



European Monitoring Centre
for Drugs and Drug Addiction



STATENS
FOLKHÄLSOINSTITUT

**2006 NATIONAL REPORT (2005 data) TO THE
EMCDDA
by the Reitox National Focal Point**

**“SWEDEN”
New Development, Trends and in-depth information
on selected issues**

REITOX

Foreword

The 2006 National Report on the Drug Situation in Sweden is 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 are changed. Part B.2.1 is written by Mr Tony Nilsson, part B.2.2 by Mr Bengt Andersson and part B.2.3 by Ms Anna Jansson, all employee at the Swedish National Institute of Public Health. The report has been prepared in cooperation with a number of national agencies, institutions and experts. Main authors for part A are Mr Bengt Andersson, Ms Kajsa Mickelsson, Mr Bertil Pettersson and Ms Jenny Sandgren at the Swedish National Institute of Public Health. For possible need of further clarification of the various reports in Swedish referred to in the NR you are welcome to contact the Swedish NFP.

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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 2005 of the NDPCo shows that for the major objectives set out in the action plan 02 – 05, improvements are achieved. Fewer have tried illegal drugs, the drug related deaths and illness 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 is prolonged.

New legislations on substitute 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 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, i. a. GBL and 1,4-butandiol. It is too early to judge if the control of GBL and 1,4-butandiol has decreased the abuse.

Drug use as measured in various surveys is stable or levelling off when studied in the different age groups as reported on in this and previous reports. The decrease in life time prevalence over the last years for the grade 9 age group in Sweden is not seen for Europe as a whole. From the school surveys in Sweden it is very clear that there are major differences in prevalence between the different age groups. In comparing grade 9 and grade 11 age groups (2004 & 2005) the life time prevalence of illegal drugs has approximately doubled for girls and more than doubled for boys over this short period of life. Cannabis is by far the major drug of experience.

When life time prevalence increased in the grade 9 age group during the 90's the last 30 days prevalence also increased. However, as the life time prevalence has decreased from 10 to 7 percent since 2001, a decrease in the last 30 days prevalence is not observed. In fact, the last 30 days prevalence increased to 4% for boys in 2005 and remained unchanged 3% for girls. An explanation for this is not at hand. It could also be noted that the marked increase in life time prevalence between the grade 9 and grade 11 age groups is not mirrored to the same extent in the last 30 days prevalence (boys 6%, girls 3%). In the older age group (grade 11) a possible gender difference has evolved in life time prevalence as well as last 30 days prevalence that is not found in the younger (grade 9) age group in Sweden but similar to what is observed for the majority of countries all ready in grade 9 as shown in the ESPAD study.

Over the last years a few regional case finding studies on problem drug use are reported as shown in chapter A4. Due to differences in study design comparisons of the results are not advisable. Studies on national estimates of problem drug use as well as a population survey are presently planned by the SNIPH in cooperation with the NDPCo and an ad hoc expert group.

According to the 2005 report of the NDPCo heroin is gaining importance among problem drug users and in particular in the younger group. It is also reported that smoking heroin is on the increase as well as multiple drug use.

A marked increase in drug prevention activities, often due to initiatives from the NDPCo is noted. 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. 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 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 MUMIN project, reported on in chapter A3, is an example on this.

A draft version of national guidelines for the treatment of alcohol and drug abuse was circulated for comments in 2006 and a first version of the guidelines is expected to come 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 i. a. 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 continue to decrease according to figures up to and including 2005 as reported in chapter A6. However, heroin deaths increased in 2005 according to the method based on data from the Forensic Toxicity Register. Efforts for early intervention to promote drug addicts to start treatment are promoted. Interventions similar to MUMIN above are running in several cities and the results will be followed up and evaluated.

Drug offences continue to increase and over the last ten years an average annual increase of approximately 7% is noted. As previously reported drug use (48%) and drug possession (32%) were the two most common offences committed by persons convicted of drug offences in 2005. In 2005 drug offences constituted just above 4% of all crimes reported.

There are no figures on the number of inmates using drugs in prison. The Swedish prison and probation service has developed a system to mirror to what extent an institution is "contaminated" by drugs as presented in chapter A8. According to the latest figures (April 04 – September 04) approximately 60 % of the institutions fall in the interval "never – rare" and less than 5 % in the "almost daily" interval. However, in the 1995 – 2004 period studied it is not uncommon that the "almost daily" six month value exceeded 10 %.

On the issue of social costs the Police authority in the Swedish region Västra Götaland in a report from 2004 estimate the daily costs related to illegal drug use for the society of the region to about 6×10^5 €. The estimate is based on the model used by the Swedish commission on drug abuse as presented in a previous NR. The number of problematic drug users in the region was estimated to just over 5000 which constitute about 20 % of the national estimate. Included in the costs are active drug users, drug users in different kind of care (treatment centres, hospitals, social service) and drug users in prison. Not included costs are criminality, judiciary, insurance companies' e t c.

As reported in this and previous NRs there are no dramatic changes in the number of seizures for the most common illegal drugs up to and including 2005. Due to organisational matters the police and custom are no longer cooperating on the statistics on seizures of illegal drugs. This is

a serious drawback regarding the possibility to have a qualified national overview and analysis of the smuggling and handling of illegal drugs.

Also the prices seem to be fairly constant over the last five years. Some notable differences from last years report is an approximately 20% increase in the brown heroin price and a decrease in the price for white heroin of about 33%. As is evident from last years NR the price for brown and white heroin has fluctuated considerable over the last 12 years. The price for marijuana increased by approximately 10% between 2004 and 2005 after having stayed rather constant since 2000.

1. National policies and context

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

A second action plan on drugs (2006 – 2010) was adopted by the parliament in April 2006. The plan is a straight forward continuation of the previous (2002 – 2005).

In 2005 a change in the Act on the Prohibition of certain Goods Dangerous to Health made it possible to control chemicals used for commercial purposes. Subsequently GBL and 1,4-butandiol was controlled and in total 22 substances are presently controlled under this Act. Seven persons were convicted for crime against the Act in 2005 and 11 850 for crimes against the Narcotic punishment act.

In two consecutive public surveys (2004 & 2005) the aim and strategies of the Swedish drug policy was investigated and received a massive opinion support.

In September 2006 the UNODC presented an evaluation of the Swedish drug policy stating "...in the case of Sweden, the clear association between a restrictive drug policy and low levels of drug use is striking...".

o Legal framework

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

In October 2006 twenty-two 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). 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 and salvinorin A.

In 2005 a change in the Act on the Prohibition of certain Goods Dangerous to Health (SFS 1999:42) made it possible to control chemicals used for commercial purposes. Subsequently GBL and 1,4-butandiol was controlled and added to the Ordinance on the Prohibition of certain Goods Dangerous to Health (SFS 1999:58). Since the regulation came into force permission for handling, scientifically or for retail as well as industrially, goods dangerous to health are generally needed. There is an exemption clause for goods that are denaturized in a way that prohibits use and goods that are part of a product or goods in such a way that it could not be used for intoxication. In these cases permission is not needed. Until April 30th 2006 permissions were handled by the Medical Product Agency (MPA) and since May 1st this task is transferred and included in the Ordinance on the Instruction for the National Institute of Public Health (SFS 2001a).

In July 2005 Ketamine was listed as a narcotic substance, list IV. The regulation is an amendment to the Ordinance on Control of Narcotic Substances (SFS 1992).

In July 2005 changes (proposed in the government bill (Regeringens proposition 2005b)) in the Care of Abusers (Special Provisions) Act (SFS 1988) was adopted aiming at strengthen the legal rights of the individual and to improve quality in the care. There is e.g. a change in the authority of the police taking directly into custody, the hospital where the care is taking place has got a higher duty of intelligence of news and are obliged to keep a patient who wants to leave the hospital. The aim of the care has been better defined.

In July 1st 2006 the new act on exchange of syringes and needles came into force (SFS 2006). The purpose of the act is to prevent the spread of HIV and other blood carried infections through the exchange of syringes and needles in a way that the individual could be motivated for care and treatment. The activity must not be performed without the permission from the National Board of Health and Welfare.

In September 2006 the Government passed a resolution to appoint an investigator to examine the laws regarding drugs (<http://62.95.69.15/>, Dir 2006:97). The investigator will analyse the connection between laws regarding narcotics, doping, solvents and other goods dangerous to health used for the aim of intoxication. The investigation is to show what can be done to make the systems easier to overview; partly by investing the present laws, partly by making the lists of controlled substances easier to grasp. The investigator is also to map how the system is used in practice, analyse the effectiveness of the system and the differences in regulations between different types of products, such as doping versus narcotic drugs. Proposals for changes will be included. By the end of 2007 the mission is to be presented and finalised.

- Laws implementation

The number of reported crimes against the Narcotic punishment act increased by 15 percent 2005 compared with 2004 to about 51 800 crimes in total. This is a little more than four per cent of all crimes reported in Sweden 2005. The majority of the reports were on consumption (51 %) followed by possession (34 %). The total increase mirrors the rise of reported crimes within these two major categories (BRÅ 2006a). If crimes against the Law on Penalties for Smuggling (SFS 2000) and driving under the influence of narcotics according to the Road Traffic Offence Act (SFS 1951) are included just about 60 000 crimes were reported in 2005. 18 357 individuals were suspected for the above mentioned crimes against the Narcotic punishment act. 15 per cent were women and 85 per cent men. This represents 12 per cent of all people suspected for a crime that year.

In 2005 11 850 persons were sentenced for crimes against the Narcotic punishment act; an increase with 10 per cent since 2004. Three fourth of the sentenced in 2005 was due to minor drug offences (BRÅ 2006). Seven persons were convicted for crime against the Act on the Prohibition of certain Goods Dangerous to Health in 2005 (BRÅ – personal communication)

8 per cent of the incoming matters to the Prosecutors in 2005 constituted of 14 960 cases of illegal drug crimes. The same year 15 023 cases were closed. (Åklagarmyndigheten 2006).

Focusing on making the struggle against drugs effective and on improving the rule of law, the Prosecutor General has run an investigation focusing on the danger of individual drugs. The result of the project was presented in December 2005 (Åklagarmyndigheten 2005a). A national common understanding of the questions at issue concerning the judgement of the danger of individual narcotics has been developed which is aimed at increasing the coherence and predictability of judgements. To the term “danger” eleven criteria has been linked; risk of addiction; poisonous, risk of physical and mental injury, risk of social insufficiency and unpredictable effects, potential of strategic usage for carrying out a crime, risk for violence, effect after very small dosages, severe reactions of abstinence and risk for self-conversion. The report also presents legal standpoints for individual drugs and give the prosecutors arguments for comparing relatively new drugs with already well known.

- **Institutional framework, strategies and policies**

- Coordination arrangements

The National Drug Policy Coordinator (NDPCo) was given a prolonged mandate until 2008 with major responsibility for the implementation of the action plan. The Coordinator was in 2006 also given the responsibility to coordinate the societal efforts against the abuse of hormonal preparations (doping) outside the sports area.

The NDPCo has initiated cooperation against drugs between crime fighting agencies in the Baltic States, Poland and Sweden. The captures for drug related crimes have increased by 50 % resulting in 160 captures and the seizure of 300 kg amphetamine (Mobiliserings mot

narkotika 2006). The seizure of 1.1 ton cocaine intended for Poland but captured in Göteborg, Sweden, was a consequence of the close cooperation and coordination work according to an interview with the NDPCo in December 2006. In a two year period the NDPCo has contributed with 1.3 million SEK to the project. The money was primarily used for operative workshops to improve the coordination of common cases and to better understand and follow the chain of events in the drug crimes.

- National plan and/or strategies

In June 2006 the parliament adopted the governmental proposition for a second action plan on drugs for the period 2006 – 2010 (Regeringens proposition 2005a). The action plan is a straight forward continuation of the previous one (2002 – 2005) with the overriding aim “a drug-free society” remaining (Regeringens proposition 2002). This aim is to be seen as a vision reflecting the attitude to narcotic drugs and an indication of the direction of the policy. As previously presented the political efforts in the area should be directed towards supply and demand with the purpose of (i) reducing the recruitment of new drug abusers, (ii) inducing more drug abusers to kick the habit and (iii) reducing the supply of drugs.

- Implementation of policies and strategies

The NDPCo was given the major responsibility for the implementation also for the second action plan.

- Impact of policies and strategies

The impact of the action plan is seen and recognised at several levels. The government reported on the effects of the action plan to the parliament in 2005 as presented in NR 2005. The annual report for 2005 of the NDPCo shows that for the major objectives set out in the action plan 02 – 05, improvements are achieved (Mobilisering mot narkotika 2005). Fewer have tried illegal drugs, the drug related deaths and illness 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. According to the UNODC the illicit Drug Index show a very low value for Sweden, indicating small drug problems compared to other States (below).

In the autumn of 2006 the UNODC presented an unofficial document evaluating the Swedish drug policy (UNODC 2006). In the introduction it is stated: It is difficult to establish a direct and causal relationship between specific policy measures and the resulting drug situation. Nevertheless, in the case of Sweden, the clear association between a restrictive drug policy and low levels of drug use is striking. Few people in Sweden are likely to take drugs in their lifetime, and even less likely to use drugs regularly. Attitudes towards drugs and their abuse are clearly negative. Preliminary calculations for the UNODC Illicit Drug Index, a single measure of a country’s overall drug problem, show a very low value for Sweden which indicates that its drug problem is small, compared to that of other States. However, the relatively high proportion of heavy drug use among drug abusers remains a concern that has been difficult to address. This document cannot provide definite answers to questions about how the levels of drug abuse are influenced by policy measures. It can only present the facts and leave the readers to draw their own conclusions.

- **Budget and public expenditure**

- In law enforcement, social and health care, research, international actions, coordination, national strategies

No new information available

- Funding arrangements

No new information available

- **Social and cultural context**

- Public opinions of drug issues

In 2005 the NDPCo did a follow up of the last year reported survey on public opinions. The aim was to investigate the citizen's view on the Swedish drug policy and possible changes compared to the previous study. The target group was the population aged 16 – 75.

The study is representative for the country as a whole and was performed as a quantitative selective survey by telephone interviews and with the public phonebook as selection basis. A total of 1150 interviews (1000 in 2004) were performed with an extra selection of 200 persons for the age group up to, and including, 25 years. The survey was performed 8 – 21 November 2005 and the response rate was 70 % (ARS Research AB 2006).

The issue of illegal drugs is perceived as very important or rather important by 94 % of the respondents. No difference between 2004 and 2005. Considering the different respondent groups it is clear that the issue of illegal drugs is regarded as a particularly important area by middle aged and older, by women, by opinion leader, by persons with academic background and by persons with immigrant parents (mother and/or father).

On the direction of the Swedish drug policy 73 % of the respondents agreed in terms of “fully correct” to the overriding principle of a drug free society. If also the statement “not quite fully correct” is included the figure is 84%.

In the 2005 survey two new Qs were included to measure the attitudes versus drug abuse and different measures against the abuse. There is a strong dislike regarding the use of drugs, although there is a tendency to a less strict view on cannabis.

There is also a strong support for measures that recreational settings should refuse people on drugs to be present as well as harder punishment for drug dealers.

A more liberal view on drugs, such as smoking of cannabis, is strongly opposed.

The age group 18 – 25 is as expected more liberal in their view on drugs. The majority is still negative but a stronger support for a less strict attitude is found in this group. 31 % of the age group 18 – 25 agrees that a more liberal view on drugs is right and 15 % agree that smoking of cannabis should be legal.

On the issue of “important areas for creating a better society” it is also clear that this group of respondents do not rank the drug issue as important as the older respondents. However, also in the younger group the support is strong for the aim and the directions of the Swedish drug policy. Means and methods proposed by the young are strengthening of young peoples self-esteem, better training/information and better treatment for drug abusers.

- Attitudes to drugs and drug users

No new information available

- Initiatives in parliament and civil society

No new information available

- Media representations

From the focal point horizon the media representations of the illegal drugs appears to be rather similar to what was reported previously. The major impression is that drug issues frequently occur in media and get quite a lot of attention. A second impression is that daily media mostly mirrors the drug issue from a news perspective as response to accidents, press releases or statements given by key persons. New drugs, large seizures, deaths and acute intoxications, risks and hazards, criminality and organized crime are topics presented in the daily papers and programs. Few articles or programs deal with analysis of the situation, policy development, success and shortcomings, alternatives e t c.

2. Drug Use in the Population

Overview / summary

Cannabis has been the only illegal drug studied in the general population since 2000. There has been a decrease in life time prevalence for women over the last years, approaching the level in the middle of the 1990s. Last year and last month figures have been more or less stable for both genders over the last years.

For school pupils turning 16 there is a striking similarity between females and males in the life time prevalence rate, 7 % over the last three years. The last month prevalence also shows similar figures for boys and girls (4% and 3% respectively in 2005).

For pupils turning 18, the figures are noticeably higher than among the pupils turning 16. Life time prevalence is close to doubled for females and was 17 % for males. There is also a more pronounced difference in the last month prevalence between females (3 %, same as age 16) and males (6 %).

For military conscripts (males aged 18), the downward trend noted in the last years continues for life time prevalence as well as last month prevalence.

2.1. Drug Use in the general population

A postal public health survey, containing one question on cannabis use, was conducted in 2006 among 16-84 year olds, comprising a total of approximately 93,000 persons (gross sample size) with a response rate of 63% (Statens folkhälsoinstitut 2007). The sampling frame was all persons 16-84 years old living in Sweden (approximately 7 million persons). The methods and results of this study are also presented in the EMCDDA Standard Table set.

Cannabis lifetime, last 12 months and last 30 days prevalence 1994-2006 is presented in table 2.1-1. The lifetime prevalence for women increased during the 1990s, but appears to have decreased slightly in the last three years. The lifetime prevalence for men aged 16-64 has varied between 15 and 18% since 1998. There have been no notable changes in the last 12 month and last 30 days prevalence since the previous study.

Table 2.1-1. Cannabis prevalence (%) among 16-64 year olds, for men and women separately, 1994-2006 (18-64 year olds 2004).

Year	Lifetime		Last 12 months		Last 30 days	
	Men	Women	Men	Women	Men	Women
1994	7	7	*	*	*	*
1996	13	7	*	*	*	*
1998	18	10	2	0	0	0
2000	16	9	1	0	0	0
2004#	18	10	3	2	1	0
2005	15	9	3	1	1	1
2006	16	8	3	1	1	0

*Not asked for

#Age group 18-64

2.2. Drug Use in the school and youth population

In 2005, national school surveys regarding drug use were carried out among pupils turning 13, 16 and 18 (Hvitfeldt and Rask 2005). In the survey on 13 year olds, 200 schools were randomly selected (not stratified on region). In the surveys on 16 and 18 year olds, 300 schools were selected at random (stratified on region). In each school, one or two classes per school (depending on class size) were randomly selected to participate in the survey. The sampling frame was 130,000, 120,000 and 110,000 respectively, with a response rate

varying between 80 and 90%. The methods and results of all three surveys are presented in further detail in table 2 in the EMCDDA Standard Table set.

The prevalence of illegal drug use among pupils turning 13 has been low during the twenty-five year period the survey has been performed. In 2005, 1% had used an illegal drug.

The lifetime prevalence of ever having used an illegal drug among 16 year olds 1971-2005 are presented in figure 2.2-1. The lifetime prevalence for both boys and girls has been 7% for the last three years. In 2005, the last month prevalence was 4% for boys, which is slightly higher than previous years (it has varied between 2 and 3 percent since 1998). The last month prevalence among girls was 3% in 2005, which is the same as previous year.

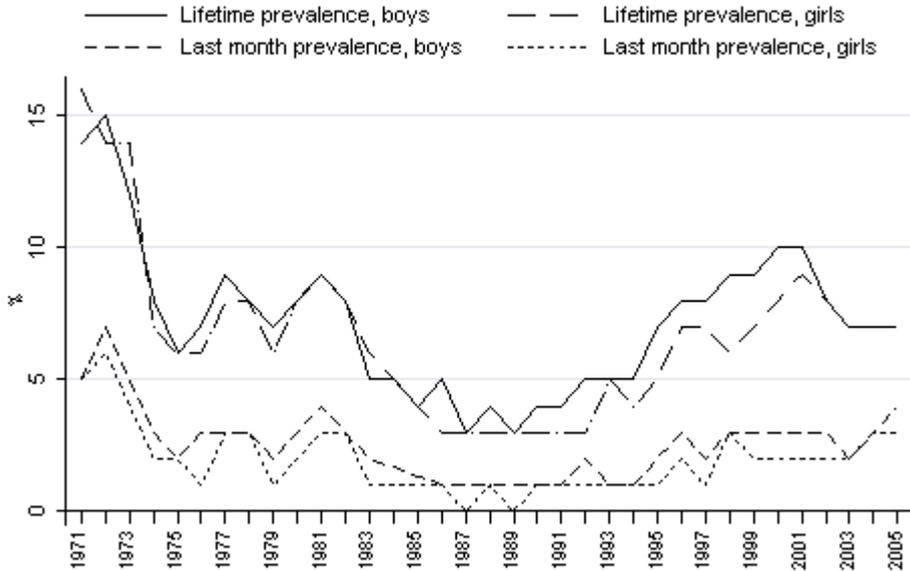


Figure 2.2-1. Lifetime and last month prevalence of having used an illegal drug among pupils turning 16 during the year of survey, for boys and girls separately, 1971-2005.

The lifetime and last month prevalence of drug use among the 16 year olds was similar among boys and girls, but there was a pronounced gender difference among the older pupils. The lifetime prevalence of ever having used an illegal drug among the pupils turning 18 was 17% for the boys (the same as previous year) and 13% for the girls (compared to 14% the previous year). The last month prevalence was 6% for the boys and 3% for the girls, which may indicate a slight increase since the previous year (5% for the boys and 2% for the girls). However, the prevalence rates are rounded to no decimals, which mean that changes must be interpreted with caution.

Cannabis is the most common substance in the surveys among 16 and 18 year olds. Among those who had used an illegal drug, the majority had used cannabis only (60% among the 16 year olds, 70% among the 18 year olds). Hash is slightly more common than marihuana (lifetime prevalence of hash was 12% and marihuana 10% among the 18 year olds). Ecstasy is the second most common substance. The 13 year olds were not asked questions on specific substances.

2.3. Drug Use among specific groups

Conscripts

Surveys among military conscripts have been carried out since 1971. The conscripts are Swedish citizens, of which the majority turned 18 during the year of survey. All male

conscripts coming to one of the five conscript offices take part in the survey. Before 2000, women also took part in the survey, but their number was so small that they are not considered to have any impact on the results. The results and methods of the latest survey (Guttormsson, U. 2006a) are also presented in table 30 of the EMCDDA Standard Table set. Approximately 42 000 persons responded to the questionnaire in 2005 (response rate of 88%).

In the 2005 survey it was shown that life time drug experience was three times more frequent among conscripts that were unemployed and not studying than for studying conscripts at the time of conscript. Regular use was five times as frequent. The group that had a work at the time of conscript came in between. A small ethnic difference was also detected in the study. Persons with foreign background (born abroad or with parents born abroad) had a life time prevalence of 16 % compared to 12 % for persons born in Sweden and with parents born in Sweden.

Lifetime and last 30 days prevalence of having used an illegal drug 1971-2005 is presented in figure 2.3-1. Lifetime prevalence has decreased in the last three years - from approximately 18% in the early years of the millennium to 13.5% in 2005. The most common substance used is cannabis (lifetime prevalence 12.6% in 2005), followed by amphetamine and ecstasy. These two substances have similar levels of prevalence (amphetamine 1.6% and ecstasy 1.8% in 2005).

The last 30 days prevalence of having used an illegal drug has also decreased over the last three years. In the years 1999 to 2002, prevalence varied between 3.0% and 3.1%. However, in 2003, the last 30 days prevalence was 2.5%, and continued to decrease to 2.3% in 2004 and 2.0% in 2005.

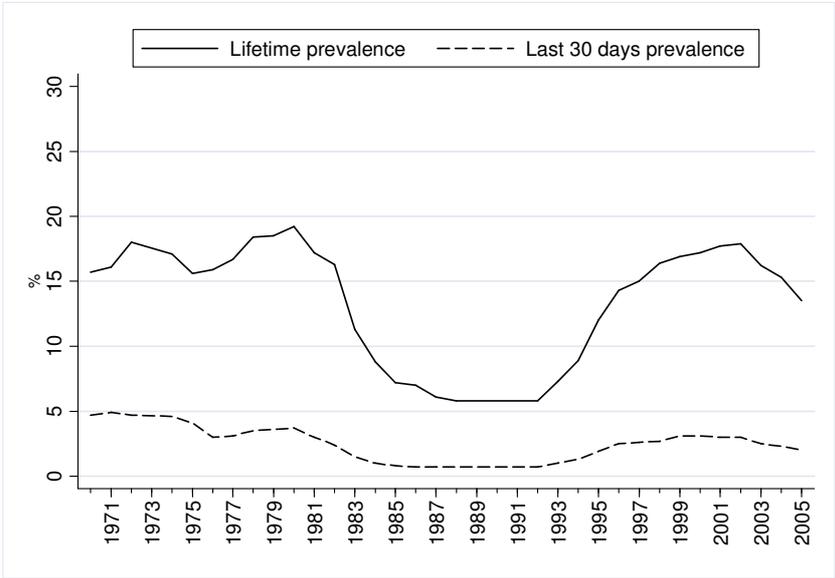


Figure 2.3-1. Lifetime prevalence and last 30 days prevalence of having used an illegal drug among military conscripts, 1971-2005

Drug use among socially integrated drug users

A study focusing on the life situation, drug use pattern and attitudes to drugs among persons who use drugs regularly, but who still are able to fulfil their social obligations is currently being carried out in Stockholm. In the initial qualitative phase of this study, twenty-five drug users aged 18 to 30 years (eight women and 17 men) living in Stockholm were interviewed.

A full report on the results and methods of the qualitative part of the study has not yet been published, but a shorter description is available in a report published by the Swedish National Drug Policy Coordinator, where researchers receiving grants describe their activities (Skårner et al. 2005). The drug users were selected with snowball technique. Among the participants, 14 were employed, six students, four unemployed and one on daddy leave. This initial qualitative study has been followed by a survey among 80 drug users in order to obtain quantitative data (results not yet published).

The participants say they use drugs in a controlled manner. They stress that using drugs is a choice, not something they *have* to do. Control and boundaries are of importance, for instance when choosing substance and route of intake. Not using heroin and not injecting drugs are considered important factors preventing drug abuse. Drugs are not used prior to, or during work. The drug use is controlled by daily routines in order for it to not affect social obligations.

In order to avoid the risks and maximize the effects of the drugs, the participants use their experience and knowledge to choose how, when and where they use drugs. The risks associated with drug use are linked to individual traits and social context, rather than the drug itself. Their perspective is based on the individual, and drug use is seen as an individual choice. The participants are very negative towards alcohol. This, as well as their view of people with abuse problems as lacking of self control, may be an attempt to create a positive self image in a society where drug use is condemned. The socially integrated drug users are not necessarily parts of a sub culture. They see themselves as legitimate citizens and display a wish to be accepted by society.

3. Prevention

Overview / summary

The increased drug prevention activities as reported on 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 to 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. 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.

3.1 Universal prevention

3.1.1 School

The previously reported assignment for the SNIPH to bring forward knowledge on effective methods and how to strengthen the alcohol- and drug preventive work in schools is running. Four major areas for the prevention of risk behaviour in school are defined:

- a good working climate in the class room
- a trustful cooperation with the parents
- a school health care system that actively works with motivational interview technique
- an active leisure time in togetherness

One important way off supporting schools and municipalities is to present a range of tested and scientifically evaluated methods and belonging supportive materials on how to apply the methods in the local work. A number of publications in the different areas of prevention are released, some of them free of charge and most of them downloadable in pdf format.

The school project has a website (http://www.fhi.se/templates/fhischoolstart_8300.aspx) where information on literature, methods, material, lecturers, conferences and contact persons could be found. Also, the SNIPH staff together with staff from other involved bodies is frequently involved in organizing and participating in training sessions on the topic.

3.1.2 Family

A first follow up of the previously presented family-oriented programme for the prevention of alcohol and drug abuse is published (Skärstrand 2005). The programme is based on experiences from the Iowa Strengthening Family Programme. The project was initiated in 2003 when also a base line study was performed. The first intervention was made in the spring 2003, pupils in grade 6, and the second intervention in the autumn of 2003, when the pupils were in grade 7. The present follow up took place in the spring 2004 and no significant difference between test- and control schools was found on the use of alcohol, narcotics or tobacco. The conclusion is that the number of pupils having used drugs is still so low that possible significant differences could not be registered. The upcoming studies, when the pupils are in grade 8 and 9 respectively, will possibly show if the programme has had any effect on the alcohol- and drug behaviour of the youth.

3.1.3 Community

As previously reported the NDPCo initiated in 2003 a project called 'Popular Education against Drugs' (*Folkbildning mot narkotika*). A partial evaluation of the project is now published (Sjöman 2005) comprising seven examples from the about forty projects initiated in 2003. The conclusions are summarized in about 31 issues stating among other things that

- The projects contribute in particular in two preventive areas (protective factors), namely positive leisure time activities and engaged parents and other adults.
- The projects are in line with the Swedish global policy aim, "A drug free society".
- The qualitative aims of the projects are not measurable but judged to be related to the possibility to carry through the planned activities.
- The most common problem is delays.
- In the youth projects the leaders are very important
- Projects dependent on external financing for continuation are most vulnerable regarding persistence.
- The now studied projects mainly use conventional popular educational methods, e.g. lectures, study circles, various cultural activities.
- Interviewed youths participating in the projects puts the major responsibility for abstaining from drugs on the individual – that is them selves.
- Interviewed adults participating in the projects puts the major responsibility for youths abstaining from drugs on them selves as parents.

3.2 Selective/indicated prevention

3.2.1 Recreational settings

As previously reported recreational settings are in focus for interventions against illegal drug use and has been so for many years. In 2006 the NDPCo produced a document to facilitate and support the work of municipalities and other bodies having recreational settings as an arena for drug preventive work (Löf 2006). The document gives information on "why", "how to do it", "the legal situation", "examples and experiences from interventions" and "learn more", giving references to useful literature and material as well as persons and organisations that could be contacted for information and support.

3.2.2 At-risk groups

Several projects are running in different parts of the country with the aim of early intervention when a person is suspected of drug abuse (Mobiliserings mot narkotika 2005). All of them are to be evaluated. So far however only the Stockholm based project "MUMIN", directed to young persons (15 – 25) have presented preliminary results from the work. In the youngest group (15 – 20), more than 50 % said yes to talking to staff from Maria ungdom (Maria youth) centre for dependency disorders when they were captured for minor drug crimes and of those, more than 50 % went on to treatment. The age group 15 – 18 was found to be easiest to motivate to treatment and girls were easier to motivate than boys.

http://www.mobilisera.nu/templates/GeneralPage_4521.asp.

Major drugs of abuse in the MUMIN project were cannabis and ecstasy. However, the girls in the MUMIN project had a much broader experience of different substances than the boys. It is also found that the clients recruited in the MUMIN project have more problems regarding drug abuse, line of criminal records and psychiatric co-morbidity than the other clients at the Maria ungdom centre for dependency disorders.

MUMIN is the akronym for "Maria Ungdom Motivational Intervention", a working method for taking care of young persons captured for drug crimes in specific youth settings. In connection with the capture and investigation the police try to motivate the young person to accept an acute caretaking from staff at the Maria Ungdom centre for dependency disorders and in the presence of close relatives. MUMIN is developed from a cooperation project between the youth section at the Stockholm County Police, the Centre for Dependency Disorders in Stockholm and the Maria Ungdom centre for dependency disorders with financial support from the NDPCo. The project started in 2004 and is today part of the regular work of the concerned bodies. A final evaluation of the project is promised.

At the Växjö university, in cooperation with the NDPCo, an academic training course in drug dependence prevention is started targeting early intervention among young persons. The first course started in 2004 and the education is partly running as distance training via Internet.

3.2.3 At risk families

No new information available

4. Problem Drug Use

Overview / summary

In 2004, regional case-finding studies were carried out in the counties of Skåne and Östergötland. The study in Östergötland was repeated in 2005. A case-finding study was also carried out in the county of Örebro in 2005. This is the only study where the hidden population of drug users was estimated, using capture-recapture methodology. However, inclusion criteria in the Örebro study were notably different from the other three studies. A summary of the methods and results of all four studies, alongside the most recent national estimates are presented in table 4-1 (the four regional studies are also presented in the EMCDDA Standard Table set of 2006). Because of differences in definitions and study design, comparisons of results should be made with caution.

Table 4-1 Methods and results of regional studies on problem drug use 2004-2005, as well as the most recent national estimates.

Region	Year	Method	Problem drug use definition	Estimate (number)	Population rate/1000
Skåne	2004	Case-finding	Injecting drug use during the previous 12 months and/or daily drug use irrespective of route of intake during the previous four weeks	3013	2.6
Östergötland	2004	Case-finding	Injecting drug use in 2004 or daily or almost daily drug use during periods of time in 2004	1318	3.2
Östergötland	2005	Case-finding	Injecting drug use in 2005 or daily or almost daily drug use during periods of time in 2005	1432	3.4
Örebro*	2005	Case-finding/ capture- recapture	All non-medical use of illegal drugs or pharmaceuticals classified as narcotics in April 2005	6700 (863)	24.4 (3.1)
National (Olsson et al. 2001)	1998	Case-finding/ capture- recapture	Injecting drug use during the previous 12 months and/or daily drug use irrespective of route of intake during the previous four weeks	26000	2.9
National (SOU 2005:82)	2003	Truncated Poisson regression	Estimation based on the hospital discharge register for hospitalization due to drug abuse	25745	2.9

*Numbers in brackets refer to the observed individuals in the case finding study

4.1. Prevalence and incidence estimates.

4.1.1 Regional case-finding study in Skåne

Skåne is the southernmost region in Sweden (population 1.2 million). Because of its vicinity to continental Europe, it is considered to be one of the most problematic area of Sweden when it comes to drug use. Drugs smuggled to other parts of Sweden passes through the area. Furthermore, it is easy to go to Denmark to buy drugs. Both of the two syringe exchange programmes in Sweden are located here, one in the city of Malmö, Sweden's third city (population 270 000), and one in Lund, an ancient university town (population 100 000).

A case-finding study was carried out in Skåne during two weeks in November 2004 (Stafström M and Noren A 2005). Cases were collected from social services, police, syringe exchange programmes, health care and prison and probation services. The agencies were asked to fill in a form for each individual drug user in their records. A total number of 6907

individuals were reported on 8947 forms. The majority of these forms came from the police (40%) and social services (34%), followed by the syringe exchange programmes (13%) and prison and probation services (8%).

Of the 6907 individuals identified, 3013 were problem drug users (problem drug use defined as injecting drug use during the previous 12 months and/or daily drug use irrespective of route of intake during the previous four weeks), 902 were abusing two or more substances (but weren't considered problem drug users) and 2992 were categorized as "other drug users" (using one substance in the last 12 months). The results indicate that problem drug use has increased since previous case-finding studies (a number of studies were carried out in different parts of Skåne in the 1980:s and 1990:s, although none covered the entire county). The characteristics of the problem drug users are displayed in table 4.1.1-1 below. The density of problem drug users did not differ between rural and urban areas. Immigrants make up 19% of the problem drug users, which is a slight overrepresentation compared to the general population of Skåne (14%). One worrying result from this study is that at least one-third of the problem drug users drive a car.

At least one thousand children in Skåne live with one parent with abuse problems, and 600 of these children live with problem drug users (there are approximately 250 000 children under the age of 18 in Skåne).

Table 4.1.1-1 Characteristics of problem drug users in Skåne (problem drug use defined as injecting drug use during the previous 12 months and/or daily drug use irrespective of route of intake during the previous four weeks). N=3013

Gender		HIV-tested		Injecting drug use	78%
Male	77%	No	2%	Immigrant status	
Female	23%	Yes	48%	Born in Sweden	79%
		Not known/ reported	50%	Nordic countries	3%
Age distribution		Having children younger than 18		Non-Nordic countries	15%
≤19	4%	No	60%	Immigrant, country of origin unknown	1%
20-24	15%	Yes. Lives with them.	7%	Not known/ reported	3%
25-34	27%	Yes, but does not live with them	22%	Immigrant status of parents	
35-44	29%	Yes (not known if living with child)	2%	Born in Sweden	68%
≥ 45	25%	Not known/ reported	10%	Nordic countries	5%
Length of time in abuse		Drives a car		Non-Nordic countries	19%
<1 year	1%	Yes	33%	Not born in Sweden, country unknown	1%
1-4 years	3%	No	27%	Not known/ reported	7%
5-9 years	19%	Not known/ reported	40%		
≥10 years	68%				
Not known/ reported	10%				

In the total study (all drug users included), cannabis was the most common substance: 53% had used it in the last 12 months. Central stimulants had been used by 47% (amphetamines 42%) and opiates by 28% (heroin 26%). Among the 2161 injecting drug users, 1160 (54%) had injected heroin and 1504 (70%) had injected amphetamine in the last 12 months (the cases were not classified according to main drug).

4.1.2 Regional case finding studies in Östergötland

Östergötland is situated in the south-east of Sweden (population 420 000 in 2005). There are two major cities, Linköping (a university town) and Norrköping (an old industrial town), both with a population of approximately 130 000. A couple of local case-finding studies have been conducted previously in the area. In 2004 and 2005 two studies covering the entire county were carried out. Both studies were performed using the same methodology. (Länsstyrelsen i Östergötland 2005) (Länsstyrelsen i Östergötland 2006).

Cases were collected from social services, police, health care and prison and probation services in February 2005 and 2006. The agencies filled in a form regarding drug use in the previous calendar year for each drug user and were asked only to report people who were *known* drug users (based on tests or verbal information). The police completed the largest number of forms, followed by social services.

The drug users were categorized into three mutually exclusive categories in the following order:

- Type 1: injecting drug use in 2004 or 2005
- Type 2: daily or almost daily drug use during periods of time in 2004 or 2005
- Type 3: having used drugs at least once in 2004 or 2005

If a case fitted the definition for more than one type, it was counted as the type with the lowest number. For instance, if a case had used cannabis daily and injected heroin once during the year, (s)he was counted as a type 1 drug user. In this text, as well as in the EMCDDA Standard table set, type 1 and type 2 is defined as problem drug use.

In 2004, a total of 2029 drug users were defined. For 2005, the corresponding number was 2244. For men, the “type 3” drug use was the most common. For women, the number of drug users was almost identical for all three types of drug use. The number of problem drug users was 1318 in 2004 and 1432 in 2005. The number of injecting drug users was 590 in 2004 and 650 in 2005. The characteristics of the problem and injecting drug users are displayed in table 4.1.2-1. Half of the problem drug users in the two oldest age categories inject drugs. The percentage of injecting drug users is lower (15%) in the youngest age group (note that the age groups differ in span).

Women make up 20% of the problem drug users. In both studies, the percentage of women was slightly higher in the younger age categories (26% in the youngest age group compared to 21% in the oldest age group in 2005). Women make up 22% of the injecting drug users and the highest percentages are found in the two youngest categories (33% among 20-24 year olds compared to 23% in the oldest age group in 2005).

Table 4.1.2-1 Characteristics of problem drug users and injecting drug users in Östergötland in 2004 and 2005 (problem drug use defined as injecting drugs at least once, or daily or almost daily drug use during periods of time in the calendar year)

	Problem drug use	2004 Injecting drug use (number and % of problem drug users)	Problem drug use	2005 Injecting drug use (number and % of problem drug users)
Total	1, 318	590 (45%)	1, 432	650 (45%)
Gender				
Male	1, 048	459 (44%)	1, 144	507 (44%)
Female	270	131 (49%)	288	143 (50%)
Age distribution				
≤19	116	17 (15%)	117	18 (15%)
20-24	218	51 (23%)	259	96 (37%)
25-39	562	296 (53%)	590	307 (52%)
≥40	422	226 (54%)	466	213 (46%)

For both studies, the use of specific substances is only presented for the total group of drug users (all three “types” included) and cases were not classified according to main drug. Cannabis was the most common substance used (66%) followed by amphetamine (56%), benzodiazepines (39%) and opiates (12%) (2005 data). Cocaine and LSD were less common (4% and 0.5% respectively). Women made up one fifth of the amphetamine, benzodiazepines and opiates users, but only 16% of the cannabis users and 10% of the cocaine users. None of the LSD users reported in 2005 were female.

4.1.3 Regional case-finding study in the county of Örebro

The county of Örebro is situated in the south-east of Sweden (population 275,000 in 2005). Örebro is the major city (population 130, 000). A regional case-finding study, followed by capture-recapture analysis, was carried out in 2005 (Lindén-Boström et al. 2006). Cases were collected from social services, police, treatment centres and prison and probation services during April 2005. The case definition included all non-medical use of illegal drugs or pharmaceuticals classified as narcotics during this month. The social services, treatment centres and the prison and probation services reported all clients with a known drug abuse problem. The police reported all arrested persons testing positive for drugs.

A total of 863 individuals were identified from 1120 reports on drug use. Social services reported the largest numbers of cases. Among the 863 individuals identified, 25% were female. Mean age was 34 (70% were younger than 40 years). The distribution of main drugs are displayed in table 4.1.3-1. Central stimulants were the most common main drug. It was especially common among women (58%).

Table 4.1.3-1 Main drug among problem drug users in Örebro (an individual reported more than once may have more than one main drug).

<u>Drug</u>	% among women	% among men	% total
Cannabis	21	32	29
Central stimulants	58	40	45
Opiates	7	21	17
Pharmaceuticals classified as narcotics	9	6	7
Others	7	7	7

In order to estimate the hidden population of drug users, capture-recapture analysis was performed using log-linear regression (based on the Poisson distribution), reaching an estimation of 6,700 problem drug users in total. This corresponds to 2.4% of the population. According to the authors, the estimate should be interpreted with caution, due to the low number of observations. Another estimation of problem drug use based on the hospital discharge register for hospitalization due to drug abuse, using truncated Poisson regression, estimated the number of problem drug users in the region to be approximately 900 in 2004 (using the same method the most recent national estimate (SOU 2005:82) reported in the Standard Table set 2005).

The methods of this study differ from the other regional case-finding studies presented in this chapter. The case definition included all drug use irrespective of frequency or duration. On the other hand, cases were only included if they had been in contact with the reporting agencies during the particular month (whereas the other studies included all clients who had been in contact with the agency during a year).

4.2. TDI Data.

No new information available

4.3. Main characteristics and patterns of use from non-treatment sources.

No new information available

5. Drug-Related Treatment

Overview / summary

National guidelines for the treatment of alcohol and drug abuse are developed and a final version is to be presented in 2007. The new regulation on medically assisted treatment have increased the number of treatment providers significantly and in a 12 month period 05/06, 2700 clients were in substitution treatment.

For the full implementation of the treatment demand key indicator a legal support is a prerequisite. A proposal from the NBHW, including the necessary decisions needed to fully implement the indicator, was presented to the government in January 2006 and is pending.

5.1 Treatment system

Improved statistics

The National Board of Health and Welfare (NBHW) presented to the government in January 2006 a concept for statistical coverage of all forms of specialised treatment for alcohol and drug abuse (Socialstyrelsen 2006a). According to the proposal all treatment of alcohol and drug abuse had to be reported to the NBHW covering among other things the manual for the Treatment Demand Indicator (in Swedish: Klienter i Missbrukarvård, KIM). Several years experience of gradually implementing this model in the treatment system shows that there exists an interest in making KIM only a platform for more extensive reporting systems. Therefore, the international well known ASI and a national system called DOK (presented in previous NRs) has gained popularity. Both of these systems also cover KIM data. So far KIM has been collected by the NBHW on voluntary basis and without the possibility to follow clients. The new concept for statistical coverage implies legal changes and if accepted by the Parliament a personal code will be used which radically improve the conditions for follow up but also research and development.

Guidelines for treatment of alcohol- and drug abusers

National guidelines for treatment of alcohol and drug abuse are supposed to be introduced during 2007. It is the National Board of Health and Welfare that has organised a thorough examination of the scientific literature and from that made guidelines for treatment. The text will be ready late in 2006 and introductory lectures and seminars will be arranged all over the country with start early in 2007. The draft guidelines were circulated for comments mid 2006 and are published on the website of the Swedish National Board of Health and Welfare (Socialstyrelsen 2006c)

Quality register

The National Board of Health and Welfare has started a project aimed at constructing a quality register for treatment of alcohol and drug dependence. This register will develop, follow and support quality within the treatment sector.

Treatment chain perspective

During the first national action plan on drugs (2002 – 2005) the NDPCo initiated a project supporting the development of a treatment chain and the cooperation between the different institutions and authorities responsible for the different steps in the rehabilitation. The project is based on the participation of four different municipalities and is named “Model Municipality Project” (MMP). The experiences gained are to be used at national level for the development of the treatment and rehabilitation of drug addicts. The major steps to be developed in the project concerns standardised instruments for the judgement of the client’s abuse and life situation, the implementation of a treatment chain perspective and the organisational problems in cooperation between different responsible authorities.

The MMP is evaluated with the intention to investigate how the support given by the NDPCo stimulates the *i)* development of a treatment chain perspective in the work, *ii)* cooperation and the *iii)* implementation of standardised instruments for judgement (Wikström and Lindberg 2006). The evaluation shows that the project creates borders as well as activities

crossing the borders. In the initial phase the participating municipalities are in particular focusing on “responsible authority” issues, mapping of the situation and setting up aims. This phase of the work intends to make the responsibilities of the different bodies involved in the “chain” visible and accepted. Work on cooperation, treatment chain and methods come in a later phase. The support from the NDPCo was directed towards organisational matters and staff competence with financial support for training, project management and seminars for all involved municipalities. The NDPCo has governed the MMP by making demands and setting up guidelines and by the financial support.

The evaluators conclude that models for the local project plans and the use of the standardised instruments for judgement have been applied while models for the organisation of cooperation and treatment chains are lacking. It was further concluded that the MMP puts the treatment of abusers in focus and the selected municipalities’ gets attention for the development of the issue. According to the evaluators the MMP has both attention/authority forming consequences as well as normative consequences. For further information on the project please contact the Swedish NFP.

5.2 Drug free treatment

No new information available

5.3 Medically assisted treatment

As previously reported a new regulation on substitution treatment came into force in January 2005. (http://www.sos.se/sosfs/2004_8/2004_8.htm). Until October 2006, 62 treatment units (20 under private management) have shown an interest to carry out medically assisted treatment with methadone and/or buprenorfin. 2700 clients in total (1500 on buprenorfin) were in treatment between July 1, 2005 and June 30, 2006. The treatment suppliers are on voluntary basis setting up a register for quality and follow up purposes. There are no official registers of clients in substitution treatment or the medical staff responsible for the treatment.

6. Health Correlates and Consequences

Overview / summary

No new information

6.1 Drug related deaths and mortality of drug users:

6.1.1 Direct overdoses and (differentiated) indirect drug related deaths

Data from the National Cause of Death Register (NCDR)

The delay in the NCDR limits its usefulness when studying trends in drug related deaths. The latest figures are from 2003, and the 2004 data isn't due until 2007. The annual number of direct drug related deaths 1990 – 2003 (based on the NCDR, EMCDDA DRD-Standard selection B, code T40.4 excluded) is displayed in graph 6.1.1.A. The deaths increased from approximately 60 per year in the early 1990:s and peaked at 190 in 2000. Since then, the number of direct drug related deaths have been approximately 160 persons per year. The most recent figure is from 2003, when 152 persons died. Mean age at death was 38 years. Women make up 21% of the diseased in 2003, which is remarkably high. In the four preceding years, the percentage of women has been approximately 15%. The data for 2003 is also presented in the EMCDDA standard table set of 2005. However, due to delay of data, the table was uploaded after the national report of 2005.

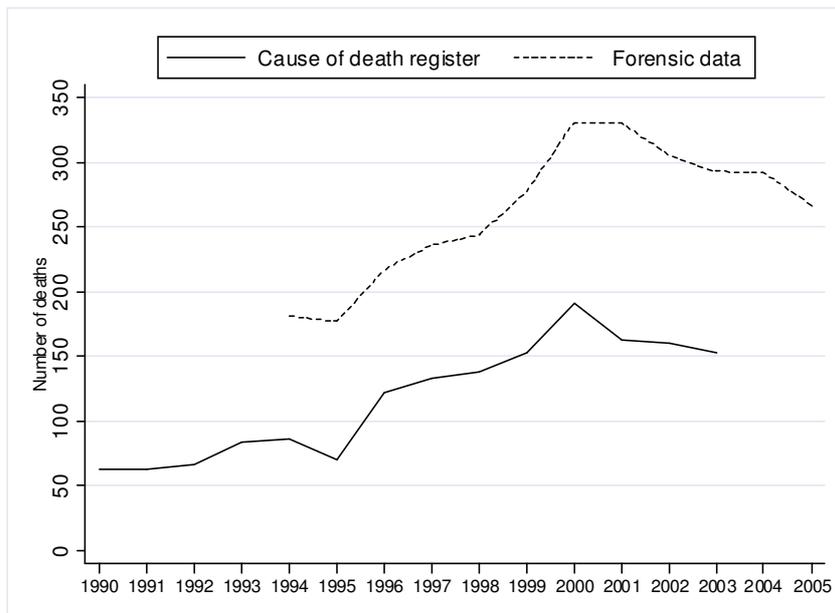


Figure 6.1.1.A. The annual number of direct drug related deaths based on the National Cause of Death Register 1990 – 2003 and the annual number of deaths with illegal drugs present (DIDP) based on forensic data 1994 – 2005.

Data from the forensic toxicity register.

Forensic investigations are performed routinely in Sweden at fatal accidents or when there is a suspicion of unnatural death, suicide or crime. Approximately 5 500 deaths are investigated each year. The SNIPH has supported the research and development of data on deaths with illegal drugs present (DIDP). The figures are based on detection of drugs in body fluids and emanate from the forensic data bases of the National Board of Forensic Medicine. Data is available until 2005. When the method is fully developed it is estimated that a trend could be mirrored within months. The annual number of DIDP 1994 – 2005 is displayed in graph 6.1.1.A together with the annual number of drug related deaths based on the NCDR - EMCDDA standard B. The DIDP is naturally higher than the EMCDDA Standard B figures, but the curves show a very similar pattern in the increase, peak and decrease phases. The DIDP continued to decrease during 2004 and 2005 (where data from the NCDR is still

lacking). The short delay in data availability makes the forensic data a useful tool when looking at DIDP trends. However, it is important to keep in mind that the presence of an illegal drug in forensic analyses does not imply causation. Furthermore, the chain of causation will vary with different substances.

The 1994 – 2005 DIDP data were divided into five mutually exclusive categories. If several illegal substances were present simultaneously, the death was placed in the highest category. For instance, if both cocaine and amphetamine was detected, the death was placed in the amphetamine category.

Categories of drug-related deaths based on forensic data figures

1. *Verified heroin*: 6-monoacetylmorphine (6-MAM) present. After intake, heroin is rapidly transformed into 6-monoacetylmorphine (6-MAM). This substance can only originate from heroin. If 6-MAM is present, it is safe to assume that death occurred close after heroin intake.
2. *Heroin/ morphine*: Deaths with morphine but not 6-MAM present, where morphine levels are equal to or higher than codeine levels. These deaths were considered to be caused by heroin but with a slower course of events. Heroin is transformed into 6-MAM after intake, which in turn is further transformed into morphine, a substance which can also originate from legally prescribed medicine. This is why the levels of codeine (another by-product of heroin) was used to determine whether or not the death occurred after heroin intake. To further make sure deaths caused by legal medicine were not included, deaths occurring among persons older than 50 were excluded (for this category only). This was to avoid counting suicides with legally prescribed medicine among elderly people.
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.

The annual number of deaths for each category of substances since 1994 is presented in graph 6.1.1.B. Both categories of deaths with heroin present in body fluids show similar trends, with a steady increase from 1994 and onwards, peaking at the turn of millennium. However, in 2005, the number of verified heroin related deaths ((6-MAM) were notably higher than the previous year (65 in 2005 compared to 45 in 2004), reaching almost the same levels as in 2001.

Deaths with amphetamine present in body fluids have also increased in number during the period, peaked in 2002 but have not decreased in the same manner as DIDP. The mean age at death is the highest in this category (39 years). There may be an increased vulnerability among an ageing group of people with a chronic abuse problem of amphetamine. The percentage of women was the highest in this category (17%).

The annual number of deaths where cannabis was detected in body fluids has doubled during the period. 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 percentage of women is the lowest in this category (7%).

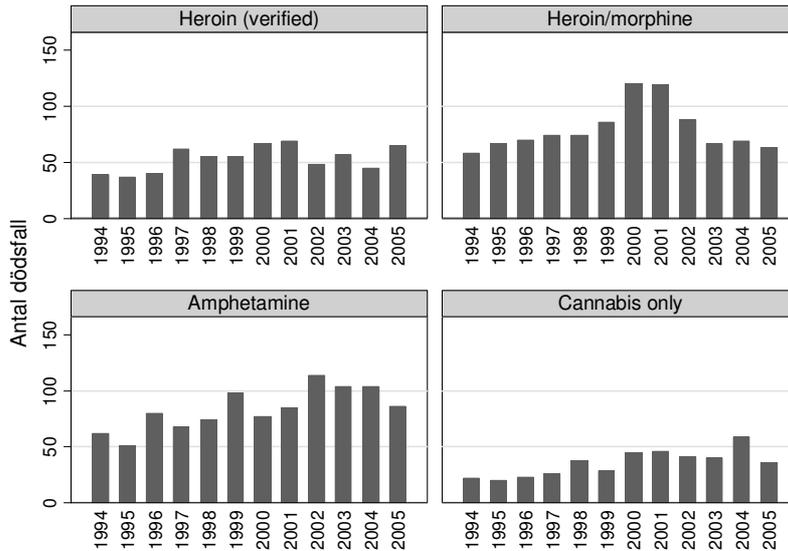


Figure 6.1.1.B. Annual number of deaths with illegal drugs in body fluids based on forensic data 1994-2005 for specific substances.

A study looking at drug related deaths and mortality among drug users in Stockholm in the years 1985-1996 used a methodology similar to the DIDP (Fugelstad et al. 2003). The study focused on drug related deaths in Stockholm, using both local hospital registers and forensic data. The forensic data in this study included not only toxicological data on illegal drugs but indications of illegal drug abuse in all forensic data available for each death (such as needle marks or police reports of drug abuse). The results were compared to the drug related deaths found in the National Cause of Death Register, based on the definition used by the National Board of Health and Welfare. The definition contains approximately the same ICD codes as the EMCDDA Standard B, but it also includes secondary diagnoses. The number of drug related deaths according to this definition is approximately 400 per year. Eighty percent of the cases defined as drug related according to the National Cause of Death Register were also defined as related to illegal drugs according to the forensic data. Many deaths among the remaining 20% were related to legal drugs (such as suicides among persons with severe illnesses or unintentional overdoses among persons addicted to legal substances). This group had a larger age span and a higher percentage of women. Among the deaths related to heroin, most were counted as related to illegal drugs both in the forensic and the register data. Among the deaths related to amphetamine according to the forensic data, only half of the deaths were classified as drug related according to the National Cause of Death Register. The amphetamine deaths found in both data sources were directly related to drug use (overdoses).

Table 6.1.1.A. Characteristics and number of deaths with illegal drugs present in body fluids based on forensic data, in total and for the separate categories of substances, 1994-2005.

	Verified Heroin	Heroin/morphine	Amphetamine	Other illegal drugs	Cannabis only	Total
No of deaths 1994-2005	639	955	1,003	129	425	3,151
% women	12%	14%	17%	15%	7%	13%
Mean age (years)	35	33*	39	27	36	35
No of deaths per year						
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

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

Psychiatric severity and mortality among problem drug users (a 15-year follow-up study).

The relationship between psychiatric severity and mortality and abstinence and mortality was studied among a group of 125 problem drug users who were admitted to the psychiatric detoxification and short term rehabilitation unit at Sankt Lars Hospital in the city of Lund between January 1st of 1988 and June 1st of 1989 (Fridell and Hesse 2006). Lund is situated in Skåne in southern Sweden (this area is described in the chapter on problem drug use). The psychiatric status of the problem drug users was studied at 5-year follow-up using The Symptom Checklist-90 (SCL-90), the Sense of Coherence scale (SOC) and Global Assessment of Functioning (GAF). Abstinence at 5-year follow up was defined as no use of illegal drugs and no abuse of alcohol. Deaths and date of death at 15 year follow-up was obtained from the Swedish Central Person Register.

All problem drug users in the baseline sample met the criteria for substance abuse or dependence according to the DSM-III-R. Women made up 33% of the sample. Mean age in the total sample was 29 years. The predominant drugs used were amphetamine (39%), opiates (28%), cannabis (18%), tranquilisers (11%) and alcohol (5%). Two thirds had used drugs intravenously. Participation rate at 5-year follow-up was 74% (6% had died, 5% refused and 16% could not be interviewed for other reasons).

At 15-year follow-up, 24% had died. The observed mortality in the 15-year follow-up was 1.6% per year. Psychiatric status and abstinence status at 5-year follow up was analysed using cox regression. Due to correlation between psychiatric scales, separate univariate analyses were performed for each of the psychiatric scales and for abstinence status. The psychiatric scales were analysed as continuous variables. Psychiatric status at 5-year follow-up was predictive of 15-year mortality. Those who died had higher scores on the Global

Severity Index of the SCL-90 ($\beta=0.82$, Wald=6.2, $p=0.01$) and lower GAF scores ($\beta=-0.07$, Wald=12.0, $p=0.0005$). Of the SOC scales, the meaningfulness scale was associated with less risk of dying ($\beta=-0.61$, Wald=7.9, $p=0.005$), and there was a trend for the manageability scale ($\beta=-0.42$, Wald=2.9, $p=0.09$), but no relationship with the comprehensibility scale ($\beta=-0.24$, Wald=0.91, $p=0.34$). Abstinence at 5-year follow-up was not significantly associated with mortality ($\beta=0.30$, Wald=1.88, $p=0.17$). There were no associations between mortality and antisocial personality disorder diagnoses at baseline.

The authors conclude that psychiatric treatment, including psychotherapy, may be more life-saving for substance abusers than drug-abuse services. The current study is limited by sample size, and therefore replications are necessary. The NIPH find it difficult to interpret the magnitude of the association between mortality and psychiatric status in this study, since the psychiatric scales are treated as continuous variables and the β -coefficients for the different psychiatric scales are not comparable to one another. Focus seems to be mainly on statistical significance.

6.2 Drug related infectious diseases:

6.2.1 HIV/AIDS, viral hepatitis, STD, tuberculosis, other infectious morbidity

25 of the 392 cases of HIV notified in Sweden during 2005 were identified as IDUs (22 men and 3 women). During the first six months of 2006 preliminary data show that eight IDUs have been diagnosed with HIV. Five contracted (self-report) HIV in Sweden, two in Russia and one is unknown.

Hepatitis C

The number of new hepatitis C cases per year, has decreased steadily since the mid 1990s: from almost 2 900 cases in 1995, to 1 900 – 2 000 in the first years of the new millennium. 1710 cases of HCV were notified during 2005 (1160 men and 550 women). 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 and 64% in 2005. The share of women among the intravenous drug users diagnosed with hepatitis C in 2005 was 28%, which is about the same as previous years. There have been no relevant changes in the age distribution among the intravenous drug users in the last five years. The figures are based on extraction from the Swedish Institute for Infectious Disease Control registers.

Hepatitis B

The number of new acute hepatitis B cases per year increased during the first years of the new millennium, peaking at 372 cases in 2003. In 2005, 217 new cases were reported. There are also indications of a decrease when it comes to the share of intravenous drug users: in 2005 they made up 40% of the new cases with a known transmission route, compared to 52% the year before. Among IDUs 30% of both men and women were in the age-bracket 15-24. Molecular analysis of Hep B-virus strains from patients with acute Hep B showed that the same three strains that have been spread among IDUs since 2003 still account for 17 new cases in 2005. Two of these strains have also been spread heterosexually to female contacts.

6.3 Psychiatric co-morbidity (dual diagnosis)

No new information available

6.4 Other drug-related health correlates and consequences:

6.4.1 Somatic co-morbidity (as abscesses, sepsis, endocarditis, dental health etc.), non-fatal drug emergencies, other health consequences

No new information available

6.4.2 Driving and other accidents

Please consult chapter B.2.3, NR 2006.

6.4.3 Pregnancies and children born to drug users
No new information available

7. Responses to Health Correlates and Consequences

Overview / summary

The national action plans on drugs (2002 – 2005, 2006 – 2010) has vitalised the fight against drugs in a conspicuous way. The action plans as co-ordinated by the NDPCo has promoted the test and implementation of new methods and strategies, improved the quality, increased the resources and introduced new and specialised projects in the prevention, treatment and supply reduction areas. Examples on responses to health correlates and consequences are presented in this chapter.

7.1 Prevention of drug related deaths:

7.1.1 Overdose prevention (safer use training, first aid training, consumption rooms, antagonists, etc.)

By support from the research program of the NDPCo a research group in Lund is managing a project to develop preventive methods to decrease overdoses (o.d.) among heroin addicts (Brådvik et al. 2006). The aims are to increase the knowledge about steps to take when a heroine abuser over dosed, to increase the efficiency of active search for treatment and to develop methods for follow up of persons who over dosed.

In a first phase the extent of the problem was investigated. 149 clients (108 men and 41 women, mean age 36) at the syringe exchange program and detoxification clinic in Malmö were interviewed in the autumn 2003. 74 % had personal experience of at least one o.d. and almost all (95 %) had seen at least one o.d. in another person over the last 5 years. Simultaneous use of other drugs, in particular benzodiazepines and alcohol, was common in the group. In addition, decrease in tolerance contributed to the o.d. In an o.d. situation there was commonly a lack of experience on how to act among the present friends and “untried” methods were used. Finally, a statistic correlation was found between o.d. and suicide attempts.

Among other things the project has resulted in a film on how to act at a heroin o.d. (“I am still thinking of you...” <http://www.alk.mas.lu.se/overdose.htm>), information material on o.d. and infections (hepatitis, HIV) distributed to IDUs at syringe exchange offices and training in strategies for detoxification of heroin addicts for different sectors in the treatment area.

7.2 Prevention and treatment of drug-related infectious diseases:

7.2.1 Prevention (vaccination, syringe provision programmes, paraphernalia and condom provision; information materials, educational approaches ‘safer use/safer sex’)

In July 1st 2006 the new act on exchange of syringes and needles came into force (SFS 2006). The purpose of the act is to prevent the spread of HIV and other blood carried infections through the exchange of syringes and needles in a way that the individual could be motivated for care and treatment. The activity must not be performed without the permission from the National Board of Health and Welfare and the agency is presently finalising the regulations governing the application of a syringe and needle exchange program. So far the previously described syringe and needle exchange programs in Malmö and Lund are continuing and the compliance with the new regulations and possible need for modifications will be decided on in the spring 2007.

As of 2005 testing and vaccination of hepatitis B is offered all inmates in the Swedish prison and probation system. Presently there is no information on the extent.

The NBHW is financing a project at the Stockholm and Gothenburg’s custody offices (two of the largest in the country) where all inmates are offered hepatitis B, hepatitis C and HIV tests. Of the 941 people taking part in the project 2005, 585 identified themselves as IDUs. Of the IDUs, 22 were HIV-positive (3.8%, 17 known cases and 5 new cases). Furthermore, 192 new cases of Hep C and 4 cases of acute Hep B were reported to Swedish Institute for

Infectious Disease Control. Approximately 2/3 of the IDUs reported amphetamine as their primary drug whereas the remaining 1/3 reported heroin as their primary drug-use.

Information on the infectious risks with injecting drug use and sexual contacts is given by NGOs in contact with addicts as well as from the social services, the health and treatment sector, the prison and probation system and many other institutions in contact with drug addicts. Condoms are frequently available for the addicts in these contacts, in particular in the existing syringe programs.

The most developed initiatives for vaccination against hepatitis are in the existing syringe exchange programmes. Up until 2006 two needle exchange programmes have existed in southern Sweden (Lund since 1986 and Malmö since 1987). These programmes also assist drug users with other medical/social support and refer them to drug-free treatment within the Social Services.

7.2.2 Counselling and testing

In 2006 a project has been initiated that will dramatically increase the opportunity for testing and counselling among homeless IDUs in Stockholm, the capital city of Sweden. The NBHW, Convictus (an NGO providing shelter for homeless IDUs) and several other stakeholders are in the process of designing a testing a counselling project that will provide its services in settings close to the IDUs. Preliminary information on the outcome should be available at the end of 2007.

7.2.3 Infectious disease treatment

No new information available

7.3 Interventions related to psychiatric co-morbidity

No new information available

7.4 Interventions related to other health correlates and consequences

7.3.1 Somatic co-morbidity

7.3.2 Non-fatal emergencies and general health-related treatment

In Stockholm, the capital city of Sweden, a special co-operation mechanism was developed within the framework of a “treatment chain perspective” in order to facilitate entry into treatment for heavy addicts (Palmstierna and Winerdal 2006). The project was named ‘Life Guide’ project¹,

Over the past decade, drug abuse has increased considerably in Stockholm County. The Stockholm County Police Department and the Social Services of the City of Stockholm have observed an increase in the number of drug addicts who spend time at the four major open drug markets – Sergelstorg in central Stockholm, the communication hub of Gullmarsplan and the suburbs of Rinkeby and Tensta. The authorities’ impression is that the persons concerned do not seem to be in contact with the normal social or addiction services, and that when they wish to undergo treatment, they fail to come into contact with these services. The Chief Commissioner of the County Police Department, the City Commissioner for Social Affairs and the County Council Commissioner for Health Care jointly decide that their respective authorities will develop a special co-operation mechanism within the framework of a special treatment chain in order to facilitate entry into treatment for heavy addicts who are regularly seen at open drug markets.

Under this mechanism, when the police make a sweep at any of the four major open drug markets in Stockholm and find addicts there who express an interest in treatment, they offer to take these addicts to the addiction emergency departments at Maria Beroendecentrum

¹ Swedish name: *LOTS för livet*.

(MBAB) or Beroendecentrum Stockholm (BCS). In order for a person to be offered interventions within the framework of the Life Guide project, he or she had to

1. be a heavy drug user;
2. be known by the police to spend time regularly at the open drug markets in Stockholm;
3. be registered as a resident of Stockholm or have ongoing contacts with the social services of the City of Stockholm;
4. not qualify for deprivation of liberty by the police;
5. be willing to accept treatment for his or her abuse.

Whenever the police are going to make a sweep at the drug markets, the MBAB, the BCS and the City of Stockholm man each of these two emergency departments with a senior social worker from the City and a nurse from the addiction services. These 'Guides' have the authority to guarantee that any patient who is taken to the MBAB or the BCS will immediately have access to in-patient detoxification if he or she agrees to participate in the project. The Guide also makes sure that the senior social worker responsible for the patient at the social-services department concerned is contacted (or that one is appointed if need be), organises a treatment conference in which the social services, the addiction services and the client participate, and gathers material for a preliminary drug-abuse investigation.

Police sweeps have been made twice a week in the late afternoon or in the evening. The initial plan was to carry out the project in April–June 2005. However, project management considered that too few people had been admitted during this period for it to be possible to draw any conclusions about the results of the project, and it was therefore decided to extend it by another period, September–December 2005. As a result, the project covered a total of 36 afternoons/evenings. It was also decided that the police officers participating in the project were to take a brief course in motivational interviewing techniques during the summer break so as to become better at getting addicts into treatment.

Evaluation of the Life Guide project

The Swedish National Drug Policy Co-ordinator, who financed the health-care providers' additional costs for implementing the project, wished to evaluate its impact. For this purpose, the Division of Forensic Psychiatry at the Department of Clinical Neuroscience of Karolinska Institute (a medical university) was engaged as an independent evaluator. The main objective of the evaluation was to ascertain whether the co-ordination of the efforts made by the police, the local authority and the specialised health-care services leads to drug abusers getting into treatment to a larger extent.

As a consequence, the evaluation focused on the following questions:

1. How many of those offered this intervention by the police were interested and agreed to participate?
2. How many of those accepting the offer were offered detoxification at a hospital?
3. How many of those hospitalised for detoxification continued to receive treatment immediately after detoxification?
4. How large a share of those offered the interventions have recently been in contact with the addiction services?
5. Are there any changes in the interventions made by the social services for those agreeing to participate?
6. Did the change in the working methods of the police between the two pilot periods have any impact on outcome as regards the number or share of those asked who accepted treatment?

During the evaluation process, each entity carries out its treatment, recording and documentation processes according to its normal procedures. For the purposes of the evaluation, the data relating to each individual client are entered into a special file managed

by the Guide. This includes all information about the client's first contact with the police, the client's investigation process and the involvement of the social services. The collection of material and the processing of data have been approved by a regional ethics committee.

Material and methods used in the evaluation

The material on which the evaluation is based includes the material submitted by Guides and police officers on special forms. To evaluate the interventions made by the social services before and after entry into the Life Guide project, the evaluators have used a special form developed by the Research and Development Unit at the Social Services Department of the City of Stockholm as well as telephone interviews with the senior social workers responsible. To evaluate health-care contacts prior to the project, the health-care register of Stockholm County Council (the 'VAL databases') has been used.

The methods used are mainly descriptive in nature, except as regards the evaluation of the likelihood of accepting a treatment offer, where multiple logistic regression analysis was used to evaluate the relative effect of the spring and autumn interventions (i.e. before and after the police officers received training in motivational conversations) as well as the effect of asking the same person several times.

Results

Participants and drop-outs

To participate in the Life Guide project, a person must be a heavy drug addict, must be known to the police, must be registered as a resident of Stockholm or have ongoing contacts with the social services of the City of Stockholm, must not qualify for deprivation of liberty by the police and must be willing to accept treatment for his or her abuse. These points make up the checklist of the police, and they are referred to when a person is first contacted and asked whether he or she wants treatment for his or her abuse. Based on these inclusion criteria, a drop-out analysis has been carried out. A total of 263 persons were asked during the two periods. Of these, 253 were heavy drug addicts (10 did not meet the first inclusion criterion). A further 10 persons were excluded for not being known to the police, 32 for not being registered as residents of Stockholm and 13 because they qualified for a different type of deprivation of liberty by the police. There thus remained 198 persons who met the first four criteria; they make up the target group for participation in the Life Guide project.

These 198 persons were asked on 257 occasions during the 34 evenings when the project was carried out (7.6 persons asked per evening). Of these, 70 said that they were willing to undergo treatment, 46 went along with the police to a hospital and 44 accepted hospitalisation for detoxification. All patients who were brought to an emergency department were offered hospitalisation.

Reasons for declining the offer of treatment

There were numerous reasons given for not wanting to accept treatment. The police gathered comments from those asked, in a non-systematic manner. Comments made by those not wanting treatment include *'Does not consider himself to have any abuse problems'* and *'Just got out, would rather spend time with my boyfriend'*, and a police officer has noted *'Runs away from Sergelstorg when I (the police officer) mention treatment and the social services'*. Other reasons why some decline the offer include claiming to be already undergoing some form of treatment and not wanting any more of it; a number claimed to be in Subutex or methadone treatment.

Among the other 26 persons who could consider treatment but still declined to go along with the police straight away, reasons given also varied. According to police notes, statements include *'Is on Subutex treatment'* – *'Wants to give up amphetamines but was going to meet*

his daughter today’ – ‘Definitely wants help, but does not want to ride in a police car. Wishes to be contacted’ – ‘Wants help, straight away, but through a social-service officer at a different local authority’. However, the most frequent reason why most of those asked did not come along was that they simply preferred to do it another day: *‘Not today. Want to think about it a little first’.*

Impact of the interventions made by the police in their contacts with the drug addicts

The majority of those who went along with the police and started detoxification at a hospital had been asked on several occasions. Of the 44 persons who wanted to be ‘Guided’, 27 had been asked at least twice. Of these 27, six had been asked three times, one four times and one six times. Seventeen persons went along the first time they were asked. Among those asked once, 10.3% thus went along the first time they were asked. Among those asked several times, 60.1% thus went along on some occasion.

The intensity of the efforts made by the police increased in the autumn as compared with the spring. In the spring, 21 out of 152 persons asked (13.8%) were hospitalised. In the autumn, 23 out of 46 persons asked (50%) were hospitalised. The police tactic of asking the same person several times resulted in a larger number of persons joining the project in the autumn, even though fewer persons were actually asked then.

Logistic regression analysis showed both of these effects to be statistically significant and independent of each other. With the outcome of hospitalisation/non-hospitalisation as the dependent variable, the ‘number of times asked’ variable (hazard ratio: 6.7; CI 95%: 3.3–13.6) and the dichotomous independent variable ‘asked in the autumn’ (hazard ratio: 9.8; CI 95%: 4.0–23.9) are both statistically significant at $p < 0.001$.

Hospitalisations

Forty-four patients were hospitalised at the MBAB or the BCS; 11 of them were women and 33 were men, and their average age was 37.8 years (range: 20–51). The principal diagnosis of 32 of them was heroin abuse, and that of 12 was amphetamine abuse. Poly drug abuse was common – at the time of hospitalisation, 22 of the heroin abusers (71%) had benzodiazepines in their urine, while 13 had cannabis and 13 had amphetamines (42%). In connection with in-hospital detoxification, maintenance treatment was planned for 18 of the 32 heroin abusers (56.2%), and some form of treatment or alternative residence was planned for 11 of the 12 amphetamine abusers. In other words, 65.9% of the patients hospitalised continued to be the subject of treatment/treatment planning immediately after detoxification.

Prior contacts with the addiction services

Only 6 of the 44 persons hospitalised claimed to have had previous contact with the Stockholm addiction services. However, checks against the health-care records of the County Council yielded a completely different picture:

Thirty-three of the 44 patients hospitalised (75%) and 130 of the 154 patients who declined participation in the Life Guide project (84%) had been in some form of contact with the MBAB or the BCS during the year prior to the intervention, i.e. they were known to the addiction services. Slightly less than half – 20 out of 44 (45.5%) – of the patients hospitalised had been hospitalised for detoxification in the past year, as had 44 of the 154 who declined participation in the project (28.6%).

Among those who were the subject of interventions by the Life Guide project, 38 (out of 44) already had a current and established contact with the social services. In all cases, the Guide contacted the senior social worker concerned, which enabled new planning to be carried out. The group included eight persons with no prior established contact with the social services:

four women and four men. The youngest woman was 32 years old and the oldest was 51. The youngest man was 24 and the oldest was 49.

In all, 46 of the 198 persons asked (23%) had been involved in regular treatment within Subutex or methadone maintenance programmes during the past six months, i.e. they were either active programme participants or had recently been discharged and were subject to an 'embargo' on applying for new participation.

Interventions made by the social services after hospitalisation

Of the questionnaires relating to the interventions made by the social services during the six months prior to entry into the Life Guide project, so far only 37 (out of 44) have been received. And for those 37 cases, only 31 follow-up questionnaires describing the interventions made by the social services one month after the project have been received. This makes it more difficult to draw conclusions. The material received does not show any significant differences as regards housing situation, frequency of contact and type of contact (financial support/drug abuse) with the social services between the time of the project and the subsequent month. The data also describes how the individuals' drug abuse has changed according to information from the social services as per one month after the intervention. As regards financial interventions by the local authority one month after the project, results show that financial support had increased by a factor of 1.47 and treatment costs by a factor of 5.0 for the group concerned. It should be noted however, that a single month of treatment cannot be expected to have any impact and that the result is rather the expected one, i.e. an increase in treatment costs without any observable impact.

Summary

The overall result of this collaboration among the police, the social services and the addiction services is that out of 198 drug abusers frequenting the open drug markets in Stockholm who were asked, 44 began treatment in the form of detoxification and 29 continued to receive other types of treatment immediately after detoxification. The investigation also shows that a considerable number of drug addicts can be 'convinced' to enter treatment when the police repeat their offer. It is probably possible to see some impact of the structured training carried out during the break between the two pilot periods, since the effectiveness of the police in getting drug addicts to come along and enter treatment increased considerably during the second pilot period, after the summer break.

It can be noted that about two-thirds of those hospitalised for detoxification continued to receive treatment immediately after detoxification. This corresponds to the proportion expected among drug abusers who apply for treatment themselves and have planned treatment. Other studies of 'clinical' populations of drug abusers, mainly of heroin, show that about 40–70% of those entering detoxification continue to receive other treatment afterwards. Since the persons asked on one or several occasions by the police would probably not have entered treatment if they had not been asked, it can be assumed that those who continued to receive treatment in connection with their hospitalisation would otherwise not have entered treatment.

Against expectations, those asked – as well as those who accepted treatment within the Life Guide project – were largely known to various parts of addiction services. A large share of them were known either to the social services or to the specialised addiction services at the BCS or the MBAB. Around one-fourth were participants or recent participants in the Subutex and methadone programmes of these two clinics.

The long-term impact of the intervention on the project participants can obviously not be evaluated after such a short time. This is also reflected in the social-services questionnaires received after the end of the project. No manifest effects on the patients can be seen yet, but the treatment interventions made by the social services became several times more extensive for the project participants, and a large proportion of the heroin abusers were

planned into Subutex or methadone programmes; these effects will be possible to evaluate after 6–12 months.

Conclusions

- Increased experience and training on the part of the police increased the proportion of drug abusers accepting treatment.
- All patients brought in by the police were offered hospitalisation for detoxification through the Life Guide project.
- All patients who were hospitalised had an active treatment contact with the social services after their detoxification was terminated (as planned or otherwise).
- The treatment interventions made by the social services increased fivefold for those patients who were hospitalised for detoxification.
- Collaboration among the authorities led to treatment interventions being made by the health-care and social services for 22% of the target group, and 15% of the target group continued in active treatment immediately after the police intervention.
- Among those hospitalised for detoxification, two-thirds immediately continued in active treatment.
- The treatment interventions were initiated even though no patient was the subject of current planning by the social services at the time of the intervention.

7.3.3 Prevention and reduction of driving accidents related to drug use
Presented in chapter B 2.3, Drugs and driving NR 2006.

7.3.4 Other health consequences reduction activities
No new information available.

7.3.5 Interventions concerning pregnancies and children born to drug users
In September 2006 the government gave the NBHW the task to propose steps to improve the treatment of pregnant drug abusers. According to the background information several hundred children are born annually with damages due to the mother's abuse of alcohol or illegal drugs. The NBHW is to investigate if pregnant women with abuse problems are given the care and necessary long lasting support needed and if the efforts are in time to create a drug free pregnancy. The NBHW shall also investigate how the act on compulsory care (SFS 1988) is applied in order to protect the mother as well as the child. The task shall be reported in October 2007.

8. Social Correlates and Consequences

Overview/summary

No new information available

- **Social Exclusion:**

- Homelessness
No new information
- Unemployment
No new information
- School drop out
No new information
- Financial problems
No new information
- Social network, etc.
No new information

- **Drug related Crime:**

- Drug offences ('arrests'/criminal reports for drug use trafficking /production / cultivation etc.)

51 400 offences against the drug punishment act were reported in 2005. An increase by 14 % compared to 2004 (BRÅ 2006a). According to the latest figures almost 19 200 persons were convicted of drug offences in 2005, an increase of around 8 % compared to the previous year (BRÅ 2006b). The number of persons convicted of drug offences has increased every year over the past 10 years. The annual increase has varied during these 10 years but averages at just under 7 per cent. This means that, viewed on the whole, drug convictions have almost doubled (increasing by more than 85 per cent) over the last ten years. The following text is quoted from the above referred BRÅ-report 2006b. For possible need of further clarification of the report referred to you are welcome to contact the Swedish NFP.

Type of offence²

At 48 per cent (7,700 persons) and 30 per cent (4,800 persons) respectively, drug use and drug possession were the two most common offences committed by persons convicted of drug offences in 2005. Drug smuggling and distribution³ accounted for 4 per cent and 5 per cent of all drug convictions respectively. The proportion of convictions relating exclusively to personal use has increased from 34 per cent in 1996 to 48 per cent in 2005. The proportion relating to possession offences has by contrast decreased from 40 per cent in 1996 to around 30 per cent in 2005.

Offence severity

In 2005, minor offences accounted for approximately 73 per cent of all convictions (just fewer than 13,800 persons). Non-minor offences accounted for 24 per cent (4,500 persons) and serious offences for just over 2 per cent (430 persons).

The altered offence structure has also affected the distribution across the different categories of drug crime severity. 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.

² Refers to summary fines and court adjudications only, as the offence type cannot be discerned in the case of waivers of prosecution

³ Distribution and distribution in combination with possession.

Substances⁴

Amphetamines and cannabis remain the two most common substances in the convictions statistics. In 2005 these accounted for 30 per cent and 36 per cent respectively of all substances mentioned in criminal convictions. Over the past 10 years there has been a shift in the proportions accounted for by cannabis and amphetamines respectively, with cannabis now being the most common substance in criminal convictions.

Sanctions⁵

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 56 per cent of all those convicted of drug offences in 2005. The convictions of slightly less than 19 per cent of those convicted of drug offences in 2005 took the form of waivers of prosecution, whereas 16 per cent involved prison sentences.

The increase in the number of persons being convicted of drug offences means that there is an increase in the numbers being awarded virtually all of the different sanctions. The number of fines has more than doubled over the period examined, from slightly over 3,000 convicted persons to 7,000. The number of persons sentenced to a prison term has increased from 1,300 in 1996 to 2,100 in 2004. In 2005 the number of persons sentenced to prison as a result of drug offences decreased by 3 per cent to slightly less than 2,000 individuals. By comparison with 1996, however, this figure represents an increase of 56 per cent. The most common length of the prison term awarded in 2005 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 1996 to 19 months in 2005.

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 per cent of all drug convictions in Sweden in 2005. Since 1996 this proportion has remained stable at between 59 and 64 per cent of all those convicted in the country as a whole.

Age distribution

In 2005, young persons aged 18–20 had the highest level of drug convictions in relation to their numbers within the population at large, with 780 convictions per 100,000⁶ of population. The groups aged 15–17 years and aged 50 years or over have the lowest number of convictions, with 223 and 36 convictions respectively per 100,000 of population. Over the period between 1996 and 2005, the largest increase in the number of drug convictions per 100,000 of population has been noted among those aged 18–20 years and those aged 50 years or over. Per capita convictions in these groups have more than doubled over the period examined.

Gender distribution

Of the total number of persons convicted of drug offences in 2005, approximately 15 per cent were women. This proportion has remained relatively stable over the past 10 years. The number of women convicted of drug offences has more than doubled over the past ten years, and the number of men convicted has almost doubled over this same period. Between 2004

⁴ Refers to convictions in which the drug offence was the principal offence.

⁵ Refers to summary fines and court adjudications only, as the offence type cannot be discerned in the case of waivers of prosecution.

⁶ Calculations conducted per 100,000 of mean population. See appendix 1 in (BRÅ 2006b) for a definition.

and 2005, the numbers of women convicted increased by 12 per cent, while the number of men increased by just fewer than 8 per cent.

- Other drug related crime (e.g. property crimes, illegal prostitution, prescription offences, violence under the influence; driving offences; etc.;)

Preliminary statistics from the Crime Prevention Council shows that the number of reported offences for drink-driving increased by 4 % to approximately 23 100. Of these 12 % was related to illegal drugs (BRÅ 2006a).

- **Drug Use in Prison:**

Drug use and problem drug use amongst prison inmates

As presented in other sections of this and previous NRs approximately 60 % of the inmates are problematic drug users at the time of conviction. The estimates on drug use in prison are mainly based on reports from staff, urinary analysis and interviews with inmates. The estimates are reported monthly per institution according to the scale

Never = 0 days/month
Rare = 1 – 5 days/month
Now & then = 6 – 10 days/month
Often = 11 – 20 days/month
Almost daily = 21 days/month and more
and goes back to 1995 (Krantz and Elmby 2005).

If an institution have several levels of security (Open; Closed; Closed enhanced) the levels are reported per se. From the “drug abuse per month” reports a six month mean value is calculated and presented. According to the latest figures (April 04 – September 04) approximately 60 % of the institutions fall in the interval “never – rare” and less than 5 % in the “almost daily” interval (Krantz and Elmby 2005). However, in the period studied it is not uncommon that the “almost daily” six month value exceeded 10 %. The report referred to also present figures on seizures, amounts and type of drugs for the 1995 – 2004 period. For possible need of further clarification of the report referred to you are welcome to contact the Swedish NFP.

- **Social Costs:**

Main results of research studies on social costs related to illegal drug use.

In a report from 2004 the Police authority in the Swedish region Västra Götaland estimate the daily costs related to illegal drug use for the society of the region to about 6×10^5 €. (Andersson, R. and Rönn 2004). The estimate is based on the model used by the Swedish commission on drug abuse as presented in a previous NR. The number of problematic drug users in the region was estimated to just over 5000 which constitute about 20 % of the national estimate. Included in the costs are active drug users, drug users in different kind of care (treatment centres, hospitals, social service) and drug users in prison. Not included costs are criminality, judiciary, and insurance companies' e t c.

9. Responses to Social correlates and Consequences

Overview / summary

No new information available

- **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” are presented in other sections of this and previous reports.

- **Prevention of drug related Crime:**

- Assistance to drug users in prisons (prevention, harm reduction, treatment, social reintegration, community links etc.)

The most common main crime for people in prison is drug related. There is also an obvious connection between these crimes and personal drug problems. According to the Swedish Prison and Probation Service (SPPS) about 60 % of the prisoners were drug addicts at the start of their penalty period. As previously reported the SPPS has received special funding for helping these people to a drug free life and an increase of the units for motivational- and treatment efforts has taken place. However, simultaneously there is an overcrowding of custody and prisons that impair the efforts to help and rehabilitate prisoners with drug problems. The overcrowding has also resulted in a stricter regime and as a result of that the contacts with the civil society have decreased which is disadvantageous to the clients in treatment for drug abuse.

- Other interventions for prevention of drug related crime, in particular : Urban security policies in the prevention of drug related crime (i.e. citizen participation, multi-agency collaboration, victims support interventions)

No new information available

10. Drug Markets

Overview / summary

No new information available

- **Availability and supply**
- Availability of drugs (perceived availability/access in population, other indicators)
 - in the general population
 - in specific groups/places/settings
 - in problem drug users

The problem with young persons in the south of Sweden going to Copenhagen for buying cannabis (presented in previous NRs) seems to have decreased significantly after the closure of the Copenhagen “free state” Christiania. This is reported in a study from the Malmö University and presented by the NDPCo in the autumn of 2006 (<http://www.mobilisera.nu/templates/GeneralPage.asp?id=4811>). The conclusion is based on information from the customs in the region and the annual report from the Danish police stating that the “drug tourism” to Christiania has ceased. However, simultaneously as fewer persons go to Copenhagen for buying drugs the selling of hash and marijuana in the Malmö region seems to increase according to the presentation from the NDPCo.

According to the NDPCo the availability of drugs is judged do be good (Mobilisering mot narkotika 2005).

- Production, sources of supply and trafficking patterns within country as well as from and towards other countries

No new information available

- **Seizures**
- Quantities and numbers of drug seizures

As shown by table 10.1 and as discussed in previous NRs there are no dramatic changes in the frequency of seizures for the most common drugs over the last years. An analysis on information related to seizures as presented in last years NR is not available since the annual report on drug statistics produced in cooperation between the police and customs is not available for 2004 and 2005.

Table 10.1. Number of seizures of different drugs by the police and customs 2001 – 2005⁷.

Year	Hash	Marijuana	Heroin ⁸	Amphetamine	Ecstasy	LSD	Cocaine
2001	5516	1640	1271	5733	632	28	328
2002	6490	1694	1052	6779	632	31	440
2003	6526	1717	1057	6671	488	18	545
2004	6686	1416	900	6733	411	17	524
2005	6829	1516	804	6499	381	32	546

⁷ Until 2003 the police and customs presented a common annual statistics on drug seizures. This has ceased and the SNIPH obtains plain figures separately from the agencies. The figures from 2004 and onwards could have higher degree of uncertainty than previously.

⁸ Number of seizures of White and Brown heroin.

Price/Purity

- Price of drugs at street level

An updated report on the drug price development is presented by CAN (Guttormsson, U. 2006b). Compared to the figures presented in last years NR the only notable difference is that the price for white heroin (median, adjusted to 2005 monetary value) has dropped from 2099 SEK/gram in 2004 to 1350 SEK/gram 2005. For brown heroin the price increased from 1004 SEK/gram in 2004 to 1200 SEK/gram 2005.

- Purity at street level and composition of drugs/tablets

No new information available

Part B – Selected issues

2.1 Drug use and related problems among very young people (<15 years)

Epidemiology of drug use among very young people: prevalence and patterns of drug use; risks, correlates and consequences

2.1.1. Drug use and problematic drug use among very young people (< 15 years old)

The Swedish Council for Information on Alcohol and other Drugs (Hvitfeldt and Rask 2005) has carried out representative national school surveys every year since 1971. The surveys comprise grade 6 (age 12–13 years) and 9 (age 15–16 years) of compulsory school and grade 2 (age 17–18 years) of upper secondary school. The surveys are carried out as anonymous group questionnaires in classrooms. After 1983, surveys of grade 6 have been carried out every two years. In 2005, 3,181 pupils from grade 6 participated. According to the findings, it is very unusual for pupils in grade 6 ever to have used narcotics. Since the surveys started in 1971, prevalence has been low – about 1 per cent of both boys and girls have used narcotics. Grade 6 pupils who have used narcotics have mainly tested it only once. Most of the pupils in this grade have never had an opportunity to test narcotics and most of them do not know anyone who could give or sell them narcotics. In the 2005 survey, 3 per cent of the boys and 4 per cent of the girls answered that they had had an opportunity to try narcotics; about 6 per cent believed or were certain that they knew someone who could give or sell narcotics to them.

Another study by the Swedish Council for Information on Alcohol and other Drugs (Andersson, Barbro 2003) investigated the drug habits of Swedish adolescents from grade 6 to grade 9; 4,000–6,000 pupils per grade participated. The study is a non-longitudinal cohort study. Data were collected via questionnaires answered in classrooms. The findings show that very few pupils – about 1 per cent – in grade 6 (age 12–13 years) have used narcotics, that 2 per cent of those in grade 7 (age 13–14 years) have done so and that the figure for grade 8 (age 14–15 years) is 7 per cent. The level of use of narcotics in grade 6–8 is almost the same among boys as among girls. Most of those who have used narcotics have used hashish or marijuana. Less than 1 per cent in grade 8 answered that they had used any one of amphetamines, smokable heroin, cocaine, LSD and ecstasy. In grade 7, lifetime prevalence of narcotics (2 per cent) is almost identical to last-30-days prevalence. In grade 8, use of narcotics among both boys and girls in the last 30 days (2 per cent) is lower than the lifetime prevalence (7 per cent) of narcotics use. About 20 per cent in grade 7 believed or were certain that they knew someone of their own age who had used hashish or marijuana; in grade 8, the corresponding figure was 50 per cent. There were almost no differences between the genders in this respect. A few per cent of the pupils in grade 7 answered that they believed or were certain that they knew someone of their own age who had used narcotics other than hashish and marijuana. In grade 8, 18 per cent answered that they believed or were certain that they knew someone of their own age who had used amphetamines, ecstasy or LSD, and 16 per cent answered that they believed or were certain that they knew someone who had used heroin, cocaine or crack. The mean age for first use of narcotics is 14.3 years.

Summary of main findings:

Few studies of drug use among very young people have been done in Sweden. The findings from the existing studies show that few individuals use or have tested narcotics according to themselves. If they have tested or are using narcotics, it is most likely cannabis they use. Gender differences are small. The use of narcotics seems to increase between grade 7 and 8.

2.1.2 Provision of additional TDI Data tables on outpatient/inpatient clients only for people < 15 years with breakdown by single year

- The national treatment-documentation system does not yet cover the special youth services.
- Approximately ten adolescents under 15 years of age (= 0.2–0.3 per cent) have been reported in the past five years by units focusing mainly on adults.
- 80 per cent of these adolescents were 14 years old.
- The gender distribution was mainly even.
- The primary drug was cannabis in 70 per cent of the cases.

Please note that the above information should by no means be regarded as representative of the national situation.

2.1.3. Profile of main groups of young people at risk of drug use and of problematic drug use

No studies, to our knowledge, have investigated the profiles of the main groups of young people (< 15 years of age) who are at risk of drug use.

However, a survey on an issue similar to this has been carried out in grade 9 (age 15–16) of compulsory school and grade 2 (age 17–18) of upper secondary school. (El-Khoury and Sundell 2005) report on risk factors for norm-breaking behaviour and differences between girls and boys during adolescence. The data for the survey were collected at schools in Stockholm in 2004, and 10,113 boys and girls answered the questionnaire. The questionnaire included questions about tobacco, alcohol and other drugs, crime, inadequate adjustment to school and other factors which prior research had proved to increase or decrease the risk of various norm-breaking behaviours. Six norm-breaking behaviours were in focus: current use of smokable and/or smokeless tobacco ('snus'); current use of alcohol for the purpose of intoxication; lifetime use of narcotics; crimes associated with a poor prognosis (burglary, robbery, car theft) committed during the past year; truancy for at least one whole day during the present school year; and bullying of other pupils during the present school year. The findings show that the risk factors were overall the same for both girls and boys. Only for one norm-breaking behaviour – serious crime – could an obvious difference involving more risk factors among boys than among girls be seen. Single risk factors seemed to have limited influence on norm-breaking behaviour, while pupils with many risk factors (independently of which ones) often manifested norm-breaking behaviours. Some risk factors appeared to be more important than others, namely: having been intoxicated before the age of 13; spending time with socially maladjusted peers; and having parents who do not know where the adolescents spend their weekends. Three risk factors (parental level of education, parental unemployment and immigrant background) seemed – independently of the type of analysis made – to lack importance for the six norm-breaking behaviours. These findings are similar to those of international research. Between 49 and 68 per cent of the variance in use of narcotics (at least once) could be explained. Two risk factors increased the overall risk: low age at first intoxication and socially maladjusted peers. The risk of narcotics use among boys and girls in grade 9 and among boys in grade 2 of upper secondary school increased when the pupils did not feel themselves to be Swedes. Having parents who do not know their adolescents' whereabouts during weekends was a statistically significant risk factor for drug use among pupils in grade 2 of upper secondary school. Less serious crime also seemed to be a risk factor for boys.

Surveys from 2000 and 2001 in Trelleborg, a medium-sized town on the south coast of Sweden, have investigated social capital and substance use among Swedish adolescents as well as peer effects on adolescent substance use. Cross-sectional survey data from Trelleborg on Swedish adolescents (1,719 questionnaires were collected) aged 12–18 were used to estimate the link between individual social capital and smoking, illicit-drug use and binge drinking (Lundborg 2005). The major conclusions drawn from the study were (1) that social capital (as indicated by measures of social participation and trust) was negatively correlated with the probability of smoking and illicit-drug use but (2) that social capital showed no statistically significant correlation with the probability of binge drinking. Another published study by Lundborg (Lundborg 2006) showed that significant and positive peer effects were found as regards binge drinking, smoking and illicit-drug use among pupils in grade 6–9 of compulsory school and in grade 1 and 2 of upper secondary school in Trelleborg; 3,253 questionnaires were collected for this study.

2.1.4. Correlates and consequences of substance use among very young people

No studies, to our knowledge, have investigated the correlates and consequences of substance use among very young people (< 15 years of age).

However, it is stated in CAN 2005 that 'there is a relationship between experience of narcotics and early intoxication. About 25 per cent of the pupils in grade 9 (age 15–16) who had used narcotics had experienced their first alcohol intoxication at the age of 13 or earlier. The corresponding figure for those who had not used narcotics was 7 per cent. El-Khoury et al. (El-Khoury and Sundell 2005) summarise some of their findings about risk factors and norm-breaking behaviours among older adolescents by stating that the prevalence of risk factors and that of norm-breaking co-varied among the individual pupils. Norm-breaking behaviour such as use of narcotics and bullying appeared only in combination with other norm-breaking behaviour, while tobacco use, alcohol use and truancy appeared alone or in combination with each other. Most of the pupils had not used narcotics, but a small share had used narcotics one, two, three or more times. The risk of most of the other norm-breaking behaviours also increased with the number of times that the pupils had used narcotics.

2.1.5. Policy and legal development

National legal development

There are no recent changes as regards legal approaches for the age group < 15 years, which is discussed in this chapter. The care of young people is regulated by the Care of Young Persons Act (SFS 1990). Measures for children and young persons within the social services are to be undertaken on the basis of agreement with the young person concerned and his or her custodian as provided in the Social Services Act (SFS 2001:453). The Care of Young Persons Act lays down conditions for e.g. the provision of care, immediate commitment to care, the nature of the care, special powers, the termination of care, preventive measures, measures to prohibit custodians from removing a young person from an institution, medical examination, procedural issues, appeals, police assistance and fines.

In August 2006, the National Board of Health and Welfare issued a General Advice document (Socialstyrelsen 2006b) with recommendations for the social services on the handling and documentation of matters concerning children and very young persons under the Acts presented above. The General Advice document provides recommendations on e.g. co-operation with other authorities, information and notification, investigation plans, contacts with experts, treatment plans and implementation plans.

Special regulations and level of enforcement of alcohol and tobacco restrictions

The legal age for buying tobacco products and low-strength beer (in the 2.25–3.5% alcohol range – the strongest alcoholic beverage sold outside the retail monopoly in Sweden) is 18 years. The age limit for buying alcohol at the Swedish monopoly stores is 20 years. However, the age limit is 18 years for drinking alcoholic beverages in restaurants, pubs and similar recreational settings.

As reported in previous NRs, strong efforts are being made to prevent underage persons from purchasing tobacco and/or alcohol. Responsibility for monitoring compliance with the legislation rests on the local authorities and the police. This applies to the whole range of settings where alcohol or tobacco is being legally sold. If the police can prove selling to underage persons of controlled alcoholic beverages or tobacco products, legal action is taken. The staff selling the product is fined or sent to prison for a maximum of six months. The owner may also be prohibited, under penalty of a fine, from marketing tobacco or beer for a given period of time. As regards tobacco, a handful of cases occur annually for each of the scenarios. Prohibitions to sell beer have been issued in about 15 cases annually over the past eight years. This appears to be a surprisingly low figure against the background of the data presented below on successful test purchases made by underage persons, since store management must be considered a main issue in compliance with the legislation. The number of staff accused of selling beer to underage persons is not available, but the number of warnings issued to owners and/or managers has been around 60 annually for the past six years (Statens folkhälsoinstitut 2006).

Unfortunately, compliance with the legislation appears to be low. For several consecutive years, a Good Templar's youth organisation has let underage members try to purchase 2.25–3.5% beer at grocery stores. Year after year, they have succeeded in buying beer in about 50 per cent of cases. In 2004, an extensive national test study where underage persons tried to purchase beer at grocery stores was carried out on two occasions. The study was initiated by the National Committee for the Implementation of the National Action Plan on Alcohol, the Swedish National Institute of Public Health and the Swedish Food and Drink Retailers' Federation. In the spring of 2004, purchases were successful in 51.4% of cases. The share in the autumn was 45.6%, despite extensive information efforts having been made in the meantime (Regeringens proposition 2005a). Similar results are obtained in the tobacco area when NGOs or researchers let young persons (age < 18) make test purchases. Apart from bad publicity, however, there are no legal consequences for the establishments in these cases, since entrapment is not allowed in Sweden.

To minimise the risk of selling to people under the age of 20 at the stores of the Swedish alcohol-retailing monopoly (Systembolaget), the staff must ask anyone who looks as though they may be under 25 to show proof of age. These age-verification checks are monitored by an external company. Around 5,000 test purchases are made every year by people aged between 20 and 25, and the results are recorded. The results have improved each year since test purchases began in 2001, when proof of age was requested in approximately 80 per cent of test-purchase cases. In 2005, staff asked for proof of age in 89 per cent of test-purchase cases (Systembolaget 2005).

Specific regulations on volatile substances

In 1977, an ordinance (SFS 1977) was issued on the selling and storage of certain volatile solvents, etc. It specifically regulates the storage and selling of volatile solvents or goods containing volatile solvents which, when inhaled, cause intoxication or could be suspected to cause intoxication. Such solvents or goods must not be sold when it could be suspected that they are purchased to be used for intoxication. To prevent the use of the solvents and goods referred to in the ordinance, the Swedish Medical Products Agency (SMPA) may issue instructions regarding their storage and selling, including an age limit of 18 years for purchasing them. The first instruction ever on this topic has recently been drafted by the SMPA and circulated for comments. A revised draft is presently under consideration.

Strategies and policies for social exclusion, ADD, etc., that refer to drug use among very young people

The issue of early risk-taking in terms of alcohol, tobacco and drug abuse in relation to social exclusion, ADD, etc., is well recognised and discussed at many levels of society. Schools and the social services are key players in the early detection of children in need of care and attention. Both the present national action plan on alcohol and drugs (Regeringens proposition 2005a) and the previous one highlight the issue of special supportive measures for girls and boys belonging to risk groups or exhibiting risk behaviour. The Proposal states that early detection and methods for providing support to children as well as parents must be further developed. The follow-up of the local authorities' work with groups at risk should be improved and the training of staff working with these groups should be developed. The county administrative boards, together with the Swedish National Institute of Public Health and the Swedish National Board of Health and Welfare, will be given the task of improving the follow-up of the efforts which the local authorities make for groups at risk as part of the integrated preventive efforts at the local level.

2.1.6. Prevention and treatment

Specific treatment options for young problematic drug users

Overall, effective treatment for young adolescents with drug-use problems are interventions which (1) are specific to the problem; (2) are structured (manual-based); (3) are based on Cognitive Behavioural Therapy (CBT); and (4) involve the parents. There are several well-researched and effective methods available, e.g. Functional Family Therapy and Multi-Systemic Therapy. However, even if proven effective, family-based interventions have one big drawback: they are expensive and hence availability is limited. In Sweden, Multi-Systemic Therapy is carried out at many locations and a randomised controlled trial is currently under way in the city of Stockholm to investigate the effectiveness of the method.

In the past five years, a clear focus in research on adolescent substance use has been to develop shorter, structured and individualised interventions based on the concept of Motivational Interviewing. Several approaches have been shown to be effective in relation to drug-using adolescents. These methods use a mix of Motivational Enhancement Techniques (MET) and CBT. In order to honour the well-known truth that the parents should be involved in their child's treatment, parent-training programmes are sometimes offered to boost the effect of the individual treatment. These shorter interventions are cost-effective, but there is of course a limit to what can be achieved in the time allocated (5 to 10 sessions). Currently, no such programmes are fully developed in Sweden; however, some are under way, e.g. for treating gambling problems in adolescents at Maria Ungdom, Stockholm.

Over the past 10 years, clinicians have become increasingly aware that a majority of adolescents with drug-use problems also have co-morbid psychiatric problems; this has been confirmed by a large number of studies. The most prevalent problems are conduct disorder, depressive disorders, anxiety disorders and attention-deficit hyperactivity disorder (ADHD).

This poses a great challenge to the treatment providers because of the unique complexity of trying to treat adolescents with dual diagnoses. In most cases, a variety of interventions are needed to help these adolescents, including family-based, individual and community-based ones.

A coming trend is increased use of pharmacological agents in the treatment of young drug users. This could be an effective path for some of the most heavily addicted persons, where no other forms of treatment help to control cravings. Those with dual diagnoses could also be helped by pharmacological agents, which could be effective in reducing symptoms of co-morbid disorders, thereby increasing the chance that the individual can cope with his or her drug-use problem. In Sweden, pharmacological treatment is seldom used as the first treatment option but is likely to be considered when other forms of treatment fail.

On a political level, the treatment of young drug users is undergoing a clear shift. The knowledge that institution-based programmes are seldom effective and could even cause harm (e.g. the adolescent may use drugs more or exhibit more criminal behaviour after institutionalisation than before it) is slowly reaching the minds of policy-makers in the western hemisphere. As a consequence, today we see more of community-based efforts to deal even with the more severe problems of adolescents – problems that most certainly would have led to the institutionalisation of the adolescent only five to ten years ago. These efforts focus on the adolescent's risk factors for substance use and are individually tailored to match the person's specific needs. Treatment is carried out by a network of co-operating providers, including the social services, schools, child psychiatrists, the police, the criminal-justice system and a variety of NGOs.

Institutional responses

The National Board of Institutional Care (SiS) exists for those who are most disadvantaged. Most young persons and substance abusers in SiS institutions have been placed there without their consent because they are in danger of injuring themselves or of ruining their lives. The treatment/care is provided under a judgement issued by an administrative court. There are also cases of voluntary admission under the Social Services Act.

At special approved homes, young persons with grave psycho-social problems are cared for under the Care of Young Persons Act (SFS 1990). The age of the young persons admitted varies from one institution to another but comes between 12 and 21. All the inmates have serious psycho-social problems, often with elements of criminal behaviour and substance abuse. The purpose of the treatment is to help the young person concerned to achieve development and maturity and to equip him or her for a life without violence, drugs and crime. Some institutions are specialised, concentrating for example on young persons with immigrant background, boys with aggression problems or adopted children. Some approved homes admit girls only, others boys only. Methods of treatment vary from one approved home to another, according to the needs of different youngsters. Methods include environmental therapy, functional family therapy, cognitive behavioural therapy and, for substance abuse, the 12-step method. Some approved homes have emergency and examination departments where activities are concentrated on immediately suspending a destructive pattern of living and ascertaining the type of care most suitable for the youngster concerned. All institutions have access to a psychologist, psychiatrist, doctor and nurse. The approved homes also give youngsters the opportunity of supplementing inadequate schooling by studying at compulsory-school level. These activities are supervised by the National Agency for Education, which gives the approved homes very high marks for staffing ratios and teacher competence. Lengths of stay at these residential-treatment centres vary from a few weeks to two years, and care orders have to be reviewed every six months. About half of the admissions are concluded within two months.

About 1,100 adolescents and children are placed at SiS institutions every year. In 2006, there are 33 institutions with 676 institutional places. In 2005, 1,189 adolescents were placed at SiS institutions (under the Care of Young Persons Act or the Social Services Act) – 454 boys and 735 girls. Mean age at registration was 16.6 years. Of these 1,189, 443 (191 boys and 252 girls) were aged 15 or less. 396 individuals were 15 years or younger and registered for care under the Care of Young Persons Act. Two per cent (8 individuals) of these were registered owing to abuse. This figure refers to abuse in general, not specifically to abuse of narcotics (SiS 2006).

Responses in the area of social reintegration

It is difficult to make a general statement about social reintegration because the young (< 15 years) problematic drug users are so few and, furthermore, because the data on drug abuse and social reintegration are very limited.

The National Board of Institutional Care presented a report (Nordqvist 2005) based on interviews with 197 adolescents who were 11–20 years old (mean age about 15 years) when they were registered by the SiS as having an adolescent drug-abuse diagnosis. After discharge from SiS institutions, the adolescents had better mental health, were less frequently involved in criminal gangs and were less criminally active. The findings presented in the report also indicate that the adolescents used narcotics slightly more at the time of follow-up than they did at the time of registration. Even though the findings show a general decrease in reported problems, there is a need for ongoing care after discharge since many of the adolescents still exhibit criminal behaviour or drug abuse. Their mental-health problems often remain and they have difficulty in maintaining behavioural changes after discharge.

Please note that above-mentioned report covers adolescents who are both older and younger than 15 years and that they have multiple problems.

Trends and changes in recent year

According to the National Board of Health and Welfare, there is limited information about young people (< 15 years of age) who have been taken into custody owing to drug abuse. Therefore it is difficult to analyse trends and changes.

Early-intervention strategies and indicated prevention for at-risk children

In 2005, the Swedish National Institute of Public Health was commissioned by the Swedish Government to set up a task force to carry out the previously proposed plan for the implementation of alcohol and drug prevention at schools. Annual reports are to be presented to the Government, with a final report to be submitted when the task has been concluded at the turn of the year 2007/2008.

The aims of the plan for the implementation of alcohol and drug prevention at schools are:

- Provide all local authorities with information about the value of a policy on alcohol and narcotics at school.
- Provide all school managers (headmasters) with knowledge about the value of a new focus for alcohol and drug prevention at schools.
- Inspire local authorities to take responsibility for stimulating schools to create policies for the promotion of pupil health and for the prevention of alcohol-related harm, drug abuse and other risk behaviours.
- Make in-service training on prevention available to teachers and other school staff.
- Produce and disseminate guidelines and other material necessary in the information and training process.

Early identification and treatment for attention-deficit disorders / Training for GPs, paediatricians, social services and families to adequately identify and respond to risk profiles like ADD, CD, ODD

Child Health Care:

Sweden has a high rate of visitors within the special child health-care services (about 95–98 per cent of all families with children are reached) and thereby good conditions for detection of health deviations among most children. Guidelines from the National Board of Health and Welfare (Socialstyrelsen 1991) state that one aim of the child health-care services is to identify children with significant developmental deviations or behavioural problems. These guidelines stress the importance of finding children who will need support when they begin school. Today, examinations for this purpose are actually carried out at schools since a majority of children begin school at the age of six (and not at seven, as used to be the case). These examinations should identify children with attention-deficit hyperactivity disorder (ADHD) (even if ADHD is not explicitly mentioned in the guidelines). No specific screening method for finding children with ADHD is mentioned.

School Health Care:

Like the above-mentioned child health-care services, the school health-care services have very good coverage. Newly written guidelines from the National Board of Health and Welfare (Socialstyrelsen 2004) stress the importance of the school health-care services being 'a major player in the health-promotion work addressed by society to children and adolescents'. Part of this work is 'to identify pupils with increased vulnerability and to determine where this vulnerability comes from'. Pupils with increased vulnerability are for instance 'pupils with functional disabilities such as ADHD'. Health checks carried out when pupils begin school will be so designed that pupils with such problems are identified. No detailed proposals as to how those problems will be identified are mentioned.

It is also emphasised that pupils with acting-out behaviour (ODD, etc.) are at particular risk of continued development of problems and that it is therefore important for such problems to be highlighted in drug prevention at schools.

Overall, there are good intentions as regards detection, but also a lack of possibilities to offer evidence-based treatment methods. Parental education/training for parents of children who are classified as at-risk children with acting-out behaviour problems is underway. The likelihood of a child becoming the subject of investigation once the child or school health-care services have identified problems varies across Sweden, as does the likelihood of obtaining specific care and treatment. The number of school-age children who receive medication for ADHD problems has increased greatly in Sweden as well as in other Northern European countries. As regards children diagnosed with ODD/OC, there is a more pronounced lack of powerful efforts.

Selective prevention for families at risk

'Individual and family services form part of social services and are generally directed by the municipal [local-authority] social-welfare committee, although other committees occur. This work is primarily governed by the Social Services Act, with voluntary participation, self-determination and participation as important underlying principles. The work of individual and family services primarily covers persons who require social assistance to attain a reasonable standard of living, initiatives relating to children who need support and protection and their parents, substance abusers and homeless persons. Under the Social Services Act, the social-welfare committee must endeavour to ensure that children and young persons grow up in secure and good conditions. (Socialstyrelsen 2005).

2.2 Cocaine and crack – situation and responses

Summary.

There is still no strong indication that cocaine is established among regular and problematic drug abusers. Most users are found in clubs, flashy restaurants and dance halls.

Cocaine has not gained any popularity among problematic drug abusers (who prefer amphetamines or heroin), and it is also not used as a recreational drug by common people. During 2005, the first anecdotal rumours have appeared that cocaine may be attracting 'ordinary' people in the bigger cities. This, however, is at a low intensity, as party-goers remain the main group of users. It seems as though cocaine and parties are linked.

The annual number of seizures of cocaine increased from 20 to 100 during the 1980s, and the amount seized went up from 2 to 5 kilos. From this rather low level, there has been a progressive – but not steep – increase up to date. Out of a total of nearly 19,000 arrests for drug-law offences in 2005, slightly over 1,000 were related to cocaine.

Very few people seek treatment for cocaine abuse, and when people with experience of cocaine come to the attention of the treatment system they have symptoms deriving from other drugs which are in greater need of care. Crack is extremely rare. Out of 56 treatment cases (46 men, 10 women) with a primary diagnosis of cocaine abuse during 2005, only three were crack cases.

Sniffing/snorting is the common cocaine-use technique. We lack data on doses. Mortality data for 2004 and 2005 are still missing. Cocaine has not yet led to any alarms being sounded by emergency departments, unlike e.g. GHB/GBL.

Cocaine has not escalated into a problem forcing the authorities to take special action. There have been no information campaigns, nothing special has happened in the treatment sector and nothing that could be defined as harm reduction.

The police have started a thorough investigation of the cannabis market in Sweden to find out how and by whom the drug is transported into the country and then how and by whom it is handled within the national borders. The findings will be presented in late 2006, but it has already been said at conferences and in the media that over 100 groups are involved in this traffic. Today, cocaine has expanded on the European illegal market, which means that it might be cheaper and easier to take it into Sweden. This may explain why prices are a bit lower than a few years ago and also why cocaine is more often noticed and talked about.

2.2.1. Prevalence, patterns and trends of cocaine and crack use

Cocaine use among the general population

There is still no strong indication that cocaine has established itself on the illegal market among regular and problematic drug abusers. Most users are found in clubs, flashy restaurants and dance halls. This is also the main target for police work aimed at cocaine and other club drugs. In Stockholm, a specially trained team has been operating since 1996. It was originally called the Rave Commission because it was set up to take action against the use of ecstasy, which was then being sold and used at rave events in parts of the country. Over the years, this police team has trained colleagues from many parts of the country, apparently with success. In the past year or two, this team has reported that cocaine is on the rise in recreational settings of the kind in question. Ecstasy, on the other hand, has lost most of its original popularity.

Cocaine has not gained any popularity among problematic drug abusers (who prefer amphetamines or heroin), and it is also not used as a recreational drug by common people (not even cannabis has reached that group). Its use is more or less restricted to 'brats' (in its Swedish sense of wealthy and ill-mannered young people from the upper classes) and wannabe brats. During 2005, the first anecdotal rumours have appeared that cocaine may be attracting 'ordinary' people in the bigger cities. This, however, is at a low intensity, as party-goers remain the main group of users. It seems as though cocaine and parties are linked.

The development can be followed by means of annual reports from the police and customs authorities as well as through surveys. A regular survey among professionals is also carried out and reported on twice a year.

The annual number of seizures of cocaine (CAN 2006) increased from 20 to 100 during the 1980s, and the amount seized went up from 2 to 5 kilos. From this rather low level, there has been a progressive – but not steep – increase up to date. Only two years are exceptions to this trend: 225 kilos seized in 1991 and 420 kilos seized in 1999; both cases can be explained by a few spectacular interceptions of parties meant for other European countries. The 1990s followed the same trend. In 1990, 80 seizures were made and the amount of cocaine seized was 9 kilos.

In 1998, there was an increase in the number of seizures (but not in the amount seized, 19 kilos). The most likely explanation is user-oriented police work. This is manifested very clearly by the 1999 results. The number of seizures was then 346 (305 made by the police), and in 2004 this had escalated to 524 seizures of a total of 29 kilos (468 seizures made, and 7 kilos seized, by the police). In 2005, 546 seizures were made and a total of 34 kilos confiscated (505 seizures and 6 kilos accounted for by the police).

Surveys among the general population are carried out at schools (years 6, 9 and 11 – i.e. ages 12, 15 and 17), among military conscripts (18-year-olds, mostly men), among young people aged 16–24 and in the entire population aged 15–75. Only the year 9 survey and the conscript survey are carried out annually. The year 11 survey has recently been added, and it seems that it too will be carried out annually.

The latest survey of the general population aged 15–75 was carried out as long ago as in 2000, which makes its value questionable.

The military-conscript study of 2004 (Guttormsson, Ulf 2005) showed that 1% had experience of cocaine (to be compared with 14% for cannabis and 2% for amphetamines). Among those conscripts who had used any illegal drug (15% had done that), 7% had used cocaine (to be compared with 93% for cannabis and 13% for amphetamines). Although the number of users in this age group is too small for any far-reaching conclusions to be drawn, those who use cocaine seem to find it attractive and not too dangerous to use. They can also afford the price.

The findings from the 2005 survey of military conscripts (Guttormsson, U. 2006a) show a very similar picture: 1% had used cocaine (13% cannabis and 2% amphetamines); among those who had used illegal drugs, 7% had used cocaine (94% cannabis and 12% amphetamines).

According to a report based on interviews with young people aged 16–24 years carried out in 2003, 7% of those with experience of illegal drugs acknowledged that they had used cocaine (CAN 2004). Obviously, those in this age group who have used it are the older persons. People aged 22–24 are the heaviest users of drugs. In general, those aged 18 or older use drugs twice as much as those who are younger. According to the findings of a range of surveys over the years, only 0.3% took cocaine the first time they used drugs. The overview presented does not show how large shares of the total sample have used individual drugs.

Crack cocaine is reported to have been used, but we have no hard data on this. Professionals believe it to be rare, according to regular (twice a year) surveys of key persons across Sweden.

Cocaine use among school students

Annual surveys have been carried out in year 9 (age 15) since 1971. In addition, annual surveys were carried out in year 6 (age 12) between 1971 and 1982. Since then, such surveys have been carried out every second year. As a consequence, in 2005 surveys were carried out in both year 6 and year 9. Surveys have also been carried out in year 11 (age 17) in 2004 and 2005. All these surveys cover drugs (legal and illegal), alcohol, tobacco, doping agents and inhalants. Nowadays, they also deal with gambling.

The findings from year 6 are at a very low level when it comes to drugs. Less than 1% (decimals are not used) have tried drugs.

In year 9, 7% state that they have used drugs. This share has been the same for three years in a row, and it has fallen in recent years. There are no gender differences. The share who had used drugs in the most recent month was 4% for boys and 3% for girls. The figures for cocaine are extremely low: 0% for boys and 1% for girls (decimals are not used in the report).

Respondents were asked if they knew somebody of their own age who they thought had used a certain drug; 7% (no gender differences) said they knew a friend who had used cocaine. That should be compared with the much lower share of actual cocaine users in the total sample for this age group. Respondents were also asked if they would be able to buy a certain drug on the illegal market; 8% (no gender differences) said they knew how to buy cocaine.

In year 11, gender differences appear: 17% of the boys and 13% of the girls have used drugs. Cannabis dominates their experience; with cocaine accounting for less than 1% (no decimals are used). When asked if they knew somebody of their own age who they thought had used a certain drug, 12% (no gender differences) said they knew a friend who had used cocaine. 14% of the boys and 12% of the girls said they knew how to buy cocaine (Hvitfeldt and Rask 2005).

Prevalence and patterns of use among specific populations

Cocaine use is a metropolitan phenomenon. In Stockholm, a project ('STAD-projektet') has been running for ten years to develop and implement prevention methods, not least in the flashy restaurants, bars and clubs of the inner city. In 2002, a survey was conducted among staff in these establishments (Gripenberg 2002a): 82% reported that they had noticed drug-intoxicated guests, 48% had seen actual drug trafficking and 46% had seen drugs being taken. All of this had happened on the premises.

The study showed that not only guests use drugs: 77% of staff reported that they had been offered drugs on the premises. 44% had been offered cocaine. 60% acknowledged that they had used an illegal drug, most often cannabis (56%). The second-most common drug was cocaine (27%). Gender differences were minimal. Younger staff (below 30) was more experienced. This group admitted to a dilemma: they were less likely to order an intoxicated guest to leave the establishment.

A parallel report from the same project (Gripenberg 2002b) shows that the most common illegal drugs in the restaurant setting are cocaine, amphetamines and ecstasy. Different groups in the restaurant trade and the police have made the same observation: party drugs are more common today than a few years ago. They also see a link between drug use in bars and night clubs on the one hand and criminals, weapons and drug trafficking on the other. Staff say that they are sometimes afraid when traffickers visit their establishment.

Cocaine is the most glamorous and expensive of the party drugs mentioned. The most popular places are also those where party drugs are the most common. Moreover, these places are the most expensive ones to visit. The establishments with the longest queues

outside of people waiting to get in are therefore sure to catch the eye of the plain-clothes police (the Rave Commission). The choice of music may indicate which type of drugs will be the most prominent: reggae tends to go with cannabis and techno with ecstasy.

All establishments which participate in this project have modified their interior layout (not least the toilets) to minimise the risk of drug use. Staff is also undergoing courses on how to handle the problem. Experience from this project has been passed on to other cities; the Swedish National Institute of Public Health is involved in this process.

In recent years, there have been several reports on young people's lifestyles and drug use. If cocaine is mentioned at all in these reports, it is only briefly.

2.2.2. Problems related to cocaine and crack use

Treatment demand for cocaine

Very few people seek treatment for cocaine abuse, and when people with experience of cocaine come to the attention of the treatment system they have symptoms deriving from other drugs which are in greater need of care. Crack is extremely rare. Out of 56 treatment cases (46 men, 10 women) with a primary diagnosis of cocaine abuse during 2005, only three were crack cases. Patients are primarily in the 25–29 age range, with females on the younger side. While daily use is rare, these patients seem to have been involved in regular use. Most often their first contact with cocaine happened when they were 15–24 years old, with 15–19 being the most common age range. This means that those with a treatment history made their debut earlier than cocaine users in general.

Sniffing/snorting is the common cocaine-use technique. We lack data on doses. Newspaper interviews with cocaine users in the club world indicate that alcohol consumption and the party atmosphere increase the intake. Alcohol is the second-most important drug among these patients, and in third place come other stimulants (amphetamines); this points in the direction of a party-going population. Intravenous abuse is uncommon among these patients (and even more uncommon among cocaine users who have never undergone treatment for cocaine abuse).

Other problems related to cocaine use

Mortality data for 2004 and 2005 are still missing. Older data will not give an accurate picture, as cocaine has been very rare in the reporting systems. Not until 2005 did signs of a problem appear, and then only in the form of anecdotal data. However, a cohort study of drug-related deaths is being performed; this will produce more detailed information.

Cocaine has not yet led to any alarms being sounded by emergency departments, unlike e.g. GHB/GBL. Overall, not much is known about cocaine use in Sweden.

2.2.3. Responses and interventions to cocaine and crack use

Treatment for cocaine

There is a tendency to see similarities between different forms of substance abuse. When a (young) person coming in has a history of substance abuse but the substance is new, he or she is dealt with using the common methodology known at the treatment centre. Nearly all treatment takes place at walk-in clinics administered by social authorities and manned with social workers. Acute cases are handed over to the medical profession at special clinics or hospitals, where different forms of substance abuse are given special care. It is common for medical care to be followed by contact with counsellors within the social services.

There are reports from other countries (e.g. the United States) of heroin abusers and also methadone patients being concomitant users of cocaine. This is not the case in Sweden.

Crack abuse will, typically, be regarded as a matter for the medical profession and will certainly be handled by drug-specialised units at hospitals and later by walk-in clinics for drug abusers.

The Swedish National Board of Health and Welfare will present national guidelines for the treatment of alcohol and drug problems during 2007. These guidelines will contain recommendations for the treatment of the abuse of different substances, including cocaine.

Harm-reduction responses to cocaine

Harm reduction of the type occurring in most EU countries is not common in Sweden although it is now possible for the counties (which are responsible for health-care) to open needle exchanges if the social authorities of the county accept it. So far, no counties have done so. This means that there are only two needle-exchange programmes, which have been running as an act of disobedience since the mid-1980s.

Cocaine has not escalated into a problem forcing the authorities to take special action. There have been no information drives, nothing special has happened in the treatment sector and certainly nothing has taken place that could be defined as harm reduction.

Law-enforcement activities in response to cocaine use

The Swedish Prosecutor-General has presented a report where illegal substances are categorised according to the risks they pose based on eleven criteria (Åklagarmyndigheten 2005a). This report is intended to help prosecutors and courts to decide on proportional reactions in drug cases. It was developed because of difficulties in finding a proper reaction to drugs not well known by authorities. Cocaine was one of these 'new' drugs. It was placed on a level with amphetamines but not considered to be as dangerous as heroin. Otherwise, no special actions targeting cocaine have been taken.

Policies and strategies in response to cocaine use

During 2007, national guidelines for the treatment of alcohol and drug problems will be issued by the Swedish National Board of Health and Welfare. The Board plans to introduce these guidelines through a series of regional conferences to facilitate their practical application. Given that the guidelines place much greater emphasis on differences in treatment response according to the substances used, treatment settings, etc., cocaine will be highlighted even if treatment demand so far has been low. This is to be welcomed, since there have been indications in 2005 (and more distinct ones in 2006) that cocaine is becoming more common on the illegal market – and possibly also as regards treatment demand.

2.2.4. Cocaine-related crime and cocaine and crack markets

Cocaine-related crime

Out of a total of nearly 19,000 arrests for drug-law offences in 2005, slightly over 1,000 were related to cocaine. The leading drugs were cannabis with 7,940 arrests, amphetamines with 7,149, heroin with 1,178, ecstasy with 1,169 and cocaine with 1,047. These cocaine arrests relate to a total of 546 seizures of 34 kilos in all.

Given that the level of cocaine hydrochloride ranges from 14% to 96% at the street level but is higher when drugs are intercepted at the border, this means that there exists organised crime within Sweden's borders. The question is how big it is. The number of persons arrested gives no definitive answer, as most of them are arrested for small-scale possession. In seizures by the customs authorities (most of the cocaine arrives by air with couriers or in parcels) of at least one kilo, the degree of purity is normally 75% to 85% at the border, but in 2004 this has decreased to between 33% and 45% (Rikskriminalpolisen and Tullverket 2005). If you consider how many doses and users this will be enough for, it seems unlikely

that all cocaine arriving in Sweden is intended to be consumed here. This is even more questionable given that the police and customs authorities often say that they intercept only 5% of the illegal drugs smuggled into the country. A national investigation in 1998 (SOU 1998:18) estimated that 11% of all illegal drugs were intercepted, and Statistics Sweden (Statistiska centralbyrån 2005) concluded that 8% were. Whatever the proportion, the conclusion must be the same as in the national investigation in 1998: Sweden is a transit country for cocaine. It is also well known that Sweden is a transit country for heroin (to Norway), which strengthens this conclusion.

Cocaine markets

The police have started a thorough investigation of the cannabis market in Sweden to find out how and by whom the drug is transported into the country and then how and by whom it is handled within the national borders. The findings will be presented in late 2006, but it has already been said at conferences and in the media that over 100 groups are involved in this traffic.

Today, cocaine has expanded on the European illegal market, which means that it might be cheaper and easier to take it into Sweden. This may explain why prices are a bit lower than a few years ago and also why cocaine is more often noticed and talked about.

The cocaine market is not believed to need the same kind of organisation, as it is much more geographically restricted to the metropolitan areas and to some other towns, but non-existent in small towns and in the countryside. Unpublished checks of criminal records carried out by the customs authorities several years ago showed very clearly that there existed a clear link to persons of South American origin. Those arrested for possession of cocaine were either couriers or residents of Sweden who very often had links to South America. That might be changing now.

So far, cocaine is being sold and used in flashy surroundings, even though it is not necessarily handed over and snorted within these bars and clubs. Still, the best way to arrest users and dealers is to keep an eye on these establishments.

2.3 Drugs and Driving

Summary

Since 1999, Sweden has a legislation laying down a zero-concentration limit for driving with measurable amounts of controlled scheduled narcotics in the blood. This legislation has brought about a dramatic increase in the number of cases tested for drug driving (DUID). Nevertheless, the situation in Sweden concerning DUID is of great concern and the process towards developing new strategies and methods are of great importance. Strategies to point out are the proposal for extended training in order to receive a driving license and mandatory treatment in cases of driving licence being deprived. Methods used today constitutes above all eye examinations followed by blood or urine test. Techniques still under development are the use of saliva to detect possible drug use.

On the specific issue of cannabis and benzodiazepines very limited information is available. In the period 1988 – 2003 the annual rate of THC is between 20 and 35 percent of all cases of suspected DUID, diazepam between 16 and 33 percent and flunitrazepam between 6 and 17 percent.

Introduction

Considerable European and world research has gone into the issue of drugs and driving already. An EMCDDA literature review in 1999 summarised the studied effects of drug use on driving. The comprehensive Pompidou Group questionnaire in 2001 was answered by 24 countries, including 21 European countries (not LT, LV, HU, LU, MT, SK, BG, RO), and the follow-up questionnaire in 2003 was answered by 11, including LU. The Pompidou Group have just sent out a new questionnaire, now including questions on alcohol, with results to be discussed at a symposium in June 2006. The International Conference on Alcohol, Drugs and Traffic Safety (ICADTS) is held every 2–3 years, with over 200 papers being presented at the last conference in 2004. EU projects are also active:

- ROSITA and ROSITA-2 examine roadside drug testing devices
- CERTIFIED assessed the drugs which caused the highest risk of impairment
- IMMORTAL studied various types of impairment and their related aspects (laws, epidemiology, risk assessment, testing) and their effects on driver licensing.

Co-ordinated by DG TREN, the EU Road Safety Action Programme 2003–2010 (COM (2003)311, s. 5.1.1) encourages continuation of work on the effects of drugs and medicines, with appropriate classification and labelling of medicines which affect driving ability. Meanwhile, the Council Resolution of 27 November 2003 ‘on combating the impact of psychoactive substances use on road accidents’ recommends increased epidemiological monitoring, the exchange of information on best practice by providing information to EMCDDA, targeted prevention campaigns and appropriate measures against drivers under the influence of psychoactive substances. The Commission expert group on drugs, medicines and driving has already made various recommendations and continues to study the matter.

The EU Drugs Strategy 2005–2012 aims to reduce drug-related harm to health and society, and also to ensure a high level of security for the public by taking action against drug-related crime (para 10). For the former, it requests the Action Plans to look at different levels of health risks involved in specific situations, such as driving under the influence of drugs (para 24).

Given careful analysis of the above research, and with the objective of avoiding duplication, EMCDDA wishes to compare and contrast countries’ experiences of people driving after taking a) cannabis and b) benzodiazepines. As most studies concentrate on one drug or all drugs, this study will focus on the two perhaps most significant, yet different substances,

stressing the similarities and the contrasts between them. Both have a high prevalence and are thus the most likely to affect citizens – yet there are fundamental legal differences with one substance being an illicit drug and the other being a conventional prescribed medicine. Benzodiazepines have been rated by CERTIFIED as one of the substances with the highest risk of impairment – higher than cannabis. There are also great differences in the average age groups of the consumers, the detection methods and the prevention methods involved (youth clubs and schools, compared with doctors and pharmacists), as well as public perception of the dangers. Finally, both have until now been some of the most difficult drugs to accurately detect using saliva, which is clearly the method most favoured by the authorities.

The basic legal provisions such as offences and penalties will be addressed separately by an ELDD Topic Overview, but there may be times where a specific description of a law is necessary to illustrate an answer below, for example if collecting samples for prevalence monitoring is illegal.

1. Policy

- a. In the last few years, has your country addressed drugs and driving at national level in the drug policy, the road safety policy, the laws? Please briefly describe any major policy developments, and how they may be particularly relevant to cannabis and/or benzodiazepines.

On which basis were the changes decided – epidemiological studies, evaluations, etc.?

The Swedish Road Traffic Offences Act

Driving under the influence of drugs (DUID) is a criminal offence under the Swedish Road Traffic Offences Act. The first Swedish legislation on driving under the influence of intoxicants other than alcohol was introduced in 1951. The most severe sentence was prison for one year; in cases of mitigating circumstances, unit fines were used. The burden of proof was based on the testimony of the drivers and witness statements about the driving skill and behaviour pattern. A medical examination was furthermore conducted together with analysis of urine and blood samples. Practice demonstrated that it was not uncommon that the physician's conclusion about impairment as a result of narcotics conflicted with the toxicology statement and no charges were brought or the person was cleared if the case went to trial (SOU 2006).

The legislation on driving under the influence of intoxicants other than alcohol was reformed in 1990 with a change of the term 'intoxicants other than alcohol' into 'substances other than alcohol'. This change made it possible to include all substances capable of affecting traffic safety, including soporifics, analgesics and tranquillisers. A driver could be convicted of drunk driving if he or she had been affected by alcohol or other substances to the extent that it could be assumed that he or she was not able to drive in a secure manner. The legislation also made it possible to convict according to two different degrees of severity.

In practice, both the 1951 and the 1990 legislation on drunk driving resulted in conviction only when the effect of narcotics during driving was visible in the individual case. At trial in court, it was often difficult to prove that the intoxication had been of such a degree as was required by the law if no accidents had happened or if the police had not observed dangerous driving. In the beginning of the 1990s, an increased incidence of people driving under the influence of substances other than alcohol was seen. This made it urgent to introduce regulation clearly indicating that narcotics and driving do not go together. A number of parliamentary bills were raised for a proposal of new legislation. The parliamentary bills

contained suggestions of introducing threshold values for different substances correlating with their effect on driving capability. Other suggestions included the introduction of zero tolerance. The suggestion of threshold values was turned down on the basis of the lack of scientific evidence for a correlation between drug concentration in the blood and proven hazard in traffic (SOU 2006).

In July 1999, legislation laying down a zero-concentration limit for driving with measurable amounts of controlled scheduled narcotics in the blood was introduced. The new zero-tolerance legislation included means of transport such as cars, trains, trams and underground trains as vehicles illegal to drive under the influence of narcotics. The definition of 'narcotic drug' is linked to the legislation on controlled substances.

Prescription narcotics constituted an exception if taken according to a certified personal prescription. However, such drivers could be convicted of clinical drunk driving in case of dangerous driving (SOU 2006).

A person with a prescription for a drug can be convicted if he or she has not been able to drive in a secure manner. This regulation also includes classified narcotic substances impossible to detect in blood samples. LSD can, for example, only be detected in urine samples.

Before 1 July 2005, a majority of medicines which are dangerous in traffic were provided with a red warning triangle advising the patient to take caution when driving while using the medicine. New regulation concerning red labelling came into force on 1 July and resulted in the removal of all red warning triangles. The reasons for this were inconsistencies in labelling and the risk that patients might not be aware of the effect of their medicine on driving skills if there was no warning triangle. The red warning triangle was replaced with a written description of the possible impact on driving skills enclosed with the medicine (SOU 2006).

However, the patient is always obliged to inform him- or herself as to whether or not a certain medicine is harmful while driving. The prescribing doctor is also obliged to inform the patient about possible risks according to Section 22 of the Swedish Medicinal Products Act (SFS 1992:859). The Swedish Medical Products Agency's Regulations (1997:10, Section 40) state that the person responsible for prescribing a medicine which may affect driving skills is obliged to carefully inform the patient. Pharmacists are also required to inform patients of possible risks (1997:10, Sections 22 and 45) (Läkemedelsverket 1997).

Concurrently with the legislation on zero tolerance in July 1999, regulation about eye examination came into force (1999:216). The police are entitled to perform an examination of a person driving a motor vehicle, train, underground train or tram in case of suspicion of driving under the influence of narcotics. The eye examination may only include external observation of the appearance of the eyes and their function, and it may only be carried out when there is a suspicion of crime. Technical aids to be used are a 'pupillometer', pen or other similar aids together with a small light. The purpose of the examination of the eyes and their function is based on scientific knowledge of how certain narcotic substances affect the pupil, eye movement and sensitivity to light (SOU 2006).

CNS depressants, PCPs and cannabis affect people's ability to cross their eyes. Enlarged pupils could be the result of abuse of CNS stimulants or hallucinogenic substances. The reverse sign is seen in people abusing opiates, namely reduced size of pupils together with absent reaction to light. The absence of reaction to light is also seen in people abusing CNS depressants and CNS stimulants.

If a legitimate suspicion of crime exists, based on an eye examination, the police are entitled to perform a body inspection together with a blood test according to the Swedish Code of

Judicial Procedure (SFS 1942). In case of refusal to undergo an eye examination, the police are entitled to perform a blood test (Chapter 28, Section 12). According to the Swedish National Police Board Regulation concerning eye examinations, only authorised police officers may perform this test.

In the near future:

- The former traffic minister, Ulrika Messing, has produced a proposal to extend the training required for driving licences. It is suggested that the traditional training in driving under icy conditions should be combined with education on alcohol and narcotics and training in high-speed driving. Such education and training would be a compulsory requirement for receiving a licence to operate a motor vehicle. This change will take effect in 2007.
- The Swedish National Road Administration has suggested that treatment should be given when a driver is deprived of his or her licence. A person who has been deprived of his or her driving licence must perform a driving test before receiving a new licence. According to the new suggestion from the National Road Administration, a driver would be required to undergo education and treatment whenever convicted of driving under the influence of alcohol or other substances.

In cases of driving under the influence of alcohol or narcotics, the ‘Skellefteå model’ will be used. This model assumes that the driver will be more susceptible to support if it is offered soon after the event. Individuals with an addiction will be offered treatment while others will be offered education about their lifestyle and driving under the influence of substances that will deteriorate driving.

2. Prevalence and epidemiological methodology

- a. What prevalence estimates does your country have for drivers who have taken a) cannabis and b) benzodiazepines? How much are they comparable?

Unfortunately, the manner in which data are collected in Sweden concerning DUID does not distinguish among individual drugs. Therefore, the results concerning this question will only give data on the number of reported offences in Sweden for driving under the influence of drugs. See Table 1.

Table B2.3-1. Number of reported offences in Sweden for driving under the influence of alcohol and/or narcotics, 1999–2005 (based on figures available at the website of the National Council for Crime Prevention, www.bra.se).

Reported offences in Sweden	Year						
	1999	2000	2001	2002	2003	2004	2005
	N	N	N	N	N	N	N
Drunken driving including serious offences	13 941	17 115	14 258	14 929	15 351	15 588	15 809
Driving under the influence of narcotics	2	297	3 778	4 662	5 485	6 597	7 416

The number of samples taken from drivers under narcotics suspicion (DUID) was relatively stable in the 1990s. A clear increase has been seen after 1 July 1999. The number of drivers with only therapeutic narcotics in their blood seems to be similar over the years, not influenced by a general increase of drug drivers. More recent figures show a ten-fold

increase in the number of persons driving under the influence of narcotics (see Figure 1) (SOU 2006) .

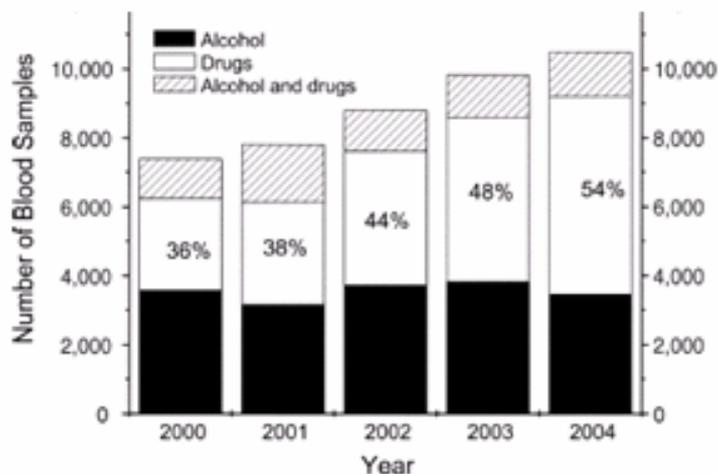


Figure B2.3-1. Number of blood samples submitted for toxicological analysis in 2000, 2001, 2002, 2003 and 2004 with a request for determination of alcohol, narcotics or both. The increasing prevalence of narcotics other than alcohol is evident (Jones 2005)

Diazepam is a commonly detected drug in the findings of analyses of blood samples from impaired drivers. The concentration is mostly in the therapeutic range, but diazepam often occurs together with illicit narcotics. Holmgren et al. carried out a study in 2000–2002 with the aim of examining blood samples from fatally injured drivers. A total of 920 drivers were studied, and in 855 drivers (93%) a toxicological investigation was performed. The proportion of positive samples containing multiple narcotics increased from 10% in 2000 to 26% two years later (Holmgren et al. 2005).

Statistics show that approximately 85% of all blood samples sent for toxicological analysis have one or more banned substances present. Amphetamines are by far the leading drug of abuse in Sweden, and they are identified in approximately 50–60% of all DUID suspects either alone or together with other controlled substances. The second-most frequently encountered illicit drug is tetrahydrocannabinol (THC), with positive findings in about 20–25% of cases. Various prescription narcotics, mainly sedative-hypnotics such as diazepam and flunitrazepam, were also highly prevalent and these occurred mostly together with illicit substances (see Table 2).

In 2000, approximately 29% of 3,809 blood samples contained THC and about 20% contained diazepam. In the following year, THC was found in 25% of 4,651 blood samples while about 19% contained diazepam. In 2002, the percentage for THC was back at 29% (N = 5,051) while diazepam continued to decline (to 14.6%) (Jones 2005).

Table B2.3-2. Most frequently detected narcotics in cases of suspected DUID in Sweden over a three-year period. Presented as percentages (Jones 2005)

Narcotic substances	1988–1990 N = 1,888	1993–1995 N = 2,621	2001–2003 N = 15,707
Amphetamines	45–55	57–60	56–61
THC ¹	20–35	20–26	25–30
Diazepam	27–33	24–26	16–18
Flunitrazepam	10–17	10–15	6–10
Codeine ²	8–11	8–9	5–6
Morphine	9–10	10–11	6–9

¹ From use of cannabis, hashish or marijuana.

² Derived from the metabolism of heroin; the codeine originates from acetylcodeine, a common impurity in street heroin.

- b. Are they regular/ongoing statistics collections, or ad hoc surveys? If a standardised research protocol exists in the national forensic laboratory to analyse fluids of a representative sample of drivers, please describe.

The Swedish National Council for Crime Prevention (Brå) is responsible for the official Swedish crime statistics. Official crime statistics are regulated by the Official Statistics Act (SFS 2001c) and Ordinance (SFS 2001b). Crime statistics are broken down on the basis of the provisions of the Ordinance, offences, individuals convicted of offences, correctional institutes and relapse into crime. Offences are furthermore divided into reported offences, solved offences and suspected individuals. The purpose of the official statistics, according to the legislation, is to provide general information, investigation activity and research (Figure2).

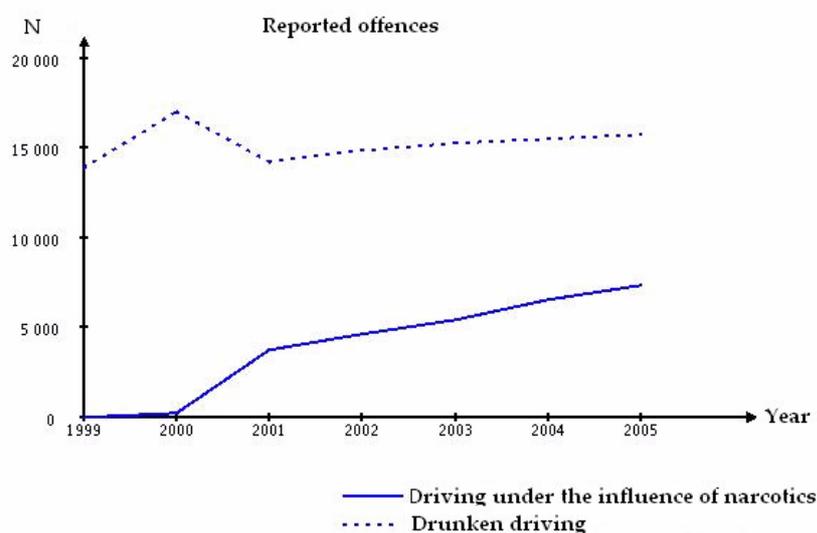


Figure B2.3-2. Reported offences of drunken driving and drug driving, 1999–2005 (based on figures available at the website of the National Council for Crime Prevention, www.bra.se).

[The National Board of Forensic Medicine](#) and its Forensic Toxicology Department
The task of the Board and the Department is to carry out blood and urine analyses to find possible traces of alcohol, narcotics, medicines or other toxins. The Forensic Toxicology Department serves the Board's six Forensic Medicine Departments. Usually, this involves chemical analyses needed by a pathologist performing an autopsy. Over 5,000 requests are

handled every year. The results show that alcohol, prescribed drugs and narcotics – or a combination of these – are present in about 70% of all deaths examined at the Forensic Medicine Departments. Alcohol is present in 45% and narcotics in 40% of cases.

Another task is to analyse blood and urine samples taken from people suspected of drunken driving. The Forensic Toxicology Department handles almost 10,000 such traffic-related cases every year. A new and effective method for tracing narcotics is hair analysis, which can find extremely small amounts of a number of substances. The chemists use a tuft of hair for their analyses.

Intensive work is taking place to develop reliable screening tests to detect other substances than alcohol, mainly on saliva sticks. Two studies have so far shown unsatisfactory results in terms of reliability.

The legislative change in 1999 brought about a dramatic increase in the number of cases of people being tested for illicit narcotics. The number of cases rose from 800 to 7,000 between 1998 and 2004.

- c. Please describe the methodology/ies. Where possible please include sampling strategies (random drivers, suspected drivers, accidents, and fatalities), dates and duration (limited to a certain time of day or week?), sample sizes, characteristics of population, etc.

Offences of driving under the influence of alcohol or narcotics are mostly detected through random police checks. Occasionally, targeted checks are performed at specific sites such as outside (state-controlled) alcohol-monopoly stores and at ferry quays. Between 1996 and 2000, 25% of all reported offences were discovered by the police at routine checks. Approximately 40% were reported through general surveillance, 24% based on information from the public and 10% based on accidents or deviant driving manner (see Table 3) (SOU 2006) .

In the mid-90s, the design of police checks changed: from checks made on specific days, at specific times of day and at specific locations towards random checks. This change may have reduced accuracy, but an increase in checks was seen.

The National Police Board is evaluating the possibility to create a new 'national traffic-safety strategy'. The intention is to create a uniform approach to work on traffic safety nationwide. It has been suggested that 2 million breath analyses should be performed each year. The National Police Board has decided to supply all traffic-police officers and police officers on patrol duty with breath analysers (SOU 2006).

In 2002, the police received a new breathing-test device called Evidenzer. The Evidenzer represents a new generation of instruments for forensic breath-alcohol analysis and is capable of being used both at the police station and at the roadside. The precursor (Intoxilyzer) was useful only at the police station. In terms of precision, both of these instruments have a high standard (Fransson et al. 2005).

The results of all breath-alcohol tests performed nationwide are collected in a central database, monitored by the Swedish National Laboratory of Forensic Science (SKL). The SKL is a government agency tasked to assist the [police](#) in carrying out crime investigations. It performs analyses of samples which have been taken from various sorts of crime scenes. The laboratory has expertise in most scientific disciplines and uses technology to find and preserve [trace evidence](#) and to establish links between people, places and objects. SKL is made up of four units: a biological unit, a drug-analysis unit, a chemical and technological unit, and a documentation unit. The SKL also issues expert opinions to the police authorities in cases where evidence found is questioned. For additional information visit the website of www.skl.polisen.se.

Table B2.3-3. Number of individuals under suspicion of intoxicated driving with tests performed using the Evidenzer, 2002–2003. N = number of analyses and % = proportion of positive analyses (SOU 2006)

Method of detection	2002		2003	
	N	%	N	%
Deviant driving	27	10.4	1,154	16.3
Checks of the state of the vehicle	8	3.1	225	3.2
Invalid inspection sticker	8	3.1	91	3.2
Speeding	12	4.6	190	2.7
Failure to use seatbelt	5	1.9	89	1.3
Running a red light	1	0.4	37	0.5
Ignoring a stop sign			12	0.2
Illegal overtaking			10	0.1
No lights	3	1.2	59	0.8
Tip-offs	46	17.8	1,087	15.4
Stationary traffic checks	15	5.8	381	5.4
Other	26	10.0	660	9.3
Random checks	70	27.0	2,040	28.9
Traffic accident, property damage	12	4.6	255	3.6
Traffic accident, minor bodily injury	4	1.5	85	1.2
Traffic accident, major bodily injury	1	0.4	11	0.2
Traffic accident, no further info	6	2.3	64	0.9
Targeted checks	14	5.4	411	5.8
Other	1	0.4	194	2.7
Number	259	100	7,060	100
Total number	11,257		11,877	

- d. Is there progress towards mandatory testing of drivers after accidents that result in fatalities, as recommended as a common EU standard*? If not, please briefly explain why not? (Lack of political will, legal difficulties, etc...)

According to information from the Swedish National Police Board, data are collected whenever a forensic autopsy is performed.

- e. Please briefly describe any conclusions, such as age groups, gender, culpability ratings, etc. What are the trends, if any?

Short facts:

- Every fourth fatal car accident is drug- or alcohol-related.
- Almost every third driver to die in traffic is affected by alcohol.
- In fatal single-driver accidents, almost every second driver is affected by alcohol or narcotics.
- At night, especially Friday–Sunday, more than half of accidents leading to death are alcohol- or narcotics-related.
- More than every third driver dying in traffic is 15–29 years of age. They have either driven under intoxication or ridden with a drunken driver. Male drivers are over-represented.
- On average, three funerals take place every week in Sweden as a result of driving under intoxication.
- On average, 300–400 intoxicated drivers are taken into custody every week. However, this is only a fraction of the number of people who actually drive under intoxication.

- The number of intoxicated drivers reported is increasing each year.
- The sentence for driving under the influence of alcohol or narcotics is a unit fine or prison for up to six months. If the offence is regarded as serious, the sentence can be prison for two years

(Statistics collected from the Swedish National Road and Transport Research Institute, www.vti.se).

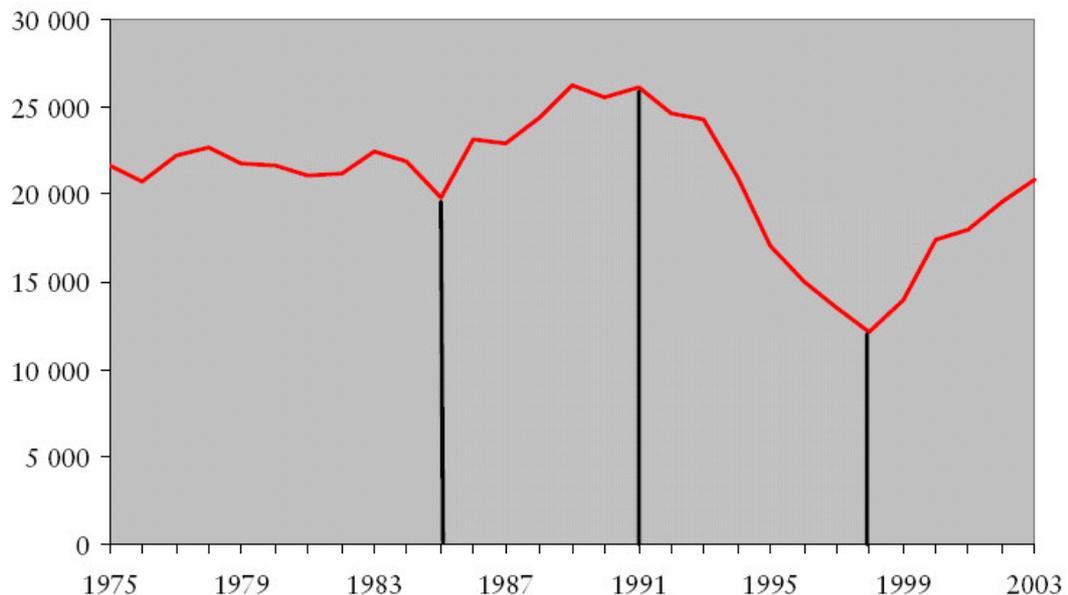


Figure B2.3-3. Number of offences against the law on driving while intoxicated, 1975–2003 (SOU 2006)

Possible explanations for the change:

The three sweeping reforms to the traffic legislation may be the reason for the difference in the number of offences during the 1990s. The 1990 reform involved two different degrees of traffic offences – drunk driving and severe drunk driving – with different sentences. Secondly, the 1990 reform involved a lowering of the limit of alcohol in the blood from 0.5 to 0.2 parts per mille. Thirdly, an integrated assessment of the offence was to be taken into consideration when sentencing, not only the level alcohol in parts per mille. The reform was evaluated and the results showed a decrease in the number of drunk-driving offences by 18% and in the number of fatal accidents by 8% (Norström and Andersson 1996).

The next reform in 1994 concerned lowering the limit for severe drunk driving from 1.5 to 1.0 parts per mille, and the maximum sentence was increased from one year to two years. The subsequent evaluation showed a continued decrease in the number of drunk-driving offences, fatal accidents and single-car accidents (BRÅ 1998).

The introduction of the 1999 legislation laying down a zero-concentration limit for driving with measurable amounts of controlled scheduled narcotics in the blood was followed by a huge increase in the number of offences involving driving under the influence of narcotics. In 1999, only two reports of driving under the influence of narcotics were seen; in 2000, the figure had risen to approximately 300 cases. But an even greater increase was to be seen. In 2001, the total number was 3,800; and in 2003, the corresponding figure had increased to 5,500.

Another explanation for the increase of offences in 2000 could be the targeted police checks as a result of Saturday opening at the state-controlled alcohol-monopoly stores (Norström and Skog 2001).

The increase in targeted police checks in the Stockholm region could also give some of the explanation for the increase in offences over the past few years.

However, the above-mentioned changes in the legislation on traffic offences do not explain the entire increase in offences over the past couple of years. There has most likely been an increase in the number of individuals driving under the influence of alcohol or narcotics over the years. A probable correlation could be seen with the increase in alcohol consumption in Sweden over the past years (Kuhlhorn et al. 2000).

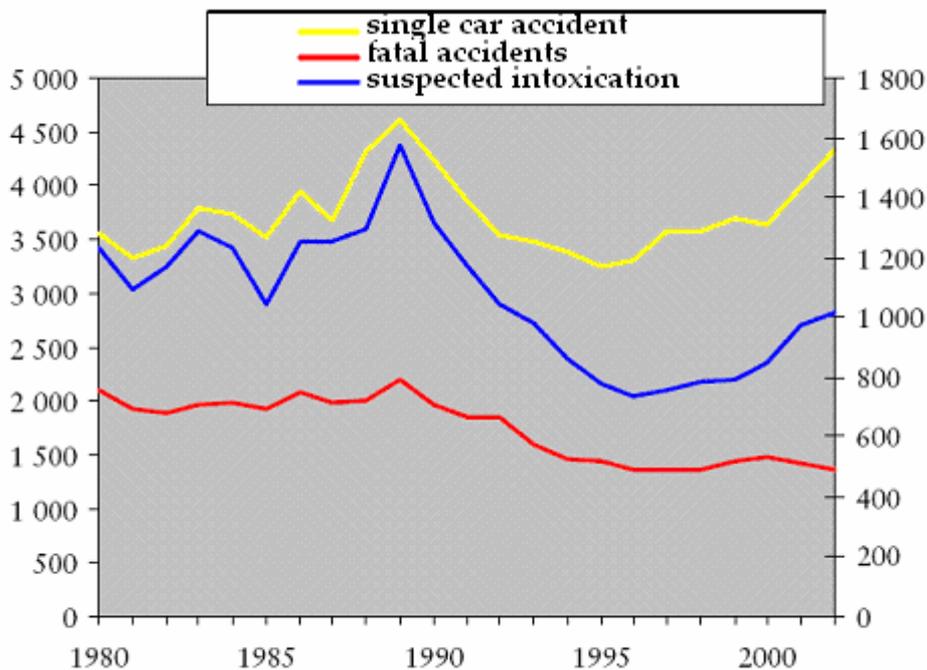


Figure B2.3-4. Number of police reports of traffic accidents with fatal outcome (*bottom curve*), all single-car accidents (*top curve*) and the number of drivers suspected of intoxication involved in traffic offences resulting in bodily injury (*middle curve*) in 1980–2002. The number of single-car accidents should be read on the left y-axis and the number of fatal accidents and cases of suspected intoxication on the right y-axis (SOU 2006)

Today, approximately 10% of all offenders involved in driving under the influence of alcohol or narcotics are women. The proportion has increased steadily since 1975, when women represented 4% (see Figure 6). An increase in the number of female drivers together with an increase in alcohol consumption could be explanations for this increase (Kuhlhorn and Björ 1998).

For the first time since 1998, prison sentences for severe drunk driving/drug driving increased at the expense of conditional sentences (see Table 4).

Table B2.3-4. Sentences for violation of the legislation on driving under the influence of alcohol and narcotics in 2003 (SOU 2006)

	Drug driving		Drunk driving		Severe drunk driving		Total	
	N	%	N	%	N	%	N	%
Sentences	158	52.5	836	18.4	5,450	99.1	6,444	62.6
Prison	4	1.3	6	0.1	2,872	52.2	2,882	22.7
Forensic psychiatric care	0	0.0	0	0.0	2	0.0	2	0.0
Probation	5	1.7	10	0.2	1,173	21.3	1,188	13.4
Conditional sentence	0	0.0	5	0.1	1,250	22.7	1,255	16.1
Hand-over to care	1	0.3	9	0.2	30	0.5	40	0.3
Fine	133	44.2	795	17.5	32	0.6	960	9.0
Other sentences	15	5.0	10	0.2	86	1.6	111	1.1
Summary fines	103	34.2	3,646	80.4	6	0.1	3,755	35.9
Abstention from prosecuting	40	13.3	51	1.1	43	0.8	134	1.5
Total	301	100	4,533	100	5,499	100	10,333	100

3. Detection, measurement and law enforcement

- a. Please describe the procedure(s) how the authorities stop vehicles and test drivers for a) cannabis, b) benzodiazepines? Using DRE (Drug Recognition Expert) training, saliva tests, urine tests, blood tests, at roadside, at police station, at laboratory.

Roadside:

In 2005, the police performed approximately 1.8 million breath tests; according to conventional statistics from the Swedish National Road Administration, these tests resulted in 15 fewer people being killed and over 100 persons not being injured. The largest percentage-wise increase in such tests over the past few years concerns drivers influenced by narcotics.

The Swedish National Police Board is at present working on a proposal for a new national traffic-safety strategy. The purpose is to bring about uniform efforts throughout the country to improve traffic safety. The strategy will suggest that the number of intoxication checks performed each year should increase to 2 million (SOU 2006).

When performing drunk-driving checks, the police use a 'screening instrument' which measures the presence of alcohol in a person's breath. In cases of suspicion of narcotics use, the police perform an eye examination using a 'pupillometer' and require blood sample to be taken.

Besides making breath tests and performing eye examinations, the police are instructed to document observations including driving manner, the driver's appearance on site, any statements made by the driver on site and any smell of alcohol from the driver. All these observations together with the eye examination and breath check play an important role for the investigation.

If the suspicion of narcotics use is more profound, the police should search the vehicle for any articles that can be connected to narcotics offences. The police are entitled to confiscate, if necessary.

Witnesses should immediately be identified and questioned about the observed driving skills and appearance of the driver.

Police station:

Blood samples are collected as quickly as possible, since narcotic substances disappear from the blood over time. The analyses performed on the blood cover all narcotic substances, including pharmaceuticals classified as narcotics.

A urine sample is collected if possible; this is of importance for certain narcotic substances which are not detectable in blood samples.

Questioning should be held as soon as possible. If the driver has prescription narcotics, he or she will have to disclose the time of administration, the number of days of administering the medicine, the amount and whether the medicine is taken on a regular basis. Furthermore, the police should be informed of the name of the doctor having prescribed the medicine and should have the prescription shown to them.

A physician can be called upon in cases of difficulty to determine the degree of influence and whether a severe sentence is to be suspected (Åklagarmyndigheten 2005b).

Table B2.3-5. Statistics on tests of intoxicated driving, 1994–2005. Statistics collected from the website of the Swedish Abstaining Motorists' Association (www.mhf.se).

	Number of tests performed/year	Drunk-driving offences	Offences of driving under the influence of narcotics
1994	1,775,800	21,011	
1995	1,484,900	17,078	
1996	1,329,000	15,023	
1997	1,146,144	13,551	
1998	1,031,863	13,398	718
1999	1,064,737	13,398	1,717
2000	1,108,853	16,619	3,805
2001	1,141,192	17,143	4,645
2002	1,280,000	18,975	5,000
2003	1,382,931	20,478	5,429
2004	1,563,000	22,098	6,549
2005	1,761,851	23,138	7,367

- b. For both substances: at what level of drug presence will the driver be charged with an offence? Any, or above certain blood or urine levels (please specify)? Or depending on a doctor's judgement?

Since 1999, Sweden has legislation laying down a zero-concentration limit for driving with measurable amounts of controlled scheduled narcotics in the blood.

- c. Do you have statistics for the past (few) years about how many people have been reported/arrested or how many offences have been reported for drug driving, and if possible for offences involving a) cannabis and b) benzodiazepines? Please provide methodological information on such statistics (e.g. on type of statistical unit (person/offence), counting rules (double-counting), stage in the criminal justice system (police report, prosecution stage, etc.).

Table B2.3-6. Number of convictions and consequences in Sweden for DUID, 2000–2005 (based on figures available at the website of the National Council for Crime Prevention, www.bra.se).

	2000	2001	2002	2003	2004	2005
Prison	4	1	4	4	7	5
Probation	4	5	5	5	10	3
Conditional sentence		3			3	1
Social-services care		2		1	1	
Fines	54	115	117	133	144	153
Penal Code applied	5	8	10	15	10	3
Summary fines	38	79	77	103	112	137
Abstention from prosecuting	41	35	48	40	69	52
Total	146	247	261	301	356	354
Sentences	67	133	136	158	175	165

- d. Is there progress towards mandatory training of police involved in traffic control, to recognise signs of impairment, as recommended as a common EU standard*?

The Swedish National Police Board states that DRE examinations should be performed only by police officers who have undergone special training on 'Drug signs and symptoms' (Rikspolisstyrelsen 1995). An update of this training is under way and the police regulations lay down that each police authority should provide training for police officers. This has led to major differences in the number of police officers entitled to perform eye examinations across the country.

A recent investigation has proposed that DRE should become part of the basic training at the Swedish National Police Academy and be offered continuously to police officers involved in such matters in all districts (SOU 2006). The National Institute of Public Health has responded to this investigation by supporting the opinion that DRE should be implemented at all police-training sites in order to reduce the differences in interventions between police districts.

4. Prevention

- a. How does your country try to prevent the problem of people driving under the influence of a) cannabis, b) benzodiazepines? Training or guidelines for GPs and/or pharmacists, publicity campaigns, enforcement outside nightclubs, provision of alternative transports at nightclubs...

Sweden's drug policy lays down that all drugs classified as narcotics are prohibited and outlawed because of the risks they pose both to the user and to other people. As a result of this, all campaigns are focused on preventing overall drug use, not on specific drugs or certain areas of particular importance.

Swedish National Road Administration

'Don't Drink and Drive' is a campaign and a project aimed at young people and works on a broad basis to prevent the increasing occurrence of driving under the influence of alcohol and narcotics. A number of activities are included, and they all share the objective of providing the strength and insight never to drive under the influence of alcohol or narcotics, to refuse to ride with a driver influenced by alcohol or narcotics and to prevent others from driving when intoxicated.

The project puts a great deal of emphasis on bringing attention to the risks of alcohol and narcotics when driving, it has nationwide coverage, and it is directed towards young people aged 15–24.

'Don't Drink and Drive' is based on emotional messages talking straight to the heart. The activities are a result of collaboration among a number of societal actors – the rescue service, the police, schools, sports associations, etc.

The message is brought home by movies, exhibitions and lectures, where victims appear in person. The purpose is to get people to think and communicate about the risks of driving with alcohol or narcotics in the blood.

The project started in 2003 and will continue until 2007 to start with.

In-depth studies, commissioned by the Government, were initiated in 1997 by the Swedish National Road Administration (SNRA).

A large quantity of information is collected to provide as complete a picture as possible of events before, during and after the fatal motor-vehicle accident. The in-depth studies are carried out by investigators at the SNRA's seven regions in Sweden. When a fatal accident occurs, the SNRA receives a message about it, often from the police. SNRA investigators also keep up to date via the media and other information channels, such as SOS Alarm (the public-service company handling emergency telephone calls).

The data collected contain descriptions of the:

- Scene of the accident – where the vehicles collided or which roadside obstacles a vehicle collided with. Brake marks and wildlife traces could also be important.
- Road – the design of the road or street, any bends or hills, road width, surface type, road signs, road markings, speed limits, visibility and the presence of trees or rocks near the road. Photos are also taken to show the direction of travel of the vehicle(s).
- Vehicle – age and condition of the vehicle together with use of seat belts and presence of airbags. Damage or harm to the vehicle and passenger or other people involved in the accident. It is also important to document the presence of anti-lock brakes.

- Other sources of information – further information is collected through co-operation with the police, emergency services, health services and emergency-breakdown companies, among others. Other important information collected relates to the course and time of events together with the time when the emergency services were contacted. Documentation about the possible influence of alcohol or narcotics is noted together with the road and weather conditions at the time of the accident. Furthermore, information about the course of events after the accident is documented, such as the arrival of rescue personnel and the type of rescue operation carried out.

These in-depth studies have led to increased knowledge about the protection offered by seat belts and other protective equipment. Other results include more measures to reduce drunk driving, such as alcohol ignition interlock devices. The studies have also made the road environment safer. Median guard-rails and guard-rails near dangerous roadside areas are common and effective solutions (Vägverket 2005).

STRADA (Swedish Traffic Accident Data Acquisition) is a national information system concerning injuries and accidents within the road-transport system. This system is a collaboration project of the Swedish Police, the Swedish Federation of County Councils, the Swedish National Board of Health and Welfare, the Swedish Association of Local Authorities, the Swedish Institute for Transport and Communications Analysis (SIKA) and Statistics Sweden (SCB). STRADA is based on data from two sources. Traffic accidents are reported by the police; coverage has been nationwide since 2003. Emergency hospitals also provide information to STRADA; in 2005, about half of the hospitals in Sweden with an emergency unit were connected (see Figure 5 for the distribution of emergency hospitals connected to STRADA in Sweden).

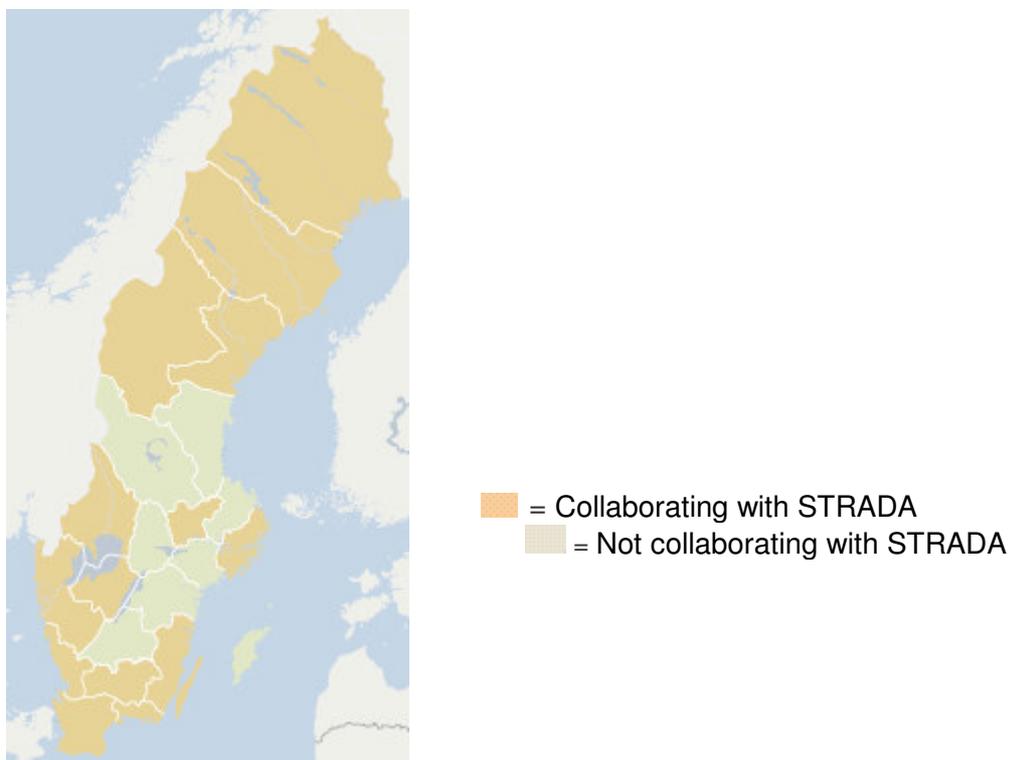


Figure B2.3-5. STRADA collaboration with emergency hospitals in Sweden

Through this collaboration, a computer system has been developed to support the collection of information. The Swedish National Road Administration is responsible for the STRADA

system and thus responsible for development and follow-up of its functionality and for the quality and availability of the information. For additional information visit the website of the Swedish National Road Administration, www.vv.se.

The Skellefteå model has been developed and evaluated in the town of Skellefteå in the north of Sweden. Its concept is that persons caught driving while intoxicated should be offered, at the scene of the crime and within 24 hours, an immediate contact with professional addiction-treatment facilities. There is a strongly held belief that people are more receptive at the time of arrest (SOU 2006).

The Swedish National Road Administration is introducing a project called 'National Collaboration against Alcohol and Drugs in Traffic'. Project activities will expand gradually and will include half of all 290 municipalities in Sweden by 2006 and 75% by 2007. The objective is that at least 10% of arrested offenders against the legislation on driving under intoxication will accept treatment for their addiction (SOU 2006).

There are similar projects running in various parts of Sweden, such as SMADIT in Stockholm County and a project in Gotland. In the county of Jönköping, a project has been running since 2002; it is called 'Snabba ryck' (translation: 'Fast Pace'). Other projects are "Kalmarmodellen", 'Trafiknykter i Kronoberg' and 'Operation trafiknykterhet'. All of these projects involve close collaboration among the police, addiction facilities, the correctional system, the social services, the county administration and the Swedish National Road Administration. In some cases, the office of the public prosecutor is also involved (SOU 2006).

It has been proposed that the education and training required to obtain a driving licence should be extended to include risk management and a special focus on alcohol and narcotics in traffic. The intention is for this proposal to take effect in October 2006 (SOU 2006).

The National Society for Road Safety (NTF) is a non-governmental organisation which works to improve road safety. The NTF is an umbrella organisation and consists of 24 county road-safety federations, 70 national, interest and professional organisations and hundreds of local voluntary associations. The national network is made up of thousands of people working to help everybody contribute to safe road traffic.

One priority area for the NTF is to reduce the number of intoxicated drivers. This objective is pursued through both national and local projects. In 2005, a national focus was placed on young drivers and on the development of methods to reduce the number of individuals driving under the influence of narcotics or alcohol.

The local projects focus on immigrants, conscripts, moped riders and young drivers. The NTF co-operates closely with the Swedish National Road Administration.

The National Liaison Group (GNS) includes the Ministry of Industry, Employment and Communications, the Swedish National Police Board, the Swedish Association of Local Authorities and Regions, the Federation of Swedish County Councils, the NTF and the Swedish National Road Administration. The objective set by the GNS is that a maximum of 270 persons should be killed in traffic by 2007. The GNS has three areas of priority: improved adaptation to speed and use of protective systems, enhanced traffic sobriety, and children and young people in traffic. For additional information visit the website of the Swedish National Road Administration, www.vv.se.

The Swedish Abstaining Motorists' Association (MHF) is a traffic-safety organisation whose focus is on traffic sobriety. The overall goal of the MHF is to reduce the number of drunken drivers in Sweden. Other goals of the MHF are to ensure that all cars are fitted with alcolocks

by 2015 and to halve the number of intoxicated drivers by 2007. Possible methods to achieve these goals include offering children and young people education on traffic sobriety, toughening the Swedish Road Traffic Offences Act and increasing the number of tests to detect intoxication. For additional information visit the website of the Swedish National Road Administration, www.vv.se.

- a. Are publicity campaigns general or targeted – if targeted, at whom / at what substance? Are they at national, regional, or local level? Please briefly describe.

There are, at the moment, no general or targeted campaigns in Sweden focused on drugs and driving. Work on programmes such as 'Don't Drink and Drive' and other above-mentioned programmes focusing on alcohol is carried out on an ongoing basis. For additional information visit the website of the Swedish National Road Administration, www.vv.se.

- b. If from public funds, please indicate the approximate amount spent on such campaigns per year in your country (per (type of) substance if possible).

See the above answer.

- c. Are there specific prevention programmes in driving schools (there is a German and a Spanish example in EDDRA)?

No, but this will be included in driver training.

The traffic minister, Ulrika Messing, has produced a proposal to extend the training required for driving licences. It is suggested that the traditional training in driving under icy conditions should be combined with education on alcohol and narcotics and training in high-speed driving. This change will take effect in 2007.

Concurrently, all driving tutors are required to pass a check in order to be approved for tutorship. A person who has had his or her driving licence suspended as a result of a traffic misdemeanour in the past three years is not considered suitable for tutorship (Sveriges Trafikskolors Riksförbund 2006).

- d. Please describe any youth/peer or community approaches to prevention that you may be aware of.

The National Institute of Public Health will publish a document on alcohol and driving. The purpose is to stimulate local work in the municipalities involving the co-operation of the police, community administration and others across Sweden.

- e. Please describe your country's policy, if any, of externally labelling medicine packaging regarding the effects on driving ability, for example with pictograms.

Before 1 July 2005, a majority of medicines which are dangerous in traffic were provided with a red warning triangle advising the patient to take caution when driving while using the medicine. New regulation concerning red labelling came into force on 1 July and resulted in the removal of all red warning triangles. The reasons for this were inconsistencies in labelling and the risk that patients might not be aware of the effect of their medicine on driving skills if there was no warning triangle. The red warning triangle was replaced with a written description of the possible impact on driving skills enclosed with the medicine (SOU 2006).

The patient, the doctor prescribing and the pharmacist are obliged to inform him- or herself/provide information about possible risks according to Section 22 of the Swedish Medicinal Products Act (SFS 1992:859) and the Swedish Medical Products Agency's Regulations (Läkemedelsverket 1997) sections 22, 40 and 45.

- f. Is there progress towards implementing a Europe-wide classification of medicinal drugs, with regard to their effects and to categories of licence?

Discussions are being held at EU level concerning different national solutions, but no joint statement has been adopted. The difficulty in this matter is the existing legislation of the different countries. Not even the Nordic countries have succeeded in agreeing.

- g. Is there a notable discussion in the media on this topic? How much does it address illicit drugs such as cannabis, and how much does it address medicines such as benzodiazepines?

Cases of suspected DUID or conviction for DUID are reported on by both the local and the national newspapers. The discussion is focused more on the overall problem of illicit-drug use and driving than on any specific drug.

The Swedish Abstaining Motorists' Association (MHF) publishes on its web site (www.mhf.se), on a daily basis, nationwide information about police actions relating to drunkenness, such as the latest convictions, driving licences suspended, etc.

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Appendix 1

List of abbreviations used in the text

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BCS	Beroendecentrum Stockholm (Dependence centre in Stockholm)
BRÅ	See NCCP
CAN	Swedish Council for Information on alcohol and Other Drugs
CBT	Cognitive Behavioural Therapy
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
NDPC	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