UNITED NATIONS
*Office on Drugs and Crime*

# SWEDEN'S SUCCESSFUL DRUG POLICY: A REVIEW OF THE EVIDENCE

FEBRUARY 2007

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# PREFACE

The supply and abuse of drugs effects every country all over the world in one way or another. The Swedish vision is that drug abuse shall remain as a marginal phenomenon in the society. Solidarity with disadvantaged and vulnerable members of society, not least, demand as such. People are entitled to a life of dignity and a society which safeguards health, prosperity, security and safety of the individual. The vision is that of a society free from narcotic drugs.

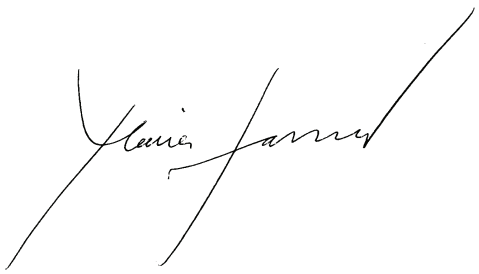
The overriding task of our drug policy is to prevent abuse. Preventive measures shall strengthen the determination and ability of the individual to refrain from drugs.

Young peoples' attitude towards drugs demands special attention. At the same time we must emphasize the importance of an interaction between control measures, other preventive efforts and treatment. This interaction is essential if the fight against narcotics is to be successful.

United Nations Office on Drugs and Crime has decided to present a report on the Swedish drug policy and its implementation. I am of course proud that the overall judgement is positive, even if there also are critical remarks. We have far from solved the drug problem, perhaps we never will, but the political commitment will remain very strong from both the Parliament and the Government. I am convinced that the path we have chosen and the steps we have taken are in the right direction even if there is much more to do.

As the report points out it is difficult to establish a direct and causal relationship between policy measures and results. Our experience is that in times where we have thought that the problems where more or less under control and the drug problem was given less priority, we could see an increase in drug consumption among young persons. We learned that we have to convince every generation.

I am convinced that it is possible to tackle the drug problem, but we need strong commitment from society and support from the general public. We have today a political consensus and support from the public for a comprehensive and restrictive drug policy, based on the UN conventions, which include both supply- and demand reduction.



Maria Larsson

Minister for Elderly Care and Public Health

# PREFACE

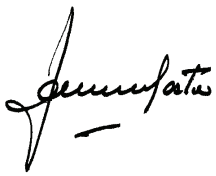
Drug use in Europe has been expanding over the past three decades. More people experiment with drugs and more people become regular users, with all the problems this entails for already strained national health systems. There are thus suggestions, at the European level, that drug policies have failed to contain a widespread problem.

Sweden is a notable exception. Drug use levels among students are lower than in the early 1970s. Life-time prevalence and regular drug use among students and among the general population are considerably lower than in the rest of Europe. In addition, bucking the general trend in Europe, drug abuse has actually declined in Sweden over the last five years. This is an achievement that deserves recognition.

I am personally convinced that the key to the Swedish success is that the Government has taken the drug problem seriously and has pursued policies adequate to address it. Both demand reduction and supply reduction policies play an important role in Sweden. In addition, the Government monitors the drug situation, examines the policy from time to time and makes adjustments where they are needed.

Sweden, of course, has had some advantages in addressing the drug problem. Sweden is not located along major drug trafficking routes. Income inequalities, which often go hand in hand with criminal activities including drug trafficking, are low. Unemployment, including youth unemployment, is below the European average. This reduces the risks of substance abuse. International surveys show that the Swedish population is particularly health-conscious, so less prone to large-scale drug use. There is a broad consensus that production, trafficking and abuse of drugs must not be tolerated. Thus a clear and unequivocal message is given to the general public, notably to the country's youth. Last but not least, with its strong economy, Sweden has the wherewithal to devote adequate resources to dealing with the drug problem. Increases in the drug control budgets in recent years went hand in hand with lower levels of drug use.

It is my firm belief that the generally positive situation of Sweden is a result of the policy that has been applied to address the problem. The achievements of Sweden are further proof that, ultimately, each Government is responsible for the size of the drug problem in its country. Societies often have the drug problem they deserve.



Antonio Maria Costa
Executive Director
United Nations *Office on Drugs and Crime*

# INTRODUCTION

The present report reviews the evolution of the drug control policy in Sweden, one of the most widely examined and debated drug control policies in the world.

The Swedish drug control policy is guided by the vision and the ultimate goal of achieving a drug-free society and the unequivocal rejection of drugs, their trafficking and abuse is considered somewhat unique. This is particularly so when the drug policy in Sweden is compared to drug control policies in other countries of the European Union. Over the years, the drug control policy in Sweden has been subject to scrutiny numerous times, either at the national level, mostly by expert Commissions established specifically for that purpose, or by scientific researchers both in Sweden and internationally.

As part of its ongoing series on drug control policies at local and national level, UNODC has decided to review the Swedish drug control policy that has evolved over the past forty years. It is a rapid assessment, based on open-source documents, supplemented by Government documents and information obtained from Government officials. While the report does not aim to be comprehensive or exhaustive, an attempt has been made to thoroughly review the available evidence, including data on drug abuse, dating back to the 1940s.

The document examines important junctures in Swedish drug control policy, including the often-discussed Stockholm experiment of drug prescription, the introduction of methadone maintenance programmes and, of course, the vision of a drug-free society. An analysis of the drug control situation in Sweden over the years accompanies the document and shows how the drug control situation has evolved over time.

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 is 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.

# PART 1: THE SWEDISH DRUG CONTROL POLICY

## The emergence of drug abuse in Sweden

Drug abuse was virtually unknown in Sweden until the 1930s. Excessive use of drugs was first reported in 1933 but was a very limited phenomenon. An enquiry in 1940 to all state- and municipally-engaged physicians gave a total of 70 known cases of drug abuse, mainly of opiates.[1]

The introduction of amphetamines in about 1938, however, resulted in drug abuse becoming more widespread. Soon, large sections of the Swedish population, were occasional or even regular users of amphetamines. Countermeasures did not lead to a sustained reduction in use. The introduction of prescription requirements for amphetamines, in 1939, for example, only brought about a short-lived stabilization of sales. Soon after, sales skyrocketed as people found ways to circumvent existing restrictions. In 1943, almost 10 million tablets of amphetamines were consumed annually and the number of estimated users was 200,000 (4.6 per cent of the population age 15-64).

In 1943, the National Medical Board of Health of Sweden issued a warning on the risk and abuse of stimulants. This measure resulted in a sharp drop in the sales of the substances. However, the market recovered and abuse continued to spread. The introduction of new central-nervous system stimulants of the amphetamine-type enlarged the market considerably.

Dexamphetamine and phenmetrazine were used as weight-reducing agent, while methylphenidate was marketed as a lower-risk version of amphetamine. The increasing diversity in the number of psychoactive substances on the market made the drug abuse problem more difficult to control.

In the first years of the emerging drug problem, authorities in Sweden usually took measures that restricted the availability of a specific drug in question. This could be done by introducing prescribing requirements for the drugs or, by further restricting prescribing practices. In addition, the National Medical Board issued circulars which alerted the medical profession that these drugs were particularly liable to abuse.

These policy measures usually had the desired effect. Immediately after their introduction, the level of sales would decline. This was the case for amphetamines in 1943. Similarly, in 1962, subsequent to a warning from the National Board on the dangers of certain groups of drugs and restrictions for doctors to prescribe amphetamines, the number of prescriptions for these substances declined significantly. [2]

## Towards a national drug control policy

### *The Narcotics Drug Committee*

So far, the two main drug policy measures in Sweden were the introduction of prescription requirements and the issuance of warnings on health-related consequences of the drugs in question. As drug use further expanded in the 1960s, it became clear that these actions, limited to a small number of specific drugs, were no longer sufficient to address the growing drug problem.

In response to a parliamentary question, the Minister of Social Affairs of Sweden announced in May 1965, that an Expert Group on Narcotics Drug Abuse to review the problem would be set up within the National Medical Board.

Two months later, on 1 July 1965, the group started its work. In January 1966, the group was reorganized and enlarged to form a Narcotics Drug Committee, comprising five subcommittees, on legislative aspects, on therapeutic approaches, on technical-diagnostic problems, on social medical aspects and on methods of prevention.

The mandate of the Narcotics Drug Committee was wide-ranging and the Committee was requested to study problems involved in the abuse of narcotic drugs from medical, legal and social aspects, focusing on the following issues:

(i) a fact-finding survey to give a picture of the strata of the population involved, the number, age and characteristics of drug abusers, and their background, to define the character of the abuse;

(ii) a study on treatment, survey existing methods of diagnosis and possible effects of the individual and on society of the abuse on narcotic drugs;

(iii) to investigate the legislative angles;

(iv) to review methods of prevention from medical, legal and social points of view and to elucidate possible causal relationships and their importance for the origin of drug abuse and its spread in society.

The results of the Committee were published in 1967 and represent the first comprehensive study on the drug problem in that country. The first report (SOU 1967:25), on drug abuse, showed the results of surveys on the extent and patterns of drug abuse in various segments of the population, discussed the forms of treatment of drug abuse and made recommendations, *inter alia,* to maintain a central registry of drug abusers.[3]

The second report (SOU 1967: 41) focused on the legal aspects of drug control. It also called for systematic monitoring of prescriptions for some drugs, including central-nervous system stimulants, narcotic drugs and depressants in order to follow the development of a problem and to be able to detect sudden changes at an early stage.[4]

The body of evidence obtained by the Committee was the basis for the adoption of legislation dedicated to address the drug problem. The Narcotic Drugs Act (*Narkotikastrafflag (1968:64)*) was adopted in April 1968. The Act made the transfer, unlawful manufacture, acquisition and possession of drugs a punishable offence and lays down penalties for drug-related crime.

### *The 1969 ten-point anti-drugs programme*

In December 1968, a meeting of all the regional chiefs of police in Sweden was convened in Stockholm and presided over by the National Police Commissioner. At the close of the meeting, it was decided that the efforts of the Swedish police against illicit traffic in drugs should be given the highest priority. The Swedish Government was notified of the decision and given information regarding developments in illicit drug traffic. [5]

Subsequently, in 1969, the Government of Sweden approved a ten-point programme for increasing public efforts against the drug problem. It aimed at the following:

1. Strengthening the resources of the police and customs to cope with the drug problem;
2. Closer co-operation between the police and customs, both nationally and internationally;
3. The right of the police, subsequent to a court decree, to use wire-tapping to uncover those who profit from the misuse of drugs by financing, smuggling and "pushing" or peddling, on a grand scale;
4. Stiffening the maximum punishment from four to six years for serious narcotics violations;
5. Improvement and co-ordination of social detection activities, emergency treatment and after-care;
6. Rendering legislation regarding treatment more effective;
7. Summoning a conference of youth organizations in order to disseminate information among young people concerning the dangers involved in using drugs;
8. Information to the public in general concerning the dangers of drug abuse;
9. Increased Swedish activity at the international level - above all, in the United Nations Commission on Narcotic Drugs - in order to secure international legislation in the matter of psychotropic substances, primarily amphetamine, phenmetrazine etc.,

10. Creation of a joint committee with, among others, the heads of the National Police Board, the Office of the Chief Public Prosecutor and Prosecutor of the Supreme Court, the National Social Welfare Board, the National Board of Customs and the National Board of Education.[6]

In line with the prevailing view of the drug problem at the time, the ten-point programme is heavy on law enforcement measures. Nevertheless, it also covers demand reduction issues, particularly the provision of treatment services to drug abusers and the prevention of drug abuse.

Drug abuse prevention was one of the main tasks of the joint committee which was formed in January 1969, pursuant to point 10 of the 10-point programme. One of the results was the establishment of a demand reduction programme operated by youth organizations. In 1969, a collection of facts about drugs ("Fakta om narkotika") was disseminated. At the same time, an advertising campaign was conducted in the newspapers concerning the risks in the misuse of drugs.

These demand reduction activities were accompanied by a further stiffening of penalties. As foreseen in the programme, the maximum penalty for serious narcotics offences under the Narcotic Drugs Act was increased from four to six years, and at the same time, the police were allowed to wire-tap - subsequent to a court decision in each individual instance - in order to uncover perpetrators of serious narcotics offences.

Sweden also stepped up its activities at the international level to bring about effective international control of psychoactive substance. In January 1970, Sweden participated in the first special session of the United Nations Commission on Narcotic Drugs in Geneva, and gave its firm support to the Draft Protocol on Psychotropic Substances.

### *Drugs on prescription-the Stockholm experiment*

In 1965, an experimental project was launched for the legal prescription of drugs, the idea being to limit the harmful effects of drug use, both on society and individual abusers."[7] The project was launched by the National Medical Board and run by a small number of doctors. Both opiates and amphetamines were prescribed for oral as well as intravenous use. [8]

The project was not a scientific experiment, as it had no control group or a planned design. It was based on a "liberal and non-authoritarian view" on drug prescription, which meant, that, although patients were under medical supervision, they were in practice free to decide on their own dosages. If they had finished with their prescriptions, they could easily request more drugs.

The number of patients participating in the scheme increased from about 10 in 1965 to more than 150 in 1967.[9] On average, 82 patients were being treated at any point in time. Altogether, some 3,300,000 dosages of amphetamines (about 15 kilograms) and 600,000 dosages of opiates (about 3.3 kilograms) were prescribed in the two-year period from April 1965 to May 1967.[10] It was widely known that many patients supplied friends and acquaintances with considerable quantities of narcotic drugs obtained on prescription.[11]

Problems became apparent soon after the experiment had started. As the legally prescribed drugs were increasingly diverted to the illicit market, the project drew criticism from the police and the drug prosecutor.[12] In one case, preliminary investigations against three individuals suspected of drug offences revealed information that one drug addict had used part of his prescription to inject other drug abusers.[13] The proportion of arrested people showing signs of intravenous drug use rose in Stockholm from 20 per cent in 1965 to 33 per cent in 1967. [14]

By 1967 almost all doctors in the project had stopped prescribing drugs, with the exception of Dr. Åhstrom, the doctor in charge of it. In February 1967, a report from the pharmaceutical bureau of the National Board containing an account of the prescriptions in the project was sent to the Disciplinary Committee of the National Medical Board. After investigation, the Disciplinary Committee concluded that there was well-founded reason to assume that Dr. Åhstrom "had misused his right to prescribe narcotic drugs. This is reason for withdrawing his right to prescribe such drugs. However, because of the difficulty to provide adequate care for his patients, this shall not take force immediately."[15] For a transition period, a specially designated pharmacy had the

right to dispense prescriptions for patients on a list provided by the National Medical Board. Dr. Åhstrom was advised to refer his patients to psychiatric care at a hospital. It was estimated that the ambulant prescription activities should be closed by 30 April 1967. Dr. Åhstrom appealed the decision but the Government did not alter its decision.

The matter came to a head with, in April 1967, the overdose death of a 17-year old woman on morphine and amphetamine which was shown to have been procured through the project received wide media coverage. It is often assumed that the public outcry accompanying this tragic event led to the closing down of the project. This is, however, not the case. The decision to stop the project had been taken much earlier. The project finally closed down on 1 June 1967, obviously not having achieved its intended goal.

As the curtailment of the project did coincide with the issuance of the reports of the Committee, a link has sometimes been made between the curtailment of the project and the subsequent and progressive restrictiveness of the Swedish drug control policy. However, a review of the documents at the time does not support a clear association.

What is true, however, is that wide reporting on the experiment, particularly long after the experiment had been terminated, continued. Over the years, it has come to symbolize a bygone era of drug policy, embodying a more permissive attitude towards drug abuse. It has also been used both as an illustration of how well-intended harm reduction measures can spin out of control and, occasionally, even to show that the well-being of some participants in the project improved. As a non-scientific experiment, it cannot serve as evidence for either argument.

***A personal perspective of the "drugs on prescription" experiment***

*I was then working at the Solna Police Authority, which is now a part of the Stockholm County Police Authority. We had three (!) known abusers in our area who lived in one-room apartments. They knew us, we knew them and we used to visit them in their homes.*

*The situation changed dramatically soon after the trials started. There were sometimes 10-20 people, all under the influence of drugs, and plenty of illegally prescribed drugs in these apartments, and there was nothing we could do about it. A few months later there were hundreds of abusers in the area and the police had totally lost control of them and the extent of drug abuse in the district. After a couple of deaths involving legally prescribed drugs, the trials were suspended.*

*During the trial period, the number of drug offences dropped to almost zero, simply because personal use and possession for personal use were not reported. However, there was a rise in nearly all other types of crime. The police were basically unable to take action against street-level drug offences.*

*Source: Remarks by Detective Superintendent Eva Brännmark of the National Police Board of Sweden at the International Policing Conference on Drug Issues in Ottawa, August 2003*

## *The role of Nils Bejerot in shaping Swedish drug control policy*

The theoretical foundation of Sweden's restrictive drug policy of the 1970s and 1980s appears to be largely based on the work of Nils Bejerot, who is sometimes referred to as the founding father of Swedish drug control policy. A deputy social medical officer at the Child and Youth Welfare Board of the City of Stockholm, Bejerot diagnosed first cases of juvenile intravenous drug use in Stockholm in 1954, much earlier than in most other towns in Europe.

In 1965, Bejerot initiated a study at the Stockholm Remand Prison to monitor the spread of intravenous drug abuse in Stockholm, which confirmed his scepticism of the consequences of legally prescribing amphetamine to amphetamine users.

In 1969, Bejerot founded the 'Association for a Drug-Free Society' (RNS), which played an important role in shaping Swedish drug policies.[16] He warned of the consequences of an 'epidemic addiction', prompted by young, psychologically and socially unstable persons who, usually after direct personal initiation from another drug abuser, begin to use socially non-accepted, intoxicating drugs to gain euphoria. He was particularly concerned with the highly psycho-social contagiousness of drug use and considered contagion to be a function of susceptibility of the individual and exposure to drugs.

One key precondition for the spread was availability. While susceptibility of the individual was difficult to influence, exposure could be limited through drug policy. Therefore, Bejerot concluded that society had to have a restrictive drug policy to limit general exposure to illicit drugs. He also argued that drug policy had to target the drug user, since the drug user was the irreplaceable element in the drug chain while drug dealers could be easily replaced in the event of being arrested. In addition, he saw the need for a broad popular support to be achieved through a broad political agreement and massive information campaigns, leading to something like a popular uprising against drug epidemics. The practical implications – which over the years were put into practice – were: (i) to increase prevention and treatment activities as well as to criminalize not only drug trafficking but also drug use, (ii) to target cannabis use as the first drug in the chain towards drug abuse (based on the 'gateway'/'stepping stone' hypotheses) and (iii) to create a national consensus on drug policies across party lines, supported by civil society pressure groups.

### *The introduction of methadone maintenance therapy*

As the prescription of amphetamines and opiates was failing in Stockholm, scientists in the nearby town of Uppsala investigated new methods of treating heroin addicts. Reports on the clinical trial with methadone maintenance, published in the Journal of the American Medical Association in 1965, created considerable interest in Sweden and the following year, in 1966, a Swedish National Methadone maintenance programme was opened at the Psychiatric Research Center in Uppsala.

Sweden thus became the first country in Europe to carry out methadone maintenance treatment, long before it became an established and accepted form of drug abuse treatment and despite the fact, that the most "problematic" drugs in terms of treatment demand were amphetamines and not opiates. The National Methadone Maintenance Programme operated in Sweden under the same conditions for 23 years and was the longest-running in Europe. The programme was rather extensive, in relation to the small population of heroin addicts, even in comparison to such programmes in other countries known to be favourable towards harm reduction policies.[17] The programme has generally been judged as being very successful. Among the positive results are: an average yearly retention rate of 90 percent; a significant decrease in drug abuse, criminality and prostitution compared with the situation before treatment and a dramatic reduction in mortality of those staying in treatment.[18]

### *Sweden's role in the negotiations of the 1961 and 1971 United Nations drug control conventions*

At the international level, Sweden has always been an active participant in bringing about international drug control. Already in the early 60s, it was party to most international drug control treaties in force at the time, with the exception of the 1936 Convention for the Suppression of Illicit Traffic in Drugs. Sweden had even become party to the controversial 1953 Opium Protocol, which restricted opium production to only seven States in the world.

In 1961, Sweden was one of 73 States represented at the Plenipotentiary Conference for the Adoption of the United Nations Single Convention on Narcotic Drugs and became a signatory to the Convention. Sweden ratified the 1961 Convention in 1964.

Concerted international action against stimulants was a major concern for the Swedish Government. Stimulants were not restricted in many countries in Europe where these substances were manufactured, making all national efforts to curb their abuse difficult. Specialized traders developed a brisk business supplying non-medical demand in countries with more restrictive regulations, mostly in Scandinavia. Taking the lead in Scandinavia, Sweden urged manufacturing States to cooperate.[19] In 1965, Sweden called on the World Health Organization's drug committees "to impose controls on stimulants and depressants."[20]

In 1970, Sweden participated in the first special session of the United Nations Commission on Narcotic Drugs and assumed an active role in promoting the control of psychoactive substances. During the negotiations for the Convention on Psychotropic Substances, Sweden, together with other Scandinavian Governments and Soviet bloc countries, formed what drug policy researcher McAllister called a "strict control" coalition that argued for stringent limitation of all classes of

psychotropic substances."[21] The provisions of the Convention that was eventually adopted in 1971, were in some respects weaker than what Sweden had hoped for, mainly due to the efforts of the pharmaceutical industry which enlisted the help of former United Nations officials to ensure that their products escaped control. The Convention did, however, succeed in placing stringent controls over amphetamines, which continued to be Sweden's prime concern in terms of abuse.

Sweden was not only advocating additional control measures at the international level. On the contrary, in the run-up to the adoption of the 1972 Protocol amending the 1961 Convention, it was Sweden that proposed a weakening of the penal provisions of the 1961 Convention, suggesting that measures of treatment, rehabilitation and social integration should be offered to drug abusers as an alternative to conviction or punishment or in addition to punishment."[22]

Sweden also proposed that the amended Convention should have a separate article requiring parties to take all practicable measures for the prevention of abuse of drugs and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved. In introducing the amendments, the representative of Sweden stated that "meaningful action against drug abuse must be directed both against supply and demand. There must, in other words, be a proper balance between control measures, law enforcement etc. on the one hand, and therapeutic and rehabilitative activity on the other. "[23] Both amendments were accepted and became articles of the 1961 Convention, as amended by the 1972 Protocol.

## Setting the vision of a drug-free society

### *A progressively restrictive policy*

At the national level, the 70s saw an increase in heroin abuse, resulting, as in other European countries, in a higher mortality among drug abusers.[24] The Narcotics Drugs Act was amended again, in 1972, with the maximum penalties for serious offences raised to 10 years. At the same time, however, drug abusers were protected from prosecution. From 1972 onwards, prosecutors could waive charges for possession of amounts equalling up to one week's use.

Nevertheless, drug abuse continued unabatedly which, possibly, led to changed attitudes within society. Very soon, some thought society had a duty to intervene against individual abusers whose lives were in acute danger and to take more vigorous action against all forms of drug trafficking.[25] A parliamentary bill was therefore introduced in 1978 (Prop. 1977/78:105) which proposed to raise the standards for drug control policy efforts. The standard should be to eliminate drug abuse not simply lower it. The bill stated that: "The struggle against drug abuse may not be limited only to reducing its existence but must aim at eliminating drug abuse. Drug abuse can never be accepted as a part of our culture."[26] The bill was approved by Parliament and endorsed the guiding principles of the drug policy: "The basis for the struggle must be that society cannot accept any other use of narcotic drugs than what is medically motivated. All other use is abuse and must forcefully be opposed."[27]

Thereafter, policy was further tightened. In 1980, new directives to prosecutors ruled out any waiver of charges unless the amount possessed for personal use was so small that it could not be subdivided, that is, at most one dose of cannabis or one dose of central nervous system stimulants. Moreover, charges for possession of heroin, morphine, opium or cocaine, should, in principle, never be waived at all. One year later, the penalties for drug offences were raised again; the maximum prison terms for non-serious offences were raised from 2 to 3 years; in addition minimum sentences for serious offences were raised from one to 2 years. In 1982, the Social Services Act was amended and permitted the State to coerce adult drug abusers into treatment.

October 1984 saw the adoption of another Government bill (Prop. 1984/85:19) on a "coordinated and intensified drug policy", which spelled out the aim of Swedish drug policy as a drug-free society: "The goal of society's efforts is to create a drug-free society. This goal has been established by Parliament and has strong support among citizens' organizations, political parties, youth organizations and other popular movements." [28] The bill encouraged people to play an

active role, stating that "everybody who comes in contact with the problem must be engaged, the authorities can never relieve [individuals] from personal responsibility and participation. Efforts by parents, family, friends are especially important. Also schools and non-governmental organizations are important instruments in the struggle against drugs."[29]

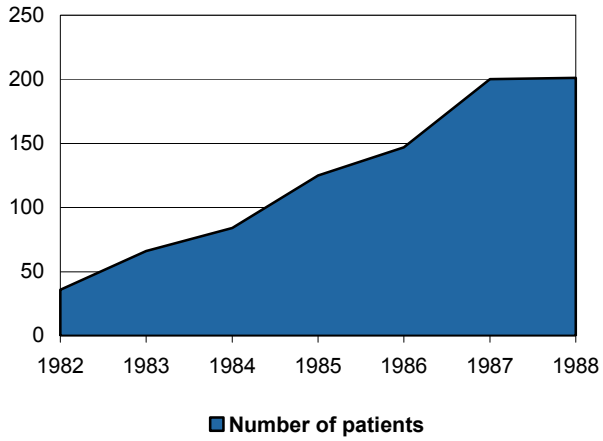
This vision of a drug-free society still remains the overriding vision. The ultimate aim is a society in which drug abuse remains socially unacceptable and drug abuse remains a marginal phenomenon. In this visionary aim, drug-free treatment is the preferred measure in case of addiction and prosecution and criminal sanctions are the usual outcome for drug-related crime. [30]

### *Changes in the treatment system*

Following the proclamation of a drug-free society, the focus was increasingly on the abuser. Drug abusers could be coerced into treatment. The Social Services Act (1980:620) made it possible to commit adult abusers of alcohol or drugs within the social services to coercive care.

A compulsory care order in Sweden can only be issued if certain legal conditions are met. The two conditions are: (a) that the person is in need of care/treatment as a result of ongoing abuse of alcohol, narcotics and volatile solvents and that (b) the necessary care cannot be provided under the Social Services Act. The first option for the substance abuser is always voluntary treatment under the Social Services Act. The social welfare committee, which works on the prevention and countermeasures of abuse of alcohol and other addictive substances, acts in consensus with the individual, according to Section 11 of the Act. The modalities of coercive care were laid down in the Care of Abusers (Special Provisions) Act (1981:243), which entered into force in 1982, at the same time as the Social Services Act. The introduction of compulsory treatment brought about an increase in the number of patients treated.

**Figure 1: Number of patients discharged after compulsory treatment in Sweden, 1982-1988**




*Source: Adapted from Mats Ramstedt, The drug problem in Sweden in 1979-1997 according to official statistics, in Håkan Leifman and Nina Edgren Henrichson (eds), Statistics on alcohol, drugs and crime in the Baltic Sea region, Nordic Council for Alcohol and Drug Research, Publication Nr. 37, Helsinki, 2000*

Conditions for coercive care were modified in 1988. The maximum coercive care period was extended from two to six months and the target group was extended to include abusers of solvents. The Care of Alcoholics, Drug Abusers and Volatile (Special Provisions) Act (1988:870) aims to motivate drug abusers so as to induce them to "collaborate in continued treatment and accept support to discontinue" abuse.[31] The conditions that have to be met include not only "running an obvious risk of destroying his life"[32] but also when "it can be feared that he will inflict serious damage on himself or on someone with whom he has a close relationship." [33]

The concept of compulsory care may be seen as a logical consequence of the pursuit of the objective of a drug free society. But it is not unique to Sweden. It has also been applied in a number of other countries, including in countries such as the Netherlands[34] which have a different vision.

In the 1990s, the number of patients admitted to residential care, both voluntary and coercive, decreased, mainly due to budgetary constraints in the early years of the decade. Subsequently, priority was given to persons who were willing to undergo treatment. Thus, as of 1 November 2005, only 6 per cent of all substance abusers in residential treatment within the social services system were in coercive care.

Other factors may have also played a role. With the advent of HIV in Sweden, the concept of "Offensive Drug Abuser Care" was developed which emphasizes outreach activities and aims at motivating drug abusers for treatment. As of 1986, so-called drug abuser care bases were established in the main municipalities and in the social welfare districts of the larger cities. A number of new residential treatment centres were opened and numerous joint projects were started by social services and prison and probation authorities. Budgetary constraints in the early 1990s led, however, to a reduction in some of these activities. As the budget situation improved in recent years, the main trend has been to develop open care options.

### *The introduction of needle exchange programmes*

In 1985, the number of newly registered HIV positive persons among injecting drug users was 142 (45 per cent of all reported cases) and in the following year, when 204 additional cases of HIV infection were recorded, a debate flared up. Should drug-free treatment continue to be the main policy of treating drug abusers or should the policy instead be aimed at limiting the social and medical damages? It was decided that both were possible. The strict line was maintained while harm reduction measures were implemented in areas where they were needed.

Needle exchange programmes started, on a project basis, in Malmö and Lund in 1987 and 1986 respectively. In Malmö, some 1000 people are involved in the programme annually.[35] Along with the Netherlands, Sweden was one of the first countries in Europe to introduce these programmes. In April 2006 the Swedish Parliament endorsed a Government Bill proposing a new law (Lag (2006:323) allowing needle exchange programmes across the country on certain conditions. The National Board of Health and Welfare may issue a permit to a regional health authority to run needle exchange programmes provided that the application has been endorsed by the local community. The programmes should be organised to motivate drug abusers to seek treatment and the applicant health authority must describe how it is going to meet the needs for detoxification and treatment. The new law took effect on 1 July 2006.

### *Drug use becomes a punishable offence*

Drug abuse became a punishable offence in 1988. At the time, it was argued that this was necessary "in order to signal a powerful repudiation by the community of all dealings with drugs."[36] In addition, it was felt that criminalizing personal consumption would have a preventive effect, particularly among youths. Further emphasis was placed on the importance of adopting a uniform approach within the Nordic countries- drug use was already an offence in Norwegian and Finnish legislation. The most severe punishment was a fine.

In 1993, the law was further tightened by introducing imprisonment into the scale of punishments (1992/93:142). Police were now empowered to undertake a bodily examination in the form of urine or blood specimen test where there are reasonable grounds to suspect drug use. The purpose of the more severe provision was to "provide opportunities to intervene at an early stage so as to vigorously prevent young persons from becoming fixed in drug misuse and improve the treatment of those misusers who were serving a sentence."[37] However, in an evaluation of the criminal justice system measures, the National Council for Crime Prevention of Sweden concluded that "based on available information on trends in drug misuse there are no clear indications that criminalization and an increased severity of punishment has had a deterrent effect on the drug habits of young people or that new recruitment to drug misuse has been halted."[38] On the contrary, the Council found that drug experimentation among young people, increased throughout the 1990s, a trend, which was similar in Sweden to that in other countries.

Swedish drug control policy also changed by introducing stricter legislation for drug-related offences:

**Progressive tightening of Swedish drug laws (1968-1993)**

| | |
|---|---|
| 1968 | Narcotics Drugs Act (*Narkotikastrafflag* (1968:64) adopted |
| 1969 | Maximum sentence for serious offences raised to 4 years imprisonment |
| 1969 | Maximum sentence for serious offences raised to 6 years imprisonment |
| 1972 | Maximum sentence for serious offences raised to 10 years imprisonment |
| 1980 | Circular of Prosecutor-General on certain questions regarding the handling of narcotics cases: dropping of prosecutions for drug offences should be limited to cases involving only possession of indivisible amounts of drugs |
| 1981 | Maximum sentence for non-serious offences raised to 3 years imprisonment |
| 1981 | Minimum sentence for serious offences raised from 1 to 2 years imprisonment |
| 1981 | Introduction of coercive care for drug abusers |
| 1985 | Prison term for minor drug offences raised to maximum of 6 months |
| 1988 | Drug use becomes punishable offence, punishable with fine |
| 1988 | Act on Treatment of Alcoholics and Drugs Misusers (1988:870) |
| 1993 | Drug use becomes imprisonment offence (1992/93:142) |

## Reaffirming the vision of a drug-free society

### *The 1998 Drugs Commission*

During the economic crisis of the 90s, major cuts were made at the local level. Municipalities were not allowed to raise taxes and this meant that resources were directed towards care of the elderly and the disabled. Resources for social services were kept at more or less constant level but were directed to areas other than the care and treatment of drug abusers. According to the National Board of Health and Welfare, the costs of addiction care expressed as a proportion of social services cost decreased gradually from 1995. Heavy drug abusers suffered most from the funding cuts. Outreach work for drug abusers became a rarity. The funding cuts coincided with an increase of drug abuse and drug-related problems.

The renewed drug problems resulted in the appointment of a Special Commission - the Drugs Commission - in 1998. The six-expert Commission had the mandate to revise, discuss and propose all possible options to improve governmental action toward the goal of a society free of drugs. The report of the Commission was issued in 2001, ominously entitled "Crossroads - the drug policy challenge."

The Commission identified major deficiencies in the field of drug control and found that "the present state of drug policy is above all due to a demotion of the drug issue as a political priority."[39] The absence of political concern, the Commission continued, is reflected in "reduced funding of the public authorities and other sectors of the community which have to deal with narcotic drugs and their consequences. During recent years, all sectors of society in this field have experienced heavy cutbacks, simultaneously with the problem itself becoming severer and more widespread."[40]

However, the overall goal of aiming for a society free from drug abuse was not put in question. On the contrary, pronouncing itself on the general direction of the policy, the Drugs Commission stated that "Sweden's restrictive policy on drugs must be sustained and reinforced. The Commission finds no arguments or facts to suggest that a policy of lowering society's guard against drug abuse and drug trafficking would do anything to improve matters for individual abusers or for society as a whole."[41]

This is not to say that the Commission did not find fault with the national drug policy at all. The Commission was most critical of activities, or the lack of sustained activities, taken to reduce the demand for illicit drugs. In its report, the Drug Commission put forward suggestions aimed at creating coherence and balance and at strengthening, renewing and developing the restrictive policy on drugs. Some of the main findings of the Commission concerned:

- Stronger political leadership: The Commission noted a need for stronger prioritization, clearer control and better follow-up of drug policy and recommended the appointment of a minister specifically charged with the direction of drug control activities. The Government responded by creating the post of a National Coordinator on Drugs who took office in January 2002.
- Measures to combat demand: The Commission noted that much of the preventive work that was done was characterized by temporary measures and projects which are often incapable of impacting on regular activities. The Commission also found grave deficiencies in the design of drug abuser care, added to which, the volume of such care is not commensurate with actual needs. Focusing on prevention, the Commission noted, that for preventive measures to succeed, they must be "included in a system of measures restricting availability, and there must be clear rules which include society's norms and values, as well as effective care and treatment.
- Measures to combat supply: The Commission did not find any real deficiencies in the legislation or the working methods used by the authorities in the control sector. Cooperation between the authorities worked. Nevertheless, it called for further resources with a view to reducing the supply of drugs.
- "Criminal welfare": The Commission saw an urgent need for resources to be allocated to the prison and probation system, particularly for the intensification of its measures to combat drug abuse.
- Competence development and research: The Commission called for improvement of knowledge of the drug situation, of laws and control measures, of methods relating to prevention and treatment and of the effects of preventive measures and measures of treatment.

### *The National Action Plan on Drugs*

The findings of the Drugs Commission were the basis for the formulation of the National Action Plan on Drugs that the Government adopted in January 2002. The National Action Plan on Drugs (2002-2005) set out three main objectives: (1) to reduce the number of persons who engage in illicit drug use, (2) to encourage more drug abusers to give up the habit and (3) to reduce the supply of drugs.

In order to implement the vision of a drug free society, it was deemed necessary that

- more people are to become involved in the work;
- more people are to say 'no' to drugs;
- more people are to know about the medical and consequences of drugs;
- fewer people should start using drugs (to be achieved by reducing the desire of young people to experiment with drugs and by breaking up environments and cultures that attract and stimulate trying drugs for the first time);
- more abusers are to obtain help to a life free of criminality;
- the availability of drugs is to be reduced.

Activity areas, foreseen in the Action Plan, include, *inter alia,* new school-based programs; interventions aimed at vulnerable groups; appropriate assistance for drug addicts; 10 million Euros for prison and probation service; and information campaigns.

The Action Plan foresees, however, a stronger goal orientation, with better coordinated measures at the local, regional and national level to limit both supply and demand. For this purpose, a National Drug Policy Coordinator was appointed by the Government with the task to implement and follow up the National Action Plan. The main duties have been

- to develop cooperation with authorities, municipal and county councils, NGOs, etc.;
- to shape public opinion;
- to undertake a supporting function for municipal and county councils in the development of local strategies;
- to initiate the development of methods, development and research;
- to serve as the Government spokesperson on drugs issues;
- to evaluate the action plan; and
- to report regularly to the Government (at least once a year).

The plan also spelled out that intensified measures were needed to make drug issues a strong political priority, to improve cooperation among authorities and between authorities and private sector organizations, to improve prevention and treatment through method & competence development and research, to develop the treatment perspective within the correctional system, to render the measures in the control area more effective, to improve the methods to monitor the development in the drugs area as well as society's responses, and to increase international cooperation.

A total of SEK 325 million (about US$ 44 million) was allocated over a period of four years to implement the plan. In actual fact, some SEK 405 million were invested in the implementation of the plan (more than US$50 million or more than €40 million at 2006 exchange rates). A large portion was spent on supporting research in order to improve the efficiency and effectiveness of measures taken. The budget signaled additional resources, since the Drug Policy Coordinator did not take over the responsibilities of other national authorities or authorities at the regional or local level.

The Government provided additional resources for the development of local prevention policies by providing earmarked grants that could be used for the development of prevention activities at the local level, including the hiring of local coordinators of substance abuse prevention on a 50:50 per cent funding basis. As a consequence, a majority of all municipalities in Sweden has such coordinators now. Coordinators work on substance abuse issues (alcohol and drugs), based on Sweden's public health model of integrated community based prevention activities.

The National Drug Policy Coordinator's Office has been operating as a catalyst and agent for mobilizing society at all levels towards a common goal: reducing drug use to come closer to the ultimate vision of a drug-free society. By doing this, the National Drug Coordinator serves another purpose: giving a human face to some abstract policies. This had been missing in Sweden's drug policy up to that time: a national anti-drug advocate and coordinator, who was responsible for the implementation of the drug policies.

The implementation of most policies is aided if championed by an individual who exercises leadership in his or her area of competence. While in the 1970s and 1980s this role was taken by people such as the late Nils Bejerot who succeeded in mobilizing broad sections of the population, a vacuum had been created in the 1990s. It has now been filled in a – seen from an institutional perspective – far more rational manner than before.

The Office of the Drug Policy Coordinator has been successful in raising awareness of the drug issue and a greater interest across society. It has also served as a signal to the local levels to take the drug issue seriously.

The current policy model was successful and has therefore been maintained. The new Swedish Anti-Drug Strategy (2004-2007) is in line with the restrictive drug policy. This involves no

tolerance to drug abuse. Drug-related crime should always lead to prosecution and criminal sanctions, and drug-free treatment is seen as a priority measure in response to addiction.

A new National Action Plan on Drugs was unanimously endorsed by Parliament in April 2006. All parties agreed that the overall goal of the Swedish drug policy remains to strive for a drug-free society. Parliament also underlined the importance of a holistic view. Drug policy initiatives should target both supply and demand. There is a wide consensus about the overall goal of the drug policy, namely the drug-free society and its objectives: to reduce the recruitment of young people to drug abuse; to enable drug abusers to stop their drug abuse, and to reduce the availability of illicit drugs. There is also consensus that a balanced approach is required.[42]

The goal is outlined as follows: The drug policy is based on the right to a life with dignity in a society that guards the needs of the individual to feel safe and secure. Narcotic drugs should never be allowed to threaten the health, the quality of life and the security of the individual nor the general welfare or the development of democracy. The goal is a society free of drugs."[43]

## Swedish drug policy in perspective

The Swedish policy is fully in line with the three United Nations Conventions on drugs: the 1961 Single Convention on Narcotic Drugs, the 1971 Convention on Psychotropic Substances and the 1988 United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. The International Narcotics Control Board, the independent, quasi-judicial expert body responsible for monitoring the implementation of treaties by Governments, carried out a mission to Sweden in 2004 and commended the Government for its commitment and efforts in the fight against drug abuse and illicit trafficking, in line with the international drug control treaties.[44] Drug control legislation in Sweden, is in many respects stricter than what is required by the treaties which do not, for example, require that drug use (as opposed to possession) be punished. At the same time, such provisions are permissible and many Governments provide for stricter sanctions in their national legislation than those required in the Conventions.

The vision of a drug-free society is not unique to Sweden but used to be shared by many of its Nordic neighbours. The Action Plan to Combat Drug- and Alcohol-related Problems, adopted by the Government of Norway in 2002, spells out that the "main vision forming the basis for the Norwegian drug control policy is a society free from drugs and substance abuse."[45] Finland, in 2002, was reported to have as its main goal of national drug control "to prevent drug use and the proliferation of drugs so as to reduce the detrimental effects on individuals and the costs entailed by drug abuse."[46] Similarly, for several years, Iceland carried out a programme called "Drug-free Iceland 2002", under which several drug prevention activities were carried out and which is considered a success in mobilizing the general public against drug abuse.[47]

Only Denmark has always adopted a slightly different view. Already back in 1994, a joint policy paper authored by the Ministries of Justice, Social Affairs and Health entitled "fight against drug abuse-elements and problems", states that "a drug-free society is seen as probably unrealistic". The same attitude is reflected in the 2003 Action Plan Against Drug Abuse, adopted by the Danish Government in October of the same year which reads, in part, as follows: "It is evident that a society without any drug abuse at all would be desirable, but from a realistic point of view this must be considered as an unattainable goal. And no Government in any country has been able to "solve" the problem of drugs."[48] Nevertheless, the plan continues, one would be "totally mistaken to assert that society's efforts against drug abuse over several decades have failed, also because unlimited resources have at no time been available for these efforts." [49]

Over the last few years, some Nordic countries seem to have adopted a similar approach, especially those which are European Union members or associated members. Finland, for example, now takes the view that "a drug free society is not a realistic objective for anti-drug campaigns."[50] The current main policy document makes no reference to the ideal of a drug-free society and its objective is now to "bring about a permanent change for the better in the drug situation in Finland.[51] Norway also appears to be moving away from the goal of a drug-free society, especially with the introduction of drug injection rooms. According to the Government,

drug injection rooms were in fact, also established to "facilitate an evaluation of the effect of exemption from punishment for possessing and using drugs in a specifically delimitated area."[52]

At the level of the European Union, drug control strategies are very general in nature, leaving much room for Member States to carry out their national policies. Neither the current EU Action Plan on Drugs (2005-2008) nor the EU Strategy (2005-2012) make reference to a society free from drug abuse, let alone, describe it as a guiding vision or principle.

The debate about the Swedish drug policy intensified after Sweden (as well as Austria and Finland) joined the European Union in 1995. Of all three new European Union members, Sweden was arguably pursing the most restrictive drug policy. Given its low rate of drug abuse compared to other European Union Member States, the policy of Sweden was seen as successful and there were repeated references to the Swedish model in drug policy discussions.[53] However, this development was not welcomed by all. While the statement of one researcher that Sweden's entry into the European Union "paralyzed the general trend towards liberalism that had been developing,"[54] is probably an overstatement, it is true that a harmonized European Union drug policy remains an elusive goal. Nonetheless, States members of the European Union are parties to the United Nations treaties and thus bound by their provisions.

As regards investment into drug control policies, a study by the European Monitoring Centre on Drugs and Drug Addiction showed that, after the Netherlands, Sweden has the highest drug-related expenditure per capita in EUR and as percentage of GDP.

**Table 1: Drug- related expenditure per capita in EUR and as percentage of GDP**

| | Per capita | % of GDP |
|---|---|---|
| Netherlands | 139 | 0.66 |
| Sweden | 107 | 0.47 |
| UK | 68 | 0.35 |
| Luxembourg | 54 | 0.15 |
| Ireland | 49 | 0.27 |
| Finland | 31 | 0.15 |
| Belgium | 18 | 0.09 |
| Austria | 18 | 0.08 |
| France | 16 | 0.08 |
| Denmark | 14 | 0.05 |
| Italy | 11 | 0.06 |
| Portugal | 9 | 0.10 |
| Spain | 9 | 0.07 |
| Germany | 9 | 0.04 |
| Greece | 2 | 0.02 |

N/A = not available

Austria: 8,114,000 population and GDP of €181,937 million; Belgium: 10,214,000 population and GDP of €214,961 million; Denmark: 5,319,000 population and GDP of €148,975 million; Finland: 5,171,000 population and GDP of €107,900 million; France: 59,099,000 population and GDP of €1,244,312 million; Germany: 82,087,000 population and GDP of €1,870,714 million; Greece: 10,553,000 population and GDP of €106,742 million; Ireland: 3,745,000 population and GDP of €67,861 million; Italy: 56,952,000 population and GDP of €1,011,082 million; Luxembourg: 431,000 population and GDP of €15,410 million; Netherlands: 15,754,000 population and GDP of €332,513 million; Portugal: 9,983,000 population and GDP of €92,031 million; Spain: 39,418,000 population and GDP of €492,989 million; Sweden: 8,868,000 population and GDP of €201,024 million; UK: 59,333,000 population and GDP of €1,165,057 million

*Source: adapted from Public expenditure on drugs in the European Union 2000-2004, EMCDDA, 2004*

# PART 2: THE DRUG SITUATION IN SWEDEN

The development of the drug problem at the national level will be reviewed in more detail to see to what extent changes in drug policy have had an impact of drug use levels in Sweden.

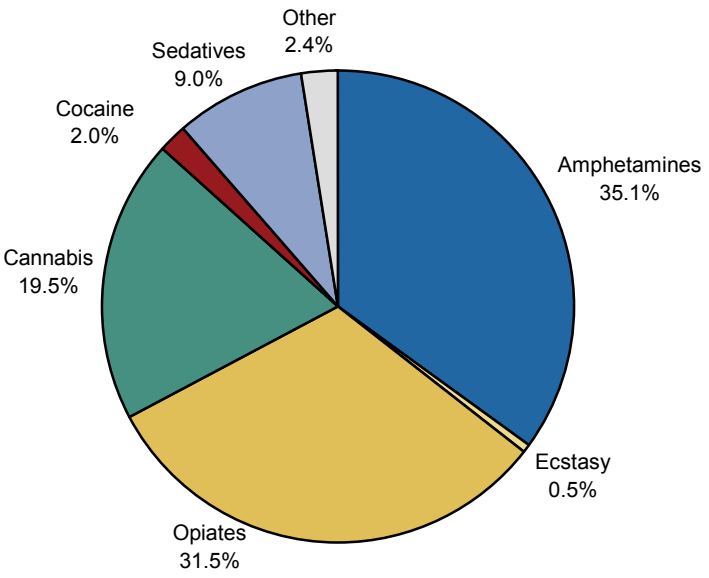
## Amphetamine - the main problem drug

Unlike most European countries, the main problem drug in Sweden is not heroin but intravenously administered amphetamine. As outlined above, Sweden was among the first countries in Europe to experience a major amphetamine epidemic, dating back to the 1930s. Despite progress made in curbing amphetamine use, amphetamine is still the main problem drug in the country.

Heroin, the main problem drug in Europe, was not known in Sweden until the late 1960s. While its abuse has expanded over the years, heroin ranks second as a problem drug in Sweden. Cocaine and ecstasy are of limited importance. As in most countries around the world, cannabis is the most widely used drug among youth and the general population.

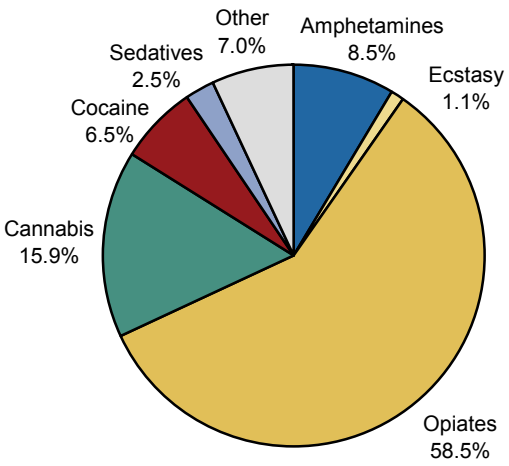
Data for treatment demand clearly show the predominant role of amphetamine abuse in Sweden. Amphetamine (35.1 per cent) outranks opiates (31.5 per cent), with cannabis in third place (19.5 per cent). The proportion of amphetamine in treatment is in Sweden four times larger than in Europe as a whole.

**Figure 2: Drug-related treatment demand in Sweden, 2003**




*Source: UNODC, Annual Reports Questionnaire Data.*

**Figure 3: Drug related treatment demand in Europe, 2000-04**




*Source: UNODC, 2006 World Drug Report*

### *Development of amphetamine use from 1940 to date*

The introduction of amphetamines, primarily benzedrine and methamphetamine (marketed as pervitin), in about 1938 marked the beginning of a drug abuse problem in Sweden. Drugs were heavily advertised (one popular slogan was "Two pills are better than a month's vacation"), sold freely and subsequently used by large sections of the population. Representative enquiries into student behaviour in Sweden found a few years after their introduction into the Swedish market that 70-80 per cent of students were occasional users of 'pep pills'.[55] Although figures are not directly comparable, in 2003, life-time prevalence of amphetamines among 15-16 year olds ini Sweden was estimated at 1 per cent (2003 ESPAD study).[56]

The introduction of a prescription requirement for amphetamine in 1939 did not lead to a sustained reduction in use. Sales were halted only for about a year before skyrocketing again as people collected prescriptions through third parties. The use of amphetamine began to rise continuously and in 1943, almost 10 million tablets were consumed annually. At that time, the number of amphetamine users was estimated at 200,000 users, equivalent to 4.6 per cent of the population age 15-64.

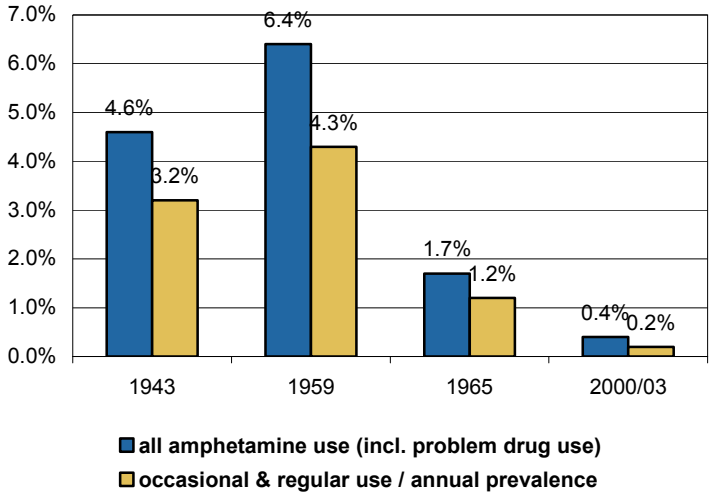
The sales of amphetamine plunged, however, when the National Medical Board of Health issued a warning on the risk and abuse of stimulants in April 1943. The decline, which has been estimated at between 40 to 60 per cent, was caused*, inter alia,* by restrictive prescription practices.

Soon after 1943, the market for amphetamines recovered and abuse continued to spread. By the late 50s, abuse of methylphenidate, a central-nervous system stimulant, was a great concern. Dexamphetamine and phenmetrazine were also widely used as weight-reducing agents.

In 1959, the total number of amphetamine users peaked at 313,000 people or 6.4 per cent of the population age 15-64, which is extremely large, even by today's global standards. (The highest level of amphetamines use worldwide is currently reported from the Philippines with an annual prevalence rate of 6 per cent, followed by Australia with 3.8 per cent).[57]

However, by 2000/2003, the total number of amphetamines users in Sweden was only a fraction of what it had been in 1959, some 25,000 persons (UNODC estimate[58]) or 0.4 per cent of the population age 15-64. The Swedish drug policy seems to have contributed to this decline.

**Figure 4: Amphetamine use in Sweden among the general population (age 15-64), 1943-2003**




*Sources: Börje Olsson,* Narkotikaproblemets bakgrund – Användning av och uppfattningar om narkotika inom svensk medecin 1839-1965 *(The Background of the Drug Problem – Use of and Conceptions about Narcotic Drugs in Swedish Medicine, 1939-1965), Stockholm 1994; and UNODC, Annual Reports Questionnaire Data.*

The massive decline in overall amphetamine use since the late 1950s, however, does not appear to have been sufficient to reduce problematic use of amphetamines. An ever larger proportion of amphetamine users eventually became dependent on the substance, partly linked to a trend towards injecting amphetamine.

Estimates of the number of heavy amphetamine abusers were still rather low in 1959, at some 3,300 persons or 0.07 per cent of the population age 15-64). By 1965, this number had increased to some 4,000 persons, despite stricter prescription requirements. Offering drugs, notably amphetamines, to drug abusers, as was done in the Stockholm experiment, could not reverse this trend. By 1969, the number of problem drug users had increased to 10,000. Given the fact that the overwhelming majority used amphetamines, the number of amphetamine abuser is estimated at 8,000 persons.

The gradual restriction of the Swedish drug control policy after 1968 is associated with a fall in both overall amphetamine use and problematic amphetamine use. In 1979, the number of problem drug users was estimated at between 10,000-14,000 persons, of which an estimated 5,600 were amphetamine abusers, equivalent to 0.11 per cent of the population age 15-64 - much lower than in 1969.

No estimates on problem drug use are available for the 1980s, but it is generally assumed that there was not much of an increase as rising drug budgets meant that ever more drug addicts benefited from treatment.

This changed in the 1990s. By 1992, the overall number of problem drug users was estimated to have increased to 17,000 (14,000-20,000), rising further to 26,000 by 1998 and 28,000 by 2001. The proportion of amphetamine as the prime drug among problem drug users, however, continued to decline, from 47 per cent in 1979 to 32 per cent in 1998.[59] Applying the ratio of 32 per cent to the number of problem drug users in 2001, calculations suggest that there were some 9,000 amphetamine related problem drug users in Sweden, or 0.16 per cent of the population age 15-64.

Less than 26,000 persons were estimated to be problem drug users in 2003, which, assuming a constant proportion of amphetamine in overall problem drug use, gives an estimate of 8,200 persons or 0.14 per cent of the population age 15-64 in 2003. This would be still more than amphetamine-related problem drug use in 1959, 1965 or 1979 though at similar levels as estimates for 1969.

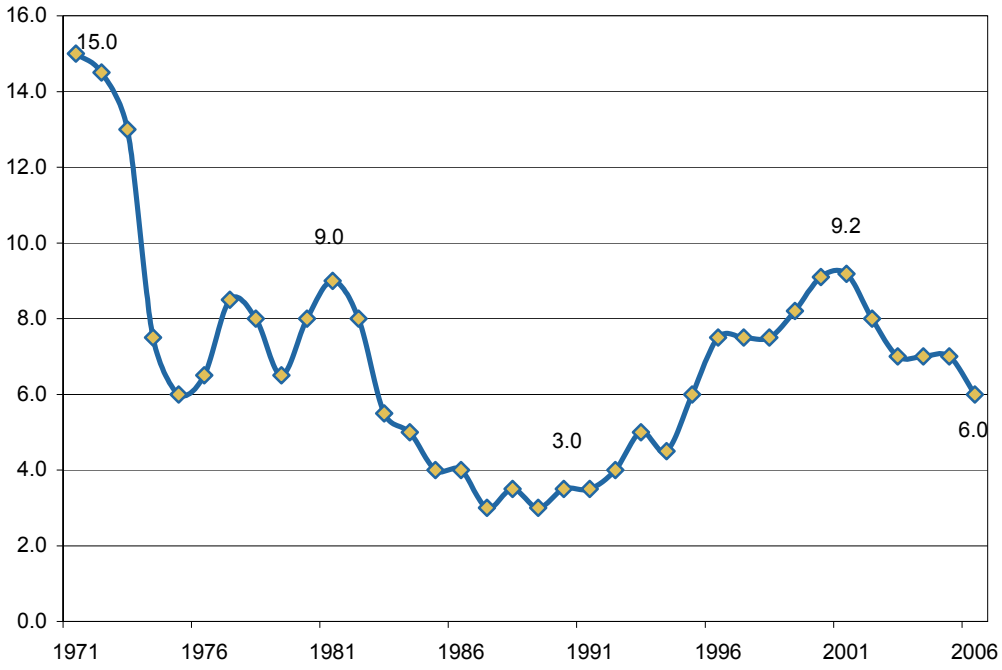
## Drug use in Sweden since 1970

As shown above, Sweden experienced significant increases in amphetamine use in the 1940s and 1950s. This period was followed by major successes in curbing amphetamine use, notably over the 1959-65 period (more than 70 per cent), mainly by addressing the prescription practices of medical doctors. Thus, within a five to six year period, Sweden's extensive amphetamine use levels have been on the way towards a gradual elimination. However, a number of new drugs emerged and existing ones, notably cannabis and LSD, became widespread within short periods of time.

Epidemiological data in Sweden has been collected systematically since the 1970s. The best available data to monitor the impact of the drug policy are the regularly undertaken national school surveys and the surveys on military recruits in Sweden.

Life-time prevalence of drug use among 15-16 year old students declined from 15 per cent in 1971 to 3 per cent in 1989. Past month prevalence rates showed an even steeper decline, falling by 90 per cent over the same period, from 5 per cent to 0.5 per cent.

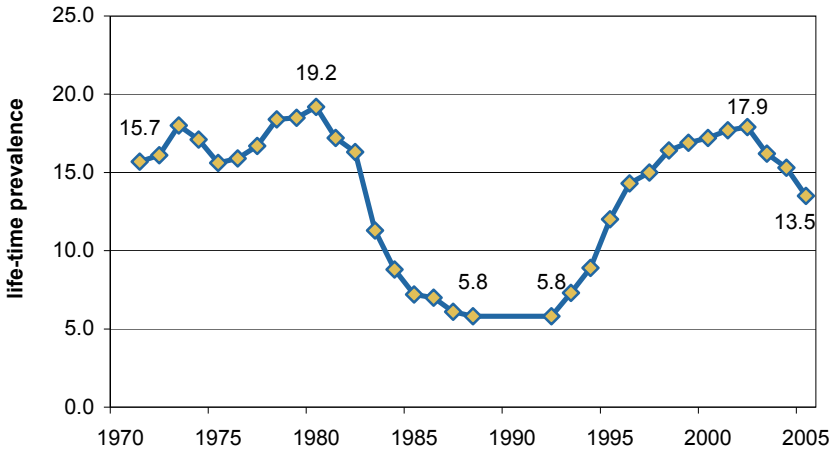
**Figure 5: Life-time prevalence of drug use among 15-16 year old students in Sweden, 1971-2006**




*Source: CAN*

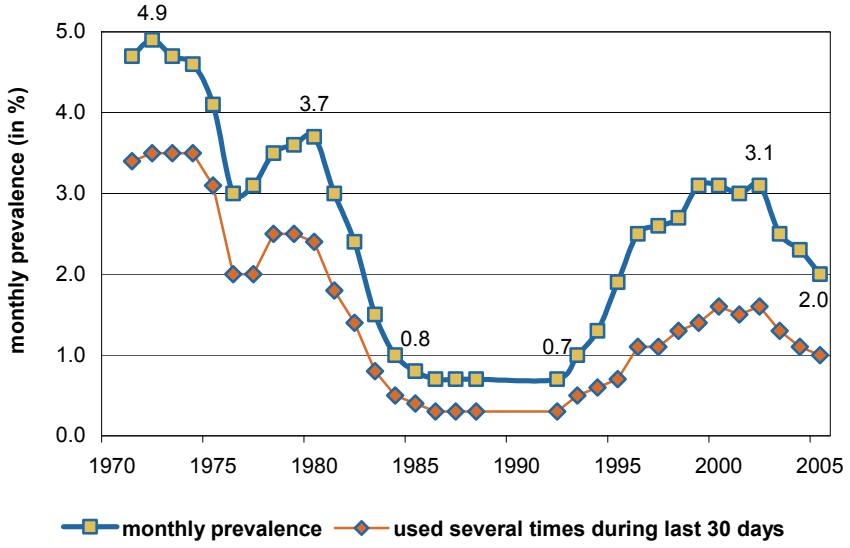
Life-time prevalence of drug use among military recruits fell by more than half, from 15.7 per cent in 1971 to 5.8 per cent in 1988. It may be noted though that the decline in drug use in the 1970s was limited to pupils in the younger age group while the decline of life-time prevalence among military recruits only took effect in the 1980s; in contrast, current use of drugs among military recruits already started declining in the 1970s (by about 25 per cent between 1972 and 1980) .

**Figure 6: Life-time prevalence of drug use among military recruits in Sweden, 1971-2005**




*Source: CAN*

**Figure 7: Past month prevalence of drug use among military recruits in Sweden, 1971-2005**




*Source: CAN*

These patterns were reflected for most drug categories. Life-time prevalence among conscripts showed steep declines for cannabis, cocaine, amphetamines and LSD between the early 1970s and the late 1980s.

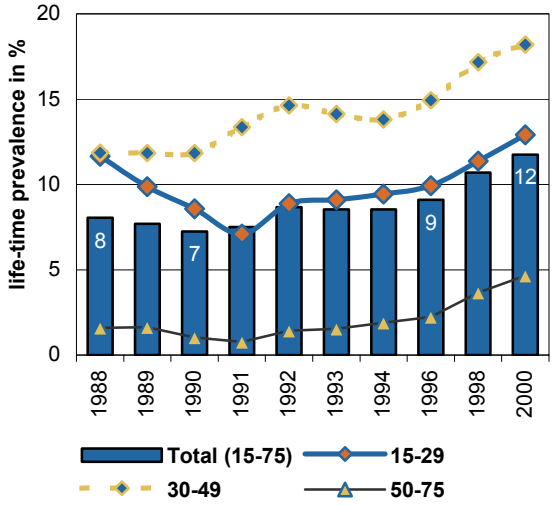
As can be seen from above, progressive restrictiveness of drug policies was associated with lower levels of drug use. The proclaimed goal of a drug-free society no longer seemed to be an utopian objective, but a goal that was within reach.

### *The expansion of drug abuse in the 1990s*

Data for the 1990s, however, clearly pointed in the opposite direction. The trend showed upwards in general population surveys where life-time prevalence of drug use among those aged 15-75 rose from 7 per cent in 1990 to 12 per cent in 2000. Increases were observed for those 15-29 year olds, 30-49 year olds and 50-75 year olds. Massive increases were evident in youth surveys and conscript surveys. In addition, the number of problem drug users rose by more than a third

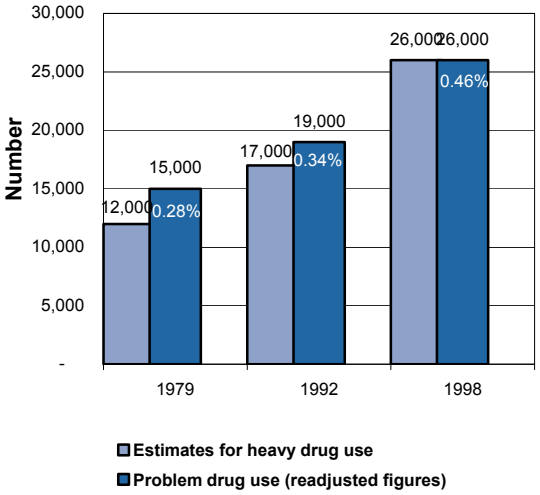
between 1992 and 1998. Drug-related treatment demand rose by more than half. The number of drug related deaths doubled over the 1990-2000 period.

**Figure 8: Life-time prevalence of drug use, sliding three year averages, 1988-2000, breakdown by age group**



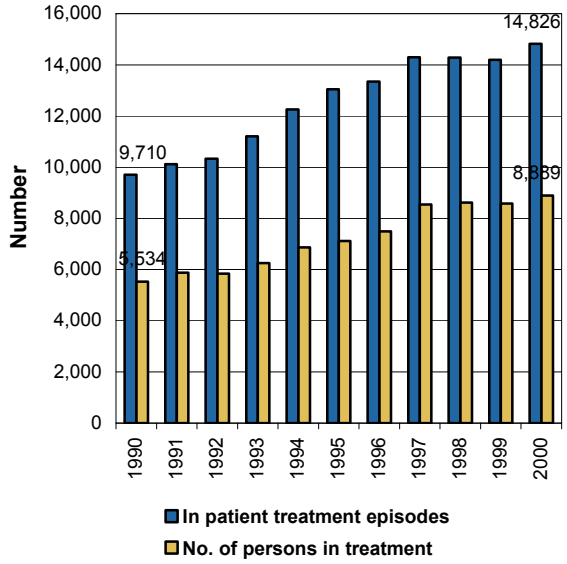

*Source: CAN.*

**Figure 9: Number of problem drug users in Sweden (and as a proportion of the population age 15-64), 1979-1998**



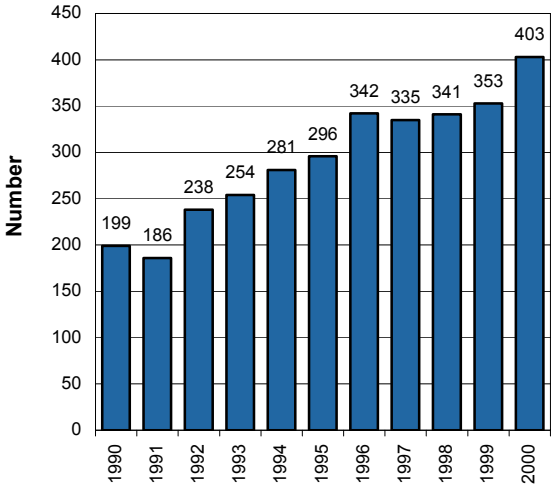

*Sources: Tim Boekhout van Solinge, The Swedish Drug Control Policy, 1979 and CAN 2006.*

**Figure 10: Treatment demand for drug abuse in Sweden, 1990-2000**




*Source: CAN*

**Figure 11: Drug-related deaths in Sweden, 1990-2000**




*Source: CAN*

Drug prices also declined, despite rising seizures, a clear indication for increased drug supply. From 1990 to 2000, prices for heroin, amphetamine, cocaine and cannabis resin declined significantly.

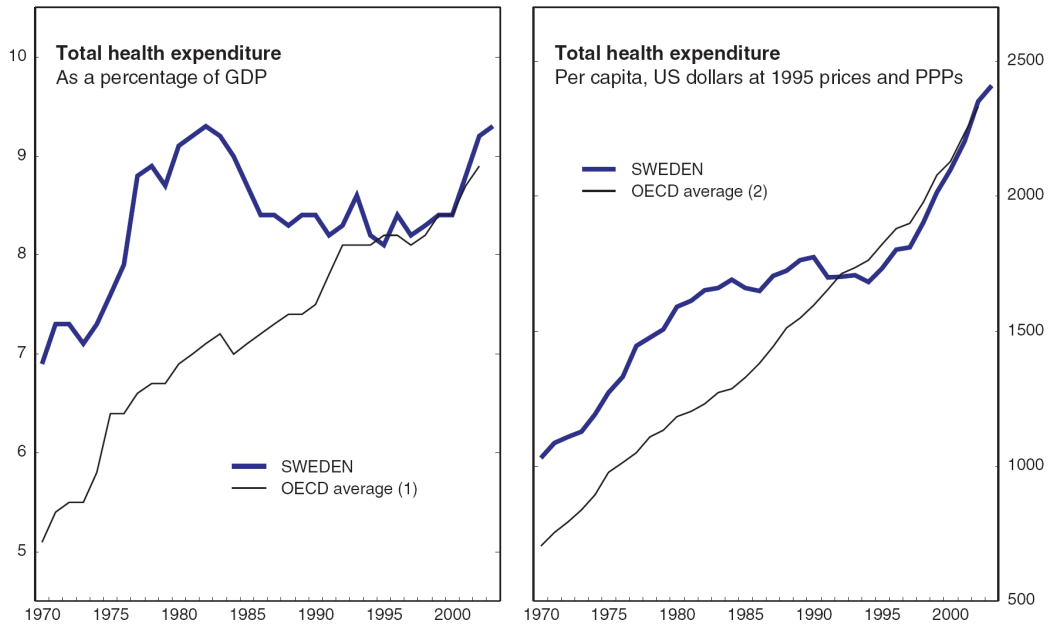
While a general increase in drug abuse in Europe was observed at the time, the deterioration of drug use indicators in Sweden was nevertheless startling. There was no 'softening' of Sweden's drug policies in the 1990s. Therefore, increases in drug abuse cannot be explained by any permissive trends. A number of other factors played a role:

### *Slowdown in economic growth and resulting budget cuts*

GDP growth, which had amounted to 2.5 per cent p.a. over the 1985-1990 period, declined by, on average, 0.9 per cent over the 1991-93 period[60]. In parallel, the general government balance moved from a surplus to a deficit of 11.3 per cent of GDP by 1993 and the debt/GDP ratio peaked at 72.9 per cent in 1993.

These conditions necessitated the implementation of severe economic austerity programmes which involved a review of the country's generous welfare system. Cuts to welfare spending included reductions in child allowances, pensions, housing subsidies as well as the health sector. Expressed as a percentage of GDP, health expenditure was slashed from levels exceeding 9 per cent of GDP in the early 1980s (one of the highest such levels at the time among industrialized countries) to levels around 8 per cent of GDP in the 1990s. It was Sweden's drug control system, notably its treatment system for drug addicts, that was heavily affected by these cuts.

**Figure 12: Total health expenditure in Sweden, 1970-2000**




*Source: OECD, OECD Economic Surveys – Sweden, Volume 2005/9, August 2005*

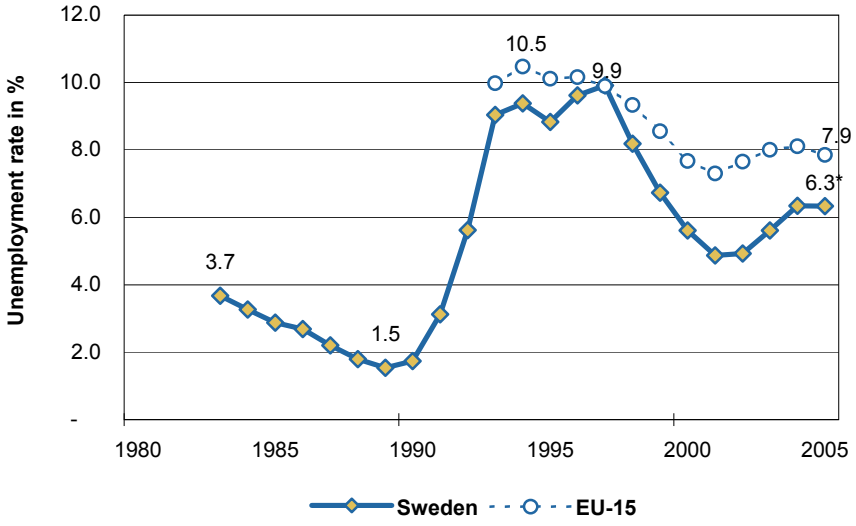
Therefore, while the basic orientation of Swedish drug policy had not changed, the overall priority of drug control, as reflected in budget allocations, undeniably declined in the 1990s.

The increasing decentralization of Sweden's health care system also played a role and *de facto* reduced the priority given to the drug problem. Because of the economic crisis at the beginning of the 1990's large cuts were effected at the local level. The municipalities were not allowed to raise taxes during a couple of years. Available resources were directed primarily towards care of the elderly and the disabled while resources for social services - which have the overall responsibility for prevention and treatment of substance abuse - were kept more or less constant. Within the social services there was a reallocation of resources to economic support and to the care of children. According to the National Board of Health and Welfare, the cost of addiction care

decreased gradually as a share of social services costs in the 1990s (15 per cent between 1995 and 2000). In terms of money spent, there was a decrease of about a quarter from almost SEK five billion in 1995 (almost €540 million or US$700 million in 1995) to SEK 3.7 billion in 2000 (€440 million or US$400 million). As a consequence, less treatment was available. The time a user could spend in treatment was also reduced. Whereas in 1989 there were 19,000 people in treatment centres (for both alcohol and drugs), this number dropped to 13,000 by 1994. Due to the budget cuts, 90 treatment homes had to be closed between 1991 to 1993.[61] Cuts also affected outreach work in many municipalities at the beginning of the 1990's so that outreach work among drug addicts became a rarity.

Reduction in employment in the public and private sector saw increases in Sweden's unemployment rate which rose from a mere 1.5 per cent in 1989 to 9.9 per cent in 1997[62].

**Figure 13: Unemployment rate in Sweden and in the EU-15, 1983-2005**




*Source: Eurostat database, Harmonized Unemployment rate.*

The effect was even more pronounced for young people. Unemployment among young people (age 15-24) rose from 3.7 per cent in 1990 to 16.7 per cent in 1994 and remained at the high levels in subsequent years (15.4 per cent in 1997).[63] Drug use and unemployment have been shown to be strongly correlated and the unemployed, notably young unemployed, are believed to be far more susceptible to drug use than those employed.

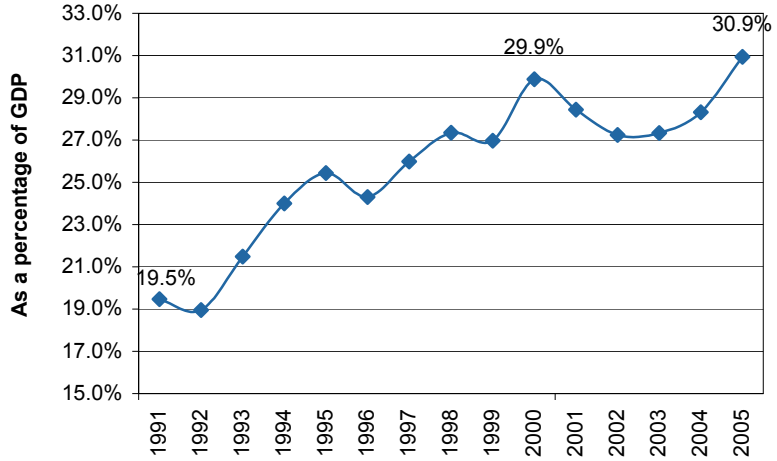
### *Widening income inequalities*

Widening income inequalities are frequently seen as contributing factors to criminal activities, including drug trafficking. Participation in drug trafficking is, *inter alia,* a function of the perceived risk/benefit equation; the risk function is, *inter alia,* influenced by the level of income inequality in society.[64] Increases in drug trafficking lead to falling drug prices and thus increases the likelihood of drug use. Though income inequality is still one of the lowest worldwide (2nd lowest among all OECD countries behind Denmark and ahead of the Netherlands and Austria in 2000), it clearly widened in Sweden in the 1990s[65].

### *Increase in imports*

Imports more than doubled between 1991 and 2000. Expressed as a proportion of gross domestic product, goods imports rose from less than 20 per cent in 1991 to 30 per cent of GDP in 2000. The mere fact that foreign trade played an ever bigger role for the Swedish economy also meant that it became *de facto* easier for drug traffickers to hide drugs in licit goods deliveries.

**Figure 14: Import of goods, expressed as a percentage of GDP**




*Source: Statistics Sweden – National Accounts .*

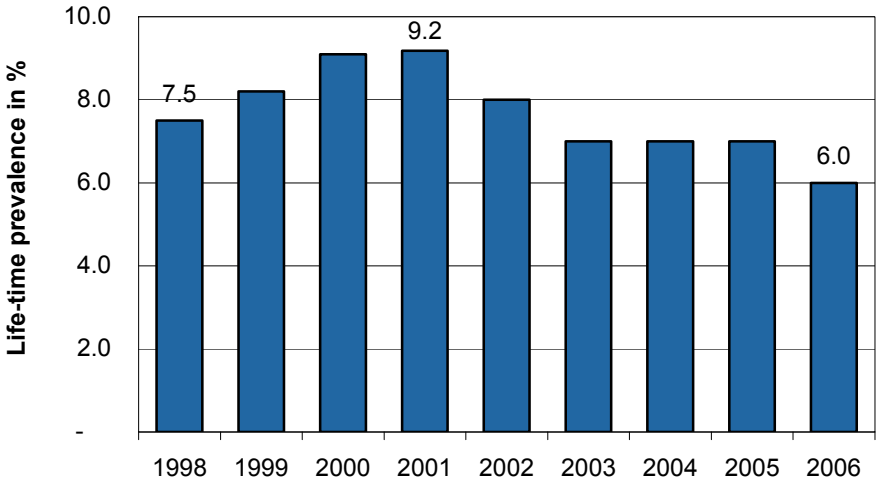
The opening of Eastern Europe following the removal of the iron curtain in 1989 and thus the emergence of ever stronger trade links with the Baltic countries and Poland as well as Sweden's' entry into the EU in 1995 and the related opening of the country towards the rest of western Europe may have also played a role in raising the attractiveness of Sweden as a drug market.

### *Downward trend in drug abuse from 2001/02 to 2005/06*

The upward trend in drug use was reversed again in the new millennium, particularly among young people. Life-time prevalence among 9th graders declined by 35 per cent between 2001 and 2006 (from 9.2 per cent to 6.0 per cent). The decline was observed among both male and female students.

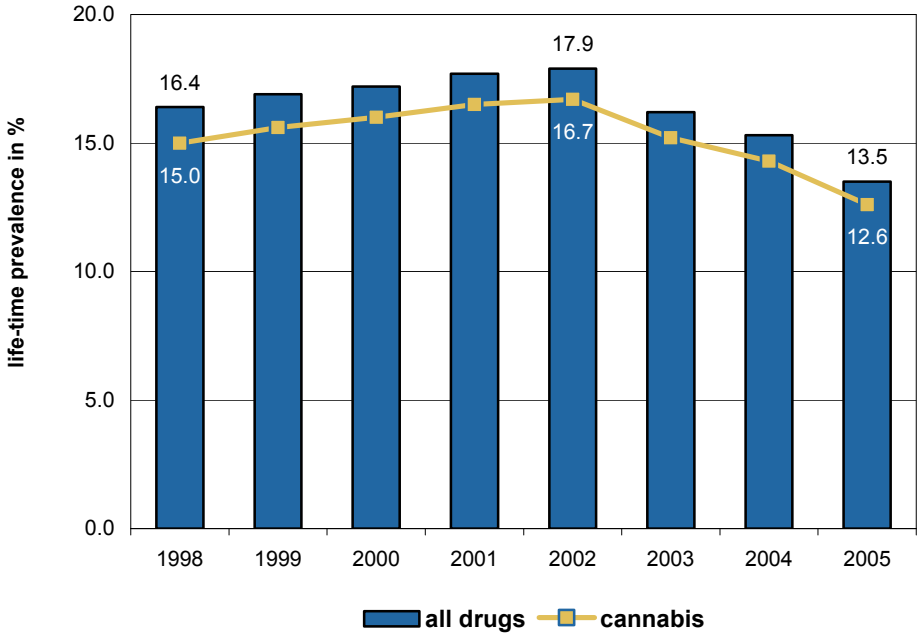
Life-time prevalence of drug use among conscripts declined significantly between 2002 and 2005 by 25 per cent (from 17.9 per cent to 13.5 per cent) for all drug categories. The declines were most pronounced for LSD (-62 per cent between 2002 and 2005), ecstasy (-56 per cent), heroin (-50 per cent) and amphetamine (-42 per cent).

**Figure 15: Life-time prevalence of drug use among 9th graders (15-16 year olds) in Sweden, 1998-2006**



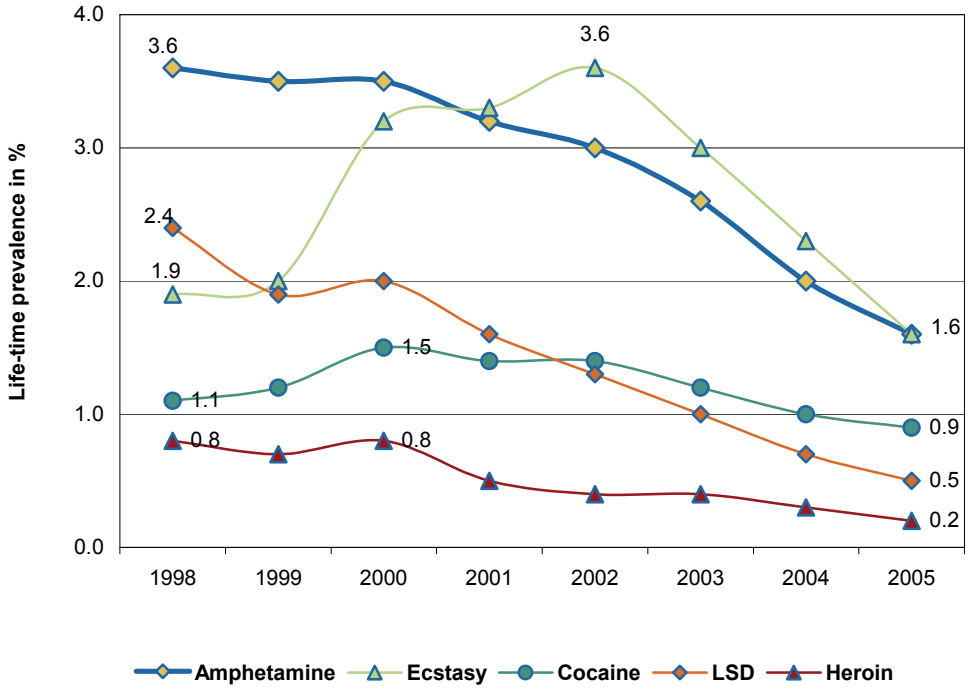

*Source: CAN*

**Figure 16: Life-time prevalence of drug use among conscripts in Sweden, 1998-2005**




*Source: CAN*

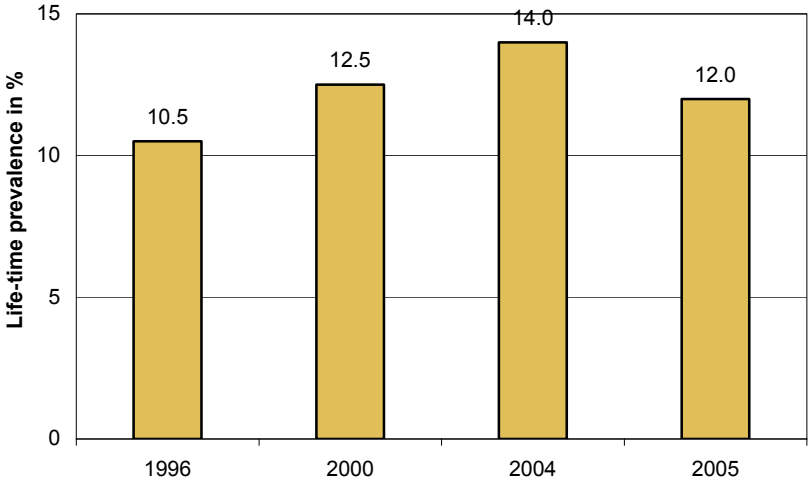
**Figure 17: Life time prevalence of drug use other than cannabis among military conscripts, 1998-2005**




*Source: CAN*

Falling levels of drug use among 9th grade students (after 2001) and among conscripts (after 2002) were also reflected in general population surveys on cannabis - a proxy for drug use in general - in 2005. Following years of increase, general population survey data showed a decline in 2005.

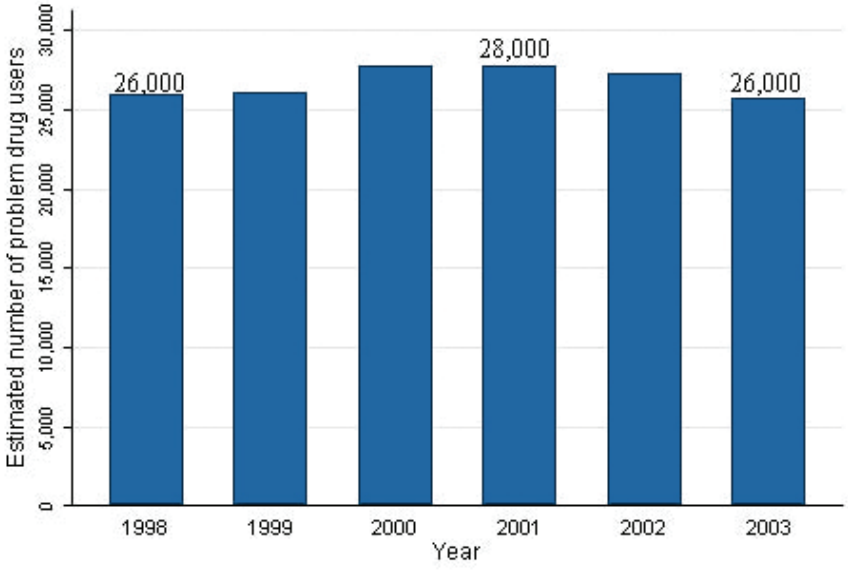
**Figure 18: Life-time prevalence of cannabis use among the general population, age 18-64, in Sweden, 1996-2005**




*Source: Statens Folkhälsoninstitut, 2005 National Report to the EMCDDA – Sweden.*

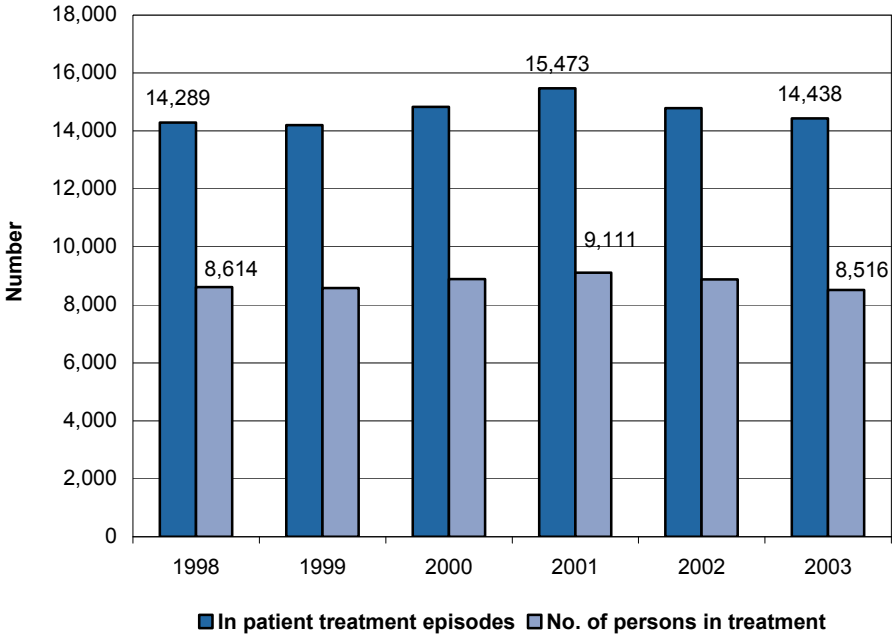
Declines were also evident in the number of problem drug users, which fell from 28,000 in 2001 to less than 26,000 in 2003 (-7 per cent). Similarly, drug-related treatment demand declined, from 15,500 episodes in 2001 to 14,400 in 2003 (-7 per cent). The number of drug-related deaths (with drugs being an either an underlying or a contributing cause) also declined, from 403 cases in 2001 to 385 cases in 2003 (-7 per cent).

**Figure 19: Number of problem drug users in Sweden, 1998-2003**



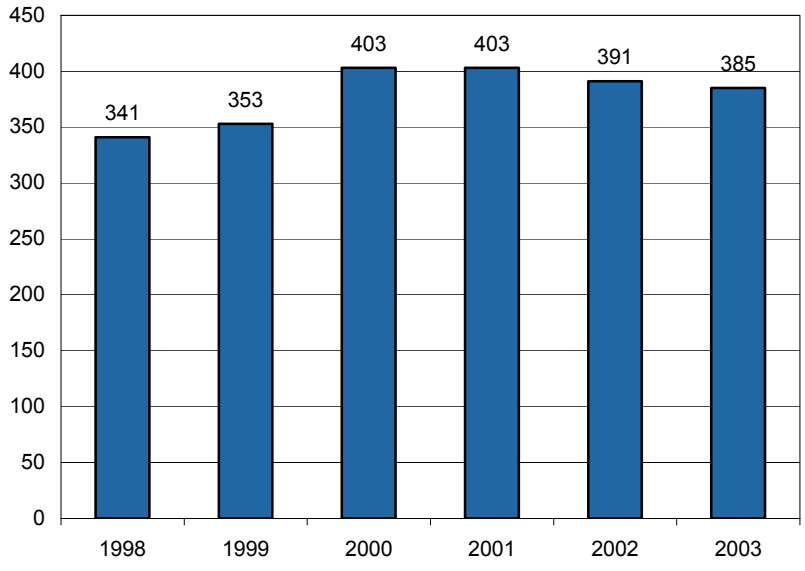

*Source: Statens Folkhälsoninstitut, 2005 National Report to the EMCDDA – Sweden.*

**Figure 20: Treatment demand for drug abuse in Sweden, 1998-2003**




*Source: CAN*

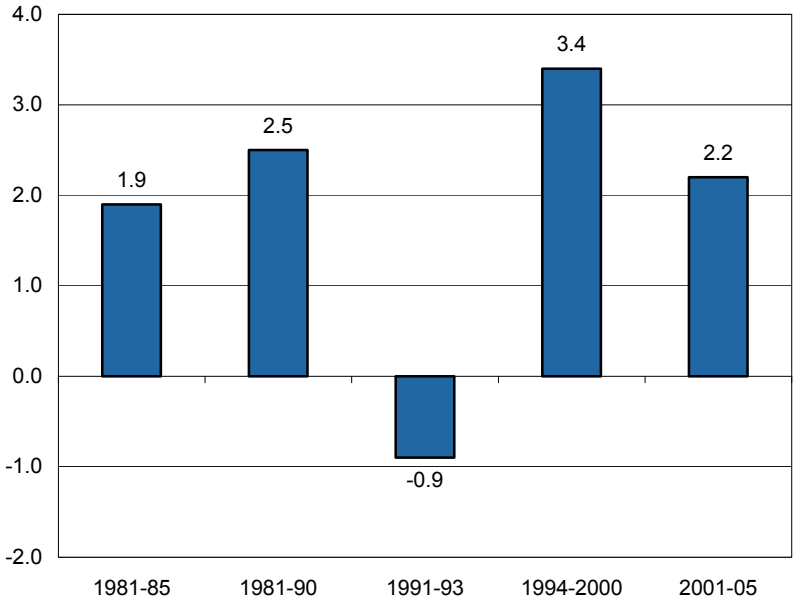
**Figure 21: Drug-related deaths in Sweden, 1998-2003**




*Source: CAN*

In examining the reasons for the general decline in drug use and drug-use related consequences in Sweden and considering the contributing factor of the economic downturn earlier on, the role of economic factors should be examined.

**Figure 22: Economic growth in Sweden, average annual changes of constant GDP, 1981-2005**




*Source: Eurostat – database*

As can be seen from the above figure, economic growth cannot explain the decline in drug use over the 2001-2005 period when the economy grew with 2.2 per cent at a lower rate than in the previous period (1994-2000). Economic growth accelerated strongly over the 2004-2005 period and boomed in 2006, with a rate of 4.8 per cent for the first two quarters. Drug use, however, started declining prior to this economic boom.

Similarly, drug use indicators continued deteriorating at the end of the 1990s when the Swedish economy had already recovered from the period of negative growth in the early 1990s. The correlation between the deterioration of Sweden's economy and increases in drug use thus only applies to the early 1990s.

While a direct link between economic growth and drug use cannot be established, there are some indirect mechanisms at work. Economic recovery had a delayed impact on the level of unemployment. If one takes an average of 5-year intervals, drug use and unemployment do correlate rather strongly. However, falling drug use rates in recent years, cannot be explained exclusively by lower unemployment rates.

All of this points to another crucial element - Sweden's drug policy. It seems to have played, once again, a significant role in lowering drug use levels in this country in recent years.

As seen above, Swedish drug policy received an impetus after the work of the Drugs Commission had been concluded in 2000. The adoption of a National Action Plan on Drugs as well as stronger political leadership on the drug issue is associated with the subsequent improvement of the drug control indicators. Moreover, investment in drug policies was seen as a measure to reduce health-related costs in the future. A recently undertaken review of total public expenditure on Sweden's drug policy revealed that it totaled between €0.5 and €1.2 billion[66] in 2002, equivalent to between 0.2 per cent and 0.5 per cent of GDP or between 0.7 per cent and 1.7 per cent of total government expenditure.

## The drug situation in Sweden - an international comparison

Over the past few years, the drug control indicators in Sweden have shown marked improvements. But how 'good' are these results at the international level? The following chapter tries to provide some answers to that question.

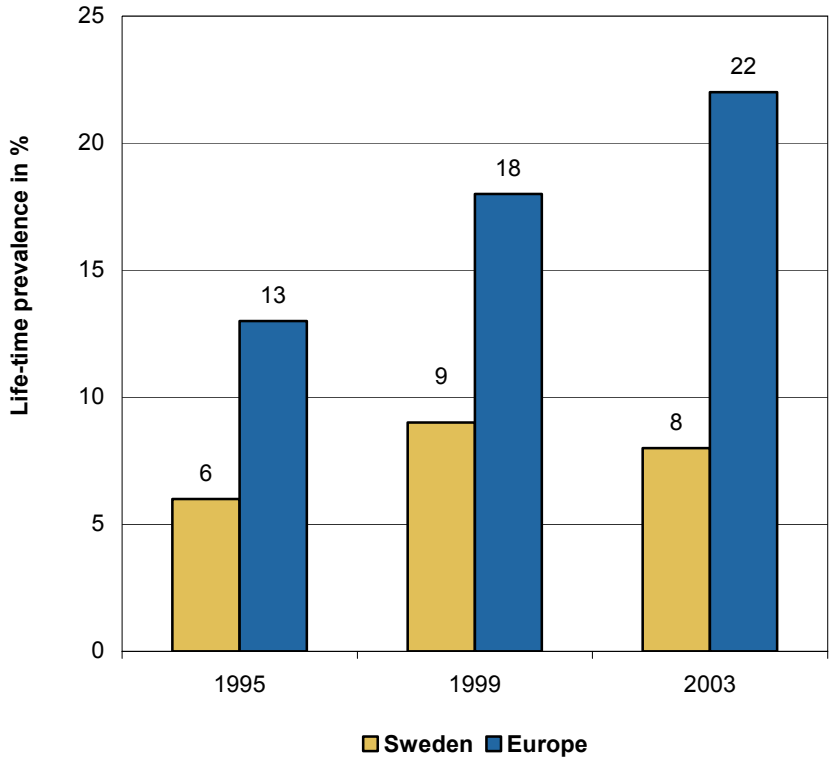
It is interesting to compare the Swedish results with those of other countries or areas participating in the European School Survey Project on Alcohol and Drugs (ESPAD), conducted on behalf of the Council of Europe and in close cooperation with the Swedish Council for Information on Alcohol and Other Drugs (CAN) in 35 European countries and areas. Results are directly comparable as ESPAD surveys take place at roughly the same time, target the same age group (15-16 year old students) and use the same methodology across all participating countries. More than 100,000 European students participated in the latest survey, including 3,200 in Sweden. The Eurobarometer survey on 'Young People and Drugs', conducted among 15-24 year olds across the countries of the EU-15 in 2004 (sample size: 7,700 people, including some 500 people interviewed in Sweden) also offers important insights.

### *Life-time prevalence of drug use among students*

The latest ESPAD study shows that illegal drug use among 15-16 year old students amounted in Sweden to 8 per cent, just a third of the European average (22 per cent).

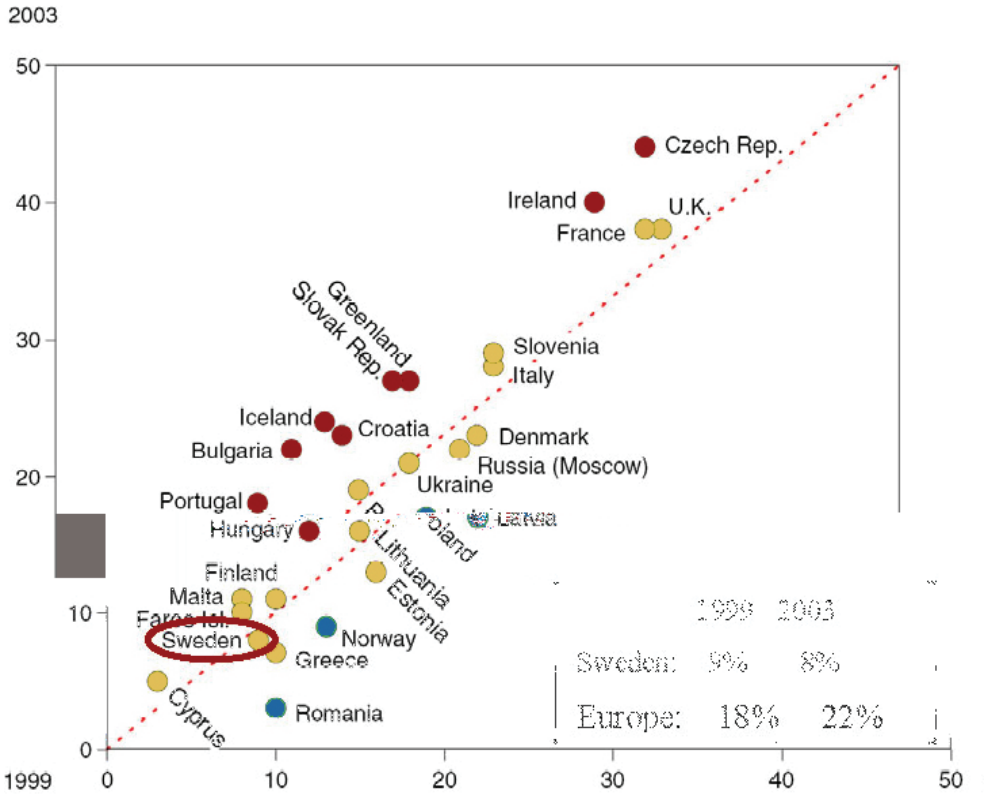
Overall life-time prevalence of drug use among students declined slightly from 9 per cent in 1999 to 8 per cent in 2003 and was thus - among 35 countries and areas investigated - the fifth lowest in Europe, after Romania, Cyprus, Turkey and Greece. Moreover, the moderate decline recorded in Sweden contrasted the overall upward trend. Average life-time prevalence of drug use in Europe rose over the same period from 18 per cent to 22 per cent.

**Figure 23: Life-time prevalence of drug use among 15-16 year old students, 1995-2003**




*Source: Council of Europe and Swedish Council for Information on Alcohol and Other Drugs*

**Figure 24: Changes in lifetime prevalence rates of illegal drug use among 15-16 year old students in Europe over the 1999-2003 period***

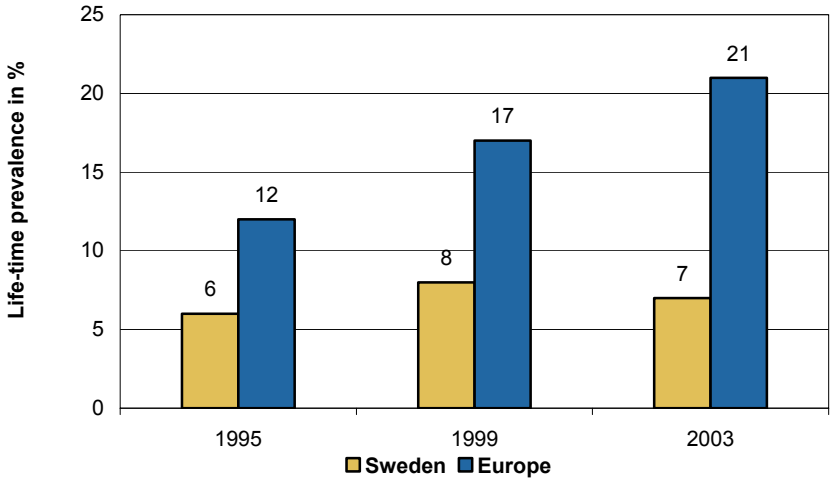



** Countries above the line show increased life-time prevalence rates while countries below the line show decreases in life time prevalence*

*Source: Council of Europe and Swedish Council for Information on Alcohol and Other Drugs (CAN) , The ESPAD Report 2003, Nov. 2004*

Like in the rest of Europe, drug use in Sweden is primarily linked to cannabis. Sweden has low levels of cannabis use as well as low levels of overall drug use. Just 7 per cent of Swedish 15- to 16- year olds tried cannabis as compared to, on average, 21 per cent in Europe. In other words, life-time prevalence of cannabis is just a third of the European average.

**Figure 25: Life-time prevalence of cannabis use among 15-16 year old students, 1995-2003**

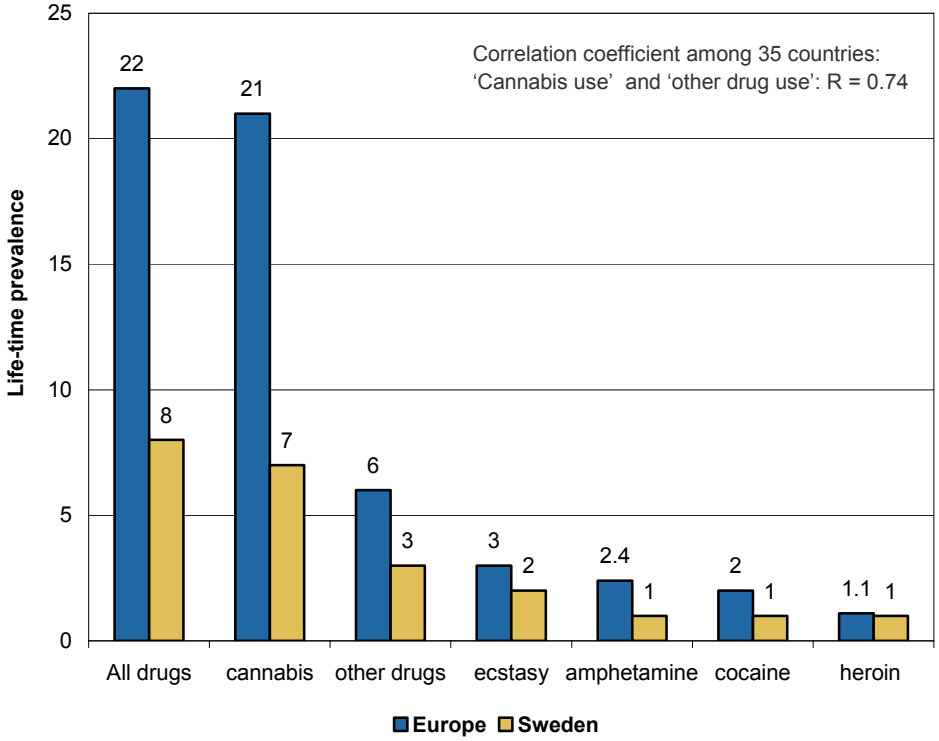



*Source: Council of Europe and Swedish Council for Information on Alcohol and Other Drugs (CAN),* The ESPAD Report 2003, *Nov. 2004*

For the more problematic current use of cannabis, as reflected in the monthly prevalence rates, the difference between Sweden and the European average is even more pronounced. While 1 per cent of Swedish youth, aged 15-16, used cannabis in the month prior to the survey, the European average amounted to 9 per cent. The monthly prevalence rate of cannabis use in Sweden is thus only slightly more than a tenth of the European average. Monthly prevalence of cannabis was lower only in Romania.

Life-time prevalence of drug use other than cannabis amounted to 3 per cent in 2003 in Sweden, half the European average (6 per cent) among 15-16 year old students. Lower rates were only reported from the Faroer Islands, Ukraine and Romania. Drug use levels among students in Sweden are also below the European average for ecstasy, cocaine, amphetamine and heroin.

**Figure 26: Lifetime prevalence of drug use among 15-16 year old students, 2003**



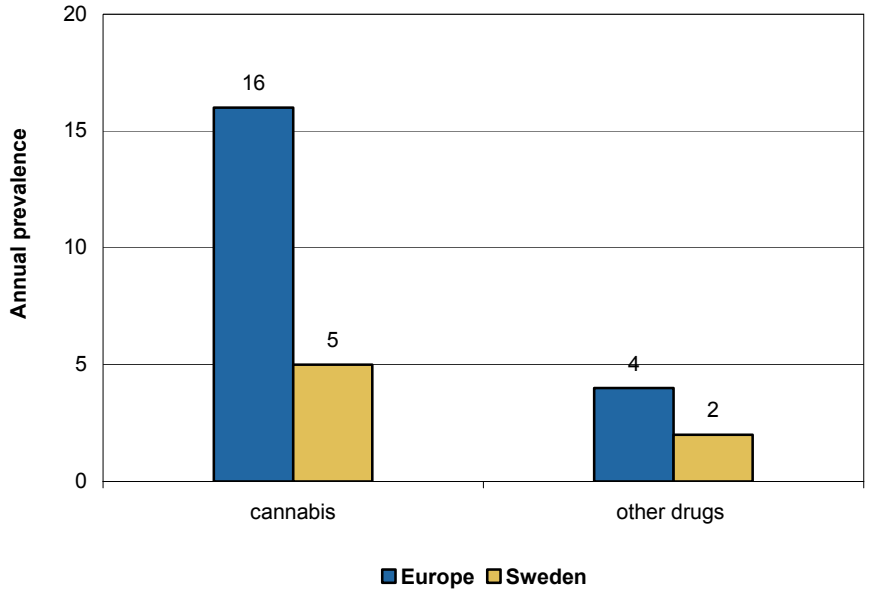

*Source: Council of Europe and Swedish Council for Information on Alcohol and Other Drugs (CAN),* The ESPAD Report 2003*, Nov. 2004*

## *Regular drug use*

### *Annual and monthly prevalence of drug use among young people*

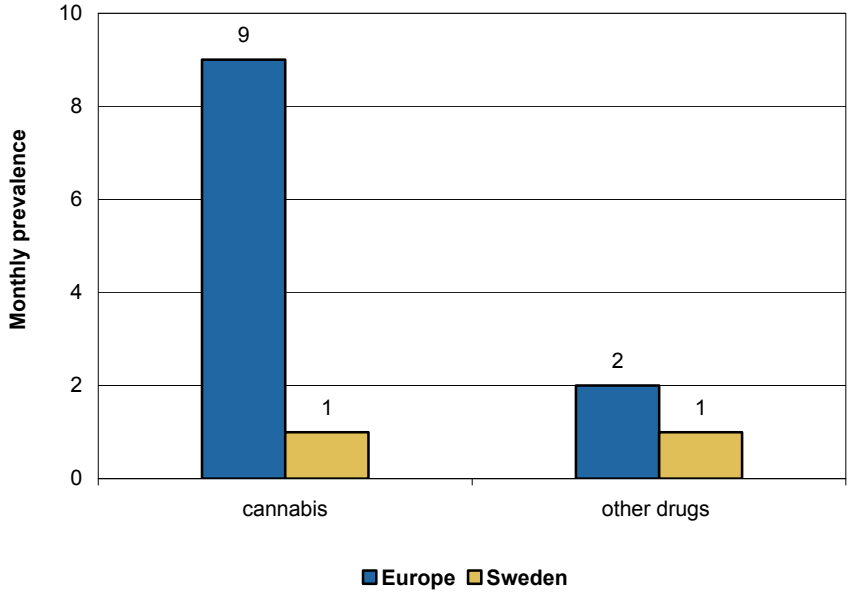
Low life-time use levels in Sweden are also reflected in below average annual prevalence and monthly prevalence rates. The 2003 ESPAD study found that annual prevalence of cannabis use in Sweden affects 5 per cent of those 15-16 year old students, less than a third of students, on average, in Europe (16 per cent). For other drugs, annual prevalence amounts to 2 per cent, i.e. half the European average (4 per cent). In terms of monthly prevalence, the differences are even more pronounced.

**Figure 27: Annual prevalence of drug use among 15-16 year old students, 2003**




*Source: Council of Europe,* The ESPAD Report 2003*, Nov. 2004*

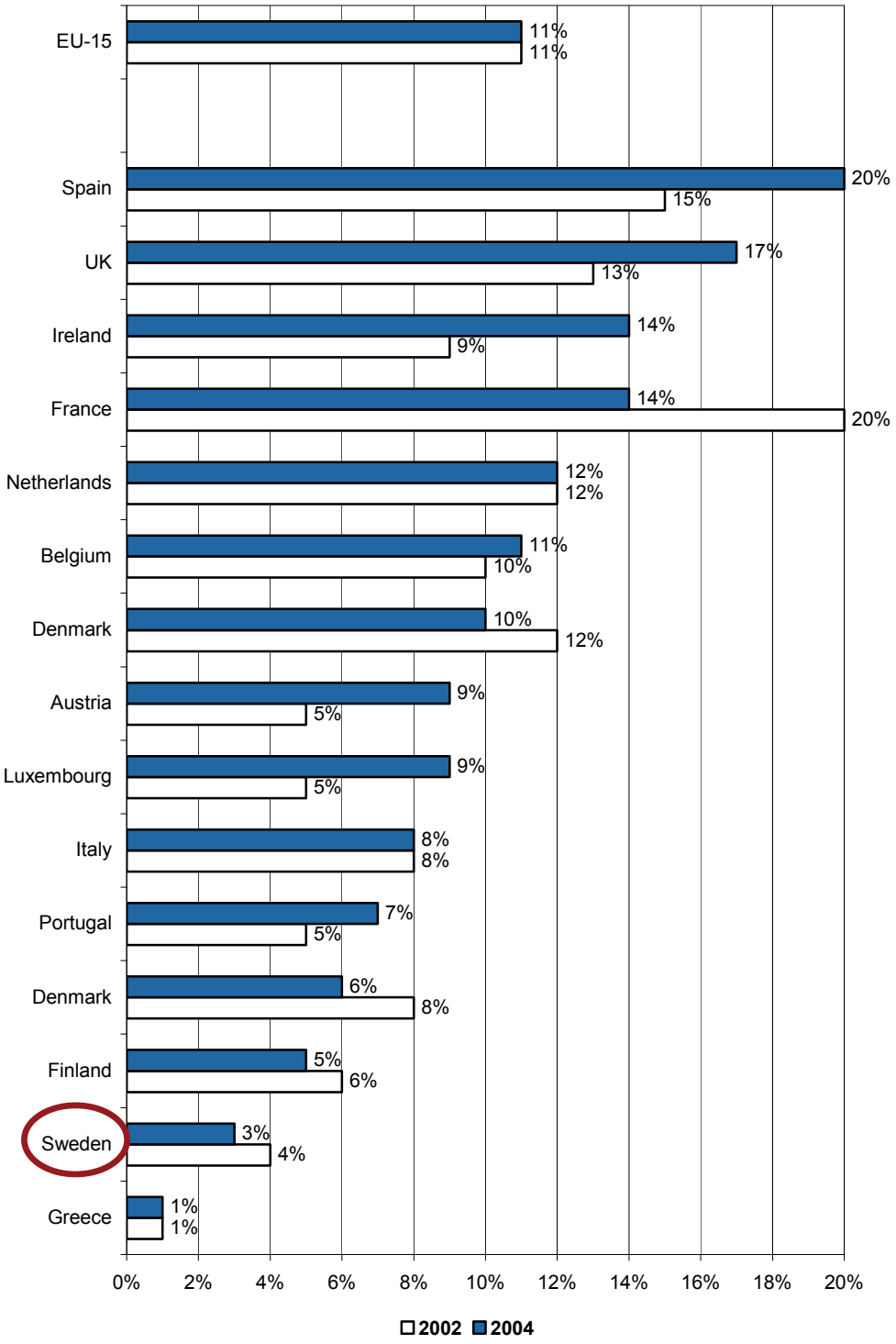
**Figure 28: Monthly prevalence of drug use among 15-16 year old students, 2003**




*Source: Council of Europe and Swedish Council for Information on Alcohol and Other Drugs (CAN),* The ESPAD Report 2003*, Nov. 2004*

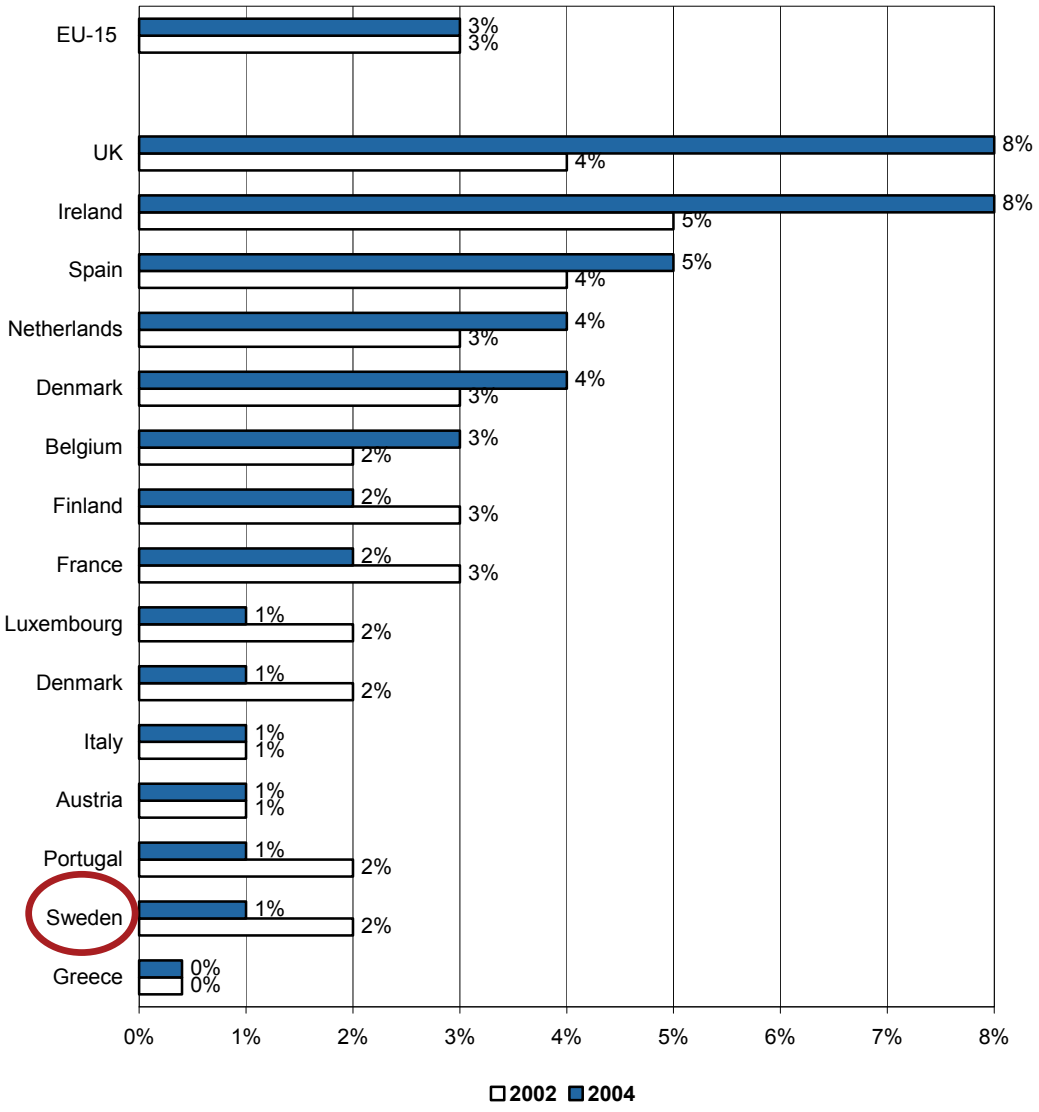
The Eurobarometer study revealed that just 3 per cent of Swedish young people (age 15-24) had used cannabis in the last month, about a quarter of the EU-15 average (11 per cent). Regular use of drugs other than cannabis was also below average.

**Figure 29: Monthly prevalence of cannabis use among 15-24 year olds in EU-15, 2002-2004**




*Source: European Commission,* Eurobarometer, Young people and drugs, *June 2004.*

**Figure 30: Monthly prevalence of drugs other than cannabis among young people (15-24), 2002-2004**



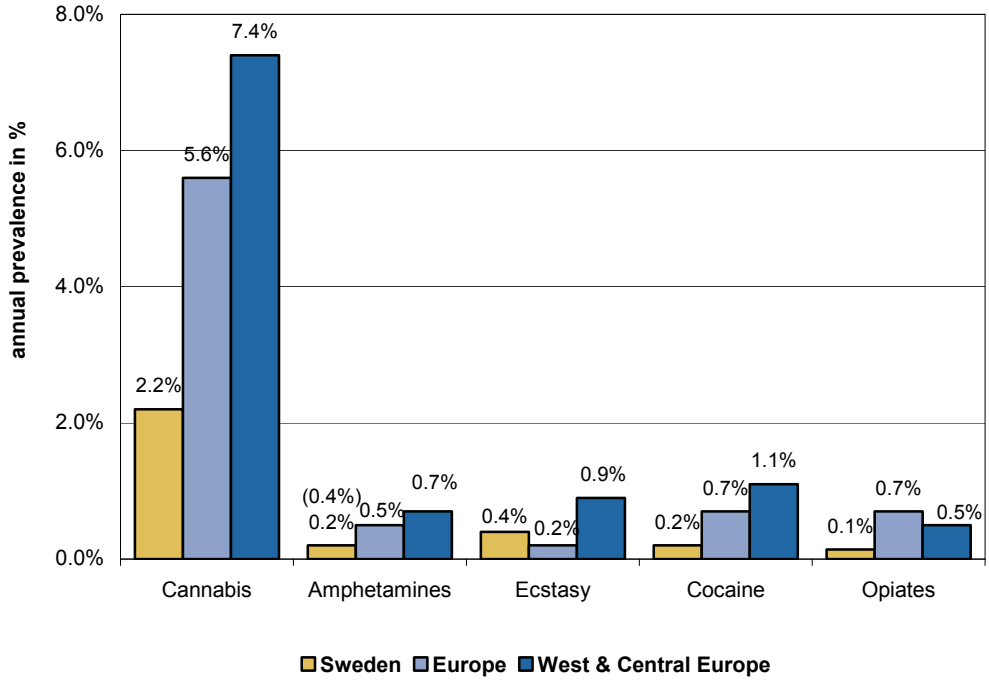

*Source: European Commission,* Eurobarometer, Young people and drugs*, June 2004.*

## *Regular drug use among the general population*

Data in the present section are primarily based on data collected by UNODC from Member States, published in the World Drug Report. Comparisons must, however, be treated with caution as underlying data differ with regard to the period when surveys were undertaken or the specific age groups investigated, which may affect results. In some cases, data are UNODC estimates, extrapolated from other available information, such as life-time prevalence rates among the general population, local studies, or student survey results in order to provide reasonable orders of magnitude of the likely extent of drug use.

Taking all of these caveats into consideration, data are, nonetheless, robust enough to state that illegal drug use in Sweden is clearly below the West & Central European average (EU-25 and EFTA countries) and – except for once substance (ecstasy) – below the overall European average.

**Figure 31: Annual prevalence of drug use in Sweden as compared to Europe among the population age 15-64, 2004 or latest year available**




*Source: UNODC, 2006 World Drug Report*

Cannabis

Cannabis is the most widely used drug in Sweden, like in the vast majority of all countries in the world.

A national postal survey, undertaken in Sweden in 2004 found for cannabis a life-time prevalence of 13.8 per cent and an annual prevalence of 2.2 per cent. A subsequent national postal survey, undertaken in 2005, revealed a decline in the life-time prevalence to 11.9 per cent and in the annual prevalence to 2.0 per cent of the population aged 16-64. This is lower than the European average of cannabis use of 5.6 per cent or for the average for West & Central Europe of 7.4 per cent (EU-25 and EFTA countries) in 2004. The annual prevalence rate of cannabis use in Sweden in 2004 was equivalent to about 40 per cent of the European average or 30 per cent of the West & Central European average. Sweden had the 6$^{th}$ lowest cannabis prevalence rate out of 40 European countries examined in 2004.

Amphetamines

For amphetamine, the most recent information from Sweden dates back to 2000 when a national general population survey showed life-time prevalence rates of 1.9 per cent and an annual prevalence rate of 0.2 per cent among population age 16-64. This is less than half the European average (0.5 per cent) and less than a third of the West & Central European average (0.7 per cent). In the United Kingdom, Estonia or Denmark prevalence rates of amphetamine use are some 7 times larger than in Sweden. Out of 38 countries, for which prevalence estimates are available, Sweden was among the 6 countries with the lowest levels of amphetamine use.

It should be noted, however, that Sweden has a significant proportion of amphetamine users among its problem drug use population - which is not the case in most other European countries. The extent of amphetamine problem drug use is not necessarily reflected in the household survey data. A UNODC estimate suggests that the total number of amphetamine users could be close to 0.4 per cent (range: 0.3 per cent-0.5 per cent) of the population age 15-64. However, even at such a levels, Sweden would be still well below the West & Central European average (0.7 per cent).

Ecstasy

The latest official estimates for ecstasy use also date back to 2000 when 0.2 per cent of the population age 16-64 was reported having used ecstasy, both in terms of life-time prevalence and annual prevalence.

However, given strong increases in the use of ecstasy among youth in the late 1990s until 2002, it is doubtful whether a general population estimate for the year 2000 is still valid for the situation today. In neighbouring Finland, ecstasy prevalence rates among the general population reportedly increased from 0.3 per cent in 2000 to 0.5 per cent in 2002. At the same time, life-time prevalence among 15-16 year old students amounted to just 1 per cent among the 15-16 year olds in 2003 and was thus lower than in Sweden (2 per cent). Against this background, the use of the 200 prevalence rate as a proxy for the current situation would probably be misleading.

Extrapolating annual prevalence estimates from the 2003 ESPAD study of 15-16 year old students – and assuming that the ratio of youth surveys to general population surveys found in other West European countries would apply to Sweden as well – UNODC estimated ecstasy use among the general population in Sweden to affect some 0.4 per cent of the population, age 15-64.

Of course, only future surveys can tell, whether this estimate reflects reality. But, even with this upward adjustment of the ecstasy prevalence rate, ecstasy use in Sweden is less than half the West & Central European average (0.9 per cent), though higher than the overall European average (0.2 per cent). Several countries have ecstasy prevalence rates that are 4 to 6 times higher than the rate in Sweden.

Cocaine

The latest official survey result for cocaine also dates back to the year 2000, and showed a life-time prevalence rate of cocaine use of 0.9 per cent among the general population and an annual prevalence rate of 0.0 per cent, that is, a prevalence rate of less than 0.049 per cent.

Given strong increases in cocaine use among youths until 2000 - and with these youth cohorts entering the general population cohort age 15-65 in subsequent years – the annual prevalence estimate for 2000 is likely to under-represent the situation of cocaine use among the general population as of 2003/04. An extrapolation from the 2003 ESPAD study, suggested that around 0.2 per cent of the Swedish population, aged 15-64, used cocaine in 2003. Even based on this upward adjusted estimate, cocaine use in Sweden is still extremely limited as compared to Europe as a whole (0.7 per cent) or the average for West & Central Europe (1.1 per cent).

Heroin/opiates

The calculation of heroin/opiate prevalence rates is somehow different from the calculation of the prevalence rates of other drugs.

It is generally accepted that household survey data are not a very appropriate tool to derive at estimates of the number of heroin/opiate abusers as in many countries heroin addicts do not necessarily live any longer in a private household. Thus heroin prevalence data based on household surveys tend to underestimate the true extent of the problem by a significant margin. Thus, heroin/opiate prevalence data are usually obtained through other methods, notably through indirect indicators such various multiplier methods, the capture-recapture method or through case finding studies. The resulting estimates provide more reasonable orders of magnitude of the number of problem drug users. For most countries in Europe (with the exception of some of the Nordic countries), this number used to be identical with the number of problem drug users. For the Nordic countries, where a significant proportion of problem drug users is not consuming opiates but other drugs (notably amphetamine), a further adjustment was made. The number of problem drug users, as a next step, was then multiplied with the proportion of people in treatment for opiates.

Based on case study findings from the 1990s and estimates derived from problem drug use estimates for the year 2001, UNODC estimated opiate abuse to affect some 0.1 per cent of the population age 15-64 in Sweden in 2001. Given a rise in the proportion of heroin users among all problem drug users, Sweden's opiates use prevalence rate is likely to have increased to around

0.14 per cent by 2003/04. But even at that level, opiate abuse in Sweden is still clearly below the West & Central European average (0.5 per cent) or the overall European average (0.7 per cent).

*Summary*

The figures above show that drug use is not only low among young people but also among the general population. Drug use levels are not only low for cannabis but for other drugs as well.

While all the comparisons of general population survey results presented above – for methodological reasons - must be treated with caution, available data and estimates are sufficiently robust to conclude that drug use is in Sweden, in general, well below the West & Central European average, and for most drugs below the overall European average. This applies to cannabis, cocaine, opiates and, to a slightly lesser extent, to amphetamines. The low rate of amphetamines use is particularly noteworthy as Sweden suffered in the 1950s from the largest spread of amphetamine use in Europe, at levels which even by today's standards would be staggering.

### *Perceived drug availability*

Drug use is said to be influenced by drug availability. Data from the 2003 ESPAD study show a positive correlation between the high availability of drugs (students reporting that drugs are 'very easy' or 'fairly easy' to get) and drug use. This means that the more students report to have 'very easy' or 'fairly easy' access to drugs, the more they are also likely to have used these substances. For cannabis, the correlation coefficient between life-time prevalence of cannabis use among 15-16 year old students and high availability ('very easy' or 'fairly easy' to obtain) amounts to 0.65.

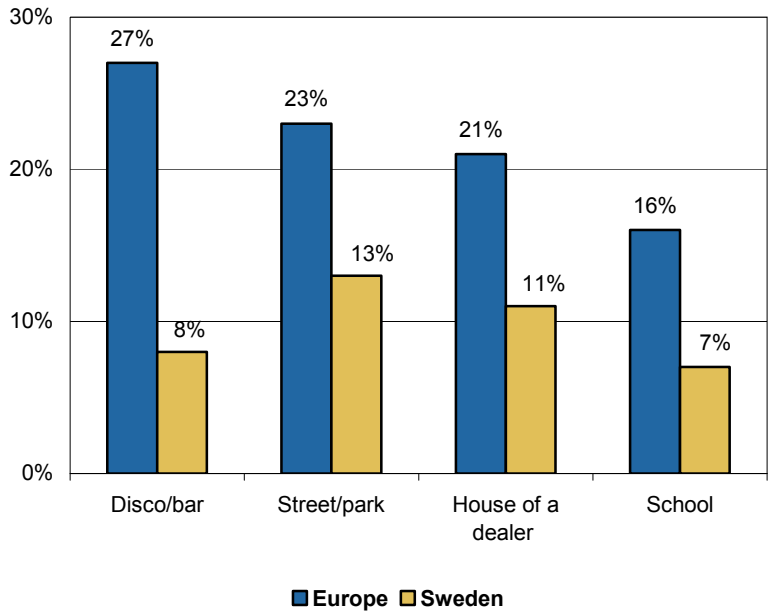
Reported availability of cannabis declined over the 1999-2003 period in Sweden (from 26 per cent of students reporting 'very easy' or 'fairly easy' availability in 1999 to 23 per cent reporting the same in 2003), as opposed to the European level where reported cannabis availability rose from 29 per cent to 35 per cent. This decline in cannabis availability in Sweden went hand in hand with a decline in cannabis use over the 1999-2003 period.

Cannabis availability reported by Swedish students is low by European standards. Sweden holds the 12$^{th}$ lowest rank in terms of cannabis availability in Europe (out of 35 countries investigated). Slightly lower levels of cannabis availability among the old EU countries were only reported from neighbouring Finland and from Greece.

Actual access to drugs, particularly cannabis, is also lower in Sweden than in Europe across all locations where cannabis is typically bought. Access to cannabis in discotheques and bars is less than a third of what it is, on average, in Europe (8 per cent versus 27 per cent); in schools it is less than half the European average (7 per cent versus 16 per cent). On the streets, cannabis seems to be more than 40 per cent less easily available than in Europe as a whole.

Reported availability of drugs other than cannabis is close to the European average in Sweden, but still lower than the EU-15 average. Availability of ecstasy, amphetamine and cocaine is below the EU-15 average but comparable to the overall European average.

**Figure 32: Locations where cannabis can be easily bought by 15-16 year old students (2003)**




*Source: Council of Europe and Swedish Council for Information on Alcohol and Other Drugs (CAN),* The ESPAD Report 2003*, Nov. 2004*

The above suggests that successes in limiting drug availability may explain some of the success of Swedish drug policy with regard to cannabis. Drug availability, however, seems to have less explanatory power for the question as to why the use of other drugs is also lower than the European average.

**Table 2: Perceived drug availability – reported 'very easy' or 'fairly easy' to get in % of all students, age 15-16, in 2003**

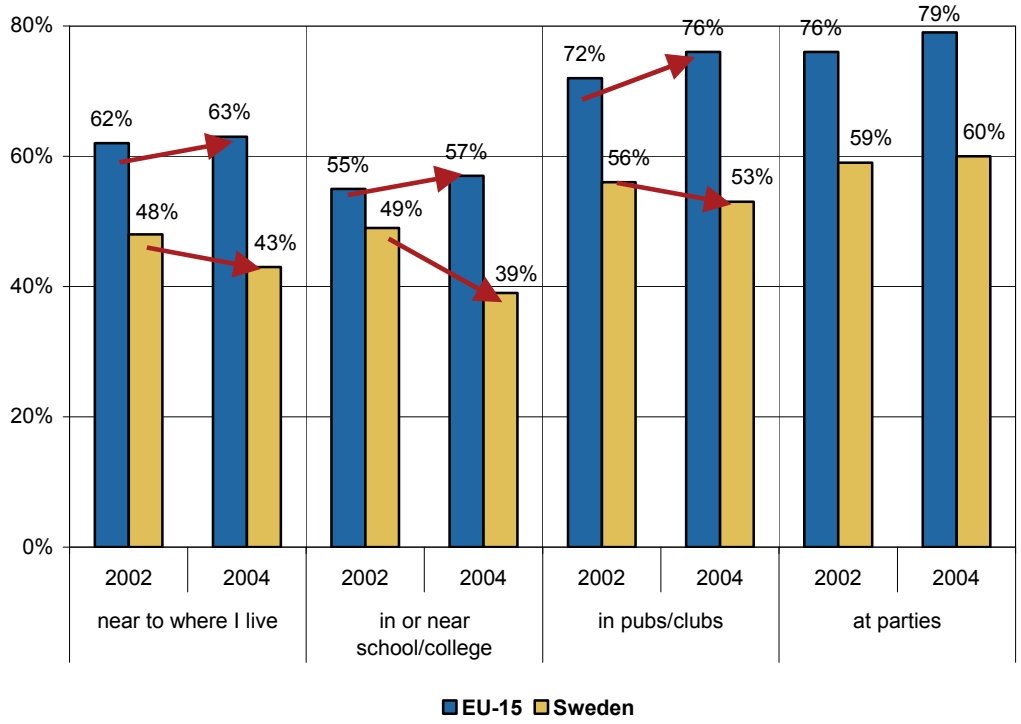
| | Cannabis | Ecstasy | Amphetamine | Cocaine | Heroin |
|---|---|---|---|---|---|
| Sweden | 23% | 17% | 13% | 13% | 13% |
| Europe (average) | 35% | 17% | 13% | 12% | 11% |
| EU-15 | 42% | 22% | 16% | 16% | 13% |
| Correlation coefficient (availability and life-time use) | 0.65 | 0.62 | 0.67 | 0.63 | 0.32 |

*Source: Council of Europe and Swedish Council for Information on Alcohol and Other Drugs (CAN),* The ESPAD Report 2003*, Nov. 2004*

The 2004 Eurobarometer study on 'Young People and Drugs' confirms the ESPAD findings that overall drug availability in Sweden is significantly lower than the EU average. While 63 per cent of the young people (age 15-24) of the EU-15 countries reported that it was 'easy to get drugs near to where they lived', the corresponding ratio for Sweden was just 43 per cent and thus the third lowest among the EU-15 countries. In contrast to the overall trend at the EU level, reported drug availability declined in Sweden between 2002 and 2004 (from 48 per cent to 43 per cent).

Perceived easy access to drugs in nearly all locations declined in Sweden while corresponding ratios increased at the EU level. The exception is perceived drug availability at 'parties' which increased slightly but is still considerably below the EU-15 average.

**Figure 33: Drug availability (reported by 15-24 year olds) – 'it is easy to get drugs …'**




*Source: European Commission,* Eurobarometer, Young people and drugs*, June 2004.*

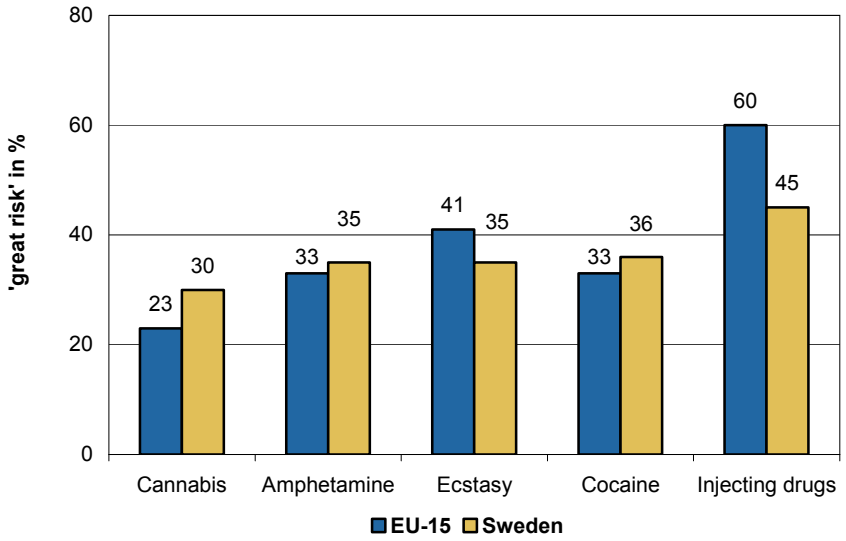
### *Perceived risk of drug use*

Another factor which may influence drug use is the perceived risk. Risk perceptions, notably among young people, can be formed, *inter alia,* through prevention work and awareness raising. The correlation between perceived risk resulting from experimenting with cannabis (using it once or twice) and life-time prevalence of cannabis use across the 35 ESPAD countries was –0.75 in 2003. This suggests that in countries where the perceived risks from drug abuse are larger, drug use also tends to be lower. Data from the United States also show that - over time - there is a fairly strong correlation between changes in perceived risk and changes in drug use levels among high-school students.

According to the ESPAD survey results, 'great risks' arising from experimenting with drugs (using them once or twice) in Sweden are considered by 15-16 year old students to arise primarily due to injecting drugs (45 per cent), followed by using cocaine (36 per cent), ecstasy or amphetamine (35 per cent) and cannabis (30 per cent).

The proportion of 15-16 year old students in Sweden, considering taking drugs once or twice to be a 'great risk' is above the EU-15 average, though still slightly below the overall European average. Except for the comparatively low risk awareness of the consequences from injecting drugs, risk ratios that are slightly below the overall European average are, however, no reason for concern. They may well be the result of a more thorough examination and debate in school on the drug problem, resulting in some more realistic risk perceptions than may be the case in some other countries.

**Figure 34: Risk perception among 15-16 year olds (2003)**
**How much do people risk harming themselves by using the following drugs once or twice? Response: ' great risk'**

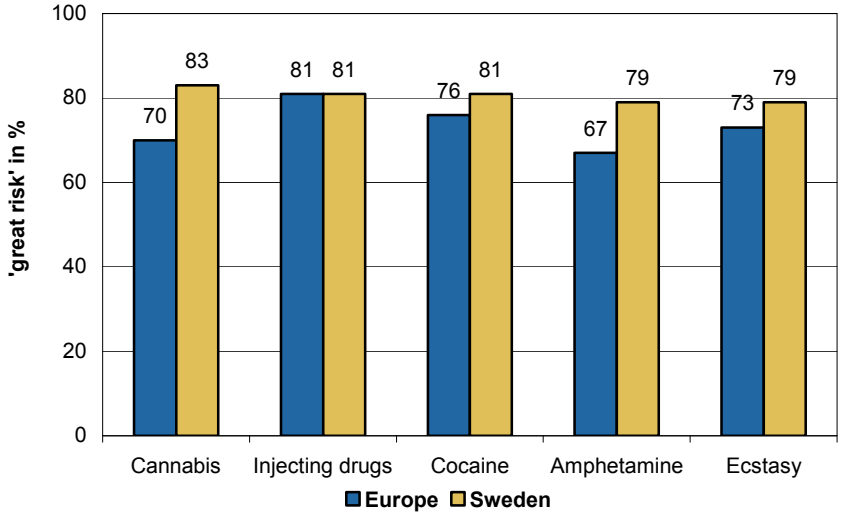



*Source: Council of Europe and Swedish Council for Information on Alcohol and Other Drugs (CAN),* The ESPAD Report 2003*, Nov. 2004*

Experimenting with cannabis once or twice is seen by 30 per cent of the 15-16 year olds in Sweden to entail 'great risks'. This is a significantly higher proportion than the EU-15 average (23 per cent) and notably higher than risks perceived in countries such as Denmark (15 per cent), Czech Republic (13 per cent) or the United Kingdom (13 per cent). Perceived risk of cannabis use was higher only in Finland and Portugal.

In addition to cannabis, the risks arising from occasional use of amphetamine and cocaine are also perceived higher in Sweden than, on average, in the EU-15, though lower than in Europe as a whole. However, for ecstasy and for injecting drug use, the perceived risks in Sweden are lower than the EU-15 average and lower than the average for Europe as a whole.

**Figure 35: Risk perception of drug use among 15-16 year olds (2003):**
**How much do people risk harming themselves by taking the following drugs regularly? Response: ' great risk'**



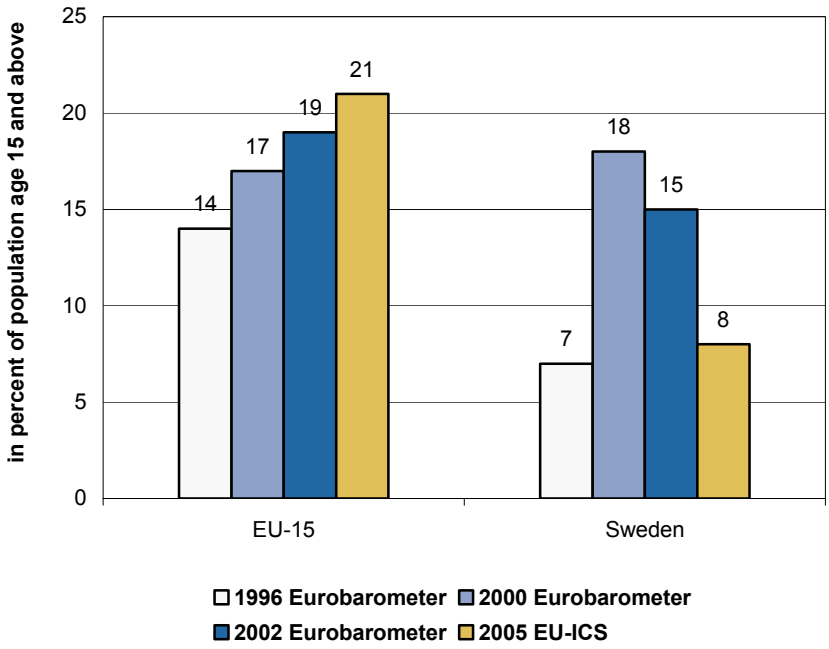

*Source: Council of Europe and Swedish Council for Information on Alcohol and Other Drugs (CAN),* The ESPAD Report 2003*, November 2004*

The Eurobarometer data showed that Swedish youth (age 15-24) has among the EU-15 the highest risk awareness for cannabis, the second highest for amphetamine and cocaine and the third highest for heroin. Risk awareness is less pronounced for ecstasy, where Sweden ranks fifth among the EU-15 countries.

### *Experiences with visible drug scenes*

Following strong increases in the 1990s in Sweden, data show a clear decline in the visibility of drug scenes in subsequent years. Confrontations of the general population with drug problems declined between 2000 and 2005 in Sweden from 18 per cent to 8 per cent while the EU-15 average continued to show an upward, from 17 per cent to 21 per cent. This reflected increases in the visible drug scenes between 2000 and 2005 in Greece, Portugal, Luxembourg, Spain, Italy, Netherlands, France and Belgium while declines, next to Sweden, were only reported from Finland, Denmark, Austria and Ireland.

**Figure 36: Contacts with drug problems* ('often' & 'from time to time') in the area of residence in the EU-15 and in Sweden, 1996-2005**




**'Over the last 12 months, how often were you personally in contact with drug related problems in the area where you live? For example seeing people dealing in drugs, taking or using drugs in public places, or by finding syringes left by drug addicts?'*

*Sources: EU Commission, Eurobarometer, Public Safety Exposure to Drug Related Problems and Crime, Brussels 2003 and Robert Manchin / Gergely Hideg, Drug related Problems in Europe's Neighbourhoods, unpublished working paper[1], August 2006, European Crime and Safety Survey, 2005.*

[1] The data used in this working paper is the copyright of the EU ICS Consortium, led by Gallup Europe. The EU ICS was co-funded by the European Commission, FP6. The consortium website is http://www.gallup-europe.be/euics. The working paper is the copyright of its author(s).

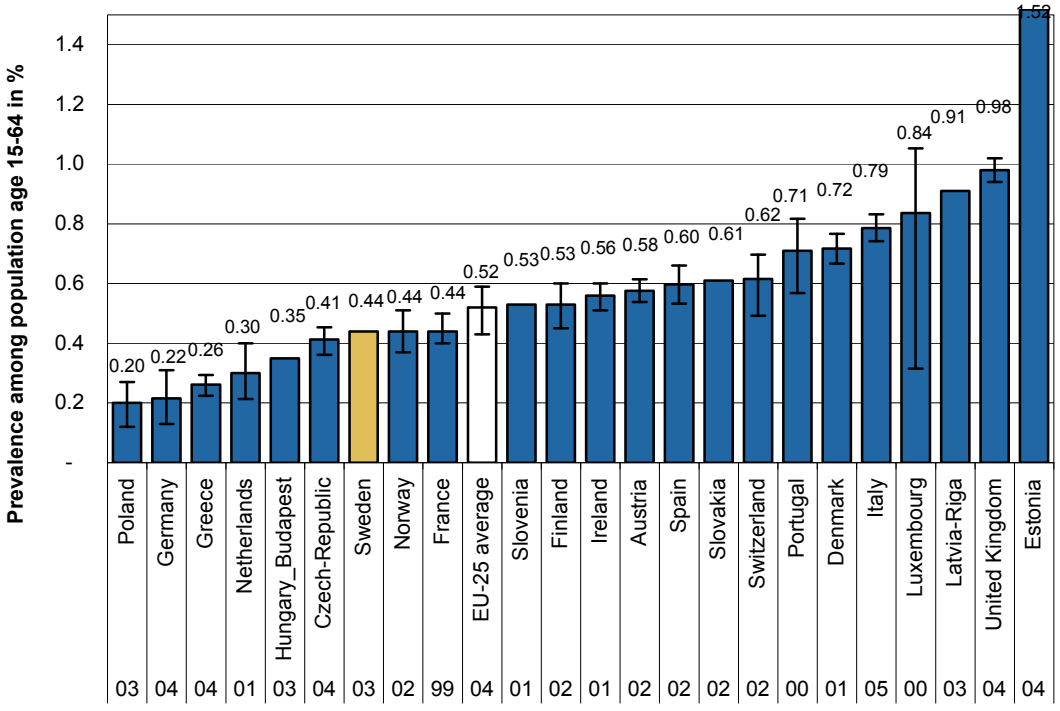
### *Problem drug use estimates*

Critics of Swedish drug policy have usually focused on the allegedly high number of problem drug users in that country that overshadow the successes achieved in keeping overall drug use levels low. As shown earlier, the number of problem drug users increased indeed significantly in the 1990s (from 19,000 in 1992 to 26,000 in 1998 and 28,000 in 2001) before declining to less than 26,000 in 2003.

Despite the increase in problem drug use in the 1990s, Sweden's prevalence rate of 0.44 per cent of the population age 15-64 is still below the EU-25 average of 0.52 per cent. Sweden has the 7th lowest prevalence rate for problem drug use among the EU-25 countries. Sweden has similar levels of problem drug use as neighbouring Norway (range: 0.37 per cent to 0.51 per cent in 2002) and lower levels than both Finland (0.53 per cent) and Denmark (0.71 per cent). Sweden's level of problem drug use is still only half as high as problem drug use in the United Kingdom (0.98 per cent) and significantly lower than in Italy (0.79 per cent) or Spain (0.6 per cent).

However, the proportion of heavy drug users among all drug users is very high in Sweden. Between 1 out of 5 and 1 out to 6 drug users in Sweden (annual prevalence) is a problem drug user while in the UK, for instance, the proportion is between 1 out of 12 and 1 out of 13. This reflects the fact that general drug use levels are very low in Sweden. However, these figures may also explain why drug use in Sweden is generally taken more seriously than in many other European countries.

**Figure 37: Problem drug use among West & Central European countries (2005 or 2004 or latest year available)**




*Sources: EMCDDA, Statistical Bulletin 2005, UNODC, Annual Reports Questionnaire Data, United Nations Population Division, World Population Prospects.*

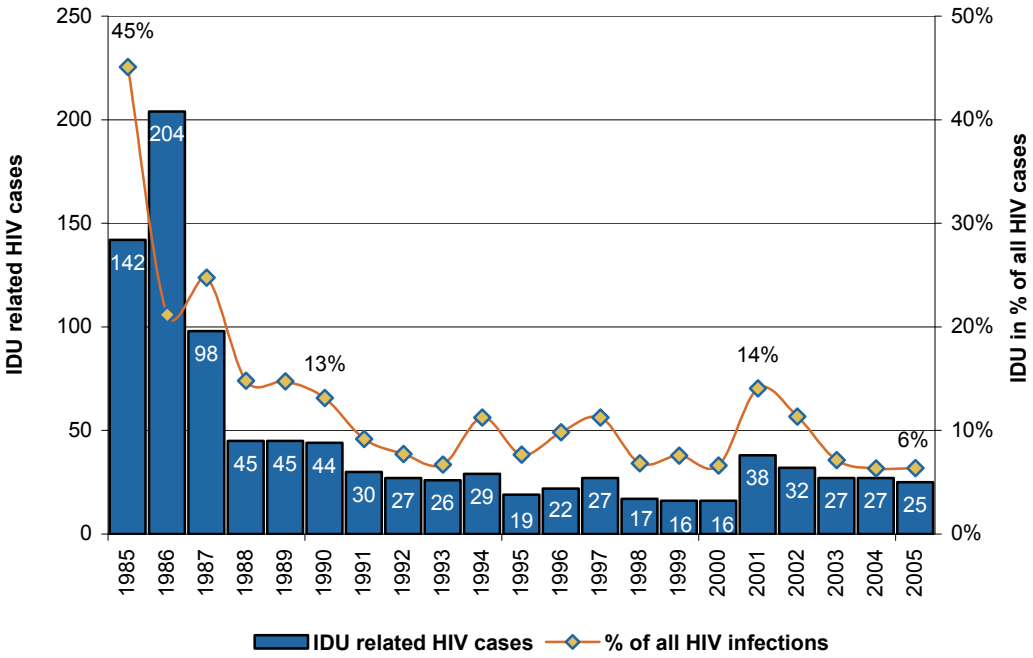
### *Intravenous drug use and HIV/AIDS*

Generally, Sweden's rate of HIV infections (0.2 per cent as of 2005) was clearly below the global average (1.1 per cent), clearly below the European average (0.5 per cent) and slightly below the West & Central European average (0.3 per cent).

Data on the main modes of transmission of HIV show that injecting drugs is of only minor importance in Sweden. Over the 1985-2005 period, three quarters of HIV infections were sexually transmitted. Transmissions by drug users via infected needles amounted to some 7,000 cases or 14 per cent of all transmissions in Sweden. This is a far lower proportion than the rate of transmission of HIV in Europe as a whole where injecting drug use over the last two decades accounted for the main mode of transmission (38 per cent), according to the European Centre for the Epidemiological Monitoring of AIDS (EuroHIV).

In addition, IDU-related HIV cases clearly declined over last two decades in Sweden, both in terms of a absolute numbers (from a peak level of 204 new cases reported in 1986 to 25 cases in 2005 (-88 per cent), and as a proportion of all reported HIV cases (from 45 per cent in 1985 to 6 per cent in 2005). Between 2001 and 2005 the proportion of IDU related HIV infections in all new HIV infection declined from 14 per cent to 6 per cent.

**Figure 37: New injecting drug use related HIV cases in Sweden, 1985-2005**




*Source: CAN*

New IDU-related HIV infections among all new HIV infections in 2004 were lower in Sweden (6 per cent) than among the EU-25 countries (9 per cent for countries reporting in 2004 or 11 per cent if data for countries reporting in previous years are included) and significantly lower than in Europe as a whole (27 per cent).

Fears that a rising number of problem drug users (from 19,000 in 1992 to 26,000 in 2003) would result in a larger number IDU related HIV infections in Sweden did not materialize. The number of new IDU related infections remained constant between 1992 and 2003 at 27 cases. This meant that the risk of infection for problem drug users actually declined between 1992 and 2003, from 0.14 per cent to 0.10 per cent.

# CONCLUSION

Following a short period of liberalization in the second half of the 1960s, Sweden has pursued restrictive drug control strategies that address both drug supply and drug demand. In parallel, Sweden has invested heavily in addressing the drug problem. Drug-related expenditures were equivalent to 0.5 per cent of GDP, the second highest proportion among all EU countries. This investment has paid off. The number of drug users in Sweden today seems to be smaller than it was before the advent of a concerted drug policy, starting in 1969 when the Government introduced a ten point programme against drugs. In 2006 6 per cent of the students age 15-16 had used drugs, down from 15 per cent in 1971.

In comparison with other European countries, Sweden also fares well. Life-time prevalence and regular use of drugs is considerably lower in Sweden than in the rest of Europe. This applies to the general population as well as to young people, a group that is considered to be most vulnerable to drug abuse. While average levels of life-time prevalence of drug use among 15-16 years in Europe amounted to 22 per cent on average, the corresponding rate in Sweden was 8 per cent in 2003, before falling to 6 per cent in 2006. Moreover, bucking the trends at the European level, drug use in Sweden has declined in recent years. Sweden is also among the European countries with low levels of injecting drug-use-related HIV/AIDS infections. On the supply side, drug prices in Sweden are among the highest in Europe and therefore, drug tourism targeting Sweden is largely unknown.

Levels of problem drug use in Sweden (0.44 per cent of the population age 15-64) are slightly below the EU average (0.52 per cent). The fact that Sweden's heavy drug use levels come close to EU average - though the country has below average drug use levels - could be seen as one of the few weaknesses. Swedish drug policy is highly effective in preventing drug use, but seems to be less effective in preventing drug users from becoming drug addicts. Nonetheless, it should not be forgotten that heavy drug use levels in Sweden are still below the EU average.

Changes in the number of heavy drug abusers over the past decades coincide with budget changes. Heavy drug abuse increased significantly from 1992 (19,000) until 2001 (28,000) at a time when funding cuts hampered access of drug abusers to treatment facilities. Higher budgets have been accompanied by a decrease of the number of problem drug users to 26,000.

Naturally, it cannot be stated with certainty that the generally positive drug abuse situation in the country is the result of – by international standards - generous anti-drug budgets and strict policies that have been applied over the last three decades. However, a review of fluctuations in abuse rates shows that periods of low drug abuse in the country are associated with times when the drug problem was regarded as a priority.

In addition to a clearly stated policy, a number of other factors also seem to have played a role for Sweden to achieve positive results. Sweden is, for example, not located along any of the major drug trafficking routes. Income inequality, which has an impact of the readiness of young people to engage in criminal activity such as drug trafficking, is low. Sweden's population at large is also very health conscious which would not be in line with large-scale drug use. And Sweden, in contrast to many other countries, has enjoyed a broad political consensus over the direction of drug policy, thus avoiding the sending of mixed messages to potentially vulnerable groups of society.

The Swedish drug policy has been one of the most widely debated and examined policy in Europe and this process intensified following Sweden's entry into the European Union. There has been criticism and the vision of a drug-free society, that is guiding policy measures has, on occasion, been derided as "unrealistic", "not pragmatic" and "unresponsive" to the needs of drug abusers.

This does not seem to be the case. Several new approaches on tackling drug abuse were pioneered in Sweden. The first methadone maintenance programme in Europe was established in Sweden, in 1966, at a time when even the concept of maintenance treatment was hardly accepted. Drug abusers in Sweden continue to have access to methadone as well as other substitution substances,

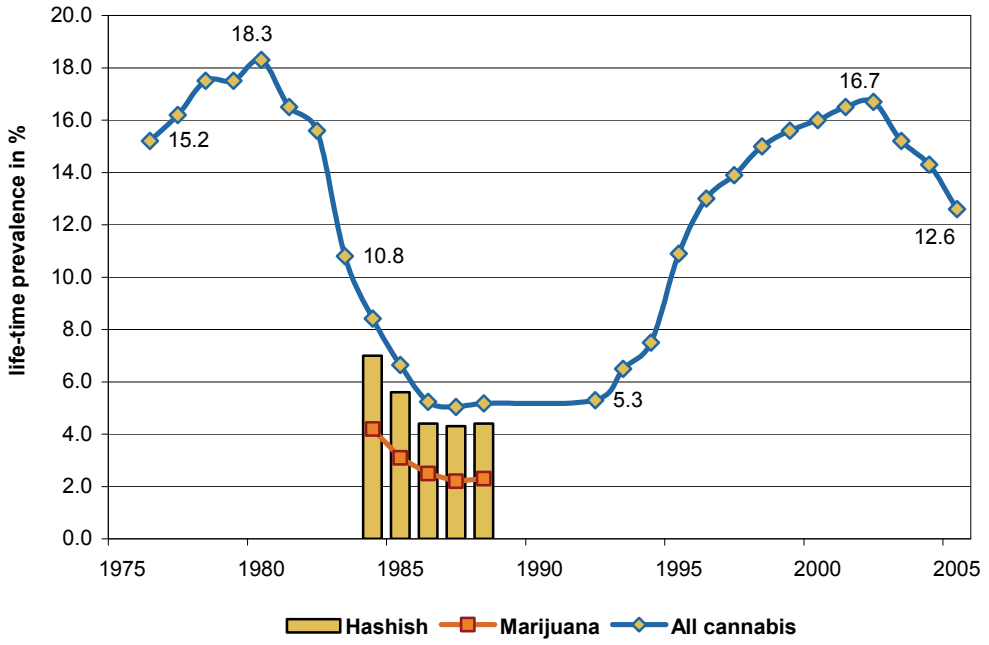
such as buprenorphine. Similarly, along with the Netherlands, Sweden was one of the first countries to introduce needle exchange programmes as one measure to stem the onslaught of HIV/AIDS. However, these measures, aiming at limiting the adverse consequences of drug abuse, were never pronounced to be the sole, overriding goal of the drug control policy of Sweden.

The ambitious goal of the drug-free society has been questioned not only outside the country but in Sweden itself, as a number of research papers on the subject attest. Nevertheless, despite several reviews of expert commissions, the vision has not been found to be obsolete or misdirected. As shown in this report, the prevalence and incidence rates of drug abuse have fallen in Sweden while they have increased in most other European countries. It is perhaps that ambitious vision that has enabled Sweden to achieve this remarkable result.

# STATISTICAL ANNEX

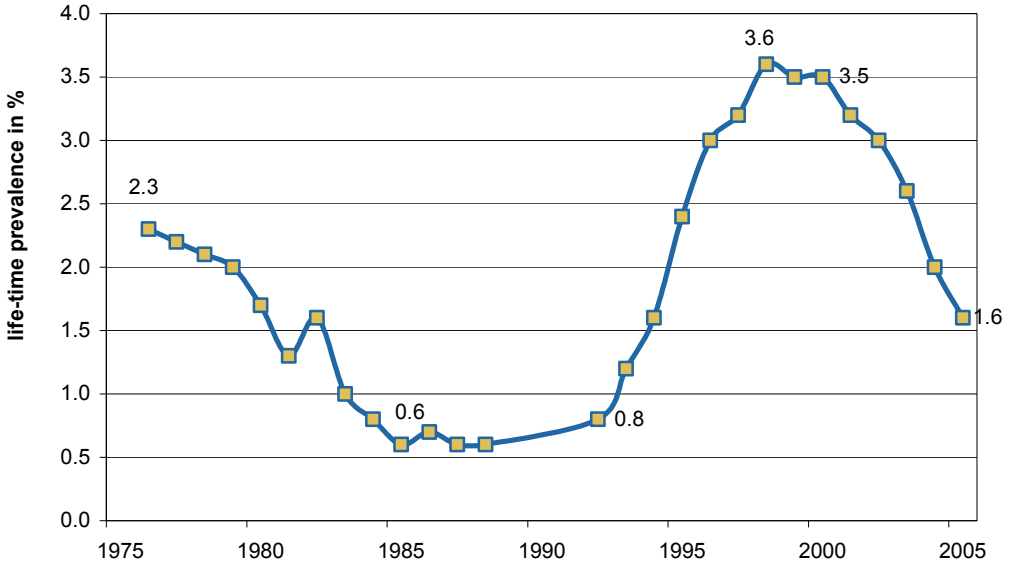
## LONG-TERM DRUG USE TRENDS IN Sweden

**Cannabis use among military recruits, 1976-2005**



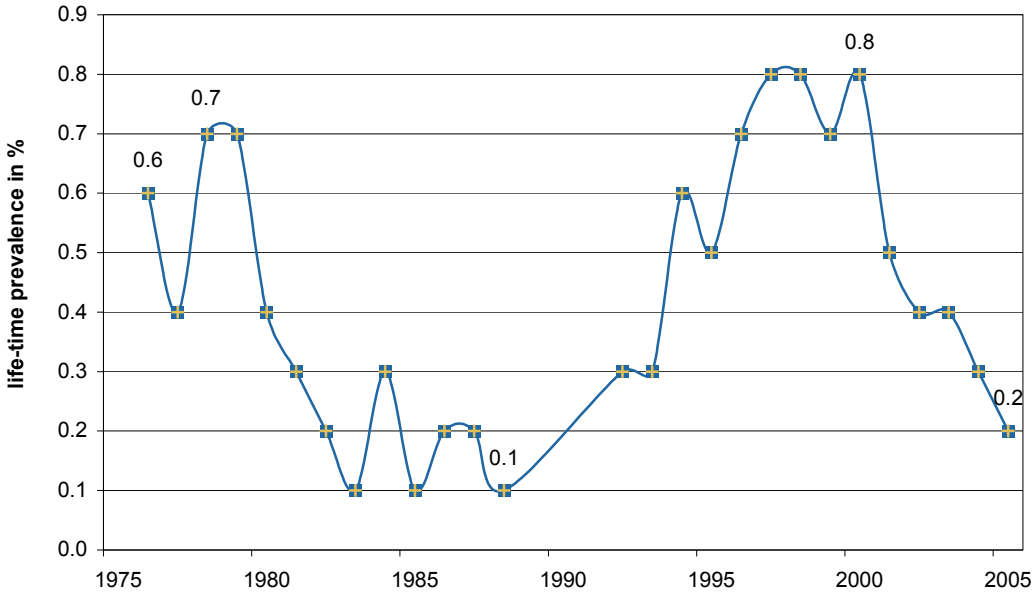

*Source: CAN*

**Amphetamine use among military recruits, 1976-2005**



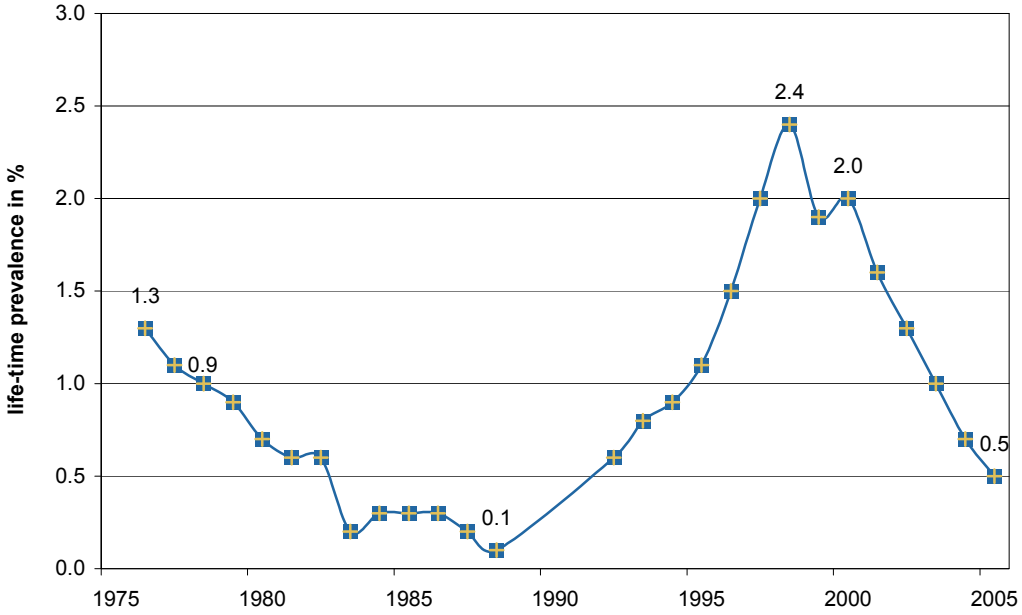

*Source: CAN*

**Heroin use among military recruits, 1976-2005**



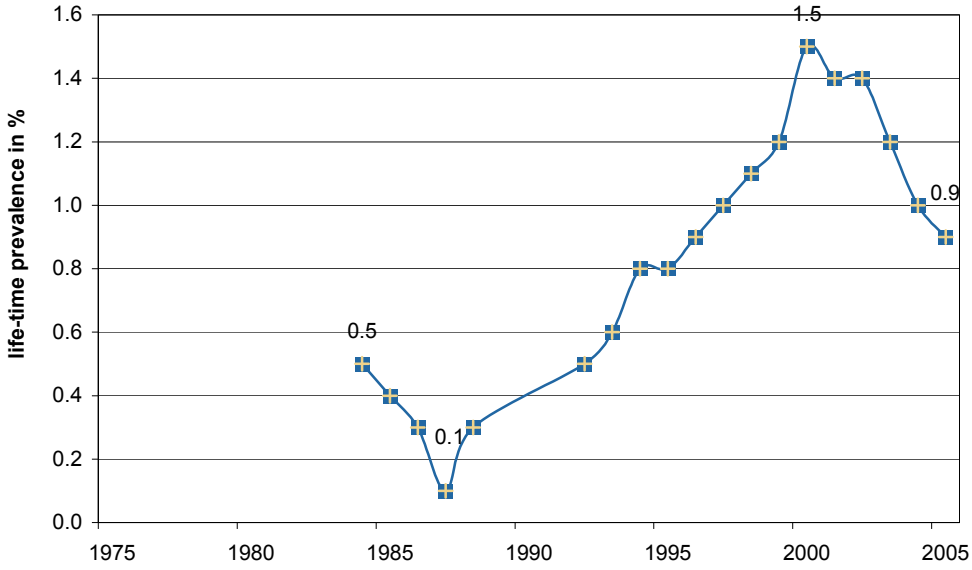

*Source: CAN*

**LSD use among military recruits, 1976-2005**



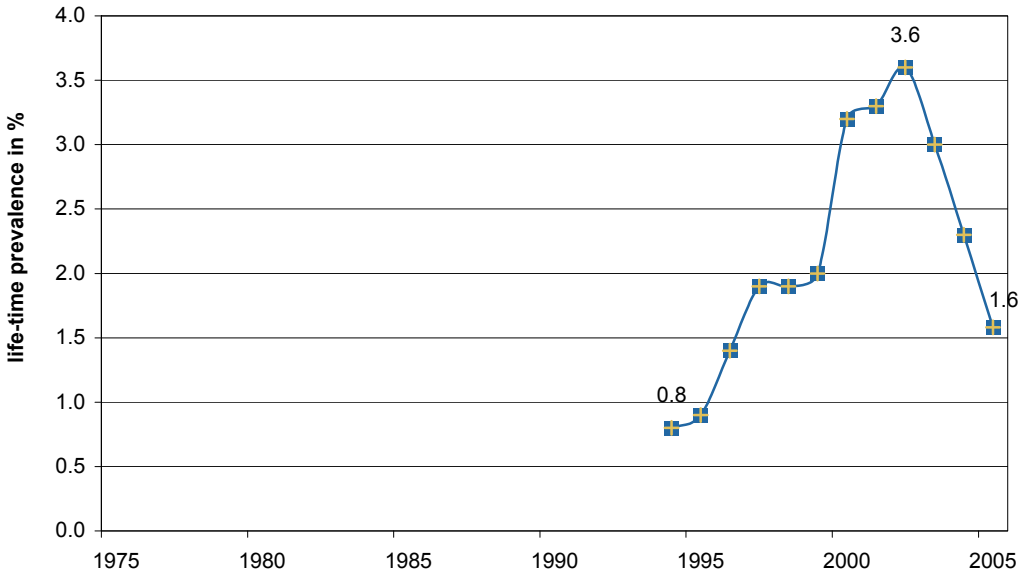

*Source: CAN*

**Cocaine use among military recruits, 1984-2005**




*Source: CAN*

**Ecstasy use among military recruits, 1984-2005**



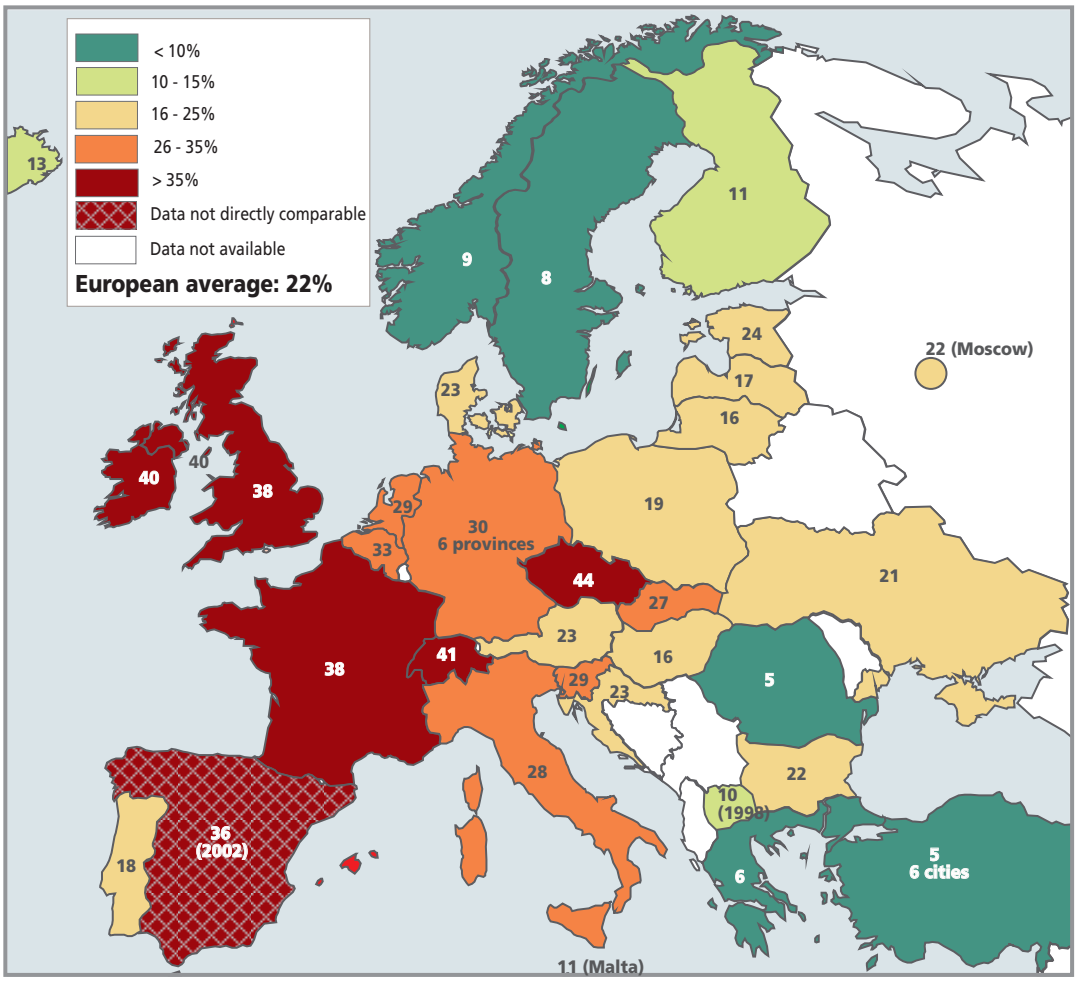

*Source: CAN*

# INTERNATIONAL COMPARISONS

## *YOUTH SURVEYS*

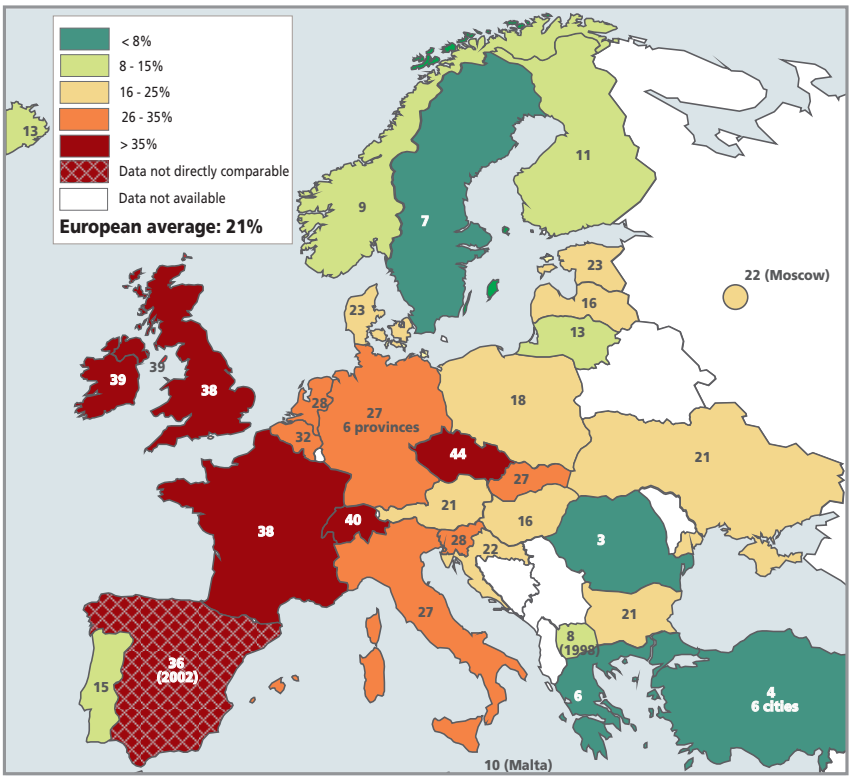
### *Surveys among 15-16 year old students*

**Lifetime prevalence of illicit drug use among 15-16 year old students in Europe, 2003**



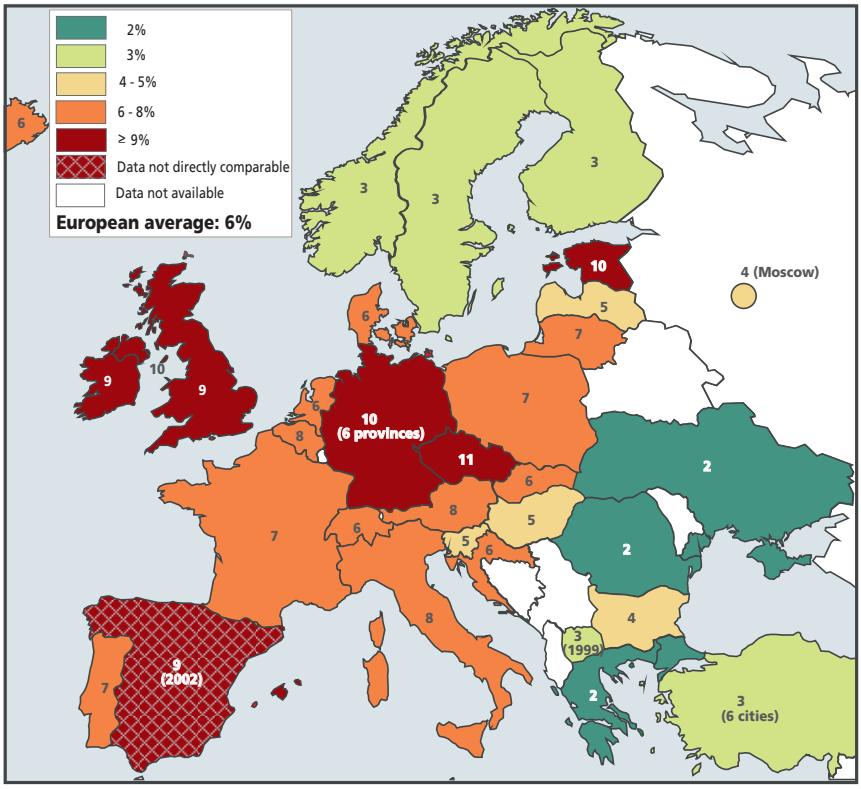

*Source: Council of Europe and Swedish Council for Information on Alcohol and Other Drugs (CAN), The ESPAD Report 2003, November 2004*

**Lifetime use of cannabis use among 15-16 year old students in Europe, 2003**



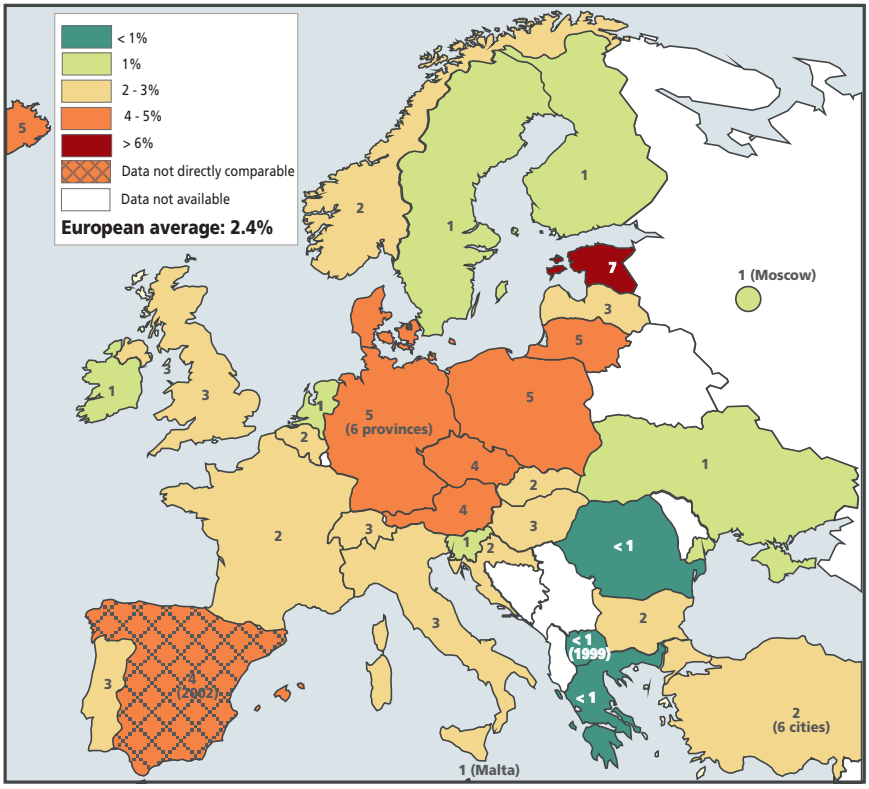

*Source: Council of Europe and Swedish Council for Information on Alcohol and Other Drugs (CAN), The ESPAD Report 2003, November 2004*

**Lifetime use of drugs other than cannabis among 15-16 year old students in Europe, 2003**



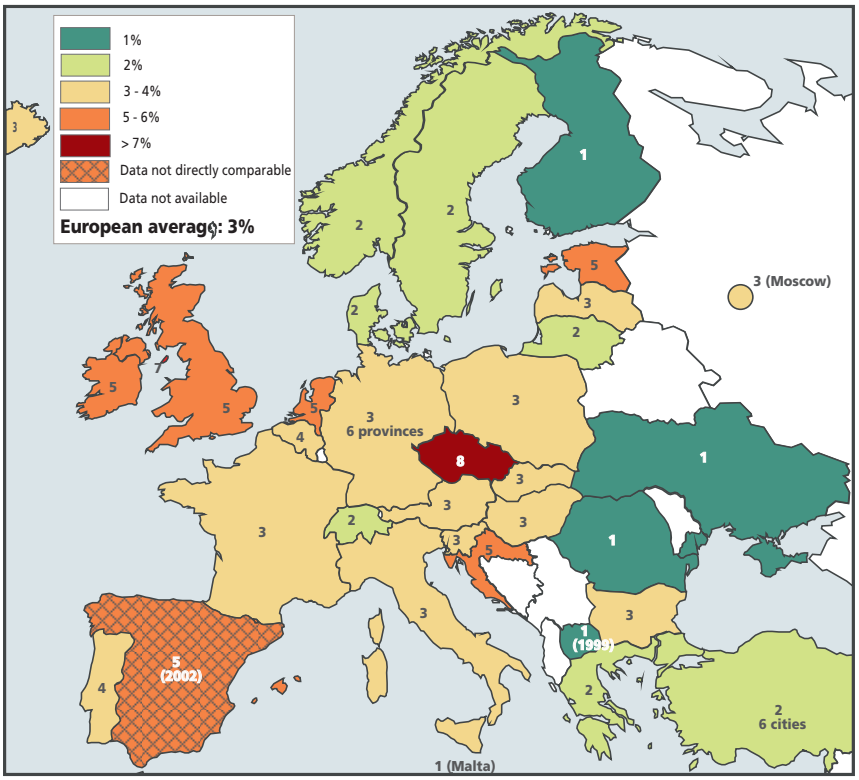

Source: Council of Europe and Swedish Council for Information on Alcohol and Other Drugs (CAN), The ESPAD Report 2003, November 2004

**Lifetime use of amphetamines among 15-16 year old students in Europe, 2003**



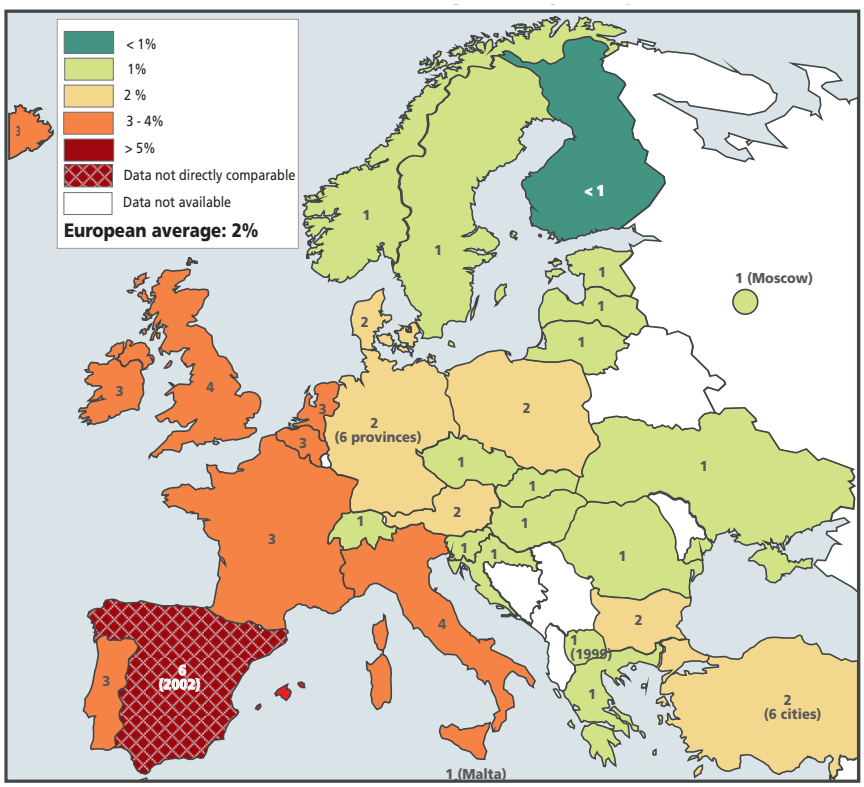

*Source: Council of Europe and Swedish Council for Information on Alcohol and Other Drugs (CAN) The ESPAD Report 2003, November 2004*

**Lifetime use of ecstasy among 15-16 year old students in Europe, 2003**



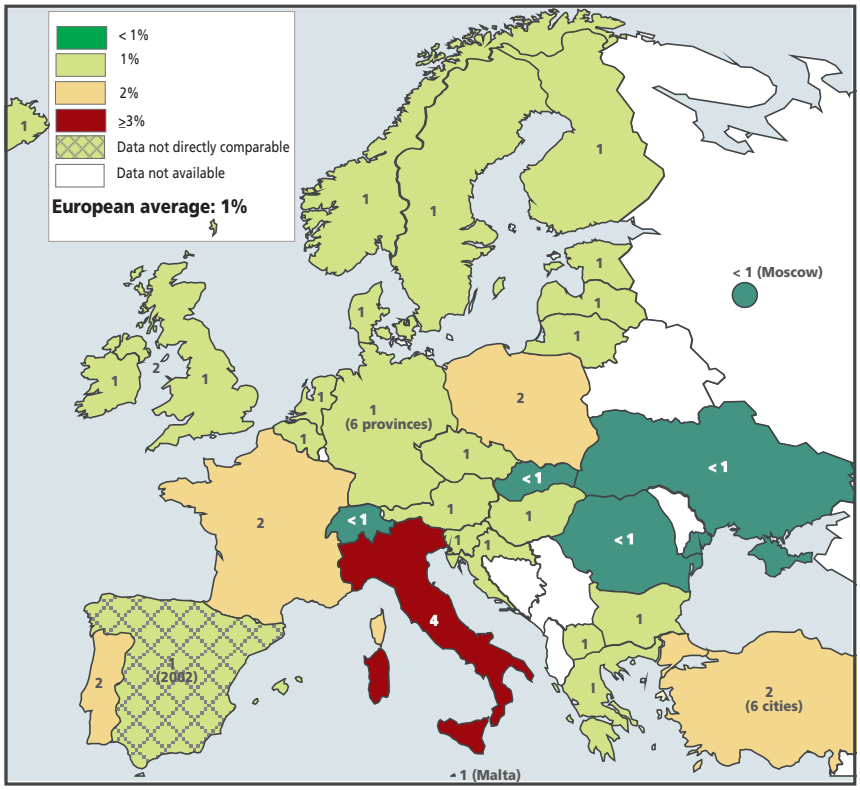

Source: Council of Europe and Swedish Council for Information on Alcohol and Other Drugs (CAN), The ESPAD Report 2003, November 2004

**Lifetime use of cocaine among 15-16 year old students in Europe, 2003**



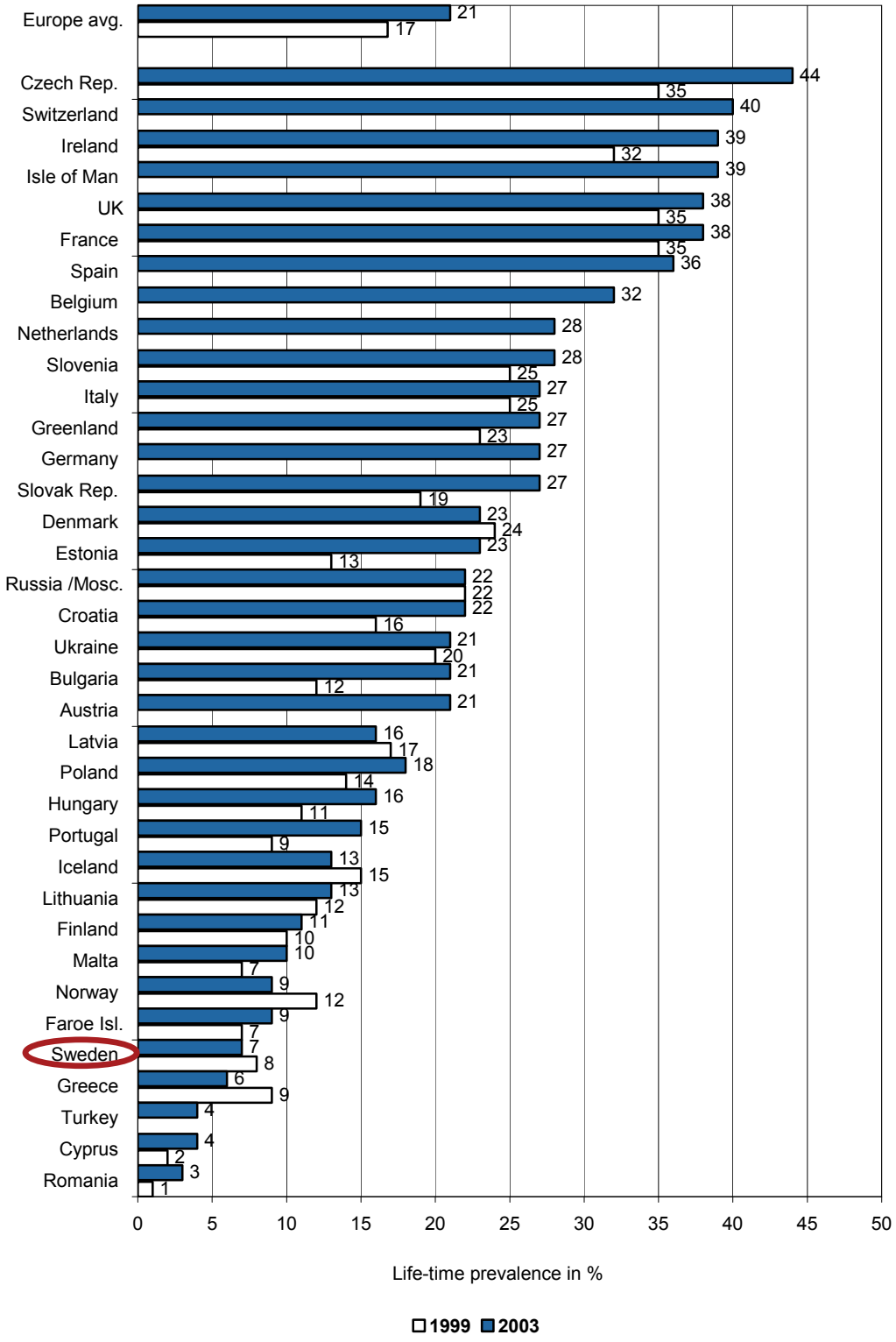

Source: Council of Europe and Swedish Council for Information on Alcohol and Other Drugs (CAN), The ESPAD Report 2003, November 2004

**Lifetime use of heroin among 15-16 year old students in Europe, 2003**



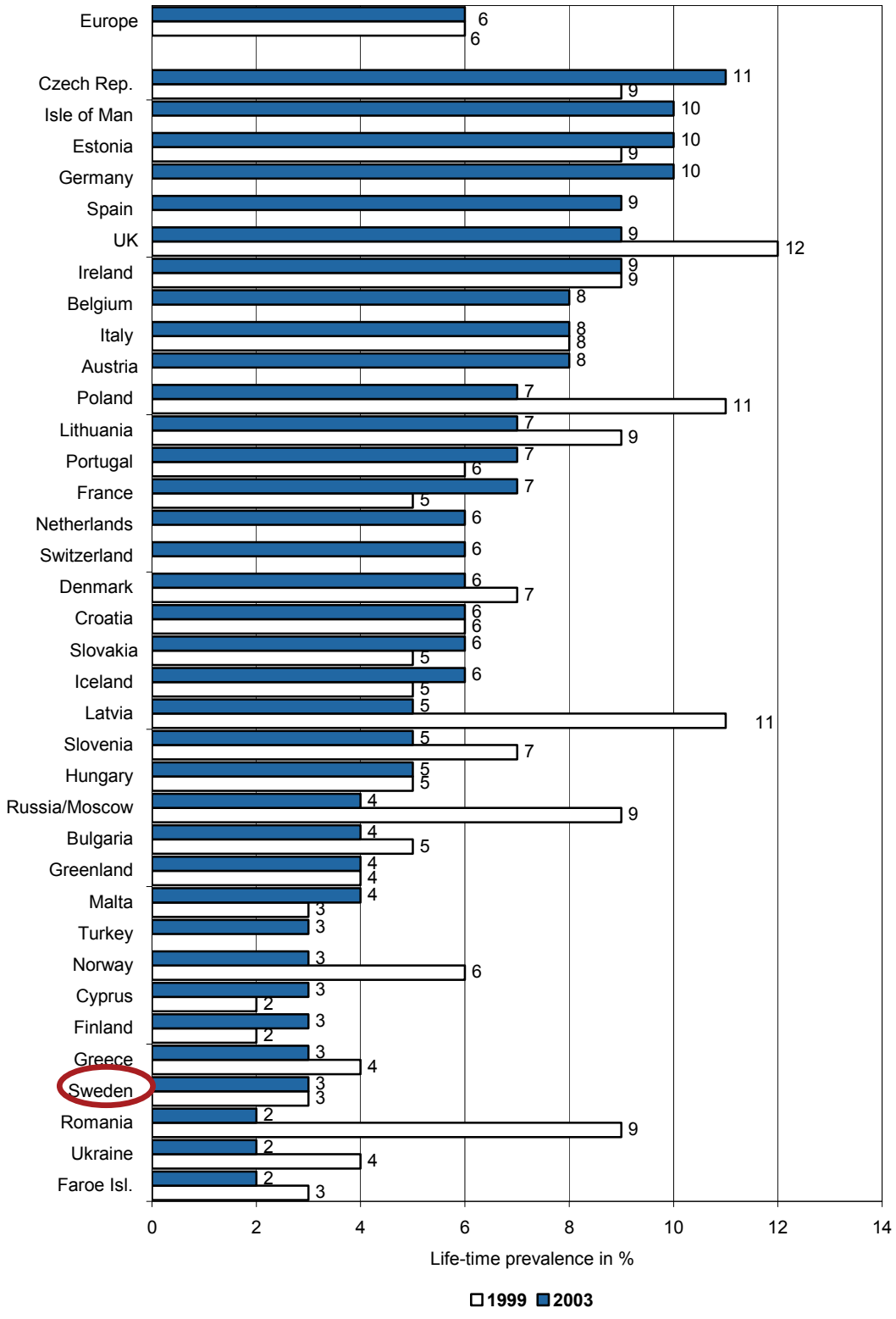

Source: Council of Europe and Swedish Council for Information on Alcohol and Other Drugs (CAN), The ESPAD Report 2003, November 2004

**Life-time prevalence of cannabis use among 15-16 year old students in Europe, 1999-2003**




*Source: Council of Europe and Swedish Council for Information on Alcohol and Other Drugs (CAN), The ESPAD Report 2003, Nov. 2004*

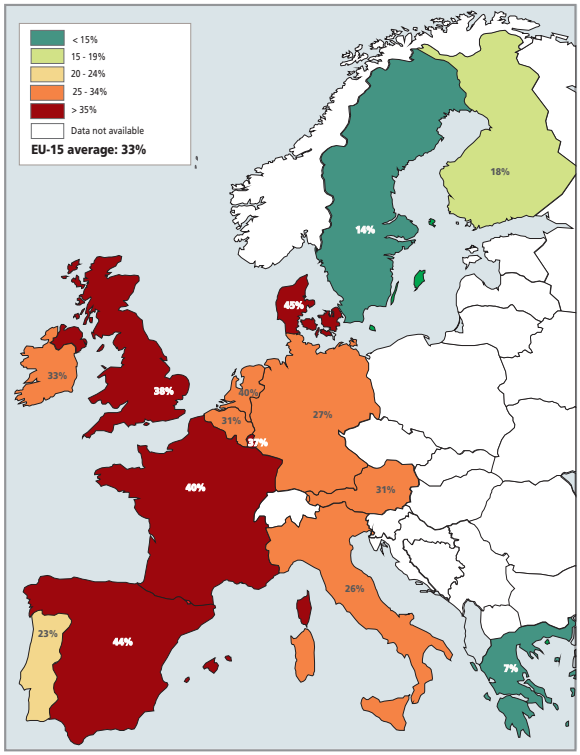
**Life-time prevalence of illicit drug use other than cannabis among 15-16 year old students in Europe, 1999-2003**




*Source: Council of Europe and Swedish Council for Information on Alcohol and Other Drugs (CAN),* The ESPAD Report 2003*, Nov. 2004*

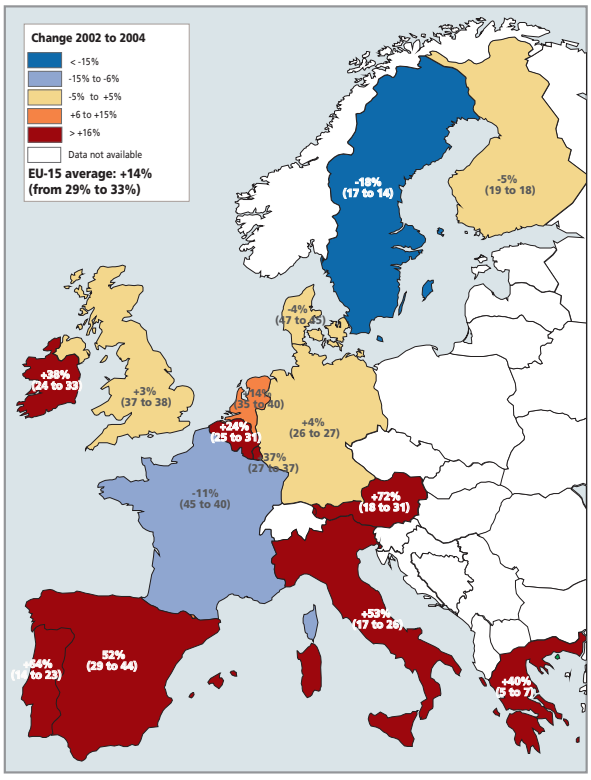
## *Surveys among 15-24 year olds*

**Lifetime use of cannabis among 15-24 year olds in EU-15, 2004**



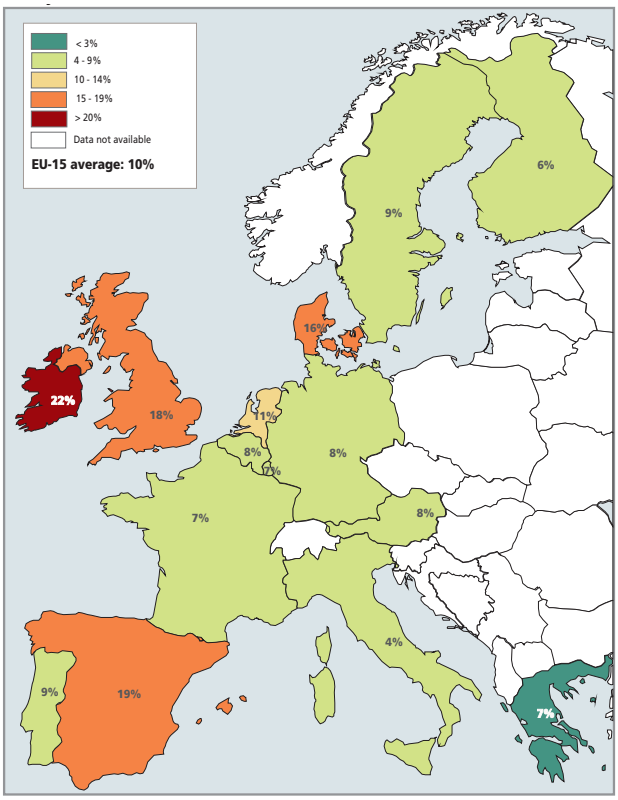

*Source: European Commission, Eurobarometer, Young People and Drugs, June 2004*

**Change in lifetime prevalence of cannabis among 15-24 year olds in EU-15, 2002-2004**



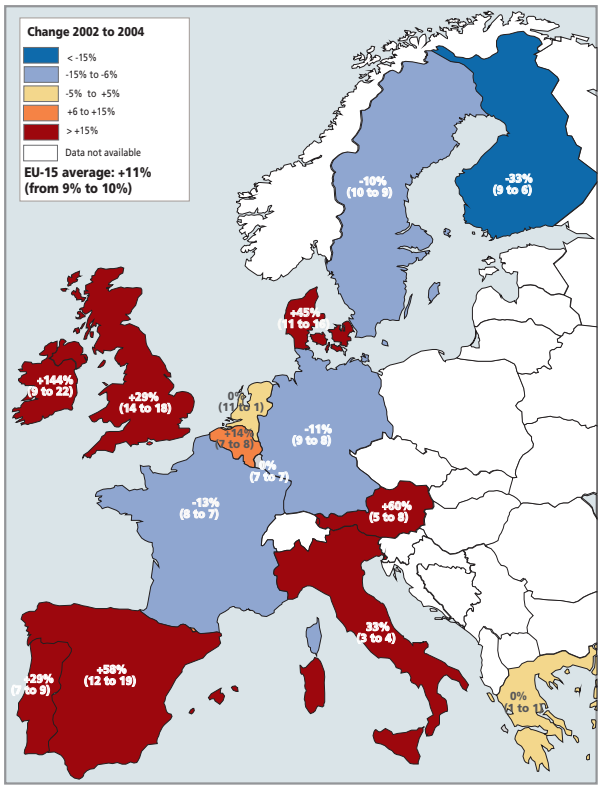

*Source: European Commission, Eurobarometer, Young People and Drugs, June 2004*

**Lifetime use of drugs other than cannabis among 15-24 year olds in EU-15, 2004**



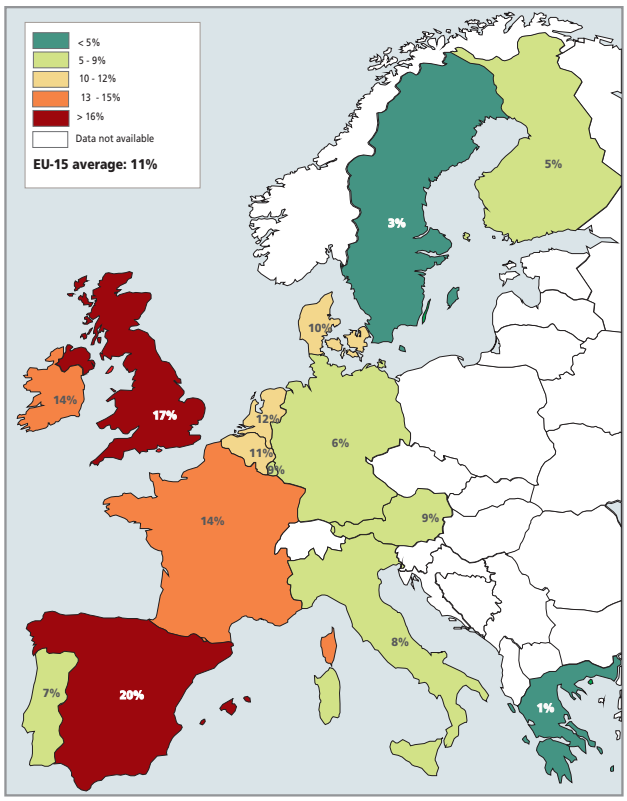

*Source: European Commission, Eurobarometer, Young People and Drugs, June 2004*

**Change in lifetime prevalence of drugs other than cannabis among 15-24 year olds in EU-15, 2004**



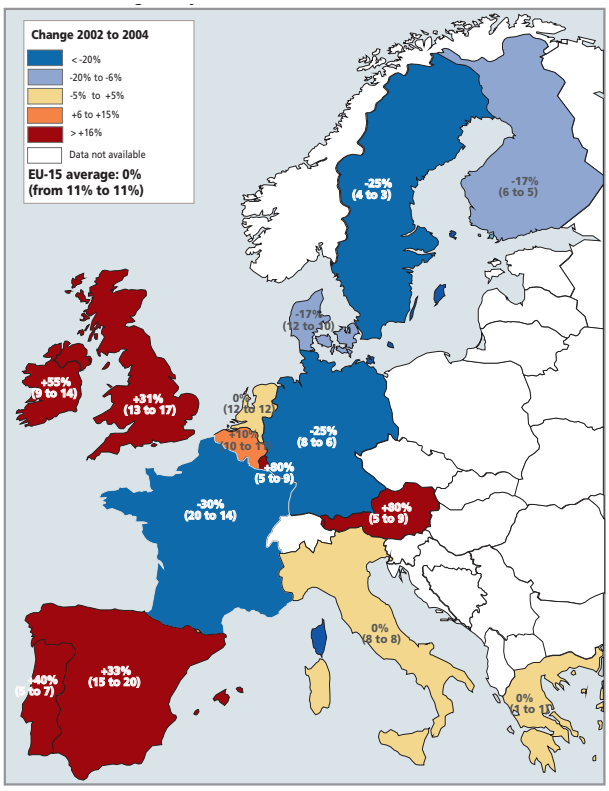

*Source: European Commission, Eurobarometer, Young People and Drugs, June 2004*

**Past month use of cannabis among 15-24 year olds in EU-15, 2004**



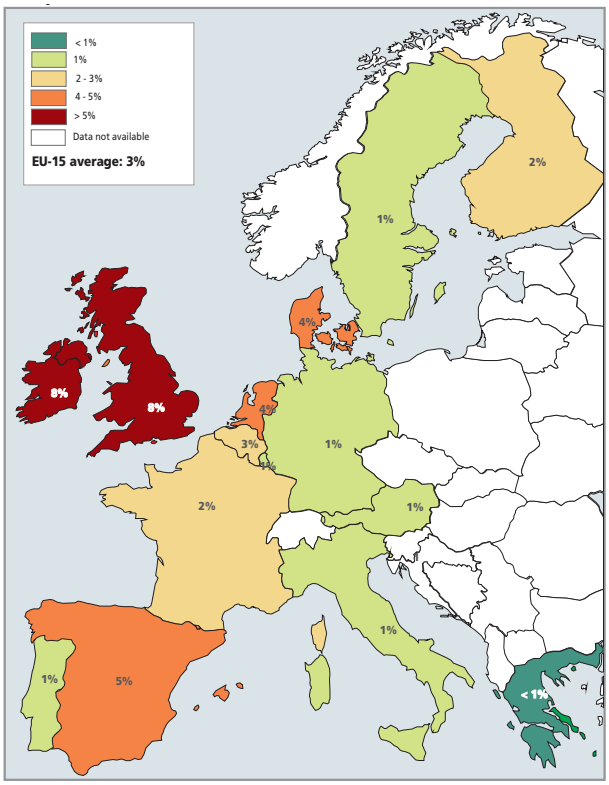

*Source: European Commission, Eurobarometer, Young People and Drugs, June 2004*

**Change in past month use of cannabis among 15-24 year olds in EU-15, 2002-2004**



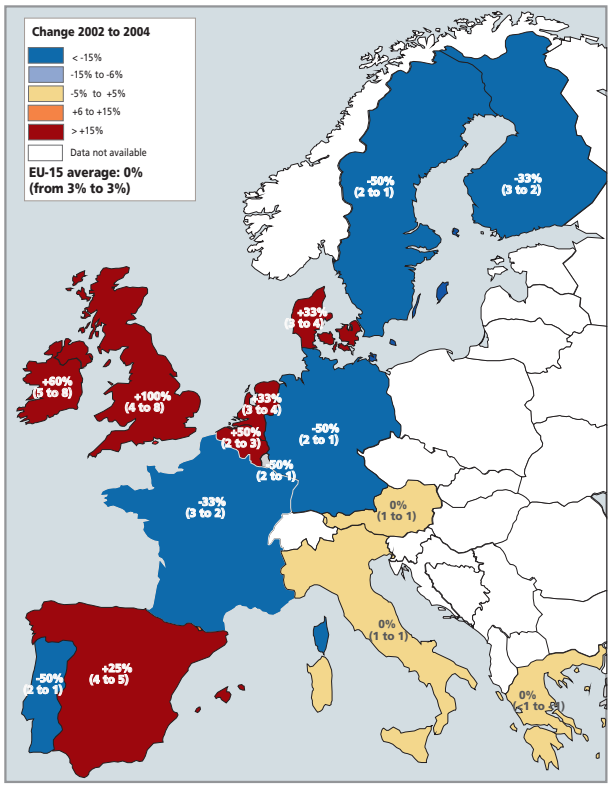

*Source: European Commission, Eurobarometer, Young People and Drugs, June 2004*

**Past month use of drugs other than cannabis among 15-24 year olds in EU-15, 2004**



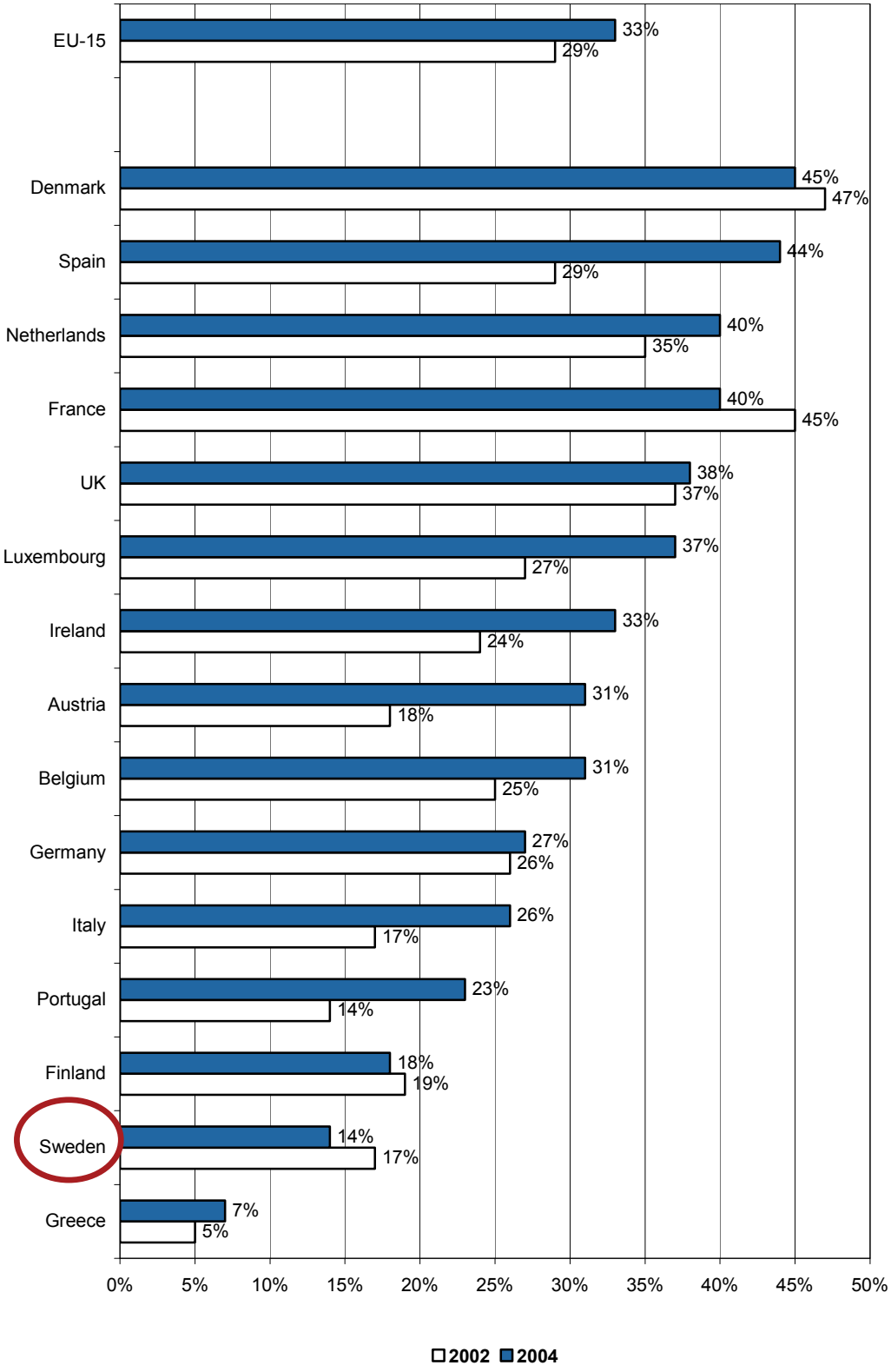

*Source: European Commission, Eurobarometer, Young People and Drugs, June 2004*

**Change in past month use of drugs other than cannabis among 15-24 year olds in EU-15, 2002-2004**



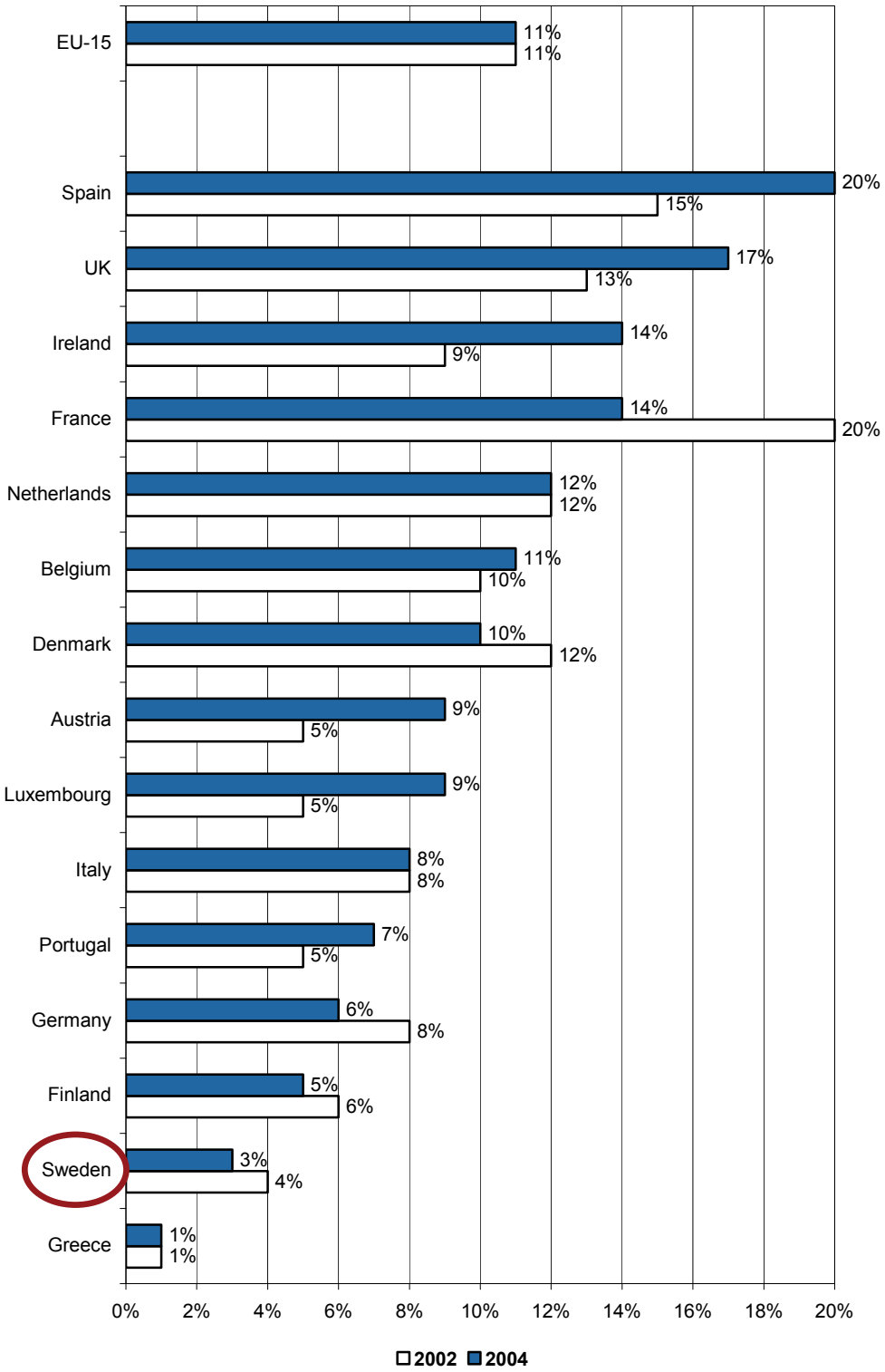

*Source: European Commission, Eurobarometer, Young People and Drugs, June 2004*

**Lifetime prevalence of cannabis use among 15-24 year olds in EU-15, 2002-2004**



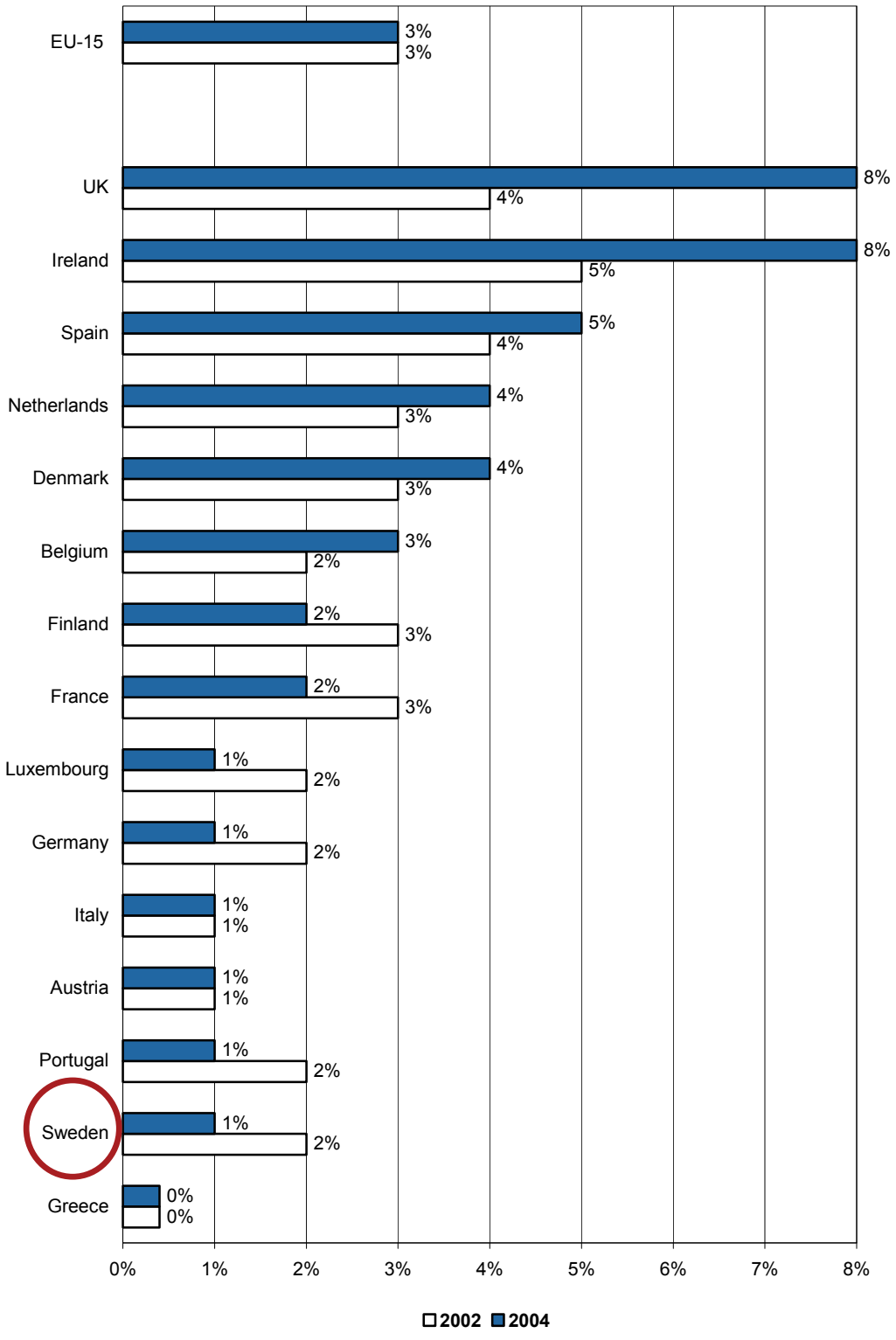

*Source: European Commission,* Eurobarometer, Young people and drugs*, June 2004.*

**Monthly prevalence of cannabis use among 15-24 year olds in EU-15, 2002-2004**




*Source: European Commission, Eurobarometer, Young people and drugs, June 2004.*

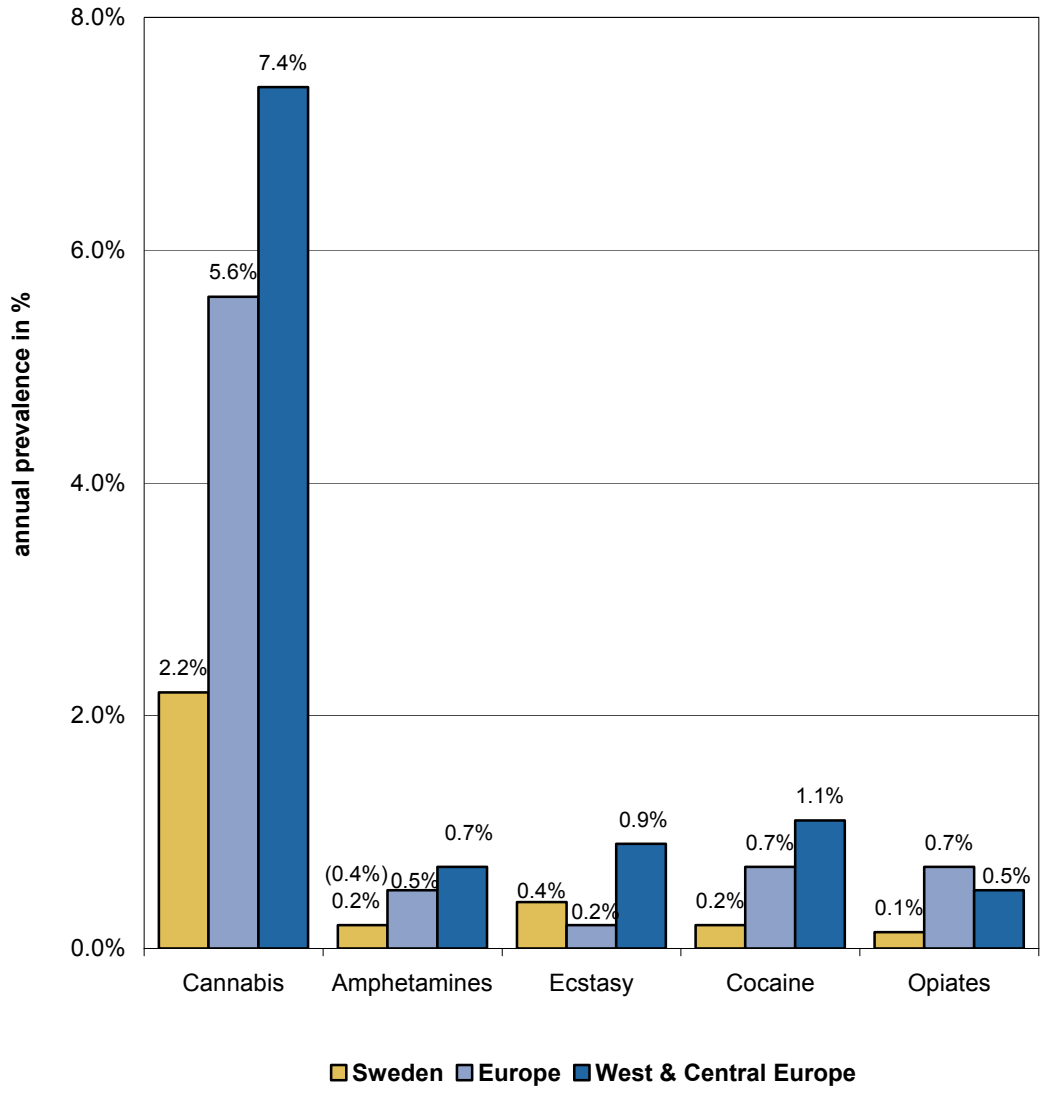
**Monthly prevalence of the use of drug other than cannabis among 15-24 year olds in EU-15, 2002-2004**




*Source: European Commission, Eurobarometer, Young people and drugs, June 2004.*

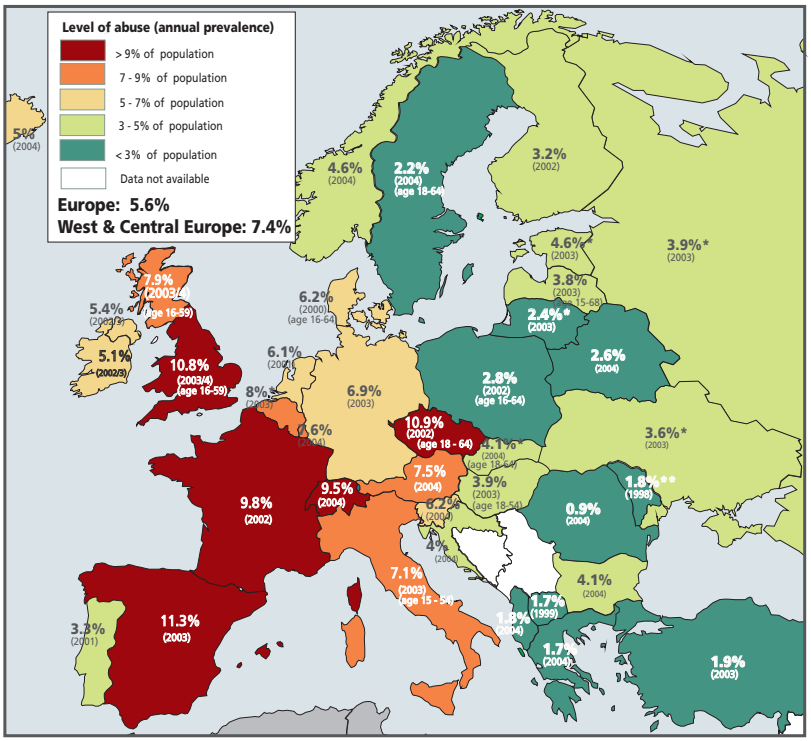
## GENERAL POPULATION SURVEYS

**Annual prevalence of drug use in Sweden as compared to Europe among the population age 15-64, 2004 or latest year available**



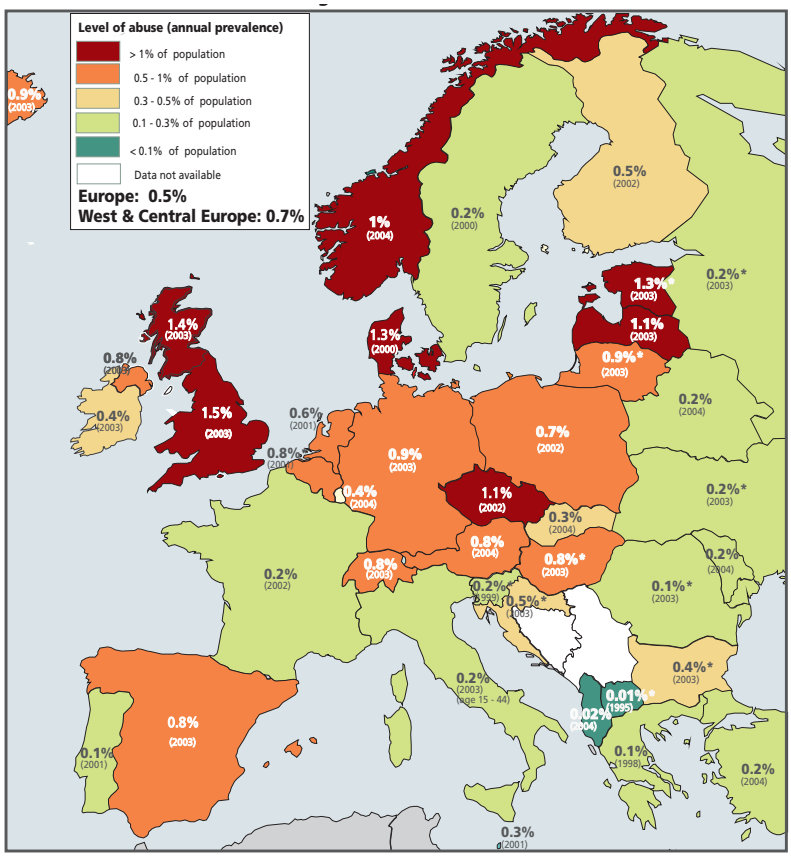

*Source: UNODC, 2006 World Drug Report*

**Annual prevalence of cannabis use among population 15-64, in 2004 or latest year available**



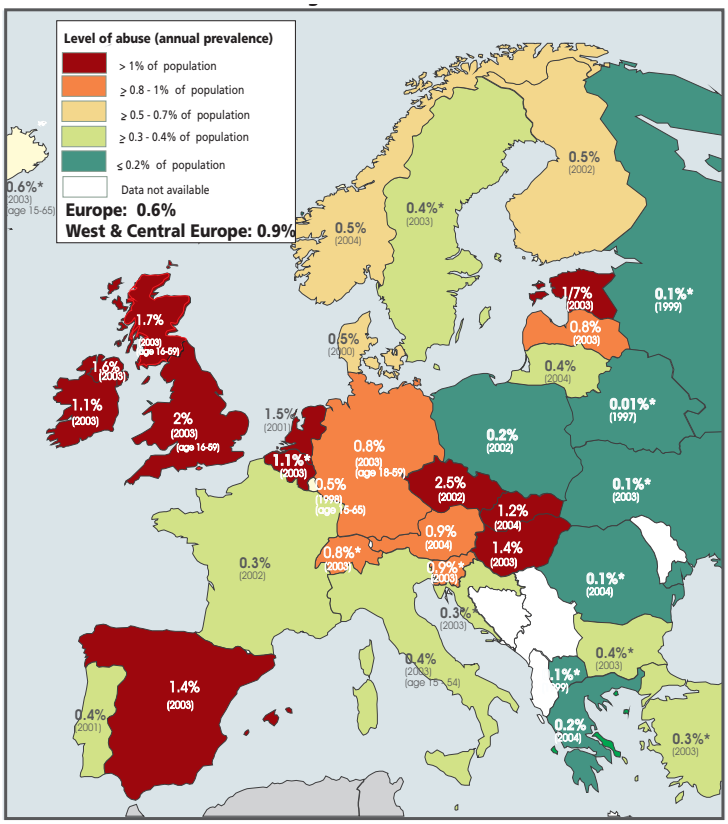

*Source: UNODC, 2006 World Drug Report*

**Annual prevalence of amphetamines use among population 15-64, in 2004 or latest year available**



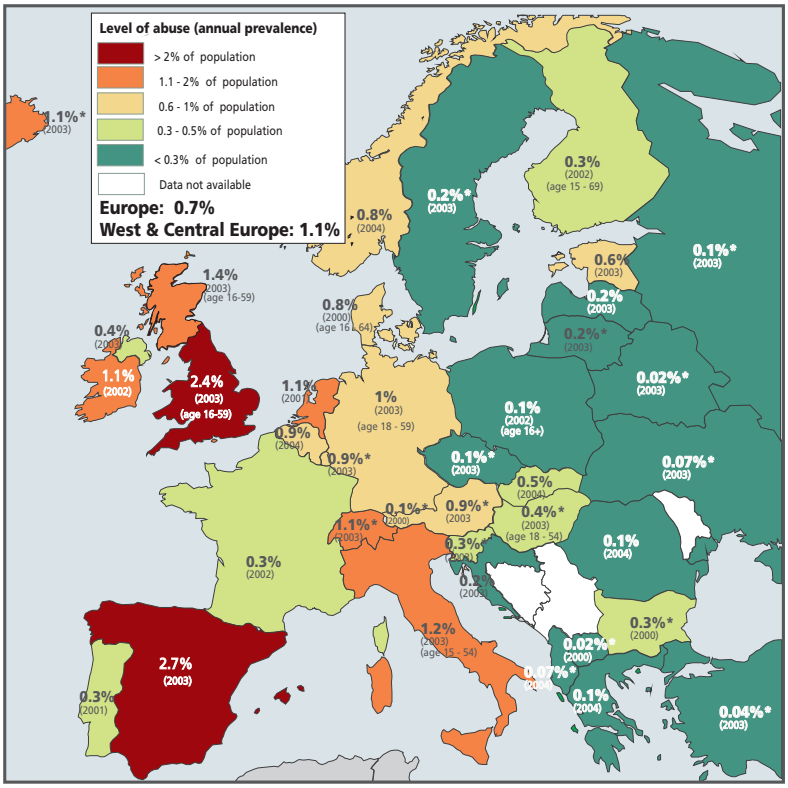

*Source: UNODC, 2006 World Drug Report*

**Annual prevalence of ecstasy use among population 15-64, in 2004 or latest year available**



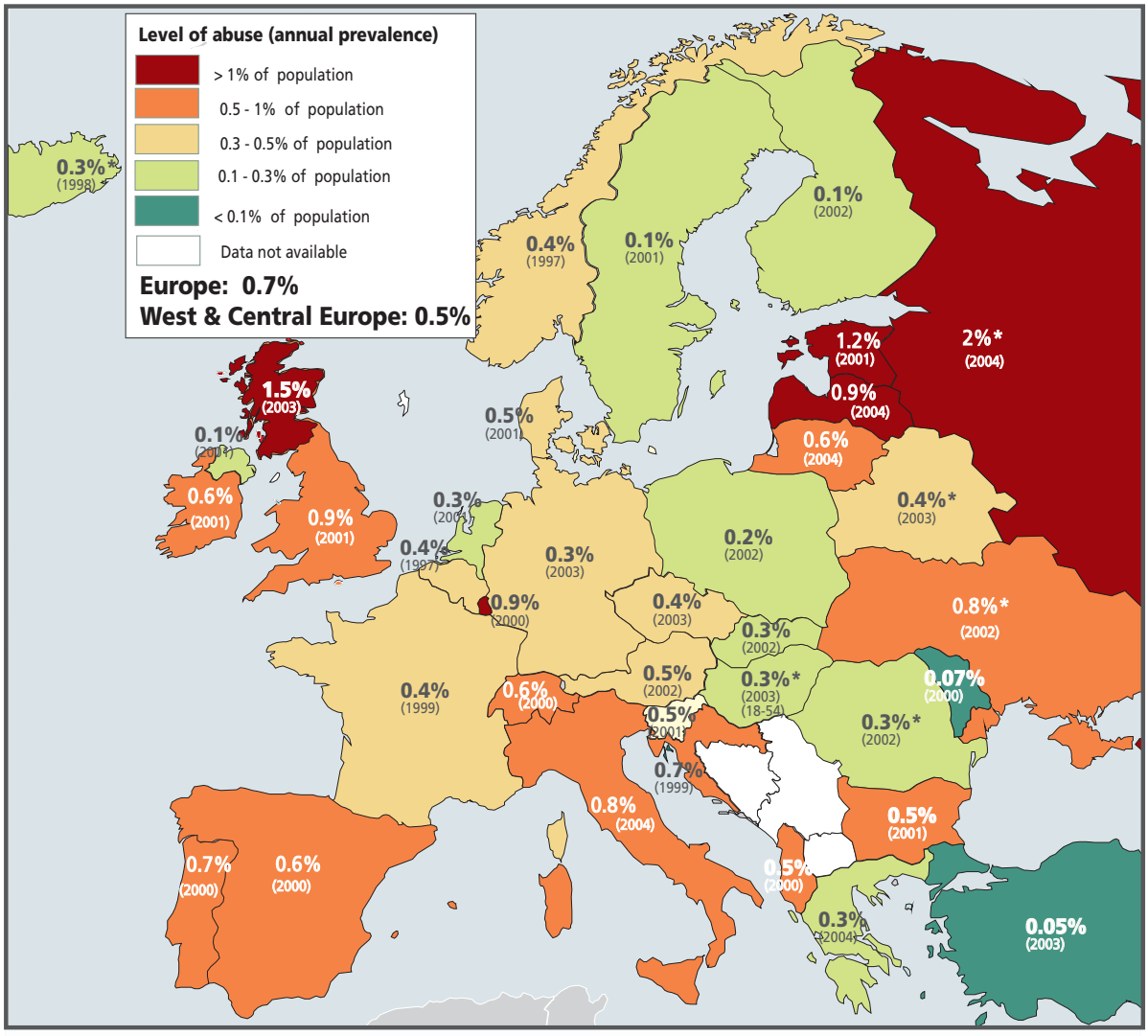

*Source: UNODC, 2006 World Drug Report*

**Annual prevalence of cocaine use among population 15-64, in 2004 or latest year available**



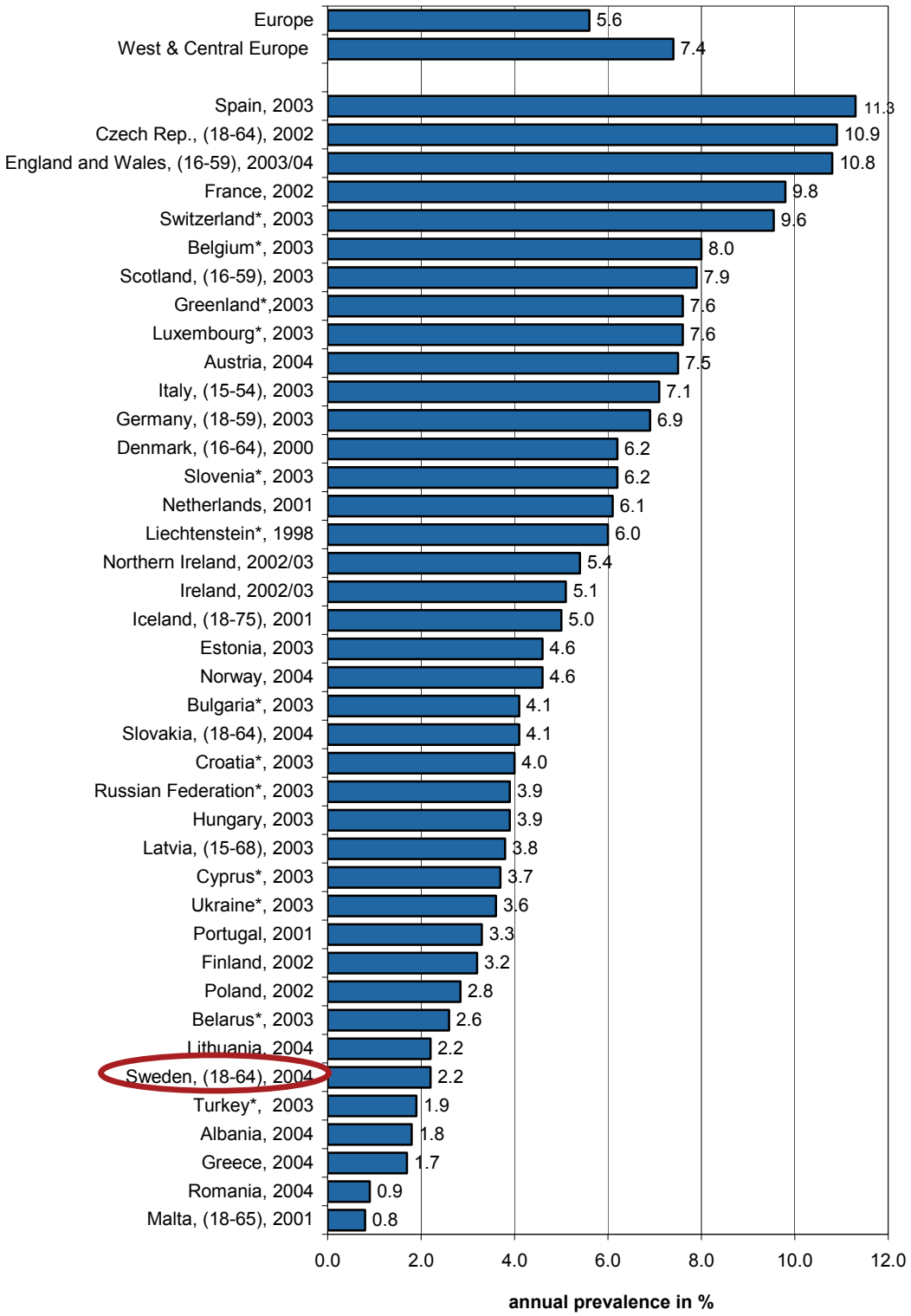

*Source: UNODC, 2006 World Drug Report*

**Annual prevalence of opiate use among population 15-64, in 2004 or latest year available**



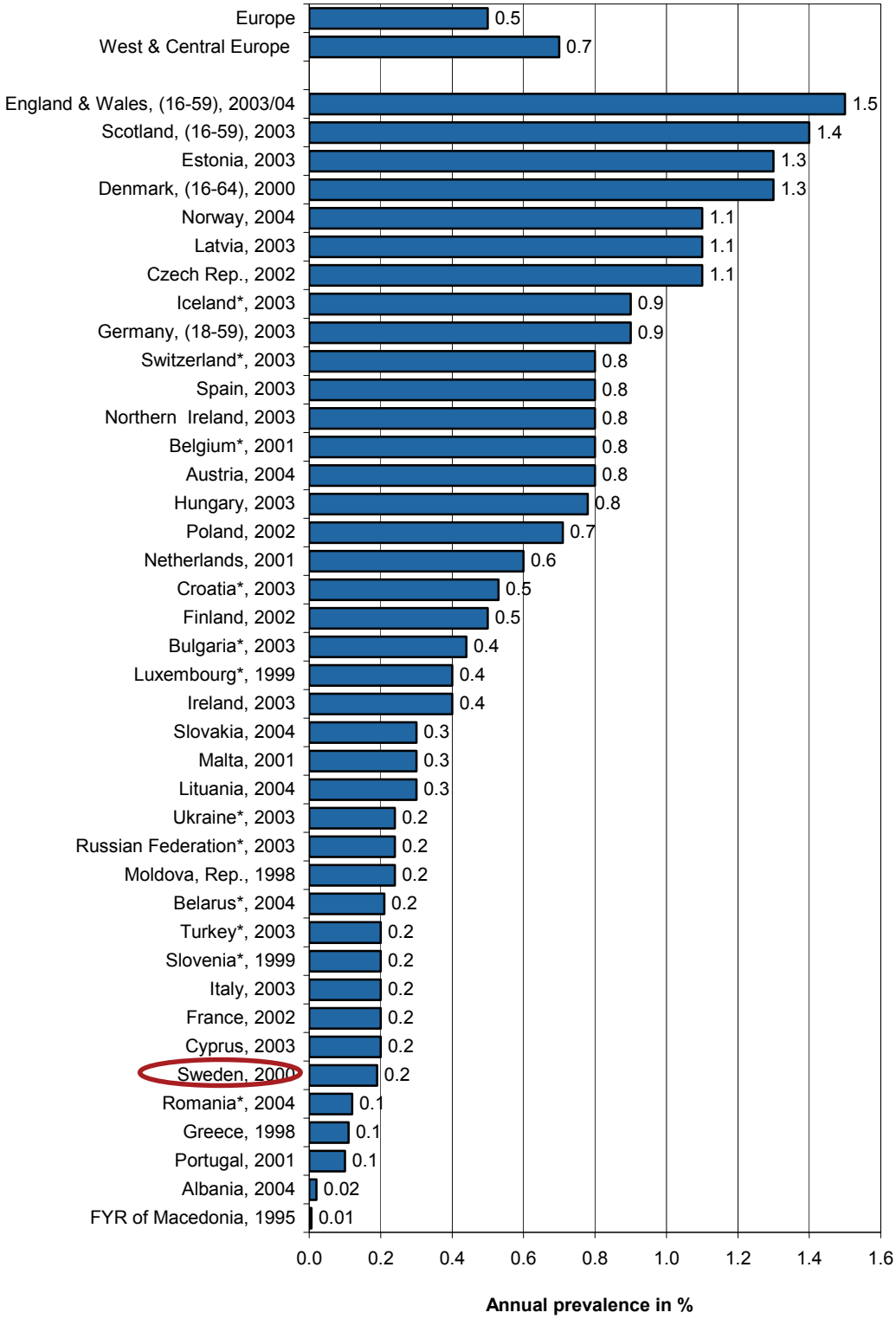

*Source: UNODC, 2006 World Drug Report*

## Cannabis use among population 15-64, in 2004 or latest year available



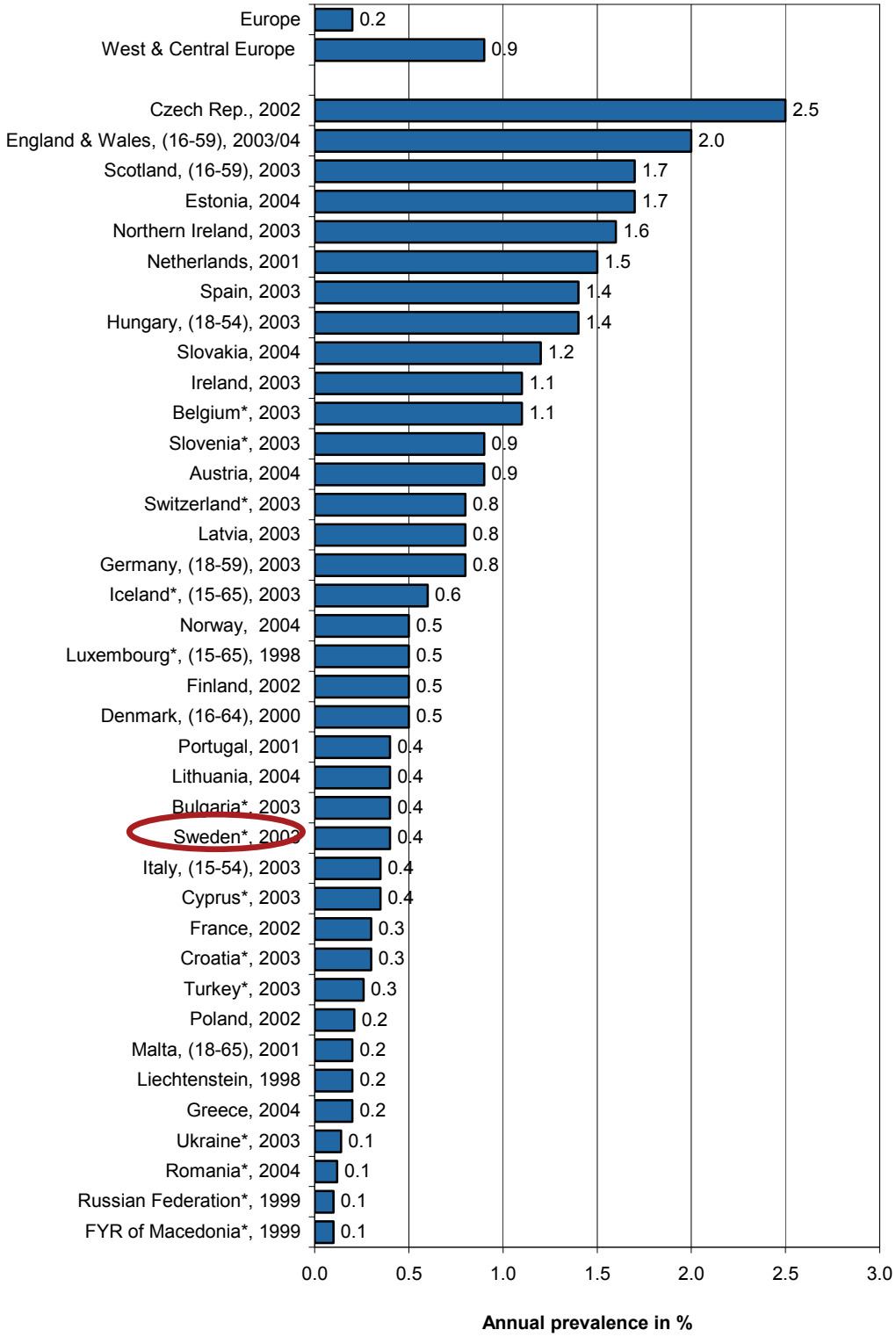

*Source: UNODC, 2006 World Drug Report.*

**Amphetamines use among population 15-64, in 2004 or latest year available**



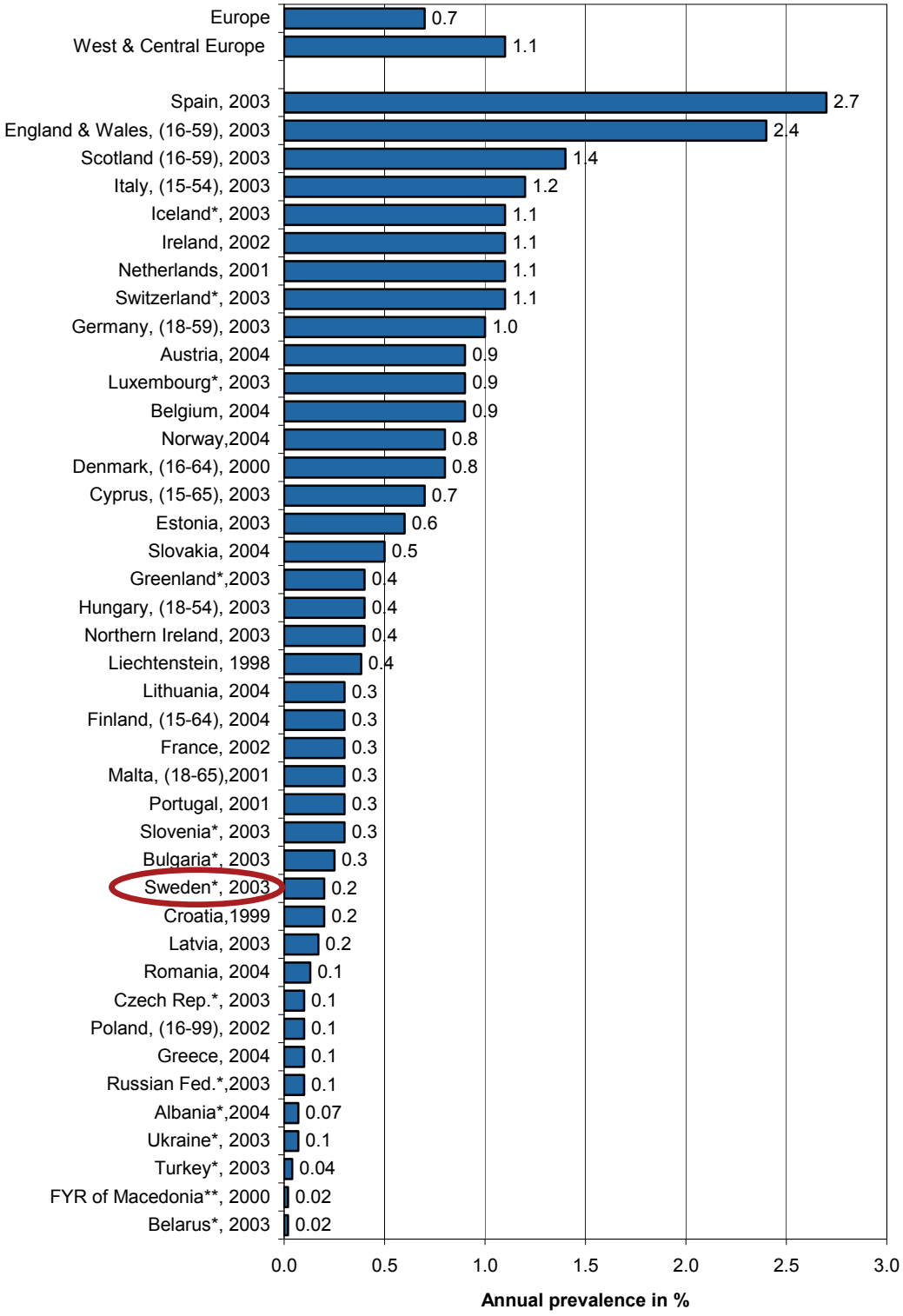

*Source: UNODC, 2006 World Drug Report.*

## Ecstasy use among population 15-64, in 2004 or latest year available



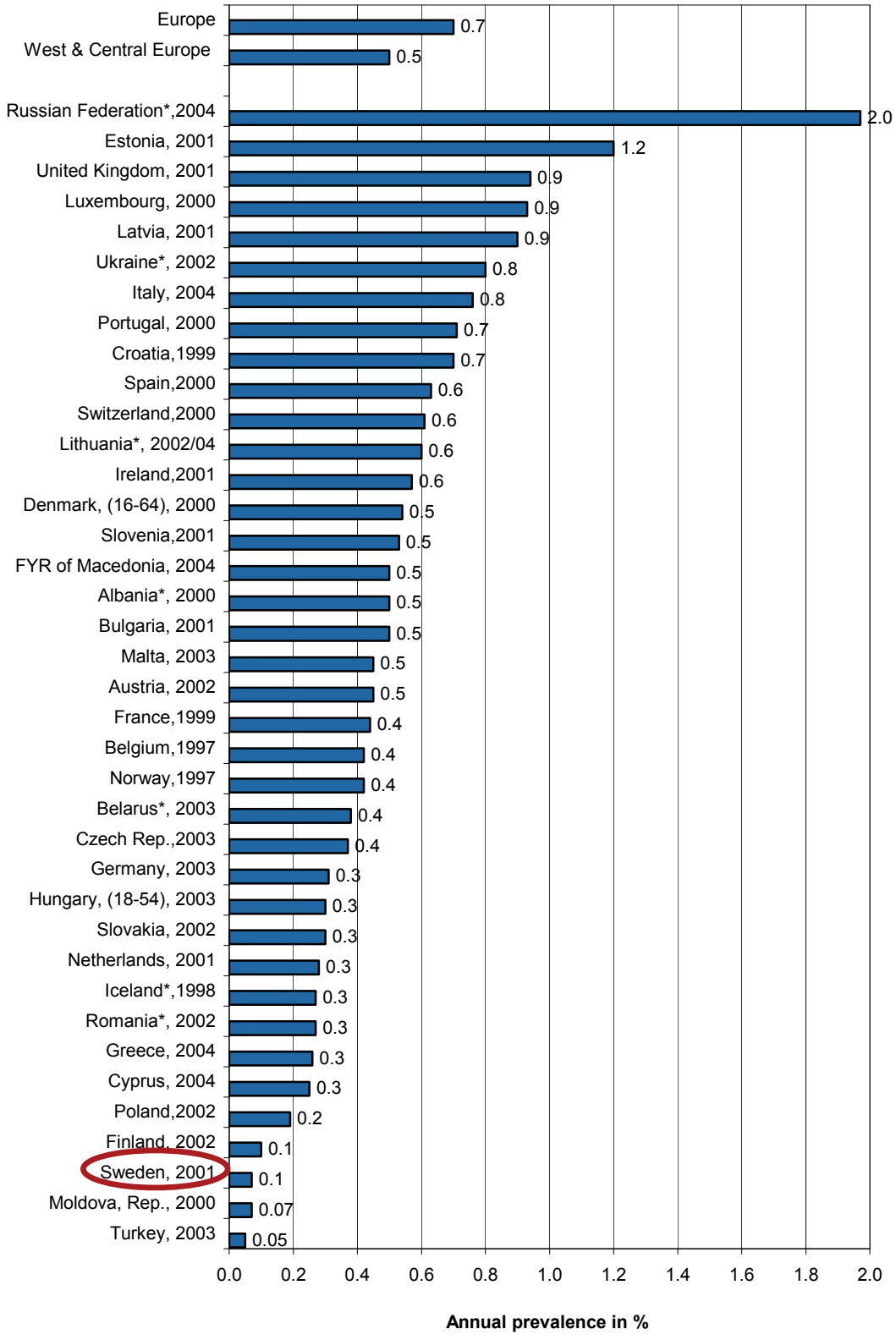

*Source: UNODC, 2006 World Drug Report.*

**Cocaine use among population 15-64, in 2004 or latest year available**




*Source: UNODC, 2006 World Drug Report.*

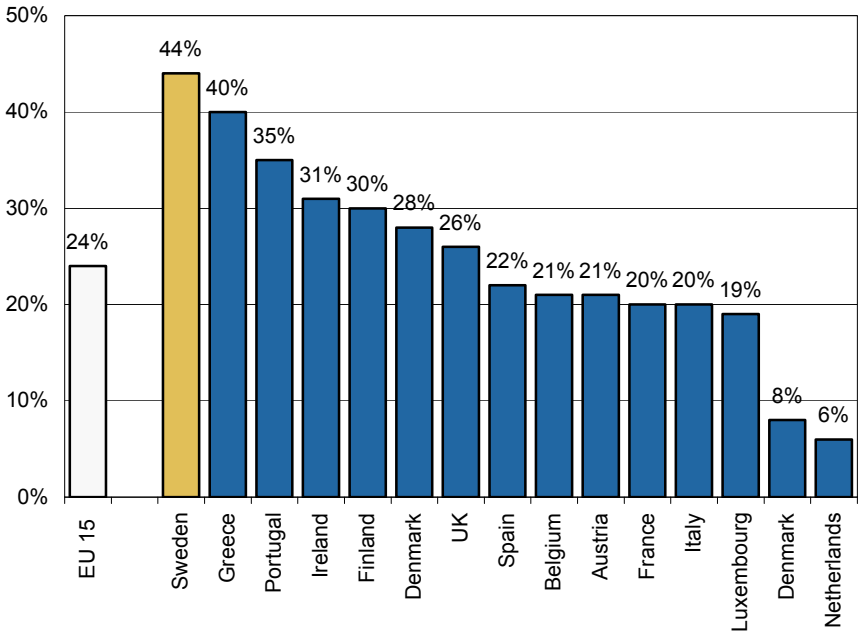
## Opiates use among population 15-64, in 2004 or latest year available




*Source: UNODC, 2006 World Drug Report.*

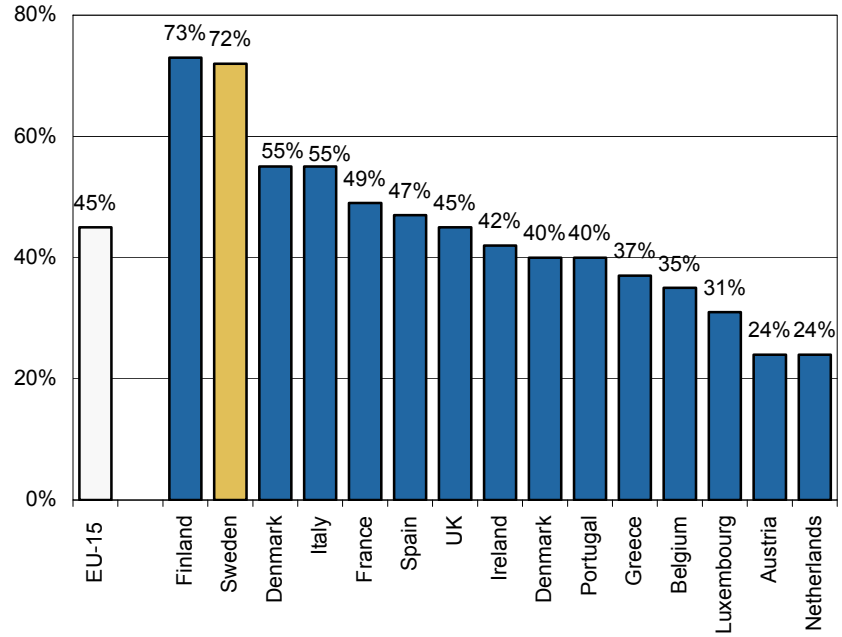
## PERCEIVED RISK OF DRUG USE

**Proportion of 15-24 year olds considering cannabis as 'very dangerous', 2004**



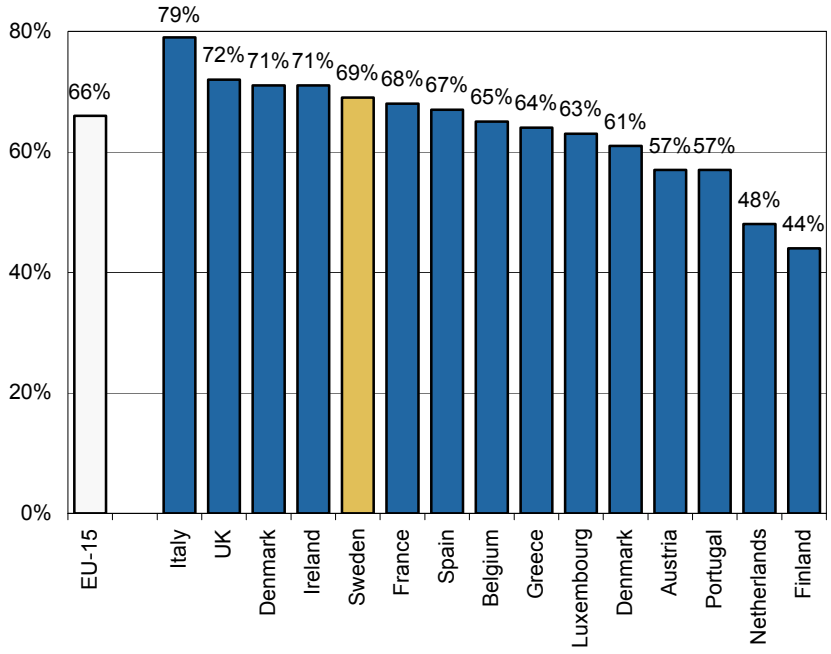

*Source: European Commission,* Eurobarometer, Young people and drugs*, June 2004*

**Proportion of 15-24 year olds considering amphetamines as 'very dangerous'; 2004**



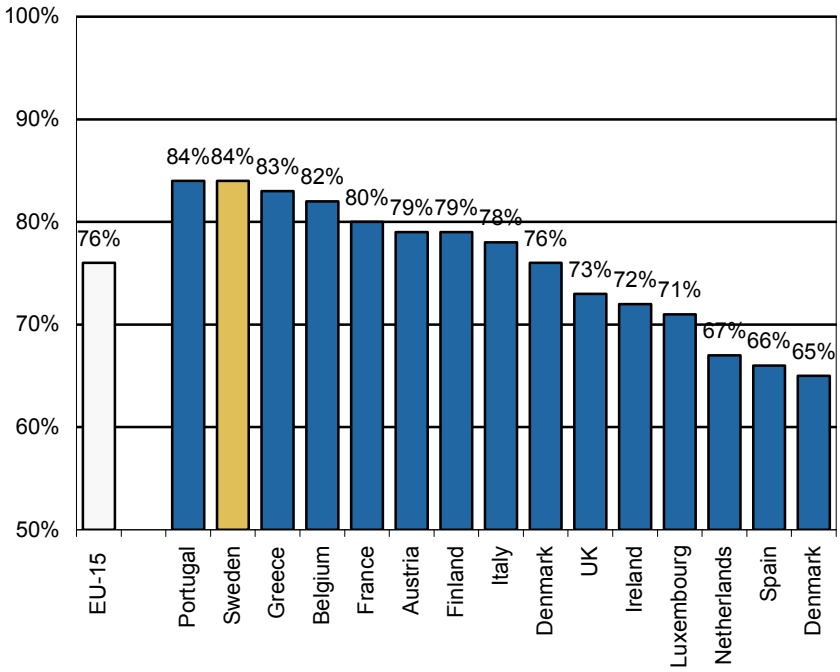

*Source: European Commission,* Eurobarometer, Young people and drugs*, June 2004*

**Proportion of 15-24 year olds considering ecstasy as 'very dangerous'; 2004**



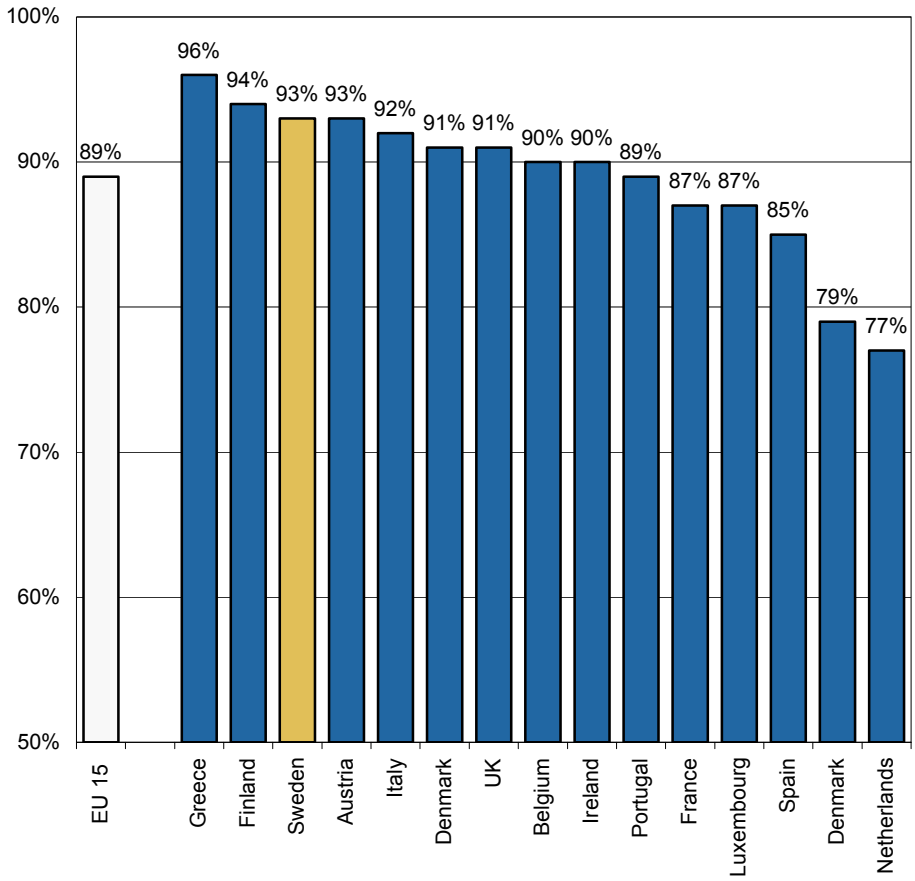

*Source: European Commission,* Eurobarometer, Young people and drugs*, June 2004*

**Proportion of 15-24 year olds considering cocaine as 'very dangerous'; 2004**




*Source: European Commission,* Eurobarometer, Young people and drugs*, June 2004*

**Proportion of 15-24 year olds considering heroin as 'very dangerous'; 2004**

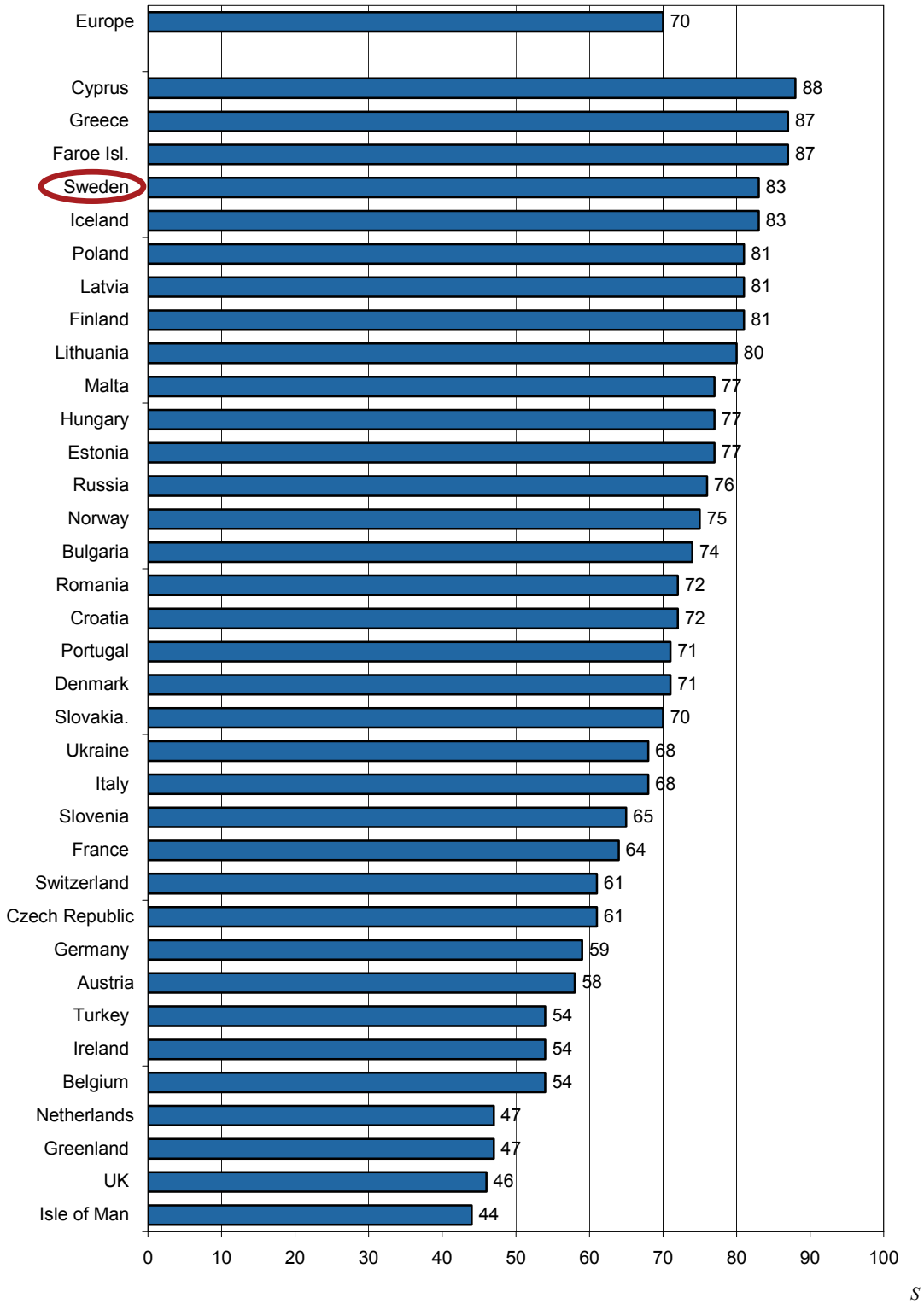



*Source: European Commission,* Eurobarometer, Young people and drugs*, June 2004*

**Risk perception of regular cannabis use among 15-16 year olds (2003):**

*How much do people risk harm themselves by regularly taking cannabis?*

*Response: 'great risk'*

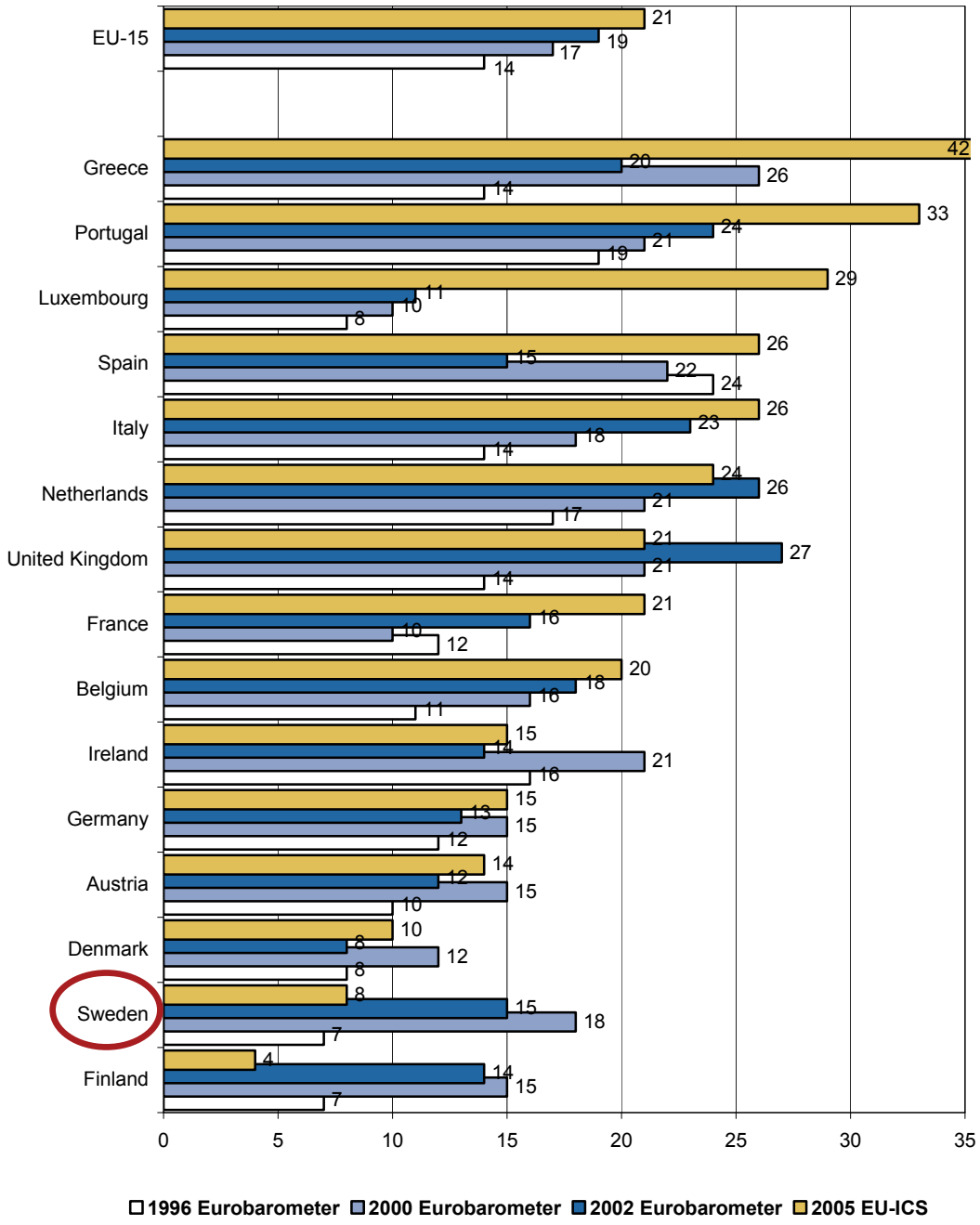



*S*

*ource: Council of Europe and Swedish Council for Information on Alcohol and Other Drugs (CAN), The ESPAD Report 2003*, Nov. 2004

## OTHER DRUG ABUSE RELATED DATA

**Contacts with drug problems* ('often' & 'from time to time') in the area of residence among EU-15 countries, 1996-2005**

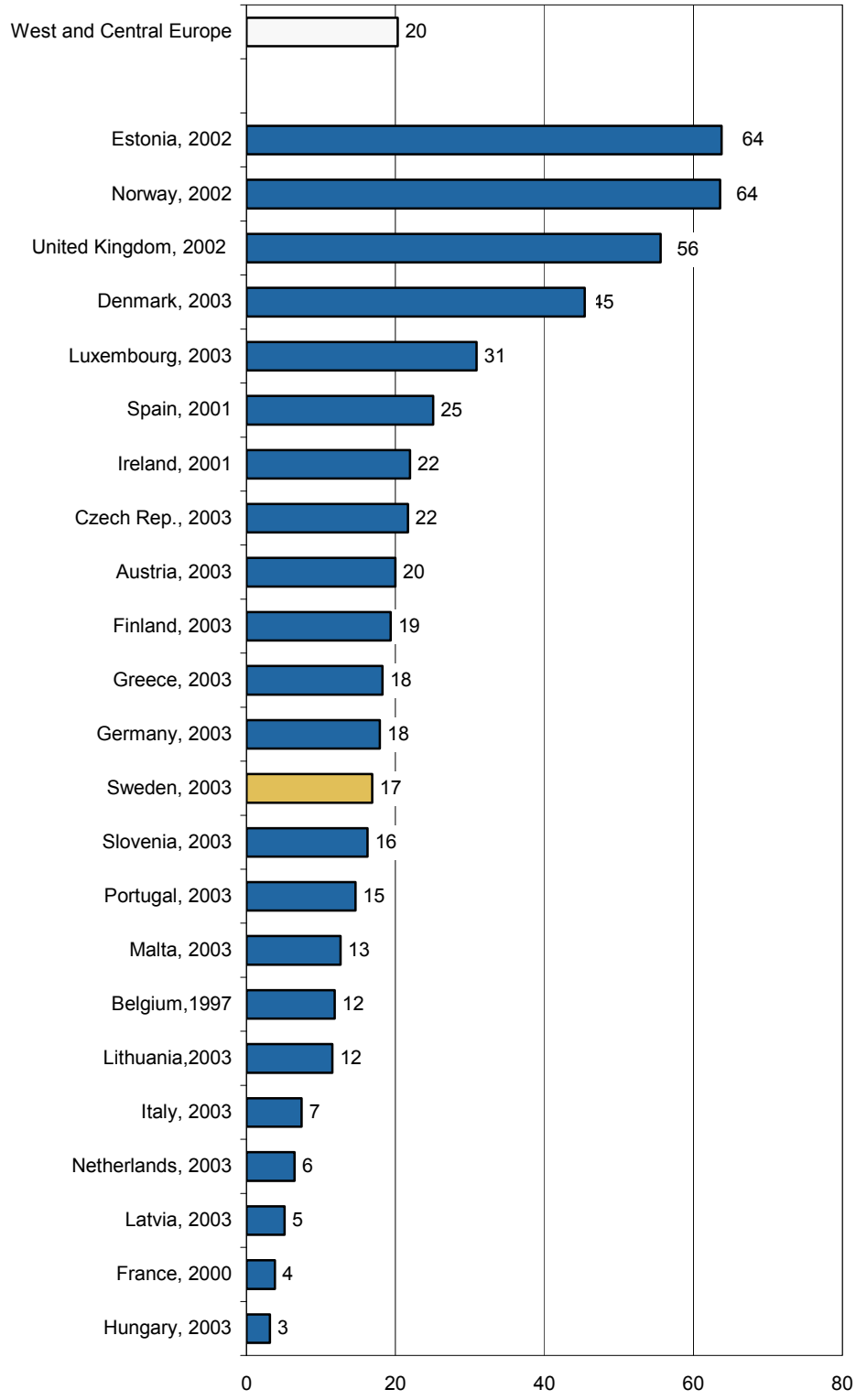



*'Over the last 12 months, how often were you personally in contact with drug related problems in the area where you live? For example seeing people dealing in drugs, taking or using drugs in public places, or by finding syringes left by drug addicts?'

*Sources: EU Commission, Eurobarometer, Public Safety Exposure to Drug Related Problems and Crime, Brussels 2003 and Robert Manchin / Gergely Hideg, Drug related Problems in Europe's Neighbourhoods, unpublished working paper[2], August 2006, European Crime and Safety Survey, 2005.*

[2] The data used in this working paper is the copyright of the EU ICS Consortium, led by Gallup Europe. The EU ICS was co-funded by the European Commission, FP6. The consortium website is http://www.gallup-europe.be/euics. The working paper is the copyright of its author(s).

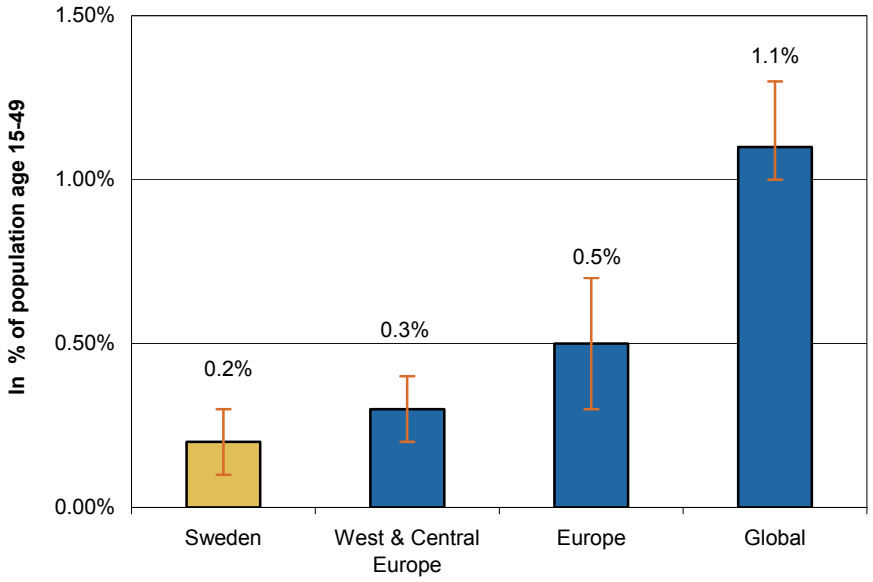
**Acute drug-related deaths in 2003 (or latest year available), per million inhabitants (national definition)**




*Sources: EMCDDA, UNODC, ARQ, CAN*

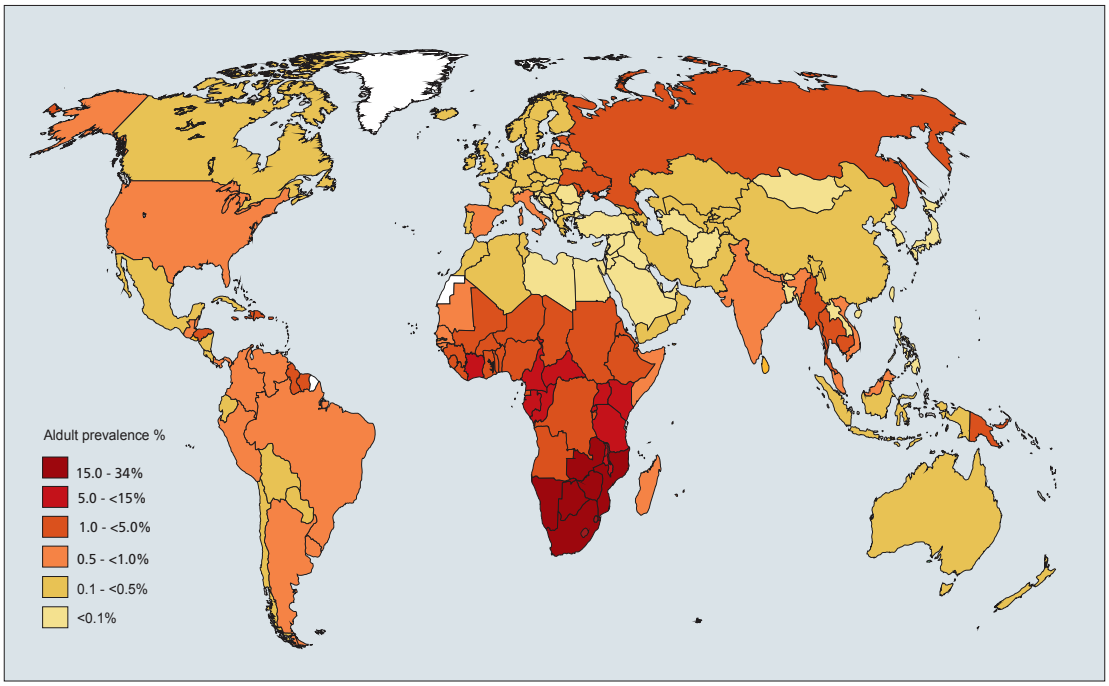
## INTRAVENOUS DRUG ABUSE AND HIV/AIDS

**People living with HIV/AIDS in 2005 as a proportion of the population age 15-49**



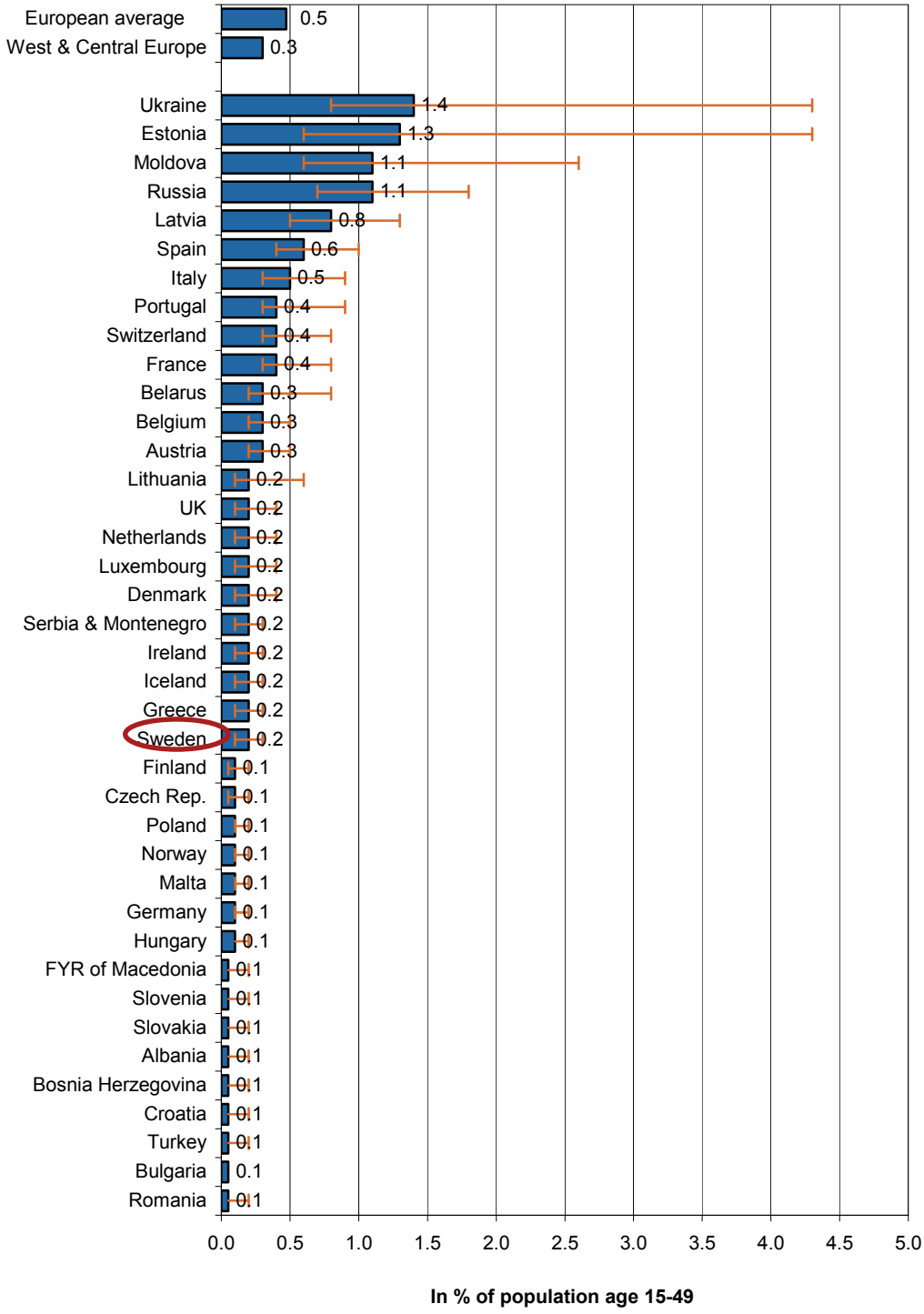

*Sources: UNAIDS,* AIDS Epidemic Update*, December 2005 and UNAIDS, A Global View of HIV Infections in UNAIDS* 2006 Report on the Global AIDS Epidemic*, May 2006.*

**People living with HIV/AIDS in 2005 as a proportion of the population age 15-49**



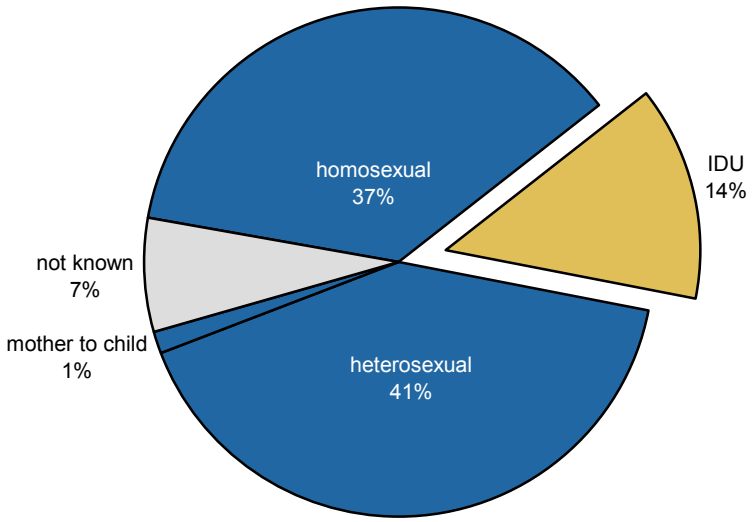

*Sources: UNAIDS,* AIDS Epidemic Update*, December 2005 and UNAIDS, A Global View of HIV Infections in UNAIDS* 2006 Report on the Global AIDS Epidemic*, May 2006.*

**UNAIDS estimates of HIV/infections in Europe in 2005 as a proportion of the population age 15-49**



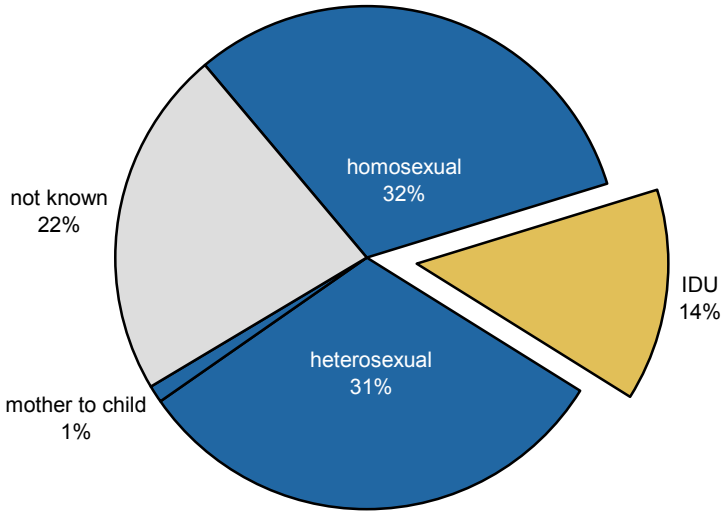

*Sources: UNAIDS,* AIDS Epidemic Update, *December 2005 and UNAIDS, A Global View of HIV Infections in UNAIDS* 2006 Report on the Global AIDS Epidemic, *May 2006.*

**Sweden: Reported HIV infections, by modes of transmission, 1985-June 2005 (N = 6,897)**



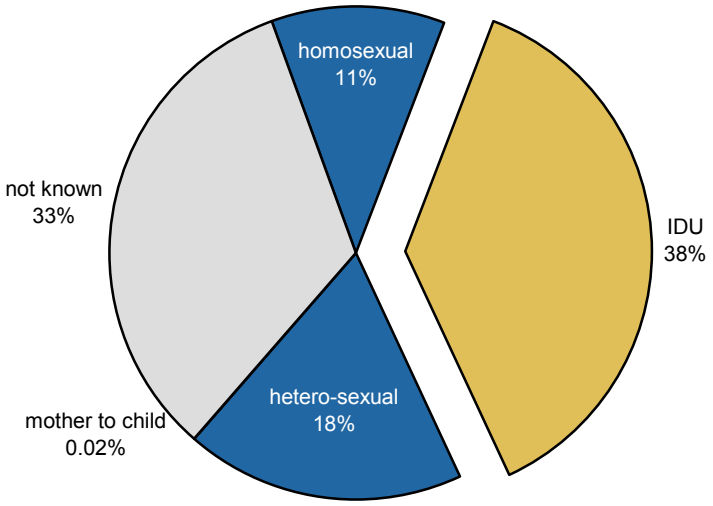

*Source: EuroHIV, HIV/AIDS Surveillance in Europe, Mid-year report 2005, Paris 2006.*

**EU-25: Reported HIV infections, by modes of transmission, 1985-June 2005 (N = 215,510)**




*Source: EuroHIV, HIV/AIDS Surveillance in Europe, Mid-year report 2005, Paris 2006.*

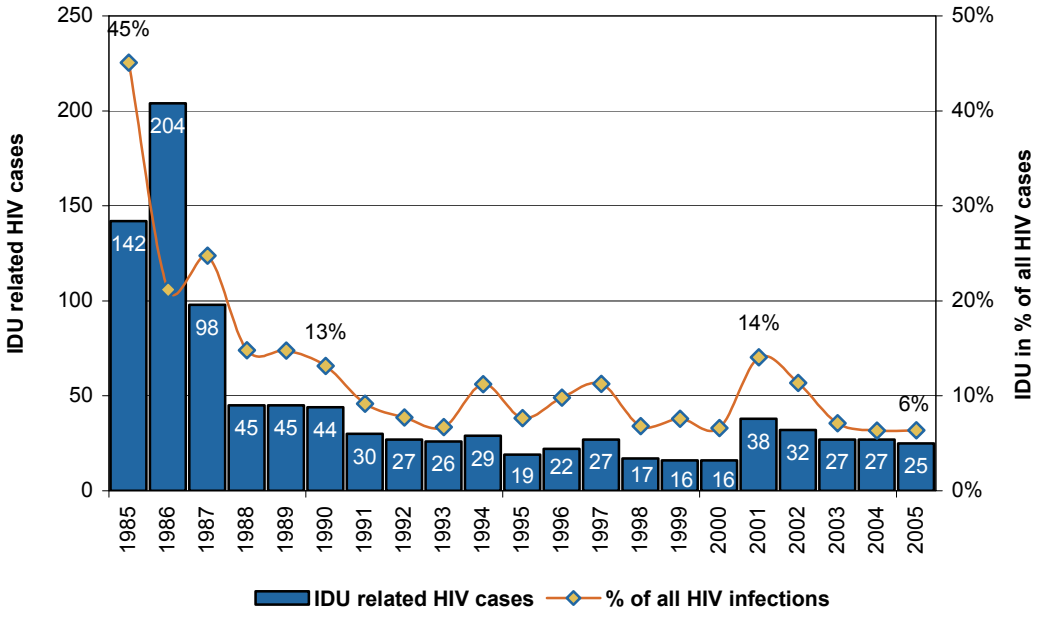
**Europe (WHO region)*: Reported HIV infections by modes of transmission, 1985-June 2005, (N = 646,142)**




** includes countries of the Caucasus region and Central Asia, but not Turkey.*

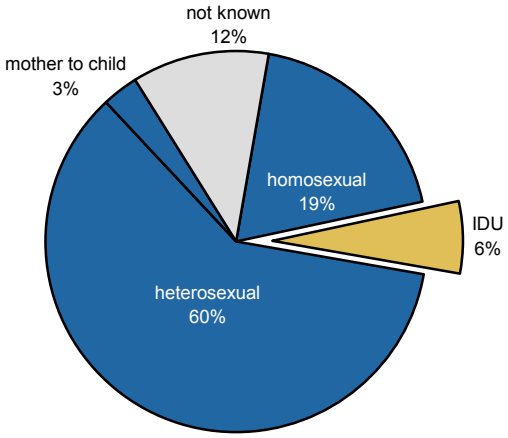
*Source: EuroHIV,* HIV/AIDS Surveillance in Europe, Mid-year report 2005*, Paris 2006.*

**New injecting drug use related HIV cases in Sweden, 1985-2005**



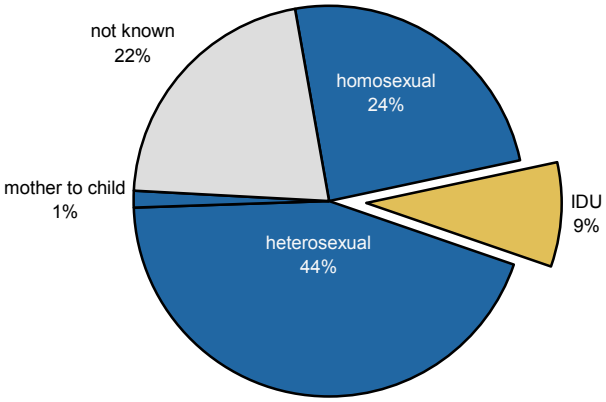

*Source: CAN*

**Sweden: newly reported HIV infections, by modes of transmission, in 2004 (N = 431)**



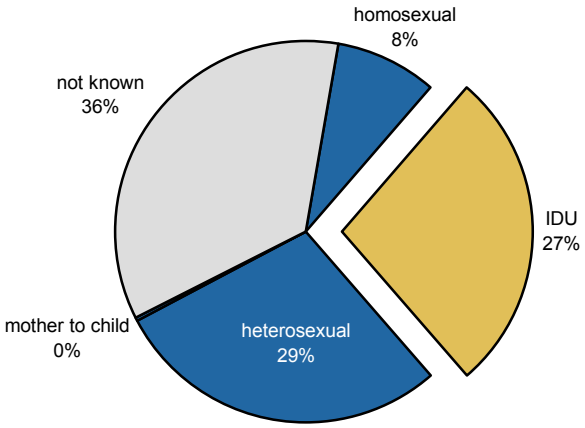

*Source: EuroHIV, HIV/AIDS Surveillance in Europe, Mid-year report 2005, Paris 2006*

**EU-25: newly reported HIV infections, by modes of transmission, in 2004(N = 24,184)**



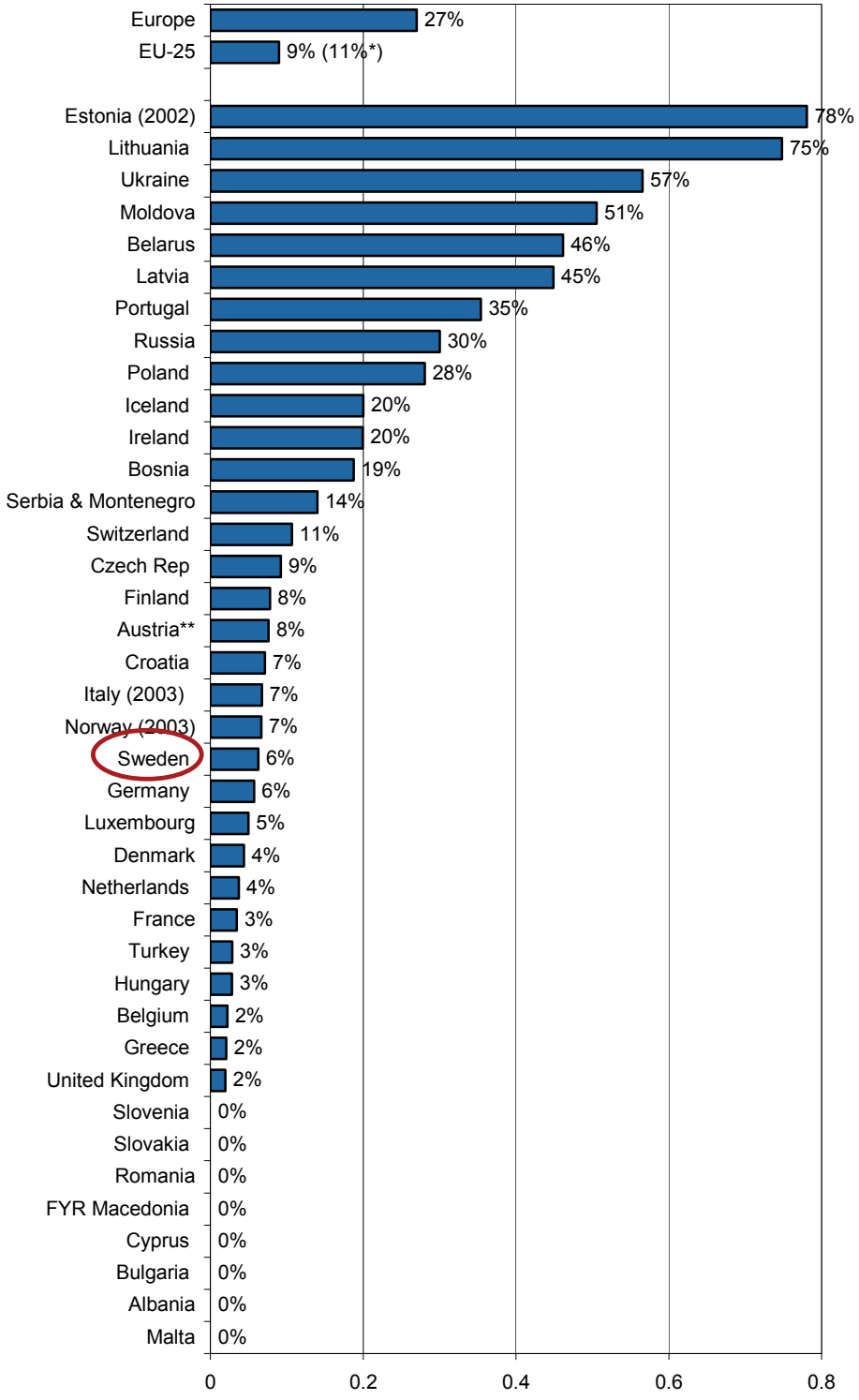

*Source: EuroHIV, HIV/AIDS Surveillance in Europe, Mid-year report 2005, Paris 2006.*

**Europe (WHO region*): newly reported HIV infections, by modes of transmission, in 2004 (N = 74,760)**




** includes countries of the Caucasus region and Central Asia, but not Turkey.Source: EuroHIV,* HIV/AIDS Surveillance in Europe, Mid-year report 2005*, Paris 2006.*

**Proportion of newly reported IDU related HIV infections among all newly reported HIV infections in 2004**

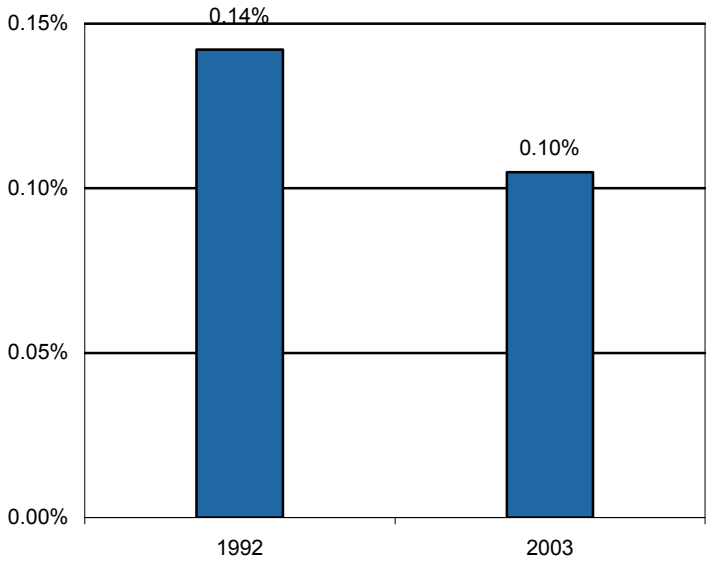



** EU estimate: 9% for all EU countries reporting in 2004 (n=21 countries) or 11% including EU countries reporting in previous years (Italy, Estonia) but not in 2004*

*Data for Austria are based on a UNODC estimate.*

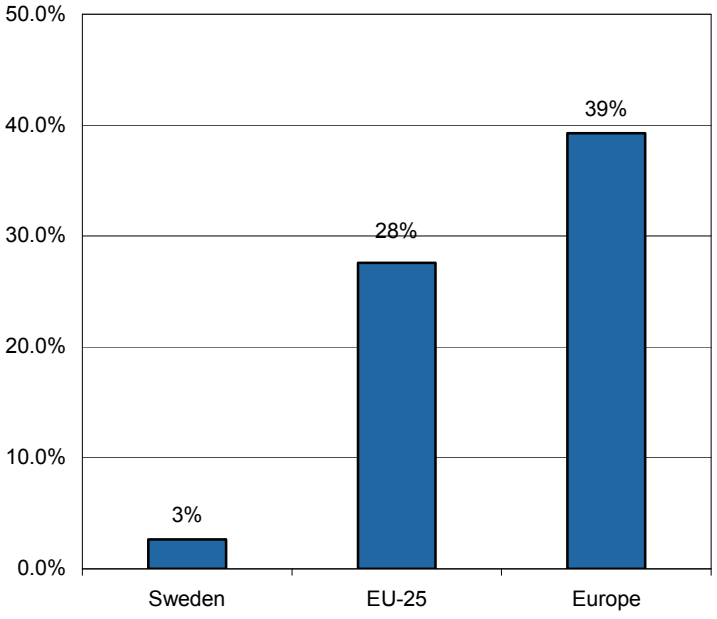
*Source: EuroHIV, HIV/AIDS Surveillance in Europe, Mid-year report 2005, Paris 2006.*

**Risk of new IDU related HIV infections among problem drug users in Sweden, 1992-2003**



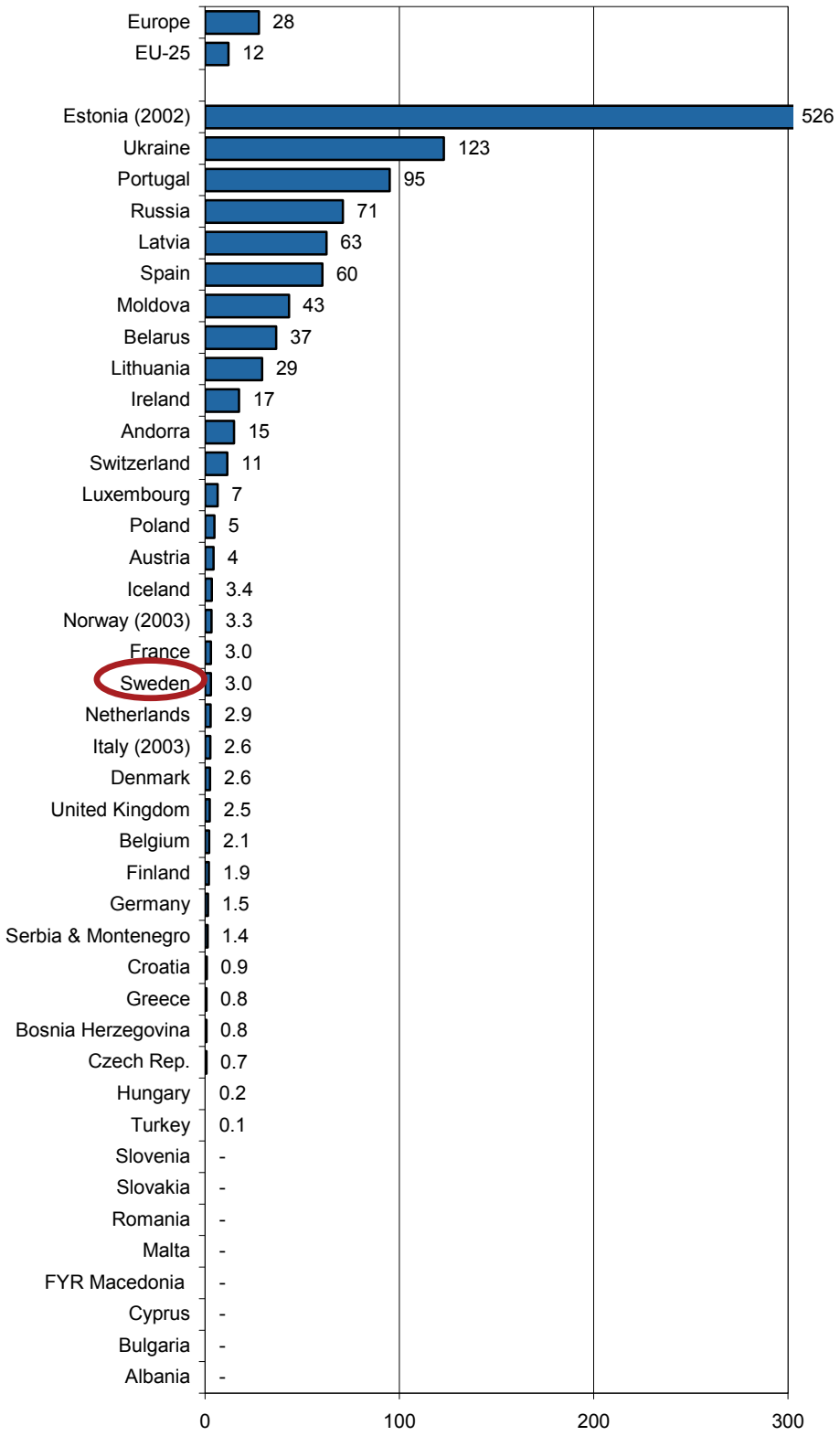

*Source: CAN*

**Proportion of IDU among newly diagnosed AIDS cases in 2004**



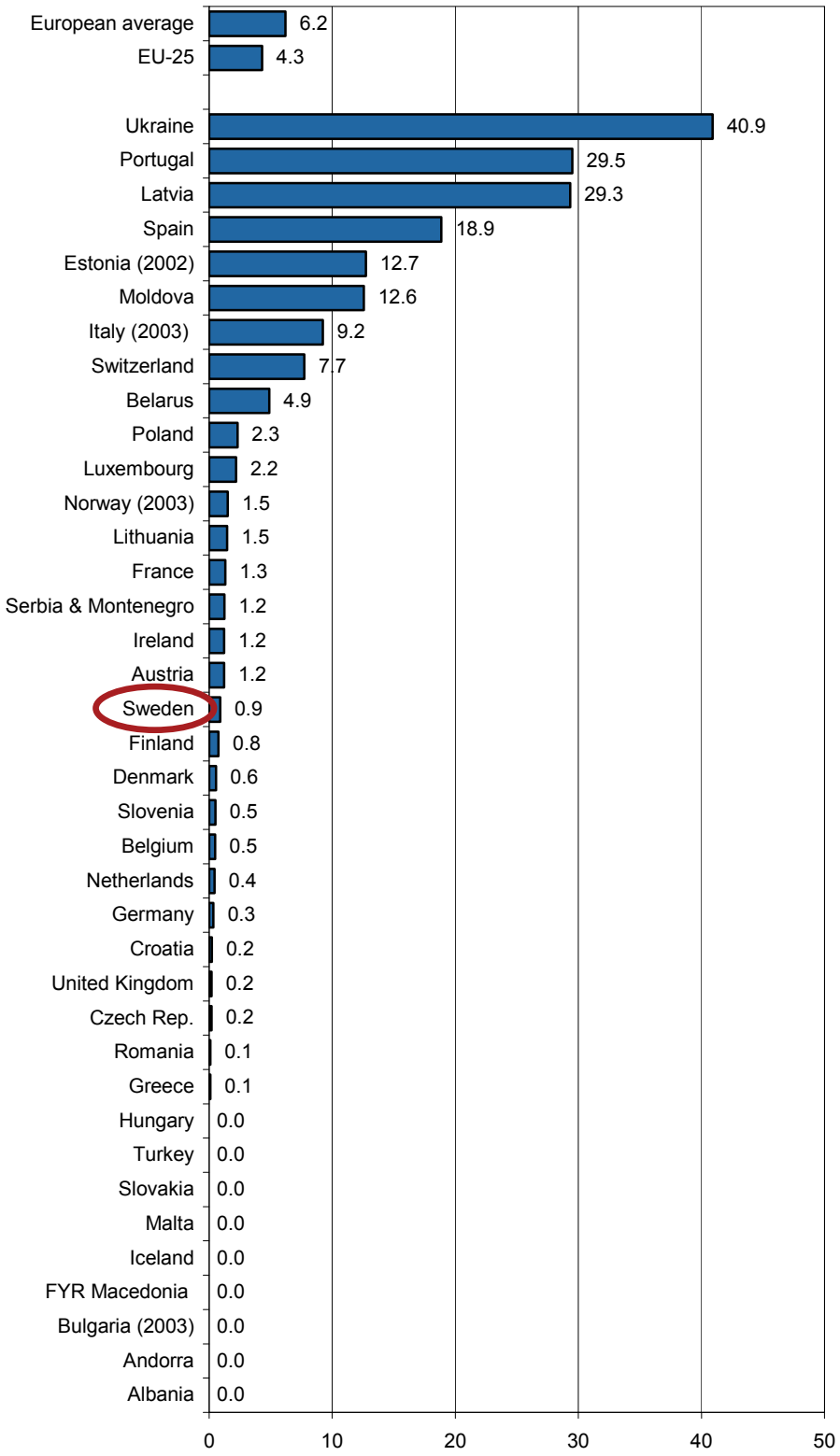

*Source: EuroHIV, HIV/AIDS Surveillance in Europe, End-year report 2005, Paris 2005.*

**Newly reported IDU related HIV infections per million inhabitants in 2004**



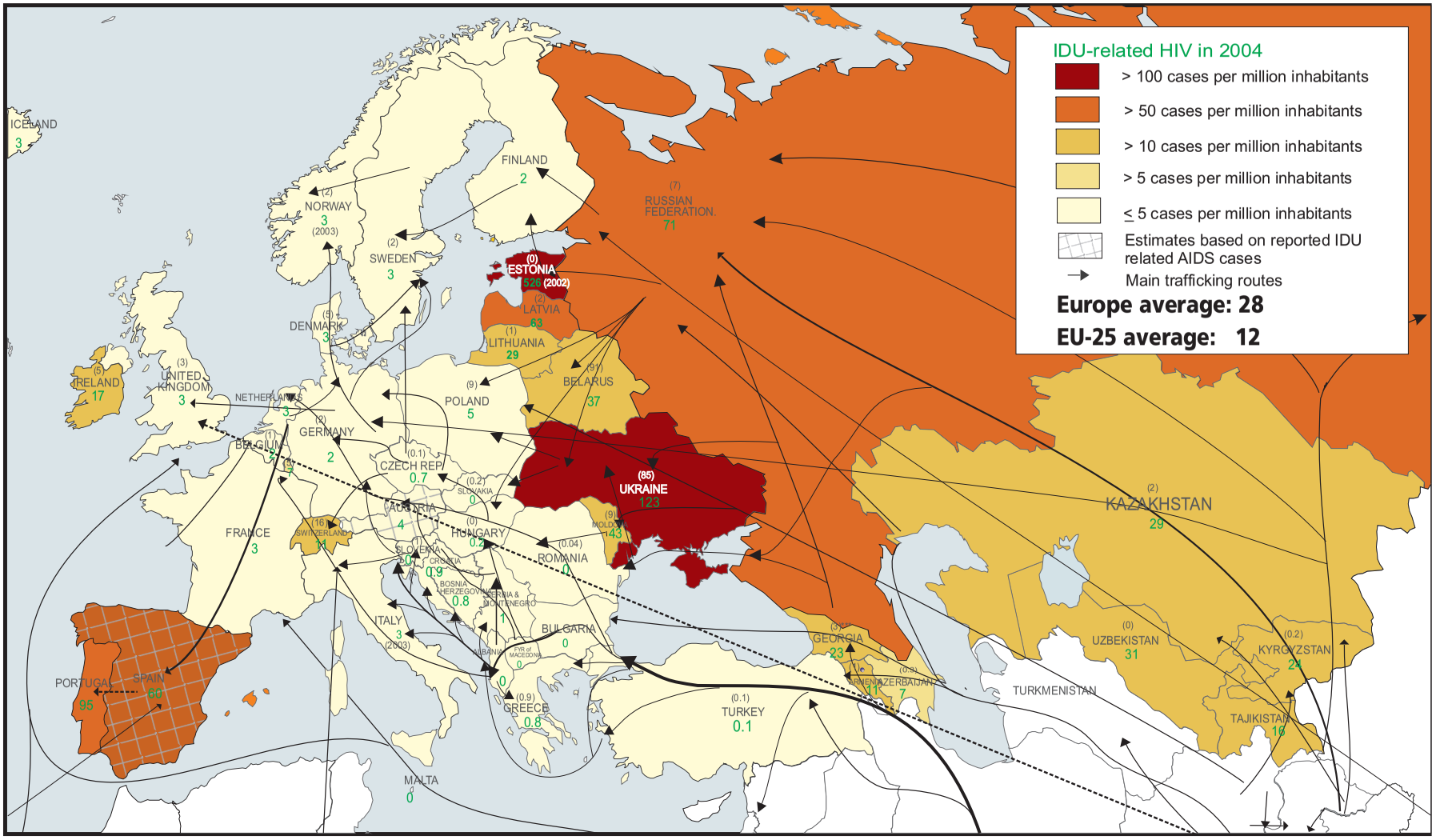

*Source: EuroHIV, HIV/AIDS Surveillance in Europe, Mid-year report 2005, Paris 2006.*

**Newly reported IDU related AIDS cases per million inhabitants in 2004**




*Source: EuroHIV, HIV/AIDS Surveillance in Europe, End-year report 2005, Paris 2005.*

**Newly diagnosed injecting drug use related HIV infections per million inhabitants in 2004 (data for 1996 in brackets)**



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