

Stakeholders in Swedish drug policy

Values, interests and involvement

Tuulia Lerkkanen



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Academic dissertation for the Degree of Doctor of Philosophy in Public Health Sciences at Stockholm University to be publicly defended on Friday 8 May 2026 at 13.00 in Campus Albano: ALB Auditorium 2, House 2, Floor 2, Albanovägen 18.

Abstract

The increased use and availability of illicit drugs, and their social and health-related harms, constitute a global public health concern. Various stakeholders across society, including individual actors and organizations, actively work to address these issues through policymaking, yet they often possess competing interests, divergent values, and conflicting moralities. This dissertation explores contemporary drug policy and policymaking in Sweden, with a particular focus on stakeholders. It aims to advance our understanding of the context and policy processes shaping drug policy by analyzing stakeholders' values, interests, and forms of involvement. The data consists of key informant interviews with national-level stakeholders, media texts, and policy documents. Utilizing the health policy triangle framework in combination with an assortment of theories and concepts to guide the analyses, the dissertation underscores the interrelationships between stakeholders, processes, context, and policy content within the domain of drug policy as public health policymaking. It comprises four related papers:

Study 1 examined stakeholders' visibility and the moral justifications of their argumentation in the Swedish drug policy media debate. **Study 2** analyzed stakeholders' strategies to influence drug policy and perceptions of their and others' opportunities to influence drug policy in Sweden. **Study 3** explored stakeholders' moral positions regarding the current ("a drug-free society") and recently proposed revision (to "a society with reduced harm from drugs") of the Swedish drug policy aim. Stakeholders' perceptions of the role of commissions of inquiry in drug policymaking were also analyzed. **Study 4** aimed to further our understanding of why harm reduction measures have become more accepted in Sweden, while punishments have become more severe, and the role of stakeholders in shaping policy processes in this case.

The findings highlight the different ways stakeholders are involved in and attempt to influence drug policy. In exploring the successes and challenges faced by stakeholders in their influence attempts, several stakeholder characteristics and contextual factors were identified. The identified stakeholder characteristics included the number of resources, highlighting how an unequal distribution of resources affects opportunities to influence drug policy, while contextual factors included the predominance of support for the restrictive drug policy. The findings also highlighted a longstanding divide between two moral positions of stakeholders within the Swedish drug policy field, as supporters or opponents of the restrictive drug policy based on the aim of a drug-free society. Yet, the studies also suggest that there are signs of fracturing stances through increasingly complex values and moralities, including a growing acceptance of harm reduction measures and a widespread will to reduce stigma, while maintaining the aim of a drug-free society with stricter penalties for drug offences. Finally, the studies suggest how to increase participation and opportunities to influence in drug policymaking among people who use drugs and their significant others, while critically discussing the potential to strengthen the role of commissions of inquiry for effective drug policy implementation. Altogether, the dissertation provides a nuanced understanding of how public health is conceptualized, contested, and implemented within the context of drug policy.

Keywords: *drug policy, harm reduction, public health policy, stakeholders, Sweden.*

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DRUG POLICY

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moral positions of stakeholders within the Swedish drug policy field, as supporters or opponents of the restrictive drug policy based on the aim of a drug-free society. Yet, the studies also suggest that there are signs of fracturing stances through increasingly complex values and moralities, including a growing acceptance of harm reduction measures and a widespread will to reduce stigma, all while maintaining the aim of a drug-free society with stricter penalties for drug offences. Finally, the studies suggest how to increase participation and opportunities to influence in drug policymaking among people who use drugs and their significant others, while critically discussing the potential to strengthen the role of commissions of inquiry for effective drug policy implementation. Altogether, the dissertation provides a nuanced understanding of how public health is conceptualized, contested, and implemented within the context of drug policy.

Sammanfattning

Den ökade användningen av och tillgängligheten till illegala droger, samt medföljande sociala och hälsorelaterade skador, utgör ett globalt folkhälsoproblem. Olika samhälleliga intressenter, däribland enskilda individer och organisationer, hanterar aktivt dessa frågor genom policyformulering och -utformning, samtidigt som de ofta har konkurrerande intressen, skilda värderingar och motstridiga moraluppfattningar. Denna avhandling undersöker samtida narkotikapolitik och policyformulering i Sverige, med särskilt fokus på intressenter. Syftet är att fördjupa förståelsen av de sammanhang och policyprocesser som formar narkotikapolitiken genom att analysera intressenters värderingar, intressen och former av delaktighet. Datamaterialet består av intervjuer med nyckelinformanter verksamma på nationell nivå, medietexter och policydokument. Avhandlingen använder hälsopolitikens triangel i kombination med en rad teorier och begrepp för att analysera och belysa relationerna mellan intressenter, processer, sammanhang och politiskt innehåll inom narkotikapolitiken som folkhälsopolitik. Den består av fyra relaterade artiklar:

I **studie 1** undersöktes intressenters synlighet och de moraliska motiveringarna bakom deras argumentation i den svenska mediedebatten om narkotikapolitiken. I **studie 2** analyserades intressenters strategier för att påverka narkotikapolitiken samt deras uppfattningar om sina och andras möjligheter att påverka narkotikapolitiken. **Studie 3** undersökte intressenters moraliska ståndpunkter angående den svenska narkotikapolitikens nuvarande mål ("ett samhälle fritt från narkotika") och den nyligen föreslagna revideringen (till "ett samhälle med minskade skador av narkotika"). Dessutom analyserades uppfattningar om statliga utredningars roll i narkotikapolitiken. **Studie 4** syftade till att fördjupa vår förståelse av varför skademinskande åtgärder har blivit mer accepterade i Sverige, samtidigt som straffen har blivit strängare, samt intressenters roll i utformningen av dessa politiska processer.

Resultaten belyser olika sätt som intressenter engagerar sig i och försöker påverka narkotikapolitiken. Analysen av intressenters framgångar och utmaningar i försöken att utöva inflytande identifierar flera intressentegenskaper och kontextuella faktorer. Bland intressentegenskaperna ingick resurstillgången, vilket belyser hur ojämn resursfördelning påverkar möjligheterna att påverka narkotikapolitiken. De kontextuella faktorerna omfattade bland annat det dominerande stödet för den restriktiva narkotikapolitiken. Resultaten be-

lyste också en långvarig klyfta mellan två moraliska ståndpunkter bland intressenter på det svenska narkotikapolitiska fältet, som anhängare eller motståndare till den restriktiva narkotikapolitiken baserad på målet om ett narkotikafritt samhälle. Studierna indikerar dock tecken på fragmentering av ståndpunkterna genom alltmer komplexa värderingar och moraluppfattningar, inklusive en växande acceptans av skademinskande åtgärder och en utbredd vilja att minska stigmatiseringen, samtidigt som målet om ett narkotikafritt samhälle med strängare straff för narkotikabrott upprätthålls. Slutligen ger studierna förslag på hur personer som använder narkotika och deras anhöriga kan få ökade delaktighet och möjligheter att påverka narkotikapolitiken, samt hur narkotikapolitikens genomförande kan bli mer effektiv genom en kritisk diskussion om hur statliga utredningar kan stärkas. Sammantaget ger avhandlingen en nyanserad bild av hur folkhälsa förstås, ifrågasätts och genomförs inom ramen för narkotikapolitiken.

List of studies

Study I Lerkkanen, T. & Storbjörk, J. (2023). Debating the drug policy in Sweden: Stakeholders' moral justifications in media 2015–2021. *Contemporary Drug Problems*, 50(2), 269–293.
<https://doi.org/10.1177/00914509231159394>

Study II Lerkkanen, T., Storbjörk, J., & Eriksson, L. (2025). Stakeholders' opportunities and attempts to influence drug policy in Sweden. *Drugs: Education, Prevention and Policy*, 1–15.
<https://doi.org/10.1080/09687637.2025.2566014>

Study III Lerkkanen, T., Storbjörk, J., & Eriksson, L. From a “drug-free society” to “reduced harm”? Stakeholders' moral positions and the significance of national commissions of inquiry in Sweden. (Under review)

Study IV Lerkkanen, T., Storbjörk, J., & Eriksson, L. Reconciling control and harm reduction? On stakeholders and drug policy formation in Sweden. (Under review)

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Abbreviations

AIDS	Acquired immunodeficiency syndrome
ANDTG	Alcohol, Narcotics, Doping, Tobacco and Gambling
CND	The Commission of Narcotic Drugs (part of UN)
DCI	Drug Commission of Inquiry (SOU 2023:62)
DSM	Diagnostic and Statistical Manual of Mental Disorders
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction (EUDA as of 2024)
EU	European Union
EUDA	European Union Drug Agency (known as EMCDDA until 2024)
HIV	Human Immunodeficiency Virus
ICD	International Classification of Diseases
MP	Member of Parliament
MSF	Multiple Streams Framework
NEP	Needle Exchange Program
NGO	Non-governmental organization
OAT	Opioid Agonist Therapy
SOU	Swedish Government Official Reports [in Swedish: <i>Statens Offentliga Utredningar</i>]
RFHL	National Association for Help for Drug Users [in Swedish: <i>Riksförbundet för hjälp åt läkemedelsmissbrukare</i>]
RNS	National Association for a Drug Free Society [in Swedish: <i>Riksförbundet för Narkotikafritt Samhälle</i>]
THN	Take-Home Naloxone
UN	United Nations
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

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Introduction

During recent decades, the availability and use of illicit drugs have increased globally (United Nations Office on Drugs and Crime [UNODC], 2025). In this dissertation, ‘drugs’ refer to “substance[s] capable of influencing brain systems linked to reward and pleasure” (Babor et al., 2018, p. 10). In particular, the focus is put on illicit drugs – substances that are classified as illegal by the International Drug Control Conventions (e.g., heroin, cocaine, LSD; International Narcotics Control Board, 2025); prescription drugs used outside medical authority, such as pharmaceutical opioids; and drugs that have not yet been regulated (Ritter, 2021).

Drug use¹ is associated with several forms of harm related to health, social relations, public order, and safety that affect individuals, social groups, and societies in different ways (Babor et al., 2018; UNODC, 2025). For example, one of the most fatal health-related harms and a current global public health concern includes opioid overdoses, the most common cause of drug-related deaths (Alho et al., 2020; European Union Drug Agency [EUDA], 2025a; Volkow et al., 2019). Other health harms associated with drug use include, for example, injuries, infectious diseases (e.g., Hepatitis C, HIV/AIDS), non-communicable physical diseases, and mental disorders (Babor et al., 2018; UNODC, 2025).² Furthermore, drug production and trafficking give rise to serious criminal activity and harm (Bennett et al., 2008; Goldstein, 1985). Drug use may thus be associated with considerable suffering, particularly among people who use drugs and their families and friends. Consequently, drugs represent a public health matter of significant concern across the globe.

¹ In this dissertation, the term ‘drug use’ is understood as a spectrum: it includes regular, occasional, recreational, and harmful drug use (see Askew, 2016). ‘Harmful drug use’ and ‘drug problems’ refer to situations in which drug use causes harm to the person who uses it or to society (Babor et al., 2018; see also World Health Organization [WHO], 1993, pp. 56–57). The term ‘recreational drug use’, instead, is understood as the non-medical use of drugs with the aim of experiencing their psychoactive effects (Becker, 1963) and using drugs “occasionally in a reasonably controlled way and in specific settings only” (Parker & Egginton, 2002, p. 419). Substance use refers to the use of illicit drugs and/or other substances such as alcohol and tobacco products (Centers for Disease Control and Prevention, 2024).

² Different types of drugs may cause different types of health harm. For example, cannabis involves fewer risks than opioids and amphetamines, even though its use is more prevalent in most societies (Babor et al., 2018). Furthermore, injecting drugs is associated with a particular risk of mortality and severe health outcomes (Babor et al., 2018).

Internationally, the focus has primarily been on the regulation and control of drugs. The majority of the countries worldwide have signed the three International Drug Control Conventions by the United Nations (UN) (UNODC, 2013), aiming to control non-medical use of illicit drugs by prohibiting their production, manufacture, sale, possession, and use (Ritter, 2021).³ Approximately half of European countries also criminalize personal drug use (UNODC, 2025). However, during the past 30 years, several countries across different continents have chosen alternatives to drug prohibition by adopting forms of decriminalization or other forms of regulating drug use and possession of drugs.⁴ For example, Canada, Uruguay, and 28 jurisdictions in the United States have legalized the cultivation, production, and sale of cannabis for non-medical use (UNODC, 2025). One of the latest examples is Germany, which legalized cannabis in 2024. Many countries have, to varying degrees, decriminalized personal use of drugs, for example the Netherlands, Portugal, the Czech Republic, and Argentina (Global Commission on Drug Policy, 2016; see also Unlu et al., 2020).

Drug policy encompasses various methods employed to address and respond to drug use and its consequences. It concerns international and national laws and measures aimed at regulating the cultivation, production, trade, sale, and use of psychoactive substances (Svensson & Svensson, 2022). When, in this dissertation, the focus is placed on national drug policy, it is understood as representing public policy, referring to laws, regulations, strategies, and actions established by the government (Pollack Porter et al., 2018).

Drug policy often consists of at least three policy areas: (1) *control*, referring to policy measures aimed at controlling and eliminating the production, trafficking, and distribution of illicit drugs; (2) *prevention*, referring to programs and strategies designed to prevent drug use among the population, especially regarding the initiation of drug use; and (3) *treatment*, referring to rehabilitation, care, and social service programs intended to provide help and support to people who use drugs, including enhancing and maintaining motivation to change their behavior and reduce their drug use (Babor et al., 2018; cf. Ritter et al., 2016). A fourth and more recent policy area, sometimes distinguished from treatment, is (4) *harm reduction*. It refers to interventions aimed at reducing the harmful consequences associated with drug use, irrespective of changes in consumption, and is of special interest in this dissertation (Marlatt & Witkiewitz, 2010).

³ The three International Drug Control Conventions by the UN (UNODC, 2013) are presented in the Background section.

⁴ Decriminalization *de jure* means formally removing criminal sanctions for the possession of drugs for personal use through legal reforms (Stevens et al., 2022). Decriminalization *de facto*, instead, means that drug use and personal possession of drugs remain criminal offenses, but criminal penalties are not executed (Unlu et al., 2020). By contrast, legalization entails that drug are legally permitted, often accompanied by restrictions such as age limits (Decorte, 2018).

Formulating strategies to control drugs and drug use, and to prevent drug use and drug-related harm, is a complex challenge at different levels of society (Babor et al., 2018; Ritter, 2021). Several actors are, or attempt to be, involved in drug policymaking, each with often-competing interests and differing understandings of what is right or wrong, or what is good or bad in relation to drugs (Houborg et al., 2016; Ritter, 2021; Ritter, et al., 2025; Stevens, 2024). Policymaking may therefore be understood as “a structured interaction that recognizes multiple actors, both within and outside the formal authority structures, and sees policymaking as a process of negotiated ordering” that also “recognizes the messiness inherent in policymaking” (Ritter, 2021, p. 16).

That this requires negotiation is unsurprising, as history demonstrates that drugs are framed by various problem constructions (e.g., Lancaster & Ritter, 2014; Lindgren, 1993). In many socio-cultural contexts, drug use has been labelled as illegal, and attitudes toward drugs, drug use, and people who use drugs have been negative, with drugs and people who use drugs associated with severe stigmatization, discrimination, poor treatment access, and negative health effects (Ahern et al., 2007; Garpenhag & Dahlman, 2021; Holeksa, 2024a; Kulesza et al., 2013; Madden, 2022; Muncan et al., 2020). For example, these attitudes may cause some people who use drugs to avoid Needle Exchange Programs (NEPs), as accessing them entails the risk of being labelled a “junkie” (Månsson et al., 2025). Others isolate themselves to avoid detection, including refraining calling emergency services in overdose situations (Soussan & Kjellgren, 2019; Storbjörk et al., 2025).

In recent decades, these attitudes and their consequences have been discussed, debated, and challenged by emphasizing human rights. Notably, in 2024, the UN’s Commission on Narcotic Drugs (CND) officially recognized harm reduction, which was described as a global paradigm shift toward public health-oriented drug policy, favoring an evidence-driven and human rights-based approach (Ahmad et al., 2024). This development was enabled by recent international shifts, a fragmentation of previous drug policy consensus favoring prohibition, and the emergence of new constellations and practices (Stevens et al., 2025a). As the longstanding idea that drugs should be combated by all means – even referred to as a “war on drugs” (MacCoun & Reuter, 2001) – appear to weaken, it becomes increasingly important to examine drug policy development and the conditions shaping drug policy change. This is where the present dissertation is situated.

Drug policy as public health policy in Sweden

This doctoral research project focuses on drug policy and policymaking, which, within the Swedish context, is part of public health policy (Prop. 2017/18:249). A discussion of the public health approach to drug policy is therefore warranted.

Public health is often defined as “the science and art of preventing disease, prolonging life, and promoting health through efforts of society” (Acheson Report 1998, cited in Pellmer Wramner et al., 2017, p. 16). It adopts a population perspective, emphasizing the importance of “using evidence to inform policies affecting the health of people” (Room, 2015, p. 367), while also aiming to reduce health inequalities within and between populations (Holland, 2023; Satcher & Higginbotham, 2008). From an ethical perspective, two major public health paradigms exist: one based on a *utilitarian view*, which values improving and maximizing health benefits for the majority of the population; and the other based on an *equity view*, which aims to improve population health while reducing health inequities⁵ in society (MacKay, 2018). These paradigms are further discussed in this dissertation.

Considering the field of substance use research, there is no consensus on the definition of a public health approach (Crépault et al., 2023). Researchers have characterized a public health approach as flexible and have criticized its frequent use in contradictory ways, across different substances, and often without a clear definition (Crépault et al., 2023; MacGregor, 2016; Mold, 2018). Despite the lack of consensus, a public health approach to illicit drugs often treats drug use as a health and social issue rather than a criminal justice issue (Crépault et al., 2023; Csete et al., 2016; Mosher & Yanagisako, 1991). Hence, the focus is on reducing drug-related harm, preventing drug-related mortality, and providing treatment, based on evidence-based policy measures (Babor et al., 2018; Csete et al., 2016; Strang et al., 2012). According to Babor et al. (2018), adopting a public health approach to drug policy involves forming policies based on systematically evaluated, sound scientific evidence, with a focus on a population perspective, thereby suggesting interventions most likely to benefit large numbers of people. In relation to the two ethical public health paradigms, prohibiting drug use and supply can be seen as an example of the utilitarian view, while harm reduction measures “grounded in justice and human rights” (Harm Reduction International, 2026) can be understood as an example of the equity view (see MacKay, 2018).

This dissertation focuses on national-level drug policy and policymaking in Sweden, primarily public policy developed by the Government, Parliament, and other government agencies making formal decisions on these matters. Swedish drug policy has been part of public health policy since 2003 (Prop. 2002/03:35). Since 2010, national drug policy has also been formulated and guided by a joint policy strategy regulating Alcohol, Narcotics, Doping, Tobacco, and Gambling (ANDTG) (Prop. 2010/11:47). According to the latest ANDTG strategy for 2022–2025, the most effective measures for reducing ANDTG-related harm and problems are to limit access to and availability of

⁵ In public health sciences, health inequalities refer to health differences between groups, while health inequities refer to health differences “that are deemed to be unfair or stemming from some form of injustice” (Kawachi et al., 2002, p. 647, see also Braveman et al., 2011).

these substances, including gambling services. Furthermore, ANDTG policy, as part of public health policy aiming for good and equitable health across the entire population, is based on solidarity. This means that “restrictions on personal freedom can be accepted in order to protect public health, which is expressed, for example, in strong support for the Swedish alcohol monopoly, age limits for the purchase of alcohol and tobacco, and the criminalization of drugs and doping” (Skr. 2021/22:213, p. 7). Non-medical drug use and possession are therefore subject to total prohibition in Sweden.

This doctoral research project examines the years between 2015 and 2025. During this period, the possibility of a shift in Sweden’s traditionally strict drug policy became discernible – a policy that had long contested alternatives such as harm reduction and was characterized by a polarized debate (Eriksson & Edman, 2017; Tryggvesson, 2012). Eventually, in March 2020, the Swedish Parliament accepted a proposal by the Social Committee on Health and Welfare (2020) that Swedish drug policy will be evaluated. In their proposal, the Committee argued that:

Sweden needs a zero vision and zero tolerance for drug-related deaths. The primary focus should be on prevention, so that people choose not to use drugs. Furthermore, attention should be paid to the individual and his or her right to receive the support and treatment needed for their addiction. Evidence-based treatment is what helps people return to a functioning life. In the committee's opinion, a continued restrictive drug policy must be combined with good addiction treatment that includes measures to minimize harm, such as reducing the spread of blood-borne diseases. The committee therefore believes that the current drug policy should be evaluated to ensure that it is compatible with the requirements for evidence-based care, proven experience, and harm reduction (Social Committee on Health and Welfare, 2020, p. 29).

The moment when Parliament decided to evaluate the national drug policy in Sweden appeared historic. In international comparisons, Swedish drug policy has been described as restrictive⁶ relative to many other Western countries (Chatwin, 2016; Ritter et al., 2016), and it has been characterized both as “the good example” and later as “the extreme example” (Tham & Edman, 2022). Furthermore, the Swedish drug policy debate could be described as a deadlock: since the 1970s, when the country established its restrictive drug policy based on the aim of a drug-free society, there have been no clear signs of moving in other directions.

This historic decision to review the national drug policy, followed by the Government’s unwillingness to evaluate the effects of the Penal Law on Narcotics (SFS 1968:64) as part of the inquiry and the critical reactions by several stakeholders, raise questions about what had driven this development. They

⁶ Considering drug policies in the Nordic countries, those have been described as “relatively repressive” (Tham, 2021, p. 3, see also Moeller, 2019).

also provide an opportunity to advance our understanding of policy processes in the contemporary drug policy context in Sweden, including whether certain stakeholders are particularly influential in such processes. The term “stakeholders” is used here in a broad sense and refers to individuals, groups, or networks of people “who have an interest in the issue under consideration, who are affected by the issue, or who – because of their position – have or could have an active or passive influence on the decision-making and implementation processes” (Varvasovszky & Brugha, 2000, p. 341). In practice, as demonstrated in this dissertation, stakeholders refer to actors such as parliamentary members, non-governmental organizations (NGOs), people who use drugs and their significant others,⁷ politically governed organizations such as government agencies, researchers, molders of public opinion,⁸ and professionals representing social services and healthcare.

Studying stakeholders in Swedish drug policy provides an interesting angle to explore contemporary drug policy, providing an in-depth understanding of drug policymaking, since stakeholders play a crucial role in policy processes (Brugha & Varvasovszky, 2000; Frank et al., 2015; Houborg et al., 2016). Stakeholders both set agendas on policy topics and participate in formulating and implementing policies, not to mention their role in producing knowledge and evidence used in drug policymaking (Frank et al., 2015).

Aim and research questions

This dissertation explores contemporary drug policy in Sweden, with a particular focus on stakeholders. The aim is to advance our understanding of the context and policy processes shaping Swedish drug policy by analyzing stakeholders’ values, interests, and forms of involvement. This aim is guided by the health policy triangle framework, which argues that to understand policy, we should not neglect the role of actors, context, and policy processes (Walt & Gilson, 1994). Thus, the four elements of policy – actors, or in this case stakeholders, context, processes, and content – and their interrelationships play a crucial role in understanding contemporary drug policy in Sweden and its possible future directions. Furthermore, through the Swedish case, the dissertation contributes to a broader understanding of stakeholder involvement and influence, as well as moral contestations in drug policy and similar policy fields. More specifically, the dissertation seeks to answer the following research questions:

⁷ Significant others (*anhöriga* in Swedish) are family members, partners, or other people who have a close relationship with a person who uses drugs.

⁸ Molders of public opinion refers to ex-policymakers and civil servants who are still active in the policy sphere.

1. Which stakeholders may be identified within the Swedish drug policy field, and how are they involved in drug policy processes?
2. How can stakeholders' perceived successes or challenges in influencing drug policy and policymaking be understood in light of stakeholder characteristics and contextual factors?
3. How can Swedish drug policy be understood through tensions and nuances in stakeholders' values and moralities?

Background

To understand drug policymaking in Sweden, this background outlines the main practicalities of policymaking in the country and discusses the Swedish sociocultural and political context. The focus then shifts to drug use and harms. A brief history of Swedish drug policy is provided, followed by an overview of contemporary Swedish drug policy through its three traditional pillars and more recent harm reduction approaches. Finally, previous research on stakeholders and drug policy is discussed, along with the contribution of this dissertation.

The Swedish context

Policymaking in Sweden

Sweden is governed at the national, regional, local, and European Union (EU) levels (Government Offices of Sweden, 2014a). As concerns the national level, in focus here, the parliament (*Riksdagen*) makes decisions and is responsible for passing laws in Sweden. Members of Parliament (MPs) are chosen by citizens in elections every four years. Voters primarily cast their ballots for political parties but may also indicate a preference for an individual MP from a given party. After elections, a new parliament reflecting the election results appoints a Prime Minister, who then appoints the ministers who will form the government (The Riksdag, 2023). According to the Constitution (SFS 1974:152), the government governs the nation. It presents proposals (government bills) on which Parliament adopts a position and is responsible for implementing Parliament's decisions. It also governs how government agencies carry out their work. There are approximately 367 government agencies (public authorities, for example the Public Health Agency of Sweden, *Folkhälsomyndigheten*, and the National Board of Health and Welfare, *Socialstyrelsen*), which help implement decisions by Parliament and the government, provide evidence-based knowledge and guidelines, and issues legally binding regulations, for example in the fields of opioid agonist therapy (OAT) and NEPs. Government agencies are answerable to the government but can

“independently decide on matters that concern the exercise of public authority” (i.e., “decisions and measures that the agency takes in matters relating to an individual”) (The Riksdag, 2023).

Of particular policymaking importance in this dissertation are the commissions of inquiry and accompanying public debates that typically precede new laws or legislative amendments (see Government Offices of Sweden, 2014b). The usual procedure is for the government to appoint a commission of inquiry tasked with investigating a specific issue. A special investigator or a group of investigators is appointed to carry out the work, guided by directives issued by the government. The commission of inquiry and its proposals are typically presented in the form of an SOU report (Swedish Government Official Reports, in Swedish: *Statens Offentliga Utredningar*). The report is then sent to relevant government agencies and other affected stakeholders for comments, in a referral system in which stakeholders are invited to provide formal responses (see Petersson, 2016). Citizens and organizations that are not formally invited may submit unsolicited referral responses. Government agencies are required to respond to referrals, though each agency decides whether it has opinions to share (Prime Minister’s Office, 2021). The commission of inquiry report, together with the referral responses, are revised into a draft bill, which is circulated to one or more of the Parliament’s committees (e.g., the Committee on Health and Welfare or the Committee on Justice) and scrutinized by the Council on Legislation (*Lagrådet* in Swedish). Proposals are compiled into committee reports (*betänkanden* in Swedish), and in the final stage, the Parliament votes on the bill (Government Offices of Sweden, 2014b).

Local self-government, led by elected regional and municipal councils, is a long-standing Swedish tradition enshrined in the Constitution (SFS 1974:152; see also SFS 2017:725). Of particular relevance for drug policy are the activities of the county administrative boards (*länsstyrelserna*) as well as the provision of treatment and other support services by regions and municipalities. The counties and 21 regions encompass overlapping geographical areas and are thus often considered as the regional level (Government Offices of Sweden, 2014a). Each region has a county administrative board, which is responsible for state administration within the county and is tasked, among other things, with coordinating work on ANDTG in its region in order to ensure that national objectives are implemented locally. Furthermore, regions are responsible for healthcare, including dependency care and several harm reduction interventions in Sweden. The 290 municipalities are responsible for social services, which include interventions for substance use problems as well as support providing housing and financial aid. While both healthcare and social services are governed by national framework legislation, individual municipal and regional councils decide on local taxation, budgets, the goals and guidelines of services, as well as the organization and forms of service provision (Swedish Association of Local Authorities and Regions, 2025).

Swedish socio-political culture

Sweden is often characterized as a strong welfare state, with its socio-political culture based on universalism combined with deliberative democracy, and policymaking rooted in consensus, dialogue, and corporatism (Elgenius & Wennerhag, 2018; Larsson et al., 2012; Peterson et al., 2018; Petersson, 2016). Sweden's narrative of progress and its framing as a Nordic Social Democratic welfare regime, characterized by universal welfare benefits grounded in a social rights perspective, active labor market policies, and a coordinated market economy (Esping-Andersen, 1990), have shaped generations in political life and social movements (Larsson et al., 2012). However, a growing body of literature explores the Swedish welfare state's transition toward more neoliberal and market-oriented trends (Bergh & Erlingsson, 2025; Elgenius & Wennerhag, 2018; Larsson et al., 2012; Palme, 2023). Furthermore, Swedish political culture has also undergone changes. For example, the old corporatist structures emphasizing the importance of involving interest groups in public policymaking have declined (Christiansen et al., 2010; Lindvall & Sebring, 2005; Svallfors, 2016). It has been argued that corporatism has been replaced by more elite-driven policymaking, for example through professional lobbying (Bergh & Erlingsson, 2025; Öberg & Svensson, 2012; Svallfors, 2016).

According to Petersson, Swedish politics can still be portrayed as deliberative, rationalistic, open, and consensual, "but only if these four concepts are reinterpreted" (Petersson, 2016, p. 659). While in the 1960s deliberation referred to lengthy commissions of inquiry conducted by well-trained specialists, today the time span of policymaking processes has shortened. The tradition of including experts in public policymaking is still strong in Sweden (see also Eriksson & Edman, 2017), but according to Petersson (2016), the authority of experts and scientists has declined and is challenged by technological failures, environmental problems, and increasingly critical media and citizens. While rationalistic policymaking used to refer to a thorough review of evidence, today political decisions are taken on a much less solid factual basis. Furthermore, openness has declined, as not all interested parties are consulted, and the commissions of inquiry are more tightly controlled by the government (Petersson, 2016). Further, the consensus culture has been challenged by growing polarization and conflicts in parliamentary politics (Bergh & Erlingsson, 2025; Dahlström et al., 2021; Elgenius & Wennerhag, 2018; Petersson, 2016).

Drugs, prevalence, drug-related deaths and attitudes in Sweden

A contested area of politics today is drug policy. Since the drug debate often emphasizes that drug use among young people in Sweden is low, while problem levels – and particularly mortality – have shown a less favorable trend, the current situation regarding illicit drugs is briefly outlined here.

What is meant by illicit drugs is defined by law. According to the Penal Law on Narcotics (SFS 1968:64), illicit drugs are defined as:

“[...] medicine or goods that are dangerous to health and have addictive properties or euphoric effects, or goods that can easily be converted into goods with such properties or effects, which

1. are subject to control under an international agreement to which Sweden is a party, or
2. have been declared by the government to be considered narcotics under the law.”

New psychoactive substances are classified as narcotic drugs on an ongoing basis and are listed by the Swedish Medical Products Agency (2025). These substances have different properties, but they all affect the central nervous system. Substances that are hazardous to health but do not fully meet the criteria for classification as drugs can be regulated under the Act on the Prohibition of Certain Health-Hazardous Goods (SFS 1999:42). As mentioned in the Introduction, illicit drugs also include controlled pharmaceuticals, such as opioid-based painkillers or benzodiazepines, when used beyond what has been prescribed by a physician – i.e., without a prescription or in greater quantities than prescribed.

Prevalence

Illicit activities, including drug use, related to any kind of stigma in society are often underreported in surveys and interviews (Andersson et al., 2023; Harrison, 1995; Reuter et al., 2021). This is essential to keep in mind considering that the knowledge we have today about drug use in the population is primarily self-reported (Public Health Agency of Sweden, 2024).

Available information suggests that cannabis is the most used illicit drug in Sweden (Public Health Agency of Sweden, 2025a). Approximately four percent of the population aged 16–64 reported in 2024 that they had used some type of drug during the past year, and a total of 3.3 percent responded that they had used cannabis at some point during the last year. This proportion has remained relatively stable over the past ten years, with slight variation from year to year. Cannabis use is more common in younger cohorts. In the 16–34-year age group, a total of six percent reported having used cannabis in the past year,

including 7.8 percent of men and 4.1 percent of women (Public Health Agency of Sweden, 2025a).

Annual school surveys on drug use, conducted in Sweden since 1971, indicate downward trends in recent years (Svensson & Guttormsson, 2025). According to the most recent survey report, five percent of ninth-grade students reported having used any illicit drugs at least once. The prevalence among upper-secondary students, in contrast, was 12 percent, representing the lowest level recorded among this group since 2004 (Svensson & Guttormsson, 2025). Still, the frequency of use among students reporting using drugs has increased.

In international comparisons, Swedish adolescents generally report lower lifetime prevalence of any drug use, including cannabis, than the average. This is particularly evident for cannabis use in the past 30 days and for high-risk cannabis users (as measured by the Cannabis Abuse Screening Test [CAST]) (EUDA, 2025b).

Based on the results of several surveys and statistics, a recent report revealed that the trend of increasing drug use observed among the population during the 1990s has persisted, to a certain extent, in the 21st century (Guttormsson, 2025). The availability of illicit drugs has increased during the new millennium, and drug prices have become lower compared to the early 21st century. In addition, drug-related crimes have tripled in the last decades, with minor offenses becoming increasingly dominant (Guttormsson, 2025; see also Johnson et al., 2023). Men are overrepresented in most data sources, but if controlled pharmaceuticals are included in the analyses, the gender differences decrease. More frequent use, harmful use, dependence, and consequences in the form of illness and mortality are more common among people with lower socioeconomic status (Guttormsson, 2025).

In terms of more severe drug problems and diagnoses, Swedish healthcare currently uses the International Classification of Diseases (ICD)-10 system – for example, for drug dependence – whereas in surveys, the Diagnostic and Statistical Manual of Mental Disorders (DSM)-5 can be used to capture substance use disorders (Hasin et al., 2013; Volkow & Blanco, 2023; WHO, 1993). In healthcare-based specialized outpatient or inpatient substance use treatment, a total of around 26,300 people received treatment for illicit drug-related primary diagnoses in 2024 (Public Health Agency of Sweden, 2026b). Of these, 65 percent were men and 35 percent were women, and the average age was 38. According to population surveys, just under two percent meet the criteria for a mild substance use disorder according to the DSM (illicit drugs and/or non-prescribed controlled medications; Sundin, 2022).

Complete information on individuals receiving interventions for illicit drug problems via social services is lacking. According to the latest estimates,

based on a combination of other available registers including healthcare registers, the total number of people with problematic drug use⁹ in Sweden during 2007–2020 ranged from approximately 63,000 to 83,000 (Public Health Agency of Sweden, 2023a). The gender difference was greater in the latter part of this period: in 2020, there were approximately 41,000 men with problematic drug use, while the number of women had decreased to around 30,000 individuals (Public Health Agency of Sweden, 2023a).

Drug-related deaths

The available statistics show that drug-related mortality increased in Sweden between 1969 and 2015 (Estrada et al., 2023, p. 39; see Figure 1). According to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA, 2020), Sweden had the highest drug-related mortality rate per capita in the EU in 2015 (together with Estonia) and 2018. This sparked a public and political debate (see Study I and Study IV). However, comparing mortality rates due to intoxications from illicit drugs and controlled pharmaceuticals between countries is difficult because there is no internationally accepted definition of these deaths. This often results in differences in how drug-related deaths are defined, classified, and coded in different countries, complicating international comparisons (The National Board of Health and Welfare, 2022).

Regardless of the data source for Sweden (see Figure 1), the trends across all four data sources are similar, with an increase until around 2015. However, the number of drug-related deaths in Sweden fell by 30 percent between 2015 and 2023 (Public Health Agency of Sweden, 2025). In 2023, 474 people died, of whom 324 were men and 150 were women. Opioids were involved in 82 percent of deaths in cases where the substance or substances contributing to the death could be identified (Public Health Agency of Sweden, 2025a, see also EUDA, 2025a).

⁹ Problematic drug use is defined as “repeated use of drugs that causes actual harm (negative consequences, including dependence, but also other health-related, psychological, or social problems) to the individual, or increases the risk of the individual suffering such harm” (Public Health Agency of Sweden, 2023a, p.7).

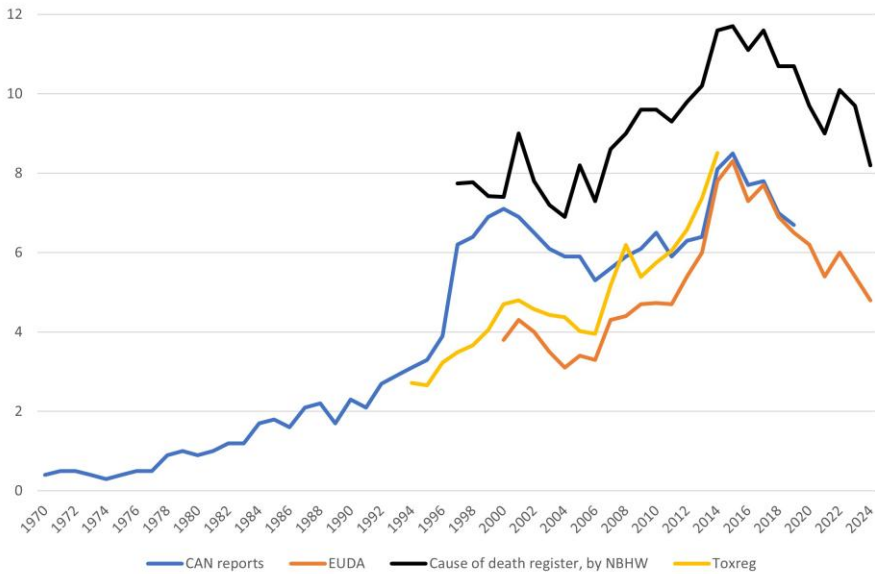


Figure 1. Drug-related deaths in Sweden 1969–2024, per 100 000 population aged 15 years and older, by four data sources.¹⁰

Attitudes toward drugs

Beyond the severe harms caused by drug use, including mortality, the development of Swedish drug policy can also be understood in the light of the populations’ attitudes toward drugs. Survey findings show that drugs have long been perceived as a serious social problem and people who use drugs as “sinners”, but also as “victims” (Bergmark & Oscarsson, 1988; Blomqvist, 2009; Hübner, 2001). The majority of the adult population in Sweden is concerned about increased illicit drug use (SOM-institutet, 2025)¹¹ and has a negative attitude toward drugs (Public Health Agency of Sweden, 2023b). However, attitudes toward cannabis are generally more positive compared to other illicit drugs, especially among younger people. Furthermore, population surveys among adults in Sweden indicate a shift in attitudes toward cannabis between 2014 and 2024. In 2024, almost a quarter of the respondents reported support

¹⁰ The figure uses data from Figure 2.6 in Estrada et al. (2023, p. 39) and has been updated with recent data. Population figures (aged 15 years and older) are based on official statistics from Statistics Sweden (n.d.). Data on deaths due to drug and narcotics poisoning (including controlled drugs) for the years 2012–2024 are taken from the Cause of Death Register published by the National Board of Health and Welfare (2025, Table 1). Drug-induced deaths reported to EUDA from 2010–2023 are based on EUDA (2025a, Figure 11.5c), and the most recent figure for 2024 is taken from the Public Health Agency of Sweden (2025b). For details on different indicators, see Leifman (2016).

¹¹ Furthermore, the highest percentage of respondents worry about organized criminality, a topic related to illegal drug markets (see Study IV).

for a less restrictive cannabis policy, compared with six percent a decade earlier. Young men are the least restrictive demographic group in this regard; in 2024, about half of men aged 18–29 even favored legalizing cannabis. A smaller share of all respondents (14%) expressed support for a less restrictive approach to illicit drugs more broadly (Leifman & Brännström, 2025).

According to the latest European Web Survey on Drugs,¹² Swedish participants perceived that the country's drug legislation causes problems for both society and people who use drugs (Public Health Agency of Sweden, 2026a). Furthermore, they reported that stigmatization and concerns about being punished could make it more difficult for people who use drugs to seek and receive care. Participants also stated that the fear of punishment can reduce motivation to respond to drug-related surveys or to answer drug use related questions honestly (Public Health Agency of Sweden, 2026a).

It can thus be understood that stigma is a central issue when considering people who use drugs in Sweden (Månsson et al., 2025; Soussan & Kjellgren, 2019; Storbjörk et al., 2025). This finding was supported by a comparative study between Sweden and neighboring Denmark, which has a somewhat more liberal approach to drugs, also suggesting that people who use drugs experience stigma as more pronounced in Sweden (Holeksa, 2024b).

A brief history of Swedish drug policy

To understand the contemporary context of Swedish drug policy studied in this dissertation (the years 2015–2025), it is essential to consider how drug policy has developed in the past. The intention is not to provide a detailed history of Swedish drug policy, as this has been addressed elsewhere (e.g., Edman, 2011; Goldberg, 2004; Lenke & Olsson, 2002; Lindgren, 1993; Tham, 2021; Träskman, 2011). Rather, the intention here is to highlight broad shifts in drug policy formation in order to understand the social, political, and cultural context underlying contemporary Swedish drug policy.

Although all three traditional pillars of drug policy – control, prevention, and treatment – have been longstanding components of Swedish drug policy, harm reduction represents a more recent development and is the focus of Studies III and IV. Therefore, when discussing the history and development of drug policy formation in Sweden, the particular policy area of harm reduction is addressed separately and, in more detail, below.

The different understandings of drug use as a problem have affected policy formation, with conceptions shifting between seeing drugs as a medical problem and as a social problem (Edman, 2011, 2013). Drug policy began to take shape in the 1960s when politicians and government agencies started to view

¹² The European Web Survey on Drugs is run by EUDA and its partners. It explores how people use and purchase drugs among those who have recently used them (EUDA, 2026a).

drug use as a social problem among young people and criminals (Lindgren, 1993). In their overview of Swedish drug policy, Lenke and Olsson (2002, p. 66) note that “the challenges that drug use and drug problems pose to a particular society are dependent not only on specific developments in drug patterns and trends but also on any peculiarities in a society’s historical, moral, and social contexts.” One peculiarity in Sweden mentioned by the authors is the long historical dominance of amphetamines. The high prevalence of amphetamines still exists in Sweden (Guttormsson, 2025). During the 1960s, use of both amphetamines and cannabis grew among youth, which transformed into a public panic, and drugs became constructed as a social problem. In 1961, Sweden, together with several other countries, signed the Single Convention under the United Nations. The debate over drugs as a societal problem was intense, particularly regarding whether people who use drugs should be punished or given treatment. Between 1965 and 1967, Sweden even experimented with a prescription program in which patients were prescribed large doses of amphetamines as well as opioids. The project was discontinued and was later described as a catastrophe and “the cause of the Swedish drug epidemic” (Lenke & Olsson, 2002, p. 67).

Perhaps to some extent related to the afore mentioned program, the Penal Law on Narcotics (SFS 1968:64) was enacted in 1968. It included actions that had already been prohibited, such as the illegal manufacture, sale, and transfer of narcotics, as well as illegal possession. During the same year, the Prosecutor General of Sweden allowed for refraining from prosecution for possession for personal use, with the justification that people should receive treatment rather than punishment. This change also reflects a shift in problem construction. In the inquiry report published in 1967, the Drug Treatment Committee (*Narkomanvårdskommittén*), the first commission of inquiry concerning substance use, debated whether drug abuse (*missbruk* in Swedish)¹³ should be seen as a disease or as a rational reaction to a dysfunctional and excluding society (Edman, 2019). The disease perspective became dominant, and drug treatment for people who use drugs began to take its current form in Sweden in the 1970s, with a drug-free orientation focused on control and socialization, and goals aimed at a cure resulting in a lifelong abstinence (Blomqvist et al., 2009).

Between 1968 and the early 1980s, the focus of drug control in Sweden gradually shifted from drug supply reduction to drug demand reduction (Johnson et al., 2023; Lenke & Olsson, 2002). In practice, this meant that harsh

¹³ In this history section, the word “drug abuse” is used when referring to problematic drug use. The word has a negative connotation in both English and Swedish. There have been suggestions to replace the word with other terms, such as “harmful use” or “problematic use” (SOU 2023:62; Swedish Association of Local Authorities and Regions, 2018). The proposal to replace the Swedish term “missbruk” (drug abuse) with “harmful use and dependence” in Swedish legislation was submitted to the Council on Legislation in February 2026 (Government Offices of Sweden, 2026).

penalties for organized drug trafficking were retained, while judicial efforts increasingly focused on individual users. One person frequently mentioned in the history of Swedish drug policy is psychiatrist Nils Bejerot, one of the founders of the National Association for a Drug Free Society (*Riksförbundet för Narkotikafritt Samhälle* [RNS]).¹⁴ In the literature, his theory of understanding drug abuse through an epidemic model had a significant impact on drug policy formation in Sweden in the 1980s, inspiring a stronger emphasis on regulating the demand side (Johnson, 2021; Lenke & Olsson, 2002; Tham & Edman, 2022).

As a result, since 1968, penalties for drug crimes have become increasingly stricter in Sweden. In 1978, the Swedish Parliament discussed the need to “eliminate drug abuse” (Prop. 1977/78:105), and in 1984, the policy goal of a drug-free society was adopted (Prop. 1984/85:19). Soon after, in 1988, drug use was criminalized in Sweden. The prohibition of consumption has been justified by arguing that it allows opportunities to intervene with help and support at an earlier stage of an individual’s drug use and that “it is important that society expresses a rejection of any unlawful use of drugs” (Prop. 1992/93:142). It has been noted that drug prohibition generally leads to reduced drug use and increased drug prices, but also an emergence of illegal markets and organized crime, and there is still no consensus among researchers on the effects of Swedish drug control (Johnson et al., 2023).

During the 1980s, drug treatment expanded due to the detection of HIV/AIDS but declined again in the 1990s because of the economic crisis (Blomqvist et al., 2009). After drug use was criminalized in 1988, consumption was a finable offense, but coercive investigative measures could only be used if imprisonment was included in the penalty scale (Johnson et al., 2023). This meant that involuntary drug tests could not be conducted, making the crimes difficult to investigate. For this reason, the legislation was tightened in 1993 by increasing the maximum penalty for drug use to six months in prison. After that, the police began prioritizing efforts against personal use, and the number of people convicted of this crime increased sharply (Johnson et al., 2023). In 2000, a drug-related commission of inquiry published its report “On the Crossroads” (SOU 2000:126), evaluating Swedish drug policy efforts from the mid-1980s and proposing measures to prevent drug abuse (*missbruk*), rehabilitate drug users, and limit the availability of drugs. The inquiry concluded that Sweden must “strengthen, renew, and develop the restrictive drug policy” (SOU 2000:126, p. 12).

¹⁴ RNS, together with other NGOs having their roots in the Swedish temperance movement, have been described as influential actors in forming Swedish drug policy (e.g., Lenke & Olsson, 2002). Like RNS, another NGO named in the history of Swedish drug policy, the National Association for Help for Drug Users (RFHL), a client organization for people who use drugs, was founded in the 1960s. RFHL was the first drug user organization in Sweden, driving for better access to treatment for people who use drugs (Laanemets, 2006).

In 2003, drug policy officially became part of public health policy in Sweden, along with several other policy areas (Prop. 2002/03:35). The overarching goal of public health policy was “to create societal conditions for good health on equal terms for the entire population” and to ensure that “public health is improved for the groups in the population that are most exposed to ill health” (Prop. 2002/03:35, p. 1). The proposal also highlighted the need for better coordination and increased focus on the connections between the use and abuse of various addictive substances (Prop. 2002/03:35, p. 84). Since 2011, policies on alcohol, narcotics, doping, tobacco, and, in recent years, gambling, have formed a joint strategy. The overall goal of the ANDTG policy is “a society free of drugs and doping, reduced medical and social harm caused by alcohol and tobacco,” and to “reduce the harmful effects of excessive gambling” (Prop. 2002/03:35; Prop. 2010/11:47; Prop. 2024/25:1).

Contemporary Swedish drug policy

The dissertation’s sub-studies concern the period between 2015 and 2025, understood here representing contemporary Swedish drug policy. As discussed in the Introduction, during this period, the possibility of a shift in Sweden’s restrictive drug policy became discernible through a broad support by policy-makers and other stakeholders for reviewing the national drug policy. The studied period begins in 2015, when drug-related mortality reached its peak in Sweden (Public Health Agency of Sweden, 2025, see also Figure 1 in Prevalence section), and concludes in 2025, when Study IV was conducted. This section provides an overview of contemporary drug policy in Sweden.

As mentioned, Swedish drug policy is guided by the three UN conventions and by parliamentary decisions that regulate the concrete formulation and application of the policy (Svensson & Svensson, 2022). The UN conventions consist of three drug control treaties signed by member states: the Single Convention on Narcotic Drugs of 1961; the Convention on Psychotropic Substances of 1971; and the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988 (UNODC, 2013). These conventions aim to prevent the harmful use of psychoactive substances while ensuring their availability for medical and scientific purposes, constituting “the cornerstone of the international drug control system” (UNODC, 2020, p. iii; see also p. 1). The 1961 Convention regulates drugs such as cannabis, cocaine, and opium, while the 1971 Convention focuses on psychoactive drugs, such as amphetamines and ecstasy. Finally, the 1988 Convention concerns drug trafficking and the regulation of precursors (UNODC, 2013).¹⁵ These

¹⁵ Precursors refer to substances that are frequently used to illicitly manufacture illicit drugs (UNODC, 2020).

conventions are used when deciding on the scope of control of substances by member states (UNODC, 2020).

In addition, all EU member states have ratified the UN conventions, which serve as the foundation for EU regulations. Consequently, the EU provides a framework that shapes Swedish drug policy (Johnson et al., 2023). To coordinate and streamline member states' drug policies, the EU has presented time-limited strategic plans with broad objectives and action plans specifying these plans in concrete terms and identifying those responsible for implementation since 1990. According to the EU's drug strategy for 2020–2025, the aim was “to protect and improve the well-being of society and of the individual, to protect and promote public health, to offer a high level of security and well-being for the general public and to increase health literacy” (Council of the European Union, 2021, p. 6). Furthermore, it adopted an evidence-based and multidisciplinary approach to the issue of drugs at national, EU, and international levels, with a focus on gender equality and health equity. The updated EU drug strategy for 2026–2030 adopts a somewhat different approach, focusing more on drug trafficking (European Commission, 2025). This new strategy was criticized by civil society, which argued that it deprioritizes harm reduction (International Drug Policy Consortium, 2025).

As discussed above, Swedish drug policy has been part of the national public health policy since 2003 (Prop. 2002/03:35) and part of the joint ANDTG strategy since 2011. Since 2018, public health policy has reoriented to consist of eight key areas, with the ANDTG strategy included under the key area ‘Health behaviors’ (Prop. 2017/18:249). Drug policy is also strongly influenced by government economic decisions, including budget allocations to customs, police, prison services, and compulsory treatment, as well as through government subsidy regulations in the field of drugs (Svensson & Svensson, 2022). Furthermore, national laws and regulations guide the regions and municipalities in their policymaking work, including policy implementation in Sweden.

Next, the pillars of drug policy – control, prevention, and treatment – are briefly presented, with special emphasis on the more recent pillar of harm reduction (central to Study III and IV).

Three traditional pillars of drug policy

As discussed in the Introduction, the *control* policy area concerns policy measures aiming to control and eliminate the production and distribution of illicit drugs (Babor et al., 2018). Within the Swedish context, together with above mentioned international regulations and strategies (the UN and EU), the Penal Law on Narcotics (SFS 1968:64) guides this policy area. According to Section 1, it is a criminal offense to:

- provide narcotics
- produce narcotics that are intended for misuse

- possess narcotics with the intent to supply
- acquire, process, package, transport, and store narcotics
- offer narcotics for sale
- possess or trade narcotics-related payments
- convey contact information between buyers and sellers or any other such act if the intent is to promote the trade of narcotics
- possess, use, or handle narcotics

In the Swedish government, drug control measures fall under the Ministry of Justice, while prevention, treatment, and harm reduction are the responsibility of the Ministry of Health and Social Affairs. Lately, as illustrated in Study IV, organized criminality has been one of the most discussed problems in Sweden. Criminal networks controlling illicit drug markets and drug market-related violence have attracted attention (Magnusson & Gerell, 2026), prompting reactions from the government. In practice, this has meant intensifying efforts to reduce access to drugs and combat drug-related crime. For example, in 2020, the government appointed a special investigator to consider a range of criminal law measures against crimes in criminal networks, including a tougher response to drug trafficking (Dir. 2020:62). In 2021, the commission of inquiry's report "Stricter penalties for crimes committed by criminal networks" (SOU 2021:68) was published, proposing, among other measures, stricter penalties for the sale of small amounts of drugs, dealing with drugs intended for sale, and criminalizing ordering drugs for personal use as a tentative offense. The Parliament accepted the bill in 2023 (Prop. 2022/23:53, 2023).

The organizations and actors (stakeholders) responsible for implementing these policies are the Swedish Police Authority (*Polismyndigheten*), Swedish Customs (*Tullverket*), and the Swedish Prison and Probation Service (*Kriminalvården*) (Johnson et al., 2023). Drug offenses mainly consist of intervention and surveillance offenses (Swedish Police, 2025). Accordingly, the police focus on preventing, detecting, and intervening in illegal trade and manufacturing, aiming to reduce the availability of drugs. Customs are responsible for combating drug smuggling (Swedish Customs, 2025), while the Swedish Prison and Probation Service (2026) organizes rehabilitation programs for inmates with substance use problems.

Prevention, the second drug policy area, concerns strategies and programs to prevent drug use among the population with a special focus on the initiation of drug use (Babor et al., 2018). In Sweden, the Public Health Agency of Sweden is the government agency responsible for prevention. The aim of drug prevention work is to improve people's living conditions and habits, so that as few people as possible start using drugs, and those who have used are encouraged to stop before becoming dependent (Public Health Agency of Sweden, 2020). Preventive work can also be adapted to people with varying degrees of drug use, for example, with the aim of reducing use.

Drug prevention work mainly takes place at the local level in municipalities, coordinated by local ANDTG coordinators (Public Health Agency of Sweden, 2020). The county administrative boards support municipalities in their prevention efforts. The actual prevention work is based on the European Prevention Curriculum (EUPC), established by EUDA (2026b), which provides knowledge on the most effective evidence-based prevention interventions and approaches (EMCDDA, 2019).

In 2025, the Social Services Act (SFS 2025:400) was reformed to strengthen municipalities' obligations to prevent and address substance use and gambling problems through more proactive, accessible, and knowledge-based services. However, because municipalities have considerable autonomy in implementing the reform, there is still uncertainty at the local level about how preventive responsibilities, low-threshold services, and evidence-based practices will be carried out.

The third pillar of drug policy is *treatment*, concerning rehabilitation, care, and social service programs intended to provide help and support to people who use drugs (Babor et al., 2018). As Storbjörk et al. (2019) summarized, the primary responsibility for organizing and providing services has since the 1980s been entrusted to the regional and local public administrations. For the time being, it is the municipalities and social services that hold the main treatment responsibility, with municipalities providing specialized substance use treatment services. The regions are responsible for health care and mental health services in Sweden, including providing medically assisted treatment for substance use problems and treating medical complications (Blomqvist et al., 2009). This includes also harm reduction intervention such as OAT and NEP.

Recently, a Comorbidity Inquiry (SOU 2021:93) was conducted to improve care and support for individuals with both harmful substance use and addiction, as well as another psychiatric diagnosis. The inquiry aimed to create a more cohesive care chain for people with comorbidities, allowing psychiatric and addiction care needs to be managed simultaneously. The final report, published in 2023, suggested that the main responsibility for treatment be shifted from social services to the healthcare system. In 2025, the government appointed a special comorbidity delegation to further develop proposals on how the regions should be given overall responsibility for all psychiatric diagnoses, including harmful use and dependence (Torkelsson, 2025).

The government has proceeded with the proposals, and the legislative referral submitted to the Council on Legislation (*Lagrådet*) in February 2026 proposes that, from July 2027, the regions will be responsible for substance use treatment while the social services will remain responsible for social interventions. A new law is proposed to regulate coordinated care and support services, through which healthcare providers and social services will work together helping individuals with certain needs for coordinated interventions (Government Offices of Sweden, 2026).

Evidently, issues concerning treatment as well as harm reduction have been discussed for a long time. Another recent commission of inquiry, briefly mentioned in the Introduction, is also closely related to prevention, treatment, and harm reduction: the Drug Commission of Inquiry (DCI) (SOU 2023:62). This inquiry forms an essential part of this dissertation. As noted in the Introduction and analyzed in Study IV, in 2020, the Parliament's Committee on Health and Welfare proposed evaluating the national drug policy in Sweden. The Parliament supported this proposal, but government representatives announced that the Penal Law on Narcotics (SFS 1968:64) would not be included in the inquiry. Despite critique from stakeholders, the government did not change its position. In 2022, the Social Minister for Health and Social Affairs announced the directive for the inquiry:

A special investigator shall propose how a continued restrictive drug policy can be combined with effective drug prevention work, good abuse and addiction care that includes harm reduction measures, and measures to ensure that no one dies as a result of drug and narcotics poisoning. The purpose of the investigation is to ensure that drug policy is compatible with the requirements of evidence-based care, proven experience, and harm reduction, and that it is developed and adapted to the challenges of today and tomorrow. (SOU 2023:62, p. 67)

Thus, greater emphasis on harm reduction is being called for, including by the government, although it has not been willing to go so far as to evaluate the Penal Law on Narcotics (SFS 1968:64) or the consequences of criminalizing personal drug use.

Harm reduction

According to the WHO (2026), there is no universally accepted definition of drug-related harm reduction: "However, it is known to cover a set of activities that are intended to minimize the negative physical and social impact, including the transmission of HIV, incurred by the behaviors related to drug use" (WHO, 2026). Harm Reduction International (2026) defines harm reduction as "policies, programs and practices that aim to minimize the negative health, social and legal impact associated with drug use, drug policies and drug laws." As discussed in the Introduction, harm reduction can also be understood as interventions that aim to reduce the harmful consequences associated with drug use, regardless of changes in consumption (Marlatt & Witkiewitz, 2010).

In practice, harm reduction includes measures such as NEPs, which provide clean needles and syringes to people who use drugs; OAT, which offers substitution treatment to people who use opioids; Take-Home Naloxone (THN), which provides an opioid overdose antidote; and safe consumption sites (SCS), which provide a protected and medically supervised environment for drug use (EUDA, 2025c). Evidence suggests that these harm reduction services engage people who use drugs, improving their health and well-being,

and may also increase access to treatment (Boucher et al., 2017; EUDA, 2025c; Jakubowski et al., 2023; Kennedy et al., 2017; McGowan et al., 2013). Furthermore, NEPs have been shown to help prevent the transmission of blood-borne viruses among people who use drugs (ECDC & EMCDDA, 2023; Hancock et al., 2020; Sweeney et al., 2019). OAT is associated with health benefits for people who use drugs, including reduced risk of infectious disease and mortality, as well as improved mental well-being and quality of life (e.g., Brothers & Bonn, 2019; Moazen-Zadeh et al., 2021; Nosyk et al., 2015). Moreover, SCS have been associated with reducing overdose-related harms and unsafe drug use behaviors (Kennedy et al., 2017).

International organizations such as the WHO, the Joint UN Programme on HIV and AIDS (UNAIDS), and the EU support the development of harm reduction measures. As noted in the Introduction, the UN's CNDR has recently officially recognized harm reduction (Ahmad et al., 2024; Council of the European Union, 2021; Rhodes & Hedrich, 2010; Room, 1997; UNAIDS, 2021). Many European countries adopted harm reduction into national drug policy through NEPs in the 1980s as a response to HIV (Fuchs & Degkwitz, 1995).

In Sweden, the development of harm reduction has been slow and controversial compared with other countries (Karlsson et al., 2021; Tham, 2021). NEPs were first introduced as trials in Malmö and Lund in 1986 and 1987, but it was not until 2006 that the law on NEPs (SFS 2006:323) was established. The official introduction of NEPs can, at least in part, be explained by framing the issue as infection control rather than drug policy (Eriksson & Edman, 2017). Implementation remained slow, and several subsequent legal amendments were introduced to improve access across all regions, as NEPs fall under the responsibility of the healthcare system. The age limit was lowered from 20 to 18 years in 2017 (Prop. 2016/17:15), and municipalities' right to veto the establishment of NEP units in their areas was abolished in the same year (Social Committee on Health and Welfare, 2017). The requirement to be a resident of a region to participate in NEPs was removed in 2022 (Prop. 2021/22:129). Currently, all regions in Sweden provide NEPs (Public Health Agency of Sweden, 2026b). In 2024, there were 32 NEPs and one mobile unit in Sweden, serving a total of 5,879 clients and distributing approximately 2 million injection needles (Public Health Agency of Sweden, 2026b).

OAT has a longer history in Sweden, as the country was one of the first to experiment with methadone substitution treatment at Ulleråker in Uppsala from 1966 to 1983 (Johnson, 2003). Opposition to providing people who use drugs with medications contributed to the program being suspended in 1979 while the issue was under review. In 1981, the National Board of Health and Welfare approved methadone treatment for people dependent on opioids (for a brief history of OAT in Sweden, see SOU 2023:62, p. 542). However, strict regulations limited access, for example through a national cap on the number of patients and continued illicit drug use typically resulted in discharge from treatment (Ekendahl, 2009). Following the introduction of buprenorphine and

physicians' ability to prescribe it freely in the early 2000s, the guidelines were revised so that OAT was regulated under a unified framework. Although the regulatory regime remained restrictive, several updates have since been implemented (e.g., National Board of Health and Welfare, 2026). The national patient cap was removed in 2005, and OAT has been recommended in treatment guidelines by the National Board of Health and Welfare since 2007 (Ledberg, 2017). OAT is currently available in every region in Sweden (Public Health Agency of Sweden, 2026b).

THN enables administration of the opioid overdose antidote in the event of an overdose (EUDA, 2025c). The possibility of introducing THN in Sweden was raised around 2016 and was soon recommended by the National Board of Health and Welfare and the Public Health Agency of Sweden (National Board of Health and Welfare, 2017). However, implementation was initially hindered by regulatory barriers, as prescribing a medication to one individual for administration by another posed legal challenges. This bureaucratic issue was eventually resolved, and since 2018, naloxone can be distributed through THN programs (SOU 2022:54, 2022, p. 18). Moreover, THN has been approved for over-the-counter sale at community pharmacies since 2024 (Swedish Medical Products Agency, 2024). According to the Public Health Agency of Sweden (2026b), NEPs are an important channel for distributing THN, and in 2024, 4,462 naloxone kits and 3,340 naloxone refills were distributed.

The social services' responsibility for the long-term rehabilitation of individuals with alcohol or drug problems (Blomqvist et al., 2009) has often included various forms of supported housing, and for many years residential facilities existed where ongoing substance use was relatively tolerated, although active use typically resulted in discharge. More recently, efforts to support stable housing have become more institutionalized through Housing First. This model was first introduced in Sweden in 2018 based on the principle that individuals need a stable living situation before they can be expected to address substance use (Knutagård & Kristiansen, 2013). According to the National Board of Health and Welfare, 35 percent of the country's municipalities had implemented Housing First in 2024 (National Board of Health and Welfare, 2024), and 88 municipalities applied for and received government grants at some point since autumn 2022 to start, expand, or develop Housing First locally (National Board of Health and Welfare, 2026). However, it is uncertain how many municipalities currently implement Housing First.

In 2023, the final report of the DCI included several proposals from the special investigator on how to strengthen harm reduction in Sweden. For example, the Government was encouraged to define harm reduction as "measures, programs, 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," to consider updating the drug policy aim from "a drug-free society" to "a society with

reduced harm from drugs,” and to review the Penal Law on Narcotics to include SCS and drug-checking measures (SOU 2023:62, pp. 43–44).

Previous research on stakeholders and drug policy

As discussed in the Introduction, drug policy formation is complex – the field consists of several actors who attempt to affect or are affected by the policy, with often-contesting interests and views on the drug problem and the best solutions to “solve” the problem (Thom et al., 2015; Ritter, 2021). Examining stakeholder involvement in drug policymaking helps further our understanding of how issues enter the policy agenda and of the factors that influence policy content and policy processes (Houborg et al., 2016).

When it comes to previous research on stakeholders and drug policies, one of the most well-known research projects was “Addictions and Lifestyles in Contemporary Europe – Reframing Addictions Project” (ALICE RAP) 2011–2016. This international EU-funded project aimed, among other objectives, to study the role of different stakeholder groups in the formulation and implementation of policy in the addictions field in Austria, Denmark, Finland, Italy, Poland, and the UK (Thom et al., 2015, p. 3). For example, case studies of OAT policy conducted in five European countries highlighted the strategies stakeholder groups used to position themselves in the policy arena and increase their policy salience, as well as how their positioning, legitimacy, and power could be affected by political change (Asmussen Frank et al., 2013; Beccaria & Rolando, 2013; Duke et al., 2013; Moskalewicz & Welbel, 2013; Perälä et al., 2013). However, Sweden was not included in these stakeholder analyses.

One of the identified strategies to increase stakeholder policy salience concerned use of evidence in drug policy formation (Thom et al., 2015), a topic analyzed in several drug policy contexts (e.g., Lancaster et al., 2018; valentine et al., 2020). Previous findings show how evidence-based knowledge by experts has been prioritized over knowledge by people who use drugs, also referred to as *lived experiences* (e.g., Bjerger et al., 2015, 2016; Lancaster et al., 2018; Thom et al., 2015; valentine et al., 2020). Furthermore, different forms of participation (e.g., Lancaster et al., 2018) and the inclusion of people who use drugs and significant others as stakeholders in drug policymaking have been examined (e.g., Anker et al., 2006; Anker, 2007; Bjerger et al., 2015, 2016; Frank et al., 2012; Madden, 2022; Madden et al., 2021; Ross, 2020). The findings of these studies highlight the limited opportunities for participation in drug policy formation, which are often perceived as largely symbolic.

Previous research has also examined stakeholders’ perceptions of specific drug policy issues, such as overall drug policy strategy (e.g., Greer et al., 2024), stakeholder power to influence policy (Zakimi et al., 2024), and their experiences or views of implementing new policy measures, such as SCS

(e.g., Houborg & Frank, 2014; Kryszajtys et al., 2022; Unlu et al., 2022), as well as analyses of the morality and power of stakeholders in drug policy processes (Stevens, 2024).

Within the Swedish drug policy context, previous research has examined stakeholder groups and their perspectives on specific drug policy-related issues. For example, studies on parliamentary debates on NEP (Eriksson & Edman, 2017; Tryggvesson, 2012) reveal two distinctive sides arguing for and against NEP, justifying their arguments based on differing values. Furthermore, a recent study on views of local policymakers, people who use drugs, and treatment professionals on NEP (Eriksson et al., 2025) sheds light on three moral dilemmas concerning Swedish drug policy: whether people who use drugs should be included in society; whether the general public should be prioritized over the health of people who use drugs; and whether practices should be oriented toward control or autonomy (Eriksson et al., 2025). In addition, recent studies on social workers' perspectives on harm reduction (Holeksa & Richert, 2024), and police officers' attitudes toward harm reduction (Nordgren et al., 2022) highlight the growing acceptance of harm reduction among these particular stakeholder categories (Holeksa & Richert, 2024; Nordgren et al., 2022).

Only a few studies on drug policy-related topics have included representatives from several stakeholder categories in their data or focused on analyzing their arguments or role in drug policymaking (Feltmann et al., 2024; Johnson, 2003, 2021; Storbjörk, 2014). They indicate how certain stakeholders have played a pivotal role in policy formation, such as when adopting new policy measures like OAT (Johnson, 2003) or blocking a policy reform with critical or mixed responses (Storbjörk, 2014). Furthermore, previous research on the role and opportunities of different stakeholders to participate in drug policy formation in Sweden has been limited, focusing on organizations for people who use drugs (Johnson, 2006; Laanemets, 2006), including Nordic comparisons (Anker, 2007; Frank et al., 2012), and recently, an analysis of Nils Bejerot (Johnson, 2021). The results illustrate the limited opportunities of people who use drugs to put forward their views and to become involved in drug policy processes (Frank et al., 2012; Johnson, 2006).

This dissertation contributes to the research field on several fronts. First, at the national level, it identifies key stakeholders active within the contemporary drug policy debate based on several data sets (Study I and Study III), and provides a more comprehensive perspective of contemporary Swedish drug policy by including several stakeholder categories and perspectives in the analyses (Studies I–IV). Secondly, it contributes to both national and international research fields, advancing our understanding of stakeholders' values and moralities (Study I) and whether stakeholders hold similar moral positions, thereby forming policy constellations (Study III). In addition, the dissertation presents what is, to the best of our knowledge, the first systematic

analysis of stakeholders' strategies to influence drug policymaking and perceptions of other stakeholders' opportunities to influence drug policy formation in Sweden (Study II). The analysis provides new insights into stakeholder involvement in drug policy formation in Sweden, updates previous findings on drug user organizations, and extends the scope of research beyond this stakeholder group (cf. Johnson, 2006; Laanemets, 2006; Anker et al., 2006). Similarly, Study III, which analyzes stakeholders' perceptions on commissions of inquiry as a tool in drug policymaking – a topic that has not been previously examined – advances our understanding of stakeholder involvement in drug policy processes. Furthermore, the dissertation contributes to the international literature on drug policy by explaining why harm reduction measures have gained greater acceptance alongside increasingly severe penal responses to drug offenses in Sweden, as well as the role of stakeholders in these processes (Study IV). In doing so, it provides a valuable perspective on the extent to which trends toward harm reduction and control can be reconciled. These analyses, grounded in a broad perspective on stakeholders' perceptions, values, and moralities, as well as their experiences, contribute to a more nuanced understanding of how public health is conceptualized, contested, and implemented within the context of drug policy.

Theoretical framework

The theoretical framework of the dissertation consists of multiple theories and concepts that were utilized in the sub-studies. The selection of concepts and theories was informed by their relevance to the empirical data and the focus of each article. In this chapter, these theories and concepts are discussed in greater detail, with particular attention to how they complement each other and how they are connected to the health policy triangle framework (Walt & Gilson, 1994).¹⁶

Health policy triangle framework

The health policy triangle framework by public health researchers Walt and Gilson (1994) forms the overarching theoretical basis of this dissertation. Originally developed to analyze health sector policies, it has since been applied to a wide range of health issues (O'Brien et al., 2020; Walt et al., 2008). The framework can be used both retrospectively and prospectively and has significantly contributed to the development of health policy research globally (O'Brien et al., 2020; Walt et al., 2008). Walt and Gilson (1994) argued that health policy research often focused on policy content, neglecting actors, context, and processes. They emphasized that concentrating on content alone “diverts attention from understanding the processes which explain why desired policy outcomes fail to emerge” (Walt & Gilson, 1994, p. 354). The triangle model illustrates the complex interrelationships between actors, processes, context, and content, with all four elements interacting to shape policy formation (see Figure 2).

¹⁶ The selected theories use different concepts in their original formulations. For example, the health policy triangle framework refers to *actors*, justification analysis uses *moral justifications*, and the policy constellation approach refers to, for example, *moral positions*. In the presentations of the theories, the original terms are used. In this chapter, the use of these concepts in this dissertation is clarified, i.e., stakeholder, values, and moralities.

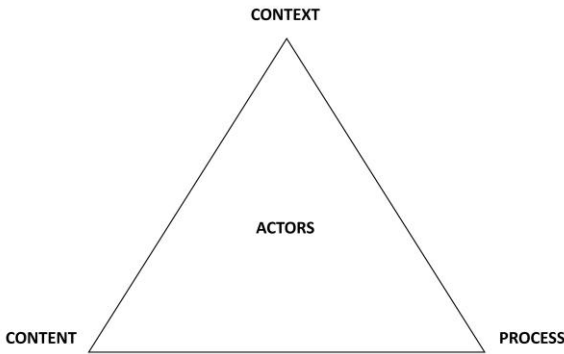


Figure 2. Health policy triangle framework by Walt and Gilson (1994)

Actors – at the center of the triangle model – refer to individuals, groups, and organizations involved in policy reform, corresponding with stakeholders in this dissertation. The three points of the triangle represent: *process*, which concerns the stages of policy formation, including agenda-setting, decision-making, and implementation (Walt & Gilson, 1994); *context*, which refers to the policy environment, encompassing social, economic, political, and cultural factors; and *content*, which denotes the regulations, legislation, strategies, and guidelines related to the specific policy objective – in this case, drug policy (Walt & Gilson, 1994; see also O’Brien et al., 2020; Zahidie et al., 2023).

Walt and Gilson (1994) summarize the interrelationships between the four policy elements (actors, process, context, and content) as follows:

In reality, actors are influenced (as individuals and as members of interest groups or professional associations) by the context within which they live and work, at both the macro-government level and the micro-institutional level. Context is affected by many factors such as instability or uncertainty created by changes in political regime or war; by neo-liberal or socialist ideology; by historical experience and culture. The process of policymaking (how issues get onto the policy agenda, how they fare once there) in turn is affected by actors, their position in power structures, their own values and expectations. And the content of policy will reflect some or all of the above dimensions. (Walt & Gilson, 1994, p. 354)

According to Walt and Gilson (1994), the framework emphasizes the critical role of actors in policy processes: actors influence the values and moralities inherent in policy while simultaneously being influenced by the policy context. Furthermore, the framework underscores that understanding policy formation as a dynamic process is essential, for example when considering a continuously shifting policy environment and the transforming relationships between actors (stakeholders).

The aim of the dissertation aligns with this framework by focusing on the actors – stakeholders – through which we can advance our understanding of the policy processes and contexts of Swedish drug policy. Due to its universal nature, the framework can be applied to analyze different policy topics at regional, national, and global levels (Zahidie et al., 2023). However, previous research has often complemented the framework with additional theories or concepts drawn from other policy theories to further elaborate the analysis (e.g., O’Brien et al., 2020; Zahidie et al., 2023), which is also the case in this dissertation. Next, the selected theories and concepts adopted in the sub-studies are discussed in more detail below. The chapter concludes with a summary of how these theories and concepts complement each other and are related to the health policy triangle framework.

Stakeholder theory

As discussed above, according to the health policy triangle framework, actors influence the policy processes and the content of policy through their behavior, interests, values and moralities, and their attempted, and at times achieved, policy goals (Walt & Gilson, 1994). Due to the emphasis on actors and their significant role in policy, stakeholder analysis based on stakeholder theory has often been used as an additional framework alongside the health policy triangle framework in health policy research (e.g., Chen & Wong, 2019; O’Brien et al., 2020; Roy et al., 2019; Vos et al., 2016; Zahidie et al., 2023). In several of these studies, the concepts of “stakeholders” and “stakeholder analysis” have been used in parallel with the concept of “actor”.

Stakeholder theory has its roots in business and management literature (Ackermann & Eden, 2011; Freeman, 1984), originally emphasizing the importance of taking into account and managing the often-competing demands of an organization’s different stakeholders in relation to its strategic goals. This theory has also been adopted in other research areas, including political science and public health policy research (e.g., Balane et al., 2020; Brugha & Varvasovszky, 2000; Hyder et al., 2010; Varvasovszky & McKee, 1998). For example, in their study, Hyder et al. (2010) highlight how considering stakeholder perspectives allows health interventions to be seen from multiple angles, providing several advantages, such as indicating required policy changes and showing how consumer ideas, concerns, and expectations can predict implementation success. Furthermore, the growing interest in adopting stakeholder theory may be explained by the pivotal role stakeholders play in an organization, a project, or a policymaking process (Brugha & Varvasovszky, 2000). Since this dissertation focuses on stakeholders within the Swedish drug policy field, adopting stakeholder theory as part of the theoretical framework was a relevant choice.

The concept of “stakeholder” has been defined in various ways (see, e.g., Ackermann & Eden, 2011; Freeman, 1984; Mitchell et al., 1997). As explained in the Introduction, stakeholders are defined as “actors who have an interest in the issue under consideration, who are affected by the issue, or who – because of their position – have or could have an active or passive influence on the decision-making and implementation processes” (Varvasovszky & Brugha, 2000, p. 341). As suggested by Houborg et al. who adopted the same definition for stakeholders in their ALICE RAP project (see Background), defining a stakeholder is an empirical question “which demands investigation of how different actors affect and/or are affected by a policy” (Houborg et al., 2016, p. 89). With this broad definition, the focus is not only on interest groups – i.e., groups of individuals or organizations that are usually formally organized and attempt to influence public policy in their favor (see Baroni et al., 2014) – but also on recognizing other groups as stakeholders in the context of Swedish drug policy, for example, representatives of top-level policymaking (such as MPs) and people who use drugs. The former can be seen as “insiders” of the government who also meet, communicate, and collaborate with other stakeholders, while the latter represents those with little or no inside connection but with lived experience (e.g., Bjerger et al., 2016). Adopting this broad definition makes it possible to obtain a wider overview of drug policymaking in Sweden. For example, by recruiting MPs for the key informant interviews in this dissertation, it was possible to include their perceptions of other stakeholders’ opportunities to influence drug policy (Study II).

Based on stakeholder theory, stakeholder analysis is not a single tool, as it encompasses a range of different methodological approaches (Crosby, 1992). Here, it is understood as a policy analysis approach, providing a conceptual framework that facilitates the analysis of interests and possible influence (Brugha & Varvasovszky, 2000). It is specifically focused on stakeholders within a broader political, economic, and cultural context. The theory concerns generating knowledge about the stakeholders, with the aim of understanding their interests, values, involvement, attempts to influence, and the resources they have brought or could bring to bear on decision-making or implementation processes in drug policy development (Brugha & Varvasovszky, 2000; Varvasovszky & Brugha, 2000). This knowledge about stakeholders helps to understand the context in which drug policy is taking shape and may illuminate possible alternatives and future policy directions in Sweden and in other countries with a similar context (Brugha & Varvasovszky, 2000; Varvasovszky & Brugha, 2000).

Stakeholder influence: access, strategies, resources, and the power/interest matrix

Considering stakeholder involvement in drug policy formation, attempts to influence policy can be regarded as one form of participation. Indeed, one

particular interest, identified at the outset of this dissertation project, concerned stakeholders' opportunities to influence drug policy in Sweden.

To influence public policy can be understood as exerting control over political outcomes, as defined by Dür and De Bièvre, who describe actors as "powerful if they manage to influence outcomes in a way that brings them closer to their ideal points" (Dür & De Bièvre, 2007, p. 3). Furthermore, they suggest that political outcomes can be understood as either an "official position taken by public authorities or the actual policy implementation" (Dür & De Bièvre, 2007, p. 3). In this context, influence can also pertain to different stages of policy formation, such as shaping the political agenda or affecting the preparation of policies (Binderkrantz et al., 2015; see also Johnson, 2006).

However, researchers have highlighted the difficulty of operationalizing the concepts of 'influence' and 'power,' of constructing reliable indicators, and of empirically assessing or measuring the influence or power of stakeholders (Dür, 2008; Dür & De Bièvre, 2007; Helboe Pedersen, 2013). Therefore, this dissertation focuses on stakeholders' perceptions of their own and other stakeholders' opportunities to influence drug policy (Study II).

To further enrich the theoretical framework when analyzing stakeholders' attempts to influence and their perceptions of opportunities to influence (as studied in Study II), the following concepts were adopted from interest group and social movement literature: *access* to political arenas (Binderkrantz et al., 2015, 2017), *influence strategies* (Binderkrantz, 2005; Binderkrantz & Krøyer, 2012), and *resources* (Tarrow, 2022), together with *the power/interest matrix grid* by Ackermann and Eden (2011).

According to Binderkrantz et al. (2017), studying interest groups' access to political arenas can be seen as one attempt to come closer to answering who is influential, since access is often more observable than influence. In this dissertation, access is understood as "entering a political arena (parliament, administration, or media),¹⁷ [and also] passing a threshold controlled by relevant gatekeepers (politicians, civil servants, or journalists)" (Binderkrantz et al., 2017, p. 307). Adopting this concept helped to shed light on the contexts in which stakeholders need to be present if they attempt to participate in drug policy processes.

Access can be understood through a resource-exchange perspective, underlining that access is an outcome of exchanging resources between stakeholders and gatekeepers (Salisbury, 1969). The cumulative perspective, in contrast, suggests that "access to one arena may also spill over to other arenas, leading to cumulative access" (Binderkrantz et al., 2015, p. 12). That participation in one arena – or stream – may ease access to other streams is also evident in the Multiple Streams Framework (MSF) (Robinson & Eller, 2010; see also Study

¹⁷ Policy arena refers to spaces where policy processes take place. It is "a political institution of importance for political decisions and/or the political agenda of a society" (Binderkrantz et al., 2015, p. 2).

IV; and Kingdon, 2013). Another essential point is that access alone cannot guarantee influence, but those with access are more likely to be influential than stakeholders without it (Binderkrantz et al., 2017).

The second concept, influence strategies, was chosen for the same study (II) as it helped categorize stakeholders' attempts to influence drug policy. Drawing on interest group research, influence strategies refer to "overall approaches to seeking influence, whereas specific activities engaged in can be described as tactics" (Milbrath, 1963, p.41; Berry, 1977, p.212, cited in Binderkrantz & Krøyer, 2012). Binderkrantz (2005) proposes classifying interest groups' influence strategies as direct strategies and indirect strategies (see Table 1), as adopted in this dissertation. Direct influence strategies are understood as strategies "in which groups approach public decision-makers" (Binderkrantz, 2005, p.696). These can be further divided into administrative strategies and parliamentary strategies. Indirect strategies, on the other hand, can be categorized as media strategies and mobilization strategies.

Table 1. Categorization of influence strategies and examples of activities, adapted from Binderkrantz (2005, p. 696)

Direct strategies		Indirect strategies	
Administrative strategy	Parliamentary strategy	Media strategy	Mobilization strategy
Contacting relevant ministers	Contacting members of Parliament	Writing letters to the editor, debate articles or columns	Arranging public meetings and conferences
Responding to requests for referral responses	Contacting party organizations	Contacting reporters	Arranging strikes, direct action, and demonstrations
Participating in expert groups (e.g., commissions of inquiry)	Contacting party spokespersons Contacting parliamentary committees	Publicizing analyses and research reports Writing social media posts	Conducting petitions

The third concept, resources, was selected because it highlights what assets stakeholders possess that can benefit them when trying to influence drug policy. Drawing on social movement literature, resources are defined as external resources, such as instability in political alignments, conflicts within and among political elites, and the presence of influential allies, and internal resources, such as professionalization (such as staffing by lobbyists or the possession of important skills), technological capabilities, and economic resources (Klüver & Saurugger, 2013; Maloney, 2008; Tarrow, 2022).

As discussed above, examining and measuring the power of stakeholders is not straightforward, nor is it the primary focus of this dissertation. Nevertheless, power plays a significant role in policymaking, and some stakeholders possess greater power than others. It can take many forms, such as coercive power, social power, and economic power (Mitchell et al., 1997; Stevens, 2024). In Study II, the power/interest matrix grid by Ackermann and Eden (2011) is adopted to further analyze stakeholders' attempts to influence drug policy, based on findings from the concepts of access, resources, and strategies.

The power/interest matrix (see Figure 3) can be used to categorize stakeholders based on their power and interest in the issue (Ackermann and Eden, 2011). Within this context, power is understood as the “ability of those who possess power to bring about the outcomes they desire” (Salancik & Pfeffer, 1974, cited in Mitchell et al., 1997, p. 865). The power/interest matrix consists of four compartments that illustrate the degree of power stakeholders have to influence and the degree of interest stakeholders have in the issue: stakeholders who have a high interest in the issue and are powerful are categorized as players; stakeholders who have a low interest in the issue but a high degree of power are called context-setters; stakeholders who have a high interest in the issue but are less powerful are defined as subjects; and those stakeholders who have both little interest in the issue and a low degree of power are categorized as the crowd (Ackermann and Eden, 2011).

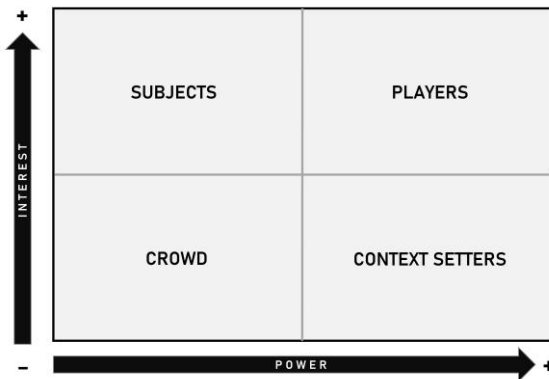


Figure 3. Power/interest matrix grid (Ackermann & Eden, 2011)¹⁸

¹⁸ Reprinted from *Long Range Planning*, 44(3), Ackermann, F., & Eden, C., Strategic Management of Stakeholders: Theory and Practice, 179–196, Copyright (2011), with permission from Elsevier.

Analyzing values through moralities and institutionalized norms

As discussed above, according to the health policy triangle framework, all four elements of policy are influenced by values, either through stakeholders' own values or values emerging from the policy context, which reflect shared cultural or social values, institutionalized norms, and prevailing ideologies (Kenter et al., 2015; Walt & Gilson, 1994). Therefore, one component of the theoretical framework concerns exploring the values through moralities of stakeholders and institutionalized norms within the Swedish drug policy field. This aligns with a growing interest in studying values and moralities in broader drug policy research (Askew & Ritter, 2025; Stevens et al., 2025b). Values and moralities are not unique to drug policy (or health policies), since all policies involve a contest of values, and values guide decision-making at every stage of the policy process (Askew & Ritter, 2023; Botterill & Fenna, 2019). Researchers have argued that making value conflicts explicit in drug policy-making may support policymakers and other stakeholders to remove barriers that slow down drug policy formation (Askew & Ritter, 2025; Ritter, 2021). Furthermore, studying values and moralities can provide in-depth knowledge of stakeholders, helping to further understand contemporary drug policy and its processes.

In this dissertation, values in Swedish drug policy are studied by focusing on stakeholders' moralities and institutionalized norms. The former is analyzed by adopting justification analysis (Ylä-Anttila & Luhtakallio, 2016) based on justification theory (Boltanski & Thévenot, 2006) and the policy constellations approach (Stevens, 2024), the latter through concepts of recognition and misrecognition (Fraser, 2000; Fraser & Honneth, 2003). These are presented in more detail below.

“Values” are defined here as concepts or beliefs pertaining to desirable goals that motivate action (Schwartz, 1992). There are multiple competing definitions of morality based on various traditions, such as moral and political philosophy (e.g., Curchin et al., 2022; Euchner et al., 2013; MacCoun & Reuter, 2001), psychology (e.g., Graham et al., 2013; Schwartz, 1992, 2012), and sociology (e.g., Hitlin & Vaisey, 2013). In this dissertation, “moralities” are understood as normative principles and preferences applied when judging what is good or bad, and what is right or wrong (Ritter, 2021; Stevens, 2024; Stevens et al., 2025b). In the field of drug policy research, there has been an occasional interchange of the concepts ‘values’ and ‘moralities’ due to their shared concern with normative commitments that inform drug policymaking and analysis (Stevens et al., 2025b). Similarly, this conceptual distinction between values and moralities is not discussed in detail in Study I.¹⁹ However,

¹⁹ For example, “value positions” are discussed interchangeably with “moral principles” (see Lerkkanen & Storbjörk, 2023, p. 272).

in Study III, the distinction is presented by defining these two concepts. The difference between values and moralities are understood through argumentation that all moralities are based on values but all values do not concern morality (Graham et al., 2011; Schwartz, 2007; Twito-Weingarten & Knafo-Noam, 2022). Furthermore, due to the focus on normative principles, different definitions of morality often shed light on how to treat others, underlining social order and social norms, while values emphasize the individual perspective, illuminating individual beliefs and principles guiding one's actions (Killen & Smetana, 2015; Twito-Weingarten & Knafo-Noam, 2022).

Hence, moralities are based on underlying values and reflect what stakeholders perceive as right and wrong. Institutionalized norms, on the other hand, capture normative principles stabilized in institutional structures, shaping stakeholder's positions and opportunities. For clarity, and instead of adopting a new concept, such as 'moral values' to cover all values based on moralities, both *values* and *moralities* are referred to in the Results and Discussion sections.

Moralities: Justification analysis

Justification analysis is an analytical framework with its roots in moral sociology and framing political claims in public debates (Ylä-Anttila & Luhtakallio, 2016). It is based on the justification theory developed by sociologists Boltanski and Thévenot (2006). The core idea of the theory is that all justifications people use to legitimize their actions can be categorized into a typology of moral justifications. This typology comprises a variety of orders of worth, each referring to different ideas of the common good. Drawing on moral philosophy, these orders of worth are grounded in different philosophical foundations concerning moral worth.

The inspired worth refers to valuing uniqueness and creativity, while *the domestic worth* is based on valuing traditions and hierarchy (Boltanski & Thévenot, 2006). *The worth of fame* refers to valuing success and acceptance of public opinion, whereas *the civic worth* values collectives and civil rights. *The market worth* refers to valuing wealth and working on the logic of competition. Finally, *the industrial worth* refers to appreciating science and technology.

These six original orders of worth have been later complemented with *the ecological worth*, referring to valuing nature and ecological sustainability (Ylä-Anttila & Luhtakallio, 2016). These orders of worth – moral justifications – form a “relatively well institutionalized cultural toolkit for justifying claims in public debates by offering shared coordinates for actors, and therefore operating as means for reaching agreement” (Ylä-Anttila & Luhtakallio, 2016, p. 3). Justification theory has been widely applied across different research fields, such as civil society and activism (Enjolras, 2025; Gladarev & Lonkila, 2013), climate change (Kukkonen et al., 2020), and substance use

and addiction (Kankainen, 2024; Perälä et al., 2013; Tsupari & Hupli, 2026). Notably, a previous application of moral justifications in a stakeholder analysis focusing on OAT (Perälä et al., 2013) supported the notion that this typology could be applied within a drug policy context. In this dissertation, it is used to analyze stakeholders' moralities behind their argumentation in the Swedish drug policy media debate (Study I). Justification analysis was chosen as it is specifically designed to analyze public debates, aligning with the study design in Study I (see Ylä-Anttila & Luhtakallio, 2016).

Moralities: Policy constellation approach

The second theory chosen for analyzing stakeholders' moralities is the policy constellations approach by criminologist Stevens (2024). The theory has its roots in critical realism (see Methodological considerations in the next chapter) and a Habermasian understanding of policymaking as processes that “operate through constellations of power, knowledge, morality and the strategic and communicative action of policy actors in interaction with each other” (Habermas, 1986, 1995, 1996, cited in Stevens, 2024, p. 34).

According to the policy constellation approach, policy formation concerns interactions of policy constellations – loosely connected networks of individuals and organizations (i.e., stakeholders) that share normative preferences and interests, with the objective of achieving policy goals based on their shared mission (Stevens, 2024). This “loosely connectedness” means that constellations are not stable groups with fixed rules, and their actions are not necessarily coordinated. All actors hold different forms of power and resources which they bring with them into policy constellations. According to Stevens (2024), the approach sheds light on the process of policymaking by examining the moralities and forms of power that are embedded within social and cultural structures.

The policy constellations approach has been previously applied to study drug policy processes in national contexts (e.g., Lasco & Abesamis, 2025; Los, 2022, 2024; Stevens, 2024; Stevens & Zampini, 2018) but also in international contexts (Stevens et al., 2025a). One example of applying the approach is an analysis of medical cannabis legalization in the United Kingdom, which found that a reform constellation leveraged economic and media power to push legalization, whereas conservative and public health constellations used institutional power to limit its scope (Stevens, 2024).

In Study III, the policy constellations approach was adopted to analyze stakeholders' moral positions concerning the drug policy aim and whether stakeholders form policy constellations around the different alternatives for the national drug policy aim. Identifying morality in the policy constellations approach focuses on analyzing stakeholders' moral positions, also called “ethico-political bases” (Stevens, 2024). These moral positions combine assumptions of what is morally good or right with preferences for policy outcomes.

Furthermore, they are produced and reproduced through cultural structures and collective social action (Stevens, 2023a, 2024). Moral positions provide the underlying value base for stakeholders' policy goals, priorities, and actions (see Ritter, 2021; Stevens, 2024).

Adopting the policy constellations approach to study stakeholders' moralities within the field of Swedish drug policy complements justification analysis by exploring moralities from a different angle. This approach provides an opportunity to examine moralities more freely, offering the possibility of identifying moralities that could not be captured through the typology of moral justifications (Boltanski & Thévenot, 2006; Ylä-Anttila & Luhtakallio, 2016) (Study I), and explore whether stakeholders form policy constellations based on their shared moral positions.

Institutionalized norms: Recognition and misrecognition

To further enhance our understanding of the cultural normative contexts in which stakeholders operate, the concepts of recognition and misrecognition, as discussed by philosopher Fraser (Fraser, 2000; Fraser & Honneth, 2003), were adopted in Study II. According to Fraser, there is a need to rethink how we understand the politics of *recognition*: she argues that, instead of understanding recognition solely as a question of identity politics that neglects distributive injustices (i.e., economic inequality observable through deprivations in education, income, and healthcare), it should be understood as a question of social status. By this, she emphasizes the importance of examining institutionalized norms and how these affect actors:

If and when such patterns constitute actors as peers, capable [of] participating on a par with one another in social life, then we can speak of reciprocal recognition and status equality. When, in contrast, institutionalized patterns of cultural value constitute some actors as inferior, excluded, wholly other, or simply invisible, hence as less than full partners in social interaction, then we should speak of misrecognition and status subordination. (Fraser & Honneth, 2003, p. 29)

Misrecognition through institutionalized norms can take many forms, for example, through codifications in law, institutionalized via government policies, or through informally institutionalized patterns (Fraser, 2000). By adopting these concepts in Study II, the dissertation provides an opportunity to discuss, based on the perceptions of interviewed stakeholders, what kinds of institutionalized norms exist within the Swedish context that may affect stakeholders and their involvement in drug policy formation in Sweden.

Multiple Streams Framework

The Multiple Streams Framework (MSF) is the final piece of the theoretical puzzle of this dissertation. MSF originates from the tradition of neopluralist policy analysis; rather than understanding policymaking as a linear problem-solving exercise conducted by authoritarian decision-makers, it aligns with the garbage can model by Cohen, March, and Olsen (1972), emphasizing that policy processes are messy and complex, involve multiple actors, and are shaped by the often-random intersections of problems, solutions, choice opportunities, and participants (Bendor et al., 2001; Ritter & Lancaster, 2018).

Like in the garbage can model, MSF conceptualizes policymaking as occurring in multiple, relatively independent streams (Kingdon, 2013). In the *problem stream*, conditions become defined as problems when they attract the attention of actors in and around government. This often occurs through indicators, such as reports on routinely monitored events by government agencies and NGOs, or through crises or disasters that draw attention. Additionally, there must be the will to act for a condition to be recognized as a problem (Ritter & Lancaster, 2018). In the *policy stream*, policy alternatives are considered by a community of specialists. Kingdon describes this stream as a “policy primeval soup,” in which policy alternatives float around (Kingdon, 2013, p.116). Only those ideas that rise to the surface of the soup become policy alternatives that meet the criteria of technical feasibility, alignment with the national mood and dominant values and moralities, as well as anticipation of budgetary and political constraints (Ritter & Lancaster, 2018). The political stream, in contrast, concerns factors such as public mood, interest group pressure, and government events, including elections (Kingdon, 2013).

Furthermore, two additional elements of MSF are policy windows and policy entrepreneurs, which are essential for analyzing linkages between the streams. Policy windows, also called “windows of opportunity,” refer to moments when the three streams – problems, policy, and politics – converge (Kingdon, 2013). An open policy window represents a brief period during which policy change may occur, provided the proposed solution to a problem aligns with the current political context. Coupling these streams requires policy entrepreneurs, in this case stakeholders/actors, individuals or organizations prepared to act when a policy window opens, since policy windows remain open for only a short time.

MSF has been widely applied across multiple policy domains (see an overview, e.g., Ritter & Lancaster, 2018), including drug policy (Duke et al., 2013; Houborg & Frank, 2026; Lancaster et al., 2014; Unlu et al., 2022; see also Ritter, 2021). It has been valued for its intuitiveness and accessibility (Ritter & Lancaster, 2018). In this dissertation, MSF was adopted in Study IV to understand recent drug policy trends in Sweden between 2015 and 2025 and the role of stakeholders in the policy processes.

Theories and concepts integrated in the health policy triangle framework

As noted, the health policy triangle framework suggests that to understand policy, we need to consider the complex interrelationships of actors, processes, context and content (Walt & Gilson, 1994). The selected theories and concepts adopted in the sub-studies of this dissertation complement each other and the health policy triangle framework by shedding light on the elements of the health policy triangle and how those are related to each other.

Applying stakeholder theory and the concepts of access, resources, and influence strategies together with the power/interest matrix grid helps to understand stakeholder involvement in policy processes, highlighting the arenas where policymaking occurs and how stakeholders may attempt to influence policy in different ways (Study II). In relation to the health policy triangle framework, these concepts highlight stakeholders' (actors') behaviors, positions, interests, and resources, all of which are essential factors influencing policy processes (see Walt & Gilson, 1994). Furthermore, as noted above, adopting the concept of access also illuminates the policy context and policy arenas relevant for drug policy formation in Sweden.

In addition to their intrinsic importance, values play a crucial role in formulating policy goals and policymaking (processes and content, see Walt & Gilson, 1994), captured here by focusing on stakeholders' moralities through justification analysis (Study I) and the policy constellations approach (Study III). Considering the health policy triangle framework, justification analysis in Study I sheds light on the interrelationships of actors (stakeholders) and their argumentation, reflecting both the content of the policy – what the policy is about and how actors argue for and against it, justifying their arguments based on values and moralities – and the policy processes, by detailing how stakeholders set the agenda on an issue in the drug policy media debate (see Walt & Gilson, 1994).

Similarly focusing on stakeholders' moralities, the policy constellations approach sheds light on how moralities, which they share with others to possibly form policy constellations, may affect both policy content and processes. This theory also underlines how moralities are collectively constructed through socio-cultural structures (Stevens, 2024), highlighting the importance of context in drug policymaking (cf. Walt & Gilson, 1994). Adopting the concepts of recognition and misrecognition in Study II when analyzing stakeholders' attempts and opportunities to influence drug policy further shows the values embedded in the policy context in the form of institutionalized norms, thus enhancing our understanding of the policy context (see Walt & Gilson, 1994). Contextual influences are also addressed via MSF (Study IV), which highlights what is politically feasible at a given moment, relevant to policy processes and actors in policymaking. In addition, MSF illuminates the policy processes, showing the different stages of policymaking and how actors

(stakeholders) participate in these processes within a context rooted in time and space (Walt & Gilson, 1994).

Materials and methods

In this chapter, the dissertation's qualitative data materials and methods are presented and discussed. It begins with introducing the three data sets – media texts, key informant interviews, and policy documents – alongside the methods of data generation. Then the coding processes and analyses are presented. In the latter part of this chapter, methodological considerations are elaborated on, including the critical realism underpinning the dissertation, stakeholder analyses and triangulation, trustworthiness, ethics, and researcher reflexivity. Finally, possible limitations are discussed.

Data generation and coding

Media texts

The choice to analyze media texts in this dissertation was primarily motivated by the role media platforms play in drug policymaking: these platforms can be seen as arenas where stakeholders debate drug policy issues, set the agenda, and propose policy options (Lancaster et al., 2011). It is important to note that media has multiple meanings; by reporting the news, it provides knowledge to the public but also frames social reality, affecting public opinion, attitudes, and perceptions about the world and phenomena (Lancaster et al., 2011; McCombs & Shaw, 1972). Furthermore, it can be seen as a platform for political debates and may influence decision-making (Christie, 1998; Lancaster et al., 2011; McArthur, 1999; Törnqvist, 2009).

In Study I, the media was a relevant source material to identify national stakeholders within the drug policy field and to examine the drug policy debate (see Varvasovszky & Brugha, 2000). Media data were also analyzed in Study IV, together with key informant interviews and policy documents.

In total, the media material consists of 877 media texts from Swedish newspapers published in print and online from 2015 to 2025. Four national newspapers were chosen due to their popularity and representation of different political views: *Dagens Nyheter* (DN; independent liberal), *Svenska Dagbladet* (SvD; independent liberal conservative), *Aftonbladet* (independent social-democrat), and *Expressen* (independent liberal). These represent two of the

largest daytime (DN, SvD) and evening papers (Aftonbladet, Expressen) in Sweden, circulating throughout the country.

Media texts were collected through the media archive Retriever (Mediearkivet) via Stockholm University Library on three occasions: for Study I, in Autumn 2020 and Summer 2021; and for Study IV, in Autumn 2025. A number of drug policy-related search terms, selected based on previous research and literature concerning Swedish drug policy, were applied to identify media texts in the four national newspapers and their online versions. In Study I, 370 media texts published between January 1, 2015, and June 30, 2021, were analyzed. For Study IV, these 370 media texts were complemented with 507 additional texts published between July 1, 2021, and September 30, 2025.²⁰

The media data included texts representing different media genres, for example, news, editorials, columns, and debate articles. Media texts in which one or more stakeholders took a stand on drug policy-related topics were included in the data (Studies I and IV). Purely descriptive news (e.g., drug-related crimes and penalties) was excluded from the first sample (Study I). For the data collection and analysis in Study IV, descriptive news texts were also included due to the differing study design and theoretical framework (see section *Study IV*).

Key informant interviews

Key informant interviews formed the primary data and were used in three sub-studies (Studies II–IV). In general, interviews can be seen as reality-constructing, meaning-making occasions in which both interviewee and interviewer are actively involved in meaning-making (Holstein & Gubrium, 1995). Furthermore, interviews can serve as a substantial and crucial source of knowledge concerning the personal and social dimensions of our lives (Brinkmann, 2014). By interviewing stakeholders, it was possible to shed light on their own experiences and how they perceive, argue, and reflect on contemporary drug policy in Sweden, as well as their and other stakeholders' involvement within the field. The identities of the informants were protected in the study (see Appendix I), which also enabled them to share a more unofficial perspective on the drug policy field and their actions, as opposed to official statements in, for example, referral responses (see below). Thus, it was possible to collect data that would not have been available through publicly available texts, such as media texts or policy documents.

A purposeful sampling strategy was used when recruiting the informants (Patton, 2014). More specifically, this involved identifying possible candidates who met the inclusion criteria: they should represent the national drug

²⁰ Concerning the media data from 2015–2021, the first data extraction yielded 2,229 independent media texts (Study I). The first data extraction of the media data from 2021–2025 yielded 1,549 independent media texts (Study IV). The sample was selected based on the inclusion and exclusion criteria, discussed above.

policy field in Sweden and/or be active within the field at that time. Furthermore, the aim was to recruit informants who were willing to share their perceptions and experiences from the policy field and who, due to their expertise and experiences, most likely possessed relevant knowledge on the topic. Therefore, these participants are referred to as key informants, as they provide essential information and insights on the different parts of Swedish drug policy (Akhter, 2022).

Furthermore, the results of the media analysis (Study I) guided the recruitment logic for the interviews: the results revealed that representatives of different stakeholder groups in the Swedish drug policy debate could be categorized as proponents, opponents, and neutral regarding the current restrictive policy supporting drug prohibition (Lerikkanen & Storbjörk, 2023) – a stance that surfaced repeatedly across their statements. Therefore, the aim was to recruit representatives of each identified group while covering all four drug policy areas (control, prevention, treatment, and harm reduction).

To map out the potential candidates for the interviews, media data (2015–2021), government agency reports (2018–2021), and policy documents (2018–2023) guided the work. In addition, snowball sampling (Patton, 2014) was used to reach and recruit people who use drugs and their significant others, since during data collection, these groups were not active or at least not as visible as many other stakeholders in policy documents or media material. Furthermore, during data collection, informants were asked whether they could name potential candidates interested in participating in the study. As described by Varvasovszky and Brugha (2000), data collection is an iterative process that continues until all relevant stakeholders have been identified. The recruiting strategy and candidates were discussed with supervisors Storbjörk and Eriksson, who both have extensive experience in researching substance use in Sweden.

Informants were recruited by contacting them either by email or by phone. In cases where no other contact information was available, candidates were first contacted via social media platforms by sending a private message. Overall, 48 attempts were made to contact potential participants, resulting in 38 completed interviews. Thus, the majority of candidates accepted the invitation to participate in the study. Two persons declined participation, and eight candidates did not respond to the invitation.

The informants received information about the study in oral and written form before their participation (see Appendix I). Furthermore, every informant gave both written and oral consent before the interview was conducted (see Appendix II). If the interview was not conducted in person, the informant sent the signed consent form to the interviewer afterward. The interviews were conducted individually, as some informants might have experienced the topic as sensitive and not something they would want to share with other participants (Brinkmann, 2014). In addition, individual interviews often guide the conversation in a direction useful to the interviewer's research interests, also

making it easier for the interviewer to create an atmosphere of trust and discretion (Brinkmann, 2014). However, if they preferred, the informants were allowed to participate with a colleague or fellow representative of the same organization. This occurred in one interview. Hence, thirty-eight interviews were conducted with 39 key informants.

The interviews were semi-structured, based on an interview guide (see Appendix III). Questions in the interview guide were formulated based on the framework by Kallio et al. (2016). First, the appropriateness of the semi-structured interview was assessed in relation to the selected research questions: since the informants were expected to discuss particular aspects of Swedish drug policy but also had the opportunity to discuss other topics they deemed important and relevant outside the interview guide, semi-structured interviews were a suitable method (Brinkmann, 2014). Second, previous knowledge of the research subject (stakeholders and Swedish drug policy) was retrieved and utilized in developing the interview guide, together with discussions with colleagues and supervisors. The third step was to formulate and test a preliminary guide in a pilot interview after obtaining ethical approval. Reflections and notes on the pilot interview were discussed with supervisors before updating the interview guide to its final form (Kallio et al., 2016).

The interview data collection occurred between April 2022 and July 2023. All interviews were conducted by Lerkkanen. A face-to-face interview was the preferred format for the project, as it is more intimate, and small body signs or gestures can make the situation less intimidating and help the participant feel more at ease (Adams-Hutcheson & Longhurst, 2017). This format was preferred by many informants. However, some informants could only participate in a telephone or online interview. Hence, flexibility was necessary when conducting interviews, as many informants would have otherwise refused to participate (see Harvey, 2011). In total, 23 interviews were conducted in person, four by phone, and eleven online (either on Zoom or Skype). They lasted around 60 minutes. Most interviews followed the interview guide systematically or at least covered the majority of the topics and questions. Interviews were digitally recorded and transcribed verbatim for analysis by Lerkkanen and Språkservice Sverige AB. Confidentiality and Personal Data Assistant Agreements were concluded with the transcription company. Furthermore, an interview log was kept and notes were taken.

Many informants held multiple roles at the time of the interview. For example, some informants were active in several drug policy-related organizations (e.g., through working in an organization or being a member of an NGO or a profession-based association). These various roles were a topic of discussion prior to and during the interview. Informants were instructed to respond from the perspective of their organizational role, unless they explicitly stated a personal viewpoint. In total, six informants had drug use backgrounds and four had significant other backgrounds. The sample characteristics are summarized in Table 3.

Table 3. Sample characteristics of the key informant interviews

Stakeholder categories	Total
Unorganized recreational people who use drugs	2
NGOs representing people who use drugs and/or opposing a restrictive drug policy, including former people who use drugs and significant others ⁱ	5
NGOs promoting restrictive drug policy, including significant others	3
Molders of public opinion ⁱⁱ	3
Professionals: Healthcare and social services	4
Researchers	3
The judicial system (police, customs, lawyers, and prosecutors)	5
Politically governed organizations involved in health and social issues	4
Top-level policymaking (MPs, people with experience in ministries)	9
Total	38

ⁱ The majority of representatives of people who use drugs, NGOs and NGOs opposing restrictive drug policy had a history of drug use. Therefore, these two categories were merged into one category. In addition, three informants representing this category were also significant others of people who use drugs.

ⁱⁱ This category represents former politicians and civil servants still active within the Swedish drug policy field.

Policy documents

Policy documents have several essential roles in the dissertation: they were used to identify possible candidates when planning the recruitment of key informants and as background information for the analyses in Studies III and IV. In practice, these policy documents refer to parliamentary debates, motions, bills, previous ANDTG strategies, and commissions of inquiry, particularly the DCI (SOU 2023:62) and “Stricter penalties for Crimes Committed by Criminal Networks” (SOU 2021:68). Furthermore, in Studies III and IV, stakeholders’ referral responses to the DCI (SOU 2023:62) were analyzed alongside other data, thus forming the third data set for this dissertation. In addition, the identification of a successful window of opportunity enabling the implementation of “Stricter penalties for crimes committed by criminal networks” led to the analysis of referral responses for this additional inquiry (SOU 2021:68) in Study IV.

Referral responses (Swedish: *remissvar*) refer to a form of stakeholder consultation in Sweden (see Background section), representing official statements by stakeholders in response to proposals presented in the commissions of inquiry. These documents complemented other data sets, as many stakeholders who submitted a referral response were either not represented elsewhere or their views on the proposals presented in the inquiries were not captured in

other data sets. Furthermore, the referral responses for the DCI particularly shed light on relevant stakeholders, including those who submitted any referral response, those who commented on proposals concerning harm reduction measures, and those invited to submit a response by the Government itself (Studies III–IV). In Studies III and IV, only the referral responses to the DCI Report (SOU 2023:62) that commented on proposals concerning the drug policy goal (Study III) and harm reduction measures (Study IV) were included. As mentioned, Study IV also included analysis of referral responses limited to statements regarding stricter penalties for drug offenses (SOU 2021:68).

Coding and analyses

The sub-studies' analyses included elements of several qualitative analytical traditions, including thematic analysis and qualitative content analysis. This involved categorizing the empirical data by coding and narrowing it down, then presenting the results with examples (e.g., quotes from the interview data) to show the reader how the researchers arrived at their findings (Järvinen & Mik-Meyer, 2020).

Abductive analysis was applied, in which an inductive approach is combined with a deductive approach (Järvinen & Mik-Meyer, 2020). Abduction can be understood as a creative puzzling with data and theoretical ideas (van Hulst & Visser, 2025), or as a continual dialogue between theory and data (Stevens, 2023a). In practice, this meant that at the beginning of each analysis, coding was inductive, but while reading the material, ideas for suitable theoretical frameworks arose and were adopted in the analysis to help interpret the findings and put them into perspective (Järvinen & Mik-Meyer, 2020). Theories that guided the coding and analyses are presented in Theoretical Framework (above).

Coding was done using Lumivero NVivo software (previously provided by QSR International). In Studies I and II, the first-round coding of media and interview data was inductive to become familiar with the data and identify the main patterns in the data sets. During later coding rounds, as in the analyses in Studies III and IV, the codes were created based on existing knowledge of the field, previous research, and the chosen theoretical framework (see Stevens, 2024). The aim and research questions of each study guided the subsequent steps of the analyses. Furthermore, the relevant codes were discussed and selected together with the co-authors (supervisors Storbjörk and Eriksson). The content of these codes was reviewed, reorganized, and formulated as results through an iterative process of going back and forth between the theoretical framework, the research questions, and the data (see Stevens, 2024; van Hulst & Visser, 2025).

Methodological considerations

This section on methodological considerations begins with a brief introduction of the theoretical positioning of this dissertation, critical realism. Next, the section attends to stakeholder analysis and matters related to strengths of the dissertation, such as triangulation, ethics, and limitations.

Critical realism

This dissertation is based on critical realism. It posits that the social world exists independently of individual experience (ontological realism) and that knowledge of the world is contingent on one's position in time, place, and society (Bhaskar, 2008; Stevens, 2024). Consistent with the tradition of critical realism, the dissertation recognizes that multiple and sometimes conflicting explanations of reality exist. The researcher's goal is to identify the explanation that best approximates reality, using reliable methods to discern between competing claims (judgmental rationality), while accepting that no single researcher can comprehend reality fully or transparently, and that any conclusion may ultimately be proven wrong (Fletcher, 2020; Stevens, 2023b, 2024).

Choosing critical realism has provided tools to better understand the complexity of drug policy formation. In particular, it has encouraged consideration beyond methodological individualism, meaning that social phenomena are not explained solely through individual actions, but also by examining social structures, groups, and institutions (Stevens, 2024). Furthermore, this approach has guided reflection on factors that advance understanding of stakeholder involvement, values and moralities, and stakeholders' perceived opportunities to influence drug policy, the mechanisms and structures at work, the interaction between agency and structure, and the impact of political and cultural context on this research topic (cf. Stevens, 2023, 2024). These reflections align with the health policy triangle framework (Walt & Gilson, 1994), highlighting the importance of considering different elements (actors, processes, context, and content) and their interrelationships in policymaking, as discussed above.

Analyzing stakeholders

Stakeholder analysis and triangulation (see below) provide the methodological basis of the dissertation (see also *Theoretical framework* chapter). When conducting stakeholder analysis, the essential first steps involve identifying the purpose of the study, as well as its scope, time frame, and level of analysis (Varvasovszky & Brugha, 2000). These considerations can also be defined as delimitations – limitations that the researcher consciously sets to keep the study's objectives achievable (Theofanidis & Fountouki, 2019).

As discussed above, stakeholder analysis is here understood as a policy analysis approach (Brugha & Varvasovszky, 2000) that helps generate knowledge on stakeholders to understand the contemporary drug policy context and processes in Sweden, including attempts to assess possible future directions. When conducting stakeholder analysis as a policy analysis, a retrospective approach is often adopted with a wide range of stakeholders, especially if the policy context is complex and lacks a clearly defined policy direction (Varvasovszky & Brugha, 2000). In this dissertation, the focus is on examining stakeholders in the contemporary drug policy context in Sweden. Therefore, the time dimension is delimited to the period 2015–2025. Moreover, as stated in Study IV, the time period begins in 2015, when drug-related mortality reached its peak in Sweden (Public Health Agency of Sweden, 2025). The designated time period concludes in 2025, when Study IV was conducted.

The second delimitation is the national focus, both in terms of drug policy and stakeholders. However, as demonstrated in the sub-studies, not all informants in the interviews and referral responses were active at the national level, including people who use drugs. Considering the doctoral research project's aim and inclusion criteria (discussed below), it was important to include informants representing this stakeholder category, as those with lived experience are heavily affected by drug policy.²¹ Furthermore, many informants representing other stakeholder categories were active at both local and regional levels and had participated in national drug policy formation (e.g., drug policy debates in national newspapers, referral responses to commissions of inquiry). Similarly, referral responses from non-national-level stakeholders, such as municipalities or regions, were included in the analyses because the content of the commissions of inquiry concerned national drug policy, thus also affecting local and regional levels.

Triangulation

Triangulation was used in the dissertation, due to its benefit to develop a comprehensive understanding of the research topic by using multiple qualitative methods and data sources (Carter et al., 2014). Triangulation includes: (1) method triangulation, or the use of multiple methods of data collection, such as interviews and observations, about the same phenomenon; (2) investigator triangulation, referring to two or more researchers participating in data collection and analysis; (3) theory triangulation, or the use of different theories to analyze the same data material; and (4) data source triangulation, referring to the use of different data sources when studying the same phenomena (e.g.,

²¹ In the dissertation, the concepts “stakeholder group” and “stakeholder category” are used interchangeably. These concepts refer to the way stakeholders can be categorized into groups. For example, professionals are a stakeholder group that includes both treatment professionals and social service professionals.

interviewing different types of people to gain multiple perspectives and validate data) (Carter et al., 2014; Patton, 1999). All forms of triangulation were used to some extent in this dissertation.

As discussed above, the empirical material consists of media texts, key informant interviews, and policy documents (method triangulation). These different data sets were chosen to provide multiple perspectives on the research topic and to complement each other (Carter et al., 2014; Patton, 1999; see also *Trustworthiness*). Furthermore, both media texts and policy documents represent different policymaking arenas for stakeholders (Binderkrantz et al., 2015). Two sub-studies (Studies III and IV) also included more than one dataset (method triangulation and data source triangulation). In the key informant interviews, informants represented different stakeholder categories, including individuals, groups, and organizations (data source triangulation). Moreover, several theories and concepts were used to analyze these same data sets (theory triangulation). Finally, investigator triangulation was also adopted, considering the support of supervisors Storbjörk and Eriksson in planning the data collection and in analyzing and interpreting the results as co-authors of the sub-studies (discussed in more detail below). Challenges relating to method triangulation are also discussed further below (*Limitations*).

Trustworthiness

In qualitative research, trustworthiness criteria refer to ensuring that credibility, transferability, dependability, and confirmability are evident in the study (Ahmed, 2024). The interview guide for the interviews was developed based on a framework that contributes to the trustworthiness of the semi-structured interview as a qualitative research method (Kallio et al., 2016). Furthermore, utilizing various data collection techniques and sources through adopting different forms of triangulation enhanced the credibility of the interpretations and reduced the impact of potential biases from single methods or data sources (Ahmed, 2024; Carter et al., 2014; Patton, 1999). Moreover, the credibility of the research was enhanced through discussions of the coding and interpretations of the results with supervisors Storbjörk and Eriksson, as well as through peer review. Furthermore, reflexivity (discussed below) can minimize potential distortions when researchers acknowledge personal biases and preconceptions during the research process (Ahmed, 2024; Walt et al., 2008). When it comes to transferability and dependability, it has been essential to be explicit about all decisions made during the research process so that readers can judge whether the findings might be applicable to similar populations outside of the study context and replicable by other researchers (Ahmed, 2024; Thomas & Magilvy, 2011). The research design and decisions made concerning the research process included iterative discussions with the supervisors, which improved the confirmability of the work (Ahmed, 2024; Shenton, 2004).

Ethics

Minimizing potential harm to participants during a research process is one of the most essential ethical issues discussed in the research ethics literature (Moriña, 2021; Traianou, 2014). As presented above, this dissertation involved collecting and processing publicly available media material, policy documents, and key informant interviews with national-level stakeholders. During data collection, many informants were active within the drug policy field, and some had their own experiences of drug use and health issues, which were expected to arise in the interviews. Since the interviews involved processing sensitive personal data, such as political opinions and health-related information, ethical review was required (Swedish Ethical Review Authority, 2021). The research project obtained ethical approval from the Swedish Ethical Review Authority (Reg. no. 2021-07012-01).

When applying for ethical approval, the possible risks and benefits to participants were considered. We estimated that the potential risks for informants participating in the study, including the possibility of being recognized from the results since some had actively participated in public debates, were low. Researchers can use different strategies to protect participants' confidentiality (Traianou, 2014). We aimed to minimize the risks for participants in three ways.

Firstly, the informants received information about the research project during the recruitment process and before conducting the interview (see Appendix I). The informants could ask questions concerning the dissertation project, data processing, and storage. Every informant gave their written and informed consent before the interview. If the interview was conducted via Zoom or telephone, the participant gave their consent verbally first and sent the signed consent form after the interview. Before and during the interviews, participants were also informed that they could choose how much information to share and what they wanted to discuss. If they wanted to correct a statement or regretted certain parts or the entire interview afterward, they could contact the interviewer to correct or delete the data. Furthermore, they could stop the interview and decline to participate in the study at any time. Two informants requested to see the transcribed interview afterward. Informed consent and informing the research participants about the PhD project and its ethical aspects (see Appendix I) can be seen as part of respecting the autonomy of the participants (Traianou, 2014).

Secondly, it was not possible to guarantee the informants' anonymity, nor was this promised to them. Instead, they were informed that all personal information would be pseudonymized by removing or changing any personal details in the results so that they could not be identified (Traianou, 2014). Furthermore, informants were informed that when the results were published, neither their name nor exact organization would be mentioned, only the type of

stakeholder group (e.g., expert, police, relatives, representative of an association).

Thirdly, when using quotes from the interviews in the results sections of the sub-studies (II, III, and IV), interview participants were cited with different identifiers in each study. This approach made identifying an individual in the dissertation more difficult.

Overall, it was judged that the benefits of the research outweighed any potential risks, particularly for the key informants.

Reflexivity

It has been suggested that researchers should pay more attention to reflexivity as a way to strengthen health policy research (Walt et al., 2008). Reflexivity captures the idea of how a researcher's reflections on their research are part of the actual research process (Flick, 2018). Furthermore, it underlines researchers' positionality. Instead of assuming that research and researchers are objective, a researcher should constantly reflect on their role as a researcher, including how their different features (such as institutional power, resources, and positions) could influence their research (Walt et al., 2008).

In the context of this dissertation, I found the metaphors 'insider' and 'outsider' relevant for summarizing my reflections on my positionality (Darwin Holmes, 2020; see also Alvesson & Sköldberg, 2017). Especially at the beginning of the PhD journey, I experienced my role as a researcher as that of an outsider, since I moved to Sweden because of this project. This was also the case regarding language: Swedish is not my first language. I acknowledged this when conducting interviews because I knew the informants would notice it from my dialect and recognize it from my name. At the beginning of the project, I was concerned that being an outsider could negatively influence the dissertation work, for example, through misunderstandings when interviewing stakeholders. From my perspective, however, we always understood each other, and if there were any misunderstandings, we discussed them. Some informants also told me afterward that it can be positive that I am not from Sweden. Being a novice and outsider can definitely be an advantage: since I was new to the field, stakeholders did not have any assumptions or expectations concerning me as a researcher. However, I can also see myself as an insider: I live in Swedish society, I can speak the language, and I study Swedish drug policy – have I not become one of the stakeholders myself then? As a researcher, I cannot isolate myself from the social world I live in to study it (Flick, 2018). Darwin Holmes (2020) discusses that this insider/outsider dichotomy may be seen as artificial, because in reality it is more of a continuum with multiple dimensions. All researchers constantly move back and forth along several axes, depending on time, location, participants, and topic. These concepts have helped me reflect on my position as a researcher in relation to the research topic and this field.

Another reflection concerns neutrality. Research is always infused with the researcher's subjectivity, and researchers are "never a neutral conduit, simply conveying a directly-accessed truth of participants' experience" (Braun & Clarke, 2022, p.4). Therefore, I actively sought to provide a balanced account of the different stakeholders' views and values across analyses and results. I am aware that I, like all researchers, approach my research topic with preconceptions, and rather than attempting to claim complete neutrality, I have aimed to critically reflect on how they may influence my research. For example, it may not be surprising that, as a PhD student in Public Health Sciences, I am interested in developing public health measures that would provide better health for all, especially concerning measures that have received broad support from the global research community based on a large number of previous studies. Furthermore, within the international substance use research field, the power of words has been acknowledged – how we label people, objects, and behavior matters, and therefore, there are recommendations to identify the person separately from their behavior to avoid stigmatization (Kelly et al., 2010; Ritter, 2021; Zwick et al., 2020). According to Bathish et al. (2024), stigma and discrimination related to drugs represent a critical public health concern, and while linguistic expressions can, in fact, serve to perpetuate stigma and thereby engender adverse social and health consequences, it is equally important to recognize the potential of language to dismantle such barriers. Therefore, I have chosen to use terms such as "people who use drugs" or "people with lived experiences" in this dissertation.

Limitations

There are several limitations to the use of key informant interview data in this dissertation, which are discussed here. This is followed by a discussion of some limitations related to the textual materials.

An important limitation concerned recruiting informants for the key informant interviews: Recruiting and identifying potential candidates took time, and some stakeholders were more difficult to reach than others. In some cases, possible gatekeepers had to be identified and contacted first (see Marland & Esselment, 2019). However, the recruitment strategy was determined with support from the supervisors. Another limitation was that all the interviews were not conducted in person. It is challenging to determine whether the different interview formats impacted the quality of the data. In his study, Harvey (2011) discusses this same issue, questioning whether respondents would provide less detailed responses in a telephone interview than when interviewed face-to-face. Yet, he argues that some data from crucial respondents were better than no data at all, as is the case with this dissertation. Furthermore, it was positively surprising how fruitful these conversations could be, even when the interview was not conducted face-to-face.

The question of the stakeholders' multiple roles could also be understood as a limitation. The informants were asked to answer the interview questions as representatives of their organization (see Appendix I), yet, as shown in the results of Studies II–IV, many stakeholders had multiple roles. Furthermore, they had personal views, which did not always align with the official views of the organization they represented. This was essential to take into account when analyzing the data and interpreting the results, in order to be explicit about the official views of a given stakeholder. Furthermore, another limitation of using interview data was that the analyses were based on self-reports, subjective experiences and perceptions. Therefore, the decision to adopt method and data source triangulation, rather than focusing solely on the interview data, was relevant, as these data sets complemented each other and made it possible to identify certain discrepancies (Patton, 1999). In many cases, such as in Study IV, the interview data overlapped with political documents in the form of referral responses – however, some discrepancies concerning stakeholders' views in the interviews became apparent when compared with other data sets. This highlights how stakeholder interests and positions, like contexts, are subject to change (Brugha & Varvasovszky, 2000).

One more limitation concerned the decision to not present informants' names in the results. At the beginning of the project, a lack of anonymity could have discouraged candidates from participating in the study, since the topic might be experienced as sensitive and the national drug policy field in Sweden is relatively small, familiar, and yet highly polarized. As discussed in the ethical considerations, however, informants' anonymity cannot be guaranteed. Naming the informants in the results would have made the project more realistic for readers and helped make comparisons between different data sets more explicit. However, certain informants key to the analysis would not have participated or spoken as openly if this had been the case.

Regarding textual data, a limitation in analyzing referral responses relates to the documents' format: statements presented in referral responses are often polished, based on relatively strict instructions by the Prime Minister's Office (2021) on how to formulate a response. For example, short responses are encouraged, and government agencies are obliged to send a response. Thus, despite the fact that it is stated that anyone can send a referral response, authors are restricted in the formulation of their response.

Media texts can be seen as more flexible than referral responses. However, as reflected in the results of this dissertation, the media platform includes its own rules, interests, and gatekeepers, namely journalists. Media's multiple roles in framing issues in a certain way – often by emphasizing juxtapositions – tend to construct only one version of reality (see Lancaster et al., 2011). These characteristics can be understood as limitations, and the role of media needs to be reflected on critically. Moreover, the generation of media data based on one researcher's selection in this dissertation can also be seen as a limitation. To address this, the data were presented and discussed with co-

authors, while the data generation process, including inclusion and exclusion criteria, was explicitly documented.

Results: Summary of findings

In this chapter, the results of the sub-studies are briefly presented. The discussion and concluding remarks following this chapter provide a more synthesized discussion, reflecting on the results of the sub-studies in relation to the overall aim and research questions of the dissertation.

Study I

Title: Debating drug policy in Sweden: Stakeholders' moral justifications in media 2015–2021

In this study, stakeholders' visibility and the moral justifications of their argumentation in the media debate on Swedish drug policy were examined. The research questions guiding the analysis were: “Which stakeholders are represented in the public debate on Swedish drug policy?” and “What kind of moral principles underlie their argumentation?” The data consisted of media texts published in four Swedish newspapers from 2015–2021 (N = 370). The justifications analysis framework (Ylä-Anttila & Luhtakallio, 2016), based on Boltanski & Thévenot's (2006) justification theory, was used as a methodological and theoretical tool to highlight the moral principles behind stakeholders' argumentation.

The results revealed that the most visible stakeholders in the media debate were politicians, government agencies, and molders of public opinion (former politicians or civil servants still active within the field). In practice, this meant that these stakeholder categories appeared most often in the media, for example, as authors of debate articles or when interviewed by a reporter. Furthermore, stakeholders with successful, active attempts to participate in the drug policy debates – as authors of debate articles or letters to the editor – included molders of public opinion, NGOs, and politicians. The results also showed that certain groups, including people who use drugs and their significant others, were identified as silent stakeholders, as they were less visible compared to many other stakeholder groups in the media.

In addition, the results of this study highlighted how all drug-related topics discussed and debated in the media revolved around the question of whether Swedish drug policy had been successful. Three positions among stakeholders

regarding Swedish drug policy based on drug use prohibition were identified: proponents, opponents, or neutral. *Proponents* defended the restrictive drug policy and, based on the justification analysis framework, mainly justified their argumentation through a combination of the policy's domestic and industrial worth (Ylä-Anttila & Luhtakallio, 2016). The domestic worth refers to paternalism, which in this study was defined as valuing control, security, the protection of children, and viewing drugs as an emerging threat (Curchin et al., 2022; Ritter, 2021). The industrial worth refers to valuing evidence-based drug policymaking (cf. utilitarian drug policy, Ritter, 2021). In some cases, proponents also argued that Swedish drug policy had been successful due to the low drug use prevalence compared to other European countries, thus justifying their stance by the policy's worth of fame. Meanwhile, *opponents* criticized the current drug policy and were interested in other policy alternatives to drug prohibition (e.g., decriminalizing drug use or legalizing cannabis). They mainly justified their argumentation by combining the industrial and civic worth justifications, the latter referring to valuing social justice and civil rights by arguing for treatment instead of punishment of people who use drugs. *Neutral* stakeholders were not openly for or against the restrictive drug policy; however, they emphasized the importance of evidence-based policymaking, justifying their argumentation with the policy's industrial worth.

The results showed that stakeholders generally combined the policy's industrial worth, that is, valuing evidence-based policymaking, with other moral justifications. This finding aligns with previous research, challenging the dichotomy of evidence and values, since not even evidence is purely value-free (Ritter, 2020; Roumeliotis, 2014; Zampini, 2018). Furthermore, the analysis revealed that these three sides (proponents, opponents, and neutral) discussed above were identified within all stakeholder groups, demonstrating that there were differing views and opinions not only between but also within the groups. This in-group dissonance may explain the persisting deadlock in Swedish drug policy, as no single or united group has been strong enough to challenge the prevailing preference for a restrictive policy. The study highlights the contesting values and moralities of Swedish drug policy, illuminating how Swedish drug policy formation may depend on the relative strength of its domestic and civic worth in society and among stakeholders in power.

In relation to the overall aim of the dissertation, the aim of Study I was to identify the key stakeholders within the drug policy field in Sweden and examine how they justify their argumentation in the drug policy debate. As discussed in the *Materials and methods* chapter, this study's media data and results were later used to guide the recruitment of informants for the key informant interviews analyzed in the other three sub-studies (Studies II–IV).

Study II

Title: Stakeholders' opportunities and attempts to influence drug policy in Sweden

This second study examined stakeholders' strategies to influence drug policy and perceptions of their own and others' opportunities to influence drug policy in Sweden. The research questions were: "What kind of strategies do different stakeholders use when trying to influence drug policy in Sweden?" and "How do stakeholders perceive their own and others' opportunities to influence drug policy?" The analysis was based on 38 key informant interviews with national-level stakeholders. The theoretical framework of the study consisted of several concepts on interest groups and social movements adopted from previous research, including access to political arenas (Binderkrantz et al., 2015, 2017, 2020), resources (Eising, 2007; Salisbury, 1969; Tarrow, 2022), influence strategies (Binderkrantz, 2005), and recognition and misrecognition (Fraser, 2000; Fraser & Honneth, 2003). Furthermore, the results concerning stakeholders' perceptions of opportunities to influence drug policy were interpreted against the power/interest matrix by Ackermann & Eden (2011).

The results revealed that the majority of stakeholders used both direct (e.g., writing a referral response, being a member of an expert group for a commission of inquiry) and indirect influence strategies (e.g., debating drug policy on social media or traditional media) in their attempts to influence Swedish drug policy. This finding aligns with previous research on interest groups (Binderkrantz, 2005). Furthermore, the majority acknowledged that there are informal ways to influence drug policy, such as having informal contacts with powerful stakeholders. Despite many denying having used informal ways to influence drug policy, some informants still described them as valuable.

The majority of informants perceived that they, together with many other stakeholders, have good opportunities to influence drug policy. However, many interviewed stakeholders also stated that they did not actively try to influence drug policy. For example, informants representing politically governed organizations (e.g., government agencies) described how they are not allowed to engage in politics, since their task is to follow guidelines and produce knowledge-based evaluations and proposals assigned by the government. Furthermore, the majority agreed that people who use drugs and their significant others represent stakeholder groups whose voices are not easily heard, and yet it is the policymakers' responsibility to involve all stakeholder groups in drug policymaking.

The findings show that stakeholders' resources (e.g., social contacts, internal resources) play a crucial role when attempting to influence drug policy; the more resources one has, the greater the opportunities to access relevant policy arenas in which to influence drug policy. Furthermore, according to the

stakeholders, institutionalized norms affect what kind of knowledge is perceived as relevant, what to argue, and how it is viewed as acceptable within the Swedish drug policy context (recognition and misrecognition; see Fraser, 2000). Supporting the current restrictive drug policy was identified as one factor, together with a large number of resources, that can enhance stakeholders' policy salience in Swedish drug policy (Houborg et al., 2016).

Comparing stakeholders' perceptions within the power/interest matrix (Ackermann & Eden, 2011), the majority were positioned either as subjects (high interest, low power) or context setters (high power, low interest), indicating that many with high interest also perceived themselves to have less power to influence than players (stakeholders with high power and high interest) and context setters. This illustrates that, with regard to drug policy, power may be concentrated in a few stakeholders (based on the interviews, this includes the Minister of Justice, Minister of Health and Social Affairs, the Parliamentary Committee on Justice, and the Committee on Health and Welfare), whom many interviewed stakeholders perceived as lacking interest in drug-related issues.

However, this study also highlights the challenges related to influencing drug policy: while the results indicate that stakeholders who support the current drug policy and have multiple resources are most likely to enhance their policy salience, these factors do not guarantee influence. Based on the perceptions of stakeholders, this study sheds light on their opportunities to influence drug policy within the contemporary Swedish context. The study also suggests that political will is needed to guarantee stakeholders more equitable involvement in drug policymaking.

Study III

Title: From a “drug-free society” to “reduced harm”? Stakeholders' moral positions and the significance of national commissions of inquiry in Sweden

This study explored stakeholders' moral positions regarding the current (“drug-free society”) and recently proposed Swedish drug policy aim (“a society with reduced harm from drugs”) by the DCI (SOU 2023:62). Furthermore, stakeholders' perceptions of the role of commissions of inquiry in drug policymaking were analyzed. The policy constellations approach (Stevens, 2024) was used as a theoretical framework to analyze key informant interviews (N = 38) and stakeholders' referral responses to the DCI (N = 76). The interviews were conducted in 2022–2023, before publication of the final report of the DCI, whereas the referral responses were published in 2024. The research questions were: “What are stakeholders' moral positions on the cur-

rent and proposed drug policy aim?” and “How do stakeholders perceive reforming and participating in drug policymaking in Sweden through commissions of inquiry?”

The results show that stakeholders formed three policy constellations around the question of the Swedish drug policy’s aim:

(1) *The progressive policy constellation* criticized the current drug policy aim and/or supported updating the current aim as suggested by the DCI. They based their arguments on social justice, combined with compassion and equity-based public health (MacKay, 2018), emphasizing the need to reduce stigma and discrimination toward people who use drugs, help those in need, and improve health for all. Some stakeholders (based on the interview data) argued for the decriminalization of drug use, combining principles of social justice and liberty in their argumentation.

(2) *The conservative policy constellation* supported the current drug policy aim and/or opposed the proposal to update the aim as suggested by the DCI. The representatives of this constellation based their arguments on conservatism, understood as an unwillingness to change. This morality was often combined with utilitarian-based public health, emphasizing the importance of maximizing benefits and minimizing harms for the majority of people (MacKay, 2018). Furthermore, this policy constellation included two subgroups, *traditionalists* and *mild conservatives*. In their argumentation, the traditionalists opposed the proposal to update the drug policy aim by emphasizing security and compassion toward children and significant others. The mild conservatives maintained the current aim while highlighting the importance of reducing stigma toward people who use drugs. Thus, in their argumentation, they combined conservatism with social justice and compassion.

(3) *A micro policy constellation* was also identified when analyzing the referral responses, reflecting the small number of stakeholders forming it. This constellation supported updating the drug policy aim, but not as suggested by the DCI. Instead, they proposed an update that would include both prevention and harm reduction perspectives, aiming to reduce drug use and drug-related harm. In their argumentation, the representatives of this policy constellation combined principles of utilitarian-based public health with equity-based public health (MacKay, 2018).

All constellations applied compassion as a morality in their argumentation, specifically emphasizing the importance of helping people in need (Stevens, 2024). However, the target of compassion varied: for stakeholders in the progressive policy constellation, the primary target was people who use drugs, while in the conservative policy constellation, the target was mainly children and significant others.

Based on the interviews, stakeholders perceived commissions of inquiry as a meaningful tool in drug policy processes. Representatives of the progressive PC found it positive that people who use drugs and significant others had been involved in the expert groups of two recent drug policy-related inquiries.

However, many stakeholders, mainly representing the progressive policy constellation, had lost faith in commissions of inquiry due to the lack of implementation after previous drug policy-related inquiries, slow processes, and the Government's decision to exclude the Penal Law on Narcotics from the DCI. This latter critique was also supported by stakeholders in other policy constellations. Furthermore, representatives of the progressive PC perceived commissions of inquiry as a government strategy to avoid responsibility, aligning with previous findings (Lundberg, 2013).

This study highlights the value-based tension between the conservative and progressive policy constellations. One aim of the study was to follow up on whether stakeholders' moral justifications identified in Study I (based on the drug policy media debate) differed from the moral positions on the drug policy aim identified in the referral responses and key informant interviews. The results revealed that the moral positions of the conservative and progressive policy constellations (Study III) aligned with the moral justifications of the proponents and opponents of the restrictive drug policy in the Swedish media debate (Study I): similar moralities were identified in their argumentation, despite the fact that the question concerned strengthening harm reduction by updating the national drug policy aim (Study III), rather than taking concrete steps toward removing the drug prohibition policy.

The findings of Study III also supported the results of Study I by shedding light on how stakeholders' moral positions in the progressive and conservative policy constellations were fragmented among stakeholders: the traditionalist wing in the conservative policy constellation emphasized security and compassion for children and significant others, while the mild conservative wing combined conservatism with social justice, stressing stigma reduction while retaining the current aim. Another contribution of this study beyond previous research is the identification of values that were not present in the media debate (Study I). Stakeholders across policy constellations valued public health with different nuances: the progressive policy constellation valued improving health for all and reducing inequalities, whereas the conservative policy constellation favored maximizing health benefits and minimizing harms for the majority of people (MacKay, 2018). Only a minority representing the micro policy constellation embraced both equity-based and utilitarian public health perspectives. This study suggests that the dominance of the utilitarian public health perspective over the equity-based one may explain the cautious development of harm reduction in Sweden. Furthermore, stakeholders' perceptions about commissions of inquiry in drug policymaking indicate the need to critically discuss and investigate how to improve this system as part of the drug policymaking process so that it would not hinder effective policy implementation.

Study IV

Title: Reconciling control and harm reduction. On stakeholders and drug policy formation in Sweden

In the last sub-study, the aim was to analyze recent drug policy processes in Sweden, with a focus on stakeholders. The research questions were: “How can we explain why harm reduction measures have become more accepted in Sweden, while punishments have become more severe, and what is the role of stakeholders in shaping policy processes in this case?” For this study, three data sets (media texts, key informant interviews, and stakeholders' referral responses to two commissions of inquiry) from 2015–2025 were analyzed using Kingdon's (2013) MSF.

The results showed that during this ten-year period, two parallel problem constructions were formed: drug-related mortality and organized criminality associated with illicit drug markets and violence. Both problem constructions were connected to opening a policy window, but only one led to policy change. The first policy window, related to drug-related mortality, concerned the DCI and whether the Penal Law on Narcotics, particularly the criminalization of drug use, would be included in the inquiry. The increased number of drug-related deaths became an issue for which many stakeholders demanded the Government's reaction in the problem stream. Simultaneously, in the policy stream, a suggestion to evaluate the social and health effects of criminalization of drug use was proposed and later supported by other stakeholders in the political stream. In 2020, the Swedish Parliament supported the proposal by the Committee on Health and Welfare to evaluate the national drug policy, opening the policy window. However, it was immediately closed by the Minister for Health and Social Affairs, who announced that drug use criminalization would not be part of the inquiry. Afterward, despite broad support for evaluating the whole drug policy, the policy window remained closed.

The other identified problem construction, organized criminality associated with illicit drug markets, was related to opening the second policy window; stakeholders in both the problem stream and the political stream demanded solutions. The concern over organized criminality drew attention away from drug-related deaths. The analysis revealed that this second policy window also opened in 2020, when the former Swedish government, led by the Social Democrats, formulated the directive for the commission of inquiry “Stricter penalties for crimes committed by criminal networks” (SOU 2021:68). In the inquiry directive, the inquiry investigator was asked to investigate and propose changes in legislation that would entail a tougher criminal

law response to drug sales. The current government, led by the Liberal Conservatives together with the Tidö Agreement²² parties, continued this policy process, leading to policy change with increased penalties for the sale of small amounts of drugs in 2023.

Using the MSF, the study demonstrated the active involvement of several stakeholders in these parallel cases, many of whom participated both in setting the agenda and proposing solutions, thus being active in more than one stream simultaneously. The stakeholders identified as policy entrepreneurs coupling the streams for the first policy window were the Committee on Health and Welfare, with support from the Swedish Association of Local Authorities and Regions, and the Public Health Agency of Sweden. For the second policy window, the policy entrepreneurs were the former and current Swedish governments.

The results of this study shed light on the institutional division of Swedish drug policy, with these two problem constructions mainly dealt with separately. The analysis of the parallel policy processes showed that the political stream favored stricter penalties due to organized criminality, accompanied by a limited debate on policy alternatives and rapid adoption of policy change, whereas the political conditions for criminalization of drug use or other policy alternatives were not favorable. The results support previous findings that Sweden has adopted a dual-track policy structure, consisting of two parallel policy tracks – public health policy and control policy (Hakkarainen et al., 2007; Karlsson et al., 2021). However, the analysis revealed that the political stream was more favorable to stricter penalties than to strengthening harm reduction through evaluating decriminalization of drug use.

These findings can be further understood by two concepts. The first concept is ‘decoupling’ (Meyer & Rowan, 1977), which refers to how organizations can separate their actions from formal structures when facing societal expectations that conflict with the organization’s principles. This decoupling leads to superficial adaptations or the adoption of new structures without changes in practice. In the Swedish case, the results indicated that the restrictive drug policy formed the core structure, and adopting new measures was unproblematic as long as those measures did not challenge this structure; for example, implementing THN in Sweden did not threaten the restrictive drug policy since the medicine cannot be misused.

The second concept to further understanding of these parallel cases is tango politics, described by Lenke and Olsson in the following way:

²² The Swedish government elected in 2022 consists of the Moderate Party, the Christian Democrats, and the Liberal Party. The government cooperates with the Sweden Democrats based on the Tidö Agreement (Government Offices of Sweden, 2022).

Political process wherein one party – in this case the Social Democrats – first ‘lost’ the political discourse on how to handle the drug question. When the treatment-first approach was defeated by the Conservatives’ repression-first approach, the Social Democrats successively positioned themselves as close to the Conservative perspective as possible, hoping that the voters would no longer be able to see which party was really ‘leading the dance.’ (Lenke & Olsson, 2002, p. 70)

In other words, tango politics in this case refers to how the prevailing restrictive drug policy remained central regardless of which political party was in charge. In conclusion, this study suggests that reconciling harm reduction with restrictive drug policy, by attempting to strengthen both approaches simultaneously, is not possible.

Discussion

This dissertation aimed to advance our understanding of the context and policy processes shaping Swedish drug policy by analyzing stakeholders' values, interests, and forms of involvement. In this chapter, the results of the sub-studies are discussed in relation to the overall aim, specific research questions, and the health policy triangle framework (Walt & Gilson, 1994). The dissertation's contributions to public health sciences, as well as its implications for public health and drug policy practice, are outlined, followed by concluding remarks.

Identifying stakeholders and stakeholder involvement

Which stakeholders may be identified within the Swedish drug policy field, and how are they involved in drug policy processes?

As demonstrated in the sub-studies, the stakeholders identified included multiple individuals, groups, and organizations that can be considered part of the Swedish drug policy field. This is partly due to the broad definition adopted at the start of the project. While Study I, which identified key stakeholders from media data, and guided the recruitment for interviews (Studies II–IV), the list of authors sending, or invited to send, referral responses to recent drug policy-related inquiries, such as the DCI (SOU 2023:62), highlights which stakeholders may be regarded as relevant from a top-level policymaking perspective in national drug policy in Sweden (Study III).

When it comes to stakeholder involvement in drug policy, the results of the sub-studies highlight the variety of ways stakeholders participate in the processes: they discuss, debate, collect and share information, and apply their knowledge and various influence strategies when attempting to influence Swedish drug policy, as demonstrated in Study II. However, the same study also showed that many stakeholders do not actively seek to influence policy. For example, as reflected in Study IV and by informants in Study II, certain stakeholders, such as government agencies, were involved in the processes due to tasks assigned by the Government, producing knowledge for decision-makers, rather than actively shaping policy. This can also be understood in light of the role of government agencies and the format of referral responses

(see Limitations, above). The results indicate that all stakeholders have their own tasks and interests, which often guide their primary goals and shape their positioning within the drug policy field, depending on the drug policy area in which they operate. For instance, social workers and health care professionals focus on their clients or patients and meeting their needs, some government agencies focus on producing knowledge for decision-making, the police and customs act as a security mechanism, and NGOs primarily focus on their target groups, whether people who use drugs, significant others, or groups sharing similar perspectives on how drug policy could be improved.

Regardless of the main task of a particular stakeholder within the Swedish drug policy field, the results of the sub-studies showed that many stakeholders shared policy goals, values and moralities with others (Studies I and III). However, the findings also highlighted differing views, values and moralities both between and within stakeholder groups, which are discussed below.

Furthermore, using the MSF, Study IV illustrated how several stakeholders participated in setting the agenda and formulating solutions for drug policy problems across different policy arenas, showing that many stakeholders were involved in multiple stages of the policy process, consistent with previous findings on the use of multiple streams (Robinson & Eller, 2010). The study also identified a community of specialists who were active in formulating policy alternatives for drug-related deaths and illicit drug markets connected to organized criminality. These specialists were identified with the help of MSF, similarly as policy entrepreneurs who managed to open policy windows, although only one window led to actual policy change. From the perspective of the health policy triangle framework, these findings highlighted the interrelationships between actors and processes, which together shape the policy content (Walt & Gilson, 1994).

Perceived successes and challenges: Stakeholder characteristics and contextual factors

How can stakeholders' perceived successes or challenges in influencing drug policy and policymaking be understood in light of stakeholder characteristics and contextual factors?

As shown in the sub-studies, stakeholders have differing interests and contesting policy goals, and not all of those goals end up on the policy agenda. The results of Study II show that many stakeholders perceived that they, together with others, have good opportunities to influence drug policy in Sweden. However, they stated that not all stakeholders have equal opportunities. Furthermore, based on their own perceptions, none of the stakeholders could be clearly categorized as having both high power and high interest in drug policy

issues (see Ackermann & Eden, 2011). Several stakeholder characteristics and contextual factors were identified that advanced our understanding of the successes and challenges faced by stakeholders when attempting to influence drug policy.

The first stakeholder characteristic of importance is resources. As reflected by the informants in Study II, stakeholders who possess different kinds of resources (e.g., money, knowledge, professional staff, influential allies, networking skills, and relevant social contacts) are most likely to succeed in their attempts compared to those with fewer resources. People who use drugs and their significant others were perceived as two stakeholder categories whose voices are not adequately heard in drug policy formation, due to a lack of resources, as highlighted by people who use drugs themselves, and due to the need for better organization, as suggested by other stakeholders (Study II). One proposal to enhance the participation of these groups was for policymakers to take responsibility for promoting more equitable stakeholder involvement.

These findings from Study II align with the concept of privileged pluralism, suggesting that “different arenas offer options for different groups to access politics, but when it comes to the major players cumulative effects are evident, i.e., the same groups dominate across all arenas” (Binderkrantz et al., 2015, p. 23). However, it is essential to emphasize the notion from Study II that, since top-level policymakers hold the greatest power to influence drug policy, neither access to political arenas nor a large number of resources automatically guarantee that stakeholders’ voices will be heard or will lead to influence.

Indeed, when it comes to the top-level policymakers, the results of this dissertation illuminate the powerful role of the major political parties in (drug) policymaking in Sweden, as they possess more resources than smaller parties (Study II), and their support is essential for policy change, as demonstrated in Study IV. However, as highlighted by representatives of top-level policymaking, a majority is required in democratic decision-making.

An interesting finding concerned the stakeholder category of molders of public opinion: according to Study I, this group had been successful in influencing the media through access and active participation. However, Study II revealed that the informants representing this group no longer felt capable of exerting real influence. This was further supported by the fact that none of the informants from other stakeholder categories mentioned molders as influential in drug policymaking, illustrating how one’s formal position, another stakeholder characteristic, matters. These stakeholders are not entirely powerless, as they still possess contacts and resources, but the results indicate that being formally positioned or organized may be crucial for increasing one’s chances of influence.

The last stakeholder characteristic that can further our understanding of stakeholders’ perceived successes and challenges in influencing drug policy

concerned the support of the current restrictive drug policy. As discussed in Study II, several informants perceived that the stakeholders supporting the current drug policy (i.e., the status quo) held a favorable position within the drug policy field.

The predominance of support for the restrictive drug policy could also be interpreted as a contextual factor to further understand stakeholders' perceived challenges in influencing drug policy, specifically from the perspective of those stakeholders who opposed the restrictive drug policy. One possible explanation explored in Study IV can be illustrated using the concepts of a dual-track policy structure (Hakkarainen et al., 2007; Tammi, 2007) and 'decoupling' (Meyer & Rowan, 1977). More specifically, as suggested in Study IV and elsewhere (Karlsson et al., 2021), Sweden has adopted a dual-track drug policy structure, consisting of two parallel tracks: a public health policy track and a control policy track – the latter of which has dominated Swedish drug policy formation. Through the concept of decoupling, the control policy approach can be understood as the core of drug policy, which governs policy formation through the support of the main political parties. Changes in drug policy, such as adopting new harm reduction measures like THN, are possible as long as these changes do not threaten the core.

Another explanation for the strong support of the restrictive drug policy suggested in Study IV is so-called tango politics – based on the aim of a drug-free society, the restrictive drug policy has prevailed regardless of which political party has been in power, effectively leading the “dance” since the 1970s (Lenke & Olsson, 2002). This echoes previous findings on Swedish drug policy and cross-party agreement, also described as the party truce (Edman, 2013; Tops, 2001), highlighting that MPs across parties have consistently supported restrictive drug policy, framed as a national project reinforcing the threat posed by drugs to the national identity (Tham, 1992). Previously identified contextual factors that may account for the strong cross-party support for restrictive drug policy in Sweden include the legacy of the temperance movement, institutionalized traditions of formal social control, and the role of the welfare state (Lenke & Olsson, 2002; Tham, 2021; Tops, 2001).²³ From the perspective of the health policy triangle framework, these historical and socio-cultural contextual factors are essential to understand contemporary policy context (see Walt & Gilson, 1994).

Thus, it can be argued that during the studied period, political support for the restrictive drug policy has largely persisted. As discussed previously, the results of Study II indicated a lack of political will and highlighted stakeholders' perceptions that drug-related issues have not been prioritized by politicians. Yet, events during the studied period suggest that this consensus may have begun to fracture. In Study IV, several political parties, excluding the

²³ The interventionist tradition (see Tham 2021, pp. 145-146)

three largest (Social Democrats, Sweden Democrats, and Liberal Conservatives), were found to support evaluating the criminalization of drug use as part of the DCI, and the Parliament voted against a new bill on the ANDTG strategy in 2021. Moreover, in November 2025, the Centre Party announced its intention to decriminalize drug use (Hambraeus, 2025), also highlighting changes within the policy field. Regardless of the fracturing consensus on restrictive drug policy, in order to be effective, policy proposals still need to align with the problem, public mood, and dominant values and moralities, while being politically feasible (Kingdon, 2013), as demonstrated in Study IV.

The third contextual factor concerned institutionalized norms, as reflected in Study II. These were analyzed using the concepts of ‘recognition’ and ‘misrecognition’ (Fraser, 2000; Fraser & Honneth, 2003). Institutionalized norms revealed underlying values within the Swedish drug policy field, such as democracy and providing stakeholders with opportunities to participate. However, based on stakeholders’ perceptions, these intentions were not fully realized due to the unequal distribution of resources among stakeholders and, in terms of access, because of the privileged pluralism discussed above (Binderkrantz et al., 2015). Study II also demonstrated that institutionalized norms set guidelines and boundaries for how stakeholders can participate in drug policy processes. For instance, stakeholders seeking to influence policy need to be organized and act within the given framework. Informal institutionalized norms were also identified, such as expectations about how to express opinions on drug policy – avoiding positions that are perceived as too liberal or too conservative.

Institutionalized norms also concerned whose knowledge is considered relevant and valuable in drug policy formation. Informants perceived that knowledge from experts and professionals was valued more highly than knowledge based on lived experiences. Furthermore, stakeholders noted that certain professions were valued above others (for example, medicine over social work). Yet, the majority of stakeholders valued and appreciated the inclusion of people who use drugs and their significant others in drug policy formation (Studies II–III), with several informants across stakeholder categories highlighting the involvement of these groups in expert committees in recent drug policy-related commissions of inquiry as a positive example. This can also be seen as reflecting Fraser’s concept of taking steps toward recognition:

Redressing misrecognition now means changing social institutions – or, more specifically, changing the interaction-regulating values that impede parity of participation at all relevant institutional sites. Exactly how this should be done depends in each case on the mode in which misrecognition is institutionalized. Juridified forms require legal change, policy-entrenched forms require policy change, associational forms require associational change, and so on: the mode and agency of redress vary, as does the institutional site. But in every case, the goal is the same: redressing misrecognition means replacing institutionalized

value patterns that impede parity of participation with ones that enable or foster it. (Fraser, 2000, p. 115)

However, previous research on involving people who use drugs in drug policy formation suggests that there is a risk that such participation is merely symbolic or superficial (Bjerge et al., 2016; Lancaster et al., 2018; Madden, 2022).

The fourth contextual factor, as illustrated in Study III, was the lack of policy implementation following commissions of inquiry. This could also be interpreted as a critique concerning stakeholder involvement in drug policy formation. The issue of non-implementation is not a new phenomenon (Hudson et al., 2019) and, according to previous research, is not limited to drug policy. Nevertheless, these findings raise the question of whether existing policymaking tools could be enhanced and critically evaluated, and whether other mechanisms or factors could better support stakeholder involvement in policymaking, as suggested in Study III.

The fifth contextual factor highlighted in Study II is political will, which can also be categorized as stakeholder characteristics concerning MPs. Indeed, although a few top-level policymakers interviewed for this dissertation argued that many MPs are engaged with drug policy issues, the interview results indicate a general lack of interest in drug policy matters among top-level decision-makers. This is interesting given that drug use is perceived by the public as almost as important as organized crime (SOM Institute, 2025).

The sixth contextual factor concerned access to policy arenas and the role of gatekeepers, aligning with previous findings (Binderkrantz et al., 2015). Although stakeholders interviewed for the project rarely discussed gatekeepers explicitly, their role was reflected in Study II, through the experiences of people who use drugs not having their debate articles published (with media acting as gatekeepers), and in Study I, where people who use drugs and their significant others were less visible in the media compared to other stakeholder categories. For one, there may be a high threshold for entering the policy arena for those engaging in illegal activities, such as drug use. On the other hand, limited media presence may also be due to a lack of interest in participating in drug policy debates in the first place.

The final contextual factor that can further our understanding of stakeholders' perceptions of successes and challenges in influencing drug policymaking concerns changes in the policy context during the studied period. For example, Study IV demonstrated how organized criminality, illicit drug markets, and violence attracted attention, which, according to the informants, may have a significant impact on the future direction of Swedish drug policy. Yet, informants also stated that as long as Sweden faces challenges with organized criminality and gang-related violence, there may be little progress toward relaxing the restrictive drug policy.

In relation to the health policy triangle framework (Walt & Gilson, 1994), these results indicated that stakeholders' (actors') characteristics, such as different types of resources, may affect their opportunities to influence – including the strategies they use and whether they gain access to different policy arenas. Based on the perceptions of stakeholders, the more resources a stakeholder has, the more likely they are to succeed in their attempts to influence policy, although success cannot be guaranteed. Nevertheless, stakeholders, together with their strategies and resources, shape drug policymaking processes and, ultimately, the content of the policy. Moreover, contextual factors – such as institutionalized norms, changes in the policy context, and socio-cultural elements – also play a significant role in drug policy formation.

Morality tensions and value combinations

How can Swedish drug policy be understood through tensions and nuances in stakeholders' values and moralities?

The main tension identified in this dissertation concerned the stakeholders' moral justifications of domestic worth versus civic worth (Study I), and the conflict between the conservative policy constellation and the progressive policy constellation (Study III). These results illuminated a longstanding divide between two major moral positions within the Swedish drug policy field that has existed since the 1960s, when the first NGOs – RNS and RFHL – were founded, representing those who support the restrictive policy based on the aim of a drug-free society; and those who support people who use drugs, opposing the restrictive drug policy, respectively (Laanemets, 2006; Lenke & Olsson, 2002, see *Background*).

However, the results of Studies I and III also revealed different value and morality nuances in stakeholders' argumentation. The studies illustrate how values and moralities have changed; instead of having two extremes (e.g., Laanemets, 2006; Lenke & Olsson, 2002), these nuances showed, for example, how several stakeholders in different data sets, including those who supported a restrictive drug policy and wanted to keep the current drug policy aim, emphasized the importance of reducing stigmatization of people who use drugs based on social justice and supported implementing some harm reduction measures, such as NEP (Study III). This clustering of values in drug policy debates has also been identified previously (Askew & Ritter, 2023, 2025; Stevens, 2024). The results of Studies III and IV also supported previous findings on acceptance and positive views toward harm reduction among stakeholders in Sweden (Holeksa & Richert, 2024; Nordgren et al., 2022). Somewhat surprisingly, Study III found that only a few stakeholders suggested to update the drug policy aim by removing “drug-free society” and instead combining the proposed aim with a prevention perspective.

Furthermore, as discussed in Studies III and IV, the dissertation demonstrated how decision-makers have aimed to combine the contemporary restrictive drug policy with a harm reduction approach. However, as shown in Study IV, attempting to reconcile harm reduction with the restrictive policy is not possible: as long as the control policy track dominates within the dual-track drug policy structure, forming the core of the drug policy, these two approaches can coexist only when the control policy track sets the boundaries for drug policy formation. Regarding harm reduction, broadening existing policy measures and adopting new ones is possible as long as those measures (e.g., THN) do not threaten the core – the restrictive drug policy based on the aim of a drug-free society.

In addition, as the results of Study IV showed, another explanation for the dominance of the control policy track may be the tango politics: how the biggest political parties in Sweden have not shown any interest in giving up the restrictive drug policy or doing anything that could threaten it (Lenke & Olsson, 2002). This may explain the deadlock, as reflected in Study I: no other stakeholders have been strong enough to challenge the hegemony of the control policy track. As the results indicated, representatives of top-level policy-making hold the ultimate power (Study II), and the support of the biggest political parties is particularly needed for drug policy change (Study IV). For example, despite broad stakeholder support for the evaluation of drug use criminalization demonstrated in Studies I–IV, the ministers representing the big political parties, Social Democrats and Liberal Conservatives, rejected it. Another explanation suggested in Study I was the in-group dissonance among stakeholders active in the Swedish drug policy debate in the media: all stakeholder categories included proponents, opponents, and neutrals regarding the restrictive drug policy based on zero tolerance. Therefore, since views differed not only between groups but also within groups, none was strong enough to challenge the restrictive drug policy.

There were clear nuances when valuing public health within drug policy, as illustrated in Study III: the conservative policy constellation that argued for maintaining the drug-free society aim based their argumentation on conservatism and *utilitarian-based public health*, while the progressive policy constellation, supporting the proposal to update the drug policy aim to a “society with reduced harm from drugs” suggested by the DCI (SOU 2023:62), based their argumentation on social justice and *equity-based public health* (MacKay, 2018). These different views resonate with a common ethical challenge in public health, as discussed by Holland (2023): due to its population-level approach to maintaining health and reducing health inequalities, public health can sometimes promise benefits to populations at the expense of individuals. In practice, this consists of a tension between the rights and needs of individuals and those of the community. Aligning with previous findings, this moral dilemma in Swedish drug policy concerns the health and well-being of people who use drugs (i.e., the individual) and general prevention efforts to protect

the public, particularly youth (Eriksson et al., 2025). In light of the aims of Swedish public health policy – good and equitable health, with the overarching objective of eliminating avoidable health inequalities within one generation (Public Health Agency of Sweden, 2021) – strengthening both public health prevention and harm reduction may not be conflicting. In addition, scientific evidence supports providing health and social care services for people with drug use problems to benefit both individuals and broader society (Babor et al., 2018).

Regardless, the results of Study IV indicated that strengthening harm reduction simultaneously with punitive measures is not possible. Hence, Studies III and IV highlighted why the current public health approach in Sweden, given the country’s drug policy, may hinder the development of harm reduction. That public health perspectives can carry different weight and mean different things depending on the substance, time, and context (Mold, 2018) is evident in this dissertation.

In relation to the health policy triangle framework (Walt & Gilson, 1994), the dissertation’s results illustrated how both stakeholders’ values and moralities identified through the policy constellations approach and justification analysis, and underlying values related to institutionalized norms discussed above (Study II), are tightly connected to drug policy processes, also affecting the policy content.

Public health contributions and implications

Drug policy formation through regulations, laws, and strategies has implications for public health (Babor et al., 2018). This dissertation provides several implications for public health and drug policy practice and contributions to public health sciences.

The results indicated that the groups affected by drug policy are also the stakeholder groups identified as not having their voices heard, namely people who use drugs and their significant others. Based on the results, there is broad stakeholder support for including these groups in drug policy-making processes. Additionally, recent commissions of inquiry, such as the comorbidity inquiry (SOU 2021:93; SOU 2023:5) and the DCI (SOU 2023:62), were mentioned as positive examples because these affected groups’ views were incorporated into the inquiry work. The results suggest that inclusion would require supporting these groups so they can become more organized, as well as political will to include and invite them into drug policy formation. Involving people who use drugs and their significant others in drug policy formation can contribute to public health by helping to form policies that better consider these groups’ health and well-being (see Askew et al., 2022; Askew & Bone, 2019; Greer et al., 2016; Lancaster et al., 2018).

Furthermore, the results of this dissertation advance understanding of how stakeholders combine arguments for evidence-based drug policymaking with different kinds of moralities. From a public health perspective, the findings illuminated how stakeholders argued both for and against evidence-based interventions, such as SCS. This finding aligns with previous research, showing that dividing public (health) policymaking based on values and evidence provides a false dichotomy (Zampini, 2018). As suggested in previous research (Askew & Ritter, 2023, 2025; Ritter, 2021), these results raise the question of whether making value conflicts explicit could enhance policy formation. Values alone may not solve drug policy-related issues, but making them explicit can provide transparency concerning what stakeholders aim to achieve (see Askew & Ritter, 2025).

Another implication for both public health and drug policy practice concerns two different public health paradigms identified in this dissertation, particularly in relation to the aim of drug policy. Swedish drug policy is part of public health policy, which aims for good and equitable health (Public Health Agency of Sweden, 2021). These different nuances of public health invite discussion on the consequences for drug policy and whether public health should be understood as more than “restrictions on personal freedom [that] can be accepted in order to protect public health” [...] [such as, through] criminalization of drugs (Skr. 2021/22:213, p.7).

Considering the public health aim of good and equitable health, policymakers could try to incorporate both aspects of this aim into drug policy, that is, to focus not only on prevention from a population perspective but also on reducing health inequities with special emphasis on the needs of people who use drugs (Public Health Agency of Sweden, 2021; see also Braveman et al., 2011; Kawachi et al., 2002). Based on the results of this dissertation, steps have already been taken in this direction through the comorbidity inquiry (SOU 2021:93; SOU 2023:5) and the DCI (SOU 2023:62). Furthermore, the results align with earlier findings of growing support for harm reduction in Sweden among stakeholders (Holeksa & Richert, 2024; Nordgren et al., 2022) and indicate that drug policy formation during the studied period has taken several steps to strengthen harm reduction, for example, by adopting THN and broadening access to OAT and NEP. However, as discussed, the directive of the DCI was widely criticized across stakeholder categories due to the decision not to evaluate the criminalization of drug use. This dissertation highlights that – despite conflicting opinions, values, and moralities – there is broad support among stakeholders to evaluate the social and health effects of criminalizing drug use. The decision not to evaluate the Penal Law on Narcotics (SFS 1968:64) illustrates the dual-track drug policy structure, in which the control policy track dominates policymaking (cf. Hakkarainen et al., 2007). The results indicate that a utilitarian-based public health approach has hindered harm reduction development and, together with the dominance of the control policy track, may continue to do so if this track remains dominant. Regarding the

flexibility of defining public health, all approaches share an emphasis on systematically reviewing policy alternatives according to scientific criteria (Babor et al., 2018) and on “using evidence to inform policies affecting the health of people” (Room, 2015, p. 367). Following this principle, one possible way to strengthen the public health policy track within the dual-track drug policy structure is to evaluate the social and health effects of criminalizing drug use.

Concluding remarks

This dissertation, aimed at advancing understanding of the context and processes of Swedish drug policy, confirms that drug policy formation can be understood as structured interaction, involving multiple actors negotiating responses to a specific problem (Ritter, 2021). It is further evident that multiple conditions must align or be coupled, including the commitment of influential stakeholders, for policy change to occur. The initial expectation that Swedish drug policy could take a new direction after 2020 has, so far, not been realized. Instead, shifts both in Sweden and internationally, as shown in Study IV, illustrate how sudden policy windows, aligned with broader conditions and political feasibility, can steer policymaking in particular directions. Moreover, tensions between values and moralities – particularly concerning public health – contribute to both the polarization and the deadlocks observed in drug policy development. Only time will show what happens next. Currently, there is no information about the next ANDTG strategy, nor about the fate of the proposals presented in the report of the DCI (SOU, 2023:62).

One aspect of the complexity of drug policy formation reflected upon during this doctoral research project is that there is no quick fix to solve drug-related problems. Furthermore, as discussed by Babor et al. (2018), it must be acknowledged that, unfortunately, drug-related problems cannot be entirely abolished. As long as people use drugs, society will face related problems in one form or another. What policy can do is aim to minimize the associated harm.

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Appendices

Appendix I: Information to research participants

Intressegruppers ställning i svensk narkotikapolitik: intressen, argument och inflytande

Information till forskningspersonerna

Vi vill fråga dig om du vill delta i ett forskningsprojekt. I det här dokumentet får du information om projektet och om vad det innebär att delta. Deltagandet är frivilligt.

Vad är det för projekt och varför vill ni att jag ska delta?

Forskningsprojektet Intressegruppers ställning i svensk narkotikapolitik: intressen, argument och inflytande syftar till att studera hur olika intressegrupper inom Sveriges narkotikapolitik ser på sin ställning i den svenska narkotikapolitiken samt vad de anser om utvecklingen, möjliga reformer och den utvärdering av Sveriges narkotikapolitik som regeringen har utlovat. Projektet finansieras av Stockholms universitet genom en doktorandanställning och ett doktorandprojekt vid Institutionen för folkhälsovetenskap. Studien har godkänts av Etikprövningsmyndigheten (Diarienummer 2021-07012-01). Forskningshuvudman för projektet är Institutionen för Folkhälsovetenskap, Stockholms universitet. Med forskningshuvudman menas den organisation som är ansvarig för studien.

Hur går studien till?

Personer från olika intressegrupper inom Sveriges narkotikapolitik tillfrågas om att intervjuas för att studera olika intressegruppers idéer, argument och möjligheter att påverka utvecklingen av Sveriges narkotikapolitik samt vilka områden och frågor de anser borde fokuseras i den svenska narkotikapolitiken. Studien vänder sig till experter och anställda med olika arbetsuppgifter och uppdrag i eller kopplade till olika delar av narkotikapolitiken (vård, kontroll, prevention eller skademinimering), tjänstemän på nationell nivå, politiker,

föreningsrepresentanter, samt personer som själva använder narkotika och deras anhöriga. Intervjun beräknas ta cirka en timme. Intervjuer görs enskilt på en överenskommen plats, den spelas in digitalt och skrivs därefter ut. Om intervjupersonen föredrar att ta med en kollega eller annan stödperson till intervjun, eller föredrar att göra intervjun via telefon eller digitalt (t.ex. Zoom), så är detta möjligt. Utöver den här intervjustudien så inkluderar forskningsprojektet också insamlandet och analys av mediatexter och politiska dokument som handlar om narkotikapolitiken i Sverige.

Möjliga följder och risker med att delta i studien

Intervjun handlar i första hand om olika intressegruppers uppfattningar och erfarenheter. Det kan handla om den organisation, arbetsplats eller förening som du är verksam inom. Du väljer själv hur mycket information du vill dela och vad du vill berätta om i intervjun. Om du i efterhand vill rätta till något, ångrar vissa delar, eller hela intervjun, så kan du kontakta den forskningsansvarige (se nedan) som då kan rätta eller helt radera uppgifterna. Du kan också när som helst avbryta intervjun och du kan tacka nej till deltagande.

Vad händer med mina uppgifter?

Projektet kommer att samla in och registrera information om dig. Information utgår från den intervjun vi nu ber att få göra och det du väljer att berätta. Enligt EU:s dataskyddsförordning (GDPR) ska fysiska personers grundläggande rättigheter och friheter skyddas, särskilt deras rätt till skydd av personuppgifter. Den lagliga grunden för behandlingen av dina personuppgifter är att den är nödvändig för att utföra en uppgift av allmänt intresse. Ändamålet för behandlingen av dina personuppgifter är att bedriva den vetenskapliga forskning som beskrivs ovan. Forskningen sker i enlighet med etikprövningslagen (SFS 2003:460). Intervjun kommer att sparas som en ljudfil och en utskrift i textformat men inte tillsammans med namn, kontaktuppgifter eller samtyckesformulär. Personuppgifter pseudonymiseras. Förteckningen över pseudonymiserade uppgifter förvaras skyddat på Stockholms universitet och separat från intervjusvar och undertecknade samtyckesformulär. Dina svar kommer att behandlas så att obehöriga inte kan ta del av dem. När resultaten publiceras nämns varken ditt namn eller din exakta organisation. I resultaten redogörs enbart för typ av intressegrupp (till exempel expert, polisen, anhöriga, representant för en förening) och personliga detaljer ändras eller utelämnas så att inte just du går att identifiera.

Ansvarig för dina personuppgifter är Institutionen för Folkhälsovetenskap, Stockholms universitet. Enligt EU:s dataskyddsförordning (GDPR) har du rätt att kostnadsfritt få ta del av de uppgifter om dig som hanteras i studien, och vid behov få eventuella fel rättade. Du kan också begära att uppgifter om dig

raderas samt att behandlingen av dina personuppgifter begränsas. Rätten till radering och till begränsning av behandling av personuppgifter gäller dock inte när uppgifterna är nödvändiga för den aktuella forskningen. Om du vill ta del av uppgifterna ska du kontakta ansvarig forskare doktorand Tuulia Lerkkanen (se kontaktuppgifter nedan). Dataskyddsombud nås på e-post: dso@su.se. Om du är missnöjd med hur dina personuppgifter behandlas har du rätt att ge in klagomål till Integritetsskyddsmyndigheten (IMY), före detta Datainspektionen.

Hur får jag information om resultatet av studien?

Är du intresserad av att ta del av det intervju-material som rör just dig ber vi dig kontakta ansvarig forskare (se nedan). Resultaten av denna intervjuundersökning kommer att publiceras i artiklar och finnas tillgängliga på vår hemsida (<https://www.su.se/publichealth/>) och i Stockholms universitets publikationsdatabas (se <https://www.su.se/stockholmsuniversitetsbibliotek/>).

Deltagandet är frivilligt

Ditt deltagande är frivilligt och du kan när som helst välja att avbryta deltagandet. Om du väljer att inte delta eller vill avbryta ditt deltagande behöver du inte uppge varför. Om du vill avbryta ditt deltagande ska du kontakta den ansvariga för studien (se nedan).

Ansvariga för studien

Ansvarig för studien är Tuulia Lerkkanen, Institutionen för Folkhälsovetenskap, Stockholms universitet. E-post: tuulia.lerkkanen@su.se Mobilnummer: 08-674 7910.

Appendix II: Letter of informed consent

Intressegruppers ställning i svensk narkotikapolitik: intressen, argument och inflytande, vid Institutionen för folkhälsovetenskap, Stockholms universitet

Samtycke till delta i studien

Jag har fått muntlig och skriftlig information om studien och har haft möjlighet att ställa frågor. Jag får behålla den skriftliga informationen.

- Jag samtycker till att delta i studien *Intressegruppers ställning i svensk narkotikapolitik: intressen, argument och inflytande*

- Jag samtycker till att uppgifter om mig behandlas på det sätt som beskrivs i forskningspersonsinformation

Plats och datum

Underskrift

Appendix III: Interview guide

Frågeguide vid intervjuer

1) Introduktion: om er organisation och ställning (hur ser ni på er 'roll' på det här området)?

- Hur skulle ni kort beskriva er organisation, dess uppdrag eller målsättning?
- Hur ser ni på den svenska narkotikapolitiken? Vad fungerar bra?
- Kan du ge exempel?
- Var är problematiskt? Kan du ge exempel? (ex dödlighet)
- Vad borde förändras? Varför? Hur?

2) Olika delar av narkotikapolitiken

- Hur ser ni på det man brukar kalla narkotikapolitikens tre ben – dvs. kontroll/förbud, vård/behandling, prevention, men även skademinimering?
- Vad borde politiken och praktiken fokusera på? Hur och varför?
- Sveriges narkotikapolitik beskrivs ofta som att den baserar sig på idén om ett narkotikafritt samhälle. Den här formuleringen nämns också i Socialdepartementets narkotikapolitiska dokument. Vad är ert perspektiv eller er åsikt om detta? Varför?

3) Möjligheter att påverka politiken

- Hur ser du/ni på er (organisations) ställning i narkotikapolitiken och dess utveckling?
- Hur gör du/ni för att försöka påverka politiken? ELLER Gör du/ni något särskilt för att försöka påverka politiken? Hur då? (Ex. skriver debattartiklar, kontaktar politiker, samarbetar/går ihop med andra aktörer, skriver remissvar, osv.)
- Hur kan man påverka formellt och hur kan man påverka mer informellt?
- (OBS: Se till att också fånga in det där om personliga kontakter och nätverkande)
- Har ni möjlighet att påverka utformningen av narkotikapolitiken? Varför – varför inte?
- Vilka (andra) har den möjligheten, att faktiskt kunna påverka utformningen? (dvs olika aktörsgrupper)
- Vad tycker du/ni, vem har mest inflytande när man tänka på utformningen av narkotikapolitiken i Sverige?

- Är det någon grupp som inte får sin röst hörd? Vem/vilka? Om ja, har du/ni några idéer hur de här grupperna skulle kunna involvera mer när man tänker på utformningen av narkotikapolitiken?
- Hur ser ni på den narkotikarelaterade dödligheten? Vad har ökningen betytt för narkotikapolitikens utveckling? Hur kan den minskas?

4) Om utredningen/utvärderingen av narkotikapolitiken och nära framtiden

- Känner du till att det har efterfrågats en utvärdering på området och att regeringen nu inlett en utredning av den svenska narkotikapolitiken?
- Hur ser ni på den föreslagna utredningen av narkotikapolitiken?
- Tycker ni det bör göras – varför? Inte – varför?
- Vad vill ni ska utvärderas?
- Vad hoppas ni blir utfallet?
- Ser du/ni på möjliga konsekvenserna av utredningen om vi tänker på den nuvarande situationen
- (hur regeringen och olika aktörer har diskuterat och beskrivit utvärderingen)?
- Tror du det kommer att bli en större reform av narkotikapolitiken? Vad?
- Vad tror ni kan bidra till att den svenska narkotikapolitiken ändras, eller förblir som den är?
- Har gängkriminaliteten och skjutningarna någon betydelse i detta sammanhang?