

The Drug Situation in Norway 2013

SIRUS

Annual report to the European Monitoring Centre
for Drugs and Drug Addiction - EMCDDA

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Foreword

Since 2001, SIRUS has been the Norwegian Focal Point for the European Monitoring Centre for Drugs and Drug Addiction - EMCDDA. All 30 member countries submit an annual national report. In addition, a number of standardised tables and questionnaires, mainly comprising epidemiological data, are submitted separately every year. Taken together, this represents our main contribution to the annual European Drug Report from the EMCDDA.

As in previous years, this 13th national report on the drug situation in Norway has been drawn up in accordance with the common reporting guidelines. Because the report is intended to focus on news and to primarily cover important developments and trends, it may appear rather fragmentary. However, we hope that the content will prove useful to readers who wish to familiarise themselves with the drugs situation in Norway. SIRUS wishes to express its gratitude to all external partners and public institutions that helped in the preparation of the report. Our thanks go in particular to the co-authors who have made textual contributions.

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Summary – some major developments and trends

Legal framework: Generic scheduling of substances

New *Regulations relating to Narcotics* entered into force on 14 February 2013. The principle of generic scheduling has now been introduced as a supplement to individual listing. Ten groups of substances, seven of them describing synthetic cannabinoids, are included on the list of controlled substances. These groups cover many of the newly developed psychoactive substances that have been discovered since 2011.

Legal framework: Possession and use of doping substances criminalised

From 1 July 2013, amendments to the Act relating to Medicinal Products were introduced with a view to harmonising legislation on doping and drugs. The acquisition, possession and use of doping substances without lawful access was thereby made a criminal offence.

New white paper

The white paper on drugs and alcohol policy (Report no 30 to the Storting (2011–2012)) was considered by the Storting (Parliament) in March 2013. The white paper sets out the political goals for a comprehensive drugs and alcohol policy: prevention and early intervention; coordination – services working together; greater competence and better quality of services; help for those with severe dependency; reducing the number of overdose fatalities; efforts aimed at next-of-kin and at reducing harm to third parties.

Strategy relating to overdoses

Norway ranks high on the European statistics for overdoses, although there is uncertainty attached to the data on which the comparison is based, including different interpretations at the national level of causes of death. In the white paper on drugs and alcohol policy, the Government proposed a national strategy to combat overdose deaths. The Storting has endorsed this proposal and adopted a zero-vision goal for overdose deaths. On this basis, NOK 10 million was allocated for 2013 and 2014 for the development of a five-year overdose strategy. The Directorate of Health will complete a comprehensive plan setting out several measures. The measures are planned and will be implemented in cooperation with user and next-of-kin organisations, municipalities and other involved parties. As part of this effort, the Norwegian Centre for Addiction Research (SERAF) has been assigned the task of initiating a trial project in Oslo and Bergen that involves distributing naloxone nasal spray to users and next-of-kin. SIRUS will carry out a follow-up evaluation of the implementation of the strategy.

Injecting drug use – stable

Estimates of the number of injecting drug users have been revised from and including 2013. The mortality multiplier method is still used. It estimates the number of injecting drug users by dividing the number of drug-related deaths by the likelihood of dying of a drug-related diagnosis. The number of injecting drug users in 2011 was estimated to be between 7,300 and 10,300. Previous national reports have shown that the number of injecting users increased from the 1970s until 2001, followed by a reduction until 2003. The figure has since remained stable.

Treatment – high number of patients and admissions

According to the National patient register, a total of 16,778 patients received treatment during the 2012 calendar year for drug problems as their primary condition. Seven out of ten were men. The number includes patients in both in-patient and outpatient treatment, and the sample is based on ICD-10 F codes. The biggest group (39%) had problems relating to the use of opioids as their primary diagnosis. The second biggest diagnosis category was multiple drug use, followed by cannabis and stimulants.

As for those who started treatment for drug-related problems in 2012, reports were submitted from 146 units concerning a total of 8,891 patients (2011: 8,817 patients from 159 units), 3,691 in in-patient and 5,200 in outpatient treatment, including opioid substitution treatment - OST. The comparative figures for 2011 were 3,921 and 4,896. Around 69 per cent of patients starting treatment were men. The average age of patients was around 34 years for men and 36 years for women. Problems with opioids were the most frequently reported diagnosis in both outpatient and in-patient treatment where the primary drug was identified. The second most frequent diagnosis was the use of stimulants for patients in residential treatment and cannabis upon admission to outpatient treatment. The latter accounted for as many as 31 per cent of the patients where the primary drug was identified. It is also notable that the proportion with cannabis as their primary drug upon admission to in-patient treatment had increased to 18 per cent, while it was 11 per cent in 2011.

Drug-induced deaths – some increase in numbers, fewer deaths caused by heroin.

Of the 262 drug-related deaths in 2011 that were recorded by Statistics Norway, 207 deaths involved opioids with or without additional drugs, 74 deaths were due to heroin, 47 deaths were recorded with methadone poisoning as the underlying cause, and 68 with other opioids, either as poisoning or opioid dependency. In addition, there were 18 deaths coded as related to other synthetic opioids'. Many of the drug-related deaths are believed to be due to extensive multiple drug use.

Since 2007, the average strength of heroin seized by the police in Norway has decreased from 36 per cent to around 15 per cent. During the same period, the proportion of heroin as the

main intoxicant has been almost halved. However, more than four out of five drug-related deaths are still due to opioids. It seems that a gradual change may be taking place in the preference for and/or availability of opioids among opioid users, and that this is also reflected in causes of death. Amphetamine and/or methamphetamine and/or cocaine were detected in 11 per cent of the deaths.

Reported crimes – increasing numbers

According to Statistics Norway, a total of 45,900 drug crimes were reported in 2012. This is 3,100 more than in 2011, and the highest number recorded since 2001. The number includes violations of both the General Civil Penal Code and the Act relating to Medicinal Products. In total, around 21,600 drug crimes pursuant to Section 162 of the General Civil Penal Code, including aggravated drug crimes, were reported. This is almost on a par with 2010, the peak year in terms of reported drug crimes. The nearly 23,500 violations of the provision of the Act relating to Medicinal Products concerning use and possession was the highest number since the early 2000s. The increase was greatest by far in Oslo.

Penal sanctions

The number of penal sanctions where drug crime was the primary offence was 15,700 in 2011. This is just over 5 per cent more than in 2010 and as much as 22 per cent more than in 2009. Never before have so many penal sanctions been recorded with drug crime as the primary offence: in 2011, they accounted for more than 47 per cent of all penal sanctions in criminal cases. Seen in relation to the increase in population, however, the number of penal sanctions for drug crimes is still lower than in the peak year of 2001. Drug crime as the primary offence was the reason for nearly 2,000 of the unconditional prison sentences (both unconditional and partly unconditional/partly suspended). Of the offenders (cases, not persons), 205 were sentenced to imprisonment for use as the primary offence. This represents more than a twofold increase from 2009. However, these are often complex cases, where other, less serious offences are taken into consideration in the overall sentencing.

Drug markets

Measured by seizures, the most common illegal substances are geographically widespread. In 2012, all the 27 police districts made seizures of cannabis, BZD and amphetamines, whereas cocaine was seized in 25 districts and heroin in 23, which is quite similar to the situation in 2011. It must be emphasised, however, that the quantities vary greatly between the different police districts. For cocaine and heroin, the amounts seized in some districts are often very small. The biggest markets are still the Oslo area and its surrounding regions, and in the counties of Hordaland and Rogaland, including the cities of Bergen and Stavanger. Moreover, the customs authorities in Østfold county make many large seizures, which can largely be explained by its proximity to the most important border crossings to Sweden, where large

parts of the drug trafficking to Norway take place by road and by train from Denmark and the Continent.

Seizures

Although the number of drug cases increased for the fourth year in a row, the seizures do not represent record-high quantities, except in the case of benzodiazepines. While the number of seizures of hash is relatively stable, there is a marked increase in seizures of marijuana and cannabis plants. In the early 2000s, hash accounted for approximately 90 per cent of cannabis seizures, but it now accounts for 70 per cent, while marijuana and cannabis plants account for as much as 30 per cent. This development may be due to extensive and increasing production of cannabis in Norway.

The number of seizures of amphetamine/methamphetamine is still high. Although slightly fewer seizures were made in 2012 than in 2011, a larger quantity of amphetamine/methamphetamine was seized than in the two preceding years. Fewer seizures were made in 2012 than 2011 of PMMA, which is sold on the amphetamine market and has caused a number of deaths.

Fewer seizures were also made of heroin than in the preceding years. Some large seizures resulted in higher quantities, however.

There are still great variations in the purity of amphetamine/methamphetamine, heroin and cocaine, from very weak (< 1%) to completely pure qualities. There is also great variation in typical street seizures.

Even though traditional drugs dominate the drug market, new synthetic substances are seized all the time. In 2012, Kripos identified 30 new substances that had previously not been seized in Norway. Synthetic cannabinoids dominate among the new synthetic substances seized in the past two or three years. Of these, AM-2201 is currently the one most frequently seized.

1 Drug policy: legislation, strategies and economic analysis

1.1 Legal framework

New *Regulations relating to Narcotics*¹ entered into force on 14 February 2013. The principle of generic scheduling is now introduced as a supplement to individual listing. Ten groups of substances, seven of them describing synthetic cannabinoids, are included on the list of controlled substances. These groups cover many of the newly developed psychoactive substances that have been discovered since 2011. The new regulations make it easier to determine whether a substance shall be deemed to be a narcotic substance. This means that it will be possible to a greater extent to be ahead of developments when it comes to new synthetic substances on the market.

From 1 July 2013, amendments to the *Act relating to Medicinal Products* were introduced with a view to harmonising legislation on doping and drugs and in order to clarify society's attitude to the use of doping. The acquisition, possession and use of doping substances without lawful access was thereby made a criminal offence. As with the use of drugs, the use of doping is, in principle, regarded as a health problem that should primarily be met with health care, preferably in the form of alternative penal sanctions.

A proposal to amend the *Drug Injection Rooms Act* (Act No 64 of 2 July 2004 relating to a Trial Scheme of Premises for Drug Injection) and pertaining Regulations No 1661 of 17 December 2004 was distributed for consultation, with a deadline for responding of 31 October 2013. If adopted, this will allow municipalities to permit the inhalation of heroin in injection rooms.

1.2 National action plan, strategy, evaluation and coordination

The white paper on drugs and alcohol policy (Report no 30 to the Storting (2011–2012)) was considered by the Storting in March 2013; cf. Recommendation No 207 to the Storting (2012–2013). The white paper sets out the political goals for a comprehensive drugs and alcohol policy:

¹ <http://www.regjeringen.no/upload/HOD/Dokumenter%20FHA/Narkotikaforskrift.pdf>

- Prevention and early intervention
- Coordination – services working together
- Greater competence and better quality of services
- Help for those with severe dependency – reducing the number of overdose fatalities
- Efforts aimed at next-of-kin and at reducing harm to third parties.

The overriding goal of Norway's drugs and alcohol policy is to reduce the negative consequences of drug and alcohol use for individuals and for society as a whole. The Ministry of Health and Care Services has overall responsibility for drugs and alcohol policy and for coordinating the presentation and follow-up of the white papers in cooperation with a total of 11 ministries.

The escalation plan for the drugs and alcohol field (see NR² 2011 and 2012) was concluded in 2012, but a number of measures from the plan will be continued. Where efforts need to be strengthened, the plan will be succeeded by strategies in the fields of public health, overdoses, competence and the implementation of treatment for drug and alcohol-related problems and mental health through the Coordination Reform.³

Extensive efforts have been made in the drugs and alcohol field in recent years, both in the municipalities and in the specialist health service. However, user organisations and experts point out that the services must be involved at an earlier stage and that the availability of services must be improved. Lack of coordination is another important challenge. Many of those who seek help for abuse problems meet new obstacles when responsibility for further follow-up is transferred to a new level and new services. The help services are perceived by many as fragmented. This is a problem both within and between sectors and levels. Providing problem drug and alcohol users with good, individually adapted municipal follow-up services is also a challenge, especially in the housing and recreational context.

Increased preventive efforts

The white paper on drugs and alcohol policy specifies the preventive efforts to be made in the drugs and alcohol field. Preventive efforts must also, and not least, be seen in conjunction with general preventive measures targeting the population as a whole as set out in public health policy. The public health strategy is described in the white paper on public health (Report No 34 to the Storting (2012–2013): 'Folkehelsemeldingen':⁴ God helse – felles ansvar

² NR- National Report

³ Report No 47 (2008–2009) The Coordination Reform. Proper treatment – at the right place and right time.

⁴ <http://www.regjeringen.no/nb/dep/hod/dok/regpubl/stmeld/2012-2013/meld-st-34-20122013.html?showdetailedtableofcontents=true&id=723818>

(‘The Public Health Report: Good health – a shared responsibility’ – in Norwegian only). The Government’s goals for public health work are as follows:

1. Norway shall be among the top three countries in the world in terms of life expectancy
2. The population shall enjoy more years of life in good health and well-being and experience less social inequalities in relation to health

As part of the follow-up of the Public Health Report, the Government will further develop performance goals and indicators with a view to following up the goals of its public health policy, including mental health and drug and alcohol problems. Systematic development of public health work is also planned. Among other things, a report will be presented to the Storting every four years on the status of and further work on achieving Norway’s public health goals. The Norwegian Institute of Public Health and the Directorate of Health will prepare reports that can be read as the basis for a political status assessment.

The Public Health Report emphasises the close connection between the social inequalities in health and welfare development and differences in living conditions and income. Public health policy shall build on the Norwegian welfare model of universal welfare benefits, the work approach, participation and inclusion. Knowledge about the importance of social capital and social support shall be improved. Early intervention produces good results. One of the biggest challenges in the drugs and alcohol field is therefore to ensure early detection and intervention when needed. An inter-sectorial approach is essential in this work.

By upholding the prohibition on possession and use, the Government wishes to send a clear message that illegal use of drugs is not socially acceptable. At the same time, it is important to comply with the obligations under international law that follow from the three conventions on drugs that Norway has ratified. The use of drugs shall, in principle, be seen as a health issue, and people who use drugs shall primarily be met with health care. That will also be Norway’s position at international meetings and negotiations.

Mobilisation against doping

Doping as a social problem shall be an integrated part of Norway’s drugs and alcohol policy. In addition to providing a legal basis for the prohibition on use and possession, as mentioned in Chapter 1.1, the Government is also mobilising against doping by increasing knowledge and focusing on prevention and good treatment services. The Directorate of Health has been given a clear responsibility for integrating doping in its preventive work. This applies to both early intervention and general prevention.

Treatment

Data from the Norwegian National Patient Register on interdisciplinary specialist treatment (IST) for 2012 show a slight increase in the number of patients compared with 2011, when

approximately 25,000 people received treatment for drug or alcohol-related problems. This includes patients with both drug and alcohol problems. In addition, a considerable number of patients with a psychiatric primary diagnosis were treated by the mental health service. Figures from BrukerPlan⁵ for 2012 show that approximately 30,000 persons above the age of 18 receive municipal help for drug and alcohol problems.

Dependency on alcohol or drugs shall be treated as a chronic illness, and a need for long-term, and often life-long, follow-up must be expected. The municipal services are the ‘pillar’ in the services provided throughout the course of treatment, in close collaboration with a supporting and more outreach-based, available and flexible specialist health service when required. The services shall be adapted to the individual user’s needs and are designed to enable them to cope, enjoy good health and a dignified life situation.

Chief responsibility shall rest with the local level. Extensive use of outreach/ambulant services that ensure close contact with individual users is important in order to identify problems at an earlier stage and improve access to the services. People with drug and alcohol problems should primarily receive help from the ordinary services, and not from a separate care service. Among other things, this means that help measures and benefits shall not be registered on the basis of the person in question’s diagnosis, but in a more general manner, for example as subsistence or housing benefits. This means that it is not possible to isolate the total expenditure on persons with drug or alcohol problems who receive municipal health and care services.

Medical expertise in the drugs and alcohol field shall be strengthened, both in the specialist health service and in the municipalities. A medical speciality in addiction medicine will therefore be established. The Directorate of Health is assisting the Ministry of Health and Care Services in this work, which is being carried out in conjunction with the general review of the specialist field that the Directorate of Health is carrying out.

A white paper called *Good quality – safe services* (Report No 10 to the Storting (2012–2013)) was considered by the Storting in 2013, cf. Recommendation No 250 to the Storting (2012–2013). In line with this, the Directorate of Health will develop a tool for improving the care pathway in the municipalities, before and after stays in an institution. The purpose is to develop care pathways for patients with drug or alcohol problems that can also be used in relation to other user groups and in other fields.

⁵ BrukerPlan is a tool that maps the prevalence and characteristics of drug and alcohol problems in Norwegian municipalities.

The Act relating to municipal health and care services⁶ requires municipalities and regional health authorities/health trusts to enter into agreements on a number of tasks, including guidelines for cooperation on admission, discharge, habilitation, rehabilitation and learning and coping services. Concrete solutions must be developed locally in cooperation between different services and levels. More knowledge is also needed about the housing situation of people with drug and alcohol problems. The Directorate of Health has been assigned the task of carrying out a survey of the housing situation for different groups of people with drug or alcohol problems. The Government will present a new national strategy for social housing work in 2014. The strategy will bring together and set targets for public efforts, highlight the division of responsibility in social housing work and show what instruments can be used to help people at a disadvantage in the housing market.

The Government will strengthen efforts to ensure that people with mental health problems and drug and alcohol problems maintain their connection to the labour market. Experience from and efforts made in connection with the National Strategy Plan for Work and Mental Health 2007–2012 will be continued through the Government's follow-up plan for work and mental health,⁷ which was presented in September 2013. Among other things, the plan describes measures aimed at strengthening cooperation between the health and care sector and the Labour and Welfare Administration (NAV). Rapid access to mental health care combined with work-related follow-up with a view to participation in the ordinary labour market is an important part of this cooperation. Trial schemes involving individual job support and the Work Proficiency Follow-up Programme are examples of this type of collaboration.

'Quality boost' in the drugs/alcohol and mental health fields

Efforts in the drugs and alcohol field in recent years have contributed to more knowledge about drug and alcohol problems, but there is a lack of good quality indicators and information about the services provided to people with drug and alcohol problems and about the use of resources. Competence-raising measures implemented through the escalation plans for the drugs/alcohol and mental health fields have been retained and integrated in the Government's competence strategy: *Kvalitetsløft rus og psykisk helse* ('A quality boost in the drugs/alcohol and mental health fields'). The strategy is intended to ensure the necessary expertise in the services offered to people with drug or alcohol problems and people suffering from mental illness. The quality boost has three focus areas:

⁶ <http://www.lovddata.no/all/nl-20110624-030.html>

⁷ <http://www.psykiskhelse.no/index.asp?id=32171>

- Competence plan for the drugs/alcohol and mental health fields (recruitment and qualification etc.)
- A better basis for management, knowledge about health challenges and treatment
- Research, development and knowledge support.

Key measures include:

- Strengthening continuing and further education
- Establishing a medical speciality in addiction medicine
- Facilitating good management.

The Directorate of Health has also established two working groups that are working on developing quality indicators in the mental health and drugs/alcohol fields; one for the specialist health service and one for the primary health service. The goal is to establish a national system of quality indicators for the specialist and primary health services that can serve as support for internal quality improvement, health policy management and corporate governance.

The Directorate of Health has signed a three-year contract for the further development and implementation of the BrukerPlan tool in all municipalities in the course of 2013.

Health and care services are priority areas in the Government's research and innovation work. Through the escalation plans for mental health and the drugs and alcohol field, considerable efforts have been made to strengthen research and the dissemination of research-based knowledge. Research activities have been strengthened through the Norwegian Institute of Public Health, the Norwegian Institute for Alcohol and Drug Research (SIRUS), the Research Council of Norway's Programme on Alcohol and Drug Research and Research Programme on Mental Health, and the regional health authorities.

One of the main tasks of the seven regional drug and alcohol competence centres is to stimulate the development of preventive measures in the field of drugs and alcohol in the municipalities. To some extent, the competence centres also engage in research in areas for which they have national responsibility. Dedicated user experience surveys will be introduced in connection with interdisciplinary specialist treatment for problem drug and alcohol use (IST), and separate key figure reports will be prepared in this field in order to monitor developments and to increase knowledge about the users' own experience of and need for the services.

Problem drug and alcohol use does not only affect the user. Many children have parents with high-risk consumption levels, particularly in relation to alcohol. In order to strengthen efforts aimed at family members of people with drug and alcohol problems, two living condition surveys focusing on children and adults, respectively, as next-of-kin were initiated in 2013. The objective is to gain more knowledge about their experiences, and how they cope with everyday life. The results are intended to form the basis for further measures. Both living conditions surveys are seen in conjunction with a large-scale survey on 'children as next-of-kin' led by Akershus University Hospital. The final report will be presented in 2014.

Strategy relating to overdoses

Norway ranks high on the European statistics for overdoses. There is uncertainty attached to the data on which the comparison is based, however, including different interpretations at the national level of causes of death. The annual registrations show that the number has decreased since 2001, when 405 drug-related deaths were registered in Norway. In 2011, 262 such deaths were registered. The figures remain high despite the fact that a number of measures have been implemented. Most overdose deaths occur in private, not in public places. Efforts to reduce the number of overdose deaths must therefore be made in several arenas. In the white paper on drugs and alcohol policy, the Government proposed a national strategy to combat overdose deaths. The Storting has endorsed this proposal and adopted a zero-vision goal for overdose deaths.⁸

On this basis, EUR 1.25 million (NOK 10 million)⁹ was allocated for 2013 for the development of a five-year overdose strategy. The Directorate of Health will complete a comprehensive plan setting out several measures. The measures are planned and will be implemented in cooperation with user and next-of-kin organisations, municipalities and other involved parties. As part of this effort, the Norwegian Centre for Addiction Research (SERAF) has been assigned the task of initiating a trial project in Oslo and Bergen that involves distributing naloxone nasal spray to users and next-of-kin. SIRUS will carry out a follow-up evaluation of the implementation of the strategy. See also Chapter 7. It will include such measures as influencing the user culture, among other things by aiming to change the method of use of heroin from injection to inhalation in order to reduce the risk of overdoses. Smoking also prevents injection-related diseases such as HIV and hepatitis, and injuries caused by harmful injection practices. As mentioned, a proposal to amend the Drug Injection Rooms Act to permit the inhalation of heroin in injection rooms has been distributed for consultation.

⁸ Recommendation No 207 to the Storting (2012–2013)

⁹ Conversion rate: 1 EUR=NOK 8.00

Grant schemes

A number of different grant schemes have been established in order to facilitate the attainment of prioritised goals. The white paper confirms the Government's goal that the municipal sector shall primarily be funded through block grants. It is therefore proposed to include most of the current grants for municipal work on the drugs and alcohol field in the municipalities' block grants. A number of targeted grant schemes divided between various items will nonetheless continue.

The grant schemes are intended to stimulate engagement and activity in relation to drugs and alcohol policy both nationally and locally, through operating grants and grants for projects and activities in pursuit of drug and alcohol policy goals. The schemes are intended to promote knowledge-based strategies and democratic work by organisations based on voluntary efforts and local involvement, categorised as: *The prevention of drug and alcohol-related problems – to help to limit drug and alcohol use and the harm caused by drugs and alcohol*. The allocated funding covers reports, evaluations, trial schemes, international cooperation, information and awareness-raising work, including the development and dissemination of methods for early intervention and mini-interventions.

Drug and alcohol measures – aimed at stimulating high-quality, coordinated preventive work in the municipalities, including work to stimulate drug and alcohol action plans and better coordination and utilisation of local resources. The allocation also covers grants for:

- the establishment and continuation of a system of municipal drugs/alcohol and crime-prevention coordinators, in cooperation with the Norwegian National Crime Prevention Council;
- operating grants for drug and alcohol policy organisations;
- project grants for the development of voluntary drug and alcohol prevention projects and activity grants for voluntary drug and alcohol prevention measures;
- grants for the regional drug and alcohol competence centres and their work on preventive strategies targeting the municipalities;
- grants for the 'doping helpline';
- operating grants for the Workplace Advisory Centre for Issues related to Alcohol, Drugs and Addictive Gambling in the Workplace (AKAN);
- grants for drug and alcohol prevention in the workplace;
- grants for the development and dissemination of knowledge about national public health measures;
- operating grants for Anti-Doping Norway's work targeting doping as a social problem.

The grant schemes are administered by the Directorate of Health.

Other grant schemes

Continuing and further education – aimed at raising the level of expertise in drug and alcohol problems among doctors and other health personnel.

User and next-of-kin organisations in the drugs and alcohol field shall be strengthened through operating grants and grants for information activities. The purpose is to promote increased user participation at both the individual and system level, and to contribute to the development of meeting places and tools for user participation.

Municipal work in the drugs and alcohol field

From 2013, the purpose of the allocation was changed to contributing to competence-raising measures and quality development in the drugs and alcohol field and measures aimed at improving coordination between municipalities and the specialist health service. The allocation will now be used for:

- The development and testing of coordination models in the drugs and alcohol field
- Cooperation on patients who are ready to be discharged
- Stimulus grants for continuing and further education
- Training in the use of mandatory treatment and coercion.

The development and testing of coordination models in the drugs and alcohol field was established in 2013 in order to contribute to the development and testing of models for improved coordination. The scheme is intended to contribute to the development of binding organisational cooperation models between municipalities and health trusts/regional health authorities, including private and non-profit service providers who have agreements with the regional health authorities.

Cooperation on patients who are ready to be discharged – in order to improve cooperation between drug and alcohol institutions in interdisciplinary specialist drug/alcohol treatment and the municipalities on patients who are ready to be discharged.

The regional drugs and alcohol competence centres

The seven regional drugs and alcohol competence centres are tasked with assisting the municipalities and the specialist health service with competence-raising measures and professional development related to drug and alcohol prevention work. They provide knowledge support to the services, and, in cooperation with the county governors, they initiate various competence-raising measures and help to ensure that the municipalities apply knowledge that is based on research and good practice. In 2013, a total of EUR 17.4 million (NOK 139 million) was allocated to the centres. The centres provide further and continuing

education, courses to raise the level of basic knowledge among e.g. NAV employees, and especially adapted courses for groups of employees in individual municipalities. The municipalities are given guidance on how to develop drug and alcohol policy action plans and competence-raising measures for employees in municipal services and the specialist health service. The implementation of national guides and professional guidelines in the drugs and alcohol field is part of this work. Regional interdisciplinary drug and alcohol forums have been established in most counties.

The centres also perform national functions in the following areas of expertise: gambling addiction; dual diagnosis; outreach social work among young people; ethnic minorities and drugs/alcohol; pregnant women with drug/alcohol dependency and families with small children; gender and drugs/alcohol; parents' role in drug and alcohol prevention work; drugs/alcohol and the workplace; drug and alcohol problems in families with children; drug and alcohol problems relating to youth and young adults, with the emphasis on early intervention; drug and alcohol prevention work based in schools.

1.3 Economic analysis

Various attempts have been made to calculate the social costs of the use of drugs in general, and alcohol in particular. However, there are extensive methodological challenges relating to such calculations, and the results vary greatly depending on which calculation model is used. The figures are therefore too uncertain to be useful. Some work is under way that may contribute to better estimates and overviews, however. For the time being, the only thing that is certain is that drugs and alcohol and their use have considerable costs, both in monetary terms and in terms of human costs. Nor is it possible to isolate the costs of prevention, treatment, care or law enforcement. In 2012, the specialist health service allocated EUR 480 mill (NOK 3,840 billion) for interdisciplinary specialist treatment for drug and alcohol problems.

Direct allocations for the drugs and alcohol field have increased by approximately EUR 145.6 million (NOK 1.165 million) since 2005. In addition, the municipal sector has received a significant financial 'boost' that has also benefited the drugs and alcohol field. This has made it possible to develop preventive and help measures for persons with drug and alcohol problems.

2 Drug use in the general population and specific target groups

2.1 Drug use in the general population

SIRUS conducted surveys of the Norwegian population's use of alcohol and drugs from 1968. The surveys have normally been carried out every five years. The drugs questionnaire was part of a more comprehensive survey that was mainly concerned with alcohol consumption and attitudes to alcohol policy issues. Data collection in these surveys was carried out in the form of face-to-face interviews. The data concerning drugs were later linked to the other data from the interview survey. The last survey using this method was carried out in autumn 2009, and the data were presented in the National Report for 2010, Chapter 2. However, one should be aware that prevalence figures from these surveys are probably biased due to a problematic sampling procedure and declining response rates. In the 2009 survey, the response rate was as low as 18 per cent.

New population survey in 2012

As a result of declining response rates in previous surveys, SIRUS entered into a collaboration with Statistics Norway on an annual national population survey using a different approach in order to measure the use of tobacco/moist snuff, alcohol, drugs and medicines. This approach involves drawing a representative sample from the population register and conducting phone interviews with the subjects after they have received an information letter in advance. The sample is drawn from the 16–79 age group, with oversampling from the 16–30 age group. In order to adapt the survey to the classification that the EMCDDA uses, only respondents in the 16–64 age group are asked about the use of illegal substances. An error was made in the 2012 survey, however, so that only those who stated that they had ever used hash/marijuana were asked about other illegal substances. This means that no data are available for 2012 on other drugs than cannabis.

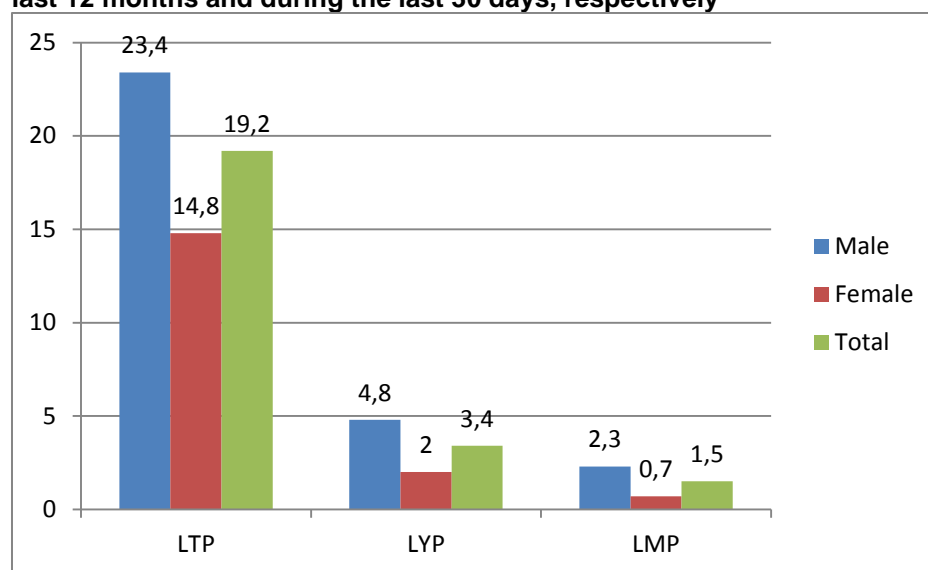
The 2012 survey had a response rate of 53 per cent and consisted of 1,947 respondents, 1,668 of whom were in the 16–64 age group. The results were weighted for age, gender, educational level and region. Since the approach and method differ, the data in the old and new series of population surveys are not directly comparable. We can nevertheless attempt to present some of the data.

Features from the 2009 survey:

- The proportion of respondents who answered that they had ever tried cannabis had fallen from approximately 16 per cent in 2004 to less than 15 per cent in 2009. The fact that lifetime prevalence has fallen during the past five years is somewhat surprising given the cumulative nature of the variable. The most likely explanation is the low response rate.

In the 2012 survey, approximately 19 per cent reported having ever used cannabis (LTP), while 3.4 per cent stated that they had used it during the last 12 months (LYP) and 1.5 per cent reported use during the last four weeks (LMP) (Figure 1). Significantly more men than women reported having used cannabis for all three time intervals.

Figure 1: Percentage in the 16–64 age group in 2012 who have taken cannabis ever, during the last 12 months and during the last 30 days, respectively*



*Net response: 1,668

Source: SIRUS/Statistics Norway

Features from earlier surveys:

- Lifetime prevalence in the 2004 and 2009 surveys was highest in the 25–34 age group, while both the proportion who have taken cannabis during the last year and during the last 30 days was highest in the 15–24 age group. What was more surprising is the relatively strong decrease from 2004 to 2009 in the proportion who have used cannabis during the last 30 days in the under-35 age group. In 2004, it was 4.5 per

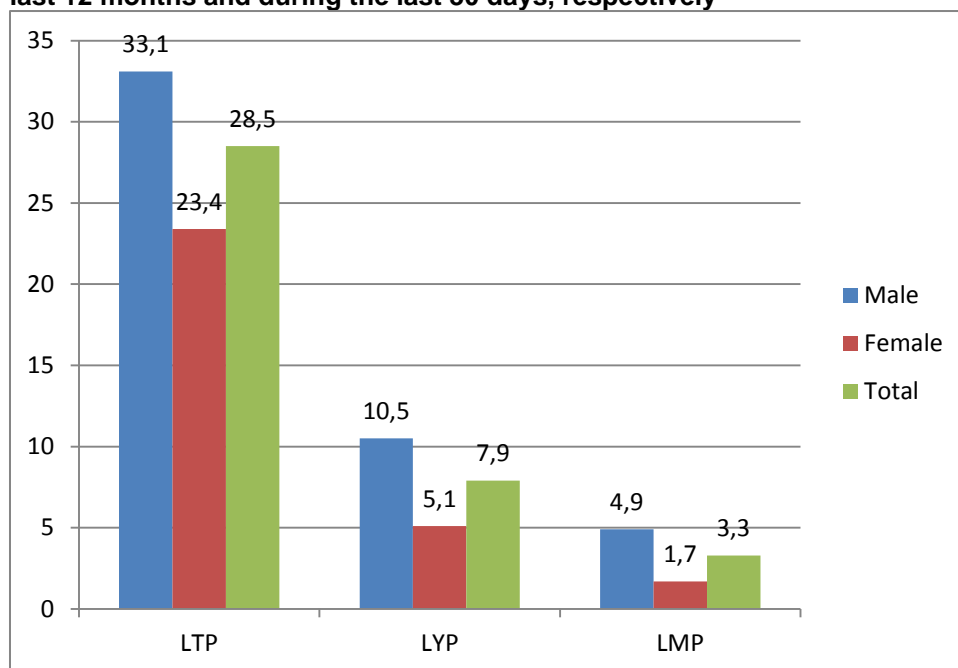
cent, while in 2009, it had been reduced to 2.1 per cent. Furthermore, last-year prevalence also decreased in the 15–34 age group, from a proportion of 9.6 per cent in 2004 to 7 per cent in 2009.

This corresponds quite well with the 2012 survey (Figures 2, 3 and 4). Lifetime prevalence was higher in the 25–34 age group than in the younger age groups (39.6%), while the 16–24 age group had by far the highest proportions for both use during the last year (11.7%) and use during the last month (5.1%). For the 16–34 age group as a whole, the proportion who reported use during the last year, 7.9 per cent, was fairly similar to the proportion in the 2009 survey. For use during the last month, the number of respondents is low in many of the age groups, which means that there may be considerable statistical margins of error.

Synthetic cannabinoids

In the 2012 survey, respondents were asked a separate question about the use of synthetic cannabinoids. In the 16–30 age group (N=706), nine per cent reported having used one or more cannabis products in the last 12 months. In addition, 3 per cent reported having used synthetic cannabinoids, but this only accounted for 0.3 per cent of the whole sample.

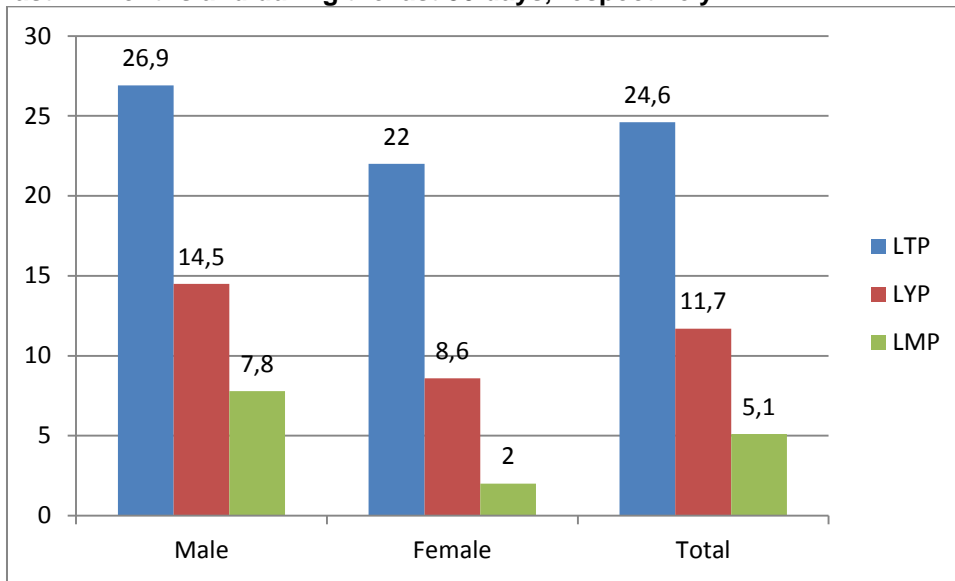
Figure 2: Percentage in the 16–34 age group in 2012 who have taken cannabis ever, during the last 12 months and during the last 30 days, respectively*



*Net response: 620

Source: SIRUS/Statistics Norway

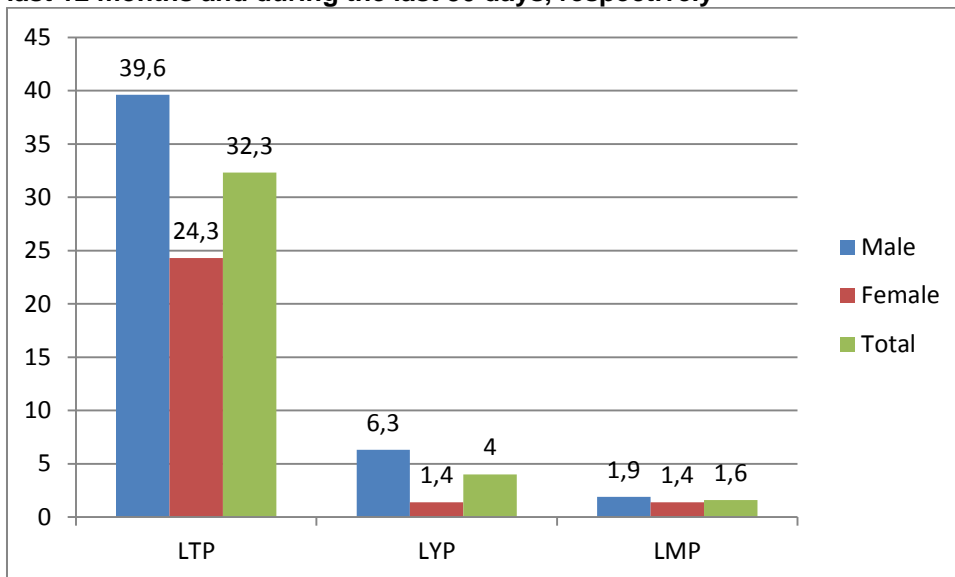
Figure 3: Percentage in the 16–24 age group in 2012 who have taken cannabis ever, during the last 12 months and during the last 30 days, respectively*



*Net response: 317

Source: SIRUS/Statistics Norway

Figure 4: Percentage in the 25–34 age group in 2012 who have taken cannabis ever, during the last 12 months and during the last 30 days, respectively*



*Net response: 303

Source: SIRUS/Statistics Norway

2.2 New study – Estimation of cocaine consumption in a community: a critical comparison of the results arrived at by three complimentary techniques

As a range of approaches are now available to estimate the level of drug use in a community, the authors of a recently published study (Reid et al., 2012) find it desirable to make a critical comparison between results from the different techniques. The paper presents a comparison of the results from three methods for estimating the level of cocaine use in the general population.

The comparison applies to a set of regional-scale sample survey questionnaires, a representative sample survey on drug use among drivers, and an analysis of the quantity of cocaine-related metabolites in sewage.

Setting: In total, 14,438 participants provided data for a set of regional-scale sample survey questionnaires, 2,341 drivers provided oral-fluid samples, and untreated sewage from 570,000 people was analysed for biomarkers of cocaine use. All data were collected in Oslo.

Results: 0.70 (0.36–1.03) per cent of drivers tested positive for cocaine use, which suggests a prevalence that is higher than the figure of 0.22 (0.13–0.30) per cent (per day) derived from regional-scale survey questionnaires, but the degree to which cocaine consumption in the driver population follows consumption in the general population is unknown. Despite the comparatively low prevalence figures, the survey questionnaires did provide estimates of the volume of consumption that are comparable with the amount of cocaine-related metabolites in sewage. Consumption estimates per user are highlighted as a significant source of uncertainty, however, as little or no data are available on the quantities consumed by individuals and much of the existing data is contradictory.

3 Prevention

Introduction

Norway's preventive work is based on a long-term, continuous perspective. For more than a decade, prevention has been rooted in the Government's action plans (See NR 2011 and 2012, Chapters 1 and 3). The white paper 'Se meg! En helhetlig rusmiddelpolitikk' ('See me! A comprehensive drugs and alcohol policy': Report No 30 to the Storting (2011–2012) emphasises the prevention of drug and alcohol problems as an important priority area from a public health perspective. See Chapter 1.1 for a more detailed description.

A new Public Health Act entered into force on 14 February 2013. The Act is intended to contribute to society developing in a manner that promotes public health and evens out social differences in health. One of the main features of the Act is that responsibility for public health work is not limited to the municipal health service. All the municipal services shall take part in the work on promoting public health. The Act gives the municipalities greater responsibility for prevention and health-promoting work in all areas of society. Drug and alcohol prevention work will therefore be a natural, integral part of this work and shall have a clear public health perspective.

The Norwegian Directorate of Health's task is to contribute to local implementation of preventive measures. The seven regional competence centres for the alcohol and drugs field are key partners in coordinating and improving local prevention in the municipalities. Preventive work that varies in its nature and scope is ongoing in all municipalities. Some of the centres have websites in English, e.g.: <http://www.borgestadklinikken.no/english>. The municipalities are responsible for local drug and alcohol prevention work and early intervention, and for following up people with drug or alcohol problems at the local level. Since 2011, the county councils (elected county-level bodies) have had a statutory responsibility for public health work at the regional level.

3.1 Universal prevention

The prevention paradox means that a small change in many people's behaviour can have a greater impact on public health than a major change in a small group. The use of illegal drugs in Norway is a small public health problem compared with the use of alcohol and tobacco, however. This raises the question of how the health authorities should address universal drug prevention. Research indicates that there is a connection between the use of tobacco at a young age and alcohol and drug use. It is therefore reasonable to see tobacco and alcohol prevention as universal prevention strategies that also contribute to reducing the use of drugs.

At present, the health sector's drug prevention work primarily targets risk groups and persons with incipient problems. These risk factors or incipient problems are not necessarily related to drug use alone – high alcohol consumption, mental illness, social problems, problem behaviour etc. can also be indications.

3.1.1 Community

Competence-raising in the municipalities

Work continues on competence-raising in the municipalities, and the seven regional competence centres play an important role in this context. The role of the county governors (seminars, counselling, supervision) has also been strengthened. Competence-raising measures target key personnel in the municipalities (administrative decision-makers, politicians, relevant sector managers, the retail and licensed trades, the police, health personnel, local school managers, teachers, parents/guardians and voluntary organisations).

In order to achieve the goal of better coordination of preventive measures, the municipalities have been required to prepare comprehensive drugs and alcohol policy action plans (cf. Norwegian legislation relating to alcohol) for several years, and to link preventive work relating to drugs and alcohol to other public health work in the municipality. This work continues in relation to both drugs and alcohol. The municipalities are required to assess their practice in relation to issuing licences for the sale and serving of alcohol as part of the drugs and alcohol policy.

Several other laws also assign the municipalities responsibility for tasks in the drugs and alcohol field. Based on the intentions of the acts and the municipalities' own needs, the municipalities are encouraged to pursue a coherent drugs and alcohol policy, and to have a plan for this work, in which drugs and alcohol policy challenges are seen in conjunction with licensing arrangements and other preventive efforts as well as rehabilitation. The Directorate of Health, the regional competence centres and the county governors assist the municipalities in the development and implementation of such plans.

Ungdata: New tool for the municipalities

Ungdata is a standardised system for local questionnaire surveys on various aspects of young people's lives, including the use of drugs, alcohol and tobacco. The surveys are adapted to pupils in lower and upper secondary school. The questionnaire consists of a compulsory basic module that is used in all the surveys and a set of optional, pre-defined questions from which the municipalities can choose. They can also add their own questions. The surveys are carried out during school hours and are conducted electronically.

The municipalities' control of the sale and serving of alcohol

In accordance with the Public Health Act, the Directorate of Health has taken a clearer stance on how the municipalities' drugs and alcohol policy *should* be designed. Among other things, this applies to the control of sales and serving activities in order to reduce the harmful effects of alcohol.

Norwegian alcohol legislation contains many provisions aimed at limiting availability, including a licensing requirement, age limits for the sale and serving of alcohol, sales and licensing hours, and restrictions on serving/selling alcohol to people who are clearly under the influence of alcohol or drugs. It is the municipalities' responsibility to enforce the law in their area. Surveys still show that municipal control of the sale and serving of alcohol is not good enough. In December 2012, the Directorate of Health launched a guide to inspections aimed at municipalities and sales and licensed premises inspectors. One of the goals is to establish a national norm/standard for good inspections and procedures.

Responsible handling of alcohol

The municipalities' use of the provisions of the Alcohol Act is considered to be one of the most important means of limiting alcohol-related harm. A big initiative aimed at *responsible handling of alcohol* has been launched in order to strengthen the local administration of the Alcohol Act. The initiative includes:

- Competence-raising in the municipalities
- Developing guides and material, including a guide for municipal supervision of licences for the sale and serving of alcohol
- Materials and tools for the licensed trade
- Encouraging cooperation between the local authorities, the police and the industry, based on a Swedish model ('Ansvarsfull alkoholserving' – 'Responsible serving of alcohol')
- Information work and campaigns
- Improved documentation and knowledge development
- A national alcohol conference
- A set of preventive measures relating to the Alcohol Act
- Interest group for municipal case officers

3.1.2 Family

Parents' role in drug prevention

Work that supports parents is one of the most important areas in relation to children and young people at all levels of drug and alcohol prevention work. One of the regional competence centres (the competence centre in Bergen in Western Norway) is continuing work on its five-year plan, focusing on the role of parents as its area of expertise. One of the measures is to develop guidelines for parental support to prevent young people from using alcohol at an early age. The nationwide campaign www.settegreenser.no, which is part of the parent-oriented efforts, has been ongoing since 2005/2006.

3.1.3 School

Schools are an important arena for drug and alcohol prevention work in the broadest sense. A good learning environment, cooperation between the home and school, adapted tuition, social competence, methods that activate pupils, authoritative classroom leadership and the school health service are key elements in this work. An electronic guide for drug prevention in schools, based on these principles, was published in early summer 2012 in cooperation with the educational authorities.

3.2 Selective prevention – at-risk groups and settings

The guide '*From Concern to Action – A guide to early intervention in the alcohol and drug field*', which was published in 2009 in collaboration with three other directorates, is part of a long-term early intervention effort in the drugs and alcohol field (See NR 2010, Chapter 3.1.1.). The guide is now well known in the municipalities, and it has been updated.

The training programme *Early prevention, drugs and alcohol and violence in close relationships* has been continued. An English summary of the report, published in autumn 2012, is now available at:

http://www.sirus.no/filestore/Import_vedlegg/Vedlegg_publicasjon/sirusrap.5.12.pdf

Several projects relating to dropping-out from school are ongoing all over the country. Some of the main objectives are: to develop and implement procedures for registering and following up pupils who play truant, to raise the level of competence among staff who work closely with pupils, and to strengthen cooperation between the home and school.

Low-threshold services and outreach activities have been strengthened, for example through grant schemes for municipal drugs and alcohol work and grants for other measures (Chapter 1.2).

3.2.1 At-risk groups

A number of methodology development projects have been initiated in different municipalities. The projects largely target at-risk young people aged between 11 and 23, children of problem drug and alcohol users and parents with mental illness, and early intervention in relation to pregnant women and parents of infants and small children. Work is under way on summarising the results of the projects, which will be used to identify ‘best practice’.

The ‘Ut av tåka’ (Out of the fog) quit smoking hash courses

The initially Oslo-based measure was described in NR 2011 and 2012, Chapter 3. It is based on intersectorial cooperation, and on the systematic development of local competence and methods based on experience from Sweden and Denmark. There have been two target groups: youth aged between 15 and 25 who are motivated to stop using cannabis, and first-line staff in the city wards whose day-to-day work involves contact with these young people. The initiative has helped professionals to develop their competence and enabled them to offer young people in their ward an opportunity to quit smoking hash, both through groups and individually.

A lot of work has been invested in the training of personnel and cooperation with city wards in Oslo in order to enable them, in the longer term, to run these courses on their own and offer them to young people in their ward. Some city wards have run groups in cooperation with the ‘Out of the fog’ project. The wards are also given guidance, and there is cooperation on follow-up. The project is also working on making the quit-smoking- hash course and method better known and on developing the methodology. A total of 98 persons were followed up through the project in 2012, compared with 64 in 2011. In 2013, the project as such was discontinued, and a permanent hash smoking cessation service was established that is now available to people of all ages, including OST clients. A team of three expert consultants is working on getting people to stop using hash in Oslo. Such courses probably reach young people who would not otherwise seek help for their drug problems. Increased focus on and knowledge about cannabis in the help services will also help more young people to seek help for their problems at an earlier stage.

Similar courses aimed at weaning people off cannabis are also held in other Norwegian cities. In Norway, the municipality of Kristiansand is leading the way in the work of getting people to stop smoking hash, and the local authority has also established a course on (the prevention and treatment of problem use of) cannabis (5 credits) in collaboration with the University of Agder. Link: www.hasjavvenning.no

Report on the use of khat in Norway

A recent summary of existing knowledge about khat and health (Ali and Kaur, 2013) shows that not much research has been done on the use of khat in Norway and that we know little about how large a proportion of the population use khat. A prevalence survey has been carried out (Gundersen, 2006). The survey showed that the use and sale of khat is concentrated in central parts of Oslo. About 250 people buy and use khat every day in various cafes in the Grønland area (editor's comment: a city ward with a large immigrant population). Approximately another 250 people buy and use khat in the Greater Oslo region. If we include people from other towns and cities, the estimate is 1,400 persons.

Those who use khat in Norway are mostly middle-aged men from East Africa and the Middle East. It is most prevalent among Somalis. Very few young people use khat. The report shows that people who use large quantities of khat can be doubly marginalised in the sense that they are on the outside of both mainstream society and their own immigrant communities. They are often unemployed, have family and financial problems, struggle with traumas and have an uncertain immigration status. In general, we can say they are not very well integrated in Norwegian society. Khat is chewed in social contexts, and khat milieus can therefore be the result of a quest for security in a society where one feels alienated. The report (Ali and Kaur, 2013) also shows that the health services know little about khat and khat use. The services do not know enough about what symptoms to look for, and many khat users are in a marginalised group that has little or no contact with the health services.

3.2.2 At-risk families

Early intervention

The work on early intervention continues unabated. The focus has primarily been on raising competence in early identification and intervention among staff who come into contact with at-risk children and young people, as well as on stimulating increased use of screening tools and mini-interventions by staff who come into contact with pregnant women, their partners and parents of small children. In relation to adults, the work is intended to help to ensure that help services/treatment measures are instigated early enough so that the use of alcohol or drugs does not develop into problem use or addiction. All the country's seven drug and alcohol competence centres are working on developing methods for identifying target groups in need of measures. The website www.tidligintervensjon.no offers concrete tools that the different services can use to discover drug-related problems and follow them up.

Self-help programmes/websites

There are several digital self-help programmes aimed at people who wish to change their use of or addiction to alcohol, cocaine or cannabis. The programmes are freely available on the

internet. Self-help programmes are aimed at people with mild to moderate drug or alcohol problems, who live in stable housing and have contact with friends, relatives or colleagues. The course/self-help is not suitable for people with a long history of problem drug or alcohol use.

Links: The Bergen Clinics Foundation/ the Bergen Drug and Alcohol Addiction Service Competence Centre: *Online self-help programmes, alcohol, cannabis and cocaine.*

<http://www.bergenclinics.no/index.asp?strUrl=1001996i&topExpand=&subExpand>

AKAN's Balance, Alcohol:

<https://program.changetech.no/ChangeTech.html?Mode=Tri&P=H8V8X8&C=HJ04HX>

The guide 'From Concern to Action' is being implemented in an increasing number of municipalities. Link: http://www.helsedirektoratet.no/vp/multimedia/archive/00334/IS-1742_Engelsk_Eng_334559a.pdf

The Norwegian Electronic Health Library runs a website on behalf of the Directorate of Health and the Directorate for Children, Youth and Family Affairs: *Screening and mapping tools for use in work with parents, pregnant women and children of parents with mental health problems and/or drug or alcohol problems* The page is used by many different professions involved in early intervention work.

Link: <http://www.helsebiblioteket.no/microsite/Kartleggingsverktøy>

4 Problem drug use

4.1 Prevalence and incidence estimates of problem drug use

Definitions

The EMCDDA defines problem use as ‘Injecting use of drugs *or* prolonged/regular use of opiates, cocaine and/or amphetamines’. ‘Opioids’ is used as a generic term for natural opiates (such as opium, Dolcontin), semi-synthetic opiates (heroin) and synthetic opioids (such as methadone, buprenorphine). This means that everyone undergoing opioid substitution treatment (OST) who is prescribed methadone or Subutex is a problem user according to the EMCDDA’s definition. Including such groups can appear strange in Norway, where the intention of OST is to get people who have used heroin for a prolonged period to stop using illegal drugs.

In the Norwegian context, however, it might nevertheless be natural to regard a subgroup of patients in OST as problem users. Around 9–10 per cent of OST patients report having used morphine substances in addition to OST medication during the last 30 days, and 15–16 per cent have been found to use stimulants (Chapter 5.3.2). The proportion who have used such drugs in the space of a whole year will be higher. In addition, some people move in and out of OST and may thus have periods of heroin use before, between or after treatment periods during the survey year (Waal et al. 2013).

In addition to the general definition of problem use, the EMCDDA also uses two underlying definitions: injecting drug users and problem users of opioids or heroin. In Norway, we primarily have estimates for the group that injects drugs, but the number of problem users of heroin in the period 2000 to 2008 has also been estimated (see NR 2009 Chapter 4.2.1 and Bretteville-Jensen & Amundsen, 2009). Estimates of users and problem users of cocaine were published in the national report for 2011, Chapter 4.1. Work is being done to calculate how many problem users we have according to the general definition.

Estimates of the number of injecting drug users have been revised from and including 2013. The mortality multiplier method is still used. It estimates the number of injecting drug users by dividing the number of drug-related deaths by the likelihood of dying of a drug-related diagnosis (ref.). Previously, there have been two sources of information about such deaths: the National Crime Investigation Service (Kripos) and the Cause of Death Registry. The last year Kripos published such figures was in 2009. Calculations of the number of injecting drug users

must therefore be adapted to data on drug-related deaths pursuant to the EMCDDA's definition.

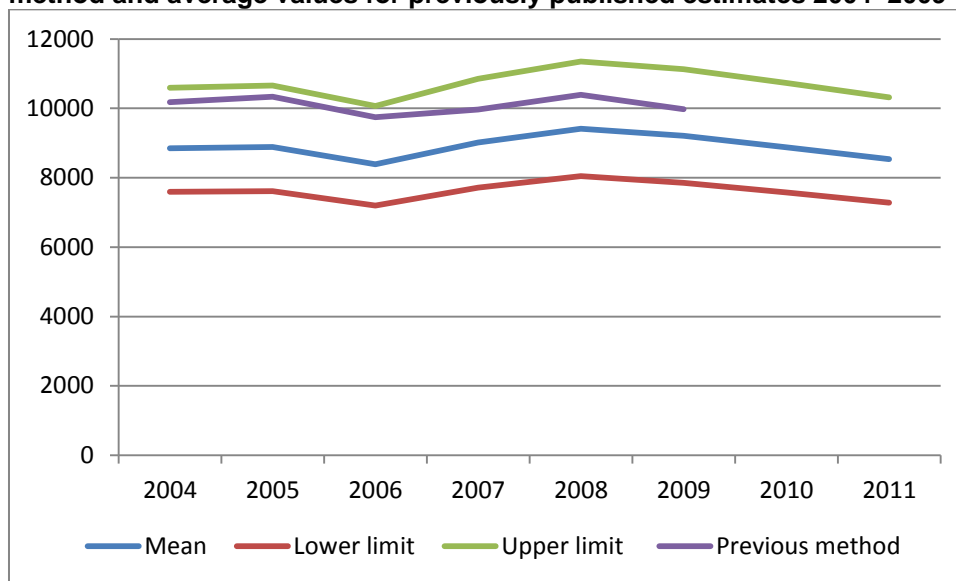
The new calculation takes into consideration the fact that some of those who die are not necessarily problem drug users according to the EMCDDA's definition. Recreational users of drugs, especially heroin, or users of legal medicinal drugs that contain opioids are examples of people who can take a fatal overdose, but who do not fall under the definition of general problem use. When calculating the number of injecting drug users, account must also be taken of the fact that not all deaths that fall under the EMCDDA's definition concern injecting drug users. The Cause of Death Registry does not record whether a person has injection marks, although it is recorded in the post-mortem report. The proportion of injecting drug users among the total number of drug-related deaths has therefore been calculated with the help of other information in addition to data from the Cause of Death Registry. The method is described in Amundsen (2013).

4.2 Prevalence and incidence estimates of problem drug use

Estimates of the number of injecting drug users in Norway

Figure 5 shows estimates of the number of injecting users in Norway, calculated using the revised mortality multiplier. The number of injecting drug users in 2011 was estimated to be between 7,300 and 10,300. The average for previously published estimates is also shown. The average value is between the lower and upper limit for the new calculation method. Previous national reports have shown that the number of injecting users in Norway increased from the 1970s until 2001, followed by a reduction until 2003. The figure has since remained stable. The most recent figures from the Cause of Death Registry are from 2011.

Figure 5: Intervals for the number of injecting users in Norway 2004–2011 using the revised method and average values for previously published estimates 2004–2009



Source: SIRUS

The figures include all injecting drug use. Heroin is still the most common drug injected, but, for an increasing number, amphetamine is becoming the main drug injected. The proportion of injecting drug users in Oslo who had primarily injected amphetamine during the past month was approximately 20 per cent in 2002–2004. In 2008–2010, the corresponding figure was approximately 35 per cent (unpublished results from a study conducted among injecting drug users in Oslo, Bretteville-Jensen, SIRUS). It has also become more common to inject heroin and amphetamine at the same time.

New injecting drug users in Oslo over time (incidence)

With the help of interviews of injecting drug users, the number of new injection drug users in Oslo has been calculated for the period 1985 to 2008 (Amundsen et al., 2013). The number of new users fell from approximately 350 in 1985 to approximately 140 in 2008 (a decrease of 60 %). The reduction was greatest during the periods 1985–1992 and 2003–2008.

4.3 Data on problem drug users from non-treatment sources

A total of 413 persons were interviewed in a study (Amundsen and Reid, 2013) that measured the quantities of amphetamines, cocaine and heroin consumed by marginalised drug users, using a multi-city questionnaire survey design. Eligible respondents were persons aged 18 years and over who had used amphetamines, cocaine, heroin or other opioids during the last 12 months in Oslo, Arendal and Tromsø. Respondents were recruited through contacts established via local caregivers working in services for marginalised drug users, both not-for-profit organisations and public services.

Forty per cent reported heroin as the drug most frequently used over the last 12 months, followed by 31 per cent reporting amphetamines and one per cent reporting cocaine. Others (28%) reported opioids as their most commonly used drug in the last 12 months. Twenty four per cent were women, 12 per cent were under 30 years of age, and 25 per cent were more than 50 years old. Among users of amphetamines, 38 per cent reported more than 20 days of use over the last 30 days. Comparable figures were 2 per cent for cocaine and 43 per cent for heroin.

In the same study, the proportion who had injected drugs in the last year varied from 73 per cent in the smallest town (Arendal), to 82 per cent in Oslo and 86 per cent in the medium-sized city (Tromsø). Estimating a nationwide proportion based on the results from these three towns and cities is of course difficult. However, by assuming that the proportion of injecting users in the total group of problem users decreases with the size of the municipality, the weighted average of the proportion of problem users who inject drugs could be 72 per cent for the country as a whole. We can use this figure to estimate the total number of problem users in accordance with the EMCDDA's definition. If the number of injecting users make up 72 per cent of the total number of problem users, we can multiply the number of injecting users by 1.4 ($= 1/0.72$) in order to arrive at an estimate of the total number of problem users. This puts the number of problem users at between 10,200 and 14,400. The estimate of the number of problem users may be somewhat low, however, because, according to the EMCDDA's current definition, it should include all OST patients. Due to the recruitment method used in the surveys conducted in the three towns/cities, persons receiving opioid substitution treatment (OST) are likely to have been somewhat underrepresented in the sample.

4.4 Intensive, frequent, long-term and other problematic forms of use

In the 2012 population survey (Chapter 2), between 0.5 and 2 per cent of the 16–40 age group reported having used cannabis more than 50 times in the last 12 months. This indicates that a relatively large group of people used cannabis once a week or more. Although the size of this group is unclear, there is reason to believe that there is a group of people in Norway who may experience considerable problems relating to their use of cannabis. This is also reflected in the fact that 1,711 of those who started treatment for drug or alcohol problems in the specialist health service in 2012 reported cannabis as their main problem, cf. Chapter 5 on treatment. However, there are no studies to clarify how big the group is and who these people are.

5 Drug-related treatment: treatment demand and treatment availability

5.1 General description of systems

The treatment systems and its organisation were described in more detail in NR 2011 Chapter 5.3. Residential treatment was thoroughly dealt with in a selected issue in NR 2012. With the exception of OST, the treatment systems have not changed in recent years.

The state has overriding responsibility for providing necessary specialist health services for the public. This also applies to people with drug or alcohol problems. The Administrative Alcohol and Drug Reform of 2004 stipulates that the four regional health authorities shall provide outpatient and in-patient interdisciplinary specialised treatment, either through their own health trusts or through private partners. In-patient treatment includes services for detoxification, stabilisation and assessment, short and long-term in-patient treatment. Interdisciplinary specialised treatment also covers treatment with methadone or Subutex, in addition to other treatment and follow-up services.

The Norwegian OST programme was established in 1998. It was run by 14 centres in the four health regions until 2010. Special guidelines were introduced from 1 January 2010, which emphasised, among other things, that OST should be integrated in the ordinary specialist health service (see NR 2010 Chapter 11). OST centres are no longer a separate type of measure, and the system of special decision-making powers has been discontinued. The four regional health authorities have established assessment units that make an overall assessment of what type of treatment is needed for the person in question, whether he/she needs OST or non-medical treatment.

The municipalities' overall effort to provide help targets the general population, at-risk groups and those who already have drug or alcohol problems, and their surroundings. The services can include mental and somatic health services, outreach ambulant services/community-based teams, services for next-of-kin, low-threshold services, assessment and referral to treatment, as well as follow-up during and after treatment in the specialist health service or in prison.

The full range of local services for persons with drug or alcohol problems includes services from a number of sectors. Key service providers are the Norwegian Labour and Welfare Service (NAV), GPs, health stations, the school health service, child welfare services, home-based care services, nursing homes, psychologists, municipal drugs/alcohol and mental health units, residential services and low-threshold health services.

The NAV offices are contact points for the local labour and welfare administration. They offer a broad range of work-related measures and municipal social services. As a minimum, the NAV offices shall provide advice and guidance, social security benefits, qualification programmes and temporary housing. The municipalities are free to assign responsibility for other municipal tasks to the NAV offices (Ministry of Health and Care Services, 2012).

Challenges

In the white paper on alcohol and drug policy of June 2012, the Government stated that ‘extensive efforts have been invested in the drugs and alcohol field in recent years, both in the municipalities and in the specialist health service. However, user organisations and experts point out that the services must be involved at an earlier stage and that the availability of the services must be improved. Lack of coordination is another important challenge. Many clients and patients experience problems when responsibility for further follow-up is transferred to new services. This is a problem both within and between sectors and levels.

Evaluations indicate that coordination between the administrative levels, the specialised and the municipal services is not good enough. The services are perceived as fragmented, often with long waiting times for treatment. The time spent in in-patient treatment has also been reduced compared with what used to be the norm. Following a stay in the specialist health service, patients shall be followed up by their municipality. The transition from state to municipal services often leads to interruption of treatment, which results in a poorer health situation for the users. Cooperation between the first and second-line services is often based on personal relations, not the structure of the treatment chain.

There is a need to clarify the individual services’ tasks and responsibilities. The biggest challenges for people with drug/alcohol dependency who need extensive help are to get sufficient care for somatic and mental illness, a lack of suitable housing and coping with their daily life and living conditions. Other challenges include a lack of participation in meaningful activities, work and a social network.’

5.2 New research – cohort study of drug users in treatment

SIRUS has carried out a ten-year prospective cohort study of drug users in treatment (Lauritzen, Ravndal and Larsson, 2012). A total of 481 clients recruited from 20 treatment facilities were interviewed upon admission to treatment in 1998/1999 and at four follow-up sessions: one, two, seven and ten years after inclusion. The facilities were categorised in four groups: communal youth facilities, psychiatry youth teams, residential units for adults and opioid substitution treatment (OST). The research questions were as follows:

- 1) What were the life situations and problems of a selection of 481 problem drug users when admitted to treatment?

- 2) How were treatment measures used within the ten-year period?
- 3) What changes in life situations and problems can be described?

The instruments used were: the European Addiction Severity Index (EuropASI), the Hopkins Symptom Checklist-25 (SCL-25), the Millon Clinical Multiaxial Inventory-II (MCMI-II) and the Childhood Trauma Questionnaire (CTQ).

The participation rate was high, 91 per cent and 89 per cent, respectively, for the first two follow-up interviews after one and two years, and 85 per cent and 77 per cent after seven and ten years. The cumulative percentages of deaths were two per cent and four per cent at the first and second interviews, and 12 per cent and 15 per cent at the last interviews.

Drug users in treatment have varied backgrounds, substance use and functionality levels. The study nevertheless highlights certain themes in the description of the cohort at the time of inclusion. The overall problem characteristics could thus pose challenges in relation to preventive strategies and future treatment initiatives. The findings confirm the need for evaluation and treatment of alcohol and drug problems in a family and generational perspective, further research on the complex weave of genetics, environmental influences and life events, and a continuation of an action plan initiated for children as next-of-kin. To help to prevent problems from developing, the report includes reflections on the need to raise competence in different arenas that work with children.

Between 60 and 70 per cent reported major learning difficulties and/or behavioural problems in primary/lower secondary school. The level of education among drug users in treatment was generally low, and the majority had very limited work experience later in life. Various models to strengthen multidisciplinary competence in, or in close collaboration with, the school system therefore need to be discussed. Daily life before admission to treatment was generally characterised by serious substance use, injecting drugs and a high risk of overdosing, insufficient social functioning outside drug circles, as well as excessive crime.

The description of changes applies to the entire selection and the four recruitment groups. The proportion of HCV infections was generally high. With the exception of those who died, the changes described appear to have several positive elements. A substantial reduction in the use of drugs and participation in criminal activity was noted after ten years. The most significant reduction was seen in the proportion of heroin users, and a considerable decrease was found in injecting heroin/drugs and in non-fatal overdoses. This can primarily be linked to an increase in daily use of OST medication. The proportion who used cannabis and sedatives/hypnotics dropped significantly within the first two years of follow-up, but the decrease was not as long-lasting and steady as for heroin use. Multiple crime decreased

significantly. The sale of drugs and robbery/theft were reduced in particular, and the study seems to confirm the strong link between such crime and individual drug problems.

The proportion who had income from employment increased to about one-third at the time of the last observation. A considerably higher proportion of clients were on disability benefits than at the time of inclusion. As a result of more stable income sources, benefits from social welfare services were strongly reduced. Another positive result involved improvements in housing. Loneliness seemed to be a persistent problem, however.

The group suffered enduring mental disorders. Although improvements were reported during the index treatment and at the two first follow-ups, the clients tended to suffer from recurring anxiety, depression and a considerable degree of cognitive difficulties. Similar troubles were found as regards relationship problems and personality disorders. The study confirms that there are significant challenges in relation to the prevention and treatment of psychiatric disorders. A large proportion of persons entering treatment for drug abuse seem to require comprehensive assistance for years. The index treatment had often not been their initial treatment, and combinations of treatment facilities were used in the course of the observation period.

In sum, the study shows substantial, positive changes and thereby gives grounds for cautious optimism regarding the prospect of problem drug users changing their behaviour over time. A crucial challenge involves helping the many who have reduced or quit their illegal drug use, but live on the fringe of society.

5.3 Treatment admission

5.3.1 Data from the Norwegian Patient Register

The Norwegian Patient Register (NPR) is authorised by the regulations of 2009 to collect personally identifiable information about patients in the interdisciplinary specialist health service. Patients are identified by a unique number across centres.

From 2010, it became possible to retrieve the number of patients with a drug problem who started in-patient or outpatient treatment in the year in question, as well as some information about these patients. The individual data are aggregated and reported to the EMCDDA . So far, only treatment started during a calendar year can be reported, without knowing whether this is first-time treatment or whether the patient has undergone treatment before.

According to NPR, a total of 16,778 patients received treatment during the 2012 calendar year for drug problems as their primary condition. Of these, 69 per cent were men and 31 per cent women. The number includes patients in both in-patient and outpatient treatment, and the sample is based on ICD-10 F codes. The biggest group (39%) had problems related to the use of opioids as their primary diagnosis. The second biggest diagnosis category was multiple drug use at 22 per cent, followed by cannabis at 19 per cent and stimulants at 12 per cent.

As for those who started treatment for drug-related problems in 2012, reports were submitted from 146 units concerning a total of 8,891 patients (2011: 8,817 patients from 159 units), 3,691 in in-patient and 5,200 in outpatient treatment, including OST. Comparative figures for 2011 were 3,921 and 4,896. Around 69 per cent of patients starting treatment were men. The average age of patients in in-patient treatment was 34 years for men and 36 years for women, fairly similar to patients in outpatient treatment (men: 34 years, women: 35 years).

More than a quarter – 27 per cent – of the patients entering treatment in 2012 had multiple drug use as their primary diagnosis (F19). Problems with opioids were the most frequently reported diagnosis in both outpatient and in-patient treatment where the primary drug was identified. The second most frequent diagnosis was the use of stimulants for patients in residential treatment and cannabis upon admission to outpatient treatment. The latter accounted for as many as 31 per cent of the patients where the primary drug was identified. It is also notable that the proportion with cannabis as their primary drug upon admission to in-patient treatment had increased to 18 per cent, while it was 11 per cent in 2011.

5.3.2 About patients in OST

At the end of 2012, there were a total of 7,038 patients in OST (SERAF, 2013), an increase of 384 from 2011. In previous years, the number of patients has increased steadily by approximately 500, while there are now signs that growth is slowing down.

Admissions

The number of admissions to OST in 2012 was 823, a decline of 308 from 2011. It was especially the number of re-admissions that decreased as a result of changes in the registration practice on the transition to a new electronic patient record system. At the end of 2012, 125 persons were waiting to be admitted for treatment, seven more than the year before.

Discharges

The number of discharged patients from OST in 2012 was 409, lower than in previous years (487 in 2011). Discharges now represent less than six per cent of all patients in treatment. In 2011, ten per cent of patients completed their treatment, while the corresponding figure for 2010 was nine per cent. This can serve to obscure the fact that the proportion who drop out of

treatment during the start-up phase may be significantly higher. Nevertheless, it seems that most of those who have settled into treatment continue and stay for a long time. The registrations distinguish between discharges as a result of a decision by the responsible treatment centre, discharges initiated by the patient him/herself and discharges due to death. GPs cannot discontinue the treatment at their own initiative. Discharges resulting from decisions take place independently of or against the patient's wishes. Until last year, the proportion who were discharged as a result of a decision – i.e. potentially against their will – declined strongly, which is in line with the new guidelines. While 39 patients (8% of discharges) were discharged as a result of a decision in 2011 (?), the number in 2012 was 65 (16%). The main reason for terminating treatment is that the patients themselves leave treatment. These patients stop showing up or state that they no longer wish to continue the treatment. Some patients specifically request other types of treatment or wish to stop using morphine substances.

The number of deaths among OST patients in 2012 was 84. As shown in Table 1, this represents 1.2 per cent of all patients in treatment. There appears to have been a slight increase from 2006, but the change is small and the two preceding years have seen a reduction in relation to the number of patients in treatment. The number of older patients in treatment is also increasing, and many of them have various chronic illnesses.

Table 1: Annual occurrence of deaths during treatment in the OST programme 2002–2012. Number and converted in proportion to the number of patients in OST (deaths per 100 patient-years)

Year	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Norway	26	31	21	30	15	32	39	63	54	54	84
% of all patients in treatment/year	1.5	1.4	0.8	0.9	0.4	0.8	0.8	1.3	0.9	0.8	1.2

Source: The Norwegian Centre for Addiction Research – SERAF

The status survey for 2012

Data about clients' current situation, such as health and social conditions and functional level, psychosocial treatment, crime and drug and alcohol use, are reported annually in the form of status surveys. A total of 5,852 forms (of 6,640 patients in treatment) were completed for 2012, 78 per cent of all patients in treatment in 2012 (7,489 persons). The average age of clients (for whom a form has been completed) was around 42, and the proportion of women was nearly 30 per cent. The average age and the gender distribution have been more or less unchanged in recent years. A total of 141 patients (2.5%) were in the 21–25 age group, and only one was under 21. Although the lower age limit for admissions has been abolished following the introduction of the new guidelines (previously 25 years), this does not appear to have affected the average age so far. A total of 53 patients were over the age of 60, which

indicates that there will be an increasing number of OST patients in care for the elderly in the years ahead.

The proportion treated with methadone was 44 per cent, while 56 per cent were treated with buprenorphine-based medication. About two-thirds have their medication prescribed by their GP, and GPs thus play a key role in OST. Just under half the patients get their medication from pharmacies.

Retention and social rehabilitation

According to the status survey, 95 per cent of the patients were in treatment by the end of 2012, while 5 per cent had been discharged. The response rate was 80 per cent, however, and the drop-out rate is probably highest among those who had been discharged at the time the survey was conducted (for whom no status form has been submitted). A better measure of retention is the proportion in treatment at the end of the year compared with the total number in treatment at the start of the year and the number of new admissions during the year. On this basis, the retention rate was 92 per cent, i.e. nine out of ten were in treatment at the end of 2011.

Occupational rehabilitation is not showing progress. In 2011, 78 per cent were neither working nor in education, while the corresponding proportion in 2012 was 80 per cent. Forty-one per cent had benefits as their main source of income, most of them disability benefit. The proportion who live on temporary social security benefits is low, as is the proportion who are financially independent. The proportion who have their own apartment or house is high, however. According to the status overview, an average of 75 per cent of patients rented or owned their own home. The lowest proportions were found in Oslo (59%) and Bergen (66%). To a certain extent, this reflects the fact that the housing market is more difficult in large towns and cities.

Drug use

The findings on drug use are based on reported use during the last 30 days. A proportion of 9 per cent reported having used an illegal morphine substance during the past month, 33 per cent cannabis and 42 per cent benzodiazepines. Half of those who reported using benzodiazepines had been prescribed the drug by a doctor. Sixteen per cent reported using stimulants. The figures are largely the same as in 2011, but illegal use of morphine has declined. The proportion was 12–13 per cent just a few years ago. The situation was also measured by calculating the overall score for frequency of drug use and the severity of ongoing use during the past month. Forty-two per cent had not used such substances at all, and 19 per cent only sporadically, while 28 per cent reported frequent use. All these findings are practically unchanged compared with recent years (SERAF, 2013).

6 Health correlates and consequences

6.1 Drug-related infectious diseases

6.1.1 HIV and Aids

In 2012, 242 cases of HIV infection were reported to the Norwegian Surveillance System for Communicable Diseases (MSIS). Eleven of the cases were among injecting drug users: ten men and one woman. The median age was 35 years (28 to 49 years). Eight of the eleven injecting drug users who were diagnosed as HIV positive in 2012 were persons of foreign origin (mostly Eastern European) who had been infected before arriving in Norway.

As of 31 December 2012, a total of 596 persons had been diagnosed as HIV positive with injecting use as a risk factor. This amounts to 12 per cent of all reported cases of HIV since 1984. In 154 of the cases, the patient had developed Aids (Table 2). No information is available regarding how many of the HIV positive injecting drug users are still alive.

Table 2: Reporting of HIV infection and Aids, Norway 1984–2012. Percentage of injecting drug users by year of diagnosis

	HIV total	HIV injecting drug use	Percentage HIV injecting drug use	Aids total	Aids injecting drug use	Percentage Aids injecting drug use
1984–1999	2,018	442	22%	675	112	17%
2000	175	7	4%	35	5	14%
2001	157	8	5%	33	8	24%
2002	205	16	8%	34	4	12%
2003	238	13	5%	53	6	11%
2004	251	15	6%	36	4	11%
2005	219	20	9%	32	4	13%
2006	276	7	3%	32	4	13%
2007	248	13	5%	11	0	0%
2008	299	12	4%	18	2	11%
2009	282	11	4%	18	1	6%

Tabellen fortsetter på neste side

2010	258	11	4%	22	3	13%
2011	268	10	4%	19	0	0%
2012	242	11	5%	25	1	4%
Total	5,138	596	12%	1,044	154	15%

Source: The Norwegian Surveillance System for Communicable Diseases (MSIS); the Norwegian Institute of Public Health

The incidence of HIV among injecting drug users has for many years remained at a stable, low level, with about 10 to 15 cases reported per year. The reason for this is not entirely clear, but a high level of testing, great openness regarding HIV status within the drug user community, combined with a strong fear of being infected and strong internal justice in the milieu, are assumed to be important factors. In addition, many of the sources of infection in the milieu have disappeared due to overdose deaths or have been rehabilitated through substitution therapy or other forms of rehabilitation. However, the extensive outbreaks of hepatitis A and B in the late 1990s and early 2000s, and the high incidence of hepatitis C, show that there is still extensive needle sharing among this group. For the last few years, the majority of injecting drug users diagnosed with HIV were persons of foreign origin (mostly Eastern European) who had been infected before arriving in Norway.

6.1.2 Hepatitis

During the nationwide outbreak of hepatitis A from 1996 to 2000, 1,360 drug users were diagnosed with acute hepatitis A. Since then, only sporadic, individual cases of hepatitis A have been reported among injecting drug users. Hepatitis A vaccination has been offered to injecting drug users free of charge since 2000.

In the period 1995–2008, a considerable increase in hepatitis B among drug users nationwide was reported to the Norwegian Surveillance System for Communicable Diseases. In 2012, seven of a total of 46 reported cases of acute hepatitis B involved injecting drug users. During the period 1995–2012, the total number of reported cases of acute hepatitis B infection among injecting drug users was 1,976. Hepatitis B vaccination has been offered to injecting drug users free of charge since the mid-1980s.

The monitoring of hepatitis C in Norway was intensified from 1 January 2008. The notification criteria were changed so that all laboratory-confirmed cases of hepatitis C must now be reported to MSIS. Previously, only acute illness had to be reported, and this resulted in a very inadequate overview of the real incidence of the disease in the country. In 2012, 1,515 cases of hepatitis C (both acute and chronic cases) were reported. In 36 per cent of the reported cases, no information was provided about the presumed mode of transmission, but in

the cases where the mode of transmission is known, 85 per cent were infected through the use of needles. For the time being, data from MSIS cannot distinguish between cases involving new infection with hepatitis C and cases where the infection occurred many years ago. It is therefore not known whether the number of cases of newly acquired hepatitis C infection has declined or increased among drug users in recent years.

Among OST patients, the status survey for 2012 (see Chapter 5.2.2) shows that 66 per cent of the clients were hepatitis C antibody positive, roughly the same proportion as in 2011. This is lower than expected, and the explanation is probably that the percentage with unknown status was as high as 20 per cent.

Since 2002, small-scale prevalence surveys have been carried out in connection with needle distribution and the drug injection room in Oslo in order to register the prevalence of several infectious diseases among injecting drug users. These surveys are the only prevalence surveys that are carried out regularly among a sample of drug users in Norway. The 2012 survey showed that 62 per cent of the injecting drug users tested had had a hepatitis A infection or had been vaccinated against the disease, while 35 per cent had had a hepatitis B infection and 64 per cent had had a hepatitis C infection. Forty-one per cent had hepatitis B markers, indicating that they had been vaccinated against hepatitis B.

6.1.3 Bacterial infections

In the period 2000–2012, six cases of botulism were reported among injecting drug users. In addition, one case of anthrax and one case of *Clostridium novyi* were reported among injecting drug users in the same period. In recent years, five to ten cases of methicillin-resistant *Staphylococcus aureus* (MRSA) have been reported annually among drug users. There is insufficient data on the incidence of other bacterial infections among drug users in Norway. Tuberculosis is very rare among drug users in Norway.

6.1.4 Risk behaviour

In connection with the 2012 prevalence study among injecting drug users attending needle distribution facilities and the drug injection room in Oslo (see 6.1.2), questions about risk behaviour were included as part of the survey. Ninety-one currently injecting drug users replied.

Results: 13 per cent reported having shared used needles and syringes in the last four weeks; 34 per cent reported having shared used injecting paraphernalia in the last four weeks; 35 per cent had taken an HIV test in the 12 months preceding the survey, and 36 per cent had taken an HCV antibody test in the 12 months preceding the survey.

6.2 Drug-related deaths and mortality of drug users

Methodological considerations

Until 2010, there were two bodies that registered drug-related deaths in Norway: Statistics Norway and Kripos (the National Crime Investigation Service). Kripos based its figures on reports from the police districts, while Statistics Norway prepared figures on the basis of medical examiners' post-mortem examination reports and death certificates in accordance with the WHO's ICD 10 codes in a General Mortality Register (GMR). With effect from 2010, Kripos stopped publishing figures for drug-related deaths. Hence, the 2009 figures were the final year of reporting from that source.

With effect from 1996, Statistics Norway's figures have been based on EMCDDA's definition of drug deaths. This broadened the inclusion criterion that had been used until then. In the period since 1996, Statistics Norway's figures have been consistently higher than the figures from Kripos. However, if suicide (by means of drugs) and drug-related deaths among elderly people above the age of 65 are eliminated from Statistics Norway's statistics, the difference is smaller, although still considerable in some years. The trends (up to 2009) were largely identical in both series of figures, however.

Situation and development

Table 3 shows that the figures for drug-related deaths peaked in 2000/2001. In the ensuing years, there has been a considerable reduction in the number of registered drug deaths. The reduction since the turn of the millennium is most probably due to the strong increase in the number of clients in Opioid substitution treatment - OST. Both the Statistics Norway figures and the Kripos figures appear to indicate that, after the reduction following the peak years of 2000 and 2001, a certain stabilisation of the number of mortalities has occurred. The number of mortalities remains relatively high.

Table 3: Drug-related deaths 1991–2011. Total number of deaths and deaths broken down by gender. Figures from Kripos and Statistics Norway (underlying cause of death)

1991–2010	Number of deaths according to Kripos			Number of deaths according to Statistics Norway		
	Men	Women	Total	Men	Women	Total
1991	74	22	96	66	22	88
1992	78	19	97	81	23	104
1993	77	18	95	76	17	93
1994	102	22	124	105	19	124
1995	108	24	132	114	29	143
1996*	159	26	185	173	31	204
1997	149	28	177	160	34	194
1998	226	44	270	228	54	282
1999	181	39	220	191	65	256
2000	264	63	327	302	72	374
2001	286	52	338	327	78	405
2002	166	44	210	240	67	307
2003**	134	38	172	193	62	255
2004	168	55	223	220	83	303
2005	146	38	184	176	58	234
2006	152	43	195	187	64	251
2007	162	38	200	217	58	275
2008	148	31	179	210	53	263
2009	146	37	183	222	63	285
2010	n.a	n.a	n.a	181	67	248
2011	n.a	n.a	n.a	201	61	262
2012	n.a	n.a	n.a	***	***	***

Source: Kripos and Statistics Norway

*The figures from 1996 onwards have been classified in accordance with a new revision. This means that figures from before and after 1996 are not directly comparable. Suicides in which narcotic substances were used are included from 1996.

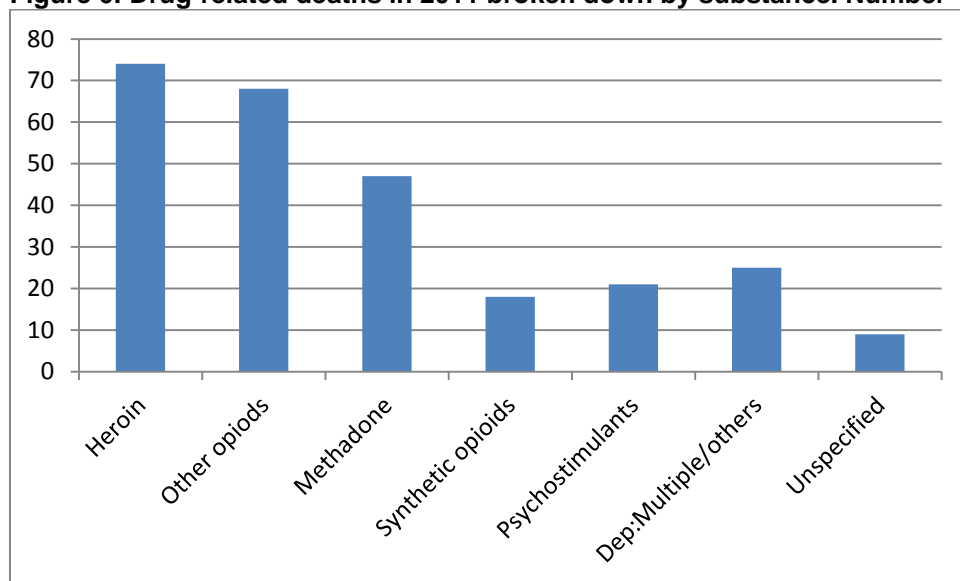
** STATISTICS NORWAY's figures from 2003 onwards are based on WHO's revised coding of causes of death.

***Figures for 2012 are not yet available.

Of the 262 drug-related deaths in 2011 that were recorded by Statistics Norway, 207 (79%) deaths involved opioids with or without additional drugs, 74 deaths were due to heroin (X42, X44, X62, X64 + T401), 47 deaths were recorded with methadone poisoning as the underlying cause (X42, X44, X62, X64 + T403), and 68 with other opioids, either as poisoning or opioid dependency (X42, X44, X62, X64 + T402 or T400, F112). In addition, there were 18 deaths coded as related to ‘other synthetic opioids’ (X42, X44, X62, X64 + T404). The remaining 55 deaths broke down as follows: 21 psychostimulants (X41, X44, X61 + T436), 9 unspecified narcotic substances (X42, X44 + T406 or T409), 25 cases of dependency on other stimulants and dependency on multiple/other drugs (F152, F192), and zero deaths from cocaine (T405) and cannabis (T407).

In 2011, 44 (16.8%) of the included deaths were coded as suicides (X62, X64), which is higher than the 10 per cent reported for 2010, but probably still a conservative estimate of the suicide rate.

Figure 6: Drug-related deaths in 2011 broken down by substance. Number



Source: SIRUS and Statistics Norway

Comments

- Many of the drug-related deaths are believed to be due to extensive multiple drug use.
- Since 2007, the average strength of heroin seized by the police and customs in Norway has decreased from 36 per cent to around 15 per cent. During the same period, the proportion of heroin as the main intoxicant has been almost halved. However, more than four out of five drug-related deaths are still due to opioids. It seems that there

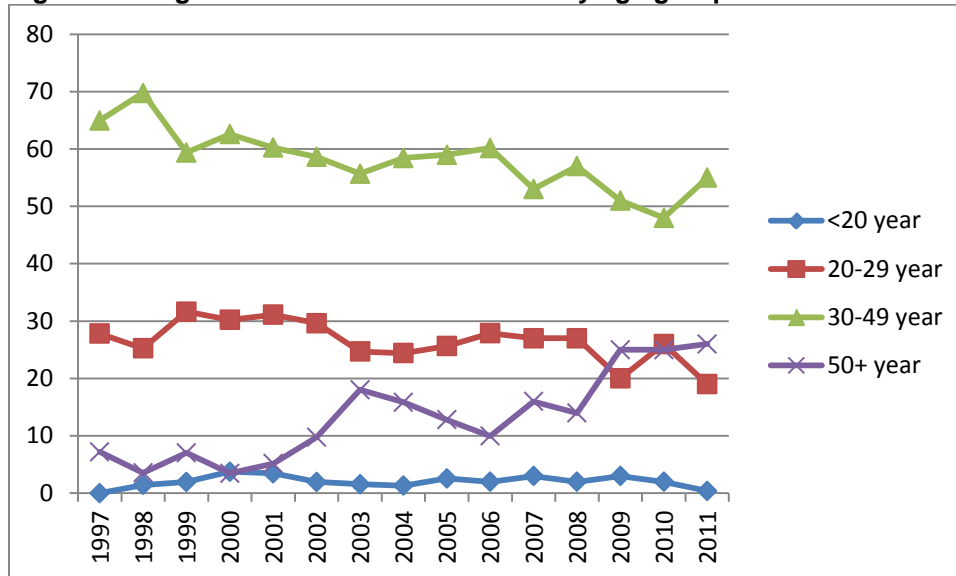
may be a gradual change in the preference for and/or availability of opioids among opioid users, and that this is also reflected in causes of death. Amphetamine and/or methamphetamine and/or cocaine were detected in 11 per cent of the deaths.

- By the end of 2012, there were around 7,000 patients in OST in Norway. There were 84 deaths from all causes among patients in OST in 2012, indicating a total mortality rate of about 1.2 per 100 person-years while in OST. The majority of deaths in OST were due to somatic causes and injuries.
- Forty-seven deaths in 2011 were reported to be due to methadone, which is slightly higher than the level in 2010. The majority of methadone-related deaths occur among persons not enrolled in the OST programme. However, it is generally a challenge to differentiate between deaths caused by methadone and deaths where methadone was present in the blood at the time of death, but was not necessarily the cause of death.

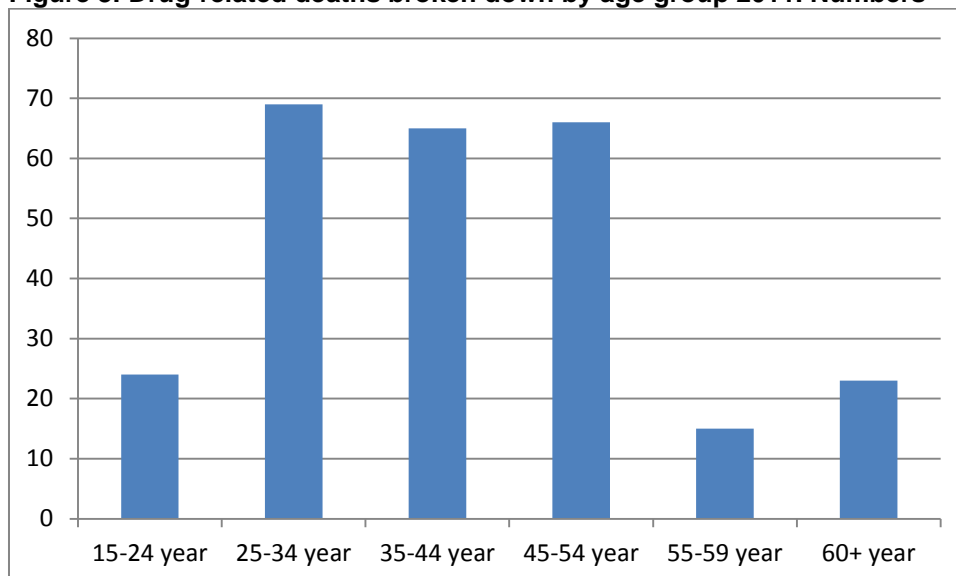
Age increasing

Figure 7 shows that the proportion of drug-related deaths among people over the age of 30 has increased steadily over the years. In the 1990s, it had reached 60 per cent, according to Statistics Norway. These statistics show that, for the years 2000 to 2009, the proportion of drug-related deaths in the 30-plus age group was approximately 70 per cent on average. In 2011, this age group accounted for 81 per cent of the drug-related deaths (212 persons). During the same period, the proportion over the age of 50 was 26 per cent of the total number of deaths (69 persons). Twelve of the deaths were in the 65-plus age group. The youngest age groups' proportion of drug-related deaths has remained relatively stable, and one death was registered among persons under the age of 20 this year.

For drug-related deaths, the mean age at the time of death has increased steadily in recent years, from around 35 years in the period 1996–2002 to 41.5 years in 2011. The increase in mean age at the time of death coincides with an expansion in the provision of OST in Norway, but the number of drug-related deaths has stabilised. It could be that OST contributes to the increase in the mean age, and, in that sense, increased age at the time of death can be seen as another positive outcome of the OST programme.

Figure 7: Drug-related deaths broken down by age group 1997–2011. Per cent

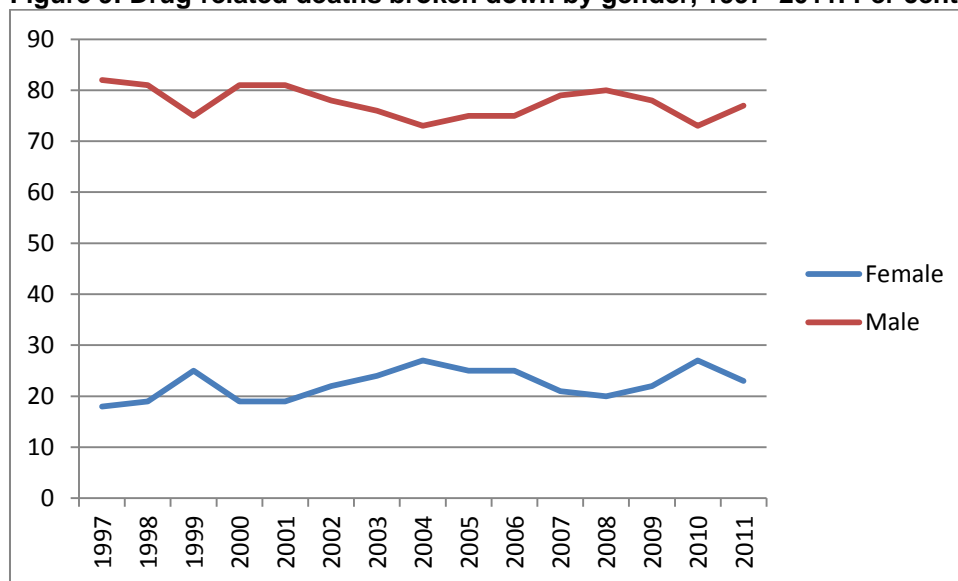
Source: SIRUS and Statistics Norway

Figure 8: Drug-related deaths broken down by age group 2011. Numbers

Source: SIRUS and Statistics Norway

Gender distribution: stable

In 2011, 201 victims of drug-related deaths were male and 61 were female. The proportion of females was 23 per cent, which, seen in a longer-term perspective, seems to be within the ‘normal range’. During the period 1997 to 2011, the proportion of women has varied between 18 and 27 per cent (Figure 9). During the period 1980 to 1990, the average proportion of women was close to 22 per cent.

Figure 9: Drug-related deaths broken down by gender, 1997–2011. Per cent

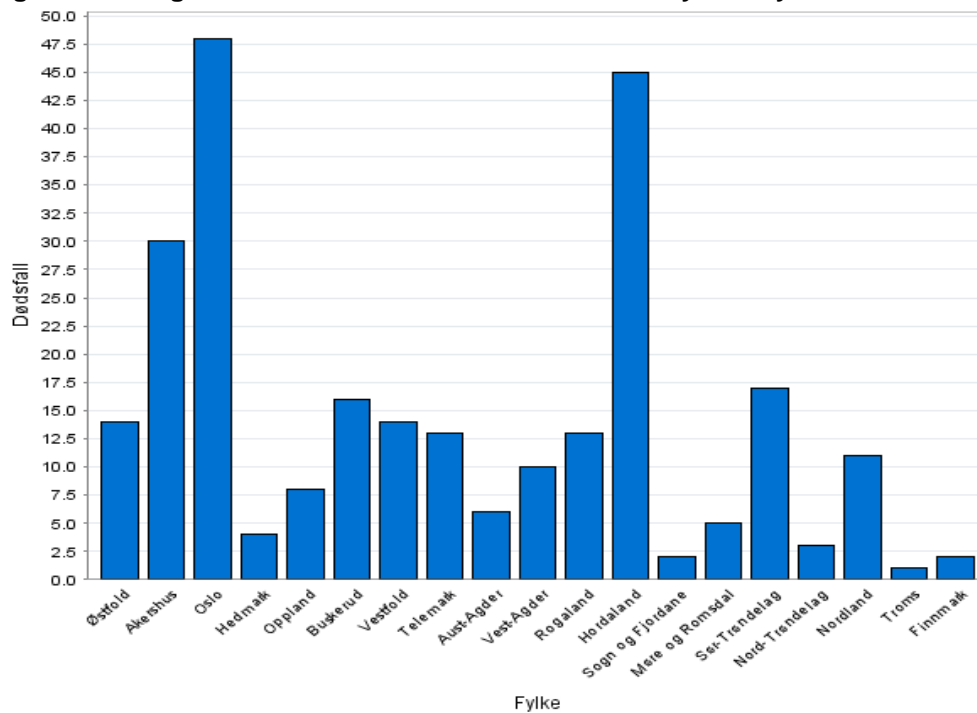
Source: SIRUS and Statistics Norway

Confirmation of cause of drug-related deaths – high autopsy rate

In 2011, there were 41,300 deaths in total in Norway. Of these, 3,072 underwent post-mortem examinations (autopsies). This means that Norway has an autopsy rate of about 75 per 1,000 deaths overall. Among the 262 deaths recorded as drug-related deaths in this report, however, 233 victims (89%) underwent an autopsy. Hence, the reported figures are in most cases based on toxicological confirmation of the drug-related death. This underlines that, in Norway, ‘unnatural deaths’ among young adults are typically investigated by means of an autopsy (including toxicology) in order to confirm the cause of death.

Geographical distribution

In 2011, drug-related deaths were recorded in all the 19 counties in Norway (Figure 10). The concentration is particularly high in the Oslo area (Oslo and Akershus). The situation seems to have gradually improved in Oslo in recent years. The number of drug-related deaths in Hordaland county has increased significantly in recent years, and is now almost as high as in Oslo. This probably reflects the situation in Bergen, the second biggest city in Norway. No national statistics are available for drug-related deaths at the municipal level. However, SIRUS has made calculations (unpublished material) that show that drug-related deaths occurred in 87 Norwegian municipalities in 2009.

Figure 10: Drug-related deaths in 2011* broken down by county

*n = 262

Source:Sirus

New study: Increased somatic morbidity after leaving opioid maintenance treatment

A new cohort study among patients (Skeie et al, 2013) showed increased somatic morbidity in the first year after leaving opioid maintenance treatment (OMT).

Background/Aims: Some patients in OMT leave treatment temporarily or permanently. The study investigated whether patients interrupting their OMT differed from non-interrupters in sociodemographic and drug-use characteristics and examined acute/sub-acute somatic morbidity among the interrupters, prior to, during and after OMT.

Methods: Cohort design.

Observation period:

Five years prior to, up to first 5 years during, and up to 5 years after interruption of OMT.

Participants:

The sample (n = 200) comprised 51 OMT interrupters and 149 non-interrupters. Data on patient characteristics were obtained from interviews and OMT register information. Data on somatic morbidity were gathered from hospital records.

Measurements:

Key patient characteristics among OMT interrupters and non-interrupters. Incidence rates of acute and sub-acute somatic disease incidents leading to hospital treatment (drug-related/non-drug-related/injuries) prior to/during/after OMT.

Results:

Interrupters and non-interrupters did not differ in sociodemographic characteristics, while longer duration of amphetamine and benzodiazepine dependence predicted OMT interruption. Interrupters scored significantly higher on drug-taking and overdoses during OMT, but still had a significant 41 per cent reduction in drug-related treatment episodes. After interruption of treatment, such episodes increased markedly and were 3.6 times more frequent during the first post-OMT year compared to the pre-OMT period ($p < 0.001$). This increase was highest during the first months after OMT interruption. There was no significant increase two to five years after interruption.

7 Responses to health correlates and consequences

7.1 National overdose strategy 2013–2018

In the white paper on a comprehensive drugs and alcohol policy, Report No 30 to the Storting (2011–2012) **Se meg!** ('See me!'), the Government proposed developing a five-year strategy aimed at reducing the number of drug overdoses (Chapter 1). The Storting approved the white paper on 18 March 2013. This is the first time a national strategy of this kind will be implemented. Based on the Storting's decision, the Directorate of Health has been tasked with drawing up a national strategy for reducing overdoses in collaboration with relevant agencies and organisations.

EUR 1.25 million (NOK 10 million) has been allocated for the preparation of the strategy and implementation of measures in 2013 and 2014.

The goal for the strategy is to stimulate the development of local strategies for municipalities with registered overdose fatalities. The strategy should have concrete goals and measures in the following areas:

- responsibility for further development and coordination of the help services
- clear assignment of responsibility when there is a risk of an overdose fatality
- further competence-raising measures among particularly involved personnel, such as ambulance personnel and accident and emergency services staff
- prevention of overdoses following discharge from institutions
- necessary information for and involvement of next-of-kin
- influencing the user culture (reducing the extent of injection)
- further development of life-saving measures.

Non-fatal overdoses can also lead to serious harm to health. The goal should therefore not only be to reduce the number of fatalities, but also to reduce the number of overdoses in general. Having survived an overdose can increase the risk of a second overdose, with a fatal outcome. The goal of the strategy should therefore be understood as to contribute to

- reducing the number of overdoses
- providing help as soon as possible after an overdose
- reducing the number of overdoses with fatal outcomes
- improving follow-up after non-fatal overdoses

Design

- The final strategy document is being prepared by a broadly composed working group. It is expected to be finalised early in 2014. It will be based on a summary of research and discussions with key municipalities and important agencies/organisations. It is seen as important to ensure that the overdose strategy is not a short-term, isolated action plan, but is integrated in existing plans and measures. Measures have therefore been included that have already been implemented or that are being planned under other ‘headings’ that will or may have an overdose prevention effect. Continued development of treatment for opioid problems will be a priority, focusing on OST in particular. There will be continued focus on developing low-threshold OST in the municipalities and preventing dropping-out from detoxification, OST and residential treatment in interdisciplinary specialist treatment.

The main focus of the strategy

- The overdose strategy is intended to contribute to ensuring that existing measures have a stronger preventive focus.
- It shall contribute to better coordination between existing measures for the prevention of overdoses (fatalities).
- In particular, it shall contribute to such coordination by stimulating the development of local/municipal action plans.
- It can initiate new measures in a few selected areas.

Several important measures are already under way.

Local overdose prevention strategies

The nine municipalities with most overdose fatalities in 2011 (latest data) have been invited to apply for grants for the period 2014 – 2017. The aim is for the municipalities to investigate local overdoses in order to develop

- local action plans
- clear assignment of responsibility for coordinating help measures
- clear assignment of responsibility when there is a risk of overdose fatalities and for follow-up after non-fatal overdoses
- clear rules for the exchange of information when there is a risk of overdoses

Encouraging inhalation instead of injection of heroin

In October 2012, the Directorate of Health held a consultation meeting to discuss whether encouraging the inhalation instead of injection of heroin by injecting drug users would be a good contribution to the work of reducing the number of overdoses in Norway.

Representatives of user organisations, low-threshold services and researchers took part in the meeting. Few objections were raised, and it emerged that low-threshold health services and some user organisations already encourage the smoking of heroin. On assignment for the Ministry of Health and Care Services, the Directorate of Health has prepared a memo listing arguments for and against heroin smoking, particularly in relation to the discussion about the possibility of permitting inhalation in injection rooms. The reason for this was, among other things, a heated debate in the media after the then Minister of Health had recommended expanding the injection room scheme to include the inhalation of heroin.

Distribution of naloxone nasal spray

At the Ministry of Health and Care Services' initiative, the National Directorate of Health submitted a memo in March 2013 recommending a trial scheme involving the distribution of nasal naloxone spray to heroin users, their next-of-kin and service providers. The Directorate of Health has tasked the Norwegian Centre for Addiction Research (SERAF) with developing and documenting such a project. Collaboration with a national naloxone project in Denmark has started. The project will run from 2013 until 2017.

Collaboration with the Patient Safety Campaign

Collaboration has been initiated with the Patient Safety Campaign with a view to, among other things, establishing a joint initiative targeting the correctional services.

The campaign is already working on developing measures to prevent overdose deaths following discharge from interdisciplinary specialist treatment.

Evaluation

The Ministry of Health and Care Services has given SIRUS the task of evaluating the National Overdose Strategy.

7.2 Low-threshold health services

Government grant schemes have resulted in more municipalities establishing low-threshold health services for drug and alcohol users. An overview from 2010 showed that 48 municipalities had established such services. The range of available services varies, but some of the cities offer very comprehensive services. The organisation, work methods and range of services vary from place to place, depending on the need and the available resources.

Many of the low-threshold services also distribute syringes. In a survey carried out by SIRUS, 24 municipalities stated that they had some form of needle exchange/distribution service. In 2012, more than three million syringes were distributed at 36 distribution sites, just over half in the City of Oslo. Sales through pharmacies come in addition to this. Although the number

of distributed syringes has probably declined somewhat in the last two or three years, Norway is still among the countries that distribute most syringes. This can be seen as positive from an infection-prevention perspective: However, good availability contributes to continuing the practice of injection at the expense of methods of use that carry a lower risk of overdoses.

Injection rooms

In 2009, the Storting decided to make the *provisional Act relating to drug injection rooms*¹⁰ permanent, which means that municipalities that wish to establish injection rooms have a legal basis for doing so. However, only Oslo has so far made use of the Act. Table 4 shows a strong increase in the number of registered users since the injection room opened as a trial scheme in 2005. The same applies to the number of injections per year. The increase is probably mostly related to the increased capacity. Very few overdoses have occurred in the injection room seen in relation to the high number of injections. This only applies to overdoses recorded while the users were on the injection room premises, however.

Table 4: The injection room in Oslo. Statistics 2005–2012

Year	2005	2006	2007	2008	2009	2010	2011	2012
Number								
of registered users	300	400	674	1,224	1,665	2,211	2,556	2,775
of users per year	277	297	486	923	-	1,484	1,539	1,557
of injections per year	8,318	8,101	11,654	19,480	25,940	28,368	29,204	33,791
of emergency calls (113)	35	36	70	122	155	164	155	196
% overdoses of all injections	0.4	0.4	0.6	0.6	0.6	0.6	0.5	0.58

Source: Agency for Welfare, Oslo

¹⁰ Proposition No 59 to the Odelsting (2008–2009) concerning the Act amending provisional Act No 64 of 2 July 2004 relating to a Trial Scheme of Drug Injection Rooms (the Act relating to injection rooms) etc.

8 Social correlates and social reintegration

See also Chapter 1.

8.1 Housing

A survey of homeless people conducted by the Norwegian Institute for Urban and Regional Research (NIBR) in 2008 (Dyb and Johannessen, 2009) found that there were around 6,100 persons with no fixed abode in Norway. This was an increase compared with 2005. The survey shows that people with drug or alcohol problems account for 59 per cent of homeless people, four of five of those who experience long-term homelessness (more than six months), 85 per cent of those who use emergency accommodation and 69 per cent of those who live in temporary housing arrangements. About 40 per cent suffer from mental illness. See also NR 2011 Chapter 8.1.1

Temporary housing

Another report from NIBR (Johannessen and Dyb, 2011) presents and discusses findings from a survey on the use and quality of 24-hour accommodation and other forms of temporary municipal housing in 2010. The data were collected through a survey sent to 107 municipalities and a survey of 145 temporary housing arrangements.

Temporary housing was operationalised in eight categories: hotels/boarding houses; night shelters etc.; campsites/caravans/cabins; family centres; women's shelters; temporary accommodation that the institutions are obliged to provide; 24-hour accommodation/hostels and other. Similar categories were used in the most recent nationwide survey of homeless people in 2008.

People with drug or alcohol dependency and persons with a dual diagnosis are the groups that most municipalities state that they have provided temporary housing for in 2010. Seventy-one per cent of the municipalities state that persons with drug or alcohol dependency have stayed in such housing arrangements, and 58 per cent state that persons with drug or alcohol dependency and known or visible mental illness (dual diagnosis) have stayed in temporary housing. About half the municipalities state that persons with known or visible mental illness have stayed in temporary housing.

'Hotels/boarding houses' are the type of temporary housing referred to by most municipalities, followed by 'other 24-hour accommodation (hostels etc.)', while just under half of the municipalities refer to 'campsites'. Four out of ten municipalities refer to women's shelters, two out of ten to night shelters.

The survey shows that it is more common for some groups to stay longer in temporary housing than others. This applies in particular to persons with drug or alcohol dependency and persons with a dual diagnosis. The most common length of stay for these two groups was more than three months in 29 and 27 per cent of the municipalities, respectively.

In autumn 2011, the Government-appointed housing committee submitted Norwegian Official Report NOU 2011:15 *Rom for alle* ('*Housing for all*' – in Norwegian only). The committee assessed the need for housing for disadvantaged groups, and how state and municipal efforts should be organised. Calculations from the housing committee estimate that there is a need for at least 2,500 more suitable houses or apartments for persons with drug or alcohol problems and/or mental health problems and illnesses (500 per year in a five-year period). The Government will present a white paper on housing policy in 2013. One of the topics covered by the white paper will be targeted efforts in relation to persons who are unable to obtain housing themselves and to continue living in it, including people with drug or alcohol dependency and/or mental illnesses.

The Norwegian Directorate of Labour and Welfare administers grants for social services and measures aimed at the disadvantaged. One of the grants, the grant for social housing work, aims to strengthen and develop the municipalities' ordinary services in order to address the need for follow-up in relation to housing.

Cooperation agreement

In autumn 2011, five ministries entered into a cooperation agreement with the Norwegian Association of Local and Regional Authorities on social housing work (the Ministry of Labour; the Ministry of Children, Equality and Social Inclusion; the Ministry of Health and Care Services; the Ministry of Justice and Public Security; and the Ministry of Local Government and Regional Development). The agreement runs until the end of 2013. It obliges the parties to facilitate interdisciplinary and coordinated social housing work, including providing assistance for people who have difficulties obtaining housing for themselves and coping with normal living arrangements. Among other things, the agreement emphasises the establishment of housing for patients who are discharged from institutions in mental health care and drug and alcohol treatment (Ministry of Health and Care Services, 2012).

8.2 Employment

There are no reliable data showing the unemployment rate for people with drug problems, but the number who have little or no income from employment must be deemed to be high. For example, eight out of ten OST patients were not employed either part-time or full-time or in education in 2011. Thirty-nine per cent had disability benefit or retirement pension as their

most important income, while only eight per cent had their most important income from employment (SERAF 2012).

Important measures in the Ministry of Labour's area of responsibility include a trial scheme involving a qualification programme for at-risk groups. The programme was introduced as a nationwide scheme from 1 January 2010. Almost 5,000 participants completed the programme on schedule during the period 2008–2010, 40 per cent of whom moved on to employment, education or other work-related measures. The number of drop-outs has increased somewhat during this period, but it is still considered to be low. Persons with drug or alcohol problems are among those who meet the conditions for participation in the programme. However, there are no figures that show the proportion of persons with drug or alcohol problems among the participants in the qualification programme. Funding of the programme has now been included in the municipalities' block grants.

Drug and alcohol problems is one of the focus areas in the *National Strategy Plan for Work and Mental Health*. Several professional development programmes have been initiated, including *Coping strategies leading to employment – drugs and alcohol and mental health problems* and guidance and follow-up guides. In connection with the national budget for 2012, the Government presented the document *Job Strategies for People with Disabilities*. Young people under the age of 30 with drug or alcohol problems can be included in the job strategy if their problems have led to permanent functional impairment.

Many people with drug or alcohol problems who have been convicted and who are serving or have served their sentences, need services from NAV, among others. The cooperation between the correctional service and NAV is laid down in a central cooperation agreement that forms the basis for agreements between the parties at the regional and local level. The purpose is to lay the foundation for further development of cooperation, and to contribute to binding and systematic collaboration.

The Government's return-to-society guarantee was introduced in Report No 37 (2007–2008) to the Storting: *Punishment that works – less crime – a safer society*. It means that everyone will be guaranteed follow-up upon release. Based on the return-to-society guarantee and the cooperation agreement, NAV will provide services to inmates. The NAV office in the municipality where the prison is located will provide these services by agreement with and in cooperation with the NAV office in the inmate's home municipality. For some inmates, it may be relevant to take part in work-related measures while serving a sentence in an institution, both in and outside prison. Some counties organise labour-market courses in prison in cooperation with the correctional service. To be able to participate in measures outside the institution, the inmate must have been granted day release, cf. the Execution of

Sentences Act. Whether an inmate is allowed to take part in such measures is decided on the basis of individual needs.

Drug and alcohol advisers can play an important part in the reintegration process (see NR 2009 Chapter 8.1.2). As part of the Action Plan 2007–2012, advisers were appointed in 30 selected municipalities, and many of them are employed at the local NAV office. The intention is that drug and alcohol advisers will provide comprehensive follow-up for individual clients. This entails assistance aimed at limiting drug and alcohol use, obtaining suitable housing, treatment, orderly finances, help to handle debts, help to start meaningful activity or keep an ordinary job. The advisers' comprehensive follow-up can include motivation, guidance, training in social skills, job-seeking assistance etc. The advisers refer clients to treatment and follow up clients in and outside measures. Some of them also carry out preventive work and information activities relating to drug and alcohol use. The drug and alcohol advisers also work in interdisciplinary teams.

9 Drug-related crime, prevention of drug-related crime and prison

9.1 Drug law offences

9.1.1 Legal basis and type of statistics

Norway does not have separate legislation relating to drugs. Two acts apply in connection with the reporting, charging and prosecution of drug crimes: the Medicinal Products Act and the General Civil Penal Code.¹¹ Statistics Norway is the Norwegian institution responsible for keeping statistics on drug-related crime in the judicial system. Four types of crime statistics are published annually (<http://www.ssb.no/kriminalitet/>):

- Offences reported to the police
- Offences investigated – clear-up rate – persons charged – recidivism figures
- Penal sanctions – persons convicted – previous criminal offences
- Imprisonments¹²

The statistics do not contain information about the types and quantities of narcotic substances involved in prosecutions, however.

Since 2010, statistics have been published about *charges brought against persons*, in addition to the two other main categories *criminal offences and persons charged*, which are already included in the statistics. The statistics for charges contain a complete overview of all criminal offences with which the persons in question were charged during the year.

¹¹ Minor drug offences that involve the use or possession of drugs are punished pursuant to the Act relating to Medicinal Products (Act No 132 of 4 December 1992) Section 24, which provides for a maximum sentence of up to two years' imprisonment. Other drug crimes are punishable pursuant to Section 162 of the General Civil Penal Code (Act No 10 of 22 May 1902 with subsequent amendments). The General Civil Penal Code Section 162 distinguishes between four degrees of gravity depending on the drug and amount involved and the nature of the offence in other respects. If a small quantity is involved, the offence is punishable by fines or imprisonment for up to two years. Aggravated drug crimes include the three other degrees of gravity. If a somewhat larger quantity is involved, the offence is punishable by imprisonment for up to ten years; if a substantial quantity is involved, the offence is punishable by imprisonment for between three and 15 years, and under particularly aggravating circumstances the punishment can be up to 21 years' imprisonment, which is the maximum punishment under Norwegian criminal law.

¹² There are three key categories in these statistics: Prison population/inmates; new imprisonments, e.g. by type of offence and type of imprisonment; discharges, e.g. by prison time.

The police and the prosecuting authorities must have made a legally binding decision concerning a specific perpetrator (before any indictment and before a case comes to court), in order for Statistics Norway to define a charge and a person charged. A person suspected of having committed a crime may be given legal status as ‘charged’ at different times during an investigation. Persons who have been charged during an investigation but who did not have the status of perpetrator when the investigation was concluded are not included in the statistics.

Since 2010, tables have also been published showing *all persons charged in each crime category*. Normally, the persons charged and pertaining information about them are broken down by *their primary offence* – i.e. the offence that, pursuant to the law, can lead to the most severe penalty. The new statistics show everyone charged with one or more offences, and not just those with a primary offence, in each of the crime categories. If a person is charged with more than one offence in a crime category, the person is classified on the basis of the primary offence in the individual crime category

9.1.2 Statistics

Reported crimes

According to Statistics Norway, a total of 45,900 drug crimes were reported in 2012. This is 3,100 more than in 2011, and the highest number recorded since 2001.

More drug crimes were committed in 2012 than the year before, including violations of both the General Civil Penal Code and the Act relating to Medicinal Products. In total, around 21,600 drug crimes pursuant to Section 162 of the General Civil Penal Code, including aggravated drug crimes, were reported. The number of drug crimes pursuant to the General Civil Penal Code was almost on a par with 2010, the peak year in terms of reported drug crimes. The almost 23,500 violations of the provision of the Act relating to Medicinal Products concerning use and possession was the highest number since the early 2000s.

The increase was greatest by far in Oslo. In addition to having the highest number, the county of Oslo also has the highest proportion of reported drug offences in relation to the population. Whether offences are solved and what penal sanctions are imposed vary greatly between different crime categories and types of offences. Drug crimes have the highest clear-up rate of all the crime categories, at 88 per cent, while crimes against property and vandalism have the lowest clear-up rates, at 22 and 19 per cent, respectively.

Charges

More and more people arrested for drug offences

In 2011, 13,185 persons (men: 83%, women: 17%) were charged with a drug crime as their primary offence, a considerably higher figure than in all previous years. That is 8 per cent more than in 2010 and 23 per cent more than in 2009. The increase and the record-high figures concern violations of both the General Civil Penal Code and the Act relating to Medicinal Products. The increase in the number of people charged with less serious violations of the Act relating to Medicinal Products as their primary offence was greatest from 2009 to 2011 (as much as 38 per cent).

Table 5: Persons charged with a drug crime as their primary offence 2002–2011

Year	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Men	8,012	7,915	8,093	8,049	8,357	8,657	8,560	8,777	10,102	10,938
Women	1,930	1,904	1,825	1,853	2,053	2,200	1,996	1,954	2,098	2,247
Total	9,942	9,819	9,921	9,902	10,410	10,857	10,556	10,731	12,200	13,185

Source: Statistics Norway

A total of 18,400 people were charged with one or more drug offences in 2011, and they were charged with a total of 39,100 drug offences. This means that drug crime accounts for almost 22 per cent of all charges for violations of the law and roughly 41 per cent of all criminal charges. Those charged with drug crimes account for nearly half of all people charged with crimes, and as many as 62 per cent in the 25–29 age group.

Of those charged with a drug offence as their primary offence in 2011, nearly 81 per cent were Norwegian nationals, which is about the same proportion as in the two preceding years. Norwegian nationals contributed most to the increase, with nearly 700 more offences in 2011 than in 2010, but there were also 300 more non-Norwegians among those charged with a drug crime as their primary offence.

Recidivism – highest among young men

The statistics for recidivism among people resident in Norway show that 46.5 per cent of the 79,500 persons charged in 2006 were charged one or more times in the course of the next five years. This proportion has steadily decreased in the last four recidivism surveys and was 49.6 per cent for those charged in 2002.

Broken down by crime category, the highest recidivism rate – 66 per cent – is found among those charged with drug crime as their primary offence. The corresponding proportion among those charged with violence was nearly 57 per cent, and 55 per cent among those charged

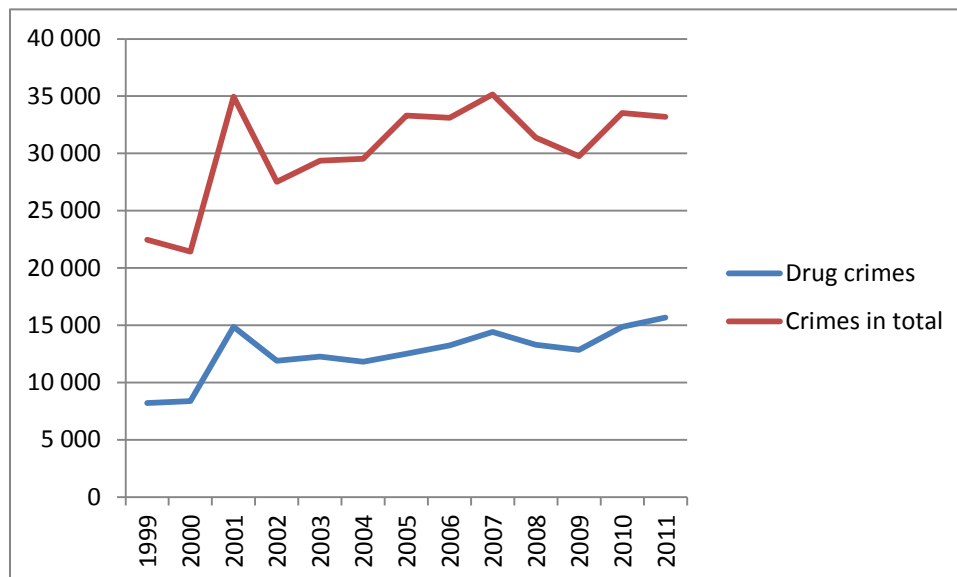
with crimes against property. Of all persons charged in 2006 with sexual crime as their primary offence, 37 per cent were charged for another offence during the period from 2007 to 2011.

Penal sanctions

The number of penal sanctions where drug crime was the primary offence was 15,700 in 2011. This is just over 5 per cent more than in 2010 and as much as 22 per cent more than in 2009. Never before have so many penal sanctions been recorded with drug crime as the primary offence: in 2011, they accounted for more than 47 per cent of all penal sanctions in criminal cases (Figure 11). Seen in relation to the increase in population, however, the number of penal sanctions for drug crimes is still lower than in the peak year of 2001.

In 2011, the number of penal sanctions where aggravated drug crime pursuant to Section 162 second and third paragraphs was the primary offence was 816. This is the highest number ever recorded. However, less serious violations of the Act relating to Medicinal Products, such as use and possession of small amounts of drugs, contributed more to the increase in the total number of penal sanctions for drug offences from 2010 to 2011.

Figure 11: Number of penal sanctions where drug crime was the primary offence 1999–2011



Source: Statistics Norway

The prosecuting authority decided more criminal cases than the courts. Around 10,900 cases where drug crime was the primary offence were settled by a fine without the case going to court. Of these cases, 6,400 violations of the Act relating to Medicinal Products were settled by a fine and registration in the criminal records.

Drug crime as the primary offence was the reason for nearly 2,000 of the unconditional prison sentences (both unconditional and partly unconditional/partly suspended). Of the offenders (cases, not persons), 205 were sentenced to imprisonment for use as the primary offence. This represents more than a twofold increase from 2009. However, these are often complex cases, where other, less serious offences are taken into consideration in the overall sentencing.

Table 6: Unconditional prison sentence* as sanction for use and possession as the primary offence 2005–2011

Year	2005	2006	2007	2008	2009	2010	2011
Drug use	142	122	156	167	94	187	205
Drug possession	37	39	20	32	25	46	47
Total	179	161	176	199	119	233	252

*Both unconditional and partly unconditional/partly suspended
Source: Statistics Norway

The majority of registered offenders in the less serious drug offences are Norwegian nationals, while foreign nationals are behind most of the aggravated drug offences. As of 10 October 2012, 1,394 offences (suspected, charged or convicted) were related to Section 162 second and third paragraphs of the General Civil Penal Code. Of these, 79 were related to Section 162 third paragraph, which concerns the most serious drug crimes. The offenders were Norwegian nationals in 942 of these cases, 28 of which were related to Section 162 third paragraph. Foreign nationals were responsible for 452 offences, 51 of which were related to Section 162 third paragraph (Kripes, 2013).

9.2 Interventions in the criminal justice system

As of 1 January 2011, there were a total of 3,866 inmates in Norwegian prisons, including those who served their sentence at home with [electronic monitoring](#) and those remanded in custody. Of all inmates at the start of the year, 30 per cent were serving sentences for drug offences, 22 per cent for crimes against property and 21 per cent for violent crimes as their primary offence. Of the 884 persons held on remand at the start of 2011, 37 per cent had drug crime as their primary offence.

9.2.1 Alternatives to prison

Serving of sentences outside institutions pursuant to the Execution of Sentences Act Section 12¹³

In 2012, 452 persons (2011: 526) were serving sentences under this system, 12 per cent of them women (Table 7). A total of 273 persons started serving their sentence in prison and were later transferred to an institution. The other 179 started serving their sentence in a treatment institution. It must be assumed that the majority had a drug problem at the time of imprisonment.

In 2012, 41,529 days were served in an institution pursuant to Section 12, which is a substantial decrease in relation to 2011, but on a par with the years before (Table 8).

Table 7: Number of sentences started pursuant to Section 12, 2004–2012

Year	2004	2005	2006	2007	2008	2009	2010	2011	2012
Men	297	379	388	396	431	457	443	466	396
Women	32	59	51	61	74	84	68	60	56
Total	329	438	439	457	505	541	511	526	452

Source: The central administration of the Norwegian Correctional Service

Table 8: Number of days served pursuant to Section 12, 2004–2011

Year	2004	2005	2006	2007	2008	2009	2010	2011	2012
Men	26,302	34,474	37,137	37,835	40,150	35,651	35,981	41,343	37,013
Women	2,235	3,786	4,347	4,224	4,841	5,963	4,796	4,344	4,516
Total	28,537	38,260	41,484	42,059	44,991	41,614	40,777	45,687	41,529

Source: The central administration of the Norwegian Correctional Service

¹³ Section 12 states that ‘A sentence may in special cases be wholly or partly executed by 24-hour detention in an institution if such detention is necessary for improving the convicted person’s capacity to function socially and law-abidingly, or there are other weighty reasons for doing so. The convicted person may be restrained against his or her will and brought back in case of escape, if necessary by force and with the aid of public authorities. The Correctional Services shall not decide on such execution if it is opposed to security reasons or there is reason to assume that the convicted person will evade the execution.’

Suspended sentence with a programme for driving under the influence

This sanction replaces the previous alcohol treatment programme. During the course of 2012, a total of 523 (2011: 573) suspended sentences were imposed on condition that the offender completed a programme for driving under the influence. A total of 85 per cent of the sentences were completed, and 81 per cent (2011: 77%) were completed without the conditions being breached or new crimes being committed. The statistics do not specify the types of drugs involved, however.

Suspended sentence with drug courts

Drug courts are an alternative to prison for people with drug and/or alcohol dependency who have been convicted of drug-related crimes. The participants regularly attend a day centre where rehabilitation services are provided by an interdisciplinary service team. The programme was originally a three-year trial project started in 2006 in Oslo and Hordaland counties. The project has been prolonged until the end of 2014 and will be evaluated by SIRUS. In 2012, 29 new sentences were implemented, 15 in Oslo and 14 in Hordaland.

Community sentences

Community sentences are often imposed for less serious offences. Community sentences were imposed in 552 cases involving drug crimes in 2011 (2010: 534). It is worth noting that 430 of the sentences concerned drug crimes pursuant to Section 162 of the General Civil Penal Code, and as many as 100 concerned aggravated drug crimes pursuant to Section 162 second and third paragraphs.

Serving of sentences with electronic monitoring

The serving of sentences with electronic monitoring was passed into law by the Act of 29 June 2007 No 83 relating to amendments to the Execution of Sentences Act. It entered into force on 1 August 2008. The Act means that convicted persons who are to serve unconditional prison sentences of up to four months, or who have four months left until being released on probation, can apply to serve their sentence with electronic monitoring. The convicted person must be resident in one of the six trial counties during the actual serving of the sentence and must live in suitable accommodation with the possibility of a telephone connection (see more in NR 2012, Chapter 9.2.1). In 2012, permission was granted for 887 new prison sentences to be served with electronic monitoring (2011: 920). So far, the vast majority are people convicted of traffic offences. No new data are available for the number convicted of a drug offence, but in 2010, drug crime as the primary offence accounted for nine per cent, or 76 cases, of new imprisonments of this kind.

9.2.2 Units for mastering drug and alcohol problems

A unit for mastering drug and alcohol problems is a reinforced unit in a prison. It functions as a separate unit that is specially adapted for inmates with drug or alcohol problems. The units are tasked with ensuring good cooperation between the correctional service, the specialist health service and the health and care services in prison. Steps also have to be taken to facilitate coordination between the correctional service, the specialist health service and the municipal services when inmates return to society.

The specialist health service shall ensure that inmates' patient rights are safeguarded through continued treatment in an institution or an outpatient clinic upon their release. The unit for mastering drug and alcohol problems shall motivate and prepare people with drug or alcohol problems for continued treatment after their release from prison. The rehabilitation can continue either by the inmate being transferred to serve his/her sentence pursuant to Section 12 in a treatment or care institution, or by the inmate receiving treatment at an outpatient drug or alcohol clinic upon his/her release. Fourteen Norwegian prisons now have such units. The most recent one was opened in spring 2012. Experience from the establishment of the units indicates that they need both a clearer framework and better professional follow-up. The then Ministry of Justice and the Ministry of Health and Care Services therefore started work in 2011 on a joint circular that clarifies the framework conditions and contains references to central regulatory provisions. In parallel, the correctional service's central administration and the Directorate of Health have appointed a select committee that will produce a professional guide for the units for mastering drug and alcohol problems. The work will be concluded in 2012. In order to monitor developments more closely, key figures are reported by the units on a monthly basis. The correctional service's education centre has started the work of evaluating the units.

In addition to units for mastering drug and alcohol problems, there is a Pathfinder unit for female inmates at Bredtveit prison (six places) in Oslo and one for men (20 places) in Oslo prison. The Pathfinder units offer rehabilitation and treatment for problem drug and alcohol users. They are a collaboration between the health authorities, the Tyrili foundation and the correctional service.

9.3 Driving offences

In 2012, drug analysis was carried out by the Norwegian Institute of Public Health (NIPH) in 9,717 cases where drivers were suspected of driving while intoxicated. Of these, about 1,073 breath tests were taken by the police locally, about 3,504 blood samples were analysed by the NIPH for alcohol only, while about 5,140 blood samples were analysed for alcohol, intoxicating drugs and narcotic substances. The NIPH routinely looks for over 40 different intoxicating drugs and narcotic substances, and detects an average of three drugs in the same

blood sample. For several of the substances, the detection limit has been lowered since legal limits for driving under the influence of substances other than alcohol were introduced on 1 February 2012. See NR 2012 Appendix 1.

In 2012, clonazepam was for the first time the second most commonly found substance (38% of all cases) after alcohol (59%). This is a marked increase compared with the previous year (24%), and it may be partly explained by the lowering of the detection limit. This means that clonazepam is now found in some cases where the substance would not previously have been detected. The NIPH most often finds clonazepam in combination with illegal substances (methamphetamine/amphetamine etc.), which indicates that the substance is increasingly being sold and used as a drug. Other substances that were frequently found were THC (35%) and methamphetamine (31%), followed by amphetamine (29%) and diazepam (22% of all cases). The analysis findings do not necessarily indicate whether or not the substance was unlawfully obtained.

Some of the methamphetamine that is taken is converted into amphetamine in the body. Many of the blood samples that contain methamphetamine will therefore also contain amphetamine, even though the person in question has not actually used both drugs. The number of cases where amphetamine was found will therefore include both amphetamine used alone and amphetamine as a bi-product of methamphetamine. It is therefore misleading to simply add up the figures for amphetamine and methamphetamine.

The fact that THC is found in a blood sample means that cannabis has been taken (usually smoked) shortly before the sample was taken, usually during the last few hours before driving (Norwegian Institute of Public Health).

Table 9: Some findings of substances other than alcohol in blood samples from drivers suspected of driving under the influence in 2012. The number of blood samples for which a broad analysis was carried out

Name of substance	Example of name of medicine Explanation	Number	Per cent
Clonazepam	Rivotril®	1,935	38%
THC	Active agent in cannabis	1,821	35%
Methamphetamine		1,574	31%
Amphetamine		1,208	26%
Diazepam	Valium® Vival® Stesolid®	1,116	22%
Morphine	Heroin, Dolcontin®	217	4%
Methadone	Methadone®	180	4%
GHB		186	4%
Buprenorphine	Subutex®, Temgesic®, Subuxone®	151	3%

Source: the Norwegian Institute of Public Health

10 Drug markets

10.1 Availability

Several factors must be emphasised when describing changes in availability. Seizures of illegal substances by the police and customs authorities are an important parameter in this context. However, the number of actual seizures and the quantities involved are affected by the internal priorities of and resources available to the police and customs authorities, and by surveillance methods and international cooperation. Big seizures in particular can be the result of surveillance and investigations carried out over time. The statistics can therefore show significant fluctuations from one year to the next, without this necessarily meaning that corresponding changes have occurred in terms of actual availability. The number of seizures must be deemed to be a better indicator of availability than the amount seized.

Measured by seizures, the most common illegal substances are geographically widespread. In 2012, all the 27 police districts made seizures of cannabis, BZD and amphetamines, whereas cocaine was seized in 25 districts and heroin in 23, quite similar to the situation in 2011. It must be emphasised, however, that the quantities vary greatly between the different police districts. For cocaine and heroin, the seizures are often small. For example, the amount of heroin seized was around ten grams or less in nine of the police districts, and in three of these, the total seizure amounted to as little as a user dose. The biggest markets are still the Oslo area and its surrounding regions, and in the counties of Hordaland and Rogaland, including the cities of Bergen and Stavanger. Moreover, the customs authorities in Østfold county make many large seizures, which can largely be explained by its proximity to the most important border crossings to Sweden, where large parts of the drug trafficking to Norway take place by road and by train from Denmark and the continent.

10.1.1 The relationship between amphetamine and methamphetamine

The seizure figures for the last few years are a clear indication that methamphetamine has partly taken over the market for amphetamines. Norway and Sweden seem to be among the European countries with the biggest market for methamphetamine, and Norway has topped the EMCDDA's statistics for the number of seizures for several years running. Moreover, analyses of wastewater in Oslo carried out by the Norwegian Institute for Water Research (NIVA) show a high incidence of methamphetamine, higher than in most other cities that were part of the survey (Thomas et al., 2012). Next to THC (cannabis), methamphetamine is the illegal substance that was most often found in traffic cases in 2012 (Chapter 9.3.).

We know little about the prevalence measured on the basis of other parameters, however. Prevalence surveys among young people/young adults and the general population do not ask about methamphetamine in particular. This is because it is assumed that the respondents are unable to distinguish between the two amphetamines to any great extent. In 2012, as in previous years, the purity of analysed seizures varied considerably. The effect of strong amphetamine can therefore feel like methamphetamine, and vice versa. There are still very few, if any, indications that methamphetamine is in particular demand in a market in which amphetamine and methamphetamine are sold interchangeably and where users do not know what they get. The seizure figures can be interpreted to mean that methamphetamine mostly comes in addition to all the amphetamine that is smuggled in every year, and not so much as a replacement.

10.2 Supply

10.2.1 Smuggling routes to Norway

Updated information from Norwegian Customs and Excise as of the first half-year 2013 shows a marked increase in seizures of *amphetamine/methamphetamine*¹⁴ in the first half-year 2013 compared with the corresponding period in 2012, and that the substances are smuggled to Norway from several European countries. *Amphetamine* is manufactured in the Netherlands, Belgium and Poland and in the Baltic states. It is assumed that *methamphetamine* seized in Norway is manufactured in the Baltics. A new trend that emerged in the first half-year is that the customs service has made seizures of amphetamine sent in the post from the Netherlands, Germany and China.

Morocco remains the most important producer of *hash* seized in Norway. The customs service seized considerably less hash in the first half-year 2013 than in the corresponding period in 2012. Only one major seizure was made in goods traffic from the Netherlands. The trend of smuggling small amounts of hash by plane and passenger car from Sweden, Denmark and the Netherlands continued in 2013.

The customs service recorded an increase in both the number of seizures and the amount of *marijuana* seized. In addition to the Netherlands, countries in Eastern and Southern Europe such as Latvia, Poland, Romania and Greece have been identified as countries from which marijuana seized in Norway has been sent. The Netherlands has traditionally been a major producer of marijuana, but large plantations have also been uncovered in the Czech Republic.

¹⁴ Seizures made by the customs service are included in the overall national statistics prepared by Kripes. See Chapter 10.3.

More and more marijuana is being produced in Albania, and marijuana found by the customs service in shipments from Romania and Greece may have been produced in Albania.

The customs service still finds *GBL and GHB* in postal consignments from Poland, Thailand and China, and there is a slight increase in the number of seizures and the amount seized compared with previous years. The biggest seizures are still made from passenger cars crossing the border from Sweden.

It is assumed that *heroin* smuggled to and sold in Norway is still manufactured in Afghanistan. The smuggling routes along the Balkans and the Silk Road further north through Iran and the Caucasus are still the most commonly used routes for smuggling heroin to Europe. The customs service seized considerably more heroin in the first half-year 2013 than in the preceding years. More seizures have been made of heroin smuggled inside the bodies of car passengers from Poland. They are assumed to form part of a Nigerian network that engages in organised crime in the Nordic countries. Germany, Denmark and Kosovo were also among countries from which heroin seized in Norway was sent.

Khat is traditionally grown in East Africa and shipped to Europe by plane. Since the Netherlands made the substance illegal in January 2013, the UK is the only country where importing khat is legal. This makes the UK the most important country from which khat is sent to Norway. Despite the prohibition in the Netherlands, the number of seizures and amount of khat seized have increased – the amount has nearly doubled. Large consignments of khat are still smuggled by car from the Netherlands to Norway. Khat is also reloaded in the south of Sweden and in Denmark before being transported to Norway.

The customs service has never seized as little *cocaine* as in the first half-year 2013. There have been no changes in production and smuggling routes from producing countries to Europe that can explain this decline. The seizures made have often been found in postal consignments from the European continent (the Netherlands, Spain, Belgium and Germany). There was one serious case in which cocaine was smuggled inside the body of an air passenger from the Netherlands.

The customs service still uncovers large quantities of *tranquillisers*. The trend of smuggling Rivotril from Hungary, directly or via Sweden and Denmark, continued in 2013. Large amounts of diazepam are seized, especially from Thailand. Most of it is smuggled by post and by courier, while one large seizure was made in a maritime container shipment in the first half-year.

The customs service seizes *ecstasy* in the form of tablets. In the first half-year, the biggest seizures were made in postal consignments, primary from Germany and the Netherlands. The production of ecstasy in Europe seems to have increased again, following a period when the

precursor PMK used in the production of the active agent MDMA has been scarce. An increasing number of seizures by the custom service of MDMA in powder form confirms that its availability has been restored. The seizures have primarily been made in postal consignments from the Netherlands, but also from Germany, Belgium and Spain.

New psychoactive synthetic substances are a priority area for customs officers. However, a decline was recorded in the number of seizures of synthetic cannabinoids in the first half-year 2013 compared with the first half-year 2012. The amendments to the Regulations relating to narcotics of February 2013, whereby generic control of seven groups was introduced, may have contributed to the decline. The seizures made by the customs service were mainly found in postal consignments from the UK and the Netherlands, as well as from China and the USA. On the other hand, the number of seizures and quantity of psychoactive substances seized have increased dramatically, mainly in shipments by post and courier from the Netherlands, China and Spain. The fact that the Regulations relating to Narcotics were amended to include control of groups of substances/compounds has probably led to an increase, since the customs service can now register these substances as drugs, and not as medicinal products/pharmaceutical substances as before (Personal communication, Directorate of Customs and Excise Enforcement Department, Anti Smuggling Section).

10.2.2 Criminal networks

The report *Den organiserte kriminaliteten i Norge – trender og utfordringer 2013–2014* ('Organised crime in Norway – trends and challenges 2013–2014') (Kripos, 2013) describes different international groups that, in the police's opinion, are behind a large part of the importation and distribution of drugs in Norway.

Baltic and Polish networks

Lithuanian groups seem to be the main suppliers of methamphetamine to Norway, while they are also associated with other drugs. Extensive sales of amphetamine and/or methamphetamine by Lithuanian and Polish nationals is reported by many police districts. People from Lithuania and Poland who have permanent residence and legitimate work in Norway are deemed to be important points of contact for Lithuanian and Polish criminal networks.

Networks from the Balkans

The Balkans are known as a hub for the smuggling of different types of drugs to and from the EU, especially heroin, but increasingly also other types of drugs. Europol reports that Albanian-speaking groups collaborate with Lithuanian groups on heroin smuggling from

Central Asia to Western Europa. Several police districts report activities relating to the import and distribution of hash, marijuana, amphetamine, cocaine and heroin that can be linked to networks from the Balkans. Criminal networks from the West Balkans and Turkey could become more active in other European countries as a result of Bulgaria and Romania's accession to the Schengen Area.

Moroccan networks

Moroccan networks have a central role in the importation of hash to Norway. They have proved adept at collaborating with different criminal gangs in Norway.

Vietnamese networks

The Vietnamese community in Europe is involved in extensive marijuana cultivation in several European countries, and indoor plantations are traditionally organised in a hierarchic structure. Several Norwegians nationals of Vietnamese origin have been known to cultivate marijuana in Norway. Close ties have also been found between the Vietnamese communities in Norway and the Czech Republic. People of Vietnamese origin who cultivate marijuana usually run several small plantations.

Somali networks

Use of the stimulant khat is part of the Somali culture. The use of khat in the Nordic countries and North-western Europe is most widespread in areas in which large Somali communities have settled. Khat is usually smuggled to Norway by Somali couriers by land, while couriers who arrive by plane are often European nationals. The Somali community is also associated with the sale of relatively large quantities of heroin to the open drug scene in Oslo.

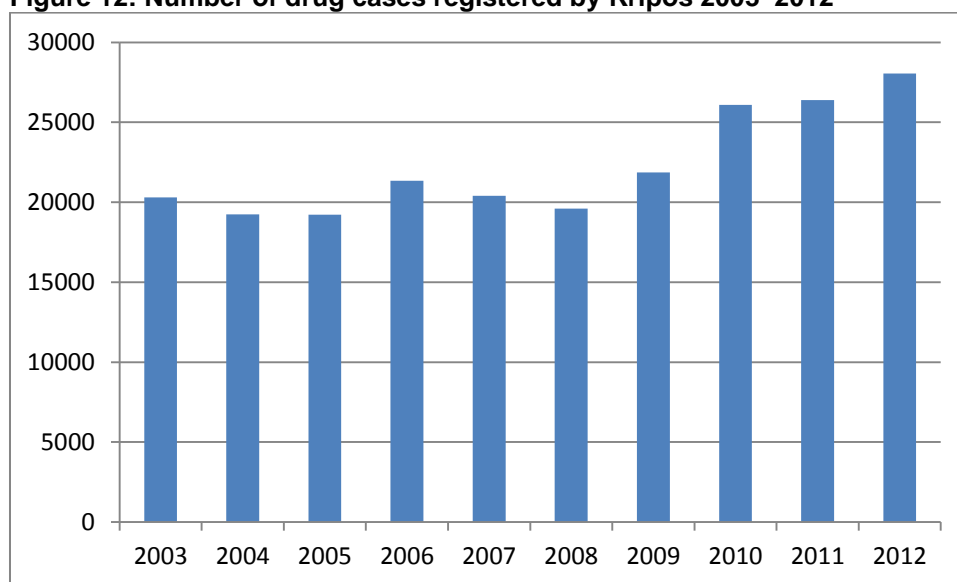
West African networks

Criminal groups from West Africa, especially Nigeria, have been associated for many years with the smuggling of cocaine and heroin in particular. Statistics showed a ten-fold increase from 2000 to 2009 in the number of drug offences for which people of West African descent were either suspected, charged or convicted. The number of cases doubled from 2008 to 2010 (Kripas, 2013).

10.3 Seizure statistics

Drug statistics from the National Crime Investigation Service (Kripos) are national statistics of seizures made by both the customs service and the police. The number of drug cases¹⁵ has increased by 6 per cent from 2011 and has now reached an all-time high (Figure 12). There were 28,048 cases in 2012, compared with 26,391 in 2011. The fact that the number of cases has increasing may be due to increased importation and availability, but it is probably also a result of the police and customs service's activities and priorities during the year in question.

Figure 12: Number of drug cases registered by Kripos 2003–2012



Source: Kripos

Main trends

- Although the number of drug cases increased for the fourth year in a row, the seizures do not represent record-high quantities, except in the case of benzodiazepines.
- Even though traditional drugs dominate the drug market, new synthetic substances are seized all the time. In 2012, Kripos identified 30 new substances that had previously not been seized in Norway. Synthetic cannabinoids dominate among the new synthetic

¹⁵ By case is meant an assignment logged by Kripos. The number of cases is irrespective of the use of the terms use, possession, sale and import in the prosecution. This means that an offence is only registered as one case by Kripos.

substances seized in the past two or three years. Of these, AM-2201 is currently the one most frequently seized. There is also an increase in hallucinogenic phenethylamines. Some variants with a particularly powerful effect are distributed as pieces of paper with an appearance similar to LSD.

- Several different substances are more and more often seized in the same case. It appears that the users increasingly use several different substances and, in part, also consider some substances as substitutes for each other. Together with the frequent seizures of new synthetic substances, this indicates increased multiple drug use and experimentation.
- Seizures of cannabis are increasing in step with general developments in seizures and account for just over one-third of the total number of drug seizures in Norway. While the number of seizures of hash is relatively stable, there is a marked increase in seizures of marijuana and cannabis plants. In the early 2000s, hash accounted for approximately 90 per cent of cannabis seizures, but it now accounts for 70 per cent, while marijuana and cannabis plants account for as much as 30 per cent. This development may be due to extensive and increasing production of cannabis in Norway.
- More and more benzodiazepines are seized, especially tablets containing clonazepam and diazepam. As many as 60 per cent more tablets were seized in 2012 than in the year before. This is the largest quantity ever seized in a year, even though more seizures were made in 2002. The illegal importation of diverted legal medicinal drugs accounts for a substantial proportion of the seizures.
- The number of seizures of amphetamine/methamphetamine is still high. Although slightly fewer seizures were made in 2012 than in 20xx, a larger quantity of amphetamine/methamphetamine was seized than in the two preceding years. Fewer seizures were made in 2012 than 2011 of PMMA, which is sold on the amphetamine market and has caused a number of deaths. Whether this is a trend that will continue is too early to say, however.
- Fewer seizures were also made of heroin than in the preceding years. Some large seizures resulted in higher quantities, however.
- Both the number of seizures and the amount of cocaine seized increased somewhat in 2012 compared with 2011. If we look at the development in cocaine seizures over a five-year period, however, the number of seizures and the quantities seized have remained stable.
- There are still great variations in the purity of amphetamine/methamphetamine, heroin and cocaine, from very weak (< 1%) to completely pure qualities. There is also great variation in typical street seizures. Mixtures with other drugs are frequent.
- In the last few years, traditional ecstasy with MDMA as the active agent has been scarce in Norway, as in other countries. This is due to the fact that the trade in

chemicals used in the traditional manufacturing method has been regulated through international agreements. New manufacturing methods using other chemicals have been established, however, and an increasing number of seizures is being reported all over Europe. Tablets containing MDMA, often of high purity, are becoming increasingly common in Norway as well. At the same time, substitutes containing other active agents, such as piperazines, have decreased further and appear to be disappearing from the market.

- GHB and GBL still account for a small proportion of overall drug seizures, but the number of seizures is steadily increasing.
- Seizures of active agents, ampoules and other items that can be linked to illegal domestic manufacturing of doping substances were made in 2012 as well.

Development in seizures for individual substance groups

The development in the number of seizures¹⁶ and quantities seized for individual substance groups is shown in the tables below. The data are based on information available as of September 2013, but uncertainty is still attached to some of the figures, since not all analyses have been completed for the 2012 drug cases. In general, however, little change is expected in the quantities and number of cases when the seizures are verified by chemical analyses, and the effects on the main trends are expected to be negligible. About 60 per cent of the drug cases are minor cases that are settled by a fine without the type of substance being verified by analysis. In these cases, the assumed drug type forms the basis for the statistics. In today's drug market, with many new psychoactive synthetic substances, however, the sources of error in connection with this information will be greater than before.

¹⁶ Seizure: A case can often involve several seizures. It may involve different types of substances, or the seizures have been made in different places and at different times. Individual packages containing the same type of drug are regarded as one seizure if the seizures were made at the same time and place, however.

Table 10: Amounts seized for the most relevant drugs 2006–2012*

Year	2006	2007	2008	2009	2010	2011	2012
Cannabis (kg)	1,544	853	1,732	2,588	1,182	2,981	2,052
Amph./methamphetamine (kg)	386	559	362	431	288.9	237.9	316.8
Other stimulants (units)	1,603	1,979	2,796	3,469	19,089 + 24 kg	9,302 + 7.7 kg	-
Heroin (kg)	93.0	8.0	55.2	130.1	102	14.6	45.2
Other opioids (tablets)	15,685	11,906	11,193	15,186	19,724	13,519	10,903
BZB (units)	1,019,710	730,443	310,435	671,232	903,692	803,653	1,320,257
Cocaine (kg)	40.5	95.0	76.8	61.1	94	48.1	66.8
Ecstasy (units)	28,636	78,725	30,678	22,700	3,969	5,495	6,579
Psilocybe mushrooms (kg)	0.84	1.36	0.5	1.66	2.0	2.6	2.67
LSD (units)	226	26	245	510	173	885	1,388
GHB/GBL (ltr)	45.5	100.9	257.3	213.4	490	524	376
Synthetic cannabinoids (kg)					0.003	10.4	5.9

* The data for 2010–2011 have been corrected as of September 2013 for several drugs after final analyses have been carried out.

Source: Kripos

Table 11: Large drug seizures pursuant to Section 162 third paragraph of the General Civil Penal Code in 2008–2011

Drug type	Number 2008	Number 2009	Number 2010	Number 2011
Amphetamine/methamphetamine (threshold: seizures > 3 kg)	14	21	12	10
Cocaine (threshold: seizures > 3 kg)	4	4	3	4
Ecstasy (threshold: seizures > 15,000 tablets)	0	1	0	0
Cannabis (threshold: seizures > 80 kg)	3	6	2	7
Heroin (threshold: seizures > 0.75 kg)	16	32	29	4
Benzodiazepines	1	0	0	0
Total	38	64	46	25

Source: Kripos

Table 12: Number of seizures in the period 2006–2012 broken down by type of drug*

Drug type	2006	2007	2008	2009	2010	2011	2012
Cannabis	11,221	9,952	10,599	11,754	14,372	15,141	15,751
Amph./methamph.	5,819	5,507	5,153	5,775	7,714	7,221	6,801
Heroin	1,087	1,204	1,145	1,430	1,575	1,314	1,277
Benzodiazepines	4,500	4,058	3,451	3,796	5,089	5,185	5,629
Painkillers/ opioids	1,161	959	936	1,078	1,223	1,240	1,277
Cocaine	726	909	854	804	877	815	860
Ecstasy	411	421	309	110	79	200	274
LSD	28	13	15	26	30	31	83
GHB/GBL	122	188	173	321	432	500	583
Psilocybe mushrooms	82	77	54	75	114	104	144
Synthetic cannabinoids					9	186	262

* The data for 2010–2011 have been corrected as of September 2013 for several drugs after final analyses have been carried out.

Source: Kripos

Comments on individual drugs

Cannabis: The amount of cannabis seized in 2012, 2,052 kg, breaks down as follows: approximately 1,605 kg of hash (78%), 314 kg of marijuana (15%) and 133 kg (6%) of cannabis plants. The breakdown differs from 2011 in that the proportion of hash is lower while the proportion of marijuana has doubled. The amount of plants is less than half compared with 2008, when the police uncovered particularly many ‘cannabis plantations’. The number of seizures of cannabis plants remains relatively high, however (2012: 364, 2011: 381, 2010: 378). It is reasonable to believe that small-scale cultivation activity accounts for a substantial proportion, and thus to assume that domestic production is a significant cause of the spread of marijuana.

Amphetamine and methamphetamine: The number of seizures of amphetamine in 2012, 2,529, was lower than in 2011, and much lower compared with 2010, while the number of seizures of methamphetamine, 4,272, was on a par with 2010–2011.

The proportion of methamphetamine compared with amphetamine culminated in 2009, but it was nevertheless estimated to be as high as around 62 per cent in 2012 (Table 13).

Table 13: Proportion of seizures of methamphetamine in relation to amphetamine

Year	2006	2007	2008	2009	2010	2011	2012
% Methamph.	26%	35.3%	43.5%	64.3%	56%	60%	62.4%

Source: Kripas

Heroin: The quantity seized in 2012, 45 kg, is not particularly large compared with the peak years 2004 (129 kg) and 2009 (130 kg). The number of seizures, which is a better parameter of prevalence, has been far more stable. Oslo Police District made more than half of all the seizures of heroin in 2012.

Painkillers, medicinal drugs classified as narcotics (opioids): No major seizures of these medicinal drugs were made in 2012. Several of the cases concerned illegal importation via internet shopping, but the number of tablets in each seizure is relatively small. It is once again buprenorphine (Subutex) and codeine (e.g. Paralgin forte) that dominate the statistics. Methadone and buprenorphine have increased their share of seizures from approximately 52 per cent to 67 per cent in three years.

Ecstasy is traditionally defined as containing the substances MDA, MDMA, MDEA and MBDB. Of these, MDMA has almost completely dominated seizures for more than 20 years. Until 2008, no other substance accounted for a substantial part of this tablet market. Then, however, MDMA was largely replaced by other drugs, mainly mCPP (1,3-chorphenylpiperazine), a drug that was included on the list of narcotic substances in 2010. There has been a sharp decline in both the quantity and the number of seizures of ‘ecstasy tablets’ in recent years, but data for 2012 show that MDMA is once again on the increase in Norway.

GHB and GBL: Although the number of seizures of GHB and GBL does not account for more than approximately 1.5 per cent of the total, there has been a considerable increase in both the quantities seized and the number of seizures. However, we cannot exclude the possibility that the chances of GHB/GBL being detected is lower than for other drugs, since the appearance and effect of GHB/GBL and alcoholic beverages are very similar. This could mean that the seizure statistics fail to reflect their actual prevalence.

New synthetic drugs

In 2012, 92 new synthetic drugs were reported to the EMCDDA’s Action on New Drugs programme. The number is record-high and has tripled since 2010. Thirty of the drugs were registered in Norway for the first time, which is also a record number. Synthetic cannabinoids dominate. As Table 14 shows, there was a clear preponderance of AM-2201 in the seizures made in 2012.

Table 14: Types of seizures of synthetic cannabinoids in 2012. Numbers and amounts*

Substances	Number of cases registered	Total amount
AM-2201	64	2486g
AM-2233	7	225g
AM-694	1	0,9g
JWH-018	20	96g +980 units
JWH-073	2	5,0g
JWH-122	10	43g
JWH-210	4	3,0g
JWH-250	1	3,5g
MAM-2201	2	5,0g
RCS-4	3	2,5g
STS-135	1	4,9g
UR-144	6	96g
5F-AKB48	2	4,5g
5F-UR-144	6	27g
AB-001	1	0,2g

*Preliminary data
Source: Kripos

10.4 Purity/potency/composition of illegal drugs and tablets

See data in Standard tables 14 and 15.

Table 15 shows that the average purity of *heroin base* continues to fall. An average purity of 13 per cent is the lowest ever measured. As in previous years, paracetamol and caffeine were found in a number of seizures, in addition to depressants such as benzodiazepines, primarily alprazolam. A typical mixture can contain 5–10 per cent heroin and a large proportion of alprazolam, which causes stronger and more untraditional intoxication symptoms. Such mixtures are registered both in heroin seized at the border and in seizures made in the user milieu.

Table 15: Average purity of brown heroin 2005–2011

Year	2005	2006	2007	2008	2009	2010	2011	2012
Purity percentage	26%	30%	36%	31%	25%	21%	15%	13%

Source: Kripis

The average purity of *amphetamine* was about 20 per cent, and 33 per cent for *methamphetamine*. For both substances, the average purity has declined in the past three years (table). As before, the purity of analysed seizures varied substantially in 2011, from less than one per cent to 96–99 per cent.

Table 16: Average purity of amphetamine and methamphetamine 2010–2012

Year	2010	2011	2012
Amphetamine	28%	25%	20%
Methamphetamine	44%	38%	33%

Source: Kripis

The average purity of *seized cocaine* decreased steadily until 2009, from 69 per cent in 2000 to 25 per cent in 2009. The level has since been between 31 and 37 per cent. Phenacetin, xylocain and caffeine are often found as additives.

Table 17: Average purity of cocaine 2000 and 2004–2012

Year	2000	2004	2005	2006	2007	2008	2009	2010	2011	2012
Purity percentage	69%	47%	50%	35%	39%	37%	25%	37%	31%	33%

Source : Kripis

As regards the THC content in the cannabis seizures, there are insufficient data for 2012 concerning cannabis resin (hash). For herbal cannabis (marihuana), the average THC content is estimated to nearly 11 per cent, while it was around six per cent in 2010–2011.

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Appendix: Lists

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List of relevant websites in English:

Ministry of Health and Care Services:

<http://www.regjeringen.no/en/dep/hod.html?id=421>

Norwegian Directorate of Health:

http://www.shdir.no/portal/page?_pageid=134,112387&_dad=portal&_schema=PORTAL&language=english

Norwegian Institute of Public Health:

<http://www.fhi.no/eway/?pid=238>

Norwegian Centre for Addiction Research:

<http://www.seraf.uio.no/eng/>

Statistics Norway:

<http://www.ssb.no/english/>

Norwegian Institute for Alcohol and Drug Research:

<http://www.sirus.no/internett/OmSirus?language=en>



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