

EUROPEAN PARLIAMENT



Directorate-General for Research

WORKING PAPER

**THE DRUG POLICIES
OF THE NETHERLANDS AND SWEDEN:
HOW DO THEY COMPARE?**

Civil Liberties Series

LIBE 113 EN

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Manuscript completed in March 2001

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3-2001

EXECUTIVE SUMMARY

The drug policies of all the countries in the European Union have a common goal: to reduce the problems that drugs entail. Opinions on how this goal should be defined and attained vary widely. The polemical tone of the debate is often sharp, leaving no scope for reconciliation. For this reason discussions between representatives of the various countries and drug-policy models are not very constructive. They all have their figures, tables and scientific investigations to substantiate their own arguments.

Different drug policies have developed ranging from “zero tolerance” strategies where the ultimate goal is to eradicate all forms of illegal drug use, to “harm reduction” strategies where the focus is on limiting harm caused by drug use. Till today, none of these strategies have been able to demonstrate its complete superiority over the other. Lack of clarity in the objectives, concepts and definitions as well as the absence of precise descriptions of policy measures actually carried out are only a few of the obstacles preventing us from drawing valid conclusions concerning the efficiencies of the different drug policies. Another of the obstacles preventing us from developing a good understanding of the differences in drug situations between countries is the lack of data that is immediately comparable. The objective of this report relates to the latter obstacle. Through a description of some important concepts on drug issues we will try to demonstrate the most important problems that can appear when comparing the results of policies. This might seem to be a straightforward task, but as we will try to show, the drug issue is too complex to allow meaningful comparison by only using single indicators.

In this report, data on drug use and related consequences in Sweden and the Netherlands are used in order to illustrate the complexity of country comparisons. The fact that these countries are proponents of different drug policy approaches, the former with its stricter “zero tolerance” policy and the latter with an elaborated “harm reduction” approach, will further highlight the difficulties and delicacies in making such comparisons. Even if the countries differ in how drug problems are conceptualised and policies conducted, they both give it top priority among social problems. This can be seen in the efforts and resources laid down on for instance legislation, prevention, treatment and research.

* * * * *

Drug use has led to extensive measures aiming at control in both countries. A major difference is that the Swedish policy is combating all kind of narcotic substances while the Netherlands focus primarily on trade in hard drugs like heroin, cocaine and amphetamine. This is reflected by substantial differences in law and law practise. For example drug use is not criminalised in the Netherlands while the opposite is true for Sweden.

The two countries have a different view of the dangers of cannabis. In the Netherlands so called coffee shops are allowed where soft drugs are sold under certain regulations. These shops are permitted for two reasons: firstly, it is impossible to control illegal trade in cannabis. Secondly under the circumstances it is important to prevent young people that use cannabis, which is judged to have lower risks than hard drugs, from ending up in an environment where hard drugs are also for sale. In Sweden the stepping stone theory in which cannabis abuse is seen as a first

step towards abuse of other drugs like amphetamines and heroin has for many years influenced the drug policy. Cannabis is also seen as a menace in itself and the National Board on Health and Welfare emphasises the risks of cannabis, in causing mental diseases and making young people withdraw from society.

When comparing drug policies, difficulties arise since different concepts, definitions and research designs are being used. Also there is a lack of data within certain crucial areas. The objective of this report is to demonstrate the most important problems in comparing the two countries. By showing the obstacles for a comparison we aim to contribute to a discussion that can improve and standardise research techniques and make realistic comparisons possible in the future.

In both countries the word “drug addict” refers to someone with an addiction, usually defined medically and socially. In Sweden all non-medical use is by legal definition considered as abuse. In the Netherlands a distinction is made between abuse and use, with a large part of the consumers falling into the user category.

Prevention holds a strong position. In the Netherlands information usually aims at giving a neutral, scientific view of drugs while in Sweden the concept of clear, deterrent anti-drug messages to the youth is salient. Early interventions among risk groups play an important role in both countries. In the Netherlands with a harm reduction approach, in Sweden mainly as part of control measures.

The Dutch concept of harm reduction and the Swedish concept of a drug free society are contradictory. Reducing harm can be seen as making drug taking less risky, while the struggle for a drug free society often means strong control measures, making life more risky for drug abusers.

The Dutch harm reduction approach fits in the concept of care while the Swedish abstinence oriented approach usually means treatment. In both countries methadone programmes are being used, but the Swedish programmes can be described as a high-threshold programme while the Dutch ones are mainly low-threshold programmes. In Sweden coercive treatment is used both within the prison system and by the Social Act. In the Netherlands coercion is used only under penal law. The country has a long tradition of ambulatory treatment of substance abusers within a juridical setting, for example probation.

In the Netherlands as well as in Sweden many different parties are conducting research on addiction. A considerable number of studies on drug prevalence have been conducted through the years. A comparison of figures is difficult due to methodological differences, but national trends are possible to follow, since studies are often replicated over time.

Local household surveys have a prominent place in the Netherlands in charting drug prevalence. In Sweden national surveys amongst school pupils and conscripts are used instead as indicators of the general drug situation. Both types of studies fail in reflecting heavy drug use.

Heavy drug abuse attracts special interest because of its consequences for the individual and society but is difficult to catch with traditional survey methods. Instead the method of case finding has been used in Sweden and in the Netherlands. Unfortunately studies of this kind are hard to compare because of different definitions of heavy drug addiction and different research

designs.

Information from treatment facilities and aid organisations could provide useful information about the drug situation in a country. This source of information is still not used in a sufficient way. More information is collected in the Netherlands than in Sweden, but co-ordination of data from different service providers is lacking. This means that it is hard to get an overview of the type of treatment and outcome of treatment in both countries.

Even when comparing the cases of drug related deaths between the two countries difficulties occur. Substantial differences can be notified concerning the identification of relevant cases, processing and classification of data and finally the collection and reporting of cases. Similar problems appear with statistics on admissions to hospitals and cases of aids.

Some conclusions can be drawn from data on HIV/AIDS among drug addicts. The rate of infected drug addicts is highest in Stockholm and Amsterdam and concerns mainly heroin addicts. The incidence of AIDS cases relating to intravenous drug use decreased in the second half of the nineties and is now described as quite stable.

Data on the number and quantities of drug seizures are difficult to compare within the country and between countries at least when one wants to use the figures to make a statement about the prevalence of drug use. Data on seizures in the Netherlands concern mainly trafficking while in Sweden they concern possession and use. Figures about seizures do not play an important role in estimating the situation concerning drug use while for Sweden the contrary is true. The large majority of drug seizures in both countries concerns cannabis.

* * * * *

Is it possible to compare figures about the extent of the drug problem between Sweden and the Netherlands? No, for the moment it is not relevant. The differences in how fundamental issues are looked upon are too large. For example what is use and what is abuse? Is it possible and/or desirable to distinguish between soft and hard drugs? What role do illegal drugs have in connection with deaths? What kind of data is meaningful to collect? The differences are both practical as concerning what kind of information doctors have to report and ideological, as if forensic medicine should look for traces of cannabis in the autopsy.

Of course it is possible through international agreements to decide which definitions should be used, but this calls for a top-down governing of research that it may be hard to get free researchers to accept and follow. Crucial for the providing of data is that the informer considers it to be legitimate and relevant. EMCDDA has given priority to develop common criteria and definitions that can be used when data is collected and analysed within the EU.

However, international agreements can not influence factors such as the willingness of drug users to expose themselves to authorities. As a consequence of the Dutch harm reduction strategy drug users have good reasons to contact authorities to get help seeing, as it is available, for example low threshold methadone and accommodation. In Sweden the policy of “it should be tough to use drugs” means that the drug user has good reasons to keep his habit secret. The legal climate in which drug use takes place can affect both answers in surveys and the authority’s knowledge of

the drug habits among clients.

Data on drug seizures can reflect developments on the drug market or use among the population, but changes in police and customs activities over time to detect drug crimes and fluctuating resources and priorities must be taken into consideration. Activities and attitudes of social workers and others that professionally meet drug users also affect figures on prevalence in a case finding study.

As we have mentioned earlier the drug issue is permeated with ideology. For example the question of if the forensic medicine profession should look for cannabis in autopsies when an unnatural death is suspected has obvious ideological implications. The Dutch might say that it is irrelevant to investigate the existence of THC since this substance stays in the body for a long time after exposure. The Swedes on the other hand can argue that there are several presumably unexplainable deaths that may depend on cannabis abuse and that these deaths may have to be counted as drug related, which only can be proved through an autopsy.

Our study also shows similarities between the two countries. Both allocate large resources against drug abuse. In both countries there is an obvious interest in dealing with the social problems that come out of drug use. The Dutch liberal model is not a laissez-faire model but an elaborated strategy to meet individual and social drug related problems. Also the harsh Swedish drug policy contains treatment and prevention activities as well as control measures.

What should be done to accomplish measures that would make comparisons between countries fruitful? EMCDDA will probably succeed in their efforts to get EU countries to use standard definitions of, for example, drug related deaths and standardised routines for establishing causes of death, reporting and coding. It is not our task to present proposals in this field but we would like to note one important aspect of a standardisation of data collecting methods.

One conclusion that can be drawn from our report is that the type of data collected is closely related to drug policy. In Sweden data that shows developments in prevalence and attitudes against drugs among youth are very important just like data on seizures of drugs made by police and customs. This data is an important indicator to evaluate whether the ideal of a “drug free society” is getting closer. In the Netherlands, with its “harm reduction” model, data on risk groups, drug related deaths and the contents of drugs are more important to evaluate the outcome of the drug policy. Another difference is on which level data is collected. In Sweden national data is important while in the Netherlands regional and local data is preferred. Again this difference can be related to the national drug policies. The fight against drugs is a national project in Sweden, while in the Netherlands actions against drug addiction are related to local conditions. In our view it would be wise to pay attention to this aspect in establishing EU standards of data collecting concerning illegal drug use.

The countries could learn from each other. It would be interesting and possible for Sweden to conduct household surveys with a similar method as the Netherlands or to continuously monitor drug taking behaviour among defined risk groups like those in Amsterdam. The Netherlands could replicate the Swedish survey among 16-year old school pupils. Both countries have reasons to improve the collecting of data on drug treatment in all its forms.

If definitions and methods of drug statistics were to be integrated, would it then be possible to declare if the Swedish or the Dutch drug policy is the best? No, it is as hopeless as if we were trying to come to an agreement through research and statistics on whether a social democratic or liberal economic policy is more successful. There are too many factors that are not possible to control in scientific studies (or by drug policies). Moreover the decision about which policy to choose is a political decision. There are still good reasons to try to integrate and co-ordinate definitions and routines concerning data collection and analyses within the area of illegal drugs. This is not necessarily to decide which policy would be the best in the European Union but to minimise drug related harm including improving the living conditions of drug addicts.

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Chapter I: What policy?

Drug use has caused extensive measures aiming at control in both countries. A major difference is that the Swedish policy is combating all kind of narcotic substances while the Netherlands focus primarily on so called hard drugs ¹.

This is reflected by substantial differences in law and law practise.

The Netherlands

General

The Dutch authorities proceed on the basis that the presence of drugs is the inevitable result of an open Western society. With this in mind they have opted for a policy based on limiting demand, the detrimental effects of the use of drugs and supply. The principal objective of drug policy in the Netherlands is to reduce the risks resulting from the use of drugs for users themselves, their immediate environment and society in general. The underlying idea is that the disadvantageous effects of drugs stem not only from the pharmacological properties of the substances, but also from the personality of the user and the conditions under which the drugs are used. In the opinion of the Dutch authorities, a policy that fails to combine these elements is doomed to failure.

This principal objective can be divided into three fields of action:

- by providing assistance aimed at limiting the health risks and improving the living conditions of drug addicts it is trying to reduce the risks for the individual drug addict.
- to reduce risks for society the policy is aimed at supply reduction by combating the illegal drug trade. To reduce the demand for drugs preventive action is aimed at discouraging drug use by first-time or potential users.
- to reduce the risks for the immediate environment of the drug user a policy to combat drug related nuisance has become more important.

The minister of Health, Welfare and Sport (HWS) and the minister of Justice are jointly responsible for drug policy. The Minister of Justice is responsible for enforcement of the criminal law and partly for probation and after care service and the Minister of Health, Welfare and Sport for aid, prevention and public health policy. Administrative prevention is the responsibility of the Ministry of the Interior. The Minister of HWS is responsible for co-ordinating drug policy.

On a local level the drug policy is implemented in close co-operation between the public health and social work authorities, the police and the courts.

Soft and Hard drugs

In the Netherlands a strong distinction is made between hard drugs and soft drugs. This distinction is based on the belief that hard drugs such as heroin, cocaine, LSD and amphetamines) poses an unacceptable risk while the risks of cannabis products (soft drugs such as hashish and marijuana) are considered to be not as great.

¹ Some of the concepts in this chapter will be presented in more detail later in the report (chapter 2).

The Opium Act

Rules on drugs were first laid down in the Opium Act of 1919 which was revised in 1928 and 1976. This Act still forms the basis for drug policy in the Netherlands. When the Act was revised in 1976, a distinction was introduced between drugs with an unacceptable risk (hard drugs) and cannabis products (soft drugs). Drugs were entered on list I and list II. List I consists of heroin, cocaine, amphetamines, LSD and MDMA and six chemical variants. List II consists of cannabis products, barbiturates and tranquillisers².

Possession of, dealing in and manufacturing any drug is a criminal offence except for medical, scientific and instructive purposes provided permission has been granted by the Ministry of HWS. Advertising the sale of drugs or issuing drugs is also a criminal offence. Use of drugs is not a criminal offence³.

The Opium Act makes all actions preparatory to the trade in drugs and any attempt to import drugs a criminal offence. The cultivation of hemp is prohibited except for specified agricultural and horticultural purposes. When the police are confronted with production of cannabis for personal or recreational use they will, after consulting the local authorities, decide about prosecution. In general a production of no more than ten plants will be classified as for personal use only, and no prosecution will follow.

There are serious penalties for offences under the Opium Act, with sentences in respect of hard drug offences being greater than for soft drug offences. A distinction is also made between possession of drugs and dealing in drugs. Possession of both soft and hard drugs for commercial purposes is regarded as a more serious offence than possession for personal use. The importing and exporting of drugs are the highest priority for the criminal investigation authorities. Accordingly, they also attract the most serious penalties. The maximum sentence for importing and exporting hard drugs is twelve years imprisonment and a fine of Fl 100 000. The maximum sentence for the possession of hard drugs for personal consumption is one year imprisonment and a FL 10 000 fine. The maximum penalty for importing and exporting soft drugs is four years imprisonment and a fine of Fl 100 000. The maximum sentence for the sale or production of a maximum of 30 grams of cannabis is one month detention or Fl 5000 fine. The maximum penalties may be increased by one third if the offence has been committed more than once.

In 1997 the Opium Act Administrative Enforcement Bill came into force (usually called the Damocles Law). This bill provides for the addition of section 13b to the Opium Act. This section gives the Lord Mayor the power to take enforcement action against coffee shops, cafes and other premises open to the public and the yards and sites belonging to them if hard or soft drugs are sold, delivered or supplied there or are present on such premises. This will mean that direct action can be taken against coffee shops. This bill too, will cover drugs premises where (mainly) hard drugs are sold, provided that the premises are open to the public.

Priorities

The principle of discretionary powers under Dutch law has played an important role in

² Until 1993, list II consisted only of cannabis products. After the ratification of the UN Convention on Psychotropic Substances these products are included in the list.

³ The Netherlands is not alone in this respect. In for example Germany, Denmark, Greece, Portugal and the United Kingdom, too, the use of drugs as such is not a criminal offence.

formulating Dutch drugs' policy. What this principle - which is included in the penal code - entails is that the Public Prosecutor's department may refrain from prosecuting an offence if it regards it as being in the interest of society and it can dismiss the case in question⁴.

On the basis of the Opium Act, the Public Prosecutor's department has drawn up guidelines for investigating and prosecuting offences. These guidelines currently assign maximum priority to investigating and prosecuting imports and exports and lowest priority to possession for personal use.

Criminal offences involving hard drugs other than for personal use have highest priority. They are followed by criminal offences involving soft drugs other than for personal use. The detection and prosecution of possession of hard drugs for personal use (0.5 g) and a maximum of 5g of soft drugs have lowest priority. The sale of a maximum of 5 g of hashish or marijuana in coffee shops is not automatically followed up if the coffee shop adheres to the guidelines of the Public Prosecutor's department. If the police arrest anyone with less than 0.5 g of hard drugs in their possession they impound it. However, the person is usually not prosecuted, instead the police contact aid workers.

In addition, laws facilitating the detection, seizure and prevention of laundering of the proceeds of the drug trade are also important. Dutch banks are obliged to report unusual financial transactions. There is also the Act on the Prevention of Misuse of Chemicals that came into effect in 1995⁵. This makes it a criminal offence to manufacture and trade in materials listed in the act, unless permission has been obtained from the Minister of HWS.

In 1997 the Synthetic Drugs Unit became operational. This unit is specialised in tackling the production of and trafficking in ecstasy, amphetamines and other synthetic drugs. The organisations forming part of this unit are the customs authorities, the Internal Security Service, The National Criminal Intelligence Service and regional police forces.

Coffee Shops and Soft Drug Policy

The policy described above has resulted in coffee shops being set up where dealing in soft drugs is permitted under certain circumstances. These shops are permitted for two reasons: firstly, to decriminalise dealing in small quantities of soft drugs and to prevent young people using soft drugs ending up in a criminal environment; secondly, the broader objective is to make a distinction between the markets for soft drugs and hard drugs.

The sale of small quantities of soft drugs in coffee shops is a criminal offence but is in practice only followed up if the coffee shop manager or owner fails to satisfy a number of conditions, the so called AHOJ-G criteria.

These are:

- no advertising for drugs;

⁴ Article 167 of the Penal Code.

⁵ The Act was introduced on 16 May 1995. It implements the European Directive of 14 December 1992 on chemical components.

- no hard drugs to be on sale;
- no public nuisance to be caused;
- no drugs to be sold to minors (under the age of 18), and no minors allowed in the shop;
- the amount sold must not exceed a quantity of 5 grams per person per sale⁶.

According to police estimates the number of coffee shops in the Netherlands was 1200-1500 in 1991. The amount is later estimated to be 1460 in 1995 and 1283 in 1996. An inventory by the Intraval Bureau showed (2000) that in 1999 the number of coffee shops had decreased to 846. One explanation for this descending trend is the criticism of neighbouring countries. Another is the implementation of the Damocles Law that aims at reducing nuisance caused by for example coffee shops. More than 88% of Dutch municipalities have a soft drug policy. App. 80% of these municipalities pursue a zero-tolerance policy on coffee shops⁷.

Sweden

General

The drug problem is seen as one of the most serious social problems in Sweden and as a consequence the country holds a firm and uncompromising attitude towards drugs. The goal for the drug policy as proclaimed by parliament in 1978 is to eliminate all drugs from society. The attitude is based on the view that drugs are not a part of the Swedish culture and therefore are unacceptable. Drug taking should remain a marginal phenomenon and socially unacceptable behaviour in Swedish society. A society, in which drugs are allowed, threatens the individual's health, quality of life and security and in the long run also general welfare and democracy.

The overall primary goal of a drug free society can according to the government be divided into three objectives:

- reducing recruitment to abuse
- more drug abusers shall end their abuse
- limiting access to drugs.

Measures to realise these objectives can be divided into three main fields of action;

- *prevention* to hinder young people experimenting with drugs. The main area for prevention is the school system where information on drugs is a regular feature. Also the attitude from the authorities that "it must be difficult to abuse drugs" is aimed at prevention.
- *rehabilitation* of drug abusers. Traditionally Sweden has allocated large sums for all kind of treatment from detoxification to outpatient and inpatient facilities. The last resource in the chain of care is the institution for compulsory care.
- *control* of supply of drugs. The main actors in this field are Customs and the Police. Special forces within the police act against street level pushing, in order to reduce supply for young people. International co-operation to reduce trafficking is also important.

In the Swedish approach, actions aimed at reducing harm caused by drugs rather than at obtaining abstinence are not accepted. An exception is allowed in the form of four methadone programmes

⁶ The tolerated quantity that can be sold per customer has been reduced from 30 to 5g. Drugs Memorandum of the Lower Chamber, 1994 to 1995 Sitting Year, Nos. 2 to 3.

⁷ Intraval Bureau (2000) Coffee shops geteld. Groningen.

with a limited number of patients as well as two needle-exchange programmes⁸.

Due to an increased prevalence of drug use among youths during the nineties the government decided in 1998 to nominate a National Committee on Narcotics. The Committee shall evaluate the Swedish drug policy and give recommendations for it. Its final report will be presented before the end of 2000.

Responsibility for the co-ordination of drug policy lies with the Minister of Social Affairs, but is also a matter for the whole cabinet. Combating drugs is not only a task for the authorities but for the whole population.

Soft and hard drugs

In Sweden all non-medical use of drugs is regarded as drug abuse and no distinction is made between soft and hard drugs. The stepping stone theory in which cannabis abuse is seen as a first step towards abuse of other drugs like amphetamines and heroin has for many years influenced the Swedish drug policy. However, cannabis is also seen as a menace in itself and the National Board on Health and Welfare emphasises the risks of cannabis in causing mental diseases and making young people withdraw from society.

The Drug Act

The Drug Act of 1968 was the first comprehensive law within the area of drug legislation⁹. The law is still the foundation of the policy.

It classifies offences according to their seriousness:

- minor drug offences: fines, or a maximum of six month's imprisonment;
- simple drug offences: from six months to a maximum of three years' imprisonment;
- serious drug offences: imprisonment of two years and a maximum of ten years.

Since 1968 a fine or a maximum of one year's imprisonment punished the unlawful sale or supplying of syringes. The provisions of the Drug Act are also included in the Customs Act. The Drug Act covers all feasible forms of processing or trading in drugs except for medical, scientific and instructive purposes for which the government has given permission.

Abuse of drugs was made a criminal offence in 1988 and the law was sharpened in 1993, when the maximum penalty was raised from a fine to imprisonment of up to six months. This enabled the police to request urine and blood samples from suspects in collecting evidence for drug possession. Subsequently, police action not only aims at combating wholesale trade in drugs but also at combatting retail trade.

In 1998 a new law (SFS.1999: 42) was passed by parliament that enables the government to prohibit certain substances as dangerous for life and health, without being classified as narcotic drugs. The main goal for this law is to make it possible to react quickly to newly designed drugs of which the narcotic effects have not been proven yet. The penalty for an offence against this

⁸ Regeringens skrivelse 1997/98:172.

⁹ SFS 1968:64. The Swedish Drug Act has been sharpened numerous times since then.

law is a fine or a maximum of one-year imprisonment¹⁰. In order to ease and broaden the classification of designed drugs the definition of narcotics as formulated in the Drug Act was changed; §8 *“Narcotics in this law means medicines or health injuring substances possessing dependence causing properties or euphonising effects or substances that easily can be transformed into substances possessing such properties or effects..”* (ibid.).

The jurisdiction of the law can be circumscribed because of the free trade regulations of the EU, i.e. if substances are allowed into other parts of the union. An example is GHB which is registered as a medicine in some EU countries, delaying the process of making the drug illegal.

Priorities

According to the Swedish criminal law the prosecutor is bound to inquire and prosecute all offences. However, the law also provides a possibility to abstain from prosecutions in certain circumstances that are carefully circumscribed in law provisions. The practise of abstaining from prosecution is laid down in instructions from the Chief Public Prosecutor. Current practice concerning drug offences (mainly use and possession for own use) are based on the instructions from the Chief Public Prosecutor in 1980 that marked a significant shift in Swedish drug policies¹¹. Before 1980 prosecution could be abstained from cases of possession for own use and a clear distinction was made between possession of cannabis and other drugs. By abstaining from prosecution the prosecutor tried to distinguish abusers from dealers. Abusers should receive treatment, dealers imprisonment. However, police officers complained about drug dealers carrying just enough drugs to avoid indictment for drug dealing. Besides this, according to the Chief Prosecutor, research had shown that cannabis was much more harmful than was previously assumed¹². The main reason though was that priority for police actions was extended from wholesale trade to retail trade in drugs. By acting on the abuser level in the drug market it was expected that the recruitment of new drug abusers would be obstructed and a deterrent effect would be had on occasional abusers.

The shift in drug policy that occurred around 1980 meant that from then on abstaining from prosecution in drug could only be applied very restrictive. In the instructions from 1980 cannabis and amphetamine were regarded as less dangerous than heroin and cocaine. In the latter cases abstaining from prosecution should in principle not be used at all. For cannabis the maximum amount of possession for which a waiver could be used was set at 0,75-1 gram. For amphetamine the limit was set at 0.1-0.2 gram. In principle abstaining from prosecution should be applied only for first time offenders and only if a fine can punish the offence¹³.

The practise of abstaining from prosecution has not changed much since the instructions issued in 1980. According to the City Prosecutor in Stockholm abstaining from prosecution is very seldom used in cases of solely drug offences. Generally it is used in cases when the offenders already have been convicted for other crimes¹⁴.

¹⁰ Prop. 1997/98:183.

¹¹ RÅC 1:94, 1980.

¹² (ibid).

¹³ (ibid).

¹⁴ BRÅ (1999).

The priorities of the police and the prosecutors are reflected by statistics. In 1998 the total number of persons guilty of offences under the Drug act was 12 200 (1997:11 400). Of these 80% concerned minor drug offences i.e. abuse and possession (1997:77%) and 2% serious offences such as trade and trafficking (1997:3%)¹⁵.

¹⁵ BRÅ (2000).

Chapter II : What are the concepts in the field of drugs and how are they used?

Comparing a complicated social phenomenon like drug abuse (or drug policy) across countries is not possible without a careful description of the definitions used. In this chapter we will present and compare central definitions in the drug field. We will also describe the drug policy in practice, using the concepts to organise the comparison.

1. Concepts of “drugs” / “hard drugs- soft drugs”

The two countries have a different view of the dangers of cannabis. In the Netherlands a distinction is made between hard and soft drugs while in Sweden this is not done.

The Netherlands

Since 1976 a distinction has been made on the basis of medical, pharmacological, sociological, and psychological evidence between drugs with an unacceptable risk (hard drugs, such as heroin, cocaine, LSD and amphetamines) and cannabis products (soft drugs, such as hashish and marijuana) the risk of which is not deemed to be so great. The official point of view is that cannabis use is by no means risk free, but certainly no more harmful than alcohol and tobacco use¹⁶.

The objective of the policy is to protect young people and young adults wanting to use soft drugs from the world of hard drugs. This policy is based on the assumption that people do not switch from soft to hard drugs because of the intrinsic properties of the drug. Rather this switch is caused by social and economic factors such as the coming together of these two drugs in a criminal environment¹⁷.

This idea has led to a strict distinction being made between the markets for soft drugs and hard drugs. At the same time, there are tough sentences for transporting, dealing in and manufacturing hard drugs. Action is also increasingly being taken against the large-scale manufacture and sale of cannabis products.

Sweden

When it comes to definitions of drugs no distinction is made between hard drugs and soft drugs, at least in law texts and in the political arena. In treatment and legal and research practices though, a distinction is made between heavy and other drug abuse, so the character of abuse is focused, not the drug. Intravenous drug abuse is seen as an especially severe form of drug abuse. Cannabis abusers are generally treated in ambulatory care and amphetamine/heroin abusers in an

¹⁶ Trimbo institute (1997).

¹⁷ This hypothesis, known as the “stepping stone” hypothesis, is based on the assumption that cannabis users run an increased risk of using hard drugs and, in particular, heroin. The change cannot be explained by the pharmacological properties of cannabis. Social factors appear to be of importance: the risk of using hard drugs increases the more the user is integrated in an environment where hard drugs are present as well as cannabis. The distinction between the drug markets is based on this, as is current cannabis policy.

intramural setting. In Sweden cannabis is regarded as a drug that is potentially dangerous, especially concerning its ability to cause different psychotic conditions¹⁸. According to a literature study made on behalf of the National Board on Health and Welfare there is no proof of the existence of cannabis-induced psychosis, but the drug probably increases the risk. Likewise there is no definite answer to the question whether cannabis smoking can cause schizophrenia, but there are indications showing a connection¹⁹.

2. Concepts of “drug addicts”, “abusers” / “users”

In both countries the word “drug addict” refers to someone with an addiction, usually defined medically and socially. In Sweden all non-medical use is by legal definition considered as abuse. In the Netherlands a distinction is made between abuse and use, with a large part of the consumers falling into the user category.

The Netherlands

A distinction is made in the Netherlands between the different forms of use, on the assumption that not all forms of drug use are harmful. Accordingly, the distinction is risk-based. Experimental use is separated from use of some regularity and excessive or problematic use.

A distinction is also made between drug use and drug addiction. In general, the more addictive the properties of a substance, the more likely it is that we are dealing with addiction, in which case the authorities speak of drug addiction. Addiction to hard drugs usually means addiction to heroin. Aid organisations also refer to hard-drug users as clients if they are addicted to heroin, morphine, methadone, other opiates, cocaine, amphetamines, ecstasy or other hallucinogens. A client who is principally addicted to alcohol but also uses heroin is regarded in these circles as a hard-drug client²⁰.

As far as heroin is concerned, it may be assumed that the number of users is not identical to the number of addicts. Not every heroin user is an addict; some users are also at the experimental stage. Furthermore, not all addicts are continuous users; there is always a certain percentage who do not use heroin for a certain time, for example, because they are taking part in aid programmes, they are kicking the habit or they are in drug-free detention. It is acknowledged that it is difficult to estimate the ratio between users and addicts.

As far as cocaine is concerned, the normal term is “use” rather than “addiction”. It is clear that cocaine is psychologically addictive, but not whether it can be deemed to be physically addictive²¹. Again the ways and circumstances in which the drug are used are decisive for the term used.

The largest gap between use and addiction is found with cannabis. It is not regarded, per se, as

¹⁸ Regeringens skrivelse 1997/9: 172:8.

¹⁹ Ramström (1998).

²⁰ Ouwehand, Cruts (1997).

²¹ Research in non-deviant settings in Amsterdam has shown that 1-4% of users can end up with addiction or an addiction-like problem, compared with 6-10% in Rotterdam. Cohen & Sas, 1993, and Intraval, 1992.

addictive, and hence the term is “soft-drug use”. In 1998 six percent of all clients in ambulatory assistance had cannabis use as a primary problem.

In conclusion, we can say that addiction is more likely if a drug is regarded as having more addictive properties. With soft drugs, the term is “use”; with hard drugs “addiction”. This distinction is used less consistently with hard drugs where the term “hard-drug use” is usually used. However, nobody ever talks about “soft-drug addiction”. The term “drug abuse”, when “drug use” is meant, is not encountered.

Sweden

According to the Swedish drug policy all non-medical use of drugs is considered as abuse and harmful. This stand is based on both the pharmaceutical and social consequences of drug use but it is also grounded on beliefs about how people form attitudes and how they act. Here the concept of “clear signals” is important. Susceptible people like teenagers can be tempted into drug abuse if they think that drugs can be harmless. This brings about a necessity of sending clear signals from the government to the people with the message that all kinds of drugs and drug use are dangerous, unacceptable and shall be suppressed. In this line of reasoning to speak of use instead of abuse therefor implies that not all use of drugs is problematic. However in research (for example prevalence surveys) a distinction has been made between use and abuse. Also in official publications the ideological importance of the right term has recently been softened.

A general condemnation of drug use as something “evil” is seen as a crucial prerequisite for a successful drug policy. In 1999, for the fourth time in a row, a big conference and exhibition “Sweden against drugs” was held. It was opened by Queen Silvia, with the minister of Social Affairs as one of the key speakers, and attracted almost 4000 visitors during three days of seminars and discussion. Three slogans concluded the conference “Of course we can prevent drug addiction! Of course people can quit drugs! Of course we can work together in Sweden and internationally for a restrictive drug policy!”. The conference is arranged by all major national authorities and organisations involved in combating drug use.

When the drug problem is investigated and described with scientific methods some distinctions are made. In official reports on the prevalence of drug abuse, a difference is made between occasional/ experimental and severe drug abuse. In between these two categories a third exists, namely regular/occasional abusers. Research on this category is rare.

3. Concepts of “Prevention” and “Information”

In both countries prevention holds a strong position. In the Netherlands information usually aims at giving a neutral, scientific view of drugs while in Sweden the concept of clear, deterrent anti-drug messages to the youth is salient. Early interventions among risk groups play an important role in both countries. In the Netherlands with a harm reduction approach, in Sweden mainly as part of control measures.

The Netherlands

In demand reduction strategies, the emphasis is on informing people about the hazards of drug use rather than purely on moralism or repression.

Information on the use of drugs is aimed principally at potential or first-time drug users such as school children, young people in fringe groups and immigrants. Youth workers and street workers are used for this purpose. Information campaigns seek to present the problem with drugs use in a realistic and non-sensational way, with the emphasis on personal responsibility for health, since all the evidence shows that deterrent and sensational information has a counterproductive effect²². It tends to make young people more curious. The national Trimbos Institute has the task of co-ordinating public information on drugs²³. To this end, it has set up a number of national projects, aimed amongst other things at information campaigns in schools and at enabling teachers, youth workers and GPs to identify addiction problems and to take action at an early stage. In addition, the Collective Prevention Act has created a role for local authorities that carry out activities in the field of public health via the health services and in co-operation with the police and justice authorities. In general (ambulatory) assistance services are involved in prevention activities and often have a special prevention division.

An example is the “Healthy school and stimulants” project aimed specifically at senior secondary school students, set up in 1991. It is being carried out jointly by the Trimbos Institute, the institutes for outpatient drug addiction, the health authorities and the local authorities. The project provides information on tobacco, alcohol, cannabis and gambling, dovetailed with the ages at which young people generally first make contact with narcotic substances.

A national centre for prevention (LSP) offers support to local, regional and national agencies in the fields of information, knowledge improvement and innovation. The main task though is to enforce co-operation between different actors in the field of prevention²⁴.

In the Netherlands combating street level dealing is usually not considered as a preventive measure but more as combating nuisance.

Sweden

In discussions on prevention the terms primary, secondary and tertiary prevention are usually used. Primary prevention is aimed at the population as a whole, secondary at risk groups and tertiary at treating persons who have addiction problems. Two of the underlying central assumptions of the Swedish drug policy are directly related to the subject of primary prevention: the “total consumption model” and the “stepping stone theory” concerning the role of cannabis. The total consumption model is dominating the field of alcohol policy and means that if alcohol is easily available consumption will rise. The more people drink alcohol the more they will experience alcohol-related damages. The abusers are recruited from among the users. The same model is applied for drugs.

The stepping stone theory emphasises cannabis abuse as a first step in a career leading to drugs like amphetamine and heroin. Young people experimenting with drugs are playing with fire.

²² R. Weijenburg.

²³ Formerly the Netherlands Institute for Alcohol and Drugs (NIAD) which on 1 September 1996 became part of the Netherlands Institute for Mental Health Care and Addiction, the Trimbos Institute.

²⁴ VWS (1999).

Keeping the number of young drug consumers down is therefore of uttermost importance. This can be done in several ways and by different means. One way is through information about the detrimental effects of drugs. The main target group for information is school children. All compulsory schools (7-16 years) have to organise some education on the subjects of alcohol, narcotics and tobacco (ANT) at least at one stage of the curriculum. Traditionally, police officers play an important role in this kind of education.

Earlier large information campaigns aiming at young people with a deterrent message were frequently used. National campaigns against drugs are seldom carried through nowadays and preventive activities are mostly implemented by local authorities and local actors. In later years programmes in which pupils are trained to resist group pressure on deviant behaviour have become increasingly popular. Other target groups are youngsters who travel abroad, visitors of Rave-parties, and individuals in a risk-zone for developing abuse.

The National Institute of Public Health has an overall responsibility for prevention of alcohol and drugs in Sweden. The institute also supplies information about drugs and finances a substantial number of time-limited projects in the field of alcohol and drugs prevention throughout the country. In this field, non-governmental organisations (NGO's) have an important role, for example by organising drug free concerts and dances for youth and providing information.

Another strategy to prevent drug abuse is to restrict supply. In the Swedish context this means to limit access to drugs for already addicted drug abusers, but also to limit opportunities for young people to come into contact with drugs. To obtain this goal police initiatives are directed towards street level retail trade in drugs. Special anti street dealing teams are operating in accordance with the motto "It should be difficult to abuse drugs". In this context Customs also contributes to prevention by targeting control specifically on youth that cross the border. Also some police actions are directly aimed at youth activities. The famous "Rave commission" in Stockholm, that was established explicitly to combat drug abuse at Rave parties, is an example of secondary prevention²⁵. Other kinds of secondary prevention activities are aimed at marginalised youth, ethnic minorities, women, children of addicted parents and drug abusers with psychiatric disorders.

4. Concept of "harm reduction"/"a drug free society"

The Dutch concept of harm reduction and the Swedish concept of drug free society are contradictions. Reducing harm can be seen as making drug taking less risky, while the struggle for a drug free society often means strong control measures, making life harder for drug abusers.

The Netherlands: Harm reduction

The Dutch policy on hard drugs is based on harm reduction. This means that the assistance to drug users is aimed at minimising health risks without solely striving for drug abstinence. Harm reducing activities include providing methadone, safe injection equipment, hygienic user spaces, information provided through peer support, food, medical care and shelter. Harm reduction is

²⁵ M. Linton (1998).

also the goal of other measures for preventing infections like HIV and hepatitis B and C. The ministry of HWS has proposed a general vaccination of intravenous drug users against hepatitis B.

In addition, assistance to drug addicts focuses on helping them to become part of mainstream-society by, for instance assisting them in managing their finances and finding a job. This pragmatic approach is a result of the view that it is not realistic to expect drug addicts to give up drug use within a short period of time and that care that is solely aimed at this objective may lead to further social isolation and mental and physical deterioration.

Methadone distribution

The distribution of methadone is an important component of drug addiction care in the Netherlands. Methadone is distributed to replace heroin, in both use-reduction programmes and maintenance programmes. The dosage of methadone is gradually reduced to nil within one to six months, with total abstinence as the target. Practice has shown that reduction is difficult, and treatment is increasingly given on basis of maintenance, with the dosage being kept stable. The primary targets are combating a further deterioration in the client's situation in maintaining contact with users. The number of methadone clients in the Netherlands is estimated at a minimum of 13 500²⁶.

Syringe exchange programmes

The safe injection programme is next to health education one of the main components of the programme for preventing HIV infection among drug users in the Netherlands²⁷. The syringe exchange programme got off the ground in the Netherlands in 1984. Now some 130 of these programmes exist, in 60 municipalities, mostly as a part of a methadone programme. In 1995 in Amsterdam there were 745.000 syringes distributed and almost all of them returned. The increased accessibility of injecting equipment did not result in an increase in drug use. The number of syringes exchanged in Amsterdam dropped from 1.000,000 in 1993 to 485 600 in 1998, while the annual number of new cases of HIV infection among intravenous drug users has dropped over these years. According to the health authorities in Amsterdam this is due to the fact that many foreign (intravenous) drug users that were taken care of by the Dutch assistance system have returned to their home countries where methadone programmes recently has been established.

Hygienic user spaces

User spaces are places where users can take drugs under hygienic circumstances, thus refraining from more risky ways of administering drugs. These places serve also to lessen public nuisance.

Peer support

The idea behind peer support is that drug users are more likely to accept information on drug use if other drug users give it. This counts especially in groups that are hard to reach by professionals.

²⁶ NDM (1999).

²⁷ Van Amedijen, Van den Hoek, Coutinho (1994).

Other Drugs substitutes

For a minority of drug addicts methadone is not effective. Experiments to determine the efficacy of alternative drug substitutes have been and are still conducted.

Heroin Experiment

In 1998 the heroin experiment started in two cities. In this experiment heroin is prescribed on medical grounds and will involve a group of 750 serious addicts who can no longer be helped by the regular care system. The experiment consists of two different treatments: treatment with methadone and treatment with methadone in combination with heroin. The aim of the experiment is to examine whether the prescription of heroin had a beneficial effect on the physical or mental health and social functioning of the addicts.

The admission criteria are a minimum age of 25 and at least five years of addiction. In addition, the participants must have received, over the last 5 years, a minimum methadone dosage of 50-60 mg per day for at least a month, as a sign that they have made a serious attempt at methadone treatment. Amsterdam and Rotterdam were chosen for the first phase of the experiment. Following the selection of the participants, from 1 July 1998, 50 addicts, 25 in Amsterdam and 25 in Rotterdam, are being prescribed heroin in addition to methadone. Two control groups with app. 60 addicts are prescribed only methadone²⁸. After a positive first evaluation of the programmes in Amsterdam and Rotterdam these will be extended. The municipalities of The Hague, Groningen, Heerlen/Maastricht and Utrecht will be included in the next phase of the experiment.

Sweden: Drug free society

The overall goal of Swedish drug policy is the attainment of a drug free society. This must be seen as the utopian political goal conveying “the message” to the people very clearly - all use of drugs is unacceptable in Swedish society. As a result control measures form the axis of the drug policy even if treatment and prevention are mentioned as important. In the 90-s when funding of treatment and prevention had been cut down control measures continued as before.

All measures are therefore first and foremost directed towards abstinence.

Harm reduction is not officially used as a concept, but in practice several of the measures undertaken do in fact have a harm-reducing component. It is as a superior policy strategy that harm reduction is criticised in Sweden. For instance when HIV and AIDS became a threatening reality in drug using circles, Sweden, in contrast to most other societies, did not rely on syringe exchange, low threshold or methadone maintenance programmes as primary strategies. Instead, extra resources were allocated for local communities to set up ambulatory-care units. Through intense social work on the street/field level, all addicts were to be identified and motivated to enter treatment with abstinence as their long-term goal (the treatment system also received additional state funding).

²⁸ Trimbos Institute (1998).

However, two regional syringe exchange programmes were started in the south of Sweden, in Malmö with 1300 exchangers and in Lund with 400 exchangers in 1998. In some hospitals drug abusers can receive vaccinations against Hepatitis A and B. Since the mid 80-s the limited number of heroin addicts in methadone treatment has been allowed to extend.

5. Concepts of “treatment”, “care” and “assistance”

The Dutch harm reduction approach fits in the concept of care while the Swedish abstinence oriented approach usually means treatment. In both countries methadone programmes are being used but Sweden puts larger emphasise on drug free treatment. In Sweden coercive treatment is used both within the prison system and in social services. In the Netherlands coercion is used only under penal law. The country has a long tradition of ambulatory treatment of substance abusers within a juridical setting (probation).

Treatment is a vague concept. In general the term treatment covers all kinds of aid activities but depending on the goals for a drug policy other concepts are used as well. This becomes particularly clear when comparing the terminology used in the Netherlands and Sweden. In this text we will use the terms treatment, care and assistance as follows:

Treatment aims at changing an undesired behaviour or condition through a specific method. *Care* means helping people without an explicit ambition to change their behaviour. The concept of *assistance* as used here is covering all kinds of aid activities regardless of their goal.

The Netherlands

A number of services are available in this context. They have been extended over recent years and access has also improved. Assistance is not geared solely at ending addiction and keeping ex addicts off drugs. If this had been the case, the programmes would not have covered addicts who were unable or unwilling to give up their habit. Some programmes are therefore aimed at getting addicts to function in society as well as possible and to limit the health risks. One important feature of this is the methadone withdrawal programme and the hypodermic exchange programme²⁹. Methadone is provided as a replacement for heroin in reduction and maintenance programmes to reduce withdrawal symptoms when stopping or reducing heroin use. The hypodermic exchange programme consists of issuing clean needles to help prevent HIV and AIDS infection. These programmes were started in 1984 and there is now a network of 130 distribution points in 30 local authorities.

Specialist addiction care consists of some 70 institutions at about 200 locations. Outpatient care is provided by 17 Consultation Agencies for Alcohol and Drugs (CADs) with a total of 133 sites throughout the Netherlands. These CAD's have until recently taken a central position in the sector of ambulatory assistance. Today a number of CAD's have been merged with other organisations. In addition, there are some thirty organisations for social drug help. For in-patient care there are 20 addiction clinics with 961 places available. These services and organisations are at the disposal of addicts who take the initiative in seeking help.

²⁹ The methadone dose is cut back in one to six months with the aim of total abstinence. If this proves impossible in practice, addicts are included in maintenance programmes. For more information see: Fact Sheet Zorg en Hulpverlening Verslaving. Nederlandse Alcohol en Drugs Rapportage. Trimbos Instituut, Utrecht.

Drug Nuisance Policy

A small part of the group of hard drug addicts in the Netherlands cause social problems, particularly in the big cities³⁰. This group is responsible for a large number of crimes against property in their efforts to obtain money to buy drugs and disturb public order through maladjusted behaviour. A study among drug addicts in Amsterdam shows that the majority of the drug users (63%) can afford their drug use from legal sources such as labour and social welfare or prostitution. A minority of users (15%) earns a living from drug trade profits and the remaining 22% commit crimes against property to earn money.

In 1993 there was a launch of a nation wide policy to reduce the nuisance caused by addicts. This combines the health, Welfare and Sport Ministry, Home Affairs Ministry and Justice Ministry in the Steering Committee for the Reduction of Nuisance and involves an integrated approach with close co-operation between the police, judicial authorities and the addiction care sector. The compulsion or dissuasion approach is the cornerstone of this policy. This approach is aimed at having as many criminal addicts as possible undergo treatment by providing them with (addiction) care under dissuasion. Via criminal law measures, the threat of detention can be used as an incentive for treatment. There are a number of different forms of compulsory treatment under Dutch criminal law. Under certain conditions, the judge may allow some addicts to enter treatment in place of (part of) a sentence. This is termed “dissuasion” because the judge will enforce the sentence should the person involved not comply with the conditions set, for instance, by dropping out of treatment prematurely. As part of the early aid intervention programme, a suspect may be offered the choice at a police station of requesting assistance by having provisional detention suspended on the condition that he or she undergoes treatment. Within the prison service, too, there are drug-free departments where help is offered to addicts as a preparation for subsequent treatment.

In spring 2000 a law Bill that enables coercive care of addicts, convicted for petty crimes, for a maximum period of two years passed the Second Chamber. If the Bill is also approved by the Upper House the first site will start in November 2000 in Rotterdam. It shall be set up as an experiment for six years. After this period a final decision grounded on evaluations will be taken. Ten municipalities will participate and the total capacity will be 350 beds located at special site in prisons.

Based on the harm reduction theory as mentioned above the Netherlands have a broad system of substitution programmes, detoxification programmes with outpatient and inpatient treatment centres, and self help groups. The use of these facilities and programmes is easily accessible and on a voluntary basis. This choice fits into the harm reduction theory: addicts (particularly to hard drugs) who cannot or do not wish to kick the habit would otherwise become isolated and deteriorate, both physically and psychologically.

Care and assistance programmes

Care and assistance programmes for nuisance causing addicts span the general, the addiction and the judicial care sectors. These programmes are:

- -The Addiction counselling departments, Forensic Addiction Clinic. Established in 1981. This

³⁰ Trimbos Institute (1995).

- special regime for addicted detainees aims to motivate them to seek help and prepare them for external treatment and social integration. Placement is voluntary. There are 20 VBA's with in total 446 places.
- Early Care Intervention Systems. This project is aimed at drug users who have (repeatedly) committed punishable offences. A criminal addict is given the choice between assistance/treatment or placement in a penitentiary facility. There are some 20 VIS projects in more than 25 locations.
- Intramural Motivation Centres. The first IMC was opened in Amsterdam in 1990 and is a low-threshold facility in clinical addiction care. Admission takes place both under dissuasion and voluntary. The IMC's tries to reach out to addicts who do not seek help on their own.
- Forensic Addiction Clinic. This a closed addiction clinic for treatment of criminal addicts who have committed series of offences, are long term addicts and require intensive care. Admittance takes place under the judicial dissuasion of detention.
- Education, work projects and employment mediation. These methods and infrastructure are developed by the Trimbos institute and are aiming at getting as many (former) addicts back in the labour process.

Drug-free sections

The Netherlands has some 400 places available in so called drug free units in prisons and detentions centres. The main aims of these units are to motivate addicted detainees to accept help and to prepare them actively for external treatment and social rehabilitation. Placement is voluntary, but those in the programmes must be motivated to end their drug use and to undergo urine tests. CAD staff and prison personnel provide medical and social care. Inmates must adhere to a schedule of activities involving for instance work, sports and discussion groups. Since 1994 the public prosecutor has the option to place addicts in a special pavilion of the Demersluis prison in Amsterdam, where inmates are pressed to subject themselves to treatment. If they continue to resist the pressure, their stay in prison will be devoid of any luxury.

Rehabilitation

Rehabilitation tasks with respect to addicts who come into contact with the police or judicial authorities are performed by CAD's, the Netherlands probation and after care foundation (Stichting Reclassering Nederland) and the Salvation army. Rehabilitation tasks include providing the first assistance for addicts at police stations in order to establish a care contact (early care), drawing up information reports for the judge, monitoring addicted (former) prisoners after imprisonment and ensuring the realisation of so called task punishment.

As mentioned above the Netherlands have a broad system of substitution programmes, detoxification programmes with outpatient and inpatient treatment centres, and self help groups. The use of these facilities and programmes is easily accessible and on a voluntary basis. This choice fits into the harm reduction theory: addicts (particularly to hard drugs) who cannot or do not wish to kick the habit could otherwise become isolated and deteriorate, both physically and psychologically.

Sweden

Assistance to drug abusers in Sweden is organised through four main actors;

- The State is responsible for coercive treatment through the National Board of Institutional Care. The supervision of voluntary treatment is a task for The National Board of Health and Welfare.
- Health services are responsible for treatment of drug related health problems. Departments of Psychiatry provide inpatient and outpatient treatment, detoxification and methadone treatment.
- Municipal Social services are responsible for treatment and financial support that enables drug abusers to end their addiction. Municipalities can organise assistance as part of their own social service or contract out treatment to other organisations. Due to disappointing results of residential treatment and cutbacks in municipal finances, social ambulatory treatment has been extended during the nineties.
- Non Governmental Organisations (NGO's) like the temperance movement have traditionally been important providers of assistance to alcoholics, especially residential treatment³¹. This tradition has been adopted concerning assistance to drug abusers. In 1997 nineteen organisations received financial support from the government for their activities. In the last decade of the 20th century many treatment institutions based on the twelve-step method developed by Alcoholics Anonymous have entered the drug treatment market. Many of these operate on a commercial basis.

Chain of care

According to §11 in the Law on Social Service from 1980, the local Board of Social Service has to provide necessary assistance for the person who needs help for his/her drug problem. Before 1998 it was possible for the person to apply in court if he/she did not agree with the assistance proposed by the Social Service. In the revised law this is no longer possible and the Social Service has the last word when deciding suitable form of treatment or assistance.

Treatment of drug abusers has since the seventies been organised in a “chain of care” model. In the first link of the chain we find outreaching work aimed at motivating drug abusers to seek help for their problems. This is done by social workers employed by the Social Service. Outreach work has low priority nowadays in Sweden.

The second link starts when a drug abuser applies for assistance and the appropriate kind of assistance is chosen. This choice is made together with the social services that pay for assistance³². The choice is between ambulatory treatment or residential. Usually ambulatory is tried first, but in case of failure the drug abuser can apply for intramural treatment in for example a Therapeutic Community. Until the nineties intramural treatment was the most used treatment facility for heavy addicts but as mentioned above we have seen a striking shift from intramural to ambulatory treatment.

The third link is preparation for entering treatment. Depending on the seriousness of addiction detoxification may be required before entering assistance. Detoxification (mainly heroin and amphetamine abusers) usually takes place in a special psychiatric ward at a psychiatric clinic or mental hospital.

The fourth link is treatment. After detoxification the drug abusers are ready to start treatment in

³¹ Stenius (1999).

³² Treatment can also be paid for by the regional social insurance office, correctional treatment, or employer himself.

an ambulatory or residential setting.

When the treatment is completed the Social Service is responsible again for the re-entry of the drug abuser to society. Housing, job and after care if necessary has to be taken care of.

Social workers, stationed in special drug units, have been responsible for guiding the client through all steps of the chain of care. Due to reorganisation and decentralisation of social services throughout the country most of these special units have disappeared and their activities have more or less dissolved into the general organisation.

The National Board of Health and Welfare has collected since 1998, data on the number of substance abusers assisted by the Social Service Act since 1988. On the 1st of November 1999 around 20 000 abusers of alcohol, narcotics, pharmaceutical products or solvents were in care of the social services. The majority of these received ambulatory care (80%). One and the same person can receive different kind of assistance at the same time, therefore the real number of persons is lower. Approximately 3 200 people (16%) were staying in an institution, 257 of these in a compulsory setting³³. Unfortunately there is no data on the type of substance.

Coercive treatment

Coercive treatment of both adult alcohol and drug abusers is the responsibility of the National Board of Institutional Care (SiS). Coercive treatment can according to the LVM proceed for a maximum period of six months³⁴. The aim for coercive treatment is to break off a severe and destructive abuse and to motivate the abuser to enter voluntary treatment. Applications for coercive treatment are made by the Social Services to the County Administrative Board. The Social Services are also responsible for assessing the need for coercive treatment of the client, who has been reported by the police, doctor, relatives or Social Services themselves. The total capacity of LVM-homes has decreased significantly from 23 homes with 800 beds in 1994 to 15 homes with 349 beds in 1999. Two main reasons can be pointed out for this development. First - the nationalisation of coercive treatment in 1994 caused an increase in costs for the municipalities. Secondly - the responsibility for investigation and appliance for coercive treatment was moved from the county administrative board to the local social services³⁵. Another reason is that many social workers doubt the benefit of LVM-care in relation to the costs³⁶.

After the cutback of LVM-care one group of patients has become prominent - persons with drug abuse combined with a psychiatric disorder. In the official statistics in the end of 1997 they formed 40% of the LVM-patients.

Methadone

Although the chain of care as ascribed above is abstinence oriented methadone programmes in Sweden an exception is made. While abstinence is the ultimate goal for these programmes it is accepted that some patients will never reach this goal. The use of methadone has been the focus

³³ Socialstyrelsen (1999a).

³⁴ LVM- Act on Care of Addicts in Certain Cases (1988: 870).

³⁵ Socialstyrelsen (2000).

³⁶ Socialstyrelsen (1998)

of discussion for many years but has recently become less controversial. Until 1988 the maximum number of methadone clients was set at 150 for the whole of Sweden. Because of the HIV/AIDS epidemic among intravenous heroin abusers in the Stockholm area the number was then raised to 300. Another reason for this expansion is the disappointing results of drug free treatment of heroin abusers. According to the Uppsala programme only 10% of those treated by drug free facilities stay abstinent³⁷. An evaluation study published in 1997 showed positive results for the Swedish methadone programme. The methadone programmes had brought about a striking reduction of criminality, consumption of health care and mortality. The general conclusion of the study was that a clear improvement of the life situation for many patients had occurred³⁸.

Today there are methadone programmes in five cities in Sweden with a maximum number of patients that is set by the National Board of Health and Welfare (800 in 2000). The programmes can be described as high-threshold programmes. The patient must meet the following criteria for admission:

- Be at least 20 years of age
- Have freedom of choice. Patients who are convicted to imprisonment, intramural psychiatric care or compulsory treatment (LVM) can not be admitted
- Have a documented compulsive intravenous abuse of opiates for at least four years
- Relapse in opiate abuse in spite of repeated treatment efforts
- Absence of poly drugs abuse.

The selection of patients to the programmes is done in co-operation with the local social services. This procedure and the careful process to find the optimal dose takes time which causes waiting lists of sometimes more than two years. (Another reason is shortage of nurses). As the criteria for admission indicates, participation in a methadone programme is regarded as a last resort for heroin abusers, a last chance to cope with their addiction.

The patients are controlled through regular urine tests to find out if illegal substances are abused, which can lead to a discharge from the programme. After two years 20% had been discharged unplanned³⁹.

Correctional care

The Swedish criminal law offers opportunities to replace imprisonment with treatment outside prison. The court and the offender agree on a programme for rehabilitation. If the offender fails, the contract is broken and the sentence can be transformed to imprisonment. In 1998 the number of drug abusers who made such a deal with the court was 314, compared to 242 the year before⁴⁰.

Over the last ten years approx. 40% of the prison population were drug abusers. As a result of the overall decrease in imprisonment the percentage of drug abusers in prison has increased, since they seldom are convicted to electronic surveillance or community service, which have come to substitute prison for many offenders. In 1998 53% of the newly admitted inmates were drug

³⁷ Socialstyrelsen (1999b).

³⁸ Romelsjö, Stenbacka (1997).

³⁹ *ibid.*

⁴⁰ KROD (1998).

abusers⁴¹.

In prison there are 400 places in drug free units. The total capacity of cells is 4243⁴². The goal for offering drug abusers treatment in prison is to prevent them relapsing into addiction and criminality when released or to prepare them for voluntary treatment when released. Drug abusers who are not motivated for treatment are placed in a special wing of the prison. The main reason is to protect other prisoners from getting into contact with drugs.

Another possibility for addicted detainees to enter treatment while in prison is by §34 of the Law on Correctional Treatment. This paragraph makes it possible to serve the last part of the sentence in a treatment setting outside prison, most commonly in residential treatment. On 1st April 1998 123 drug abusers were in treatment according to §34⁴³.

Drug abusers can also be convicted to probation (sometimes with an order to undergo treatment). If treatment is not started or is interrupted imprisonment can be the consequence. On 1st April 1998, 4037 persons with known drug abuse were under probation.

⁴¹ Kriminalvården (1999).

⁴² KOS (1998).

⁴³ *ibid.*

Chapter III : Sources of information and their results

In the Netherlands as well as in Sweden many different actors are conducting research on addiction. A considerable number of studies on drug prevalence have been conducted through the years. A comparison of figures is difficult due to methodological differences, but national trends are possible to follow, since studies are often replicated over time.

When the drug situation in a certain country is assessed, a variety of different data reflecting different aspects of the drug phenomena collected/gathered by different methods are used. In some cases, the data is collected with the immediate purpose to estimate the prevalence of drug use. Different household surveys and case-finding studies are examples of this. In other cases, indicators which in some way are related to use of drugs are used, for instance number of addicts in treatment, drug-related deaths, convictions for crimes against drug laws and drug seizures by the police and customs.

It is important to realise that no single survey or indicator can be used to get a valid picture, since they often only shed light on a limited aspect of the problem. School surveys and surveys among the general population can give a good picture of the proportion of the population that have some experience with drugs, but they seldom reflect more serious forms of drug use. There is also the problem of drop out which we will discuss later. Many indicators are problematic to interpret since they not only reflect levels and intensity of drug use but also activity by the authorities. Therefore, utilisation of multiple surveys and indicators must necessarily be used, both to assess the validity of the information and in order to make a comparison between countries.

The most important sources of information in this area are:

- regular population household surveys to measure prevalence of drug use among the whole population;
- local household surveys;
- surveys among youth;
- casefinding studies concerning heavy drug abuse;
- information systems concerning the demand for aid and care; nationally aggregated information on clients receiving outpatient treatment and care;
- health statistics; for instance information on admissions to general hospitals, data on drug users diagnosed with aids, information on drug deaths;
- law enforcement sources such as information concerning drugs seizures, police arrests.

Before turning to a more detailed description of methods and indicators used in The Netherlands and Sweden as well as their most important results, an overview of their existence in the both countries is presented.

The Netherlands

The Dutch authorities are convinced that information on drug use and drug related problems is crucial for determining drug policy and for prevention and harm reduction policy. Until recently the main source of information about development in the Netherlands was collected by extrapolating local surveys to a national level etc.

A number of organisations are actively involved in the Netherlands with research in the field of drugs and drug addiction⁴⁴.

There are also a number of private research agencies, such as Intraval, the Office for Social Research and Statistics and the Driessen Agency. The National Institute for Public Health and the Environment (RIVM) collate the results of drug research. Every four years this organisation publishes the Public Health Future Surveys, setting out government public health priorities.

On initiative of the Minister of Public Health, Welfare and Sports the Trimbos Institute installed a National Drug Monitor (NDM) in 1999.

The NDM has three major objectives:

- the monitoring of addiction and use;
- co-ordination of the different activities in the field of drugs and addiction care;
- integration of data coming from the different activities in reports to national and international organisations.

The definition of monitoring is, according to the Minister of Public Health, Welfare and Sports, the registration and interpretation of figures and to observe and draw attention to facts about prevention and care. The NDM will publish a report every year, the so-called National Drug Monitor Jaarbericht. The first was published in 1999⁴⁵.

In the Netherlands the most important sources of information on prevalence of drug use are the following:

- Local Surveys. Since 1987 Amsterdam has seen a series of surveys measuring the prevalence of drug use in the population of 12 years and older. The surveys have been carried out four times now. In 1996 two other Dutch cities (Utrecht and Tilburg) were studied using the same method.
- School surveys. Since 1984 four national school surveys have been carried out.
- Various other studies, some of which are ad hoc, others of which are only indirectly aimed at measuring prevalence. These include local school surveys, substance oriented studies, studies of users groups etc. Also in this category is the national survey of the Central Bureau of Statistics that collects limited data on illicit drug use in their General Social Survey.
- Estimations. Because of the lack of national prevalence data, several attempts have been made to estimate the national level of drug use, mainly based on the studies mentioned above⁴⁶.

⁴⁴ -the Amsterdam Institute for Addiction Research (AIAR), a joint initiative of the Jellinek Centre and the University of Amsterdam;

-the Centre for Drug Research (CEDRO), University of Amsterdam;

-the Institute for Addiction Research (IVO), Erasmus University of Rotterdam;

-the Centre for Addiction Research, University of Utrecht;

-the University of Nijmegen Research Group on Addictive Behaviour (UNRAB);

-Institute for Psycho-Social and Social-Ecological Research (IPSER), University of Limburg;

-Scientific Research and Documentation Centre of the Ministry of Justice;

-the Trimbos Institute; Netherlands Institute of Mental Health and Addiction.

⁴⁵ Nationale Drugmonitor (1999).

⁴⁶ Langemeijer (1997).

Sweden

Household surveys on drug issues have little sophistication and do not play an important role in mapping the developments concerning drug use in Sweden. More important are surveys among school pupils and conscripts and case-finding studies in which authorities report the drug abusers whom they have knowledge about. Numerous studies of this kind have been conducted on both a national and local level. This data concerning consuming patterns among youths of alcohol, tobacco and drugs plays an important role in Swedish drug policy. Sweden also produces statistics about patients in treatment, drug convictions and seizures from police and customs.

The following sources of information on drug prevalence are available: national household surveys among the general population are conducted regularly. Poll institutes such as SIFO, TEMO and Ungdomsbarometern are contracted by The Council for Information on Alcohol and other Drugs (CAN) to conduct household surveys. No local household surveys have been conducted.

CAN and The National Institute of Public Health (Folkhälsoinstitutet) conduct annual national surveys among pupils in elementary schools at the age of 12 and 16 years. They also conduct surveys on drug abuse among conscripts (men, aged 18). Also local authorities now and then conduct local surveys among youth.

Sweden has a tradition of case finding studies where information is collected from the authorities that have contact with drug abusers.

Every year an extensive report by the CAN and National Board of Public Health is published with data about developments within the field of alcohol and other drugs (in Swedish with a summary in English).

A national early warning system (CRD) has been developed by the CAN and was launched in 2000.

a. Household surveys on the whole population

Local household surveys have a prominent place in the Netherlands in charting drug prevalence. In Sweden surveys among school pupils and conscripts are instead used as indicators of the general drug situation. Both types of studies fail in reflecting heavy drug use.

The Netherlands

In 1997 the first national drugs use survey was conducted in the Netherlands⁴⁷.

Respondents: The national survey on licit and illicit drug use is a nationally representative survey, covering all persons in the Municipality Population Registry of The Netherlands, as recorded at January 1st 1997 and aged 12 years and older (for Utrecht, this date is 1st January 1996). It covers 22.000 people, who are questioned face to face.

⁴⁷ Abraham, Cohen, van Till, de Winter (1999).

Objective: The objective is to give an outline of “average” drug use prevalence in the Netherlands as a whole, and to monitor distinct drug use prevalence for the four large cities each and the five population strata separately.

Method: The national survey is carried out by CEDRO and the methodology and instruments were similar to the Amsterdam drug use survey of the population of 12 years and older. It covers both legal drug use (tobacco, alcohol and medicines) and illegal drug use. The following questions about various drugs have been asked: have you ever used the drug in question? Have you used it 25 times or more often? How old were you when you first used it? Have you used it in the last 12 months? How old were you when you last used it? Where did you get it? Have you used it in the last 30 days? On how many days in the last 30 days have you used it? Interviews are carried out at home and are entered in the computer direct by the interviewer. However, if there is insufficient privacy in the place where the interview is carried out, the replies can be entered by the respondents themselves.

In general, this national household survey corresponds with the earlier Amsterdam household surveys. The main differences are; in addition to the use of conventional drugs, the survey also asks questions for the first time about anabolic steroids. Hallucinogenic substances are also covered in greater detail in the national questionnaire than was the case previously. Another difference is that for the first time there is a question about the origin of the drugs used: where the user got the drugs. In the national survey there is no health questionnaire.

Results:

- almost 16% of the population had used cannabis and about 2,5% used it recently (in the month before the interview). This means that The Netherlands has about 323.000 actual users.
- consumers of cannabis are not regularly using other illicit drugs;
- only 0.3% of the Dutch population ever used heroin. The actual use by the whole population is so minimal that it is not possible to make an estimation;
- life time prevalence of cocaine among people aged 12 and above was 2,1%. The last month prevalence was 0,2%;
- only approx. 2% of the people questioned ever used amphetamines. Last month prevalence use was 0.1%;
- only approx. 2% of the people questioned ever used ecstasy. Last month prevalence use was 0.3%.

The national survey also learns that there are great differences between the different major cities. Partly this has to be related to the kind of population in a city (for example, if there is a large group of students, a group with higher drug prevalence than average).

Sweden

Since 1980, the private polling institutes SIFO and TEMO have conducted surveys among people between 15-75 years regarding their use of drugs.

Respondents: The size of the sample varies from 1000 to 1500 persons. The drop out rate in this

type of surveys varies between 25-30%⁴⁸.

Objectives: The questions are aimed at measuring the prevalence of drug use and people's attitude towards drugs.

Method: The surveys are of the omnibus type, which mean that they were part of a whole packet of questions about other subjects ordered by other customers to the poll institutes. They are conducted by using personal face to face interviews.

Results: During the last ten years the studies show that 8-10% of the population have used drugs at least once. This means that app. 650 000 citizens in this age group have ever tried a drug. The drug mostly used is cannabis. In the 1998 survey, however, the rate of lifetime prevalence of cannabis was 13%. Two percent had tried amphetamine once and one percent cocaine. Less than 1 % had used drugs during the month preceding the survey.

There are indicators showing higher lifetime prevalence in cities than in the countryside. TEMO's surveys 1992-1996 also show large regional differences in drug experience. Generally speaking citizens of the three major cities in Sweden (Stockholm, Gothenburg and Malmö) have experienced drugs more than twice as much (14%) as in the rest of Sweden (6%)⁴⁹.

The sociologist Börje Olsson who is an experienced researcher in the field of prevalence studies explains the figures this way:

*"Most people who have tried drugs do so only once or a few times. A small amount of people do so more or less regularly for some time, generally in their youth and later finish doing it. Some continue for a longer time without forming an addiction or becoming known to authorities as a drug abuser. Only a small number of all who have tried drugs develop such an extensive and problematic abuse that it comes to the knowledge of the authorities"*⁵⁰.

b. Local household surveys

No local household surveys have been conducted in Sweden. In the Netherlands household surveys have taken place regularly in some big cities. As expected life time prevalence drugs is much higher than last month's use. Cannabis is the most used drug.

Besides the National survey conducted in 1997 local household surveys have been conducted in several cities.

Amsterdam

Household surveys are carried out by the Centre for Drug Research (CEDRO) of the University of Amsterdam as part of the drug policy research programme of the city of Amsterdam. They have been carried out in 1987, 1990, 1994 and 1997, using the same method so that changes in the pattern of drug use can be identified.

⁴⁸ CAN Rapport 2000.

⁴⁹ *ibid.*

⁵⁰ Olsson et al (1999).

Respondents: Inhabitants of the local authority of Amsterdam over the age of 12, excluding the homeless, drug tourists and prisoners.

Objective: To collect general data on drug use that can be regarded as representative of the general population of Amsterdam.

Method: The method being used was as follows: For the 1997 study the survey population is defined as all persons in the Municipal Population Registry of Amsterdam, recorded on January 1st of 1997, age 12 years and older. In the period April 1997 to April 1998 almost 8.000 inhabitants of Amsterdam aged 12 and above were asked to take part in a household survey on drug use and lifestyle⁵¹. A total of 3.798 respondents were interviewed. The questionnaire was almost identical to the previous ones. In the previous surveys the respondents were asked questions by an interviewer. A different approach was adopted for the 1994 survey: 2 179 persons were interviewed, while the other half (2 185) completed their questionnaires on a computer. The reason for dividing the sample into two was the assumption that people answer more freely if they do so on a computer: answers are less likely to be influenced by feelings of embarrassment, fear of rejection or simply bragging about drug use. In addition to the normal questionnaire, in 1994 respondents were asked to fill in an "SF-36" health questionnaire. The respondents themselves entered answers to the questions on general health.

Frequency: The survey was carried out for the first time in 1987 and was repeated in 1990, 1994 and 1997.

Results: The household surveys carried out by CEDRO show that:

- the lifetime prevalence of the use of cannabis had increased from 23.2% in 1987 to 36.3% in 1997. Last months prevalence increased from 5.6% in 1987 to 8.1% in 1997;
- the life time prevalence rate of heroin was 1.1% in 1990 and 1.7% in 1997. The rate of last month use had slowly increased from 0.0% in 1987 to 0.2%in 1997;
- in 1987 the lifetime prevalence of cocaine was 5.7%, in 1997 the rate was 9.3%. Last month use was 0.6% in 1987 and 1.0% in 1997;
- life time prevalence for amphetamines was 4.5% in 1987 and 5.9% in 1997. Last month prevalence was 0.3% in 1987 and 0.3% in 1997;
- lifetime prevalence of ecstasy had increased considerably from 1.3% in 1990 to 6.9% in 1997. Last month prevalence rate was 0.1% in 1990 and had increased to 1.1% in 1997)⁵².

Sweden

No household surveys on drug use in cities have been conducted in Sweden.

⁵¹ The market research institute NIPO had executed the surveys of 1990, 1994 and 1997. Trained NIPO interviewers are being used to avoid selective non-response.

⁵² Abraham, Cohen, Van Til, Langemeijer (1998).

c. Surveys among youth

In the Netherlands and in Sweden surveys among young people work with different age groups which makes direct comparisons impossible.

The Netherlands

In co-operation with the public health inspectors, the NIAD carries out the young person's health surveys. In 1984 the first such survey of smoking, drinking and cannabis use was carried out by the SWOAD, the forerunner of the NIAD, in co-operation with the health inspectors and the Netherlands Association for Health Care. This survey provides representative data on the situation in the Netherlands as a whole with regard to young people attending school. This research provides results that can be compared, because the questionnaires of the study are almost identical, so trends in substance use are easy to deduce. Standard survey methods have been used since 1984. The SWOAD survey in 1984, the NIAD/VU survey in 1988 and the NIAD survey in 1992 all related to the young people's health survey. Accordingly, it is possible to say something about developments in the use of soft drugs by children of school age. In 1996 the NIAD changed their name to the Trimbos institute. The Trimbos institute is an executive body appointed by the Ministry of HWS. It is the Dutch focal point of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

The last of these so-called "Peilstation onderzoeken" was executed in 1996.

Respondents: Representative selection of pupils between the ages of 10 and 18 in full-time elementary and secondary education. The sample consisted of 10104 pupils, 2888 respondents from schools for primary education and 7216 from schools for secondary education. The selection is based on CBS statistics of the total population of pupils in elementary school and all pupils of secondary school of all levels of difficulty.

Objectives:

- acquiring an understanding of the prevalence and incidence of smoking, and alcohol and drug use, gambling and minor criminal offences - individually and combined - for young people aged 10 to 18;
- identifying background characteristics of use within the total survey population;
- comparing the results with data from other countries and with previous Dutch research.

Method: Two questionnaires are used. They are distributed to pupils from the age of 10 undergoing full-time education; one version is for elementary education and one for secondary education. The questionnaires are structured in more or less the same way, although the elementary education version is considerably simpler. The content of the questionnaire is constant, with only one or two questions being added. Questions on the use of hard drugs are included only in the questionnaire for secondary education⁵³.

Frequency: Every four years.

⁵³ de Zwart (1998)

Results:

- life time prevalence of cannabis among young people increased from almost 5% in 1988 to 20% in 1996. Last month use has increased from 2% in 1984 to 11% in 1996;
- the percentage of pupils aged 12 and above who have tried heroin is low. 1,1% of respondents say they have used heroin. Use of these drugs in the last four weeks was minimal, i.e. 0.5%;
- in 1992 less than 1% of respondents had ever used cocaine. Last month use was minimal, i.e. 0.2%. In 1996 2,9% of all students of 12 and older ever used cocaine. Last month use was 1,1%;
- questions concerning ecstasy were first included in 1992. The 1992 survey shows that ecstasy is the most popular hard drug among young people: 3.3% of respondents admitted to having used this drug, while 1% had used it in the previous four weeks. In the survey from 1996 of all the pupils of 12 years and older 5.6% had used ecstasy. Last month use was 2.2%;
- amphetamines are the most popular hard drugs after ecstasy. The lifetime prevalence of the total number of young persons over the age of 12 who were interviewed in 1992 was 2.1%. Use in the previous month was 0.6%. In 1996 lifetime prevalence was 5.1%. Use in the previous month was 1.8%⁵⁴.

Information on risk groups

In 1996 the Trimbos Institute has conducted a survey on behalf of the Ministry of HWS on the use of ecstasy, which included an epidemiological study of its use at large house parties. Amongst more than 1000 visitors of house parties 64% had taken ecstasy⁵⁵.

In 1997 a second survey was conducted to examine the use of illicit drugs and gambling by pupils at the so called secondary school for special education (VSO) and by youths participating in help projects for truants. The first survey was held in 1990. This is another example of research among identified risk groups.

A sample of 1.566 pupils from VSO and 323 from the truant project were selected. The objectives of this survey are as follows: First to gain insight in the prevalence of smoking, alcohol and drug use and the connection with skipping school. Secondly to identify the background elements of the use by the survey population.

Compared to the results of the Peilstation surveys pupils from VSO and truant projects scored higher on last months drug use than regular schools. Participants of truant projects scored higher on all drugs than VSO pupils⁵⁶.

Antenna's survey of young people in Amsterdam

The Jellinek Centre in co-operation with the Bongers Institute at the University of Amsterdam carries out annual "antenna" surveys among young people in specific risk situations in Amsterdam.

⁵⁴ de Zwart, Stam, Kuipers (1997).

⁵⁵ Trimbos Instituut (1999).

⁵⁶ Stam, Mensink, de Zwart (1998).

Objective: To collect data on drug use amongst secondary school pupils and to collect comparable data for groups of young people at risk of drug use.

Method: In 1995, 596 pupils between the ages of 14 and 17 in the upper years of secondary schools were interviewed. In addition to this general group, a group of young people at risk was also approached. In 1994 the risk group were young people who were known to be frequent coffee shop visitors, and in 1995 young people who visited house parties and discotheques. Participants were asked to complete a questionnaire. A third source of data is information provided by a panel of experts that reports the latest developments twice a year. The target group for the 1998 Amsterdam antenna survey consisted of persons who were active in the city's night life: trendy clubbers and ravers⁵⁷.

Results: The 1998 survey among trendy clubbers and ravers (N=465) showed that compared to the survey in 1995 ecstasy is still the second most used illegal drug (after cannabis). Noticeable is the sharp increase of cocaine use in this (risk) group. The lifetime prevalence of cocaine in 1998 was 48% (1995: 33%), last month use was 24% (1995: 14%) and last night use was 11% (1995: 7%).

In addition to these surveys, mention must be made of the regional and local surveys, which in many cases are carried out by the local health authorities that survey drug use. Sometimes they are carried out as part of a general health survey of the population, and sometimes only young people are surveyed. Although this regional data provides a representative picture at regional level, it cannot be extrapolated to the national level. Furthermore, research methods differ quite markedly between regions, which means that a reliable comparison of data is not possible. In order to produce more compatible data the Monitor Alcohol and Drugs (MAD) model has been developed. By using standardised surveys and information provided by assistance and police in regions and cities relevant information can be obtained that can be used for policy development by local and central government. Using key-informants, qualitative fieldwork and small randomised surveys collects data that cannot be obtained from registers and surveys. Data is collected on the subjects of estimating the prevalence of illegal drug and problematic alcohol use, reflecting trends in the patterns of use, to describe the relations between users patterns and assistance, the identification of problem groups and risk factors. The results of a pilot study in the regions of Utrecht, Rotterdam and Parkstad Limburg were published in July 2000⁵⁸.

Sweden

Household surveys among youth

From 1971 to 1994 the poll institute SIFO carried out household surveys among youth. Questions about alcohol and drug use were included in an omnibus survey. From 1994 another institute, TEMO that repeats the survey every other year, has conducted the surveys about substance use. Because the methods used by the SIFO and TEMO institutes differ in various ways results are not comparable⁵⁹.

⁵⁷ Korf, Nabben, Lettink, Bouma (1999).

⁵⁸ Trimbos (2000 b).

⁵⁹ Andersson, Lindén-Boström (1998).

Respondents: Young people in the age between 16-24 years. In the SIFO surveys 12-24 years.

Objectives: To chart trends among young people with respect to their drinking habits and drug use. In recent year's questions on the use of sleeping pills, tranquillisers and anabolic steroids were included.

Method: Personal face to face interviews with youths selected by post-code area. Since the beginning of the nineties a gradual shift to telephone interviews has occurred. The sample size is between 1000 and 2000 people. The interviews are followed up by a posted questionnaire containing attitude questions. In the 1996 survey 81% returned a posted questionnaire⁶⁰. The total number of interviewed persons was 2350. The drop out rate of telephone interviews by TEMO was app. 20%⁶¹.

Results: The SIFO surveys (age 12-24) showed a rate of lifetime prevalence of 5% in 1968 followed by a slow increase to 9% in 1971, reaching a peak in the beginning of the 80-s with 18%. The figures decreased again and in 1990 the figures are back at 6%.

The TEMO survey in 1994 amongst youth (15-24) showed a lifetime prevalence of 4%. In 1998 the rate had risen to 11%. The sample is small and hard to break down into age categories. In the 1994 survey the sample was 500 persons. In 1996 the sample was larger, app. 2000, divided in age groups of 200 persons⁶².

Surveys among school pupils

Respondents: Every year since 1971 national data has been collected in a survey among pupils (age 16) in elementary schools⁶³. The exact number of respondents changes every year but generally lies around 6000 pupils.

Objectives:

- a description of the current situation concerning use of drugs among youth
- a description of developments over time.

Methods: By using a clustered selection a representative sample of school classes (N=280) is chosen. Pupils in the selected classes fill out a questionnaire anonymously and under examination, like circumstances in the classroom. The results can not be traced to the individual schools. In the Swedish nine-year compulsory school (7-16 years of age) all pupils follow the same curriculum and no comparison can be made between different courses in this age cluster. The questionnaires contain a number of items reaching from lifetime prevalence of smoking, drinking and drug taking to questions concerning social situation. When the study is presented in the mass media the figure on life time use is highlighted and comparisons are made with earlier years.

Results: The prevalence figures reached an early peak in 1972 when 15% of the boys and 14% of

⁶⁰ CAN rapport 98.

⁶¹ Andersson, Lindén-Boström (1998).

⁶² Ibid.

⁶³ The same survey is conducted in grade six (12 year) every other year.

the girls reported that they had used drugs at least once. In 1974, soon after the peak prevalence went down to 9% for boys and 8% for girls, figures that remained stable for ten years. During the first half of the 1980-s there was a new decline with the result that during the second half of the 1980-s the life time prevalence went down to 3-4%. The 1990-s showed an increase and by 1996 8% of the boys, 7 % of the girls had used drugs at least once. Also this time the figures had stabilised on just about the same level for some years. The results from 1999 show that 9% of the boys and 7% of the girls have ever tried drugs. Last month prevalence was almost 3% for both sexes. The drug in question is solely cannabis for more than two thirds⁶⁴. While the numbers have increased it is important to keep in mind that more than 90% have not tried drugs. Also the attitudes against drugs are negative. In 1999 less than 10% of the abstainers admitted that they have felt tempted to try drugs.

Surveys among military conscripts

Respondents: All Swedish boys go through a two day long test to find out if they are suitable for the military service. Since 1970 all military conscripts answer a questionnaire on life style issues.

Objectives: To collect data on prevalence, type of drug used, date of first time use, access to drugs, last month use.

Method: No selection is made. All conscripts fill out a questionnaire anonymously under examination like circumstances. The questionnaire contains 19 questions, 9 of them about drug use and takes 15 minutes to complete. Data concerning social background, for example housing and education are also included⁶⁵. The results are provided and reported by CAN.

Results: The studies among conscripts show a similar picture as among school pupils. During the 70-s around 18% had used drugs with a peak of 19,2% in 1980. During the 80-s the figures went down and the all time low was in 1988 and 1992 with 5,8%. Later in the 90-s prevalence has risen again and in 1999 the figure was 17%, which is almost the same level as in the seventies.

There are considerable regional differences with higher figures in the largest three cities - Stockholm and Malmö 27% and Gothenburg 23%. The main drug is cannabis but 4% of the conscripts have tried amphetamine and 1% heroin. The boys who have tried drugs drink more alcohol, smoke more, have less education and live by themselves more often than the abstainers.

Local surveys among youth

At the local level surveys among students have been conducted in the Stockholm and Malmö regions that show developments over time.

Stockholm

Respondents: A survey among students in second grade of upper secondary school (age 17) in three municipalities in the Stockholm region was conducted in 1991 and repeated in 1996. The

⁶⁴ Andersson, Hibell, Sandberg (2000).

⁶⁵ Guttormsen (2000).

cities have different socio-economic structures (with Täby at the top and Botkyrka at the bottom).

Objectives: To study lifetime prevalence in 1991 and 1996.

Methods: The study was methodologically careful with a randomised sample of about 2000 in Stockholm and in the other two cities all students were surveyed with about 500 students taking part in each city. The drop out rate in Stockholm was 17% both years, Botkyrka 19% both years, Täby (1991 23% and 1996 16%).

Results: In 1991 there were considerable differences between boys from Stockholm and the two other cities. In Stockholm 20% had tried drugs, in Botkyrka 7% and in Täby 13%. For girls the picture was different with 9% in Stockholm and Botkyrka and 6% in Täby. Five years later all the figures had increased and now the picture was similar in all three cities. In Stockholm 24% of the boys had used drugs, in Botkyrka and Täby 21%. For girls now Täby had the highest figure, 17%, Stockholm had 14% and Botkyrka kept its lower figure, 9%⁶⁶.

Malmö

A survey conducted in Malmö in southern Sweden showed about the same picture.

Method: All students the same age categories as in Stockholm were surveyed by means of a questionnaire. 1994 N = 2065. 1997 N = 2298. Drop out was low, 13.9% in 1991, 11.0% in 1997.

Results: Lifetime prevalence for boys increased from 16.9% in 1991 to 25.7% in 1997. For girls the figures are: 14.3% in 1991 to 15.1% in 1997⁶⁷.

Difficulties

When interpreting surveys and especially the variable “life-time prevalence” there are some difficulties when drawing conclusions.

First there is the problem of drop out. Not all students in the sample fill in a questionnaire. CAN has analysed the consequences of drop-out in school surveys. They found that pupils in the dropout group scored higher on questions concerning smoking and drug use, as well as on other background factors usually connected with drug use. But when included in the large elementary school pupil survey the effect of drop out was not more than one percent on the total result. The higher the drop out the more cautious one should be in interpreting the results of a survey of this kind⁶⁸. Another problem with surveys among students is that young people who have quit school are excluded. The quitters have a special profile just as the dropouts. In Sweden this problem partly can be solved by the surveys among conscripts.

A shortcoming with the Swedish national surveys among youth is that they only provide data on two age categories: 16 (compulsory school) and 18 (conscripts). No national data are available for other age categories. This lack of data might be important because local surveys among

⁶⁶ Grönberg (1997).

⁶⁷ Borgfors, Bylund 1998).

⁶⁸ Grönberg (1997) (Andersson, Hibell 1992).

school pupils shows that a considerable number of youngsters have their first experience with drugs after compulsory school. In the Stockholm region the rate was between 46 and 62% and in Malmö 33%. This is also confirmed by the 1996 conscript survey, where 73% of the boys with drug experience had their first experiment after compulsory school⁶⁹. This condition has been recognised by the national Drug Committee which has proposed to conduct surveys in the age group between 15-24 years.

d. Case-finding studies concerning heavy drug abuse

Heavy drug abuse attracts a special interest because of its consequences for the individual and for society. It is difficult to catch with traditional survey methods. Instead the method of case finding has been used for some years in Sweden and in the Netherlands. Unfortunately studies of this kind are hard to compare because of different definitions and different research designs.

In the described surveys from both countries experiences with drugs generally mean cannabis and concern experimental and occasional use of the drug. The household studies only include persons living in a household possessing a telephone. Difficulties in reaching heavy drug abusers by household surveys are well known.

The definitions of heavy drug abuse differ between the two countries, making comparisons difficult. In the Netherlands by heavy drug use is meant heavy heroin use. In Sweden definitions are wider, daily and almost daily cannabis and amphetamine abuse are included. All injection of drugs, regardless of frequency, is defined as heavy abuse.

Information on the number of persons with heavy drug abuse often serves as a yardstick for measuring society's drugs problems. Comparisons of results over time are also used to evaluate the effects of drug policies. Interpreting data in this area is complicated due to a number of reasons.

The most important obstacle in gathering statistical information on the heavy abuse is the illegal nature of drugs. Information about drug habits is likely to be ambiguous because respondents will not always admit to drug use. There is also a lack of willingness to participate in surveys. In general, the scientists assume that the less illegal the use of certain drugs and the less moral condemnation of their use, the more complete the picture will be of the use of such drugs. Furthermore, it is not possible using household survey techniques to contact some heavy drug abusers because they have no fixed residence, live on the streets or are in prison.

Secondly there are numerous pitfalls due to differences in research designs used to collect data. Of importance here are the differing definitions used to separate heavy drug abuse from recreational use. Is cannabis included as a hard drug? Another problem is the quality and the source of data, etc.

Comparisons between different periods or between different countries are often hampered by the same problems as described above. Given that the compatibility of studies within one country is

⁶⁹ Guttormsen (1997).

problematic and surrounded by cautions for comparing results, these restrictions are particularly valid for cross cultural comparisons.

Case-finding studies

In both countries secondary sources are used to collect data on heavy drug use. The method of case-finding studies is used, i.e. information from authorities that count the proportion of drug addicts among their clients.

In the Netherlands the use of drugs has been decriminalised and there is a low threshold for providing help for hard drugs, with the result that quite a good picture is obtained of the scope and nature of drug use compared with other countries⁷⁰. The estimates are based on information from addiction units and the police. However there are a number of drug users who have no contact with any drug units.

The hard drugs most commonly used are heroin, cocaine, amphetamines and ecstasy. There is also an increasing poly-drug use. Compared to other drugs the use of heroin is often associated with readily apparent serious problems, such as social deprivation, poor health and crime. In general the population of heroin addicts consists of unemployed, poorly educated single males. Users of this hard drug also come into contact more frequently with drug units and the police. This means that there are relatively reliable statistics on them.

Also in Sweden, attempts have been made to assess the extent of hard drug abuse on the basis of case-finding methods. This means that people who, through their profession, come into contact with drug abusers report to the researcher. A number of statistical methods are then used to calculate the number of unrecorded cases. Besides the police and addiction units information is provided by social service, health service, prisons and probation.

The Netherlands

Attempts to estimate the number of heavy heroin addicts have been made several times. The first figures on heroin use date from 1979 and 1983 and they are an extrapolation of treatment figures⁷¹. Driessen reported that in 1989 the number of users was estimated to between 10 000 and 20 000⁷². Other researchers counted between 20 000 and 30 000 in 1983⁷³.

According to the National Drug Monitor the number of opiate addicts in 1998 was estimated at between 25 000 and 29 000. Estimations on the number of cocaine users are not available⁷⁴. This situation reflects the very different attitudes in the Netherlands to cocaine compared to heroin, (where cocaine use is not by definition problematic), while heroin is seen as a very heavy drug.

In the government's drug memorandum of 1995 the figures are presented from surveys carried

⁷⁰ Memorandum on Dutch drugs policy. Continuity and change. Lower Chamber, sitting year 1994-1995, 24 007, Nos. 2-3.

⁷¹ Spruit, de Zwart (1993).

⁷² Driessen (1990).

⁷³ Spruit, de Zwart (1994).

⁷⁴ Nationale Drugmonitor (1999).

out by the Intraval agency⁷⁵. This survey was an estimate of opiate addicts on the basis of extrapolation from aid organisation figures.

Objective: The aim of the case finding study was to find out the number of hard drug users in the Netherlands and their links with crime. Data supplied by the police and drug addiction centres are used. The survey is a secondary analysis: the figures collected at local authority level are extrapolated to the national level⁷⁶.

Method: Data supplied by the police and drug addiction centres are used. The number of registered opiate addicts is used as a basis and experts are asked to estimate how many clients they see. The inventory is a secondary analysis: the figures collected at local authority level are extrapolated to the national level and an estimate of the total population of opiate addicts is made. 16 local authorities where some sort of drug survey already had been carried out or where data on drug use and drug users had been systematically collected the data. In addition there are interviews with contact persons and key informants. One reason why it is easy to monitor this group is the large number of methadone programmes⁷⁷.

Results: The number of heroin addicts in the Netherlands was estimated at 27 000, or 0.2% of the population over the age of 15. The average age is at present about 33.

A comment needs to be made on this form of extrapolation. The figures relate to recorded users. The existing recording systems have a number of disadvantages for epidemiological research, which makes them less reliable; these disadvantages are related to the method of recording. The method stands or falls by the validity and reliability of the estimates of experts on the extent of aid provided. As stated above, Driessen's survey in 1990 produced a lower estimate. However, there is no indication that the number of heroin addicts has increased significantly in recent years, which is the conclusion one might draw from the research by Driessen and Intraval. It is more likely that the number of addicts has been over-estimated because the percentages of addicts in contact with assistance used in the past were too high⁷⁸. Although the number of people reached by the drug aid organisations can be regarded as fairly high in the Netherlands - it is estimated at 70%-80% - data based on information from the bodies involved are not sufficient⁷⁹.

What is true of heroin – where there is availability of relatively good data concerning this group of users through contacts with drug centres - does not apply to cocaine users. It is assumed that the majority of the users tend to use cocaine for recreational purposes and they are not known to assistance organisations. Special research methods need to be used to collect information on this category of cocaine users. In Rotterdam “Snowball sampling” was used for the Rotterdam survey: 110 persons were interviewed who in turn provided information on 1 051 users⁸⁰.

The snowball method was also used in the Amsterdam survey carried out in 1987⁸¹. This research

⁷⁵ Bieleman, Snippe & Bie (1995).

⁷⁶ The survey covers the following cities: Amsterdam, Rotterdam, The Hague, Utrecht, Groningen, Maastricht, Arnhem, Enschede, Breda, Dordrecht, Alkmaar and Leeuwarden.

⁷⁷ Trimbos Institute (1998).

⁷⁸ de Zwart, Mensink (1996).

⁷⁹ Trimbos (1998).

⁸⁰ Intraval (1992)

⁸¹ Cohen, P. (1989)

was carried out by CEDRO. Interviews were conducted with persons who had used cocaine 25 times or more often.

Sweden

To collect data on heavy drug use national case-finding studies have been carried out in Sweden in 1979 and 1992.

Method: In the national case-finding study 1979 local authorities throughout the country, that could be expected to come into contact with drug abusers, were asked to report all persons to have been known drug abusers during the last six months. To guarantee confidentiality but to avoid double counting each person was identified by his or her initials, year of birth and day of birth. From the whole population of known drug abusers the researchers selected the severe drug abusers. The definition used to identify severe drug abuse is all intravenous drug abuse and all daily and almost daily drug abuse including cannabis. An assessment of the number of unknown drug abusers was done by the capture-recapture method.

In 1992 the same researchers, but this time with a representative sample among municipalities, repeated the case-finding study. The notifying period was extended from six to twelve months. The researchers tried to take these methodological differences into account when interpreting the results compared to the survey from 1979.

Results: According to the 1979 survey the estimated number of severe drug abusers in Sweden was 10 000-14 000 persons. Of these 7 500-10 000 were intravenous drug abusers. 80% had abused amphetamines. Of the total number 60% had been reported from the three big cities. The average age was 27.

In the second survey in 1992 the number of heavy drug abusers was estimated at 14 000-20 000. Intravenous drug abusers were 93% of the total number of heavy addicts. 77% abused amphetamines. The biggest change occurred concerning the drug of preference, 15% preferred heroin in 1979 and 26% in 1992⁸². The average age had increased to 32 years. Although the number of reported young was very small a low but continuous inflow of heavy drug abusers seems to have occurred between 1979 and 1992⁸³.

Local case-finding studies have been conducted in the big cities. Stockholm: 1967, 1979, 1984, 1992, 1995, and 1996. Malmö: 1977, 1979, 1987, 1992, and 1996. Gothenburg: 1979, 1987/88. The case-finding studies were conducted in different ways with different designs. This causes difficulties in comparing results of the studies over time and between cities⁸⁴.

The case-studies method has become less useful due to a decline in societal work with drug abusers, resulting in less contact with drug abusers and less knowledge of patterns of use among clients⁸⁵.

⁸² Olsson, Byqvist, Gomér (1993).

⁸³ CAN rapport 98.

⁸⁴ CAN rapport 98.

⁸⁵ Olsson, B, in SOU 1999, bilaga 2. Olsson took part in the two UNO-studies and is currently working with updating the figures.

A new case-finding study by CAN among marginalised groups started in 1998 in a number of cities. The results are expected to be published in 2000.

e. Information systems concerning the demand for aid and care

Information from treatment facilities and aid organisations could provide useful information about the drug situation in a country. This source of information is still not used in a sufficient way. More information is collected in the Netherlands than in Sweden, but co-ordination of data from different service providers is lacking. This means that it is hard to get an overview of how many people have received what kind of treatment for whatever reasons in the two countries.

The Netherlands

In addition to population surveys, figures from treatment organisations are an important source of information on drug use and drug related problems. This section discusses briefly the ways in which information is gathered in the Netherlands.

As concerns the number of people that aid organisations reach views are divided. According to estimates by the Ministry of Justice, 75% of the number of addicts have contact with such bodies⁸⁶. According to the IVV, the figure is 85%⁸⁷. Concerning opiate addicts the Trimbos estimate the number in contact with assistance agencies at between 70% and 80%.

Estimates of the number of people that aid organisations reach differ considerably, which casts a shadow on the validity and reliability of this source of information. For example, there will always be one group of drug users which have no contact with any aid organisation whatsoever⁸⁸. Information concerning the group which has never sought help from aid organisations comes mainly from the police concerning drug users they have arrested. Furthermore, a considerable space of time may elapse between starting the use of drugs and the eventual decision to contact an aid organisation, and the aid figures provide no information on this period. A pilot study conducted for the EMCDDA showed that the average latency time between first use of opiates and first demand for treatment in Rome, London and Amsterdam was 7-8 years⁸⁹.

There are two specialised information systems on aid: the national alcohol and drugs information system (LADIS) of the addiction care information foundation (IVV) and the patients register of intramural mental health care (PiGGz).

LADIS collects information from organisations in the category of ambulatory care. The information relates to variables like age, gender, ethnicity, type of substance, and so on. The

⁸⁶ Ministry of Justice (2000).

⁸⁷ IVV. The possibilities of LADIS for the Pompadour group. Utrecht: Stichting Informatievoorziening Verslavingszorg (1996).

⁸⁸ This is a major problem for scientific research, since the picture of the group as a whole is formed on the basis of features of a sub-group who can be seen or surveyed.

⁸⁹ EMCDDA (1999).

standardisation introduced by LADIS makes national statistics possible, and these statistics have been published annually since 1986. These statistics cannot be traced back to institutions or individuals. In order to prevent the same people being counted twice, the IVV introduced a unique client code in 1994. From 1998 all facilities and municipalities involved with ambulatory care are committed to deliver data to the LADIS. The Central Methadone Register (CMR) in Amsterdam and the Streetcornerwork foundation are the only units not participating yet.

The second major national information system is the register of inpatient mental health care (PIGGz), which contains data on patients taken into institutions for mental health care, including addiction clinics. The system records personal features, diagnosis, and type of entry and data on release. The International Classification for Disease (ICD) codes are used for diagnosis.

Results:

Ambulatory care

The following conclusions can be drawn from the data from the LADIS information system. The total number of persons treated by ambulatory assistance in 1999 was 53.863. Drug users formed the majority 48.9%, followed by alcoholics 41.9%. The average age of drug clients was 33.8 years. Of the hard drugs clients 10.666 persons participated in a methadone programme. A minority (12.9%) of the opiate users inject the drug. More than 70% prefer smoking the drug.

Heroin addicts form the largest group of persons seeking help. The number of cocaine users did increase considerable in 1998 while the number of users of ecstasy and amphetamines decreased sharply. The number of cannabis clients (3.281) stayed the same as in 1998. However, after the type of drug has been recorded, LADIS provides no further information on the nature, duration and method of use⁹⁰.

Intramural care

Special addiction clinics and special wards at general psychiatric hospitals (APZ) execute Intramural care of drug addicts (and alcoholics).

The number of admissions to drug clinics, including general psychiatric hospitals, in 1996 and the type of drug was:

Table 1: Admission to intramural care by type of drug

Cannabis	Cocaine	Heroin	Ecstasy/Amphetamine
309	306	3055	58

Several pieces of data point to a steady increase of the number of beds in these facilities as well as the number of patients (from 1.117 beds in 1994 to 1.474 in 1998). Like in ambulatory care the proportion of drug users has also increased while the proportion of alcoholics has remained stable.

⁹⁰ IVV (2000).

Day care as an alternative to intramural care has increased considerably during the second half of the nineties (from 78 beds in 1994 to 138 in 1998). The existence of waiting lists for intra mural care as well as for ambulatory care shows that the total capacity of assistance is not sufficient⁹¹.

Sweden

Information from treatment centres is traditionally quite poor, especially concerning ambulatory care where a central registration of persons in treatment does not yet exist. For patients in intramural care statistics are collected and presented by the Central Bureau of Statistics (CBS) on sex, age, and type of substance use and duration of treatment.

Ambulatory care

In Sweden the social services are responsible for the main part of treatment of alcohol and drug abusers. Besides this, the social services take care of a substantial part of ambulatory care and in big cities also of intramural treatment. Due to budgetary reductions ambulatory care has replaced intramural care in many sites during the nineties. A systematic national recording of data concerning the clients of ambulatory care is under construction. One local exception is the Maria Polyclinic for Young People in Stockholm that produces annual data on the number and characteristics of youth seeking assistance. Also the Social Service in Stockholm keeps record of drug abusers who have made use of the social service or health services.

At the national level two inventories were made in the nineties (1996 and 1998) to get a picture of facilities that are involved in ambulatory care by the Social Services⁹². Approximately 54 000 measures of care were executed in 1996, more than half within outpatient care, for example structured day-care, treatment and counselling by specialised agencies or social service offices, support from contact persons (volunteers offering help on a personal basis), etc. Currently a new information system to systematically collect data from social services is under construction by the National Board of Health and Welfare. In a first report including data from this new information system it was emphasised that due to a new information system the quality of the data presented is not satisfactory and the first years and results should be interpret with care⁹³.

As concerns data on measures by the Social Services for substance abusers the National Committee on Narcotics has recognised “a serious lack of knowledge” on which facilities are used for what type of abusers. This is due to the fact that data is not based on individuals. The committee has proposed a Bill in which the social services are obliged to deliver such data to a central registration.

Intramural care

Traditionally, intramural care has had a stronger position than ambulatory care and here the situation concerning data is better. The National Board of Health and Welfare provides data on drug abusers staying in residential care. In 1997 the number of treatment facilities and boarding houses taking care of adult abusers was app.350. Of these 300 are open for both alcoholics and

⁹¹ RVZ, RMO (1999). Dossier verslaving en verslavingszorg.

⁹² Socialstyrelsen (1996), Socialstyrelsen (1998).

⁹³ Socialstyrelsen (1999c).

drug abusers. The total capacity was 6500 beds, but no distinction is made between treatment facilities and boarding houses. This means that no specified data can be provided on the type of treatment and if treatment is executed at all⁹⁴.

On December 31st 1997 around 3000 substance abusers were staying in an intramural assistance setting on a voluntary basis. Of these 45% were alcohol abusers, 15% drug abusers and 30% poly drug abusers. The total number of admissions during the whole year is not registered⁹⁵. According to the latest assessment from 1994 in one year between 10 000 and 14 000 individuals were treated in residential care (both voluntary and coercive treatment, hospitals not included)⁹⁶.

The SiS provides data on coercive treatment. The research department of SiS is developing a documentation system, in which agencies for voluntary treatment can also participate. On November 1999, 257 clients were staying in coercive treatment. Of these 38% were drug abusers, 42% were alcohol abusers and 20% a combination of alcohol and drugs⁹⁷. In the nineties the number of clients was reduced sharply, from 748 on December 31st 1989 to app. 300 in 1998.

Patients in psychiatric care

Another source of information is statistics provided by the National Board of Health and Welfare and the Centre for Epidemiology concerning patients treated by psychiatry. Within the Health Service the majority of drug abusers are treated by psychiatry. This concerns both detoxification and treatment of mental complications caused by drug abuse. The number of discharges of patients from intramural treatment with the diagnosis narcomania (ICD 304) has increased considerably. In 1987 the number of such discharges were 3405, in 1996 it had increased by 69% to 5767. As a result of the overall deinstitutionalisation of intramural psychiatry the total number of patients has been reduced, although to a lesser extent among drug addicts. (From 0,7% of the total number of patients in intramural psychiatric care in 1979 to 4,8% in 1997)⁹⁸.

f. Health statistics

Even to compare the numbers of drug related deaths in the two countries is difficult. Substantial differences can be notified concerning identification of relevant cases, processing and classification of data and finally the collection and reporting of cases. Similar problems appear with statistics on admissions to hospitals and cases of Aids.

Drug related deaths

Data on drug related deaths could be considered as an important indicator for estimating and monitoring developments in problematic drug use. In the case of the Netherlands the relatively low deaths rate among drug addicts is often put forward as a positive outcome of the Dutch drug policy which has the reduction of harm as a guiding principle. The rate of drug related death has been stable for a number of years. The death rate in Sweden on the contrary has increased during preceding years. In a superficial comparison this indicates that drug related death among Swedish

⁹⁴ Socialstyrelsen (1998).

⁹⁵ Socialstyrelsen (1999a).

⁹⁶ Socialstyrelsen (1998).

⁹⁷ Socialstyrelsen (1999).

⁹⁸ CAN Rapport 99.

drug users occurs more frequently than among the Dutch. A closer look shows the problem of comparing death rates.

To examine the difficulties in comparing data on drug related death an EU working group under co-ordination of the Trimbos institute in the Netherlands has investigated practises and figures in the EU countries⁹⁹.

According to the report the quality and comparability of statistics on drug-related deaths can be influenced at many successive levels during the data generation process.

Three stages can be identified:

- a. identification or detection of cases
- b. data processing, classification and coding
- c. data collection and reporting.

a. At the first stage the identification and detection of cases of drug related death the situation in both countries is quite different.

Two kinds of registers are usually used to collect data on drug related deaths. A General Mortality Register (GMR) and a Special register (SR). The GMR is a register run by the national bureau of statistics. In both countries the International Classification of Diseases (ICD) codes are used to code causes of death. The big difference can be identified in the field of the SR concerning the rate of forensic autopsies in cases where drugs are suspected to be involved in the cause of death. In spite of the fact that the relationship between concentrations of drugs in the body and death is not always clear, toxicological analysis is seen as indispensable in all questionable drug-related deaths.

In the Netherlands autopsies are done in cases of unnatural death or suspicion of it, when legal authorities (i.e. the public prosecutor) think it is necessary and order it by force of law. If a doctor feels unable to issue a certificate of natural causes of death, the police call in a consultant doctor. If the consultant records unnatural death, his report is added to the Public Prosecutor's file. The corpse is then subjected to a post mortem exam to investigate the presence of all prohibited drugs and methadone (cannabis excluded). The proportion of exams in case of drug related death is not known but local studies indicate a percentage in the range of 30-40.

In Sweden the law prescribes that all cases where the influence of drugs is suspected or has to be excluded have to undergo forensic examination. The police decide. A study in Stockholm showed that up to 90% of the known drug addicts who died had been examined forensically, including a toxicological analysis¹⁰⁰.

An autopsy is conducted at a hospital if the physician is not able to establish the cause of death. In the case of suspicion of an unnatural death an autopsy is conducted by forensic medicine to examine the cause and circumstances of death - natural, accident, murder, suicide or abuse of drugs or medicines. An autopsy is considered as the most reliable way to establish a cause of

⁹⁹ Laar van, de Zwart (1998).

¹⁰⁰ The number of autopsies in Sweden has decreased from 50% of all deaths in 1974 to 16% in 1996.

death. In 1996, in 71% of all male death cases (female: 53%) in the age interval 15-44 an autopsy was executed¹⁰¹.

In the Netherlands there is no national special register. A comparison between overdose data in the Amsterdam and Rotterdam special register and corresponding data from the national statistics register suggests a serious level of underreporting¹⁰².

Developing registration systems at regional or local level is urgently needed to provide a picture of mortality in connection with drug use and in order to follow developments over time. In late 1997, at the request of the Ministry of HWS, the Trimbos Institute started to look into the way in which drug-related deaths in the Netherlands are recorded. The objectives of this project are both to describe the various methods of recording deaths and to bring together a working group for improving the quality of data.

b. The next stage concerns processing, classification and coding of data. The fact that both countries use ICD codes to classify causes of death does not guarantee comparable data. Each country selects its own set of ICD codes that are used to classify underlying or contributory causes. Underlying causes are directly related to death, e.g. an overdose of heroin while a contributory cause can be said to have contributed to the cause of death. The most important difference though is that in the Netherlands only underlying causes are registered, homicide and suicide are excluded. In Sweden both underlying and contributory causes are used. Accidents, suicides and homicides are counted. In both countries persons who died while visiting the country or drug addicts that died from AIDS are not included in the death register as a drug related death.

The difference can be illustrated by the following example. A man died when he was walking in a park and hit by lightning. The toxicological analysis showed cannabis in the body. In Sweden this case would be coded as a contributory cause of death and be registered as drug-related death. To highlight the difference an example from the Dutch practise follows. For a death to be recorded as a result of an overdose, it must be the result of the active ingredients of the drug itself and not of the side effects resulting from drug use. Accordingly, a fatality at a house party is not recorded as a drug death as it is obviously a death that has occurred as a result of hyperthermia. In this case the active ingredients in ecstasy have not directly caused death, although the use of ecstasy may well have played a role. The same applies with regard to drug use in road accidents. If a person killed in an accident appears to have been using drugs, the fatality would not be registered as a drug death.

In addition to a record of fatalities as a result of overdose, Amsterdam keeps a record of the number of drug users who have died in the city (foreigners included). The figures include deaths as a result of AIDS, accidents, suicide, liver diseases and other complaints. In 1996, 116 drug users died in Amsterdam. In 26 cases deaths were as a result of an overdose and in 39 cases HIV infection was involved. The other cases involve accidents, suicides, liver diseases and other diseases which in Sweden would have been notified as contributory causes of death. The overall trend in Amsterdam has been a steady decrease of drug related death during the nineties¹⁰³.

¹⁰¹ Laar van, de Zwart (1998).

¹⁰² *ibid.*

¹⁰³ Van Brussel, Buster (1999).

The EU working group conducted a case study with the data from the Netherlands and Sweden to illustrate the difficulties when comparing existing data.

When looking at the ICD definitions used by both countries the problems which are connected with the processing and classification of data becomes obvious.

Table: 2 Definitions according to (ICD-9)

Netherlands	Sweden
292 drugs psychosis	304 drug dependence
304 drug dependence	965.0 opiate poisoning
305.2-9 non dependent drug abuse	968.5 poisoning by cocaine and related substances
E850.0 accidental poisoning by opiates and related narcotics	969.6 poisoning by hallucinogenic drugs
E854.1-E854.2 accidental poisoning by hallucinogens and psychostimulants	969.7 poisoning by psychostimulants

In the Netherlands the codes 304 and 305.2-9 are rarely used as an underlying cause of death but more frequently as contributory. In stead E codes are used as underlying cause. Hardly any cases are counted for code 292. So when comparing figures on drug related death it is of crucial importance to know how the ICD codes are classified, as underlying or as contributory.

c. As far as data collection and reporting the main difference is concerned it is the obligation of physicians to provide data to the national register.

In the Netherlands there is no systematic way of reporting deaths as a result of drug use. The figures are based on information supplied by doctors and pathologists, although there is no obligation to supply such information. In Sweden they are committed to providing such information to the national register.

Results in terms of drugs related death

Because of the different case definitions no valid conclusions can be drawn. In a next step the EU working group has analysed the national data on drug related death by a selection of ICD-9 codes as recommended in 1996 by an EMCDDA working group, called Sub-task 3.3. In this selection underlying causes of death are included: 304, E850-E858 and E980.0-E980.5.

Table: 3 The subtask 3.3 selection of ICD-9 codes in cases and rates per million.

	1987	1988	1989	1990	1991	1992	1993	1994	1995
NL	55	54	57	69	63	64	69	74	53
SW	150	158	142	154	166	165	182	179	209
NL	3,57	3,51	3,70	4,48	4,09	4,16	4,48	4,81	3,44
SW	17,05	17,95	16,14	17,50	18,86	18,75	20,68	20,34	23,75

From this table the working group concluded that the number of death in the Netherlands is higher when applying the definitions of the taskgroup 3.3. But the difference between the two countries is largely maintained. The Netherlands shows a stable trend and Sweden an increasing number of drug related death. The negative trend in Sweden has continued, in 1996 there were 250 drug-related death, in 1997 the number was 265. The Swedish National Committee on Narcotics has recognised this negative trend and announced a further investigation into the reasons for it.

According to the EU working group attention should be paid to two factors when explaining the differences between the Dutch and Swedish death rates.

- In Sweden, 30% of the drug-related deaths are based on the contributory cause of death, whereas such cases are not included in the Dutch statistics and,
- The rate of forensic examinations is much lower in the Netherlands.

Besides these factors we would like to add some other possible explanations. Usually heroin abusers are the category of drug abusers with the highest drug related mortality. The steady increase of drug related deaths in Sweden during the nineties has occurred despite the relatively low number of heroin abusers. Half of the drug related deaths were related to opiate abuse¹⁰⁴. One reason is the ageing of the drug abusing population. Among the younger drug abusers (age 19 - 29) mortality has remained about the same through the nineties¹⁰⁵.

The average age of drug addicts has increased in recent years. This means that while the increase in the number of hard-drug addicts is not great, hard-drug addicts are living longer in both countries. Local health authorities report increasing numbers of older and chronically ill drug addicts.

Another factor might be an increase in poly-drug use. The interactive effects of different substances can be hard to calculate for the user. A study about drug related deaths in Stockholm showed that during the period 1985-94 over 500 deaths occurred relating to heroin abuse, in almost all cases due to intravenous abuse of heroin. The causes of death that related to one single drug were rare. In half of the cases alcohol was also found. Other substances regularly involved are benzodiazepines. Cocaine is rare in these cases, probably due to the low prevalence of cocaine in Sweden¹⁰⁶.

¹⁰⁴ Olsson et al (1999).

¹⁰⁵ CAN rapport 98.

¹⁰⁶ Fugelstad, Rajs (1998).

The relatively low number of deaths amongst drug users in the Netherlands despite the higher number of heroin addicts can possibly be explained by the extended network of facilities which users can fall back on. The public health approach - treating addicts as patients instead of criminals - seems to be paying off here. The low-threshold methadone programmes are of importance too: overdosing is less frequent.

One important explanation for the difference in death rate can be the fact that a low percentage of the Dutch drug addicts are injecting their drug (13%) while in Sweden a large majority does so.

HIV and Aids among drug users

Some conclusions can be drawn from data on HIV/AIDS among drug addicts. The rate of infected drug addicts is highest in Stockholm and Amsterdam and concerns mainly heroin addicts. The incidence of AIDS cases related to intravenous drug use has decreased in the second half of the nineties and is described as quite stable.

The Netherlands

In the Netherlands between 1982 and 1998 there were 4 846 recorded cases of people with AIDS. In 1998, 11% of all AIDS diagnosis was related to (intravenous) drug users. Amongst drug users, AIDS is one of the major causes of death after overdosing. Cases of AIDS are recorded by the national AIDS information system that is kept by the health service inspector. However, there is no obligation to report incidents of AIDS so the numbers may be slightly underestimated.

In the Netherlands only local studies concerning HIV-positive drug addicts exist (ranging from 2% to 26%) and a national average is not available. In 1998 the number of people infected with HIV was estimated at between 8 000 and 12 000 in the Netherlands¹⁰⁷.

The prevalence of hepatitis B among intravenous drug users is estimated at 60 to 75%. As concerns hepatitis C more than 80% of the intravenous drug users in Amsterdam are infected¹⁰⁸.

Sweden

In Sweden HIV/AIDS is classified as a sexually transmitted disease and all cases have to be reported by physicians according to the Swedish Law on Contagious Diseases. The National Board of Health and Welfare records all cases of HIV as well as Hepatitis.

From 1986 until 1999 the annual number of newly reported HIV-positive drug abusers has gradually decreased from 205 to 15 cases. The share of newly reported drug abusers of the total of newly reported HIV-positive cases has almost been halved from 21% in 1986 to app. 7% in 1999¹⁰⁹.

In 1997 the total number of people recorded as being HIV-positive was 4 666, including 754 (16%) intravenous drug abusers. The total number of people with AIDS diagnoses recorded until

¹⁰⁷ Trimbos (1998).

¹⁰⁸ Van Brussel, Buster (1999).

¹⁰⁹ CAN rapport 98.

1997 was 1554, including 177 (11%) intravenous drug abusers. The Stockholm region stands for app. 75% of all HIV-positive intravenous drug abusers in Sweden. The majority of these cases are heroin addicts.

g. Law enforcement information sources

Data on the number and quantities of drug seizures are difficult to compare within the country and between countries at least when one wants to use the figures to make a statement about the prevalence of drug use. Anyhow some interesting differences and similarities between them can be concluded upon. Data on seizures in the Netherlands concerns mainly trafficking while in Sweden it concerns possession and use. Figures about seizures do not play an important role in estimating the situation concerning drug use while for Sweden the contrary is true. Both countries have in common that the large majority of drug seizures concern cannabis.

Quantities of seized drugs do not, in general, tell much about drug use in a particular country. The general assumption is that an increase in the quantity of seized drugs simply indicates an increase in trade. This means that the Dutch figures can be related to the country's central position as a transit country for all kind of commodities. Sweden can be regarded, as more peripheral in this respect and Sweden's position as a transit-country of drugs is marginal.

The most common indicator of which and what volumes of narcotic substances are available on the drugs market is provided by seizures made by the police and customs. Customs seizures are mainly of consignments of drugs smuggled into the country, whereas police seizures are done when drugs have entered the country. As a rule, this means that customs seizures are fewer in number but greater in terms of volume than seizures by the police. It must be stressed, however, that statistics on seizures have to be interpreted with great caution, since, in addition to indicating the availability of drugs, they also reflect the police, customs and other law enforcement agencies' resources, strategies, priorities and methods. Also changes in the way data is collected and processed dictates that a comparison over time and between countries cannot be used as a single indicator for describing developments.

With this caution in mind we will give a description of the activities in this field in both countries.

The Netherlands

Information on seizure of drugs in the Netherlands is the responsibility of the Central Research Information Service (CRI). Given that there is no obligation to make returns the data does not cover all seizures. Given that the CRI does not register quantities of less than 5 grams, figures on such seizures will have to be obtained from the data contained in police reports on offences under the Opium Act.

In accordance with the guidelines on the detection and punishment of criminal behaviour pursuant to the Opium Act, personal use is not specifically targeted. There is no question of taking persons into custody for bringing into, or taking out of the area, or for possessing a small quantity of hard drugs intended for personal consumption. Accordingly, there are no random street arrests aimed at seizing small quantities. However, the police will take a repressive view in

the event of drugs sold openly on the streets and will arrest people and seize drugs. If a case is followed up, a report is drawn up on the quantities seized.

Statistics from 1992 to 1998 show a number of trends. For example, there is a noticeable and significant increase in the quantities of cocaine seized (from 3 433 kg to 11 452). As regards cannabis an increase in the seizures of home-grown cannabis (Nederwiet) occurred. In 1992, a total of 313 242 plants were seized, in 1996 the figure had risen to 1 272 526 plants. In 1998 the number was down to 353 178 plants. Recent statistics also show the rise of synthetic drugs. Seizures of amphetamines have increased especially. The establishing of the Synthetic Drug Unit in 1998 might be an explanation for this trend¹¹⁰.

Sweden

The goal for the Swedish drug policy is to obtain a drug free society. Consequently data on seizures of drugs is an important variable to evaluate if the drug policy is leading to that goal.

Guarding the Swedish border to prevent smuggling of drugs into the country is a task for customs and is of highly symbolic value. The Swedish borders to the continent in the South are the first obstacles for traffickers to pass and a lot of effort is made to prevent drugs from coming into the country. Therefore the supply reducing activities carried out by Customs attract a lot of attention in the mass media.

In interpreting data the number of seizures, rather than the amounts, are regarded as the most valuable indicator reflecting the drug situation within the country. One large single seizure can change the whole picture of the total amount seized¹¹¹. Extensive statistics are published every year. Custom personnel regard their efforts to keep drugs from entering the country as their most important task. Actions are directed to wholesale quantities as well as daily doses carried by drug users coming by ferries especially from Denmark. All seizures, regardless of the type of drug or quantity, are reported to the prosecutor. The Customs Department collects data on seizures by Customs.

The police also make seizures. Here also the number of seizures are considered to tell more about the drug situation than the quantities seized. A problem in interpreting figures by the police is that these can be heavily influenced by changes in police priorities and changed routines of reporting drug offences¹¹². The National Police Board collects data on drug offences.

Data on these subjects has been collected since the sixties and longitude series do exist that are used to reflect changes in use, drug policy and activities by authorities.

With the difficulties and complexity concerning the interpretation and comparison of data on the number and quantities of drug seizures we have chosen not to show the results. Instead an account is given for the relation between the number of seizures and the quantities. This clearly mirrors the differences in drug policies in goals for police and custom activities.

¹¹⁰ VWS (1999).

¹¹¹ CAN Rapport 98.

¹¹² *ibid.*

When comparing the variable number of seizures and quantity of seizure the following picture appears.

Table: 4 Seizures in quantity and number

1998	cannabis	Cocaine	heroin	amphetamin es	ecstasy pills	LSD dose
NL kg	118 122	11 437	2 043	n.a.	1673 592	35 964
SW kg	496	19	71	135	21 273	2 704
NL number	2681	1 168	797	n.a.	583	15
SW number	5061	172	1 285	4 859	104	61

As said before the quantities and numbers can vary from year to year but the quantities confirm that the Netherlands and Sweden take different positions in the international trade of narcotics. More interesting in the above table is the proportion between the quantity and number of seizures. The number of seizures in Sweden exceeds those in the Netherlands while the contrary is true for the quantities seized. This shows the different priorities in both countries. In the Netherlands activities are aimed at wholesale dealers and in Sweden the users.

Purity and prices

Another indicator of drug availability on the user level is data on the purity and prices of drugs. Generally it is assumed that the lower the price of a drug the higher the availability. Likewise a high degree of purity of a drug is assumed to indicate high availability. In this respect data on the price and purity of drugs can be used as an indicator of the availability of the drug.

In the Netherlands a number of studies have been conducted concerning the purity of heroin, ecstasy and cannabis. The most striking example are studies on the content of THC in imported and Dutch grown (Nederwiet). The latest study by the Trimbos institute shows that the average content of THC in Nederwiet is slightly higher than in imported marijuana ¹¹³.

Since 1992 ecstasy pills have been analysed by the Drug Information and Monitoring System (DIMS). Studies on the product sold as ecstasy show that the content of these products does vary considerably. This information might have contributed to the strong decrease in popularity of ecstasy as noticed during the last few years.

In Sweden there is no systematic collecting of data in this field.

¹¹³ Trimbos (2000).

Chapter IV: General conclusions

Drug use has led to extensive measures aiming at control in both countries. A major difference is that the Swedish policy is combating all kind of narcotic substances while the Netherlands focus primarily on trade in hard drugs like heroin, cocaine and amphetamine. This is reflected by substantial differences in law and law practise. For example drug use is not criminalised in the Netherlands while the opposite is true for Sweden.

The two countries have a different view of the dangers of cannabis. In the Netherlands so called coffee shops are allowed where soft drugs are sold under certain regulations. These shops are permitted for two reasons: firstly, it is impossible to control illegal trade in cannabis. Secondly under the circumstances it is important to prevent young people that use cannabis, which is judged to have lower risks than hard drugs, from ending up in an environment where hard drugs are also for sale. In Sweden the stepping stone theory in which cannabis abuse is seen as a first step towards abuse of other drugs like amphetamines and heroin has for many years influenced the drug policy. Cannabis is also seen as a menace in itself and the National Board on Health and Welfare emphasises the risks of cannabis, in causing mental diseases and making young people withdraw from society.

When comparing drug policies, difficulties arise since different concepts, definitions and research designs are being used. Also there is a lack of data within certain crucial areas. The objective of this report is to demonstrate the most important problems in comparing the two countries. By showing the obstacles for a comparison we aim to contribute to a discussion that can improve and standardise research techniques and make realistic comparisons possible in the future.

In both countries the word “drug addict” refers to someone with an addiction, usually defined medically and socially. In Sweden all non-medical use is by legal definition considered as abuse. In the Netherlands a distinction is made between abuse and use, with a large part of the consumers falling into the user category.

Prevention holds a strong position. In the Netherlands information usually aims at giving a neutral, scientific view of drugs while in Sweden the concept of clear, deterrent anti-drug messages to the youth is salient. Early interventions among risk groups play an important role in both countries. In the Netherlands with a harm reduction approach, in Sweden mainly as part of control measures.

The Dutch concept of harm reduction and the Swedish concept of a drug free society are contradictory. Reducing harm can be seen as making drug taking less risky, while the struggle for a drug free society often means strong control measures, making life more risky for drug abusers.

The Dutch harm reduction approach fits in the concept of care while the Swedish abstinence oriented approach usually means treatment. In both countries methadone programmes are being used, but the Swedish programmes can be described as a high-threshold programme while the Dutch ones are mainly low-threshold programmes. In Sweden coercive treatment is used both within the prison system and by the Social Act. In the Netherlands coercion is used only under

penal law. The country has a long tradition of ambulatory treatment of substance abusers within a juridical setting, for example probation.

In the Netherlands as well as in Sweden many different parties are conducting research on addiction. A considerable number of studies on drug prevalence have been conducted through the years. A comparison of figures is difficult due to methodological differences, but national trends are possible to follow, since studies are often replicated over time.

Local household surveys have a prominent place in the Netherlands in charting drug prevalence. In Sweden national surveys amongst school pupils and conscripts are used instead as indicators of the general drug situation. Both types of studies fail in reflecting heavy drug use.

Heavy drug abuse attracts special interest because of its consequences for the individual and society but is difficult to catch with traditional survey methods. Instead the method of case finding has been used in Sweden and in the Netherlands. Unfortunately studies of this kind are hard to compare because of different definitions of heavy drug addiction and different research designs.

Information from treatment facilities and aid organisations could provide useful information about the drug situation in a country. This source of information is still not used in a sufficient way. More information is collected in the Netherlands than in Sweden, but co-ordination of data from different service providers is lacking. This means that it is hard to get an overview of the type of treatment and outcome of treatment in both countries.

Even when comparing the cases of drug related deaths between the two countries difficulties occur. Substantial differences can be notified concerning the identification of relevant cases, processing and classification of data and finally the collection and reporting of cases. Similar problems appear with statistics on admissions to hospitals and cases of aids.

Some conclusions can be drawn from data on HIV/AIDS among drug addicts. The rate of infected drug addicts is highest in Stockholm and Amsterdam and concerns mainly heroin addicts. The incidence of AIDS cases relating to intravenous drug use decreased in the second half of the nineties and is now described as quite stable.

Data on the number and quantities of drug seizures are difficult to compare within the country and between countries at least when one wants to use the figures to make a statement about the prevalence of drug use. Data on seizures in the Netherlands concern mainly trafficking while in Sweden they concern possession and use. Figures about seizures do not play an important role in estimating the situation concerning drug use while for Sweden the contrary is true. The large majority of drug seizures in both countries concerns cannabis.

Discussion

Is it possible to compare figures about the extent of the drug problem between Sweden and the Netherlands? No, for the moment it is not relevant. The differences in how fundamental issues are looked upon are too large. For example what is use and what is abuse? Is it possible and/or desirable to distinguish between soft and hard drugs? What role do illegal drugs have in

connection with deaths? What kind of data is meaningful to collect? The differences are both practical as concerning what kind of information doctors have to report and ideological, as if forensic medicine should look for traces of cannabis in the autopsy.

Of course it is possible through international agreements to decide which definitions should be used, but this calls for a top-down governing of research that it may be hard to get free researchers to accept and follow. Crucial for the providing of data is that the informer considers it to be legitimate and relevant. EMCDDA has given priority to develop common criteria and definitions that can be used when data is collected and analysed within the EU.

However, international agreements can not influence factors such as the willingness of drug users to expose themselves to authorities. As a consequence of the Dutch harm reduction strategy drug users have good reasons to contact authorities to get help seeing, as it is available, for example low threshold methadone and accommodation. In Sweden the policy of “it should be tough to use drugs” means that the drug user has good reasons to keep his habit secret. The legal climate in which drug use takes place can affect both answers in surveys and the authority’s knowledge of the drug habits among clients.

Data on drug seizures can reflect developments on the drug market or use among the population, but changes in police and customs activities over time to detect drug crimes and fluctuating resources and priorities must be taken into consideration. Activities and attitudes of social workers and others that professionally meet drug users also affect figures on prevalence in a case finding study.

As we have mentioned earlier the drug issue is permeated with ideology. For example the question of if the forensic medicine profession should look for cannabis in autopsies when an unnatural death is suspected has obvious ideological implications. The Dutch might say that it is irrelevant to investigate the existence of THC since this substance stays in the body for a long time after exposure. The Swedes on the other hand can argue that there are several presumably unexplainable deaths that may depend on cannabis abuse and that these deaths may have to be counted as drug related, which only can be proved through an autopsy.

Our study also shows similarities between the two countries. Both allocate large resources against drug abuse. In both countries there is an obvious interest in dealing with the social problems that come out of drug use. The Dutch liberal model is not a laissez-faire model but an elaborated strategy to meet individual and social drug related problems. Also the harsh Swedish drug policy contains treatment and prevention activities as well as control measures.

What should be done to accomplish measures that would make comparisons between countries fruitful? EMCDDA will probably succeed in their efforts to get EU countries to use standard definitions of, for example, drug related deaths and standardised routines for establishing causes of death, reporting and coding. It is not our task to present proposals in this field but we would like to note one important aspect of a standardisation of data collecting methods.

One conclusion that can be drawn from our report is that the type of data collected is closely related to drug policy. In Sweden data that shows developments in prevalence and attitudes against drugs among youth are very important just like data on seizures of drugs made by police

and customs. This data is an important indicator to evaluate whether the ideal of a “drug free society” is getting closer. In the Netherlands, with its “harm reduction” model, data on risk groups, drug related deaths and the contents of drugs are more important to evaluate the outcome of the drug policy. Another difference is on which level data is collected. In Sweden national data is important while in the Netherlands regional and local data is preferred. Again this difference can be related to the national drug policies. The fight against drugs is a national project in Sweden, while in the Netherlands actions against drug addiction are related to local conditions. In our view it would be wise to pay attention to this aspect in establishing EU standards of data collecting concerning illegal drug use.

The countries could learn from each other. It would be interesting and possible for Sweden to conduct household surveys with a similar method as the Netherlands or to continuously monitor drug taking behaviour among defined risk groups like those in Amsterdam. The Netherlands could replicate the Swedish survey among 16-year old school pupils. Both countries have reasons to improve the collecting of data on drug treatment in all its forms.

If definitions and methods of drug statistics were to be integrated, would it then be possible to declare if the Swedish or the Dutch drug policy is the best? No, it is as hopeless as if we were trying to come to an agreement through research and statistics on whether a social democratic or liberal economic policy is more successful. There are too many factors that are not possible to control in scientific studies (or by drug policies). Moreover the decision about which policy to choose is a political decision. There are still good reasons to try to integrate and co-ordinate definitions and routines concerning data collection and analyses within the area of illegal drugs. This is not necessarily to decide which policy would be the best in the European Union but to minimise drug related harm including improving the living conditions of drug addicts.

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