000 of population. The groups aged 15–17 years and aged 50 years or over have the lowest number of convictions, with 210 and 46 convictions respectively per 100,000 of population. Over the period between 1997 and 2006, the largest increase in the number of drug convictions per 100 000 of population has been noted among those aged 50 years or over. Per capita convictions in this group have more than tripled over the period examined. Similarly for those aged 21–29 years the convictions per capita have more than doubled since 1997.

Gender distribution.
Of the total number of persons convicted of drug offences in 2006, approximately 15% were women. This proportion has remained relatively stable over the past 10 years. The number of women and the number of men convicted of drug offences has more than doubled over the past ten years. Between 2005 and 2006, the numbers of women and the number of men convicted increased by 15% respectively.

Other drug related crime.
Driving offences.
Preliminary statistics from the Crime Prevention Council shows that the number of reported offences for drug-driving increased by 34% from 2005 to 2006. Over the

[46] Refers to summary fines and court adjudications only, as the offence type cannot be discerned in the case of waivers of prosecution.
[47] Calculations conducted per 100 000 of mean population as presented in appendix 1 to the 2006 BRÅ report previously referred to.

period there is an almost threefold increase in cases of drug driving. For further information please consult the 2006 NR selected issue on the topic.

Table 8.2 Annually reported cases of drug driving, 2001-2006.[48]

Drug driving offences	2001	2002	2003	2004	2005	2006
	3776	4659	5485	6597	7416	9955

Organizational patterns of drug crime.
The police and customs have mapped 140 networks that smuggle and sell cannabis in Sweden[49]. The project, financed by the NDPCo, has been running for three years as part of the national action plan on drugs. The project has also led to a fivefold increase in the amount of sized marijuana. Between 25 and 30 of the networks have the capacity to handle at least 1000 kg of cannabis annually. Within the frame of the project ten of the high capacity networks were taken out by the police and customs. The estimated amount of cannabis smuggled in to Sweden every year is 25 to 30 ton. This is a lot more than previously estimated and almost all of it originates from Morocco. While the sized amount of hashish has slightly decreased between 2004 and 2006 the amount of marijuana has increased from 56.5 kg to 322 kg.

Prescription offences
Please consult section 10 in this report.

Drug use in prison.
No new information

Social costs.
No new information

[48] http://www.bra.se/
[49] http://www.mobilisera.nu/templates/GeneralPage.asp?id=4998

9. Responses to Social correlates and Consequences

Overview / summary of framework, strategies and interventions in relation to prevention of social consequences

Rehabilitation and after-care is a bottle-neck in the management of drug abusers. One prominent reason for this is that several agencies can be expected to be involved in the process but that not all of them are prepared to put in enough resources, and if one part sways the client will not receive what is needed. To overcome some of these obstacles the government has strongly supported and argued for the "treatment chain" perspective and a "contract for life" philosophy in the rehabilitation of drug abusers as previously reported on. This is also valid for the prison and probation rehabilitation efforts.

Establishing a national action plan on drugs with a corresponding funding has implied that responses to the actual situation have been possible to launch. It has also been a period of formulating agendas and to lay down broad outlines for responses to various aspects of the drug problem. The cost for the municipalities for persons with alcohol and/or substance abuse has increased by 7.7% between 2000 and 2005 and housing per se with close to 65% over the same period according to the annual situation report from the NBHW on individual- and family care[50].

Social Reintegration

Housing, Education, training, Employment, Basic social assistance etc.
Efforts and strategies to deal with the social correlates and consequences and to implement a "treatment chain perspective" where most of the factors in the heading are of importance are presented in previous NRs and other sections of this NR. In the annual situation report from the NBHW on individual- and family care as referred to above it is concluded that the costs for housing has increased by 65% over the years 2000–2005. It is also stated that the support to women exposed to violence and their children needs to be further developed, documented and the methods to be evaluated.

Prevention of drug related Crime

No new information available

[50] http://www.socialstyrelsen.se/NR/rdonlyres/D49E1CF7-7F94-4B19-B614-41E086AB128E/7091/20071319.pdf

10. Drug Markets

Overview / summary on drug market

Drugs purchased via the Internet appear to gain increasing interest. Designer drugs with an alleged psychotropic quality as well as various forms of seeds, fungus and plants marketed as pleasant experiences and still legal are for sale. For the traditional drugs the market seems rather unchanged with stable or dropping prices in spite of the efforts to reduce the supply. Medicines are according to some sources an increasing part of the drug market and this includes buprenorphine.

Availability and supply

Availability of drugs

GHB

The number of arrested persons stating that GHB is the drug they use the most or second most has doubled over the last year in the custodies of Göteborg at the Swedish west coast. Of a total of 288 interviews, 33 (11%) report on this high preference for GHB according to a "Custody project" running in Sweden[51]. Also the numbers of persons intoxicated by GHB when arrested have doubled, from 15 in 2005 to 29 in 2006. The "Custody project" also demonstrates a link between the use of GHB and anabolic androgen steroids (AAS). Of the 33 persons with high preference for GHB, 29 had also used AAS.

Medicines

The NDPCo highlight in a report the over-prescription of medicines classified as narcotic drugs. Every day about 700 000 daily doses of drug classified medicine are picked up at Swedish pharmacies, giving a total of about 255 million DDD per year. The police give evidence that a steadily growing amount become part of the illegal drug market. In 2005 the Stockholm City Police captured just over 13 000 pills registered as pharmaceuticals and in 2006 it had grown to close to 20 000 pills according to a series of reportage on the issue in a major Swedish newspaper[52]. Flunitrazepam, diazepam and other benzodiazepines are found as well as Sobril, Stillnoct and similar sedatives. Subutex is also found among the diverted pharmaceuticals. The Swedish pharmacies sound the alarm about physicians suspected for unprofessional and unethical prescription of drugs to abusers but present regulations limit the possibility to investigate the physicians and reduce or stop their prescription rights.

Limiting the validation time for the prescriptions and reduce the size of the packages are among the examples given in a report by the NDPCo on how to limit the abuse potential of medicines classified as drugs[53]. In the report the NDPCo also propose the establishment of a medicine journal for all patients and available to the health care system. The journal should give important information to the physician treating a patient on previous medication and diagnoses, known sensitivity to particular drugs, prescribed doses and time of medication etc.

Buprenorphine

There is a notable use of buprenorphine (*Subutex*) outside the treatment programs as shown in a study with drug users in the most southern part of Sweden[54]. 33 persons have in personal interviews described their drug abuse and the use of buprenorphine outside the treatment programme in a project run by the University of Lund and financed by the NDPCo. The all in all picture is that buprenorphine is used

[51] http://www.mobilisera.nu/templates/GeneralPage.asp?id=4985
[52] http://www.dn.se/DNet/jsp/polopoly.jsp?a=642158
[53] http://www.mobilisera.nu/upload/balldin_total.pdf
[54] http://www.mobilisera.nu/upload/Subutex_slutlig.pdf

for self medication and used in the same way as in regular treatment, placed under the tongue and taken daily.

Cocaine and other illegal drugs

In an inquiry performed by the CAN for the NDPCo 33% of the reporters working in i.e. social services, health care, police, out patient service or NGOs experienced that the number of persons using cocaine increased over a six month period in 2006[55] (Table 10.1). The increase was most pronounced in major cities among persons also using other illegal drugs. 27% of the CRD reporters[56] judged that there was also an increase in the supply of cocaine (Table 10.2) over the six month period. In both cases cocaine was the drug judged to increase most among the drugs commented on. 234 CRD reporters in 28 municipalities and 21 county police agencies were asked to respond to the questionnaire and the response rate was 84%. According to the reporters it is chiefly persons in the age group 21–30 that use cocaine and most commonly at private parties, in the home and at some recreational settings.

Table 10.1. Change in the number of persons using drugs according to the local reporter's judgement over a six month period (April – September 2006). Expressed as percentage of the CRD-reporters statements.

Drug	Not occurring	Increase	No change	Decrease	Don't know	No answer
Cannabis	1	24	62	3	10	-
Amphetamine i v	2	7	68	5	18	-
Amphetamine not i v	1	15	64	-	20	-
Heroin i v	4	7	53	6	30	-
Heroin smoking	2	14	45	3	35	-
Cocaine	1	33	35	1	30	-
Ecstasy	1	7	49	12	31	-

Table 10.2. Change in the availability of drugs according to the local reporter's judgement over a six month period (April – September 2006). Expressed as percentage of the CRD-reporters statements.

Drug	Not occurring	Increase	No change	Decrease	Don't know	No answer
Hashish	1	18	54	2	26	-
Marijuana	1	9	46	2	43	-
White heroin	3	7	30	7	52	-
Brown heroin	4	7	53	6	30	-
Amphetamine	1	22	47	1	29	1
Cocaine	1	27	26	1	44	1
Ecstasy	1	5	40	5	50	1
Benzodiazepines	1	24	43	1	32	-

The response to the questions in the questionnaire should mirror the personal knowledge acquired by the respondent in the daily work at the local/regional level. Since the selection of municipalities is not randomised the investigation is not claiming to be representative for the country. The strategic selection brings however good possibilities to get some information on drugs and trends relatively quickly, which is the primary purpose of the inquiry.

[55] http://www.mobilisera.nu/upload/Kokainrapporten.pdf
[56] the CRD (CAN reporting system on drugs) method is presented in previous NRs

Internet as a source of supply
During the last few years, the sale and purchase of illegal drugs by means of the Internet has increased considerably. At least 70% of the customs seizures of illegal drugs at the main Swedish airport Arlanda in Stockholm enter the country by air freight and is ordered over the Internet[57]. The Swedish Customs authority as well as the Police recommends that more resources should be allocated to collection of intelligence from the Internet and coordination thereof[58].

The Swedish Police has received funding from the NDPCo for a project with the purpose to fight drug crime at the Internet. A second purpose of the project is to spread knowledge to Swedish governmental bodies and to initiate investigations and projects related to the use of Internet as a tool for illegal drug sale and purchase. The Interpol has shown an interest in the work procedures developed within this project and collaboration is established between the project and Interpol's "Drug net".
The illegal sales over the Internet of pharmaceuticals and drugs have increased all over the world. WHO has presented a rate of counterfeit drugs of all the legal drugs/pharmaceuticals sold over Internet of 50%[59]. The Medical Products Agency (MPA) in Sweden runs a project with the aim to map the prevalence of illegal sales and purchases of pharmaceuticals/drugs over the Internet. Among those drugs, there are several narcotic drugs. Another task for the MPA as a consequence of the increased Internet sales and purchases of pharmaceuticals is to inform the Swedish citizens on the risks of using illegally acquired medicines and drugs.

Production, sources of supply and trafficking patterns within country as well as from and towards other countries
According to a report from the police[60] the most common route of cannabis from the Morocco to Sweden is through Spain and lately, Portugal. France is another "first" country in the illegal smuggling route through Europe. In the Netherlands, there are indications that the country function as a storage station for drugs, cannabis in particular. This is also the country where most lorry-drivers are recruited for further smuggling through Europe.

Seizures.
As shown in table 10.3 some variation in the frequency of seizures occurs over the period 2001–2006 and the trend varies for different drugs. Regarding quantities the Customs state for 2006 to have seized the largest amounts ever of cocain (1350 kilo), heroin (64 kg) and opium (39 kg)[61]. Other quantitative seizure records broken under 2006 are ecstasy- and flunitrazepam pills. Those have increased with 350% since last year. The amount of seized amphetamine of 231 kilos is lower than for 2005 but higher than in 2004. The seized amounts of cannabis are for 2006, the lowest so far for the 21st century. The seized 5 tonnes of khat is less than the preceding year and are now on par with level of the first year of registration of this drug, 2002.

[57] Personal communication Lars LA Granström at the Drugs Law Enforcement, Swedish Customs
[58] http://www.mobilisera.nu/upload/internet_total.pdf
[59] http://www.lakemedelsverket.se/upload/nyheter/2007/olagarapport%202006.pdf
[60] http://www.polisen.se/mediaarchive/4347/3473/Nationellt%20cannabisprojekt.pdf
[61] http://www.tullverket.se/download/18.786665b01173a55b4888000998/statistik_2002_2007.pdf

Table 10.3. Number of analyzed seizures according to Police and Custom forensic laboratories 2001-2006[62, 63].

Year	Khat	GHB	Cannabis[64]	Heroin[65]	Amphetamine	Ecstasy	Cocaine	LSD
2001	285	154	7156	1271	5713	621	328	28
2002	241	123	8184	1052	6660	631	440	31
2003	292	68	8243	1057	6657	489	545	18
2004	314	159	8102	900	6773	411	524	17
2005	310	60	8345	804	6499	381	546	32
2006	333	152	9365	800	6842	309	772	50

Price of drug at street level.
Table 10.4 from the CAN report ”Narkotikaprisutvecklingen i siffror”[66] shows a decrease in the median street level price of hashish and amphetamine 1996–2006. For brown heroin the decrease is more than 30% and for cocaine 28%. White heroin prices fluctuate more, with a peak in 2000. From the year 2000 prices for ecstasy, khat, LSD and GHB are collected. Khat prices are down 66% since 2000, ecstasy 39%, GHB 21% and LSD is pending. Illegal drugs are cheaper in larger cities and in the southern parts of Sweden.

Table 10.4. The price (median) at street level 1996-2006 in SEK per gram adjusted to the 2006 monetary value (from the above quoted CAN report).

Year	Hashish	Marijuana	Amphetamine	Brown heroin	Cocain	White heroin	Khat	Ecstasy	GHB	LSD
1996	94	89	305	1498	1109	1941				
1997	88	102	331	1380	1214	1766				
1998	99	111	332	1519	1050	2072				
1999	99	94	286	2008	1210	1926				
2000	87	74	272	1089	980	2451	300	163	38	87
2001	85	74	266	1063	1063	2127	266	159	32	106
2002	83	73	260	1041	833	1666	312	156	29	104
2003	82	71	255	1123	817	2042	306	128	31	92
2004	81	73	254	1017	814	2034	254	124	31	92
2005	81	81	253	1215	810	1367	253	101	30	61
2006	80	80	250	1000	800	1500	100	100	30	85

Purity at street level and composition of drugs/tablets
No data available.

[62] http://www.polisen.se/mediaarchive/4347/3473/Arsrapport_2004.pdf
[63] 2005 & 2006, personal communication, Gunvi Linder, Rikskriminalpolisen, KPE/KUT
[64] Marijuana and hashish
[65] White and brown heroin
[66] http://www.can.se/documents/CAN/Rapporter/rapportserie/CAN-rapportserie-102-narkotikaprisutvecklingen-i-sverige-1988-2006.pdf

13. Drug-related research in Europe

Summary Sweden.
The action plan on drugs, initiated in 2002 and in its second phase running until 2010, has significantly increased drug related research and the funding for this research. In the period 2002 – 2006 more than 70 researchers and 104 research projects have received grants for drug related research from the government. This investment in research has yielded extensive inroads in the battle against drugs according to the coordinator's 2006 report[67]. A broad analysis of developments and trends for drug related research or an interpretation of the developments of this research is not currently available.

1. Research structures

1.1. Drug related research in national policy

- Describe how research is addressed in your national drug policy/strategy/action plan
- Which are the main areas highlighted
- Describe restraints for drug-related research in your country

In Sweden's national drug policy, methods to reduce the number of new recruits to drug abuse are a main focus for research. As a consequence of this, priority is given to research involving identification of, and prevention within high-risk social and demographic groups. Drug abuse within the correctional system is also an area proposed for increased research activity.

The national drug policy also emphasizes knowledge and competence in this area of research as a basis for prevention, and therefore related research studies should be continually reviewed and analyzed. Of particular importance are findings from research and method development studies that can be immediately applied in the field. The national drug policy therefore sets a high priority on a few vital research areas:

- Research efforts to stimulate a well-functioning drug prevention system in the workplace. The following research efforts have been discussed in this context: pilot projects for development of preventative methods in high-risk elements such as the hotel and restaurant industry, as well as for workplaces staffed by youths or younger adults, and research regarding the cost of narcotics.
- Development of knowledge in social and behavioural sciences should be fortified. Among other things, this requires increased knowledge of effective preventative methods and the implementation of such methods. The knowledge base and statistics from consumption and injury patterns over time should also be fortified according to the drug policy. The government is planning to make regulatory changes to provide better statistical background for narcotic-related deaths.
- Gender research involving drug abuse amongst males, with a focus on social consequences, preventative measures and a clearer gender perspective in regards to drug abuse, care and treatment should be developed with a concomitant increase in gender-focused treatment programs. Along these lines, the knowledge base regarding drug abuse amongst young women should also be further developed.

[67] http://www.mobilisera.nu/upload/slutlig_2006.pdf

- Instigation of measures which are not directly related to prevention of drug abuse, but rather those affect the growth and development of children and youth are another focus for research and evaluation.

The goal of the national drug policy, in regards to care and treatment processes, is also to set up a more knowledge- and experience-based entrance point for drug abusers. Efforts from both higher academic institutions as well as community-based research and development units play an important role in this work, according to the national drug policy. In practice, however, the most significant research efforts in healthcare and treatment follow two lines: 1) psychological and social methods on one side, and 2) the implementation of new drug treatments on the other. Medical research projects account for approximately one third of all research in this area, but in turn are also relatively extensive and of high scientific quality.
Regarding restraints in Swedish narcotics research, the lack of continuity in research projects is perhaps most noticeably. In other words, a number of projects are time-limited since the funding for such projects is either finite or limited by competition from other projects, such that continuation of the research is not guaranteed. As well, the government states that narcotic-related research efforts have not reached the stage where all programmes working with prevention are systematically documented and subjected to review or follow-up.

A better cooperation between different disciplines, e.g. medical and social sciences is required. In this regard, clinical treatment research is particularly neglected.

Another weakness is the lack of international comparison of prevention research.

Certain limitations exist in drug-related research, as noted by the Centre for Social Research on Alcohol and Drugs (SoRAD), which in their studies indicated that there is a lack of interest for primary prevention efforts in the workplace, despite the presence of alcohol and drug policies there.

References:
- Swedish Government proposal 05/06:30 – National alcohol and narcotics policy document[68]
- Discussion with leading researchers

1.2 Describe how research, politics and practice are integrated, that is, if they are and if so, how.
Government authorities have an important role regarding integration between research, policy and practice. The Swedish National Institute for Public Health (FHI) plays an important role as a centre of knowledge (including compilation of research findings) and as a support mechanism for regional and local public health work. They operate in close cooperation with education coordinators, researchers and other players with practical and theoretical knowledge in prevention efforts. The government's assignment to FHI is in principle to coordinate the cooperation between these groups.

The NDPCo also plays an important role here. They promote research in the narcotics area through financial support of universities and other institutions, through directed research as well as cooperation with other authorities i.e. the Swedish Prison and Probation Service.

68
http://www.riksdagen.se/Webbnav/index.aspx?nid=37&dok_id=GT0330&rm=2005/06&bet=30

Despite this, cooperation between research, politics and practice could be more effective. Building upon research findings through changes in policy at the higher levels of government is a complicated process with many players involved.

1.3. Main structures for drug-related research: which organisations and foundations are the main coordinators of research?

- The National Drug Policy Coordinator
- The National Board of Institutional Care (SIS)

Which are the most important institutions and organisations that conduct research?

- Universities: Karolinska Institute, Malmö University, Uppsala University, Gothenburg University, Sahlgrenska University Hospital, University Hospital MAS in Malmö, Stockholm University, Örebro University
- Centre for Social Research on Alcohol and Drugs (SoRAD)
- The Swedish Prison and Probation Service
- Stockholm Prevents Alcohol and Drug Problems (STAD)

Which are the most important financial supporters and research funds (and if possible their size)?

- The National Drug Policy Coordinator
- The National Board of Institutional Care
- The Swedish Research Council
- Council for Working Life and Social Research (FAS)
- Sweden's Riksbank's Jubileum Fund
- The Swedish Medical Research Council

2. Main recent studies and publications.

2.1. Main recent studies since 2000.

There is no systematic mapping of ongoing or finalized research projects in the drugs area and no official ranking of the importance of known projects. The research projects initiated by the NDPCo must be considered of importance[69], as well as the following projects:

- Drugs in Eurasia: Smuggling, society and conflict. This project's intent was to map the routes that "heavy" narcotics follow from Afghanistan, Central Asia and Euroasia before they arrive in Sweden. Project supervisor: Dr Svante Cornell, Institute for Eastern European Studies / Peace and Conflict Studies at Uppsala University, Uppsala. Project funding: 2 100 000 SEK.
- An investigation of Maria Ungdoms clients and their parents, the treatments offered to clients, as well as treatments and care of admitted patients. Project supervisor: Anders Tengström, St. Görans Hospital, Stockholm. Project funding: 1 890 000 SEK.
- Systematic multi-step strategies for integrated treatment of heroin addiction: A Swedish multi-centre study. The study gives a rational ground for health care organisation and also introduces modern methods. Project supervisor: Senior lecturer Marcus Heilig, Huddinge University Hospital, Huddinge. Project funding: 1 200 000 SEK.
- New pharmacological treatment principles for drug addiction. Project supervisor: Senior lecturer Bo Söderpalm, Sahlgrenska University Hospital, Gothenburg. Project funding: 1 060 000 SEK.

[69] http://www.mobilisera.nu/upload/slutlig_2006.pdf

- Brain damage associated with heroin abuse and development of new pharmacological therapies. Project supervisor: Professor Yasmin Hurd, Karolinska Institute, Stockholm. Project funding: 1 140 000 SEK.

2.2. Swedish researchers' publications in international peer-reviewed scientific journals during 2006 on drug related research.

- Aleman, K. (2006). Psychoanalytic conceptions of the mind in relation to personality disorders of drug abusers. Journal of Projective Psychology & Mental Health, 13(2), 122-132.
- Blid, M., & Gerdner, A. (2006). Socially excluding housing support to homeless substance misusers: Two Swedish case studies of special category housing. International Journal of Social Welfare, 15(2), 162-171.
- Berman, AH (2006). Auricular acupuncture as an adjunct to treating substance use disorder. Addiction Treatment& Prevention, 10, 25-44.
- Byqvist S (2006). Patterns of Drug Use Among Drug Misusers in Sweden. Gender Differences. Substance Use & Misuse, 41(13):1817-1835.
- Byqvist, S (2006). Drug-Abusing Women in Sweden, Marginalization, Social Exclusion and Gender Differences. Journal of Psychoactive Drugs, 38(4):427-440.
- Brådvik L, Berglund M (2006). Long-term treatment and suicidal behaviour in severe depression: ECT and antidepressant pharmacotherapy may have different effects on the occurrence and seriousness of suicide attempts. Depression and Anxiety, 23:34-41.
- Druid H, Strandberg JJ, Alkass K, Nyström I, Kugelberg FC, Kronstrand R. (2006). Evaluation of the role of abstinence in heroin overdose deaths using segmental hair analysis. Forensic Sci Int 2007, May 24, 168(2-3):223-6. (Epub 2006 Mar 24)
- Ekendahl, M. (2006). Why not treatment?--untreated substance abusers' accounts of their lifestyles and efforts to change. Contemporary Drug Problems, 33(4):645-668.
- Ellgren M, Spano SM, Hurd YL (2006). Adolecent cannabis exposure alters opiate intake and opioid limbic neural populations in adult rats. Neuropsychopharmacology 2007 Mars, 32(3):607-15 Epub 2006 Jul 5)
- Emdad, R., Bonekamp, D., Söndergaard, H. P., Björklund, T., Agartz, I., & Ingvar, M. et al. (2006). Morphometric and psychometric comparisons between non-substance-abusing patients with posttraumatic stress disorder and normal controls. Psychotherapy and Psychosomatics, 75(2):122-132.
- Fazel, S., Grann, M., & Goodwin, G. M. (2006). Suicide trends in discharged patients with mood disorders: Associations with selective serotonin uptake inhibitors and co-morbid substance misuse. International Clinical Psychopharmacology, 21(2):111-115.
- Fridell, M, Hesse, M (2006). Psychiatric severity and mortality index in substance abusers: a 15 year follow up of drug users. Addictive Behaviors, 31(4):559-565.
- Johansson BA, Berglund M, Lindgren A (2006). Efficacy of maintenance treatment with naltrexone for opioid dependence – a meta-analytical review. Addiction, 101:491-503.
- Leão, T. S., Johansson, L., & Sundquist, K. (2006). Hospitalization due to alcohol and drug abuse in first- and second-generation immigrants: A follow-up study in Sweden. Substance Use & Misuse, 41(3):283-296.
- Lundborg, P (2006). Having the wrong friends? Peer effects in adolescent substance use, Journal of Health Economics, 25:214-233.

- Shama HS, Lundstedt T, Boman A, Lek P, Seifert E, Wiklund L, Ali SF (2006) A potent serotonin-modulating compound AP-267 attenuates morphine withdrawal-induced bood-brain barrier dysfunction in rats. Ann NY Acad Sci, Aug, 1074:482-96.
- Shama HS, Ali SF. (2006) Alterations in blood-brain barrier function by morphine and methamphetamine. Ann NY Acad Sci, Aug 1074:198-224.
- Storbjörk, J. (2006). The interplay between perceived self-choice and reported informal, formal, and legal pressures in treatment entry. Contemporary Drug Problems, 33(4):611-643.
- Strandberg JJ, Kugelberg FC, Alkass K, Gustavsson A, Zahlsen K, Spigset O, Druid H. (2006) Toxicological analysis in rats subjected to heroin and morphine overdose. Toxicol Lett, Sep 30, 166(1): 1-8.
- Westin UE, Boström E, Gråsjö J, Hammarlund-Udenaes M, Björk E. (2006) Direct nose-to- brain transfer of morphine after nasal administration to rats. Pharm Rec, Mar, 23(3):565-72.

3. Collection and dissemination of research results.

3.1. Information flows.

- Describe the role of the National Focal Point in drug-related research and how it proceeds in information, collection and dissemination.

Since its creation the Swedish Focal Point has been located within the Swedish National Institute of Public Health (SNIPH) - a Government agency under the Ministry of Health and Social Affairs. The SNIPH is not given a mandate to support or initiate drug-related research per se but to closely follow development in this research area. Main services provided by the SNIPH include the following:

- collecting, harmonising and analysing national research information;
- providing such national information to the EMCDDA;
- providing reports and manuals arising from such information to the public;
- cooperating in the conceptualisation of new key indicators and core data sets;
- monitoring and analysing national scientific, legal and policy developments;
- coordinating and animating the national drug information network(s);
- observation and investigation of the need for classification of non-medicinal substances as narcotics, as well as control of such substances according to Swedish law (1999:42) regarding the prohibition of certain health-endangering substances
- promote access to statistics of sound quality
- spread knowledge and experience through the website, printed reports, conferences and publications

3.2. National drug scientific journals and other journals.

- Acta Psychiatrica Scandinavica. Psychiatry, national/international contributions, peer-reviewed, abstracts, also in English.
- Alkohol och Narkotika. Alcohol and other drugs, national contributions, not peer-reviewed, no abstracts
- Apropå. Criminology, national/international contributions, not peer-reviewed, no abstracts
- Dagens Medicin. Medicine, national contributions, not peer-reviewed, no abstracts
- Forskning och framsteg. Science in general, national/international contributions, not peer-reviewed, no abstracts
- Journal of Scandinavian Studies in Criminology. Criminology, national/international contributions, peer-reviewed, abstracts also in English

- Läkartidningen. Medicine, national/international contributions, peer-reviewed, abstracts, in English in the web edition.
- Narkotikafrågan. Narcotics, national contributions, not peer-reviewed, no abstracts
- Nordisk alkohol och narkotikatidskrift/Nordic studies on alcohol and drugs. Alcohol and other drugs, national/international contributions, not peer-reviewed but referees, abstracts also in English
- Psykisk hälsa. Psychiatry, national contributions, not peer-reviewed, no abstracts
- Scandinavian Journal of Public Health. Medicine & social policy, national/international contributions, peer-reviewed, abstracts also in English
- Socialmedicinsk tidskrift. Health and social policy, national/international contributions, peer-reviewed, abstracts also in English
- Socialpolitik. Social and financial issues, national contributions, not peer-reviewed, no abstracts
- Socialt perspektiv. Social policy, national contributions, not peer-reviewed, no abstracts

3.3. Other means of dissemination (websites, Nat. drug conferences …)

- Reports from the NDPCo and reports, manuals and guidelines from a number of agencies and institutions involved in supply- and demand reduction, treatment, care and other activities related to the prevention, monitoring and control of drugs and drug abuse. Generally not peer reviewed.
- Drug conference/exhibition: “Sweden against Drugs”. This is the largest manifestation of Swedish narcotics policy. It takes place every other year since 1993 with different themes for each edition e.g. new facts and research findings. The arrangers are central authorities and organisations which represent preventative efforts, healthcare, treatment and control efforts in the narcotics area.

Agencies, authorities and institutions with websites related to research:

- Alkoholkommittén (www.alkoholkommitten.se)
- Centre for Social Research on Alcohol and Drugs (www.sorad.su.se)
- Dopingjouren (www.dopingjouren.se)
- Kunskapskällar'n (www.kundskapskallarn.goteborg.se)
- Medical link (www.medicallink.se)
- National Board of Health and Welfare (www.socialstyrelsen.se)
- NoDrugs – Swedish Customs Agency drug webpage (www.nodrugs.se)
- Public Health Guide (www.folkhalsoguiden.se)
- Rådgivningsbyrån in Lund (www.droginfo.com)
- Stockholm Prevents Alcohol and Drug Problems (www.stad.org)
- Sweden Poisons Information Centre (www.giftinformationscentralen.se)
- Swedish Council on Technology Assessment in Health Care (www.sbu.se)
- Swedish Customs Agency (www.tullverket.se)
- Swedish Government (www.regeringen.se)
- Swedish Medical Products Agency (www.lakemedelsverket.se)
- Swedish National Institute of Public Health (www.fhi.se)
- Swedish Parliament/Riksdagen (www.riksdagen.se)
- Swedish Police Service (www.polisen.se)
- Svenska föreningen för alkohol- och drogforskning (www.sad.forsk.se)
- The National Board of Institutional Care (www.stat-inst.se)
- The National Drug Policy Coordinator (www.mobilisera.nu)

- The Swedish Council for Information on Alcohol and Other Drugs (www.can.se)
- The Swedish National Council for Crime Prevention (www.bra.se/)

14. Bibliography

- No bibliography is presented.
  All references are given as Internet addresses in foot notes in the text.

- Databases are given in foot notes in the text.

15. Annexes

- None of the SQs or STs are used in the text. References are given to ST 2 in section 2 and SQs 25 & 26 in section 3.

- The following graphs are used in the text.
  - **Table 6.1.** Characteristics and number of deaths with illegal drugs present in body fluids based on forensic data, in total and for respective substance category, 1994-2006.
  - **Figure 6.1.** Number of direct drug related deaths per year 1994 – 2004 based on the NCDR (EMCDDA DRD-Standard selection B, code T40.4, dextropropoxyphene, excluded) and the annual number of deaths of DIDP based on forensic data 1994 – 2006.
  - **Table 8.1.** Persons found guilty of drug offences by type of offence, 1997 – 2006.
  - **Table 8.2.** Annually reported cases of drug driving, 2001-2006.
  - **Table 10.1.** Change in the number of persons using drugs according to the local reporter's judgement over a six month period (April – September 2006).
  - **Table 10.2.** Change in the availability of drugs according to the local reporter's judgement over a six month period (April – September 2006).
  - **Table 10.3.** Number of analyzed seizures according to Police and Custom forensic laboratories 2001-2006.
  - **Table 10.4.** The price (median) at street level 1996-2006 in SEK per gram (adjusted to the 2006 monetary value).

- Maps. Not used in the text

List of abbreviations used in this and previous NRs

BCS	Beroendecentrum Stockholm (Dependence centre in Stockholm)
BRÅ	See NCCP
CAN	Swedish Council for Information on alcohol and Other Drugs
CBT	Cognitive Behavioural Therapy
CRD	The CAN Reporting System on Drugs
DUID	Driving under the influence of drugs
ELDD	European Legal Database on Drugs
GNS	The National Liaison Group
KIM	Klienter i missbruksvård (“Clients in treatment”)
MBAB	Maria Beroendecentrum (Maria centre for dependence disorders)
MHF	The Swedish Abstaining Motorists’ Association
MMP	Model Municipality Project
MOB	See NDPC
MPA	Medical Products Agency
MUMIN	Maria Ungdom (youth) Motivational Intervention
NAC	National Alcohol Commission
NBHW	National Board of Health and Welfare (Socialstyrelsen)
NCCP	National Council for Crime Prevention (BRÅ)
NCDR	National Cause of Death Register
NDPCo	National Drug Policy Coordinator (Mobilisering mot narkotika)
NR	National report
NTF	The National Society for Road Safety
SFS	Svensk författningssamling (Swedish code of statutes)
SiS	Statens institutionsstyrelse (National board of institutional care)
SKL	Swedish Forensic Laboratory
SMI	Swedish Institute for Infectious Disease Control
SMPA	Swedish Medical Products Agency
SNIPH	Swedish National Institute of Public Health (Statens folkhälsoinstitut)
SOU	Swedish official government reports
SPPS	Swedish Prison and Probation Service
SRA	Swedish Road Administration (Vägverket)
STRADA	Swedish Traffic Accident Data Acquisition