NATIONAL DRUG POLICY: SWEDEN

PREPARED FOR THE SPECIAL SENATE COMMITTEE ON ILLEGAL DRUGS

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INTRODUCTION

This paper provides a brief introduction to Sweden's national drug policy. This includes:

- Background information to its drug policies;
- A review of the national drug strategy;
- The legislation with respect to illicit drugs;
- The debate and recent studies;
- The costs associated with illicit drug use; and
- Data related to drug use and drug-related offences.

This paper forms part of a series of country pictures being prepared by the Parliamentary Research Branch of the Library of Parliament for the Special Senate Committee on Illegal Drugs.

BACKGROUND TO SWEDISH DRUG POLICY(1)

Sweden, a Nordic country covering 450,000 km^2, has a population of roughly 9 million. Approximately 2/3 of the population lives in rural areas and the others generally have their roots in these areas. The population is relatively homogenous, with almost 90% being Lutheran. It would appear that Swedish people tend to be conformist and that strange or deviant behaviour is not easily accepted. Sweden has a social democratic tradition and is well known for

(1) For more in-depth information on the background to Swedish drug policy, please see Tim Boekhout van Soliinge, *The Swedish Drug Control System: An in-depth review and analysis*, Centre for Drug Research, University of Amsterdam, Amsterdam, 1997.

its welfare system which in the past included jobs, housing, universal health care, a social safety net and a secure future for its population. It is only in the last century that it has become a "rich" country. Economic problems in the last decade or so, however, have had negative effects on its welfare system.

Popular movements have a long history in Sweden and have helped shape it. These movements are eligible for state subsidies and are nationally established with many local branches. Some of the popular movements in the fields of drugs (for example, Parents Against Drugs, Hassela Solidarity and the Association for a Drug-Free Society who all strive for a drug free society and a corresponding strict drug policy) have played, and still play, an important role in the development of Swedish drug policy.(2) Others with influence include individuals and groups from the treatment sector, the police and the organization European Cities Against Drugs.

In Sweden, drug policy is viewed as part of its welfare and social policy. The drug phenomenon is seen as one of the most serious social problems (if not the most important problem) and drugs are viewed as an external menace to the country.(3) Drug abuse is often perceived as a cause for other social problems. Many are of the view that the drug problem puts traditional Swedish values at risk. It is not only drugs, but also the liberalization debate, that are seen as coming from other countries to influence Swedish values. These concerns have increased since Sweden became a member of the European Union in 1995, as most of the other members of the EU have adopted a more liberal approach when it comes to the drug issue.

In comparison to other Western countries in Europe, Swedish drug policy is regarded as restrictive. One of the aims of the policy is to make it clear that drugs are not tolerated in society. Drug use is regarded as deviant behaviour and such behaviour must be stopped. Some examples of this restrictive attitude include:

- The overall goal is that of a drug-free society;
- Harm reduction programs are only available in a limited fashion;
- Treatment is based on obtaining complete abstention and it is possible to force people into treatment;

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(2) *Ibid*., p. 72.

(3) European NGO Council on Drugs and Development, *A Snapshot of European Drug Policies: Report on the state of drug policies in 12 European countries*, October 2001, p. 27.

- Consumption of narcotics is an offence, and urine and blood test are used to detect those suspected of drug use;
- Drug legislation is strictly enforced;
- Discussions regarding the medical value of cannabis are almost non-existent;
- Swedish legislation strictly adheres, and even surpasses, the requirements set out in the three United Nations drug conventions.

Historically, Sweden has not had a problem with illegal drug use and such use was not regarded as a serious social problem. As in many other western countries, this changed in the 1960s. In Sweden in 1965, there were signs of increased drug use, including use of cannabis, amphetamines, LSD and opiates. Amphetamines were, and are, more of a problem than heroin, which was the problem drug in many other countries. Drug addicts have historically been people injecting amphetamines intravenously.

Amphetamines were introduced into Sweden in 1938, and were promoted for weight loss and as stimulants. They were used by large segments of the population and were also related to a criminal subculture. Over the years, as the controls on amphetamines increased (for example being only available on prescription), the occasional and experimental use declined, while regular use and abuse increased. In addition, the way the drug was taken (intravenously rather than orally) had changed. "The development of the consumption of central stimulants from the late 1930s to the mid 1960s could be described as the transformation of a socially accepted medicine used by many, and different kinds of people, to an illicit drug basically consumed in a deviant environment."[4] This long history of use is one of the reasons that amphetamine use was and remains a major concern in Sweden.

While Swedish drug policy is currently very restrictive, this was not always the case. In fact in the 1960s, its policy was fairly liberal, basically reflecting a harm reduction approach.[5] For example, from 1965 to 1967, it was possible for severe drug abusers to obtain prescriptions for morphine and amphetamines. This non-scientific experiment (involving approximately 120 people) was used by Nils Bejerot, a police doctor and very influential figure

(4) Boekhout van Solinge, *Supra* note 1, p. 59.

(5) United Nations Office for Drug Control and Crime Prevention, *Country Drug Profile: Sweden*, 1998, p. 1.

in Swedish drug policy, in his study of the relationship between drug use and drug policy in the period between 1965-1970. Some of his findings included: that changes from restrictive to permissive policy and vice versa was reflected in the rates of intravenous drug use; that this experiment was the origin of the Swedish drug epidemic; and that the experiment did not have the desired effect of crime reduction. His findings are still widely accepted in Sweden even though they have been criticised.(6) Other examples of a more liberal policy include that police focussed their efforts on large-scale drug trafficking and that a Prosecutor General's instruction provided for the waiver of charges for minor drug offences.(7) Thus, the focus was more on the supply side of drugs.

With increased drug use in 1965, the Committee on the Treatment of Drug Abuse was established: it published four reports from 1967 to 1969. The first report dealt with treatment and the second with repressive measures. It is this second report which led to the adoption of the *Narcotic Drugs Act* in 1968. The Committee's reports indicated that the drug problem was on the increase. This finding, in conjunction with the findings of Bejerot, are partly responsible for the more restrictive approach adopted by Sweden in the late 1960s. In addition, since 1968, the government organized a massive media and school campaign against drugs. This led to a generation growing up with messages based on the gateway theory, among others.(8) This theory is used as a justification for being restrictive in relation to cannabis and "Swedish drug policy actually focuses on cannabis, since it is alleged 'drug careers' start with this substance."(9) In addition, the dangers caused by cannabis itself (psychosis, addictive character, higher risk of suicide, etc.) are seen as reasons for having a restrictive policy.

Over time, Swedish policy became more restrictive and repressive. For example, penalties for drug offences have increased several times. The current Swedish policy, with its primary goal of a drug-free society, was instituted in the late 1970's because of what was thought to be an increasing social problem. "The reason for this, in some respect, unrealistic pursuit, can partly be found in Sweden's positive experience with the welfare state and its firm belief in being

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(6) Boekhout van Solinge, *Supra* note 1, p. 45.

(7) United Nations Office for Drug Control and Crime Prevention, *Supra* note 5, p.1.

(8) European NGO Council on Drugs and Development, *Supra* note 3, p. 27.

(9) Boekhout van Solinge, *Supra* note 1, p. 88.

able to change society."[10] There are other examples of a more restrictive approach. For example, in 1980, a waiver of charges was only available if amounts possessed for personal use were sufficiently small that they could not be subdivided and the waiver would no longer apply to all drugs. In addition, the early 1980's saw police focusing on street trading. "The aim was no longer to target big dealers, but the drug users, since they are considered to be the motor of the 'drug engine.'"[11] This more restrictive policy has continued over the years with even more strengthening of penalties, by criminalizing use, and allowing urine and blood tests for those suspected of use, etc. Although the original goal of the urine and blood tests was to detect new users and provide them with appropriate treatment, it would appear that the tests are no longer being used for this sole purpose as known drug users are also being targeted.[12]

Some authors have drawn a link between Sweden's restrictive drug policy and its restrictive alcohol policy. The temperance movement has a long history in Sweden and the country has developed a fairly restrictive alcohol policy, including a state monopoly on the sale of alcohol. The following has been stated:

> Swedish attitudes towards alcohol are relevant since a restrictive alcohol policy makes a restrictive drug policy a logical option. Moreover, the total consumption model on which the alcohol policy is based, is thought to be valid for illicit drugs as well. By limiting the total consumption of drugs, the total harm caused by drugs is alleged to be lower as well. However, it was shown that this correlation is far from clear when it comes to (different) illicit drugs.[13]

NATIONAL DRUG STRATEGY

Sweden is a party to the three international conventions on drug control and has adopted a comprehensive drug control strategy. Its vision is that of a drug-free society and the policy is built on three pillars: prevention, treatment and control measures.

Following the creation of a Commission on Narcotic Drugs, the Swedish government presented a new action plan in January 2002, which is to be valid until 2004. A total

(10) *Ibid*., p.53.

(11) *Ibid*., p. 130.

(12) *Ibid*., p. 116-117.

(13) *Ibid*., p. 103.

of SEK 325 million (approximately $50 million Canadian) has been allocated over the three-year period to combat illegal drug use. The action plan was presented as a means to reverse the disturbing trend in drug abuse.(14)

Sweden's vision, when it comes to drug policy, has not changed since the early 1980s: it is that of a drug-free society. This vision is reflective of Sweden's restrictive drug policy. It is based on a balance between reducing demand for, and supply of, drugs. More specifically, the objectives are:

- To reduce the number of new recruits to drug abuse (mainly through prevention directed at young people);
- To encourage more drug users to give up the habit (through care and treatment); and
- To reduce the supply of drugs (through criminal measures).(15)

One of the key new features of the drug strategy is the creation of a national anti-drugs coordinator position. The position was created to have clear leadership in the drug policy area, make it possible to follow up on the plan's goals, and determine whether new initiatives are required to combat new problems. The coordinator will be responsible for implementing the action plan as well as coordinating the national drug policy in general. The key tasks for the new anti-drugs coordinator are:

- 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 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).

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(14) Ministry of Health and Social Affairs, *National Action Plan on Narcotic Drugs*, Fact Sheet, February 2002.

(15) *Ibid*.

Of the SEK 325 million, 100 million (approximately $15 million Canadian) has been allocated to a special drugs initiative within the Swedish Prison and Probation Service. The goal is to offer care and treatment to all drug abusers in this system. In addition, the National Prison and Probation Administration is required to:

- Develop methods for preventing drugs being brought into institutions and detention centres;
- Investigate the obstacles to treatment outside institutions; and
- Produce special programmes for contract care, i.e. care in accordance with a contract between the person convicted and the community.(16)

With respect to the police, the National Police Board and the National Council for Crime Prevention will be required to carry out their own review of police efforts to combat drug-related crime.(17)

In Sweden, while the national policy is created at the national level, much of the responsibility for implementing the goals of the action plan remains with the municipalities. For example, they have responsibility for the care of drug abusers pursuant to the *Social Services Act*. In addition, prevention initiatives are also carried out at the local level. Thus, strategies in municipalities will be based on local concerns.(18) Enforcement of the legislation remains at the national level, however, through the police and customs services.

Treatment is one of the three pillars of Sweden's drug policy. One of the stated goals of Swedish drug policy is to rehabilitate the user rather than to punish them by way of the criminal justice system. Since 1982, it has been possible to force people into drug treatment (also applies to alcohol and other products) for a period of up to six months. The main reason for this type of treatment is to protect the user or others in cases of life threatening situations and to motivate the user to continue treatment on a voluntary basis. The use of compulsory treatment appears to be uncommon and its effectiveness has been questioned.(19)

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(16) *Ibid*.

(17) *Ibid*.

(18) *Ibid*.

(19) Boekhout van Solinge, *Supra* note 1, p. 165.

The goal of treatment in Sweden is generally to obtain complete abstention. In the last several years, there has been a shift from compulsory treatment and institutional treatment towards out-patient treatment. In the past, the emphasis was put on long-term, in-patient programs. The treatment was often done in therapeutic communities based in rural areas of Sweden. Many of the institutions involved in treatment are non-governmental but are paid for their services by the government. This has created a very influential lobby group that obviously requests more resources for treatment initiatives as this is needed for their survival.

Treatment initiatives were very well funded in the past (particularly in the 1980s because this is when HIV/AIDS started to manifest themselves). Pro-active efforts were made to locate drug addicts and provide them with proper treatment. A person could often be in treatment for a period of two years (often in a therapeutic community). It would appear, however, that treatment is less easily available today than it was 10 to 15 years ago. In addition, the time a user spends in treatment has shortened. These changes are due to cutbacks in social service spending at the municipal level that occurred in the 1990s. "Whereas in 1989 there were 19,000 people in treatment centres (for both alcohol and drugs), in 1994 this number had dropped to 13,000. In the same period, the number of people in compulsory care dropped from 1,500 to 900. Due to the budget cuts, 90 treatment homes were closed between 1991 to 1993."(20)

Methadone substitution programs have been available in Sweden since the end of the 1960s. Currently, approximately 600 people are involved in methadone substitution programs in Stockholm, Uppsala, Malmo and Lund. The programs are strictly regulated and are officially viewed as being experimental. Some of the conditions for participation include that: the patient must be aged over 20 and demonstrate at least four years of intravenous opiate abuse; he or she must have tried several forms of drug-free treatment; the person in question must have entered the program on a voluntary basis (for example, the person must not be detained, under arrest, sentenced to a term of imprisonment or be an inmate of a correctional facility). For those participating in methadone substitution programs, other drugs are not permitted and the patient must visit the clinic on a daily basis. At this time, the maximum number of people that may be in the program at one time is 800. Pilot projects are under way with Subutex.

While Sweden has spent large sums of money on treatment, few of its programs have been properly evaluated. Therefore, it is difficult to provide details of their effectiveness.

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(20) *Ibid*., p 125.

"The official aim is to rehabilitate drug addicts and a lot of effort and financial means are allocated to achieve this; much more than in many other European countries. However, despite all these good intentions, the reality is that the effectiveness of these very expansive programmes is relatively low. In the long run, the Swedish drug treatment programmes do not show better results than what is found internationally."(21)

With respect to harm reduction initiatives, there are few low threshold services in Sweden and most are staffed by voluntary organisations. They offer a series of services, but no prescriptions. Needle exchange programs are operated at clinics for infectious diseases in hospitals in Lund and Malmo, and are thus fairly limited. Harm reduction initiatives, such as needle exchange programs, are difficult to promote under a vision of a drug-free society where drug use is not accepted. A proposal in the late 1980's to introduce needle exchange programs throughout Sweden was quashed by Parliament because it "was felt that a higher availability of needles would not stop the spread of HIV, on the contrary, it was thought to increase intravenous drug use."(22)

The criminal justice system also plays a role with respect to treatment. In 2000, more than 5,000 drug users were placed in prison. While in prison, offenders have access to treatment programs for drug abuse and some offenders are transferred outside prison for treatment. There are also initiatives to keep drugs out of prisons, for example by conducting searches and urine tests. While in prison, the offender is not offered syringes and substitution treatments are not available.

As previously stated, Swedish legislation allows, under certain conditions, that a sentence may be served outside prison. The necessity of drug treatment is one of the reasons that is often raised. Another alternative to imprisonment is a probationary sentence combined with institutional drug treatment. An example of an alternative to prison is the following:

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(21) *Ibid*., p. 162.

(22) *Ibid*., p. 129.

> Since 1998, persons with drug addiction problems who have committed a drug offence can access treatment signing a 'treatment contract.' It is a real contract between the drug addict and the Court in which the two parties have rights and obligations like in all contracts. However, certain conditions must be fulfilled by the drug addict: the person must need treatment and he must be motivated to undergo treatment; he/she is a misuser of drugs; and the drug habit contributed to the drugs crime, which should not be serious (less than 2 years foreseen as penalty). The person is not sent to prison and a personalised plan of treatment is established. The health authorities are responsible for the treatment and shall report to the local prison and probation administration and to the public prosecutor if the probationer seriously neglects the obligations stated in the personal plan.(23)

With respect to cannabis, it is viewed as a dangerous drug "and its use is regarded as the beginning of a career in drugs."(24) This is one of the reasons that prevention measures pay specific attention to cannabis as this should lead to less experimenting with the drug which will prevent new recruits into the drug scene.

With respect to prevention, drug education programs start early and regularly appear throughout the school curriculum. "Without exaggeration, this opinion-forming could be described as a process of indoctrination. Considering the magnitude of these programmes, the contents of them have gradually become something indisputable and conclusive that one incorporates them into one's own value system."(25)

LEGISLATIVE FRAMEWORK

A. Classes of drugs

The main drug legislation in Sweden is the *Narcotic Drugs Criminal Act 1968*. The term "narcotic drugs" is defined in section 8: they include medicinal products or substances hazardous to health with addictive properties and which are subject to control under an international agreement to which Sweden is a party or which the Government has declared to be

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(23) European Monitoring Centre for Drugs and Drug Addiction, *Country Profiles – Sweden*, European Legal Database on Drugs, 2001.

(24) Boekhout van Solinge, *Supra* note 1, p. 15.

(25) *Ibid*., p. 177.

'narcotic drugs' within the meaning of the Act. No distinction is made between soft and hard drugs. As will be discussed later, the nature of the substance is, however, among the criteria to determine the seriousness of an offence. Narcotic drugs are set out in five lists. List I deals with illegal drugs without medical use; lists II to IV deal with narcotic substances with medical usage and regulation of its import/export; and list V deals with narcotic substances outside international controls. Pursuant to the legislation, narcotic medicines may only be supplied on prescription from a doctor, dentist or veterinarian.

B. Offences

In Sweden, almost all forms of involvement with narcotics are prohibited pursuant to the *Narcotic Drugs Criminal Act*. This Act lists the behaviours and practices which constitute drug offences and includes possession for personal use, supply (which is fairly broadly defined), manufacture, etc. Even consumption (drug use) has been prohibited since 1988. In this case, "it is not addiction which is a criminal offence according to this law, but the act of adding a drug to the human body."(26) The police are entitled to conduct urine or blood tests in the case of people suspected of having used drugs.

The *Smuggling Criminal Act 2000* regulates illegal import and export of drugs. Other relevant legislation includes: the *Doping Criminal Act 1991* which regulates the importation, supply, possession of performance enhancing drugs for example; the *Act on Prohibition of Certain Substances which are Dangerous to the Health 1999* which regulates possession and supply of substances that entail danger to life or health and are being used, or can be used, for the purpose of intoxication – this legislation does not regulate substances regulated by other Acts.

There are also a number of relevant laws outside the criminal law area. They include: the *Social Service Act 1980* which covers the possible forms of care for drug users; the *Act on the Forced Treatment of Abusers* which provides that an addict who is dangerous to himself or to others may be ordered by a court to undergo compulsory treatment (which involves deprivation of liberty for up to six months for adults and even longer for those up to the age of 20). Other legislation deals with possible expulsion from school for students who abuse

(26) Edited by Nicholas Dorn and Alison Jamieson, *European Drug Laws: the Room for Manoeuvre*, DrugScope, London, 2001, p. 188.

drugs, revocation of a driving licence for drug addiction, etc. There is zero-tolerance with respect to driving under the influence of drugs.

C. Penalties

Punishment is determined by rules contained in the Swedish *Penal Code*. There are three degrees of penalties for drug offences: minor, ordinary and serious. Penalties for minor drug offences consist of fines or up to six months' imprisonment, for ordinary drug offences, up to three years, and for serious offences, two to ten years imprisonment. The penalties regulated under the *Smuggling Criminal Act*, are identical to the penalties listed above.

The seriousness of the offence is based on the nature and quantity of drugs and other circumstances. The government has stated that the term "minor drug offence" is to be reserved for the very mildest of offences. For example, it should generally only involve personal use or possession for personal use of very small amounts. In these cases, a fine may be warranted. The fine is based on the offender's income. Minor offences include: amphetamine up to 6 g, cannabis up to 50 g, cocaine up to 0.5 g and heroin up to 0.39 g; ordinary offences include: amphetamine from 6.1 g to 250 g, cannabis from 51 g to 2 kg, cocaine from 0.6 g to 50 g and heroin from .04 g to 25 g; and serious offences include: amphetamine 250 g or more, cannabis 2 kg or more, cocaine 51 g or more and heroin 25 g or more. The trafficking of drugs will generally led to imprisonment.

With respect to smuggling, in determining whether the offence is serious, one must consider whether it formed part of an activity pursued on a large scale or on a commercial basis, involved particularly large quantities of drugs or was otherwise of a particularly dangerous or ruthless nature.

In 1996, of the 5,862 people sentenced for drug-related offences, 3,760 were sentenced for minor offences, 1,708 for ordinary offences and 391 for serious offences. Of the 1,274 who were sentenced to imprisonment, 54 were for minor offences, 893 for ordinary offences and 326 for serious offences.(27)

As in other countries, there are several alternatives to imprisonment. For example, the court can choose other sanctions including probation, conditional sentence or

(27) *Ibid*., p. 206.

compulsory treatment. These sanctions appear to be used frequently in drug cases.[28] The following has been stated with respect to compulsory treatment:

> Generally a drug addict who is found guilty of any type of crime can in certain circumstances be ordered to undergo detoxification treatment. Treatment can take place in conjunction with a prison sentence or else together with probation, a conditional sentence or conditional release from prison. The consent of a convicted person to undergo treatment under certain conditions may constitute a reason for ordering probation instead of imprisonment (so-called *contract treatment*). In practice, probation and conditional sentencing in connection with compulsory treatment are usually used for drug offences of *normal* severity, that is in cases where imprisonment would otherwise be imposed.[29]

Swedish legislation also allows for the forfeiture of any drugs used in the commission of an offence, any gains made, the property used as an aid in an offence, etc.

D. Prosecutorial discretion

The following is a description of prosecutorial discretion is Sweden:

> The prosecutor has an absolute duty to prosecute. This means that the prosecutor must initiate proceedings for the prosecution of an offence. This is a principal rule to which there are a number of exceptions. For minor drug offences, the sanction imposed is imprisonment for a maximum of six months. In the Circular of the Prosecutor-General on Certain Questions regarding the Handling of Narcotics Cases, the Prosecutor-General stated that the dropping of prosecutions for narcotic drug offences should be limited to cases involving only possession for personal use of indivisible amounts or corresponding to at most a roll-up of cannabis resin or a dose of some stimulant of the central nervous system, with the exception of cocaine, i.e. such a small amount of a narcotic substance that it would not normally be further divided and sold. Having regard to the difficulties in individual cases of determining the magnitude of this quantity, prosecutions should go ahead in cases of doubt. If circumstances give grounds for assuming that the possession, despite the small amount, is

(28) *Ibid*., p. 190.

(29) *Ibid*., p. 191.

> not intended for personal use, the prosecution should not be dropped. As a consequence of these remarks, prosecutions should also not be dropped where an abuser is found in possession of narcotic drugs amounting to personal use for a certain period. In addition, it is of great importance that the dropping of prosecutions should be mainly limited to occurrences of the nature of first offences.(30)

DEBATE IN SWEDEN

The Swedish vision of a drug-free society is so widely accepted that it is not questioned in the political arena or the media. The drug policy has support from all political parties and, according to the opinion surveys, the restrictive approach receives broad support from the public. For example, a survey in 2001 revealed that 96% were opposed to legalizing any drug that is classified. In addition, another survey in 2000 revealed that 91% were against decriminalizing cannabis use.(31) The state of Swedish public opinion has been described as follows:

> The role of public opinion is central to understanding the attitude of the different political parties. Opinion polls show that a large majority of the people subscribe to a restrictive drug policy. The same polls indicate that drugs are perceived as one of society's main social problems. The moral panic surrounding drugs is such, that no political party dares to speak out against any measures that may appear to move in the direction of a more liberal drug policy. Supporting the restrictive policy, or even asking for more restrictive measures to curb increase in the drug problem are essential for a political party to win votes. Saying the contrary, to back a more liberal approach, is not an option for a political party and would almost mean its political death. It has been pointed out that anti-drug pressure groups have been the driving forces behind influencing public opinion, and through them the political parties. It has also been shown that besides the social movements, the media have also contributed to the drug scare that exists today and the defining of drugs as a major social problem.(32)

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(30) European Monitoring Centre for Drugs and Drugs Addiction, *Supra* note 23.

(31) National Institute of Public Health, *National Report: Sweden 2001*, Stockholm, December 2001, p. 14.

(32) Boekhout van Solinge, *Supra* note 1, p. 172-173.

Thus, the Swedish population in general has a negative view of drug use and is convinced that drugs pose a major threat to society. These themes have been advanced by government, the media and other organizations in Sweden, and others do not often criticize them. Scientists are generally the only group that raises doubts with respect to the current policy. Criticism of the drug policy can have negative consequences on a person. For example, they may be professionally and personally criticized, they may be regarded as a traitor, and, such a stance can have a negative impact on their employment situation. Much of the prevention in Sweden is based on providing information about the dangers of drugs. The purpose of these messages is to scare youth away from drugs. This has fostered a view in the Swedish population that drugs are evil and should be avoided at almost all costs.

In recent years, the consequences of downsizing preventive and treatment efforts have dominated the debate.

RECENT REPORTS OR STUDIES

In 1998, the government created a Commission on Narcotic Drugs. Its mandate was to evaluate Sweden's drug policy and to propose, within the concept of a restrictive drug policy, measures for its strengthening and streamlining. The Commission was not to deviate from the overall aim of a drug-free society. The terms of reference were to:

- propose improvements of methods and systems to assess the drug situation and to evaluate the goal of a drug-free society;
- evaluate and propose measures to strengthen and streamline drug prevention measures;
- analyse the development of treatment programmes, including those in the prison and probation system, and propose measures to improve treatment and rehabilitation of drug abusers;
- evaluate the extent and focus of national funds for the development of treatment and of measures to prevent drug-related crime,
- analyse the need for changes in the working methods in the judicial system and in penal and criminal procedural legislation;

- review existing research, propose how research can be stimulated, strengthened and organized and identify important but neglected areas for research in the drug field;
- frame strategies for targeted information measures and for the formation of opinion.

The Commission recently published a report entitled *The Crossroads* (referring to one direction that calls for a significant increase of resources in the form of commitment, direction, competence and funding and another that implies a lowering of goals and considerable acceptance of drug abuse).

The Commission noted that the drugs issue was not a political priority in recent years which has led to reduced funding for all sectors involved while the drug problem has become more severe and widespread. The following are some of the Commission's main findings and recommendations.(33)

Leadership: The Commission noted that there is a need for stronger priorisation, clearer control and better follow-up of drug policy and of concrete initiatives at all levels of government. Thus, it recommended stronger leadership in relation to drug policy, with the Government playing a more active role, both nationally and internationally. In addition, it recommended a model for stronger local initiatives and improved local co-ordination. Despite the shared responsibilities, the Commission saw no reason for altering the basic allocation of responsibilities where drug questions are concerned. It was of the view that national leadership should be reinforced by the appointment of a minister specifically charged with the direction of drug policy activities. In addition, to facilitate and intensify development and co-ordination of local initiatives, it was proposed that local drug policy strategies be put in place by municipalities and county councils.

Demand reduction: The Commission noted that there are no hard boundaries between preventative measures, care and treatment, and the restriction of supply. For preventative 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

(33) The information set out in the following section is based on The Swedish Commission on Narcotic Drugs, *Summary of the report The Crossroads from the Swedish Commission of Narcotic Drugs*, Sweden, 2000.

effective care and treatment.'"[34] The Commission views schools as the most important arena for drug prevention work and proposed that guidelines be set out for all school instruction concerning tobacco, alcohol and narcotic drugs. It also noted that preventative strategies were also required for young adults and are lacking in most municipalities. The Commission proposed that all young persons and their parents have access to local counselling on alcohol, drugs and abuse-related issues. The Commission made several other comments regarding prevention, including the need for reinforcement of specialist competence regarding young persons and substance abuse. It also added that for those who had started drug abuse, early detection and a clear reaction is important.

The Commission viewed care and treatment as an essential element of drug policy measures as they help reduce drug abuse and also the harm to drug abusers. It found that this is a field which has been subject to extensive spending cuts and downgrading by the municipalities in recent years, and that availability of treatment was not uniform throughout the country. The deficiencies in the system were most apparent for severe abusers and for long-term treatment measures. Severe abusers, in particular, need to be the subject of long-term, co-ordinated initiatives involving all agencies that are able to provide initiatives tailored to the individual needs of the client. In addition, the Commission found a need for improving the competence of those in the field of care and treatment. It set out the following guiding principles regarding care and treatment:

- All drug abusers shall be reached by an offer of help and, if necessary, care for the abuse.
- Advice, support and assistance shall reach people at an early stage of abuse.
- Measures of care shall be aimed at achieving a life free from substance abuse and illegal drugs.
- Care and other measures on behalf of substance abusers shall be of good quality.
- Measures to combat substance abuse shall be sustainable and long-term.

(34) *Ibid*.

The Commission also noted a downscaling of measures to channel drug abusers into care and rehabilitation in the prison and probation system. This is important due to the intensive contact that system has with drug abusers. Thus, the Commission saw an urgent need for more resources for the maintenance and improvement of measures and also for an intensification of measures to combat drug abuse. It also made recommendations with respect to controlling availability of drugs in prisons, including increased search powers and increased penalties for refusing a blood test.

Supply reduction: The Commission did not find any real deficiencies in the legislation or the working methods used by drug authorities although it was found to be imperative that these authorities be allocated more resources. Police and customs have not gained control over the illegal market. In fact, indicators show that supply is more generous, prices are lower than in the past and the variety of drugs has expanded. Some minor recommendations were made with respect to minimizing the possibility of legal drugs entering the illegal market. With respect to combating illegal drug trade, the Commission recommended that the organizational structure of the police be examined (for example, the way in which the dissolution of specialized drug squads has affected the quality of police investigations) and that any shortcomings be followed-up. The Commission also recommended that special investigation methods (such as controlled deliveries) be reviewed and that the findings lead to the drafting of guidelines on the subject.

Competence development and research: The Commission was of the view that it was important to improve knowledge concerning different aspects of narcotic drugs, measures used to combat drug abuse and the effect of drug policy. For example, knowledge of the drug situation is necessary for planning measures and evaluating drug policy. The Commission found that knowledge and methods used in prevention and treatment were deficient and that measures should be based on knowledge and documented experience. Therefore, recommendations were made to increase knowledge and competence regarding those involved with drug issues, particularly those involved in prevention and treatment. The Commission stated that documentation, follow-up and evaluation should be improved and warns "against belief in simple solutions of the 'cookbook' variety."(35)

COSTS

(35) *Ibid*.

As in other countries, systematic figures on drug-related costs are not readily available.(36)

A. Public Costs

Treatment for alcohol and drug abuse has been estimated to cost municipalities SEK 3.7 billion (over $500 million Canadian) per year (55% of which is for institutional care). The police used 6% of its budget to combat drugs during 2000 (for a total of SEK 702 million – over $100 million Canadian). The police had 869 people involved in drug issues while customs had 1,080 involved in border defence. No costs were available for customs.

B. Social Costs

The Commission on Narcotic Drugs estimated the social costs at SEK 7.7 billion per year (does not take into account prevention, training and evaluation).

ADMINISTRATION(37)

As discussed above, the coordinator will now be responsible for coordinating the national drug policy. In the past, this role had been played by the Ministry of Health and Social Affairs. With respect to the legal distribution of narcotic drugs and psychotropic substances, the Medical Products Agency is responsible for issuing authorizations for the import and export of drugs. This Agency also provides drug related statistics to the UNDCP.

The Swedish National Police have responsibility for drug enforcement. The Drug Offences Division of the National Police Board conducts criminal investigations in relation to organized crime, or other drug-related offences, on a national or international scale. The Swedish Customs Service is responsible for points of entry.

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(36) The following information is based on the *National Report – Sweden 2001*, *Supra* note 31 at p. 15.

(37) The information is the following section is based on the United Nations Office for Drug Control and Crime Prevention, *Country Drug Profile – Sweden*, *Supra* 5, at p. 12

The National Institute of Public Health coordinates demand reduction activities. It is also the National Focal Point in the REITOX network. Operational activities are coordinated at the regional and municipal level. There is also local coordination with the participation of social services, the police, prison and probation services, medical services, schools and other concerned parties. Thus, in prevention and care and treatment, local groups and municipalities play a key role.

Because of its encompassing nature, the drug issue also involves many other ministries, for example the Ministry of Justice and the Ministry of Foreign Affairs.

STATISTICS

A. Use[38]

Pursuant to surveys among youths in the 9th grade (15-year-olds) and among 18-year-old military conscripts, an obvious trend in the 1990s is the increase in lifetime prevalence use of drugs among teenagers, particularly older teenagers. There has also been an increase in recent use (last year, last 30 days) among teenagers and younger adults. For example, the percentage of 15 year olds who have tried drugs has risen from 4% to 9% from 1992 to 2000. It is interesting to note that the number was 14% in the beginning of the 1970s and had decreased to around 8% in 1982. With respect to military conscripts, the trend is similar. According to these surveys, consumption of illegal drugs is low compared to other European countries, although the trend points to an increase in use. It should be noted that these numbers have been criticized. First, they are applicable to only 15-16 year old students and 18-year-old conscripts. Thus, these prevalence rates do not consider older groups where some first-time experimentation with drugs will occur. In addition, it has been argued that there will be underreporting of drug use when drugs are viewed in such a negative light and the questionnaires are filled out at school (where some will feel they are being observed by their teachers).[39]

In 2000, a running three-year average of lifetime prevalence for the 15-64 age group was 12% (with the highest at 17% for the 24-44 age group). Since 1988, last year

(38) The information is this section is mostly based on the National Report – Sweden 2001, *Supra* note 31.

(39) Boekhout van Solinge, *Supra* note 1, p. 138.

prevalence has never been over 1%. Overall, males are twice as likely to have used drugs than females although the difference is not as high in lower age groups.

Most who have experimented with drugs have tried cannabis and the majority of these have tried only cannabis (in Sweden, cannabis is usually taken in the form of hashish). The second most popular drug in Sweden are amphetamines. Cocaine would be the third most popular drug for older people while for youths it would be ecstacy and LSD. During the 1990s, the availability of drugs has increased, in particular amphetamine and heroin. In Sweden, as was discussed earlier, the typical drug addict uses amphetamines intravenously. It would appear, however, that heroin use is on the increase in Sweden.(40)

In general, the surveys indicate that overall drug use is fairly low in Sweden. With respect to severe drug abusers (defined as intravenous or daily drug use), it would appear that Sweden has a fairly serious problem with a range from 14,000 to 20,000 people. This is close to the European Union average.(41) As discussed earlier, one distinction is that the main problem drug is amphetamine rather than heroin as is the case in many other countries, although most drug abusers are multiple drug users and heroin use appears to be on the rise.

B. Offences

The number of suspected people who were reported has increased from 6,567 in 1985 to 12,470 in 1999. The police registered 32,423 violations of the *Narcotic Drugs Criminal Act* in 2000 which is similar to the numbers in the last decade. The number of violations to the *Goods Smuggling Act* has decreased by 85% since 1980, to 350.

In 1998, 92% were suspected for use or possession (from 76% in 1975). In addition, the number of those suspected of selling or manufacturing is now 19% (from 40% in 1975).

The number of sentences for violations of the *Narcotic Drugs Criminal Act* or the *Goods Smuggling Act* is now 12,470 in 1999 (from 2,601 in 1975). Cannabis was involved in 51% of sentences in 1998. In 1998, the sentences were divided in the following fashion: 38% for fines; 27% for prison; 14% for prosecution waivers; 14% for probation; and, 8% for other sanctions. Imprisonment was generally from two to six months.(42)

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(40) *Ibid*., p. 109.

(41) United Nations Office for Drug Control and Crime Prevention, *Supra* note 5, p. 9.

(42) National Report 2001, p. 27.