

We can do better!

Knowledge-based drugs policy
focused on life and health

*Summary of the report We can do better! (Vi kan bättre!)
by the Drug Commission of Inquiry*

Stockholm 2023



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Summary

On 24 March 2022, the Government decided to commission a special investigator to propose how a continued restrictive drugs policy can be combined with effective drug prevention work, good care for harmful use and addiction and addiction issues that includes harm reduction measures, and measures to ensure that no one dies as a result of medicine and drug poisoning. The aim of the commission of inquiry is to ensure that the Swedish drug policy is consistent with the requirements of evidence-based care, best practice and harm reduction, and that it evolves and adapts to present and future challenges. The terms of reference of the Drug Commission of Inquiry and the interim report *Naloxon can save lives – assessments of the current situation and next steps*, are available in English.¹ The full report of the Drug Commission of Inquiry, *We can do better! Knowledge-based drugs policy focused on life and health* (SOU 2023:62), is only available in Swedish.

The following section provides a translation of the report's summary chapter and includes a description of the field of knowledge, together with a summary of proposals and their rationale.

What are drugs?

Drugs is an umbrella term for natural or synthetic chemical substances with the ability, through effects on the central nervous system, to influence sensory perception, mood or behavior, such as inducing sleep, creating hallucinations or removing pain. Drugs have been used since ancient times, for example for intoxication or performance enhancement. The ability to alter sensory impressions or create hallucinations has been used in religious rites, and the ability to induce

¹ Via sou.gov.se/avslutade-utredningar/socialdepartementet.

sleep and remove pain has long made drugs a central component of medical practice.

Drugs have negative effects beyond the person using them. This ranges from the person's immediate environment to conflicts between nations. Relationships with loved ones suffer when a person's interest and preoccupation shifts from a previous focus, for example on family and relatives, work and hobbies, to drugs. Access to drugs is often prioritised over work, housing and responsibilities to children and other family members. The state loses labour and tax revenue when the person is unable to work, and those who have developed an addiction often become socially vulnerable and engaged in criminality, or perform sex for money to finance their drug use. When states around the world prohibit drugs, opportunities arise for profitable organised crime to illegally supply people who use drugs with drugs, leading to further violence and other crimes.

However, we have not been tasked with evaluating the full scope of drug policy and our proposals focus on life and health. We therefore do not make proposals on how drug offences or drug-related crime should be addressed.

What is addiction?

Addiction is a biopsychosocial condition. Repeated use of drugs leads to the development of tolerance, which means that progressively larger and more frequent doses are needed to achieve the desired effect, or that the effect does not occur at all.

Physical addiction means that the body eventually requires the substance to function normally, and the person suffers, for example, from severe anxiety, sweating and shaking if the substance is missing. Psychological addiction means that more and more of the person's thinking and activity revolves around the substance, more time is spent in situations where access is available, and the person becomes increasingly preoccupied with ensuring constant access to the substance.

Addiction can be difficult to break, sometimes seemingly impossible. However, several psychological and pharmacological methods have been developed to facilitate recovery from addiction, and many people are helped when these methods and interventions are available.

International system effects of drugs

Drugs have played a role in international relations, historically perhaps most clearly in the opium wars between the UK and China in the 19th century. In modern times, civil wars in Colombia and the wars in Afghanistan, for example, are largely explained by drugs, and the global drug problem is nowadays highly international.

To address the problem, there are UN drug conventions, with which Sweden has undertaken to comply and which are aimed at protecting health by prohibiting all production, illicit sales and trading in drugs. Both the UN (United Nations Office on Drugs and Crime (UNODC)) and the EU (European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)) now have organisations to both prevent drug-related crime and stimulate the development of preventive measures as well as support and treatment, including harm reduction.

Why should we take care of each other?

The basic idea of a welfare society is that all citizens are part of a community in which we are responsible, to some extent, for taking care of each other. Different philosophical perspectives have worked together to shape the idea of the welfare community where society as a whole assumes responsibility for promoting people's well-being, reducing inequalities and protecting the most vulnerable. However, there is no single theory or philosophical tradition that alone defines the concept of a welfare society; rather, it is a combination of different ideas and values that have shaped this concept.

Philosophers such as Thomas Hobbes, John Locke and Jean-Jacques Rousseau contributed to the development of the ideas of community contract and social contract. These theories emphasise that individuals come together and form communities to protect their rights and create security. Society has a responsibility to ensure the welfare and security of its citizens.

Christian ethics emphasise the importance of loving one's neighbour and caring for those in need. Concepts such as mercy and charity have influenced the idea of collective responsibility to help and support the weakest in society. For example, Martin Buber emphasises the importance of relationships and solidarity between people, under-

lining the need to see each other as fellow human beings and to assume responsibility for each other's well-being.

In liberal schools of thought, such as *justice as fairness* by John Rawls, it is argued that society should be structured in a way that favours the most disadvantaged. This can be interpreted as meaning that a welfare society should endeavour to reduce economic and social gaps in order to achieve a more equal distribution of assets.

The principle of equality of all citizens before the law was already established in the 1809 Constitution (Instrument of Government), and was later also expressed in the UN Declaration of Human Rights. This has been further developed in the Convention on the Rights of Persons with Disabilities (CRPD), the Charter of the European Union and the European Convention on Human Rights. The Health and Medical Care Act (HSL) states in its opening section:

The goal of the health and medical care system is good health and equal treatment for the entire population.²

Care should be provided with respect for the equal value of all people and the dignity of the individual. Priority should be given to those with the greatest need for health and medical care. This reflects the ethical platform for health and medical care adopted by the Parliament, where the *principle of human dignity* emphasises that all people are of equal value and have the right to care regardless of age, gender, education, social or economic status. Thereafter, the *principles of need and solidarity* in HSL state that those with the greatest need of health and medical care shall be given priority as regards care.

How many people use drugs?

Although drug use is lower in Sweden than in most other European countries (half) or the USA (a quarter), between half and one million Swedes have used drugs at some point in the past year. The exact figures vary from year to year and depend on the survey method, but in general – despite several campaigns, action plans and mobilisations against drugs, as described in the chapters of the full report – the number has not been reduced over the last twenty years. More-

² Chap. 3, sec. 1 of the Health and Medical Care Act (2017:30).

over, the proportion of people who use drugs aged 30–44 has increased.

Multi-substance use has increased, new synthetic drugs are constantly emerging and substances have become more potent. Boys/men use more often than girls/women and are also in the majority for the measures provided in the case of harmful use or addiction. Mental health problems in particular, but also other diseases, are much more common among people who use drugs and more extensive the greater or more frequent the use.

Stigma and barriers to care and support

Research has identified several factors as barriers to seeking care and support in different types of settings, such as negative attitudes of care professionals, stigma or structural barriers such as discrimination. Overall, facilitating and hindering factors can be divided into three levels:

- individual (motivation)
- social (stigma and support from family members and care and support professionals)
- structural (legal barriers and policy constraints, such as high fees, insufficient access and long waiting times, insufficient training of treatment teams and unhealthy management culture).

To promote care and support uptake and reduce stigma, long-term strategies are needed. This can be done by improving access to treatment, preventing stigma and discrimination, and providing information and training.

We can do better!

In the report we describe the development of law in the drugs area from the 1960s onwards, as well as the legal procedure in the case of drug offences and the responsibilities and roles of the different stakeholders, with a focus on minor drug offences.

We note that the principles laid down in Sweden's laws and obligations in international conventions as well as philosophical and moral frameworks are not being followed as regards care, support and harm reduction for people with harmful use or addiction on drugs. We provide more information about this in the different chapters of the report, and also provide assessments and proposals to address the main actionable gaps. We can do better – let's do better!

Our analyses, proposals and assessments

The purpose of our proposals and assessments in various areas is described below, together with a brief background. A selection of proposals and assessments is presented here in summary form; for a complete and precise description, please refer to the various chapters of the full report. They are addressed to the Government, agencies, municipalities and regions.

Since society's resources are limited and the condition represents a serious threat to life and health, it is particularly important that preventive measures as well as support, treatment and harm reduction are knowledge-based and effective. The inquiry's proposals have paid particular attention to this perspective.

High mortality in the case of harmful use or addiction to drugs

The most serious and significant consequence of drug use is premature death through accidental poisoning or suicide. Sweden has less drug use than comparable countries, but a high mortality rate. During the ten-year period up to 2022, almost 900 people died per year, which is an increase in the number of individuals. However, expressed as a proportion of the population who died, the proportion remained virtually unchanged during the period: 8 per 100,000 inhabitants, since the population increased during the same period.

One of the clearest tasks in our terms of reference is to analyse this mortality and its causes. This is difficult, as the entire social structure is involved and both context and conditions vary greatly between countries. In addition, there are major differences in the classification and collection of statistics on deaths, even though both UNODC and EMCDDA are trying to standardise reporting. How-

ever, there are similarities in different countries' strategies to reduce mortality. They are based on combinations of naloxone, OAT (opioid agonist treatment), low-threshold clinics, needle and syringe programmes, user rooms (often referred to as medically supervised injection sites or similar) and *drug checking*, in addition to different models of information and communication.

In countries where personal drug use is criminalised, various attempts have been made to exempt people from criminal liability for raising the alarm or assisting in emergencies. These are commonly referred to as 'good Samaritan' exemptions. Much attention has been paid to Portugal, which has succeeded in reducing a high rate of drug-related mortality through various measures, including replacing punishment with needs assessments for care and support. However, it is now seeing an increase in mortality again as funding for several of the interventions has been withdrawn. A similar trend is being seen in Estonia.

A more in-depth analysis of mortality, including the difficulty of distinguishing intentional from unintentional poisoning and finding reasons for changes over the period, is provided in a separate chapter of the report. In particular, we address shortcomings in the prescribing and monitoring of opioids in health and medical care.

An important and high-priority measure is to ensure that the antidote naloxone is available where accidental poisonings can be expected. Naloxone is administered by injection or nasal spray and quickly unblocks the respiratory centre. It thus has the potential to prevent death in that situation, provided it is available.

In our interim report '*Naloxone can save lives – assessments of the current situation and next steps*', we concluded that naloxone is by no means available in all situations where it is most likely to save lives, and that its availability should be increased.

In the US, naloxone was recently made available without a prescription. Last year, the Swedish Medical Products Agency studied the possibility of doing the same in Sweden. Since, according to that agency's assessment, it was not possible to achieve this within the current regulatory framework, we are proposing legislation to make naloxone more accessible.

Here one can reflect on the comparison with society's mobilisation to place defibrillators everywhere, so as not to miss the chance to save a life. It is difficult not to see the stigma associated with

harmful use or addiction to drugs as a factor in not having the same commitment to save lives even more easily with a nasal spray.

To cope with an increasingly rapid introduction of new psychoactive substances, sometimes referred to as ‘designer drugs’, there is a need for continuously updated knowledge of the substances on the market, together with rapid processes for their chemical and legal classification. This is a challenge, and the authorities are lagging behind in terms of definition, as a small change in a molecule can give the substance a similar effect, but the investigation and classification must be done again. Several countries have introduced generic classification where substances are regulated at group level. We have made an overview of the problem and its handling in Sweden and internationally, and conclude that the current system works sufficiently well and that the advantages of a change do not outweigh the disadvantages.

The Government is encouraged to

- adopt a programme to reduce deaths due to drug and medicine poisoning and to supplement the Government’s vision with a concrete target of reducing mortality by at least 20 % from the 2022 level five years after the introduction of the programme.
- instruct the National Board of Health and Welfare to analyse the development and situation and to lead the implementation and follow-up of a national programme to reduce the number of deaths from drug and medicine poisoning.
- adopt a specific law on the management of medicines outside the health and medical care sector which act as opioid antagonists. This would allow also non-health and medical care professionals to provide and administer naloxone in an emergency situation.
- instruct the National Board of Health and Welfare to investigate how death investigations in this area can be organised in order, in the long term, to strengthen knowledge about what measures should be taken to reduce deaths by poisoning caused by drugs or medicines.

The Regions are encouraged to

- intensify the work of prescribing naloxone to people who use drugs or have prescriptions for opioid medicines.

Preventive measures

Not everyone who tries drugs develops harmful use or addiction, but everyone suffers the direct negative effects and no one can know in advance whether or not they will develop harmful use or addiction. Effective prevention must therefore be a cornerstone of an effective drug policy. As few people as possible should start using drugs, and those who do should be encouraged to stop before addiction develops. Societal efforts to reduce the availability of drugs also contribute to this.

Evidence from the area of alcohol suggests that restricting access is effective in reducing the development of harmful use or addiction. But there is good access to drugs everywhere in Sweden, despite attempts to restrict it. Restricting access cannot be the only strategy in prevention. Efforts must also be made to empower individuals to resist the temptation to start using.

As long as prevention is not fully effective, it must also be complemented by effective measures to rehabilitate, support and reduce the harmful effects of harmful use or addiction. Drug addiction is a serious and fatal condition, so multiple and repeated interventions must be in place to safeguard life and health. Much of what is currently being done lacks evidence of efficacy or is even proven to be ineffective, which is always a waste of resources but can sometimes be simply harmful. Ineffective methods must be phased out!

To be effective, prevention efforts should be broad and tailored to people with different levels of drug use, with different types of interventions depending on whether the aim is to

- prevent children and young people from coming into contact with, and trying out, drugs
- delay the onset of drug use
- reduce harmful use or addiction
- reduce the damage to health caused by use.

Research into the reasons for beginning to use drugs is difficult to carry out, but the available research indicates that interventions should aim at counteracting a fragile socio-economic or family situation, support learning at school, focus particularly on people with mental health problems, including addiction disease, in their immediate environment and combine universal, selective and targeted prevention measures.

UNODC has published the *International Standards for Prevention* as a scientific basis for the field of prevention. The EMCDDA also regularly compiles knowledge about evaluated methods in the field of drug prevention and reports on the state of the evidence.

Existing organisation at national, regional and local level within the ANDTS² area has generated a lot of knowledge that has gradually developed the field. Most municipalities now have coordinators for ANDTS work, and the county administrative boards in each county have coordinators for prevention work.

The regional coordinators must work to ensure that the focus of the national strategy is disseminated and implemented regionally and locally. We believe this is an appropriate structure that should be built on. Research shows a positive result of almost two decades of supporting and developing local work through better structures at various levels, training of coordinators, method development and implementation support.

Experience from the alcohol area indicates that the municipalities that have had more initiatives and more developed policy work, collaboration and more resources, enjoy a more favourable development. However, our own analysis shows that the scope of the ANDT prevention work decreased by one-tenth during the period 2016–2021. This applies to both structural conditions and activities.

It is estimated that the societal costs of drug-related problems in Sweden are about 100 times greater than what society has chosen to spend on drug prevention work so far.

² Alcohol, drugs, doping, tobacco and gambling.

The Government is encouraged to

- instruct the Public Health Agency of Sweden to develop, on the basis of existing knowledge, target group-specific knowledge support with criteria relating to the quality of drug prevention work and to carry out training courses on knowledge support at regional level.
- continue the ongoing initiative for increased parental support implemented by the Swedish Agency for Family Law and Parental Support. This is partly to develop equal access to parenting support for more parents and partly to actively work to identify the parents who are most in need of support. The support should be supplemented with information on how parents can communicate about drugs with their children.
- instruct the Public Health Agency of Sweden to compile current science on health effects linked to the most common narcotic substances, and to provide a knowledge base as a basis for different stakeholders.
- strengthen drug prevention work by adopting a programme to prevent drug use among children and young people.
- instruct county administrative boards to support municipalities in the implementation of the programme, and instruct the Public Health Agency of Sweden to lead the implementation.

Regions and municipalities are encouraged to

- prioritise the coordination of prevention work between different areas, and create a stable structure for this.
- ensure knowledge of drugs, risk- and protective factors and health effects in primary care.
- ensure routines for detection, early intervention and routines for referral procedures in primary care settings.
- enable research and development on methods to prevent unfavourable development among children and young people.

- strengthen the structure for the work with early coordinated interventions for children and young people.

Care and support measures in the case of harmful use or addiction

Direct and indirect negative health effects create a need for health and medical care interventions. Responsibility for providing care and support in the case of harmful use or addiction is shared between municipal social services, regional health services, the National Board of Institutional Care (SiS) and the Prison and Probation Service. There are also many non-profit and private stakeholders operating in the field.

The Swedish care and support landscape for people with harmful use or addiction is broad and in many aspects well-functioning. However, there are shortcomings and gaps that can be filled and which we address in our assessments and proposals. National monitoring in this area needs to be improved in various ways.

Some of the care of people with harmful use or addiction to drugs is provided by primary care, but the volume is difficult to estimate because there is no national health data register for primary care. Over the past 20 years, the number of patients, doctor's visits and inpatient care in the regions' specialised care has increased.

The regions' care for children and young people varies greatly, and there are major differences between regions in the provision of child and adolescent psychiatry.

Prescription of opioid drugs and benzodiazepines should be more evidence-based, in terms of indication, choice of drug, quantity and handover, as well as tapering and discontinuation.

It is remarkable that there are still such major shortcomings in terms of following recommendations in national guidelines in regional health care. Compliance needs to be significantly improved and the variation across the country reduced.

People with harmful use or addiction to drugs are also often socially vulnerable. Special care and support measures are therefore needed for particularly vulnerable groups. This applies, for example, to girls and women, LGBTQI³ people, clients in institutions or persons who perform sex for money.

³ Homosexual, bisexual, trans and queer persons as well as intersex persons.

Some ways to specifically meet the needs of these groups are to offer high availability without an appointment, to have addiction expertise at maternity and child health centres and not to unnecessarily require total abstinence from drugs in order to access help and support. Mobile and outreach activities are one way to meet the needs of those who experience high thresholds.

Many stakeholders interact around the same person in different aspects of simultaneous measures and at different stages of a rehabilitation or recovery process. Deficiencies in collaboration and transitions between stages pose clear risks for people with harmful use or addiction.

The Government is encouraged to

- instruct the Swedish Agency for Health and Care Services Analysis (MyVA) to develop a model for monitoring care and support for people with harmful use or addiction. The model will thereafter be managed by the National Board of Health and Welfare.
- instruct the National Board of Health and Welfare to develop comprehensive indicators, mainly focusing on health outcomes of care and its accessibility for people with harmful use or addiction.
- instruct the National Board of Health and Welfare to contribute knowledge support on how youth clinics can reach young people with risky use.
- instruct an appropriate party to establish an anonymous support line and support experiments with digital care for people who use drugs.
- allocate special funds for the transition to good and close care for detection, early intervention and effective collaboration between primary care and specialised addiction care.
- amend the Health and Medical Care Act to clarify the health and medical care's responsibility for coordinating care for children or young people under the age of 21 when there is such a need.

- instruct the National Board of Health and Welfare to study ways of identifying and supporting at an early stage more individuals with ADHD.
- instruct the National Board of Health and Welfare and the Swedish Medical Products Agency to support implementation and learning about appropriate prescribing of narcotics-classified medicines.
- instruct the Swedish Dental and Pharmaceutical Benefits Agency (TLV) to study smaller package sizes of narcotic-classified medicines.

Regions and municipalities are encouraged to

- clarify within their operations the responsibility of health and medical care for treating the harmful use of, or addiction to, drugs by children and young people, especially child and adolescent psychiatry and, together with the municipalities, to coordinate the structure for taking into care.
- implement existing knowledge support and, through regional guidelines, support and compensation models for care providers, to steer towards reduced prescription of narcotic-classified medicines and a development of appropriate support for patients.

Opioid agonist treatment (OAT)

OAT has existed for 60 years in Sweden and has evolved from a highly contested and controlled exception activity to a cornerstone of treatment for people with opioid addiction. The number of patients in medication-assisted treatment for opioid addiction has increased 3–4 times. This increase is considered to reflect better access rather than increased morbidity. The evidence for OAT is good, but participation is hampered by various non-evidence-based rules for the programme. Examples of these are

- requirements to “show motivation” by first becoming drug-free without help

- requirements for work, housing or other organised social conditions
- requirements to have entered the programme in a particular way or to have first undergone certain other treatments or procedures.

A particular problem is that the path to a good life situation for most people with addiction problems is via relapse from time to time. Being excluded from treatment in these situations, or having to qualify again from the beginning, becomes a particularly problematic barrier.

OAT is also developing. In Sweden, buprenorphine is now available as a depot preparation, i.e. long-acting so that visits can be spread out for stable patients and perhaps also moved to a level of care closer to the patient. Preparation forms are available with added antagonists that make it almost impossible for unauthorised diversion from the facilities to the drug market and, in addition, that also limit the risk of accidental poisoning from secondary use of drugs.

It also improves knowledge of alternative substances for the proportion of patients for whom methadone does not work. For example, heroin-assisted treatment is available in Denmark, and in Australia hydromorphone is being studied as a complement to OAT. Alternative formulations such as nasal sprays, oral films and patches are also being studied.

Research shows that OAT reduces crime and the use of (other) drugs, improves the social situation and improves quality of life and health. The full potential of OAT has not been realised due to weak implementation of new knowledge, partly because new preparations are more expensive than older ones.

In our dialogues with OAT stakeholders, a lack of consensus on the requirements and content of the treatment has clearly emerged.

The Government is encouraged to

- instruct the National Board of Health and Welfare to revise the national guidelines for care and support in the case of abuse and addiction, the knowledge support for OAT and the regulation on OAT in order to promote good, equal, accessible and safe care. It needs to be made clear that OAT involves harm reduction, treat-

ment and recovery. The rapid growth in knowledge in the field justifies a readiness to update guidelines and regulations.

- instruct the National Board of Health and Welfare to implement the necessary measures to be able to use the patient register to identify and monitor which patients are prescribed OAT and which medicines are used.

The Regions are encouraged to

- investigate the conditions for free of charge OAT treatment and medicines during the first year of treatment.
- within the framework of the national mental health programme area, develop a person-centred care pathway for opioid addiction with a focus on OAT.
- offer more patients access to OAT and increase compliance with national guidelines by the main authorities promoting collaboration between levels of care and implementation of new knowledge to increase accessibility.

Measures by social services

Harmful use or addiction leads to difficulties in maintaining family, work and housing, which in turn leads to the need for social services. The number of measures by social services, including LVM,⁴ has remained more or less unchanged since 2000, but the organisation, volume, availability and quality vary greatly between municipalities.

Our report describes various treatment methods and measures for people with harmful use or addiction. For the municipalities, the focus is on psychological and psychosocial methods, but we also touch on measures for family members, measures relating to housing and so on. We make comparisons between municipalities and regions, and analyse how well the measures comply with recommendations and priority levels in national guidelines for care and support for substance abuse and addiction, as well as with other policy docu-

⁴ The Care of Drug Abusers (Special Provisions) Act (1988:870).

ments. Compliance with these can be significantly improved and the variation across the country reduced.

Homelessness contributes to low quality of life and increases the risk of ill health. Housing is therefore an important aspect of municipalities' harm reduction activities. Several, but not all, municipalities offer some form of housing ladder that guarantees shelter and housing at a level that people can manage. A successful approach used by one fifth of municipalities is *Housing First* – a model that offers a combination of housing and housing support without requiring total abstinence from drugs. As housing is often a condition for an ordered social life in general, including work, employment, relationships and also access to certain treatments, it is an important component on the path to a more ordered life and also to health.

The Government is encouraged to

- instruct the National Board of Health and Welfare to map out different types of housing forms based on different legislation (e.g. the Social Services Act (2001:453), SoL, and the Act (1993:387) on Support and Service for Certain Disabled People, LSS), for people with harmful use or addiction, and to study the need for guidance in the area to create more uniform application of the regulations in Sweden. The work should pay particular attention to how housing can be ensured for people with simultaneous harmful use or addiction and exposure to violence.

The Swedish National Board of Institutional Care (SiS)

The Swedish National Board of Institutional Care (SiS) performs a combination of state and municipally financed operations. The authority takes care of persons pursuant to LVM (the Care of Drug Abusers (Special Provisions) Act) and LVU (the Care of Young Persons (Special Provisions) Act).

The Government is encouraged to

- regulate that a so-called coordinated individual plan (SIP) must also be drawn up when a person is being cared for with the support of LVM and the Swedish National Board of Institutional Care (SiS) deems that it is necessary for the person's needs to be met.

The Swedish Prison and Probation Service

A relatively large proportion of the Prison and Probation Service's clients have harmful use or addiction to drugs, many of them addicted to opioids. In its review, the UN's Economic and Social Committee has called upon the State party, Sweden, which has ratified the International Covenant on Economic, Social and Cultural Rights, to intensify its efforts to enable people in prisons to take part in OAT.

The Government is encouraged to

- enable the Prison and Probation Service to summon the region and/or municipality to a so-called coordinated enforcement plan. If there is a need for care and support measures after release, it must be stated which principal agency assumes responsibility after the end of the enforcement period.
- instruct the Prison and Probation Service and the Swedish National Board of Institutional Care (SiS) to produce guidelines for when a coordinated plan should be initiated.
- instruct the Digitalisation Authority to produce guidelines for how digital coordination meetings can be carried out in a technically secure manner in accordance with current legislation.
- instruct the Prison and Probation Service to study how accessibility to OAT within the Prison and Probation Service can be ensured.

Regions and municipalities are encouraged to

- continue the work on developing a so-called coordinated individual plan (SIP). The regions and municipalities will be financially compensated for the new undertaking to participate in coordinated enforcement planning with the Prison and Probation Service. The Swedish Association of Local Authorities and Regions (SKR) will receive funds through an agreement to continue to support the implementation of SIP and to implement coordinated enforcement planning.

The law enforcement process

Our terms of reference have prevented us from making proposals in the area of criminal law. However, we have endeavoured in various ways to identify how the possibility of care and support can be strengthened within the framework of existing law.

The Government is encouraged to

- instruct the National Board of Health and Welfare and the Police Authority, in consultation with the Swedish National Council for Crime Prevention (Brå) and The Swedish Association of Local Authorities and Regions (SKR), to produce guidance on how children and young people under 21 who are suspected of drug offences can be offered care and support when there is such a need.
- instruct the Swedish Police Authority to review how the authority uses decisions not to report offences on suspicion of personal use and possession in respect of personal use of drugs and, if necessary, to produce regulations or guidance on how decisions not to report offences should be used.
- consider initiating a review of the Penal Law on Narcotics and the penalties for drug offences in order to investigate, among other things, how the law affects medical and socially detrimental consequences, and whether people with harmful use or addiction are offered care and welfare measures to a sufficient extent.

Harm reduction measures

To safeguard the lives and health of those whom the system does not reach with measures to prevent or recover from harmful use or addiction, measures can be offered to minimise the direct and indirect harmful effects. These are usually summarised as harm reduction measures. There are several such measures at different levels, the best known being

- prevent overdose related deaths by distributing for example, naloxone
- medication-assisted treatment for opioid addiction (OAT)
- measures to prevent infections and other physical illnesses
- measures to improve the social situation, such as housing or employment.

The immediate goal in the case of harm reduction measures is normally not to stop the person from using drugs, but to help the person to survive and be in good health, which is also a prerequisite for later helping the person to become drug-free.

One of the clearest dividing lines in the public and scientific debate is the question of the balance between legal measures and harm reduction measures. It involves several difficult questions, in particular whether it should be illegal to possess and use drugs and how criminalisation of personal use affects society in terms of organised crime, violence and corruption. These issues are also part of drug policy, but clearly fall outside the responsibility and mandate given to this commission of inquiry. We address these issues where they are relevant to our judgements and proposals, but have not covered them comprehensively.

People with harmful use of or addiction to drugs are at great risk of dying prematurely or having a greatly reduced quality of life due to related physical illness, violence and exploitation or a weak social and economic living situation. They therefore constitute a group that should be given very high priority when allocating resources to various health and medical care measures and social services initiatives – all in accordance with the Health and Medical Care Act with

its ethical prioritisation platform, several international conventions to which we are committed and also our constitution.

There is a wide range of measures that have been shown to have the potential to reduce these risks and have been introduced to varying degrees in different countries. Due to their common goals, they are usually summarised as harm reduction measures, even though they are very different in nature and applied at different system levels.

However, the very premise of harm reduction measures is controversial. A common argument is that if society mitigates the consequences of drug use, the incentive to abstain is reduced. It is also argued that some of the harm reduction measures involve society ‘tolerating’ drugs to the extent that the messages of prohibition and harmfulness are eroded.

The arguments in favour of harm reduction are more pragmatic, while the arguments against focus more on a question of principle. The very notion of harmful use or addiction as a “self-inflicted” disease and the stigma attached to addiction also seem to have an impact, as similar arguments are very rarely heard about other injuries or physical illnesses, that airbags in cars or bicycle helmets make us worse at complying with traffic rules, or that cancer treatment causes people not to follow advice on healthy lifestyles. Or that marathon runners, footballers and mountaineers should go without medical care when they are injured.

Some countries take the concept a step further and offer, in addition to needle and syringe exchange and health services, the possibility to take drugs under supervision at a drug use center (also called medically supervised injection site or similar). This is usually referred to as a user room, or sometimes an injection room, but it is more than just that. The facilities often offer needle and syringe exchange, health counselling and other support. The arguments in favour of such activities are that

- the risk of fatal overdose is reduced
- somatic problems are treated and the need for emergency medical care is reduced
- injecting in stairwells, parks and public spaces disappears
- another point of contact is established to provide information, health services and motivation for treatment.

The counter arguments often put forward are that

- drug use risks being sanctioned in the eyes of the public and there are concerns that the facilities may even make easier and increase drug use and injecting.
- user rooms are difficult to combine with a regulatory framework where it is actually illegal to use drugs.

The research on user rooms has not shown an increase in drug use or risk-taking, but rather better health and utilisation of health services and fewer disturbances to the neighbourhood. It has shown that deaths in user rooms are prevented, but has not been able to show that the measure contributes to a reduction in drug-related mortality at the community level. In Sweden, user rooms have never existed, not even in a research context, but in Denmark, Iceland and Norway they have been introduced as part of a heightened ambition to safeguard the user's life and health. French studies show cost-effectiveness.

Opioids, such as heroin, morphine and fentanyl, block the respiratory centre in the brainstem and sometimes cause breathing to stop after drug use, especially after injection. The risk has increased as more potent drugs have become available over time, concurrent use of multiple substances has become more common and drugs are sometimes 'spiked' with more powerful substances, such as fentanyl – sometimes without the user's knowledge.

Some countries offer drug checking, where people who use drugs can get test strips to check the content of what they have in their possession. In Sweden they are available semi-officially through user associations. A practical problem is that test strips, which may be available at festivals or at various testing facilities with a wider target group, are not precise enough, while the more accurate testing methods often take too long. However, the technology is evolving rapidly. The evidence for effectiveness is weak, as studies are lacking.

Despite their impact on life and health, harm reduction measures in Sweden represent a relatively small proportion of the total number of measures for people who use drugs or have harmful use or addiction. We briefly describe the most important measures below and in the different chapters of the report in more detail, as well as how different countries have chosen to combine them.

The Government is encouraged to

- define the harm reduction perspective as “measures, programmes and policies that aim to reduce the health, social and economic harms of drug use for individuals and society, and to increase the quality of life for individuals, without requiring drug-free status”.
- consider proposing to Parliament to change the objective of drug policy as a whole from “a drug-free society” to “a society with reduced harm from drugs”.
- instruct the National Board of Health and Welfare to revise the national guidelines for care and support in the case of substance abuse and addiction so that they reflect the updated definition, and to propose methods and working methods accordingly.
- instruct the Swedish Agency for Health and Care Services Analysis (MyVA) to map the extent to which unjustified demands for a person to be drug-free are made as a condition for taking part in various programmes.
- include the issue of user rooms and *drug checking* within the scope of the above-mentioned potential review of the Penal Law on Narcotics.
- allocate funds to stimulate knowledge development in the area of harm reduction and low-threshold activities so that municipalities and regions, and if possible also governmental stakeholders, research parties and civil society, can implement and evaluate pilot schemes and forms of cooperation to strengthen harm reduction work.

Regions and municipalities are encouraged to

- expand the range of low threshold activities that can simultaneously offer several harm reducing and health promoting measures.

Needle and syringe programmes and access to sterile syringes and needles

Needle and syringe programmes (NSP) are one of the most important harm reduction measures. They have a direct impact by reducing the circulation in the community of unsterile injection tools, thus reducing infectious diseases such as HIV, hepatitis B and C and secondary infections. However, NSP services also have a significant indirect health impact, by providing a point of contact for information, dialogue, prevention and support to motivate people to change treatment. However, the treatment components differ greatly between facilities.

Due to differences in approach to harm reduction measures, NSP services have been lacking in many regions for many years, but by the end of 2023 all regions will have started such activities. This is encouraging and important.

One point of discussion is whether it is appropriate to require the return of used syringes and needles. It has been argued that this is necessary to remove them from the external environment, but it also becomes a barrier for people who want to visit the facility. Practices vary between sites and many countries have removed the return requirement.

The Government is encouraged to

- amend the Act (2006:323) on the Exchange of Syringes and Needles so that the purpose also includes the task of promoting mental and physical health. The authorisation requirement is replaced by a notification requirement. The age limit for the activity is still 18 years, but younger people should also be able to take part in the activity if there are special reasons. The requirement for the return of syringes and needles is removed and replaced with wording that the facility should promote the return of syringes and needles.
- amend the legislation so that it is no longer prohibited to sell syringes and needles in pharmacies.

Information about drugs to people who use drugs

People who use drugs seek for and are interested in factual information on the effects, harms and risks of drug use. The dilemma here is whether to provide information about what is actually harmful and forbidden, and whether this risks increasing curiosity and lowering thresholds for drug use.

In Sweden, syringe and needle exchanges and other care and support facilities are used as information points, while user associations and civil society provide information via websites. Countries such as Canada, the USA, Germany and Norway have websites with detailed and factual information on the effects of drugs and how to reduce the risks associated with drug use. In Norway, the Directorate of Health supports the website rusopplysningen.no indirectly through funding through the association that operates the website.

The Government is encouraged to

- instruct the Public Health Agency of Sweden, together with civil society and the target group, to study the best way to produce and disseminate information on different substances and non-judgemental information on risks to people who use drugs.

Relatives' and closely related persons' situations

We recognise that relatives and those close to people with harmful use or addiction have an important role but often are in an entirely desperate situation. We develop this in the report.

The Government is encouraged to

- give the National Competence Centre for Relatives (Nka) a specific task to build up knowledge about relatives of people with harmful use or addiction and/or co-morbidity. We also believe that a national support line for, among others, relatives should be established.

- clarify social services' responsibility for supporting the relatives of a person with harmful use or addiction to drugs.
- give the ongoing inquiry entitled Stronger support for relatives of the long-term or seriously ill (Dir. 2023:77) a supplementary term of reference to consider whether the Patient Act (2014:821) can be amended so that the health and medical care services are obliged to offer education to individuals and relatives about, among other things, addiction diseases, and consider whether the Social Services Act (SoL) should be supplemented with a provision stating that a child's need for information should be given special consideration if the child's parent or another adult with whom the child lives permanently has harmful use or addiction to drugs.

Regions and municipalities are encouraged to

- include relatives of persons with harmful use or addiction in the regional agreements within the area of harmful use or addiction.

Measures to increase skills and competence

Sweden has a wide range of initiatives and stakeholders aimed at preventing drug use and reducing damage to life, health and society in the surrounding area caused by drug use. However, we nevertheless see that the safety net has large gaps, and many people fall through.

Knowledge is increasing, but so are the challenges. It is therefore of great importance that we plan not only for measures, but also for how we ensure knowledge, expertise and knowledge development.

The long-term supply of skills also needs to be secured. Basic training programmes for social workers, psychologists, doctors, nurses and other professional groups who meet people with harmful use or addiction or their relatives should provide basic knowledge of how preventive, supportive, therapeutic and harm reduction work against harmful use or addiction and co-morbidity should be carried out. Training should also include the meaning and consequences of harmful use or addiction and co-morbidity.

Ongoing knowledge enhancement initiatives for municipalities should also be considered. These range from basic training for pro-

professionals within health and care, to specialisation, continuing education and postgraduate training and a strong academic platform. This contributes to new knowledge and enables participation in international scientific exchange and the acquisition of new knowledge.

Research grants need to be announced periodically in the future as well. Swedish government research funding for the area is lower than in most comparable countries. We also see a need for a national research centre. Commissioned and collaborative research also needs to be strengthened based on nationally identified significant knowledge gaps in the field of drugs, where research should be able to be initiated to address them.

On the other hand, strong structures are needed to continuously translate knowledge into treatment guidelines and care programmes and to monitor compliance and effect.

The Government is encouraged to

- supplement the National Board of Health and Welfare's instructions so that the authority is given a clearer and collective responsibility, sectoral responsibility, for implementing the national ANDTS objectives (alcohol, drugs, doping, tobacco and gambling) for care, support and harm reduction related to the National Board of Health and Welfare's areas of activity. This means responsibility for monitoring, analysing and reporting on initiatives and outcomes in health and medical care and social services regarding harmful use or addiction. In addition, the authority must be supportive and proactive in relation to the stakeholders concerned. The authority shall also be able to initiate research of relevance for being able to fulfil its mission.
- clarify initiatives in the area of support, care and harm reduction in cases of harmful use or addiction in agreements with the Swedish Association of Local Authorities and Regions (SKR).
- instruct the Swedish Research Council for Health, Working Life and Welfare (Forte), in dialogue with other relevant authorities, to study how a national research centre can be established for prevention, care, support and harm reduction in the field of ANDTS, to investigate the conditions for establishing an inter-

disciplinary research school in the field, and to investigate and propose a reasonable level of government research funding in the field of ANDTS in order to gradually approach a level for the purpose on a par with other comparable OECD countries.

- instruct the National Council for Health Care Expertise to draw up proposals to ensure the future supply of expertise in prevention, treatment and harm reduction in connection with harmful use or addiction.
- instruct the National Board of Health and Welfare to carry out a feasibility study on the need and conditions for reinforcing knowledge about harmful use or addiction for staff in health and medical care and, if necessary, social services, and propose how relevant training programmes can be structured with a focus on continuing education.
- consider, together with the other Nordic countries, initiating Nordic co-operation on care, support and harm reduction in connection with harmful use of or addiction to drugs, where knowledge development and research is disseminated through representatives from relevant authorities and research representatives.