Swedish drug policy – a balanced policy based on health and human rights

Government Offices of Sweden
Ministry of Health and Social Affairs

Swedish drug policy – a balanced policy based on health and human rights

Sweden's drug policy has been firmly established for a long time, both across political boundaries and with the support of the Riksdag, but also through strong support from the general public. It is a natural part of the strategy for alcohol, narcotics, doping and tobacco (ANDT) adopted by the Riksdag and of public health policy.

The aim of this document is to provide basic information on Swedish drug policy. It also provides information on the results achieved in Sweden.

Content

Facts about Sweden's drugs policy

The vision of a drug-free society has long enjoyed concerted political support in Sweden. Swedish drugs policy is part of the public health policy, which aims to reduce health inequalities in the population. The drugs policy relies on a balanced strategy in which restricting supply and reducing demand are equally important components. The model focuses on preventive efforts, care and treatment, social measures and measures to improve the health of individuals with substance abuse and addiction problems. Action in the area is guided by a coordinated national strategy on alcohol, drugs, doping and tobacco.

Drug use, misuse and addiction

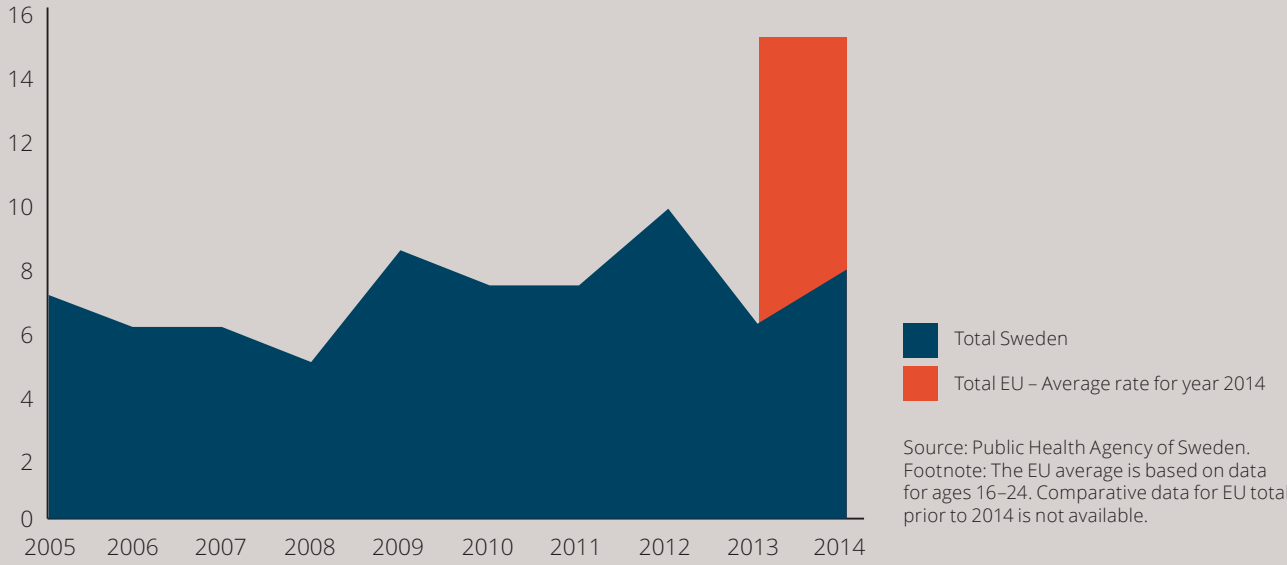
Cannabis is the most used illicit drug. Despite this, cannabis use in Sweden is low compared with the European average (see figure). An estimated 29 500 people in Sweden have developed problematic drug use. The number of people injecting drugs is estimated at 8 000. Those who are injecting drugs use both heroin and amphetamine-based drugs. This group has a high mortality rate and a high incidence of hepatitis C. However, the incidence of HIV is low by international comparison.

Preventive work

Preventive work against drugs has developed from small-scale projects and campaigns to structured local work using methods that are continuously evaluated and adjusted over time. This preventive work has resulted in a relatively stable and low level of drug use among young people.

Preventive work is often based on cross-cutting measures in schools, clubs and associations, social services, health and medical services, psychiatric services, etc. The objective is to strengthen protective factors around children and adults. This work is supplemented by targeted interventions aimed at individuals and groups in risk zones. To limit drug use, the police and social services also collaborate to offer social support at an early stage.

Annual prevalence among young adults, Aged 16-24, Cannabis
(i.e. per cent who have used cannabis during the year)



Source: Public Health Agency of Sweden.
Footnote: The EU average is based on data for ages 16–24. Comparative data for EU totals prior to 2014 is not available.

New psychoactive substances
The number of new psychoactive substances that are spread via the internet has increased in recent years. At the same time, the classification system has speeded up and the authorities' overview and knowledge of marketing structures and psychoactive substances has improved. Sweden is very active in the EU information exchange mechanism, which leads to other EU countries also becoming aware of new substances in the market at an early stage. As a step in further reducing the availability of new psychoactive substances, the police and customs authorities can now confiscate substances that may come to be classified as drugs.

Care and treatment of individuals with drug misuse or addiction problems
Care and treatment for drug misuse or addiction is generally provided on the principle of voluntary participation. In exceptional cases, mandatory protective legislation may be used if the individual does not consent to voluntary care and if this person risks seriously harming themselves or other people.

County councils and municipalities currently offer a range of care and treatment measures, from psychosocial to purely medical. Government agencies regularly update their knowledge base on effective evidence-based measures, so as to provide guidance to regional and local actors.

Substitution treatment is the most common form of treatment for opiate addiction. Around 3 700 people are receiving substitution treatment using both methadone and buprenorphine at 114 centres throughout Sweden. Individuals in correctional care are also entitled to treatment, such as substitution treatment and psychosocial treatment, on the same terms as other people.

Of those who are injecting drugs, approximately 2 500 people in Sweden have access to clinics where syringes and needles are distributed. These clinics are located in six places in the country. They have medical staff and links to other healthcare facilities and municipal social services that can offer care and support. The purpose of the clinics is to reach a group of people who are otherwise difficult to reach and to offer measures to improve their health and encourage them to seek care and treatment for drug misuse or addiction.

International cooperation
Drug problems do not stop at national borders and therefore call for cross-border solutions. These should be based on human rights and the right to the best possible health. Since drug trafficking is often a part of organised crime, measures need to be coordinated with other countries and international organisations. Sweden now has several cooperation agreements with other countries, often involving police and customs cooperation, and participates actively in joint international efforts.

Challenges
The mortality rate among drug users in Sweden is high, but measures are being developed to better understand causal links so as to be able to intervene in time. Another major challenge is to level out existing regional differences in the measures currently offered to individuals who are addicted to drugs.

General background on Swedish drug policy

The UN drug conventions and the global framework

Within the UN system there are several conventions[1] that seek to satisfy the medical use of psychoactive substances and simultaneously ensure that these substances do not emerge onto the illicit market. The conventions have the overall purpose of protecting health and welfare. The means of attaining health and welfare is to control and combat all illegal production, trade, sale and use of drugs. The 1961 and 1971 conventions are accompanied by lists of the substances covered by the conventions ("controlled substances"). There are several important actors to guarantee that the conventions are followed and implemented. The Commission on Narcotic Drugs (CND) comprises the parties to the conventions and meets annually in Vienna (also the location of the United Nations Office on Drugs and Crime (UNODC)). The CND reports to the Third Committee and to the General Assembly's Economic and Social Council (ECOSOC). The World Health Organisation (WHO) is responsible for evaluating the substances that are to be controlled within the remit of the conventions. WHO submits its proposals to CND, which decides whether the substances are to be listed under the conventions or not. If, for example, WHO judges that the danger posed by a substance should be changed on the basis of new scientific knowledge, WHO proposes this to CND, which makes a decision on the issue. The International Narcotics Control Board (INCB) is a body that reports on how parties to the conventions are complying with the provisions and intentions of the conventions.

Sweden has signed the UN's drug conventions and also backs the Political Declaration adopted by CND in 2009 towards an "integrated and balanced strategy to counter the world drug problem".[2]

A policy on a zero vision that grew from the bottom up

Each country has its own individual culture and norms. In Sweden there is an ideological view of drugs that means that governments and Riksdag have taken the view that drugs are harmful to health and should not exist in a society that cares about the health of its citizens. In the 1960s and 1970s Sweden had a relatively liberal view of drugs, which had the consequence of an increase in drug use and substance use disorders, leading to the more balanced and restrictive line that Swedish governments have taken ever since. Swedish drug policy has grown from the bottom up, from social workers, the police and civil society, and today has broad popular support. According to surveys,[3] it is not socially acceptable to use drugs in Sweden. This is an important aspect to prevent people from using drugs, or developing substance use disorders, and is therefore important to maintain. Sweden operates and sets great store by a balanced policy based on restricting both supply and demand. The overall objective of Swedish drug policy is a drug-free society. Sweden has also signed conventions on human rights and within the framework of the vision of a drug-free society, people with drug abuse problems must be entitled to effective and humane treatment, initiatives to protect them against infection and other psychosocial initiatives.

A broad strategy against drugs

Sweden's zero vision, a drug-free society, is the umbrella for all drug

1 The Single Convention on Narcotic Drugs (1961), the Convention on Psychotropic Substances (1971) and the Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988)
2 Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem 2009
3 Sweden's successful drug policy: A review of the evidence, UNODC 2007

policy initiatives in whatever policy area they may be carried out. There is a broad strategy for alcohol, narcotics, doping and tobacco (ANDT strategy) 2010-2015.[4] Regarding narcotics, the strategy contains concrete targets set by the Riksdag in terms of limiting access to drugs, protecting children and young people from drugs, reducing the number of young people who use drugs and develop substance use disorders, increasing access to treatment and care for people with substance use disorders, limiting drug-related deaths and driving health-based public health policy in the international arena. The targets are monitored annually by the Government and resources are earmarked for initiatives. The Swedish ANDT strategy has attracted a great deal of attention and appreciation internationally precisely because it is a balanced and broad approach with several cross-sectorial initiatives, strategic and ongoing monitoring and an appropriate structure.

Division of responsibilities and national actors

In Sweden, care, treatment and prevention initiatives are largely decentralised. The municipalities are responsible for social services and support and treatment for people with substance use disorders. The county councils are involved in and responsible for the health care within which medical treatment, e.g. substitution treatment and needle exchanges, is carried out. Schools run local work on prevention together with the police, social services, youth workers and voluntary bodies. The prison and probation service is also an important actor because many people in custody have substance use disorders and are offered treatment or an opportunity to serve their sentence in the form of treatment.

4 Government Bill 2010/11:47

Questions and answers regarding Swedish drug policy

Why has Sweden criminalised personal use? Does that mean penalising people with substance use disorders?

The conventions that form the basis of Swedish drug policy set minimum requirements on legislation aimed at limiting drug use to medicinal use only, and on criminalising the illegal growing and sale of the substances covered by the conventions. It is therefore possible for countries that have ratified the conventions to choose whether or not to criminalise personal use.

In Sweden, using drugs, i.e. having drugs in your body, has been a criminal offence since 1988 and imprisonment was added to the scale of sanctions for personal use in 1993. The intentions of the legislator were to send a clear signal that drugs are not acceptable in society and to give the police authority grounds to carry out drug tests in the event of suspected drug use. Criminalisation of personal use has been added to protect people from the harmful effects of drugs, to enable early intervention to offer care and treatment, and as part of efforts to prevent young people from using drugs, as well as becoming involved in criminality. The initiatives carried out by the police authorities when young people are tested often take place together with social services. In Stockholm, for example, testing takes place at Maria youth centres and motivational talks and access to care and treatment are offered there by the county council and social services at the time of testing. According to statistics from the National Council for Crime Prevention, up to 35 000 people are tested for drugs each year.[5] Imprisonment for personal use is not applicable as the sanction for personal use of drugs is a fine. Persons with substance use disorders are also often involved in criminal activities, and a large proportion of those in the custody of the Prison and Probation Service are people with substance use disorders. However, they have been given a custodial sentence for crimes other than personal drug use (e.g. peddling, theft, assault, etc.).

Prohibiting both personal use and the possession and sale of drugs in Sweden makes it harder for "open drug scenes" to arise, i.e. places where drugs are used and sold more or less openly. This is an important element in systematically reducing access to drugs and preventing people from using drugs.

Can the fact that drug use is criminalised prevent people from seeking care and treatment?

Because at individual level there is no legal obligation for the social services to report to the police authority, there is no opportunity to monitor how many of the people convicted for personal use or possession choose to take up the treatment they are offered. Protection of personal privacy is strong in Sweden and people who seek help for substance use disorders are not reported to the police authority, which means that people who seek care and treatment are able to do so without risking criminal sanctions. There is strong trust in social services and the government has received no indications that the fact that personal use is illegal prevents people with substance use disorders from seeking treatment.

What is Sweden's attitude to the care and treatment of people with substance use disorders?

Care and treatment for people with substance use disorders is as important a part of drug policy as limiting availability and criminal sanctions. Having ratified the UN's drug conventions and the International Covenant on Economic, Social and Cultural Rights, Sweden sees it as of the utmost importance to allocate resources to offer evidence-based and individually tailored care and treatment. There are several pieces of legislation that work together in providing for the right to support and treatment. The Social Services Act (SFS 2001:453) gives people with substance use disorders the right to interventions to break the negative cycle, and the Health and Medical

5 National Council for Crime Prevention report 2010:16

Services Act (SFS 1982:763) obliges county councils to provide care and treatment without stating any specific diagnosis. The Care of Young Persons (Special Provisions) Act (SFS 1990:52) gives young people the right to protection. Together these acts clearly set out the right to care, support and treatment. This involves an opportunity for voluntary abstinence treatment, out-patient treatment, treatment centres, motivational talks, substitution treatment, etc. In some particular cases where there is a risk of the person seriously injuring themselves or someone close to them, compulsory care may be relevant. Compulsory care is regulated under the Care of Persons with Substance Use Disorders in Certain Cases Act (SFS 1988:870) and the Compulsory Psychiatric Care Act (SFS 1991:1128).

Medicine-assisted rehabilitation for opiate dependence (substitution treatment) with methadone or buprenorphine (Subutex or Subuxone) is not defined as harm reduction in Sweden but is included in the guidelines for care of those with substance use disorders drawn up by the National Board of Health and Welfare. Sweden was one of the first countries in the world to develop a methadone programme. Today substitution treatment using Subutex/Subuxone and methadone is provided by the county councils at 114 places in Sweden. The programmes cannot be viewed in isolation and those who participate in them also need a great deal of psychosocial intervention for the treatment to be effective.

How is compulsory care used in Sweden and how does it relate to the conventions on human rights?

Sweden is a signatory to most of the conventions on human rights, such as the International Covenant on Economic, Social and Cultural Rights, the Convention against Torture, etc. In Swedish drug policy there are many elements that seek to improve the health of the population in general by preventing the use of drugs, but also many initiatives for people with substance use disorders – to improve their health, prevent the spread of infection, undergo abstinence treatment and other forms of treatment, get help with housing, social interventions, employment, etc. If the opportunities for voluntary measures are exhausted, the Care of Persons with Substance Use Disorders in Certain Cases Act states that if anyone as a consequence of continuing abuse is placing their physical or mental health in serious danger, is running a clear risk of destroying their life, or if there is a fear that they may seriously harm themselves or a person close to them, a court may decide on compulsory care provided that the care cannot be provided in any other way. This opportunity exists in the majority of countries, but tends to be incorporated under the framework of national psychiatric legislation. It is important that the decision is made in a manner that complies with the rule of law and the human rights conventions. The purpose is to, for a limited time (maximum six months), motivate the person to seek voluntary treatment. The vast majority of people who undergo compulsory care, 75 per cent, choose, and are given the opportunity during the period the decision is valid, to transfer to voluntary treatment.[6]

What is Sweden's attitude to risk- and harm reduction?

Harm reduction is a concept used internationally, but that has not been clearly defined and that can incorporate a number of initiatives whose purpose is to limit harm rather than to treat the substance use disorder. This may involve needle exchange initiatives to prevent the spread of infection, or it may involve injection rooms or legally prescribing e.g. heroin to prevent overdoses, etc. Medicinal treatment with methadone or buprenorphine is not defined as harm reduction in Sweden but is instead a medicinal treatment for opiate dependency in accordance with the National Board of Health and Welfare's guidelines on the care and treatment of people who abuse drugs.

6 The Swedish National Board of Institutional Care http://www.stat-inst.se/om-sis/missbruksvard-lvm/

Since 2006 there has been a statutory opportunity for county councils to set up needle exchanges. These are found in Malmö, Lund, Helsingborg, Kalmar, Kristianstad and Stockholm and cover an estimated 2 000-2 500 people across Sweden. The purpose is to prevent the spread of infection among persons who inject drugs, and in the population in general. In Sweden, needle exchanges are provided to prevent the spread of infection and have been effective in reaching a group of people with substance use disorders and who are otherwise hard to reach.

What is Sweden's view on the rights of people with substance use disorders?

Sweden is criticised by advocates of human rights for the fact that using drugs is a criminal offence, in other words there is a risk of criminalising people with substance use disorders. Furthermore, we are also criticised because there are elements of compulsory treatment. Critics emphasise the right to health and that the health of people with substance use disorders is made worse by the limited range of harm reduction initiatives offered in Sweden.

The UN Convention on the Rights of the Child recognises a child's right to grow up in a drug-free environment as a human right. The UN International Covenant on Social, Economic and Cultural Rights talks about the right to health. All societies attempt to protect their citizens from risks that they cannot foresee; these may be anything from additives in food to seat belts in cars. This is part of the duty of society and of governments to protect citizens from risks. The majority of people who start to use drugs do so at a young age when it is difficult to make their own assessment of the long-term risks. The right to health also means obtaining treatment for substance use disorders and in Sweden many different treatment options are offered, such as out-patient treatment and treatment centres, medicinal treatment, abstinence treatment, etc. The majority of treatment initiatives seek to achieve a drug-free existence. It is also the duty of society to draw attention to the risks of drugs and to conduct work to prevent the use of drugs. Besides the individual concerned, substance use disorders also affect society in general, socially and economically, and those close to the individual concerned in particular. The fact that using drugs is a criminal offence follows on from the Swedish zero vision, but proceedings are conducted in line with the rule of law and combined with an offer of treatment. An important part of the discussion on human rights is that society allocates resources to every aspect as part of a balanced drug policy.

Sweden is reported to have a high mortality rate among people who abuse drugs – why is this the case and what does Sweden intend to do about it?

The mortality rate of people with drug abuse problems is often used as an indicator of whether or not society's drug policy initiatives are successful. However, this is a comparison that is hard to make between countries because there are considerable differences between them in terms of the way data is gathered and reported. In Sweden there is a large number of databases and statistics are extremely reliable. There is also a tradition of transparency and open reporting. That said, however, it can be stated that drug-related mortality is high in Sweden from a European perspective (Sweden is among the 10 countries with the highest mortality rate out of the 27 EU Member States).[7] Drug-related mortality has increased in Sweden since 2006, which is worrying, and the Government is working to produce more rapid reporting systems and attempting to identify the reasons for this trend.

Common initiatives to prevent people dying due to substance use disorders include increasing access to substitution programmes. This trend also has its risks and in Sweden in 2014 more people died from poisoning by substitution drugs (methadone and Subutex) than from heroin.[8] Most of

7 European Drug Report 2014, European Monitoring Centre for Drugs and Drug Addiction
8 Karolinska Institutet: Toxreg 2014

the substances seem to derive from the illegal market and not from the opioid substitution treatment programs.

How do we know whether Swedish drug policy is successful?

There are many ways of measuring whether drug policy is effective, but it can also be difficult to make international comparisons. The most relevant comparisons are made within the country and over time to follow trends and outcomes. One measurement is to look at how many people have used drugs during their lifetime. Here, Sweden shows considerably lower figures than many other comparable countries and the figures have improved since the 1990s. Another way is to look at how many young people have used drugs, both once and regularly. Here too, Sweden is in a considerably better position than many other countries and the trend shows continued low use during the 2000s.[9] How many people are involved in problematic drug use can also be an indicator (although there is no commonly agreed view of what problematic use is). Due to considerations of personal privacy, there is no national register in Sweden of people who use drugs or whose use is problematic. Estimates made in 2007 refer to approximately 29 500 people in Sweden who are heavy drug users (which is commonly defined as users taking drugs daily for four weeks or having injected drugs) according to information from the Public Health Agency of Sweden. The Public Health Agency of Sweden calculated that approximately 8 000 people inject drugs.

In summary, it is difficult to define what a successful drug policy is. However, experience can be obtained from the field of alcohol, where initiatives and research internationally indicate that broad preventive initiatives and low prevalence and consumption among young people limit the harmful effects of alcohol in society.

Why does Sweden emphasise that cannabis is dangerous and why does Sweden not divide drugs into "hard and soft" drugs?

Currently cannabis is classified as one of the narcotic drugs that requires the strongest controls under the UN's conventions on drugs. This means that all countries should treat cannabis as a dangerous substance in order to comply with the convention. There is thus no science or evidence presented to WHO that so far has led the organisation to reach a different assessment than that which currently applies. This means that there is no scientific support or support in the conventions for classifying different substances differently.

We know that cannabis can have a negative impact on people's health and opportunities for social development. Cannabis can cause psychological illnesses such as psychoses, hallucinations, depression, etc. in both the long and the short term.[10] The intellectual capacity (IQ) of people who start smoking cannabis at a young age can be permanently impaired, with deterioration in reasoning and learning capacity, memory, strategic planning, etc. The use of cannabis is also addictive. People do not die of the drug cannabis itself, as far as we know, but people die in road accidents and other accidents caused by the use of cannabis.

Studies have shown that the active ingredient in cannabis, THC, which can be extracted from cannabis (or manufactured synthetically), can provide desirable medical effects such as pain relief, etc. However, there are no studies that show that such effects can be obtained by smoking cannabis. The cannabis on the market today is considerably stronger than that which was available in the 1970s, 1980s and even the 1990s. In Europe, demand for treatment of cannabis dependency has increased in the majority of countries in recent years

9 European Drug Report 2014, European Monitoring Centre for Drugs and Drug Addiction and ESPAD survey 2011
10 http://www.wfad.se/wfad2014-forum-summaries/4942-grand-finale#Nora Volkow and Madeline Meier

since substance use disorders caused by the substance have increased.[11]

What does Sweden think about access to medicines in the world? Don't the conventions make this more difficult?

The UN's drug conventions seek to promote health by making narcotic drugs required for treatment in the health care system available while simultaneously preventing substance use disorders. The substances listed as addictive within the framework of the conventions, and which thereby risk contributing to substance use disorders and damage to health, can nevertheless be used as part of treatment and be prescribed by doctors (e.g. morphine for pain relief, amphetamines for ADHD, etc.). The UN's conventions and its drug control body, INCB, are important guarantees that medicines are to be made available worldwide when they are judged to be effective in care and treatment. The question of whether THC (the active substance in cannabis) can be made available for medical use already has support in the conventions today, for example. The countries that consider that THC substances should be available for medical use are able to sell it at a pharmacy or similar, when prescribed by a doctor, after normal pharmaceutical testing has been carried out. The Swedish Medical Products Agency is the agency that approves substances that can be used for medical purposes. The Swedish Medical Products Agency has only approved an oral spray containing cannabis sativa for medical use, but has not approved cannabis or substances that contain THC as medicines in Sweden.

It is important that medicines are made available worldwide. This is part of the cooperation on health and medical care being carried out bilaterally and multilaterally. To improve access to medicines, there is a need for functioning health systems and trained staff to prescribe medicines safely and effectively in Sweden and the rest of the world.

What is Sweden's view of the situation outside Sweden in relation to production and transit countries and their development?

Sweden agrees that the consequences of drugs are a global problem that has many dimensions. At global level it is essential to set aside resources and support for the most vulnerable countries such that they do not need to work against production and trade on their own. Today global consumption patterns look different to those of 30 years ago. Today there are very few pure production and consumption countries and instead there is widespread drug use in production and transit countries too. It is important that alternative economic but legal opportunities to generate income are developed for disadvantaged and vulnerable producers. It is also important that economic and social development in low and middle income countries continues. Investments must also be made in education and social initiatives to prevent recruitment to criminal gangs and cartels. Swedish aid, bilateral and multilateral, is important for supporting initiatives in this direction.

We do not believe in the legalisation of all drugs. We believe that a humane, restrictive and balanced drug policy, drawing on existing conventions where resources are allocated to every aspect of what is needed for a successful drug policy, in production, transit and recipient countries, is to be recommended. Conventions on drugs together with conventions on trafficking, money-laundering and human rights create a good basis. The challenges lie in implementation, doing the right things, refining methods, developing partnerships, evaluation and allocating resources.

11 European Drug Report 2014, European Monitoring Centre for Drugs and Drug Addiction

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