

The Drug Situation in Norway 2012

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

Foreword

As in previous years, this 12thth national report on the drug situation in Norway has been drawn up in accordance with the reporting guidelines common to all member states in the EMCDDA. In addition to the annual report, we submit separately a number of standardised tables, mainly epidemiological data, as well as several comprehensive questionnaires in the fields of demand

reduction and policy. SIRUS wishes to express its gratitude to all public institutions that have provided relevant information. Our thanks go in particular to the co-authors who have made textual contributions and to the authors of the selected topics, Chapters 11 and 12.

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Summary. Main findings – Part A

Legal framework

The Coordination Reform entered into force on 1 January 2012. It will be gradually introduced over the course of the next four years. As an overriding framework, the reform is important in relation to drug and alcohol policy. The goal is to achieve better and more coherent health services through improved coordination of the primary and specialist health services. The most important legislative amendments relating to the Coordination Reform are:

- A new Public Health Act, which gives the municipalities greater responsibility for prevention and health-promoting work in all sectors of society
- A new joint act relating to municipal health and care services

Drug driving limits set

With effect from 1 February 2012, the Storting introduced 'drug driving limits' for 20 narcotic substances and potentially intoxicating medicinal drugs. Norway thereby became the first country in the world to set legal and sentencing limits for substances other than alcohol.

The amendments to the *Road Traffic Act* entered into force on 22 July 2012. Among other things, the amendments are intended to ensure greater agreement between the Road Traffic Act's provisions on drink driving and the regulation of driving under the influence of other intoxicating or narcotic substances.

White paper on drug and alcohol policy launched

On 22 June 2012, the Government presented a white paper on drugs and alcohol policy. This is the first white paper in Norway setting out a comprehensive drugs and alcohol policy that covers alcohol, drugs, addictive medicinal drugs, and doping as a social problem. In the white

paper, the Government presents targets and measures ranging from effective prevention, early intervention and help for people with extensive drug and alcohol problems to measures targeting next-of-kin and third parties affected by the harm caused by drug and alcohol use. The main topics in the report are challenges and policies relating to alcohol, which is the substance that causes most harm, and drugs.

The policy relating to doping as a social problem is integrated in the white paper. Based on the fact that doping can cause physical, mental and social problems, the Government advocates mobilising against doping through preventive, treatment and crime-combating measures, and it proposes criminalising possession and use of doping. The white paper will be considered by the Storting in its spring session 2013.

Implementation of the national action plan 2007–2012. Several challenges remain.

The action plan expires in 2012. The white paper states that the plan will be succeeded by strategies in the following focus areas: public health, overdoses and competence.

The Directorate of Health has reviewed the results and use of policy instruments under the Action Plan. The summary shows that, with a few exceptions, all 147 measures in the Action Plan had been implemented or initiated, and that many of the sub-goals in the plan had been achieved in whole or in part.

In addition, the Action Plan has led to a high level of activity, and the implementation rate has been high. The county governors, research institutions, expert milieus, user and next-of-kin organisations, voluntary and private players and others have contributed to many important results. Although the Action Plan has helped to increase the focus on prevention, competence and quality

in the municipalities and in specialised interdisciplinary drug and alcohol treatment, much still remains to be done before the goals can be said to have been attained. The challenges include:

- In interdisciplinary specialised treatment, there is an express need for increased capacity at all treatment levels. Going forward, increasing the number of detoxification places with the possibility of subsequent in-patient treatment should be given higher priority. As regards people with concurrent mental illnesses and drug or alcohol problems, there are still large gaps between the recommended treatment and practice, both in the specialist health service and in the primary health service.
- There is still a need for adapted, permanent housing arrangements in the municipalities, with necessary residential follow-up services and meaningful activities/work.
- The number of drug-related deaths is still very high in the international context.

Use of cannabis among young adults. Decline in lifetime prevalence, stabilisation in recent use.

Every four years since 1998, SIRUS has conducted questionnaire surveys on the use of drugs among young adults in the 21–30 age group, the last one in 2010. The proportion who reported ever having used cannabis increased from 22 per cent in 1998 to 34 per cent in 2006, followed by a decline to 26 per cent in 2010. The increase in lifetime prevalence in the first half of the 2000s can to some extent be explained by the increase that was found among those aged 15–20 in the latter half of the 1990s, who were in the age group 21–30 in 2006.

As regards more recent use, there was an increase from seven per cent in 1998 to ten per cent in 2002 and 2006, while the corresponding proportion in 2010 had stabilised at nine per cent. There were far more men than women among young adults who reported ever having used cannabis. This applies to both those who reported ever having used cannabis and those who

reported having used it during the last six months.

As for other illegal drugs, there was an increase up until 2006 among those who reported ever having used one or more of the substances amphetamine, cocaine or heroin, while there was a decline from 2006 to 2010. The decline reflects the pattern for younger age groups. Use during the last six months also tended to decline towards the end of the 2000s.

Injecting users. Stable estimates, but amphetamine has increasingly become the main drug injected

The number of injecting users in Norway has probably been quite stable since 2003. In 2010, it was estimated to be between 8,300 and 11,800. Heroin is still the most common drug injected, but for an increasing number amphetamine is becoming the main drug injected. In Oslo, the proportion of injecting drug users who had primarily injected amphetamine during the past month was around 20 per cent in 2002–2004. In 2008–2010, the corresponding figure could be as high as 35 per cent. It has also become more common to inject both heroin and amphetamine.

Treatment demand

The Norwegian Patient Register (NPR) is authorised by the regulations of 2009 to collect personally identifiable information about patients in the interdisciplinary specialist 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, as well as some information about these patients. 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.

In 2011, reports were submitted to the NPR from 159 units in the specialist health service concerning a total of 8,817 patients who started treatment for primarily drug-related problems. The number of patients broke down as 44 per

cent in in-patient treatment and 56 per cent in outpatient treatment, including opioid substitution treatment. The average age in in-patient treatment was 35 years for men and 34 years for women, fairly similar to patients in outpatient treatment.

The primary drug on admission is decided on the basis of the F-codes in ICD-10, but for just over a quarter of the patients, the primary diagnosis was multiple drug use. Where the primary drug was identified, opioids were the most frequently reported drug in both outpatient and in-patient treatment. The second most frequent drugs were stimulants for patients in in-treatment and cannabis upon admission to outpatient treatment. The latter accounted for as many as 31 per cent of patients where the primary drug was identified.

Drug-related infectious diseases

In 2011, 269 cases of HIV infection were reported to the Norwegian Surveillance System for Communicable Diseases (MSIS). Ten of the cases were among injecting drug users, while five of the ten were persons of foreign origin who had been infected before arriving in Norway. The incidence of HIV among injecting drug users remains at a stable, low level with about 10 to 15 cases reported per year. 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 in this group, although a large number of syringes are handed out every year.

In 2011, 1,676 cases of hepatitis C (both acute and chronic cases) were reported. No information was provided about the presumed mode of transmission in about half of the reported cases. In the cases where the mode of transmission is known, 83 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 newly acquired

hepatitis C infection has declined or increased among drug users in recent years.

Drug-related deaths. Some decline.

In 2010, 248 persons died of drug-related causes, a decline of 37 compared to 2009. Of the total number that were recorded by Statistics Norway, 173 deaths involved opioids with or without additional drugs, 93 were deaths due to heroin, 36 deaths were recorded with methadone poisoning as the underlying cause, and 44 with other opioids, either as poisoning or dependency. Twenty-five of the deaths were coded as suicides, which is probably a conservative estimate of the suicide rate.

The mean age at the time of drug-related death has steadily increased in recent years. From a level of around 35 years during the period 1996–2002, it increased to 40.4 years in 2010. The increase in mean age at the time of death coincides with an expansion of the provision of Opioid substitution treatment -OST in Norway, while the number of drug-related deaths has stabilised. It may be that OST contributes to the increase in the mean age, and in that sense, increasing age at the time of death may be seen as another positive outcome of the OST programme.

Drug markets

Measured by seizures, the most common illegal substances are geographically widespread. In 2011, all the 27 police districts made seizures of cannabis, benzodiazepines and amphetamines, whereas cocaine was seized in 25 districts and heroin in 24. It must be emphasised that the quantities vary greatly between the different police districts. For cocaine and heroin, the seizures are often small. The amount of heroin seized was less than ten grams in 15 districts, and in four of these, the total seizure amounted to as little as a user dose. The amount of cocaine seized was less than ten grams in 12 districts, in four only two grams or less. The biggest markets are still the Oslo area and the regions that include the biggest towns and cities. 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.

According to Kripos, the number of drug cases and seizures was higher in 2011 than in any previous year. However, with the exception of hash and GHB, no record-high amounts of drugs were seized in 2011.

Only in 1995 were greater quantities of cannabis products seized than in 2011, and never before was so much hash seized. The number of cultivation cases also increased, although the quantity of cannabis plants has been higher before. Based on the number of seizures, the proportion of marijuana was higher than ever before.

During 2009–2011, almost 40 new synthetic substances have been found that are not classified as illegal drugs. In addition, many intoxicating plant materials have been found that are not included on the list of narcotic substances either.

The number of heroin seizures in 2011 was lower than in the previous two years, but on a par with the average for the last ten years. It is more striking that the seizures only amounted to 15 kg in

quantity. Only in 2007 has less heroin been seized since the turn of the millennium. Moreover, the average heroin content has fallen to a historically low 15 per cent.

For the total number of seizures of stimulants, amphetamine, methamphetamine and cocaine, the statistics show a slight decline in relative terms.

The amount of amphetamines seized was the lowest since 2005, while the number of seizures was almost as high as the record year 2010. Methamphetamine accounted for 60 per cent of the total number of seizures of amphetamines.

The amount of cocaine seized is the lowest since 2006, while the number of seizures is on a par with recent years.

No significant changes have been registered in the seizure data for benzodiazepines, but a large number of units are still seized.

Although seizures of ecstasy remained low in 2011, both the quantity and the number of seizures of MDMA have started to rise following a big decline in the two preceding years. Other drugs than MDMA were found in about half of the seizures of such tablets, which normally carry a logo.

PART A

New Developments and Trends

1. Drug policy: legislation, strategies and economic analysis

1.1 Legal framework

The Coordination Reform

The Coordination Reform¹ entered into force on 1 January 2012. It will be gradually introduced over the course of the next four years. As an overriding framework, the reform has a bearing on drug and alcohol policy. The goal is to achieve better and more coherent health services through improved coordination of the primary and specialist health services. The most important legislative amendments relating to the Coordination Reform are:

- A new Public Health Act, which gives the municipalities greater responsibility for prevention and health-promoting work in all sectors of society
- A new joint act relating to municipal health and care services²

Drug driving limits

With effect from 1 February 2012, the Storting introduced 'drug driving limits' for 20 narcotic substances and potentially intoxicating medicinal drugs. Norway thereby became the first country in the world to set legal and sentencing limits for substances other than alcohol. The limits are described in Appendix 1.

The amendments to the Road Traffic Act³ entered into force on 22 July 2012. Among other things, the amendments are intended to ensure greater agreement between the Road Traffic Act's

provisions on drink driving and the regulation of driving under the influence of other intoxicating or narcotic substances.

1.2 National action plan and/or strategy

1.2.1 White paper on drug and alcohol policy

On 22 June 2012, the Government presented a white paper on drugs and alcohol policy.⁴ This is the first white paper setting out a comprehensive drugs and alcohol policy that covers alcohol, drugs, addictive medicinal drugs, and doping as a social problem. In the white paper, the Government presents targets and measures ranging from effective prevention, early intervention and help for people with extensive drug and alcohol problems to measures targeting next-of-kin and third parties affected by the harm caused by drug and alcohol use.

The main topics in the report are challenges and policies relating to alcohol, which is the substance that causes most harm, and drugs.

The policy relating to doping as a social problem is integrated in the white paper. Based on the fact that doping can cause physical, mental and social problems, the Government advocates mobilising against doping through preventive, treatment and crime-combating measures, and it proposes criminalising possession and use of doping. The white paper also describes efforts to achieve the correct prescription and use of addictive medicinal drugs.

¹ Report No 47 (2008–2009) *The Coordination Reform. Proper treatment – at the right place and right time.*

² Act of 24 June 2011 No 30 relating to municipal health and care services

³ Amendments to the Road Traffic Act concerning driving under the influence. Proposition 9 L (2010–2011) to the Storting, Proposition 105 L (2010–2011), Legislative decision 26 (2010–2011)

⁴ Report to the Storting No 30 (2011–2012) *Se meg! En helhetlig rusmiddelpolitikk* ('See me. A comprehensive drugs and alcohol policy' – in Norwegian only)

A preventive, solidarity-based drugs and alcohol policy will be continued. Five areas are emphasised:

- 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 white paper will be considered by the Storting in its spring session 2013, and it will form the basis for the Government's drugs and alcohol policy after the Action Plan for the drugs and alcohol field 2007–2012 has run its course.

More about the focus areas – with the emphasis on drugs

Up-to-date knowledge about risk factors will be emphasised, and selective prevention must be intensified to ensure that everyone who needs help receives it at an early stage. The interdepartmental and inter-agency cooperation on preventive work must be further developed to ensure coherent help services. The importance of preventive efforts in the following key areas is emphasised, among others: recreational settings, families, kindergartens and schools, workplaces and in traffic. Private, charitable organisations are regarded as important contributors.

Limiting the availability of drugs and alcohol is seen as the most effective prevention method. This entails pursuing a restrictive alcohol policy, combating drugs through prohibition, targeting drug trafficking and organised crime, and cooperating internationally. The Government will not introduce schemes that entail legalisation of drugs.

Efforts aimed at limiting organised drug crime, increasing the quantity of drugs seized and early discovery, as well as swifter regulation of new drugs will be strengthened. International cooperation on combating drugs will continue,

whereby Norway will contribute to reducing the cultivation, manufacturing, distribution and sale of drugs, to promoting human rights and to increased use of Norwegian aid funds for alternative development purposes.

Endeavours will be made to implement targeted, comprehensive information measures and efforts aimed at influencing attitudes, including the targeted use of interactive services.

Those in need of extensive help will often require assistance from a broad range of services, including treatment for somatic and mental illnesses. Help for people struggling with drug and alcohol problems is best provided by the ordinary health services.

More flexible treatment systems and offers of places on user-controlled programmes are relevant for those with concurrent drug or alcohol problems and mental illness. Opioid substitution treatment (OST), which is one of several possible treatment programmes, must be further developed in order to ensure equal and rapid access to help.

The services must become involved at an earlier stage, be more coherent and be built more closely around the person who needs help. Through better coordination, it is possible to succeed in ensuring that fewer people break off treatment. The Government therefore proposes to introduce measures to ensure greater and improved coordination in order to give everyone the best possible help. The white paper announces the gradual introduction of funding of treatment as mentioned in the Coordination Reform.

People with drug or alcohol problems shall be dealt with on the basis of equality of status and respect. Help will be offered without participants being required to be drug-free, at the same time as freedom from drugs must be a goal for most. The help shall be adapted to the individual's needs, and individuals shall be involved in designing the services and in decisions that concern them.

It is a goal to reduce the problem of open drug scenes. People with drug problems shall to a greater extent be given medical help instead of traditional punishment. In order to reduce the number of overdose fatalities, the Government proposes that this work be enshrined in a separate, national five-year strategy (see Chapter 7.1.2).

It has been discussed, among other things at a consensus conference and a subsequent report in 2011, whether Norway should introduce heroin-assisted treatment. Following an overall assessment, the Government believes that there are not good enough grounds for introducing a trial scheme of heroin-assisted treatment at the present time, but it will follow international developments closely.

Efforts targeting homelessness must also include young people with drug or alcohol problems, and work in relation to young unemployed people must be more focused

People struggling with drug problems must be ensured adapted help and rehabilitation instead of punishment, and alternative sanctions for less serious drug offences will be considered.

The drug courts project is still running. The results of the project will be evaluated.

The Government will initiate a 'quality boost' in the drugs/alcohol and mental health fields in order to raise competence and increase research and development work in the field of drugs and alcohol, with the following focus areas:

- Competence plan for drugs/alcohol and mental health,
- A better basis for management, knowledge about health challenges and treatment,
- Research, development and knowledge support.

The goal is to raise competence in relation to drugs and alcohol, dependency and mental health in all sectors. The recruitment and qualification of personnel, management, further and

continuing education and the establishment of a medical specialisation in drugs/alcohol and dependency medicine are among the focus areas. There is a need for more and better data in the drugs and alcohol field, and the work of obtaining adequate data will be continued.

1.2.2 Implementation and evaluation of the national action plan 2007–2012

The action plan expires in 2012. The white paper states that the plan will be succeeded by strategies in the following focus areas: public health, overdoses and competence.

In June 2012, the Directorate of Health published a report that reviews the results and use of policy instruments under the Action Plan. The report was also included as an appendix to the white paper. The summary shows that, with a few exceptions, all 147 measures in the Action Plan had been implemented or initiated, and that many of the sub-goals in the plan had been achieved in whole or in part.

In addition, the Action Plan has led to a high level of activity, and the implementation rate has been high. The county governors, research institutions, expert milieus, user and next-of-kin organisations, voluntary and private players and others have contributed to many important results. Although the Action Plan has helped to increase the focus on prevention, competence and quality in the municipalities and in specialised interdisciplinary drug and alcohol treatment, much still remains to be done before the goals of the Action Plan have been attained. The report underlines that several challenges remain, however:

- Poverty and social inequality in relation to health play an important role in the development of drug or alcohol problems in the population. The development of drug or alcohol problems can be prevented to an even greater extent, among other things by ensuring good conditions for children and young people to grow up in, and by offering help at an early stage to those who are in the process of developing an abuse problem.

Better utilisation of the preventive potential of the Norwegian Alcohol Act and the control of the sale and serving of alcohol is also possible.

- There is still a need for adapted, permanent housing arrangements in the municipalities, with necessary residential follow-up services and meaningful activities/work.
- In interdisciplinary specialised treatment, there is an express need for increased capacity at all treatment levels. Going forward, increasing the number of detoxification places with the possibility of subsequent in-patient treatment should be given higher priority.
- The number of drug-related deaths is still very high in the international context.
- Availability, continuity and individual treatment are key factors if the treatment is to be effective. There is still work to be done in this area.
- As regards people with concurrent mental illnesses and drug or alcohol problems, there are still large gaps between the recommended treatment and practice, both in the specialist health service and in the primary health service.
- An important task going forward is to ensure that the drugs/alcohol and mental health field is included in a satisfactory manner in the work on the Coordination Reform.

1.2.3 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 in the drugs and alcohol field in the municipalities' block grants. A number of targeted grant schemes will nonetheless continue:

- Municipal efforts in the drugs and alcohol field

The grant funds have been spent on various measures, such as residential follow-up services, low-threshold health services/harm-reduction

measures, work-related measures, outreach/ambulant services, measures targeting youth and young adults in particular, emergency drug and alcohol treatment facilities, models involving contact persons/coordinating representatives, and various activities.

- Further/continuing education in the drugs and alcohol field

The purpose of this scheme is to stimulate the municipalities, the correctional services and the police to offer further/continuing education in the drugs and alcohol field to their staff.

- Voluntary work etc.

The initiatives that receive funding are intended to supplement public services and contribute to improving and coordinating the overall efforts aimed at the target groups. Emphasis will be placed on the organisations' ability to document cooperation with the municipality, which will have chief responsibility for services for people with drug and alcohol problems, and on their having established a system for user participation.

- Measures targeting prisons, prostitution and human trafficking

The purpose is to improve follow-up of and services offered to people in prison-related and prostitution-related programmes, including victims and possible victims of human trafficking. In 2011, the prison and prostitution projects received grants totalling EUR 0.83 million (NOK 6.7 million)⁵ for the establishment of a broad range of health and care services for people with experience of prostitution and for victims of human trafficking.

- Drugs and alcohol policy organisations and the development of voluntary prevention projects in the drugs and alcohol field

⁵ Conversion rate 1 EUR = NOK 8.00

The purpose is to strengthen voluntary organisations that work on reducing the use of and harm caused by drugs and alcohol. The grant schemes are intended to stimulate engagement and drugs and alcohol-related policy activities both nationally and locally. The schemes are intended to promote knowledge-based strategies and democratic work by organisations based on voluntary efforts and local involvement. The grant schemes will be evaluated.

- Other grants

Grants are also given to, among others, the Workplace Advisory Centre for issues relating to alcohol, drugs and addictive gambling in the workplace, the Drugs and Alcohol Helpline, the 'doping helpline', and for the establishment of municipal drugs/alcohol and crime-prevention coordinators in collaboration with the Norwegian National Crime Prevention Council.

The regional drugs and alcohol competence centres

The seven regional drugs and alcohol competence centres carry out a broad range of activities. They are tasked with assisting the municipalities and the specialist health service with competence-raising and professional development. In cooperation with the county governors, they initiate various competence-raising measures and help to ensure that the municipalities utilise knowledge that is based on research and good practice. The implementation of national guides and professional guidelines is part of this work. Each competence centre carries out extensive information activities through publications and newsletters. The centres also collaborate on national online services such as www.forebygging.no, www.kommunetorget.no and www.tidligintervensjon.no.

The competence centres attend to national functions in the following areas of expertise: gambling addiction; co-morbidity 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 and 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.

An evaluation carried out in 2011 shows that the centres provide important expert support, especially to the municipalities. A total of EUR 16.4 million (NOK 131 million) has been allocated to the centres in 2012.

1.3 Economic analysis

The Norwegian welfare model, which includes drug and alcohol policy, is based on rights and universal schemes under which benefits and services are provided according to needs and not symptoms. Expenditure on drug-related problems is divided between several budget chapters, mostly in the form of universal welfare services and rights irrespective of diagnosis. The uncertainty attached to calculating the size of drug-related expenditure is so great that it is simply not possible. In addition, there is a lot of grant funding for which 'drugs' is one of several purposes.

In 2012, more than EUR 125 million (NOK 1 billion) more will be spent on the drugs and alcohol field than was the case in 2005. Strengthening of the municipalities' finances and the increase in the basic allocations to the four regional health authorities comes in addition.

Figures from the mapping tool BrukerPlan (User Plan) show that 30,000 people nationwide have been registered as recipients of municipal services due to drug or alcohol problems. Estimates show that 64,000 and 41,000 people, respectively, receive municipal services or have been assessed as needing municipal services due to such problems. Figures from the Norwegian National Patient Register for 2011 show that approximately 25,000 people received interdisciplinary specialist treatment for drug or alcohol problems. In

addition, a considerable number of patients with drug or alcohol problems as their secondary diagnosis and a primary psychiatric diagnosis were treated by the mental health care service. However, the individual differences in the amounts involved are too great to enable the total figure to be estimated.

The Directorate of Health's reporting form IS-8 is used to report the municipalities' efforts in the field, measured by the number of full-time equivalents. The reporting shows that the number of full-time equivalents devoted to services for people with drug or alcohol problems increased from 3,620 in 2010 to 4,008 in 2011.

Norway's contribution to international organisations such as UNODC, EMCDDA and the European Council totalled approximately EUR 4.4 million (NOK 35 million) in 2011. Substantial aid funds that are also spent on drug problems come in addition.

2. Drug use in the general population and specific target groups

2.1 Drug use in the general population

SIRUS has conducted surveys of the Norwegian population's use of alcohol and drugs since 1968. The most recent survey was carried out in autumn 2009, and the data were presented in the national reports for 2010 and 2011, Chapter 2. A new survey was conducted in autumn 2012, but the analyses and results are not yet available.

2.2 Drug use among young adults

Main findings of questionnaire surveys conducted in 1998–2010 in the 21–30 age group.

Every four years since 1998, SIRUS has conducted questionnaire surveys on the use of drugs among young adults in the 21–30 age group. The results for the years 1998, 2002 and 2006 were published in the national report for 2007, Chapter 2.2.2. Both the age categories and intervals (here: ever used, used during the last six months) deviate from the EMCDDA's system (ever used, used during the last year, used during the last 30 days). The data cannot therefore be presented in the standardised table that the EMCDDA uses as the basis for its trend analyses.

Methodology and sampling

The 2010 survey was conducted in a corresponding manner to previous surveys, based on systematic samples of the population register with the aim of ensuring a representative sample for this age group. However, in the 2010 survey a sample of persons recruited via *TNS Gallup's* web panel for the relevant age group was included in addition to the ordinary sample. Some minor changes were also made to the questionnaire (Bretteville-Jensen in Skretting og Storvoll (eds.), 2011).

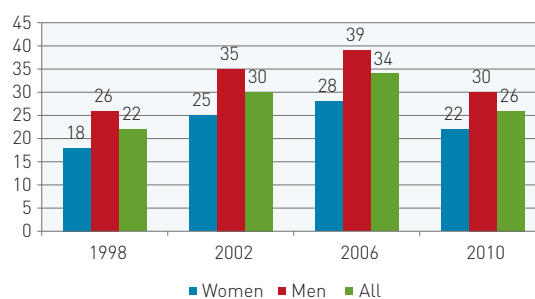
2.2.1 Data

Cannabis

As shown in Figure 1, the proportion of young adults who reported ever having used cannabis increased from 22 per cent in 1998 to 30 per cent in 2002 and 34 per cent in 2006. This was followed by a decline to 26 per cent in 2010. The increase in lifetime prevalence in the first half of the 2000s can to some extent be explained by the increase that was found among those aged 15–20 in the latter half of the 1990s, who were in the age group 21–30 in 2006.

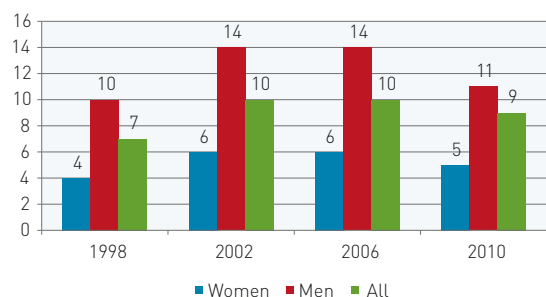
As regards use during the last six months (Figure 2), there was an increase from seven per cent in 1998 to ten per cent in 2002 and 2006, while the corresponding proportion in 2010 had stabilised at nine per cent. There were far more men than women among young adults who reported ever having used cannabis. This applies to both those who reported ever having used cannabis and those who reported having used it during the last six months.

Figure 1: Percentage in the age group 21–30 who reported ever having used cannabis



Source: SIRUS

Figure 2: Percentage in the age group 21–30 who reported having used cannabis during the last six months.

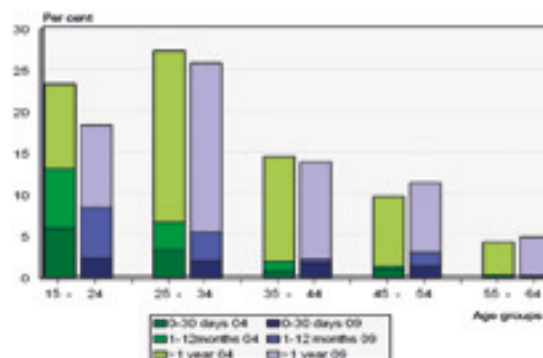


Source: SIRUS

Since the surveys of the population in general (15–64 years) use different age groups and other intervals for use, the data in these surveys are not directly comparable. However, the tendency seems to be fairly similar as regards changes in lifetime prevalence (Figure 3). A sample of the age groups that overlap the 21–30 age group also shows a marked decline. Among those aged 15–24, lifetime prevalence fell from 23 per cent in 2004 to 18 per cent in 2009 and, among the 25–34 age group, there was a decline from 27 per cent to 14 per cent. The population surveys measure use during the last year. The data for this interval also show a decline, from 13 per cent to 7

per cent for the 15–24 age group, and from 8 per cent to 6 per cent for the 25–34 age group.

Figure 3: Percentage in different age groups in 2004 and 2009 who have used cannabis: ever, during the last year and during the last 30 days, respectively.

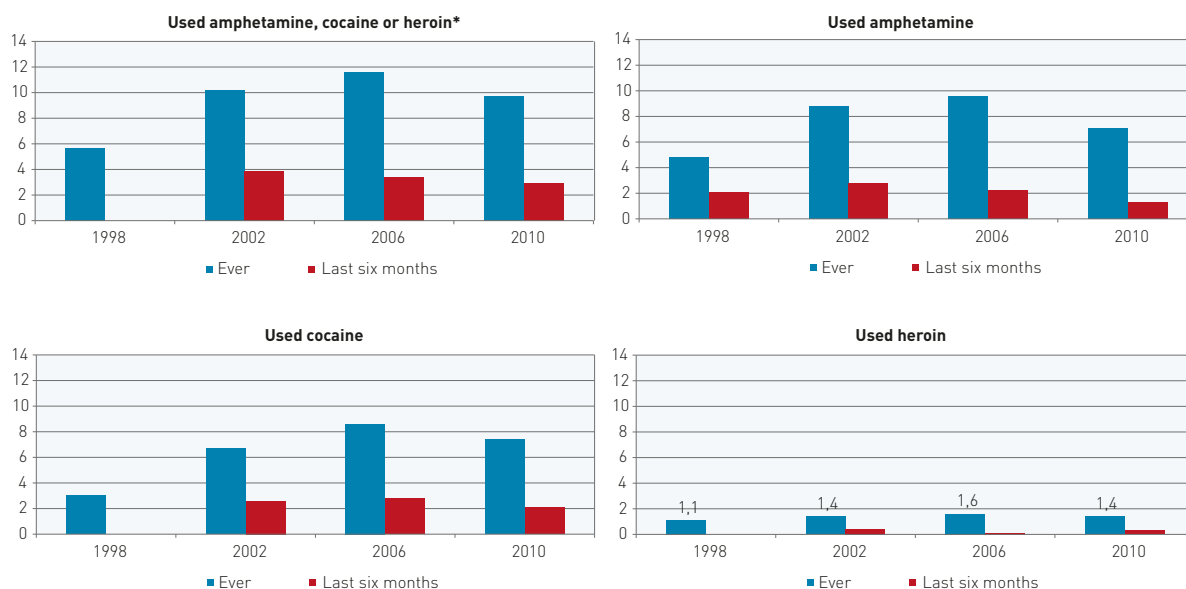


Source: SIRUS

Other illegal drugs

From 1998 to 2006, there was an increase among those aged 21–30 who reported ever having used one or more of the substances amphetamine, cocaine or heroin, while there was a decline from 2006 to 2010 (Figure 4). The decline reflects the pattern for younger age groups. Use during the last six months also tended to decline towards the end of the 2000s.

Figure 4: Percentage of people aged 21–30 who report having used various substances: ever and during the last six months.



* In 1998, the respondents were not asked about their use of cocaine and heroin during the last six months.

Source: SIRUS

3. Prevention

Introduction

Norway's preventive work is based on a long-term, continuous perspective. In recent years, prevention in Norway has been rooted in the Government's Action Plan (2007–2012). One of the five main goals has been a clear focus on public health. Information work has been strengthened, with more information targeting parents. Public support for the voluntary sector will continue as part of the effort to improve quality. Work on drug and alcohol prevention in the workplace has been intensified.

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.

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 can have a greater impact on the public's health than a major change in a small group. As a public health problem, however, the use of drugs in Norway is small compared with the use of alcohol and tobacco. 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 are required to prepare comprehensive drugs and alcohol policy action plans (cf. Norwegian legislation relating to alcohol), and to link preventive work relating to drugs and alcohol to other public health work in the municipality. The action plan should emphasise a coherent approach that includes both drugs and alcohol, and 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, and rehabilitation. The Directorate of Health, the regional competence centres and the county governors assist the municipalities in the development and implementation of such plans.

On assignment for the Directorate of Health, SIRUS has carried out a study based on qualitative interviews, participatory observation at meetings and document analyses in eight selected municipalities in order to shed light on the effect of these plans (Baklien og Krogh, 2011).

The evaluation emphasises that many action plans are more concerned with practical aspects of drugs and alcohol problems than with drugs and alcohol policy. Municipal finances, consideration for business interests, a liberal attitude among some politicians, and, not least, the tendency to focus on instruments rather than on goals and visions, set tight limits on what it is possible to achieve. This indicates that a lot remains to be done in order for the intention behind the drugs and alcohol policy action plans to be realised. See NR 2011 Chapter 3.1.1 for a more detailed description.

The municipalities' control of the sale and serving of alcohol

Norwegian alcohol legislation contains many provisions aimed at limiting accessibility, 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 (see more details in Appendix 2). It is the municipalities' responsibility to enforce the law in this area. Surveys show that municipal control of the sale and serving of alcohol is not good enough. On the basis of a project carried out by the Directorate of Health in collaboration with the regional competence centres in 2009/2010, the directorate initiated work in 2011 on a guide to

inspections that was 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. During the past year, the directorate has held several nationwide seminars targeting the municipalities, among other things to stimulate increased collaboration between the municipalities and the police on inspections. The Directorate of Health and the National Police Directorate have established close collaboration in this area.

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. Based on a model from STAD (Stockholm Prevents Alcohol and Drug Problems), the Directorate of Health recommends Norwegian municipalities to strengthen their cooperation with the police and business and industry on the responsible handling of alcohol. The STAD project is now called 'Ansvarsfull alkoholserving' ('Responsible serving of alcohol') and it is run in most Swedish municipalities. It has been documented that it produces good results, including a 30 per cent reduction in nightlife-related violence. In Norway, this programme is called *Responsible host*, and it is now operated in 59 municipalities. Evaluations from Bergen and Trondheim, among other places, do not show the same good results as in Sweden. This is assumed to be due to the fact that we have not implemented the programme or method from Sweden in full.

The Directorate of Health is concerned with building on the experience from both Sweden and Norway. In autumn 2011, development work was initiated under the heading 'Responsible handling of alcohol'. The elements included in the new initiative are:

- Cooperation between municipalities, the police and the hospitality industry
- Training of licensed premises staff
- Improved methods for and better organisation of the municipality's inspections and supervision

- Licensed premises must develop greater awareness of their own alcohol policy
- Active use of the media

The police will have an important role in this work. Closer cooperation with the police has been established at both the local and central level. In collaboration with the National Police Directorate, seminars have been held for the police councils (crime prevention partnerships between the police and the municipalities) to strengthen local cooperation on the administration of the Alcohol Act. The City of Oslo has initiated the project Making Nightlife Safer Together (SALUTT – ‘SAMmen Lager vi UTelivet Tryggere’), in order to improve control of licensed premises. The project is a close collaboration between the City of Oslo, the police and the Directorate of Health.

3.1.2 Family

Parents’ role in drug prevention

Work in support of 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 parent as its area of expertise. One of the measures is to adapt the Ørebro Prevention Programme to a Norwegian context and Norwegian conditions. 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 still 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 was published in early summer 2012.

3.2 Selective prevention – at-risk groups and settings

Pursuant to the Action Plan (2007–2012), services shall be available to children and young people who are particularly at risk of developing drug or alcohol problems. Six measures in the plan are intended to contribute to early intervention and greater accessibility of services for children and young people:

- Raising competence in the municipalities, for example through guidance from expert teams in the child welfare service.
- Improving competence in early identification and early intervention among staff who come into contact with at-risk children and young people.
- Strengthening the municipalities’ low-threshold services and outreach activities.
- Introducing a specific waiting-time guarantee for children and young people with mental health problems and for young alcoholics and drug addicts under the age of 23.
- Ensuring that GPs have the tools they need to assess problem alcohol use in patients.
- Studying the prevalence of mental health problems and drug and alcohol problems among children and young people, and their treatment and follow-up needs.

Work is under way on all these measures.

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.

The website established in 2009 by the Directorate for Children, Youth and Family Affairs and the Directorate of Health, which has an overview of screening and mapping tools, is used by many different professions involved in early intervention work. Link: <http://www.helsebiblioteket.no/microsite/Kartleggingsverktøy>.

The training programme *Early prevention, drugs and alcohol and violence in close relationships* has been continued. An evaluation report will be presented in autumn 2012.

Motivational interviewing (MI): MI is a key part of early intervention efforts. A national MI network has been established and is working on an MI strategy. The Western Norway competence centre in Bergen and the Directorate of Health are responsible for support pages for training in MI and they also offer MI analysis. Link:

<http://www.helsedirektoratet.no/psykisk-helse-og-rus/motiverende-samtale-mi/Sider/default.aspx>

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.

The waiting-time guarantee is intended to ensure that children and young people under the age of 23 with drug and alcohol problems or mental health problems do not have to wait for more than ten days for their application for help to be considered, and no more than 65 days for treatment.

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 course in Oslo

This Oslo-based measure was described in NR 2011 Chapter 3.2.1. It is based on intersectorial cooperation, and on the systematic development of local competence and methods based on experience from Sweden and Denmark. There are 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. Young people are reached earlier than before.

A lot of work has been invested in training 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. In total, 98 persons have been followed up through the project in the first half-year of 2012. This is more than in the whole of 2011, when the total number was 64. Relevant personnel in all city wards will have received training by the end of 2012.

Similar courses aimed at weaning people off cannabis are also held in several other Norwegian towns and cities. 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.

The 'Freeland' project

It is assumed that many people who come to Norway as asylum seekers develop problem drug and alcohol use after their arrival. The Oslo Drug and Alcohol Addiction Service Competence Centre conducted a survey on this issue in 2011. The intention was to investigate whether people living in asylum reception centres develop a drug/alcohol problem caused by the situation they are in. The report *Freeland – ventefasen, rus og livsinnhold* ('Freeland – the waiting phase, drugs and purpose in life' – in Norwegian only) (Oslo kommune velferdsetaten, 2012) focused

on the everyday lives of people living in asylum reception centres.

The qualitative part of the survey showed that 85 per cent of asylum reception centres have experienced cases of drug or alcohol use. On the other hand, 67 per cent of the asylum reception centres state that drugs and alcohol are not a problem at their centre. At the same time, however, the survey showed that 23 per cent of the reception centres have experienced cases of drugs being sold at the centre. It also emerged that some people already have a drug or alcohol problem when they come to Norway, and that the problem often escalates in step with the length of their stay.

The report will be followed up with a questionnaire focusing on ethnic minorities that will be sent to all the drugs and alcohol institutions in Norway in 2012. The intention is to map the extent of the problem and to study the attitudes and needs of staff in relation to users from different ethnic backgrounds. Whether the users' drug and alcohol problems can be linked to their asylum background will be a key question.

Khat project:

More knowledge is needed about the treatment of problem use of khat, and the Directorate of Health has initiated a survey in which existing literature in the field is reviewed, including reports from the UN. This is being done in cooperation with the Norwegian Centre for Minority Health Research. Afterwards, the plan is to carry out a prevalence survey that investigates how widespread khat use actually is in Norway, and how many people have a problematic pattern of use.

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 suited to identify 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.

All the drug and alcohol competence centres now have MI instructors. They will contribute to competence-raising in the municipalities that work on early intervention in particular. The interviewing method is suitable in many contexts when it is desirable to encourage another person to change his/her behaviour, and it is very suitable for conversations about lifestyle changes, for example in the health and care sector.

In 2010 and 2011, endeavours were made to establish a national system for the implementation of tools and methods for relevant services in their dealings with pregnant women, their partners and parents with small children. Work is also under way on developing online screening tools that will make the early intervention methods available.

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.

Link: 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>

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>

3.3 Recreational settings

Outreach work

Outreach workers work on secondary prevention among children and young people. The main principle of the method they use is to actively reach out to young people in need of support or help. These individuals are often not reached, or reached to an insufficient extent by other parts of the public support system. The intention is to establish contact with these youth at the earliest stage possible, and to motivate them to alternative activities, help or counselling.

The Norwegian Association for Outreach Work with Youth (LOSU) represents most of the country's 60 outreach units, numbering approximately 250 outreach workers. Link: <http://www.losu.no/>

The activities carried out by the Norwegian Association for Outreach Work with Youth in 2011 included:

- Organising five regional conferences for outreach services in Norway to strengthen the professional preventive approach in outreach methodology.
- Producing a municipal guide for outreach social work among young people.
- Having close contact with central authorities concerning social and legal challenges relating to unaccompanied minor asylum seekers and young people who are victims of human trafficking.
- Taking part in international cooperation. LOSU is a central member of the global association for outreach social work, Dynamo International, which is based in Brussels.
- As part of its work in Dynamo International, LOSU has followed up input to the European Commission on the importance of outreach social work in relation to the social inclusion of at-risk youth.

Online registration tool

With support from the Directorate of Health, the Oslo Drug and Alcohol Addiction Service Competence Centre has worked during 2010 and 2011 on creating a new online registration tool for outreach services. The tool, which will be tested in ten municipalities, could lead to new procedures for the documentation of practice in outreach services. At the same time, it provides better information security in connection with the registration of personal data and the submission of statistics to local and central authorities, and it creates new possibilities for better registration and handling of governing data for the development of the services. Requirements specifications have been prepared together with the Directorate of Health and key players in the field. The new registration tool will be introduced in ten pilot municipalities throughout Norway in 2012. The project will be evaluated, and the possible continuation and wider introduction of the tool in more municipalities will be considered in that connection.

National and local media campaigns

No recent media campaigns have targeted the use of drugs in particular. Several big national information campaigns relating to alcohol are carried out every year, however.

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 begin a life without using illegal drugs, subject to follow-up and rehabilitation.

In the Norwegian context, however, it might be natural to regard a subgroup of patients in OST as problem users. In 2011, around 10 per cent of OST patients report using morphine substances in addition to OST medication during the last 30 days, and 15 per cent have been found to use stimulants. This is a somewhat lower proportion than in 2010. 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. 2012).

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.

Calculating the number of injecting drug users

Table 1 shows estimates of the number of injecting drug users in Norway, calculated using the Mortality Multiplier. The estimates include figures for overdose fatalities from the Norwegian Cause of Death Register supplied by Statistics Norway and from the National Crime Investigation Service (Kripas) up until 2009. The estimated number of injecting users in Norway increased from the 1970s until 2001, followed by a reduction up until 2003. The figure remained stable up to 2010.

Table 1: Ranges for the number of injecting drug users in Norway 2002–2010, calculated using the Mortality Multiplier*

Year	Lower limit – upper limit
2002	10,500–14,000
2003	9,200 – 12,800
2004	8,700 – 12,200
2005	8,900 – 12,400
2006	8,400 – 11,700
2007	8,600 – 12,000
2008	8,800 – 12,500
2009	8,800 – 12,500
2010	8,300 – 11,800

Source: SIRUS

*Round figures

The figures include all injecting use. Heroin is still the most common drug injected, but, for more and more people, 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 both heroin and amphetamine.

5. Drug-related treatment: treatment demand and treatment availability

See also information in Chapter 11.

5.1 General description of systems

The treatment systems and the organisation were described in more detail in NR 2011 Chapter 5.3. With the exception of OST, they have not changed in recent years. Nor have there been any significant changes as regards strategy and policy.

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, and short and long-term in-patient treatment with a duration of more than six months. Interdisciplinary specialised treatment covers OST, including treatment with methadone or subutex, in addition to other treatment and follow-up services. The scope and content of the services vary between health regions and between hospitals in the same region. The services are also organised differently in the health regions. Interdisciplinary specialised treatment is the part of the specialised health service that has had the strongest percentage growth in resources in recent years.

OST – change of system

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). The basic model of a tripartite collaboration comprising social security offices, GPs and the specialist health service was retained, and the indication for OST shall be assessed by the specialist health service.

Integration of OST in the health trusts was completed in 2011. OST centres are no longer a separate type of measure, and the system of special decision-making powers has been discontinued. The health trusts' admission bodies have been given overriding authority. Each health trust shall have a body that makes an overall assessment of whether OST is the correct treatment option, but how this is organised is decided by the health trusts. The same applies to how the treatment start-up and stabilisation shall take place. Following the change, OST has been established as a separate unit with a separate management in some places, as a dedicated team in other places, and in yet others as an integral part of the interdisciplinary specialist treatment without a separate management over and above a coordinator.

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. Over and above these tasks, the municipalities are free to assign responsibility for other municipal tasks to the NAV office (Ministry of Health and Care Services, 2012).

Challenges

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 users 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 services for people with drug or alcohol problems and the municipal services is not good enough. The help 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 was normal before. 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 the treatment, which results in a poorer health situation for the users. Cooperation between the first and second-line services is good, but it 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 somatic and mental illness, a lack of suitable housing and coping with their day-to-day life and living conditions. Other challenges are a lack of participation in meaningful activities, work and a social network (Ministry of Health and Care Services, 2012).

5.2 Access to treatment

5.2.1 Waiting times

Pursuant to the Patients' Rights Act, referrals to the specialist health service shall be assessed within 30 working days. In cases where the patient is granted a right to treatment, an individual deadline shall be set for when he/she shall receive the necessary treatment at the latest. A special waiting time guarantee for children and young people under the age of 23 with mental health problems or drug-related complaints stipulates that they shall be assessed within ten working days.

The Patients' Rights Act entitles patients to free choice of treatment facility, but not free choice of treatment level. For example, a patient cannot choose in-patient treatment if he or she has been granted a right to outpatient treatment.

Waiting times for treatment for drug and alcohol problems appear to be decreasing. The Norwegian National Patient Register publishes statistics every quarter of waiting times for treatment and violations of treatment guarantees. In interdisciplinary specialised treatment, the average waiting time in 2011 was 72 days for patients who were entitled to prioritised treatment (both alcohol and drug problems), a reduction of eight days from 2009. In the first four months of 2012, the waiting time decreased further to 66 days. The average waiting time for patients in mental health care was 54 days in 2011, roughly the same as in the two preceding years. If the patient does not wish to accept the offer of treatment he/she is given, but chooses instead to wait for an

available place in a particular institution, the waiting time will usually be considerably longer.

5.2.2 Treatment demand

The Norwegian Patient Register (NPR) is authorised by the regulations of 2009 to collect personally identifiable information about patients in the interdisciplinary specialist 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. These individual data are then aggregated and reported to the EMCDDA via the Norwegian focal point. 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.

In 2011, reports were submitted to the NPR from 159 units in the specialist health service concerning a total of 8,817 patients who started treatment for primarily drug-related problems (2010: 8,750 patients from 158 units). The number of patients broke down as 3,921 in in-patient treatment and 4,896 in outpatient treatment, including OST. Around 68 per cent of the total number of patients in treatment were men. The average age of patients in in-patient treatment was 35 years for men and 34 years for women, fairly similar to patients in outpatient treatment (men: 34 years, women: 35 years).

The primary drug on admission is decided on the basis of the F-codes in ICD-10, but, for just over a quarter of the patients, the primary diagnosis was F 19 – multiple drug use. Opioids were the most frequently reported primary drug in both outpatient and in-patient treatment. The second most frequent drugs were stimulants for patients in in-treatment and cannabis upon admission to outpatient treatment. The latter accounted for as many as 31 per cent of these patients where the primary drug was identified. The proportion of cannabis as the primary drug

upon admission to in-patient treatment was 11 per cent.

5.2.3 About patients in OST in particular

According to the status report for 2011 (SERAF, 2012), there were a total of 6,640 patients in OST at the end of 2011, an increase of 625 from 2010. The number of admissions was 1,131, which is a slight decline from 2010. Of these, 55 per cent were first-time admissions and 45 per cent were re-admissions. At the end of 2011, 116 were waiting to be admitted to treatment, 38 fewer than the year before.

The number of discharges was 487 in 2011, slightly fewer than in 2010, but roughly on a par with the number since 2007. The number of discharges appears to have stabilised at around 500, despite the fact that there is an increase in the number of patients in treatment. The discharges represent less than ten per cent of all patients in treatment. In 2010, 9.4 per cent of patients concluded their treatment. The figure was 7.5 per cent in 2011. This can serve to obscure the fact that the proportion who break off treatment during the start-up phase may be significantly higher. Nevertheless, it seems as though 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 OST centre, discharges initiated by the patient him/herself and discharges due to deaths. GPs cannot discontinue the treatment at their own initiative. Discharges resulting from decisions take place independently of or against the patient's wishes. The proportion who are discharged as a result of a decision – i.e. potentially against the patient's wishes – is declining strongly in line with the new guidelines. In 2011, 39 patients nationwide were discharged as the result of such a decision. The main reason for terminating treatment is primarily that patients leave treatment themselves. This concerns patients who stop showing up and patients who 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. There is no increase in the number of deaths (see Chapter 6.3). The trend is that it is easier to be admitted to treatment, but also that more people choose to leave.

The status survey for 2011

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 from the centres. A total of 5,753 forms (of 6,640 in treatment) were completed for 2011, a proportion of 80 per cent. The average age of clients (for whom a form has been completed) was around 40, and the proportion of women was 29.6 per cent. The average age is increasing slightly and the gender distribution has been more or less unchanged in recent years. Eight per cent were under the age of 25. Only five persons were under 20. Although the lower age limit for admissions has been abolished following the introduction of the new guidelines (previously 25 years), this does not seem to have affected the average age so far.

The proportion treated with methadone was 47 per cent, while 53 per cent were treated with buprenorphine-based medication. Nationwide, 67 per cent now get their medication prescribed by their GP. GPs thus play a key role in OST, a role that seems to be increasing. Almost half (47%) are issued their medication at a pharmacy, and an additional 32 per cent receive it from municipal services. Only three per cent received their medication from an OST centre.

Retention and social rehabilitation

According to the status survey, 96 per cent of the patients were in treatment, while 4 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 a status form has not 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 90 per cent, i.e. nine out of ten were in treatment at the end of 2011.

Occupational rehabilitation is showing slow progress. The majority of the patients move towards a life on welfare benefits, but they appear to have ordered finances because the use of social security is low. The proportion with income from employment is unchanged and low (see also Chapter 8.2).

The proportion who have their own apartment or house is high, however. According to the status overview, an average of 76 per cent of patients had their own rented or owned housing. The lowest proportions were found in the two largest cities, Bergen (54%) and Oslo (63%). To a certain extent, this reflects the fact that the housing market is more difficult in large towns and cities and that the price level is higher there. The situation in Oslo is also affected by the fact that housing is **not** a criterion for admission to the OST programme (see also Chapter 8.1).

Drug use

The findings on drug use are based on reported use during the last 30 days. Nationwide, 10 per cent had used heroin during the past month, 32 per cent had used cannabis and 40 per cent had used benzodiazepine substances. Fifteen per cent had used stimulants, primarily amphetamine. 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 per cent had not used such substances at all, and eighteen per cent only sporadically. All the findings are practically unchanged compared with recent years (SERAF, 2012).

6. Health correlates and consequences

6.1 Drug-related infectious diseases

6.1.1 HIV and Aids

In 2011, 269 cases of HIV infection were reported to the Norwegian Surveillance System for Communicable Diseases (MSIS). Ten of the cases were among injecting drug users. The median age was 38 years (28 to 51 years). Five of the ten injecting drug users who were diagnosed as HIV positive in 2011 were persons of foreign origin who had been infected before arriving in Norway.

As of 31 December 2011, a total of 585 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, but as little as five per cent of all reported cases since 2000. Development into AIDS has been reported in 153 of the cases (Table 2). No information is available regarding how many of the HIV-positive injecting drug users are still alive.

The incidence of HIV among injecting drug users has remained at a stable, low level for many years, 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, and some 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 in this group, although a large number of syringes are handed out every year in Norway (see Chapter 7.3).

6.1.2 Hepatitis

During the nationwide outbreak of hepatitis A from 1996 to 2000, 1,360 drug users were identified as having acute hepatitis A. Since then, only

Table 2: Reporting of HIV infection and Aids, Norway 1984–2011. 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
1984–99	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	.	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	%	32	4	13 %
2007	248	13	5 %	11	0	0 %
2008	299	12	4 %	18	2	11 %
2009	282	11	4 %	18	1	6 %
2010	258	11	4 %	22	3	13 %
2011	269	10	4 %	19	0	0 %
Total	4,895	585	12 %	1,019	153	15 %

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

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 MSIS. In 2011, 18 of a total of 56 reported cases of acute hepatitis B involved injecting drug users. During the period 1995–2011, the total number of reported cases of acute hepatitis B infection among injecting drug users was 1,969. 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 2011, 1,676 cases of hepatitis C (both acute and chronic cases) were reported. No information was provided about the presumed mode of transmission in about half of the reported cases, but in the cases where the mode of transmission is known, 83 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 newly acquired hepatitis C infection has declined or increased among drug users in recent years.

Among OST patients, the status survey for 2011 (see Chapter 5.2.2) shows that, for the country as a whole, 65 per cent of the clients were hepatitis C antibody positive, roughly the same proportion as in 2010. 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 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 2011 survey showed that 65 per cent of the injecting drug users tested had had a hepatitis A infection or had been vaccinated against the disease, while 33 per cent had had a hepatitis B infection and 63 per cent had had a hepatitis C infection. Twenty-eight per cent had hepatitis B markers, indicating that they had been vaccinated against hepatitis B.

6.1.3 Bacterial infections

Six cases of botulism were reported among injecting drug users in the period 2000–2011. In addition, one case of anthrax and one case of *Clostridium novyi* were reported in 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 about the incidence of other bacterial infections among drug users in Norway. Tuberculosis is very rarely seen in drug users in Norway.

6.2 Drug-related deaths and mortality of drug users

6.2.1 Drug-related deaths

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. With effect from 2010, Kripos has 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 Kripas. However, if suicide (by using drugs) and drug 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 are 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 OST. Both the Statistics Norway figures and the Kripas figures appear to indicate that a certain stabilisation of the number of mortalities has occurred after the reduction following the peak years of 2000 and 2001. The number of mortalities remains relatively high, however.

Concerning the 248 drug-related deaths in 2010 that were recorded by Statistics Norway, 173 (70 %) deaths involved opioids with or without additional drugs (Figure 5), 93 were deaths due to heroin (X42, X44, X62, X64 + T401), 36 deaths

Table 3: Drug-related deaths 1991–2010. Total number of deaths and deaths broken down by gender. Figures from Kripas and Statistics Norway (underlying cause of death).

1991–2010	Number of deaths according to Kripas			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	***	***	***

Source: Kripas and Statistics Norway

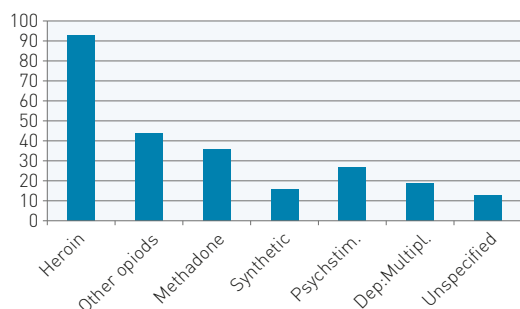
*The figures from 1996 onwards have been classified in accordance with a new revision. Hence, the figures before and after 1996 are not directly comparable. Suicides in which narcotic substances were used are included from 1996.

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

***Figures for 2011 are not yet available.

were recorded with methadone poisoning as the underlying cause (X42, X44, X62, X64 + T403), and 44 with other opioids, either as poisoning or dependency (X42, X44, X62, X64 + T402, F112). The remaining 75 deaths broke down as follows: 16 other synthetic narcotic substances (X42, X44, X62 + T404), 27 psychostimulants (X41, X44 + T436), 13 unspecified narcotic substances (X42, X44 + T406), 19 cases of dependency on other stimulants and dependency on multiple/other drugs (F152, F192), and zero deaths from cocaine (T405). In 2010, 25 (10 %) of the included deaths were coded as suicides (X62, X64), which is probably a conservative estimate of the suicide rate.

Figure 5: Drug-related deaths in 2010 broken down by specific death. Numbers



Source: SIRUS and Statistics Norway

Many of the drug-related deaths are believed to be due to extensive multiple-drug use. The heroin-specific metabolite monoacetylmorphine was detected in 38 per cent of the deaths, but other substances were found to be present as well in 40 per cent of heroin/morphine-related deaths. Methadone was detected in 16 per cent of the deaths, but it was the only detected substance in only 18 cases. Amphetamine and/or methamphetamine and/or cocaine were detected in 16 per cent of the deaths.

Statistics Norway reported 36 deaths due to methadone in 2010, which is at the same level as 2009. The majority of methadone-related deaths occur among persons not enrolled in the OST programme, and multiple drugs were typically involved. The fact that methadone-related deaths

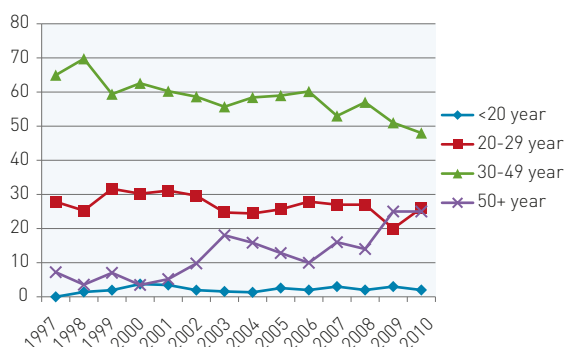
remain at a similar or even lower level than in 2009 (39), while the number of patients in OST is steadily increasing by 500–600 per year, illustrates that there has to be a fair balance between access to OST and control measures to limit the ‘leakage’ of methadone from the OST programme. However, it 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 6 shows that the proportion of drug-related deaths among those over the age of 30 has increased steadily. 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 2010, this age group accounted for 73 per cent of the deaths (180 persons). During the same period, the proportion over the age of 50 was at the same level as in 2009, as this age group accounted for as many as 25 per cent of the total number of deaths (62 persons). Ten of the deaths occurred in the 65-plus age group. The youngest age groups’ proportion of deaths has remained relatively stable, and four deaths were registered among persons under the age of 20 this year.

The mean age at the time of drug-related death has steadily increased in recent years. From a level of around 35 years during the period 1996–2002, it increased to 40.4 years in 2010. The increase in mean age at the time of death coincides with an expansion of the provision of OST in Norway, while the number of drug-related deaths has stabilised. It may be that OST contributes to the increase in the mean age, and in that sense, increasing age at the time of death may be seen as another positive outcome of the OST programme.

Figure 6: Drug-related deaths broken down by age group 1997–2010. Per cent

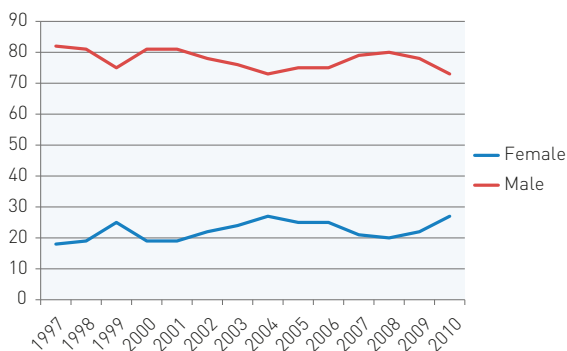


Source: SIRUS and Statistics Norway

Gender distribution: stable

In 2010, 181 of the deaths were males and 67 females. The proportion of females was 27 per cent, which, seen in a longer-term perspective, seems to be within the 'normal range' although at the higher end. During the period 1997 to 2010, the proportion of women has varied between 18 and 27 per cent (Figure 7). The average proportion of women was close to 22 per cent during the period 1980–1990.

Figure 7: Drug-related deaths broken down by gender, 1997–2010. Per cent



Source: SIRUS and Statistics Norway

6.2.2 Death and poisoning related to PMMA

The toxic ecstasy-like drug PMMA (parame-thoxymethamphetamine) was found in Norway in summer 2010. The drug was first found in a seizure in July the same year. Shortly afterwards, the drug was found in a blood sample that was taken in connection with an unnatural death. In autumn 2010, the Norwegian Institute of Public

Health introduced routine testing of blood for PMMA in all such cases, and in cases involving suspicion of driving under the influence.

During the two-year period from July 2010 to June 2012, 26 deaths involving the use of PMMA were registered. The drug was also found in the blood of around 100 persons suspected of driving under the influence or of drug use in the same period.

In a new study, the Institute of Public Health, in collaboration with the Gade Institute at the University of Bergen and the University Hospital of Northern Norway, compared the first cases of PMMA-poisoning, 12 fatal and 22 non-fatal (Vevelstad M, Oiestad EL, Middelkoop G et al., 2012). The analysis results in all the cases were compared, and the forensic post-mortem reports and the circumstances surrounding all the deaths were reviewed.

In eight of the twelve deaths, the person in question was found dead. In the remaining four cases, there were serious symptoms, such as severe respiratory problems, an extreme increase in body temperature, sudden collapse, heart failure, spasms or the simultaneous failure of several vital organs. Up to nine of the deaths may have occurred in connection with sleep. Sixty-seven per cent of the deaths involved men, and the mean age was 30 years. In the non-fatal cases of poisoning, the mean age was 27 years, and 86 per cent were men.

Much higher concentrations of PMMA were found in all the fatal cases than in the non-fatal cases. This may indicate the use of several or large doses of PMMA. There was nonetheless some overlapping between PMMA concentrations in the fatal cases and concentrations among living drivers without dangerous symptoms. This indicates that it is not just the dose that is decisive, but that there are also individual differences in sensitivity to the dangerous effects of PMMA. The Institute of Public Health has initiated studies to investigate such risk factors.

Concurrent use of PMMA and several other intoxicating substances was frequent in both the fatal and the non-fatal cases. Only PMMA was found in 25 per cent of the PMMA deaths, while the remaining deaths were the result of a combination of PMMA and other substances. Two-thirds of the combination deaths were due to PMMA combined with other stimulants such as amphetamine/methamphetamine or cocaine/MDMA. The other combination deaths were due to PMMA combined with drugs with tranquillising effects, such as morphine/heroin or alcohol.

6.2.3 Mortality among OST patients

Of the 6,640 patients in the OST programme in Norway at the end of 2011, 54 deaths from various causes were reported by the centres during 2011, indicating a total mortality rate of about 0.8 per 100 patient-years while in OST. This is on par with the previous year (Table 4). The majority of deaths in OST were due to somatic causes and injuries.

It is generally accepted that the annual mortality rate among untreated injecting heroin users is in the range of two to four per cent. In a study of Norwegian OST programme participants for the period 1997–2003, an annual mortality rate of 2.4 per cent was found prior to treatment, and 3.5 per cent post-treatment among those who terminated OST. In the same study, the annual mortality rate was 1.4 per cent for those in active OST. For patients in active OST, causes of death were: somatic causes 55 per cent, overdoses 27 per cent and trauma 18 per cent, whereas, for the observed times prior to and after OST, overdoses dominated as the cause of death. The annual mortality rate for patients in OST has gradually decreased in Norway since 2002, from an estimated 1.5 per cent to a current rate of 0.8 per cent.

6.2.4 Hepatitis C as the cause of death among injecting drug users

A very high proportion of injecting drug users are infected by hepatitis C, a disease that often becomes chronic and that, if left untreated, can lead to premature death. However, it has not been clear how early the disease becomes a common cause of death. A new study (Kielland et al., 2012) has now found that it took less than 30 years from the injecting drug users were infected by the disease until it became as common a cause of death as overdoses.

The study included 523 persons who were admitted to in-patient treatment due to drug problems during the period 1970–1984 and who had been infected by hepatitis C. The disease became chronic for around two-thirds of the patients, while for the rest, the hepatitis C virus disappeared by itself. They were all followed via the Cause of Death Register until 2008. The purpose was to be able to compare general and liver-related mortality for people with chronic hepatitis C and those who became free of the virus. The average follow-up period was 33 years.

The general mortality rate in the study was 2.1 per 100 person-years for men and 1.4 per 100 person-years for women. Ten persons with chronic hepatitis C died of liver-related causes. The average age at the time of infection was 20.4 years for this group and the average age at the time of death was 47.5, varying from 34 to 54 years.

Since hepatitis C has become a common cause of death after the age of 45–50 for chronic carriers of the hepatitis C virus, and a high percentage of injecting drug users have been infected also after 1984, the number of deaths will probably increase in the time ahead. This group is not offered treatment for hepatitis C to the same extent as others who are infected.

Table 4: Annual occurrence of deaths during treatment in the OST programme 2002–2011. 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
Norway	26	31	21	30	15	32	39	63	54	54
% of all in treatment/year	1.5	1.4	0.8	0.9	0.4	0.8	0.8	1.3	0.9	0.8

Source: Norwegian Centre for Addiction Research -SERAF

7. Responses to health correlates and consequences

7.1 Prevention of drug-related emergencies and reduction of drug-related deaths

7.1.1 Emergency assistance

The municipality is responsible for organising an accident and emergency service to attend to the population's need for emergency assistance. This includes emergency assistance for people with mental illness and drug or alcohol problems.

Emergency drug and alcohol treatment facilities have been established in several cities in recent years. The measures are organised differently, and the type of services offered varies. What they have in common is that they are open 24 hours a day, are easily accessible and provide assistance to users in an acute life situation.

The accident and emergency service in Oslo has a project called *Prosjekt ungdom og rus på legevakta* ('Young people and alcohol/drugs at the accident and emergency service'), which is a specialised team that is part of the municipal emergency drug and alcohol facilities. In a collaboration between the municipality and the health authorities, the accident and emergency services in Oslo and Bergen have set up dedicated reception facilities for people with drug or alcohol problems, and observation beds for short-term admissions. Wards have been established in both Oslo and Bergen to take care of persons with drug or alcohol problems in emergency situations.

The ambulance service is often called out to drug addicts who have overdosed. Figures from the emergency medical communication centre (AMK) for Oslo and Akershus show that a total of 3,300 ambulance call-outs in 2011 were due to overdoses. The AMK centre in Bergen registered

97 overdose call-outs relating to the use of opioids during the period October 2011–March 2012, compared with 224 in the previous half-year. In the same period, 108 call-outs relating to overdoses of GHB/GBL were registered, compared with 101 in the previous half-year. The AMK centre also registered 66 overdose call-outs where the type of drug was unknown during the period October 2011–March 2012.

The National Health and Care Plan (2011–2015) points out that it is important that the service has the required competence as well as experience of treating these patients in a responsible, coherent and respectful manner. Drug users shall be ensured good follow-up after an overdose in cooperation with the local help services. This means that ambulance personnel must not abandon people with drug or alcohol dependency in need of further follow-up.

Naloxone is the most common antidote used for overdoses. It is normally ambulance personnel who administer naloxone in connection with opioid overdoses, and doses are administered by intramuscular or intravenous injection. It is now being discussed whether naloxone in the form of a mouth spray should be available to others as well, as first aid for someone who has overdosed until the ambulance arrives.

Project: Young people and drugs/alcohol, Oslo accident and emergency service

The purpose of the project is to identify and provide targeted assistance for young people under the age of 23 who come to the accident and emergency service with drug or alcohol-related problems. Many of them have been in a life-threatening situation involving serious poisoning. The goal is to get these young people to think about the event that has led to their arrival

at the accident and emergency service. The project will establish new procedures for systematic work vis-à-vis the target group and for cooperation at Oslo accident and emergency service. The project will test and adapt work methods developed by the 'Maria Ungdom' youth project in Stockholm to local conditions. The effects of the work in the project will be assessed. The objective is to see how the service/programme can be continued and further developed by the accident and emergency service.

The intervention programme can be divided into different phases: emergency interview at the accident and emergency service, follow-up conversation, advice by telephone, letters. One of the phases consists of establishing contact with local support services. If the person in question is under the age of 18, a notification of concern is sent to the local child welfare service. If the situation is acute, the child welfare emergency service is contacted. The project cooperates with and makes referrals to the labour and welfare administration, the child welfare services, drug and alcohol outpatient clinics and psychiatric district centres. Assistance is offered to next-of-kin.

A total of 702 young people were registered in 2011. Of this number, 84 (45 girls and 39 boys) came to the accident and emergency service more than once because of a drug or alcohol-related event. Forty-two were registered as homeless. Thirty-eight were considered to have drug or alcohol dependency. Most of them struggled with both drug or alcohol problems and mental health problems. Some also suffered from mental illness.

7.1.2 Reduction in overdoses and overdose fatalities

The Norwegian Centre for Addiction Research (SERAF) has reviewed all overdose fatalities in Oslo in the period 2006–2008 (Gjersing et al., 2011). See also NR 2011 Chapters 6.3 and 7.1.1. The report shows that a big majority, 186 of 232 of those who died of an overdose, were in contact with the help services during the year before their death. They had often been in contact with three

or four services. The help services were described as fragmented and lacking in the areas of written procedures, coordination and exchange of information. The fatalities occurred to a considerable extent during the first three weeks following release from prison or discharge from in-patient treatment. A corresponding pattern was not found after the conclusion of OST treatment.

The report showed that next-of-kin felt that they were not seen or followed up by the help services to any great extent. They had a clear wish to be notified in emergency situations. The high incidence of overdose fatalities can primarily be explained by the culture of multiple injection use dominated by heroin. According to the report, if a significant reduction in the number of deaths is to be achieved, steps must be taken to enable users to take the drugs in a less risky manner. Different treatment options must also be available to a sufficient extent. The report proposes several concrete measures aimed at changing the user culture and improving the coordination of help services through comprehensive, systematic long-term work.

Overdose team

As the only municipality in the country, the City of Trondheim has established a dedicated overdose team/health team that is out on the street interacting with people with drug and alcohol problems. The team was established in 2001. See more details in NR 2011 Chapter 7.1.3. Clear procedures have been established for what is to be done before and after overdoses and overdose fatalities. The team works in close collaboration with the AMK centre, the ambulance service and St Olav University Hospital. It is also called out when the AMK centre receives notice of a possible overdose. The team receives information from users when potent heroin arrives in the city, and it comprises health professionals who can initiate immediate harm-reduction measures. Everyone who has taken an overdose or been present when an overdose has occurred is followed up by the overdose team. They are offered an emergency bed at a round-the-clock supervised care facility. If a fatality should occur,

the next-of-kin will be followed up by the overdose team for as long as they wish. The number of overdose fatalities in the city is relatively low. The explanation is said to be close contact with the users, and training and guidance given to injecting drug users.

National strategy for the reduction of overdose fatalities

The Government will task the Directorate of Health with drawing up a separate national strategy for reducing overdoses in collaboration with relevant agencies, such as user and next-of-kin organisations and the municipalities. The goal is an annual reduction of the number of overdose fatalities. The purpose is to stimulate the development of more local strategies for municipalities that have registered overdose fatalities. The local strategies should have concrete targets and measures in the following areas:

- Responsibility for further development and coordination of the health services and a clear assignment of responsibility when there is a risk of overdose fatalities
- Further competence-raising among particularly involved personnel, such as ambulance personnel and accident and emergency services staff
- Prevention of overdoses following discharge from institutions
- Necessary information to and involvement of next-of-kin
- Influencing the user culture (reducing the extent of injection) and further developing life-saving measures.

The results will be summarised and evaluated after five years. The Directorate of Health will prepare indicators for measuring the development of the overdose situation and assess the need for professional guidelines. The need for more knowledge about causes and effective measures will be continuously assessed and implemented in the strategy (Department of Health and Care, 2012)

7.2 Responses to other health correlates among drug users

7.2.1 Psychiatric and somatic co-morbidity

Psychiatric District Centres that cover all municipalities have been established as part of the escalation plan for mental health for 2008–2010. The centres offer assessment and outpatient, ambulant and in-patient treatment. The Psychiatric District Centres are tasked with assisting the municipal health and care services with advice and guidance and with ensuring continuity in the specialist health service; in other words, they will be both the gateway into and the way out of mental health care. The Psychiatric District Centres are still under development. They are expected to develop round-the-clock contingency services. Ambulant teams and emergency teams play an important role.

A large proportion of patients admitted to somatic wards and emergency wards in mental health care services have extensive drug or alcohol-related illnesses. Closer cooperation is therefore required between interdisciplinary specialised treatment and the other services in the specialist health service. A report from 2010 found that about 30 per cent of patients in interdisciplinary specialised treatment also received treatment from the mental health care services for their mental health problems, either concurrently with, before or after the specialised treatment.

A requirement for increased competence and better quality of services has been included in the regional health authorities' letters of assignment in recent years. In addition, all patients referred to interdisciplinary specialised treatment are required to be assessed in relation to their need for other services in the specialist health service. This applies to mental health care in particular. Many of the services in interdisciplinary specialised treatment are currently organised under the mental health care services. The structure of the services in interdisciplinary specialised treatment should be coordinated as far as possible with the structure of mental health care

services and other specialist health services, so that the services are adapted to the needs of patients with concurrent illnesses.

Around 150 ambulant teams/community-based teams have been established in the field of mental health care and interdisciplinary specialised treatment. The teams cooperate extensively with the municipal services and provide services for people with mental illnesses, people with drug/alcohol dependency and people with both these types of illnesses. Over time, the Psychiatric District Centres have developed know-how and competence in the treatment of drug/alcohol and dependency illnesses. All the Psychiatric District Centres are required to have outpatient services for patients with drug and alcohol problems.

Several municipalities are working together with the specialist health service on outreach treatment teams based on the ACT (assertive community treatment) model. These teams will follow up users where they live and spend their time, and they have overall responsibility for providing treatment and follow-up. The teams are required to have expertise in the integrated treatment of drug and alcohol problems and mental illness. They can follow up individuals over time, for example by offering practical assistance in relation to housing, conversational therapy, follow-up and support in work situations, financial guidance and advice on substitution treatment. Most of the big urban municipalities have established ACT teams or other outreach teams.

New professional guidelines

Although several measures have been initiated to improve the services for people with concurrent drug or alcohol problems and mental illness, the services are still inadequate when it comes to assessment, treatment and follow-up. Detailed recommendations for further development of the services are set out in the national professional guidelines for assessment, treatment and follow-up of persons with concurrent drug or alcohol problems and mental illness, which

were published by the Directorate of Health in March 2012. Key recommendations in the guidelines:

- People with acute psychoses will be entitled to treatment in the mental health care service, regardless of whether the psychosis was drug or alcohol-induced.
- In order to provide coordinated services, the agency that first comes into contact with a person with concurrent drug or alcohol problems and mental illness must ensure that he/she is followed up in relation to both illnesses and assess the need for an individual plan.
- Even if responsibility is assigned to one agency, other agencies will also be responsible. A binding collaboration must always be established.
- Disagreement about who is responsible must not result in patients receiving poorer treatment.

The municipal health service cannot reject a concrete enquiry from a patient without carrying out an assessment. If the municipality is unable to provide adequate health care, the patient shall be referred to the relevant service. The same applies to the specialist health service. In addition to the paper version of the guidelines, some aids have been developed to make it easier to start using the guidelines:

- Online version in which the guidelines are specified and operationalised as an online reference book with direct links to scoring tools, referral forms, patient information with links to knowledge resources suitable for in-depth study, training material and videos teaching required skills.
- Patient-mediated interventions aimed at making the contents of the guidelines as accessible to patients, users and next-of-kin as possible, and thereby influencing professionals' behaviour and the services offered by the help systems.
- Snakkomrus ('Talk about drugs and alcohol'): An online resource developed

especially for employees of the municipal health and care services, NAV and the specialist health service. The website contains online mapping tools, professional material, films and other learning material that can help to make employees better advisers in conversations about the use of alcohol and other drugs (Directorate of Health, 2012).

7.2.3 Needle exchange programmes

The primary objective of needle exchange programmes is to reduce the risk of infectious diseases associated with the sharing of injection

equipment. Approximately 3.3 million syringes were handed out in Norway in 2007, largely through low-threshold services. In a follow-up survey carried out by SIRUS, 14 towns/municipalities reported that almost 3.1 million syringes were handed out in 2009. Of these, 85 per cent or 2,635 million were distributed in the three biggest cities Oslo, Bergen and Trondheim. In 2011, these cities reported about the same number, 2,639 million, 1.87 million of them in Oslo alone (see also Chapter 12). Sales through pharmacies come in addition, but we lack an overview of sales to drug users in this context.

8. Social reintegration

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

A new 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'). 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 Act related to medicines and the General Civil Penal Code.⁶ 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 – relapse figures
- Penal sanctions – persons convicted – previous criminal offences
- Imprisonments⁷

⁶ Minor drug offences that involve the use or possession of drugs are punished pursuant to the Act relating to medicines (Act No 132 of 4 December 1992) section 24, for which the maximum sentence is 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.

⁷ 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 statistics do not, however, contain information about the types and quantities of narcotic substances involved in prosecutions.

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 for which the persons in question were charged during the year.

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 42,800 drug crimes were reported in 2011. This is almost six per cent fewer than in 2010. However, the number of registered drug crimes in 2011 is the second highest number in the period 2003–2011, but fewer than in the peak years 2001/2002.

In total, 20,000 drug crimes, including aggravated drug crimes, were reported pursuant to section 162 of the General Civil Penal Code, almost 2,000 fewer than the year before. There were also fewer reported offences for drug use, which is regulated by the Act relating to Medicines. The 13,100 registered cases in 2011 were five per cent fewer than in 2010. The number of reported violations of the provisions of the Act relating to Medicines for possession of small amounts of drugs was 8,200, which was on a par with the year before. Drug crimes have the highest clear-up rate of all crime categories, with 87 per cent completed investigations in 2010, while the figure for drug use was 95 per cent.

Charges

A total of 37,900 charges were brought for drug crimes in 2010. That is 21 per cent of all charges for infringements of the law and 41 per cent of all criminal charges. In total, almost 17,200 persons were charged with one or more drug infringements, 48 per cent of all charges for crimes. The corresponding figure in the 21–29 age group was 60 per cent.

A total of 12,200 persons charged had drug crime as their primary offence in 2010, almost 14 per cent fewer than in 2009 (Table 5). Persons charged with drug crime as their primary offence were more than a third of all persons charged with crimes. The proportion of women was generally low, 17 per cent in 2010.

The number of persons charged is considerably higher than what has previously been registered in the statistics. This applies to both the number of persons charged for violations of the General Civil Penal Code and persons charged with less serious violations of the Act relating to Medicines. In relative terms, the increase was greatest for those who were only charged with drug use. A total of 2,900 persons were charged with drug use as their primary offence in 2010, which was 22 per cent more than the year before. In 2010, 82 per cent of those charged with drug crime as their primary offence were Norwegian citizens. This is roughly the same percentage as in 2009.

Penal sanctions

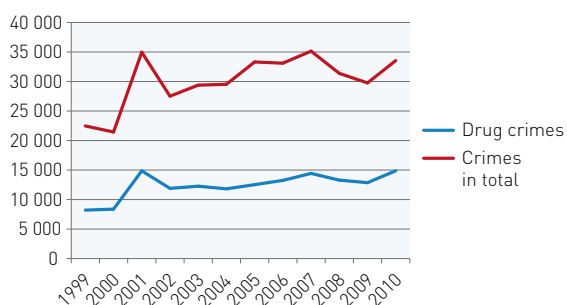
Drug crime was the primary offence in connection with almost 14,900 penal sanctions, slightly more than 44 per cent of all penal sanctions in criminal cases in 2010. The number of penal sanctions where drug crime was the primary offence increased by almost 16 per cent in relation to the year before, back at the level of the peak year of 2001 (Figure 8). The prosecuting authority decided more criminal cases than the courts. More than 10,200 cases where drug crime was the primary offence were settled by a fine without the case going to court.

Table 5: Persons charged with drug crime as their primary offence 2002–2010

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

Source: Statistics Norway

Figure 8: Number of penal sanctions where drug crime was the primary offence 1999–2010



Source: Statistics Norway

The biggest percentage increase was for unconditional prison sentences. There were 400 more such penal sanctions in 2010 (both unconditional and partly unconditional/partly suspended) than the year before. Drug crime as the primary offence was the reason for just over 1,900 of the unconditional prison sentences. Of the offenders, 187 were sentenced to prison for use as the primary offence. This represents a twofold increase from 2009. However, these are often complex cases, where other, less serious offences are taken into consideration in the overall sentence.

Table 6: Unconditional prison sentence as sanction for use and possession as the primary offence 2005–2010

Year	2005	2006	2007	2008	2009	2010
Drug use	142	122	156	167	94	187
Drug possession	37	39	20	32	25	46
Total	179	161	176	199	119	234

Source: Statistics Norway

9.2 Interventions in the criminal justice system

The average number of inmates in Norwegian prisons was 3,624 in 2010. This is an increase of seven per cent on the year before, and more than in any of the preceding 50 years. Almost 30 per cent of inmates at the start of 2010 had drug crime as their primary offence. By comparison, crimes against property accounted for 22 per cent and crimes of violence for 21 per cent.

There were 1,959 new imprisonments in Norwegian prisons in 2010 with drug crime as the primary offence. A total of 591 of the imprisonments were for aggravated drug crimes pursuant to the General Civil Penal Code section 162 second and third paragraphs. While the proportion of women was slightly more than 9 per cent for drug crimes in all, it was as high as 13 per cent for aggravated drug crimes.

Table 7: Number of sentences started pursuant to section 12, 2004–2011

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

Source: The central administration of the correctional service

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

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

Source: The central administration of the correctional services

9.2.1 Alternatives to prison

Serving of sentences outside institutions pursuant to the Execution of Sentences Act section 12⁸

In 2011, 526 persons (2010: 511) were serving sentences under this system, 11 per cent of them women (Table 7). A total of 340 persons started serving their sentence in prison and were later transferred to an institution. The other 186 started serving their sentence in a treatment institution.

In 2011, 45,687 days (2010: 40,777) were served in an institution pursuant to section 12, which is a substantial increase in relation to the previous two years (Table 8).

Suspended sentence with a programme for driving under the influence

This sanction replaces the previous alcohol treatment programme. During the course of 2011, a total of 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 78 per cent were completed without the conditions being breached or new crimes being committed.

⁸ 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 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 is offered 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 2011, 26 new sentences were implemented, 14 in Oslo and 12 in Hordaland. Eighteen suspended sentences were completed during 2011. Seven sentences were completed without the conditions being breached, while the rest, 11 sentences, were interrupted, mostly because of new crimes being committed (the central administration of the correctional service, 2012).

Community sentences

Community sentences are often imposed for less serious offences. Community sentences were imposed in 534 cases involving drug crimes in 2010 (2009: 463). It is worth noting that as many as 102 of the sentences (2009: 86) concerned aggravated drug crimes pursuant to the General Civil Penal Code section 162 second and third paragraph.

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.

On 1 September 2008, the Ministry of Justice established a trial project with electronic monitoring as a new way of serving sentences outside

prison. The project includes six counties with different geographical and demographic conditions: Vestfold, Oslo, Hedmark, Rogaland, Troms, and Sogn og Fjordane.

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 trial counties during the actual serving of the sentence and must live in suitable accommodation with the possibility of a telephone connection. If there are household members over the age of 18, they must consent to the convicted person serving his/her sentence at home with electronic monitoring. All use of alcohol and other drugs is completely prohibited.

In principle, permission to serve a sentence with electronic monitoring will not be granted if the sentence concerns crime committed in the convicted person's own home, serious crimes of violence or sexual offences. Moreover, young offenders and first-time offenders will be prioritised target groups. The scheme has a capacity of 130 convicted persons at any given time. So far, the vast majority are people convicted of traffic offences. In 2010, permission was granted for 887 new prison sentences to be served with electronic monitoring (2009: 705, 2008: 95). Drug crime as the primary offence accounted for nine per cent or 76 new imprisonments in 2010.

Two surveys have been conducted of the recidivism rate two years after release for 99 convicted persons who served their sentences with electronic monitoring in 2008 and 801 convicted persons who served their sentences with electronic monitoring in 2009 (Rokkan, 2012). The surveys show an average recidivism rate resulting in a new unconditional sentence of approximately ten per cent.

Eighty-four convicted persons had been given a new sentence after the sentence that was served

with electronic monitoring in 2009 (10.5 % of the sample). Of these, 19 were convicted of crimes of violence, 19 of drug offences, 17 of driving under the influence and 11 of economic crime. Most of those who relapsed into crime committed a different type of offence to the reference conviction. Of the 35 who repeated the same type of crime, most repeat drug crimes and driving under the influence, with ten convicted persons in each category. Of those who did not repeat the same type of crime, most were convicted of drug crimes and crimes of violence, with seven and ten new convicted persons, respectively.

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 be continued either by the inmate being transferred to serving his/her sentence pursuant to section 12 in a treatment or care institution, or by the inmate receiving treatment from 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

See also Appendix 1.

In 2011, drug analysis was carried out by the Norwegian Institute of Public Health (NIPH) in approximately 9,100 cases where drivers were suspected of driving while intoxicated. Of these, about 1,200 breath tests were taken by the police locally, about 3,400 blood samples were analysed

by the NIPH for alcohol only, while about 4,600 blood samples were analysed for alcohol, intoxicating drugs and narcotic substances. The NIPH routinely looks for over 30 different intoxicating drugs and narcotic substances, and detects an average of three drugs in the same blood sample.

Among drivers who test positive for drugs, THC and methamphetamine were the most common substances, followed by amphetamine (Table 9). In the benzodiazepine group of sedative drugs, there was also an increase in the detection of clonazepam in 2011, which indicates increasing illegal sales. The analysis findings do not necessarily indicate whether the substance taken is illegal or not.

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. If we wish to say something about the use of amphetamine and methamphetamine combined, 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 2011. The number of blood samples on which a broad analysis was carried out.

Name of substance	Example of name of medicineExplanation	Number 2011	Percent
THC	Active agent in cannabis	1,428	31 %
Methamphetamine		1,343	29 %
Amphetamine		1,208	26 %
Clonazepam	Rivotril ®	1,114	24 %
Diazepam	Valium ® Vival ® Stesolid ®	1,006	22 %
Morphine	Heroin, Dolcontin®	238	5 %
Methadone	Methadone®	135	3 %
GHB		134	3 %
Buprenorphine		89	2 %

Source: Norwegian Institute of Public Health

10. Drug markets

10.1 Availability

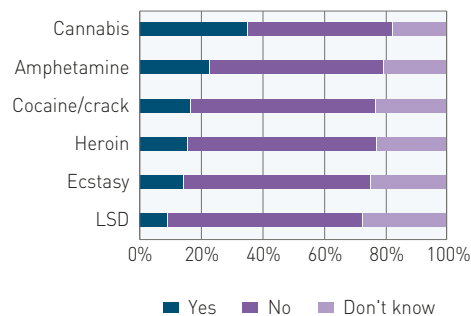
Several factors must be emphasised when describing any changes in availability. Seizures of illegal substances by the police and customs authorities are an important parameter in this context. However, the number of actual seizures and the quantities involved are affected by the internal priorities of 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. It is therefore a matter for debate to what extent seizure statistics are a good tool in connection with such assessments.

Measured by seizures, the most common illegal substances are geographically widespread. In 2011, all the 27 police districts made seizures of cannabis, BZD and amphetamines, whereas cocaine was seized in 25 districts and heroin in 24. It must be emphasised, however, that the quantities vary greatly between the different police districts. For cocaine and heroin, the seizures are often small. The amount of heroin seized was less than ten grams in 15 of the police districts, and in four of these, the total seizure amounted to as little as a user dose (0.2 g). The amount of cocaine seized was less than ten grams in 12 of the police districts, and in four of these, the seizure was as little as two grams or less. The biggest markets are still the Oslo area and the regions that include the biggest towns and cities. 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.

It nonetheless appears to be relatively easy to obtain drugs also outside the big towns and cities. In the latest population study from 2009, respondents were asked whether they could obtain various substances within the space of 24 hours. Figure 9 shows the results for the illegal substances concerned. The proportion of 'yes' answers seems high considering that the survey also includes small places with, presumably, poorer access to narcotic substances.

Figure 9: Percentage 'yes' answers in 2009 to the question: Do you believe that you could obtain any of the following substances in the space of 24 hours?



Source: SIRUS

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 show a high incidence of methamphetamine, higher than in most other cities that were part of the survey (Thomas

et al, 2012). Methamphetamine is also among the illegal substances that are most often found in traffic cases, and the proportion is increasing.

However, we know little about the prevalence measured on the basis of other parameters. 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. Their effect can be quite similar depending on the strength of the drugs in the mixture and how they are taken. As will be shown in Chapter 10.4, the purity of analysed seizures varied substantially. The effect of strong amphetamine can therefore feel like methamphetamine and vice versa.

Anecdotal information from individual users in hard-core drug milieus, which have attracted extensive media coverage in 2012 as well, describes dramatic effects that are said to be the result of methamphetamine use, and a market in which amphetamine and methamphetamine are sold interchangeably and where users do not know what they get. The latter is probably true. There are very few, if any, indications that methamphetamine is in particular demand. On the other hand, the demand for amphetamine has been great in Norway for several decades. Although the main market consists of marginalised users, amphetamines are part of the nightlife scene and are also used by people with regular jobs. The seizure figures show that methamphetamine mostly comes in addition to all the amphetamine that people attempt to smuggle in every year, and less as a replacement. One simple explanation for the change could be that illegal producers outside Scandinavia have switched from manufacturing amphetamine; the market is already there.

10.1.2 The internet as a market place for new, synthetic substances

As in many other European countries, an increasing number of new synthetic substances have been discovered in Norway in the last two to three years. National Crime Investigation Services

– Kripos has registered almost 60 such substances. So far in 2012 (per October), 28 individual substances that were discovered for the first time in Norway have been reported to the EMCDDA. This applies to synthetic cannabinoids in particular, but also to new chemical compounds in the groups cathinones, tryptamines and phenethylamines. Buying and selling largely take place on the internet, and users share their experiences through forums and user-managed platforms and provide detailed tips on everything from doses, methods of use and expected drug experiences to concrete tips on importing and customs-related information. It is probable that the positive user reports that are shared freely online could contribute to making such substances more popular. In addition, low prices, ready availability and the absence of legal consequences of the use and sale of a large number of substances mean that the potential for the spreading of substances of this type may be increasing.

As regards prevalence, the basis for comparison is so far inadequate. In addition to the fact that several of these substances are relatively new on the market, there are many of them, and users often do not know what they contain. At the same time, the market mechanisms that apply to the spreading of substances of this type make it difficult to monitor. It was not until 2011 that Kripos started to keep seizure statistics for synthetic cannabinoids, and questions concerning their use were not included in SIRUS's nationwide population survey until 2012. The other psychoactive substances that are available on the Norwegian market are not currently included in the official statistics for seizures, but, as mentioned above, analysed samples are reported to the EMCDDA's Action on New Drugs on a running basis, including in the form of an annual overview of the number and quantity, with data from both Kripos and the Norwegian Institute of Public Health.

So far, little information is available about the users, but some users of synthetic cannabinoids seem to be very young – some with extensive experience of a number of different substances,

others novices without much experience of drugs. One common denominator is that they all use the internet as their source of reference and base themselves on user know-how that is often selective and may be misleading.

The introduction of synthetic cannabinoids to the Norwegian drugs market contributes to changing the way drugs are bought and sold. The low price means that the substances are able to flow freely around in social milieus without being linked to a real economy. Unlike other drugs, which are distributed through long distribution chains and complex economic systems, the new psychoactive substances are characterised by a shorter distance between producers and users, which helps to keep prices down. Combined with low production costs, this leads to international online providers taking over the role of dealers and to the market moving away from physical sales in certain milieus to virtual networks that operate across national borders. The low price makes it possible for the drugs to be shared freely in the user milieu, without being linked to financial transactions as is the case with other drugs. It has also become more common for users to make their own 'spice' mixes by ordering pure synthetic cannabinoids in powder form, which is dissolved in acetone and mixed with tobacco or herbs. This is resold at a big profit.

10.2 Supply

10.2.1 Smuggling routes to Norway

Updated information from the customs service as of the first half-year 2012

According to the customs service, most of the *amphetamine/methamphetamine* on the Norwegian market comes from illegal laboratories in the Netherlands, Lithuania and Poland. Lithuania and the Netherlands still have a dominant role as suppliers of synthetic drugs to Norway. As in 2011, the customs service has registered a sharp decline in seizures of amphetamine and methamphetamine. However, large seizures of amphetamine in other countries that were intended for

Norway indicate extensive smuggling. During the first half-year of 2012, the customs service uncovered an attempt to smuggle liquid methamphetamine for the first time. The shipment is assumed to have been manufactured in the Czech Republic.

Hash seized in Norway mainly comes from production areas in Morocco. Large quantities of hash are smuggled from North Africa via the south of Spain and the Netherlands. The customs service has registered a substantial increase in the number of seizures of hash in goods traffic from the Netherlands. At the same time, a considerable increase has been registered in the smuggling of smaller quantities by plane, bus and passenger car. Fewer attempts to smuggle drugs inside couriers' bodies were uncovered than in the same period in 2011.

Seizures of *marijuana* smuggled into Norway remain at a stable, high level. So far, the customs service has uncovered substantial amounts of marijuana in goods traffic and passenger cars. Marijuana is produced many places in the world, both in and outside Europe. A substantial amount of the marijuana found by the customs service comes from the Netherlands and the Czech Republic.

The customs service has uncovered smuggling of *GHB and GBL* to Norway from the Netherlands, Poland and Germany. The customs service has registered a sharp decline in seizures of drugs dispatched by post and sent by courier. Large seizures abroad of GBL intended for Norway indicate that there is still a market for these drugs.

Heroin sold in Norway mainly comes from Afghanistan via Turkey along the so-called Balkan route to Western Europe. The customs service has uncovered heroin smuggling by train and car in 2012. The tendency from 2011 of a decline in the number of seizures and the amounts seized has continued. Fewer attempts to smuggle drugs inside couriers' bodies have been uncovered than in the same period last year. Part of the reason may be that the heroin that is smuggled is of poor quality. Diluted heroin and less access to

good quality may have contributed to increased demand for and sales of Rivotril, Subutex and other tranquillisers.

Khat is transported from production areas in Africa to Europe. Cargo planes carrying large amounts of *khat* arrive in the Netherlands and the UK daily. From there, the drug is smuggled to Norway by bus, plane and car. The customs service has uncovered attempts to smuggle large quantities of *khat* by road in 2012. There are many indications that considerable amounts are reloaded in Denmark and Sweden before being transported to Norway. However, most customs seizures are uncovered by checking airline passengers who arrive from the Netherlands and the UK.

Cocaine sold in Norway comes from production areas in South America. It is then transported via West Africa or directly to ports and airports in Europe. Cocaine is smuggled to Norway using various means of transport and couriers from Poland, the Netherlands and Spain. The customs service has registered a significant decline in the amount of cocaine seized in 2012. The proportion of couriers who smuggle cocaine inside their bodies and in their hand luggage remains at a stable, high level.

The customs service has uncovered smuggling of large quantities of tranquillisers. This applies in particular to large quantities of Rivotril, which is smuggled directly from Hungary or reloaded in Sweden and Denmark. During the period, large quantities of *diazepam* have been seized while being transported by road from Slovenia or sent in the post or by courier from Thailand and the UK.

Hallucinogens (LSD) are smuggled from the Netherlands to Norway in the post and by courier. The customs service has seen an alarming increase in attempts to import LSD in 2012 compared with previous years.

The customs service has also registered an increase in the import of *new synthetic drugs*. New variants of synthetic cannabinoids and other

synthetic, psychoactive substances have been discovered in shipments by post and courier. So far in 2012, several attempts have been uncovered to illegally import synthetic cannabinoids in shipments by post and courier from China, the USA and the UK. Although the Norwegian Medicines Agency decided to put eight substances on the list of narcotic substances in 2011, many of the synthetic substances that are seized are not regulated (personal communication, Directorate of Customs and Excise Enforcement Department, Anti Smuggling Section).

10.3 Seizure statistics

10.3.1 Main features

According to Kripos, the number of drug cases and seizures was higher in 2011 than in any previous year (Figure 10). However, the increase from 2010 was far smaller than the increase from 2009 to 2010. The increase in the number of cases and seizures can primarily be explained by a marked increase in seizures of cannabis and GHB/GBL, while the development for other classes of drugs was more stable or in decline.

- With the exception of hash and GHB, no record-high amounts of drugs were seized in 2011.
- Only in 1995 were greater quantities of cannabis products seized than in 2011, and never before was so much hash seized. The number of cultivation cases also increased, although the quantity of cannabis plants has been higher before. Based on the number of seizures, the proportion of marijuana was higher than ever before.
- During the last two years, almost 40 new synthetic substances have been found that have not been or are not classified as drugs. In addition, many intoxicating plant materials have been found that are not included on the list of narcotic substances either. The quantities are often very large for several of these substances, with a high number of user doses per weight unit. The quantities of synthetic cannabinoids that were seized

in 2011 can thereby correspond to as much as 1,000–1,500 kg of hash.

- The number of heroin seizures in 2011 was lower than in 2009 and 2010, but on a par with the average for the last ten years. It is more striking that the seizures only amounted to 15 kg in quantity. Only in 2007 has less heroin been seized since the turn of the millennium. Moreover, the average heroin content has fallen to a historically low 15 per cent.

- For the total number of seizures of stimulants, amphetamine, methamphetamine and cocaine, and other stimulants, the statistics show a slight decline in relative terms.

- The amount of amphetamines seized was the lowest since 2005, while the number of seizures was almost as high as the record year 2010. Methamphetamine accounted for 60 per cent of the total number of seizures of amphetamines.

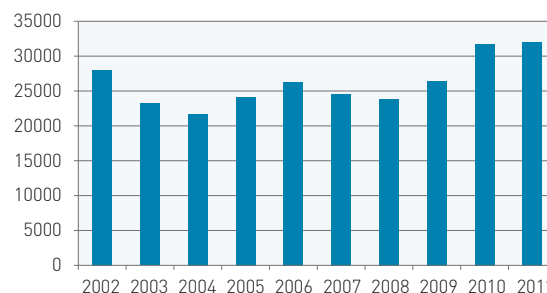
- PMMA, which was introduced to the user market in 2010, and which has been linked to a number of overdose fatalities in Norway (see Chapter 6.4) is still on the market.

- The amount of cocaine seized is the lowest since 2006, while the number of seizures is on a par with recent years.

- No significant changes have been registered in the seizure data for benzodiazepines (BZD), but a large number of units are still seized.

- Although seizures of ecstasy remained low in 2011, both the quantity and the number of seizures of MDMA have started to rise following a big decline in the two preceding years. Other drugs than MDMA were found in about half of the seizures of such tablets, which normally carry a logo.

Figure 10: Total number of drug seizures 2002–2011.



Source: Kripos

Data basis and sources of error

The annual report from Kripos on the status of and developments in drug trafficking contains national data that include all seizures by the police, the customs service, the prisons and the Armed Forces. The data are based on verified analysis results for use in ordinary criminal cases, as well as on information from the police districts when drug offences are decided locally through fines or by summary trial based on a guilty plea. The latter categories are decided without the seizures being tested at the Kripos laboratory. In these cases, relevant information is usually given about what the seizures probably contain. The sources of error are not deemed to have a significant bearing on the main trends, but experience indicates that some of the minor seizures may include other types of drugs than those stated in statements to the authorities. This could apply in particular to the ratio between amphetamine and methamphetamine or to so-called 'ecstasy tablets' that no longer always contain MDMA or analogues.

10.3.2 Statistics for 2011

In 2011, 26,446 drug cases were registered (Table 10). Of the total number of drug cases, 10,327 were analysed, while 16,119 were fixed-penalty cases. The increase in the number of cases since 2010 is 2.3 per cent, while it was as high as 19 per cent from 2009 to 2010. All of the increase from 2010 concerns the smallest drug seizures, where the cases are settled by a fine, while the analysis cases show a decline of 3.9 per cent in real terms. The fact that the number of analysis cases was

higher at the start of the 2000s can largely be explained by changes in the Director General of Public Prosecutions' prosecution directive of July 2006, in which the upper limit for the use of fines for possession of cannabis was raised from 5 grams to 10–15 grams.

Table 11 shows that the quantities seized (naturally) vary considerably from one year to the next. As an indicator of the size of individual seizures, based on quantitative criteria for prosecution that meet the definition of aggravated drug

crime in the General Civil Penal Code section 162 third paragraph, 25 such large drug seizures were made in 2011, which is far fewer than in the two preceding years (Table 12).

Table 13 shows the changes in the number of seizures during the period 2006 to 2011, while Figure 11 shows the market share in 2011 for the most common substances.

Table 10: Number of drug cases 2002–2011

Year	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Analysis cases	12,737	11,163	11,132	11,498	12,066	9,565	8,406	8,887	10,749	10,327
Fine cases	10,633	9,131	8,119	7,714	9,277	10,845	11,194	12,980	15,338	16,119
Total all cases	23,370	20,294	19,251	19,212	21,343	20,400	19,600	21,866	26,087	26,446
% fine cases	45.5	45.0	42.1	40.1	43.4	53.1	57.1	59.3	58.8	60.9

Source: Kripas

Table 11: Amounts seized for the most relevant drugs 2006–2011*

Year	2006	2007	2008	2009	2010	2011
Cannabis (kg)	1,544	853	1,732	2,588	1,181	2,981
Amph./methamphetamine (kg)	386	559	362	431	294	238
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	102.3	15.0
Other opioids (tablets)	15,685	11,906	11,193	15,186	19,724	13,519
BZB (units)	1,019,710	730,443	310,435	671,232	921,596	804,848
Cocaine (kg)	40.5	95.0	76.8	61.1	94.2	46.0
Ecstasy (units)	28,636	78,725	30,678	22,700	3,420	5,327
Psilocybe mushrooms (kg)	0.84	1.36	0.5	1.66	2.0	2.6
LSD (units)	226	26	245	510	174	885
GHB/GBL (ltr)	45.5	100.9	257.3	213.4	492.4	534
Synthetic cannabinoids (kg)						10.0

* The data for 2011 have been corrected as of September 2012 for several drugs after final analyses have been carried out.

Source: Kripas

Table 12: Large drug seizures pursuant to the General Civil Penal Code section 162 third paragraph in 2008–2011.

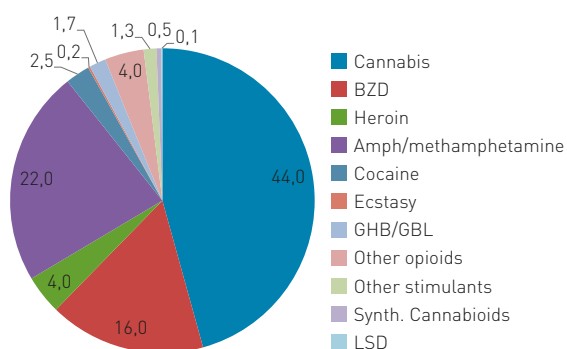
Drug type	Number 2008	Number 2009	Number 2010	Number 2011
Amphetamine/methamphetamine (threshold: seizures > 3 kg)	14	21	12	10
Cocaine (threshold: seizures > 3 kg)	4	4	3	4
Ecstasy (threshold: seizures > 15,000 tablets)	0	1	0	0
Cannabis (threshold: seizures > 80 kg)	3	6	2	7
Heroin (threshold: seizures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

Source: Kripas

Table 13: Number of seizures in the period 2006–2011 broken down by some types of drugs*.

Drug type	2006	2007	2008	2009	2010	2011	Average 2006–2011
Cannabis	11,221	9,952	10,599	11,754	13,284	13,962	11,795
Amph./methamph.	5,819	5,507	5,153	5,775	7,287	7,221	6,124
Heroin	1,087	1,204	1,145	1,430	1,575	1,364	1,300
Benzodiazepines	4,500	4,058	3,451	3,796	5,089	6,716	4,601
Painkillers/ opioids	1,161	959	936	1,078	1,223	1,240	1,100
Cocaine	726	909	854	804	877	840	835
Ecstasy	411	421	309	110	79	198	254
LSD	28	13	15	26	30	31	24
GHB/GBL	122	188	173	321	436	515	293
Psilocybe mushrooms	82	77	54	75	114	104	84
Synthetic cannabinoids						199	-

* The data for 2011 have been corrected as of September 2012 for several drugs after final analyses have been carried out.
Source: Kripas

Figure 11: Market share for different drugs in 2011. Number of seizures. Percentage.

Source: Kripas

Comments on some of the individual drugs

Cannabis: The amount of cannabis seized, 2,981 kg, breaks down as follows: approximately 2,548 kg of hash (85 %), 219 kg of marijuana (7 %), 214 kg of cannabis plants (7 %) and 0.26 kg of cannabis extract. This breakdown is not very different from 2010, but the amount of plants is less than half compared with 2008, when the police uncovered particularly many ‘cannabis plantations’.

The number of cannabis seizures breaks down as follows: 73 per cent hash, 24 per cent marijuana and 3 per cent cannabis plants. Seen in relation to the number of seizures, the proportion of hash is somewhat lower than in 2010 (76 %), but it is higher for marijuana (22 %). As regards cannabis plants, 417 seizures were made in 2011, which is

higher than ever. 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 2011, 2,894, was lower than in 2010, while the number of seizures of methamphetamine, 4,327, was substantially higher than the year before (3,645).

The proportion of methamphetamine compared with amphetamine culminated in 2009, but it was nevertheless estimated to be as high as 60 per cent in 2011 (Table 14).

Table 14: Proportion of seizures of methamphetamine in relation to amphetamine.

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

Source: Kripas

Heroin: The amount seized in 2011, 15 kg, again shows a strong decline. Although the amounts have varied greatly in the 2000s, the annual number of seizures, which is a better parameter of prevalence, has been far more stable. As before, most heroin seizures are made in the biggest towns and cities in Norway. Together, Oslo Police District and Hordaland Police District

(Bergen) made 65 per cent of all the seizures of heroin in 2011.

Painkillers, medicinal drugs classified as narcotics (opioids): No major seizures of these medicinal drugs were made in 2011 either. 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.

Cocaine: Following a strong increase in the number of cocaine seizures after the turn of the millennium, the number of seizures culminated in 2007. Although the number of seizures (840) and the amount seized (46 kg) were relatively high in 2011 as well, the number is falling in relation to the general increase in cases since 2007. From accounting for approximately 1.5–2 per cent of drug seizures at the start of the 2000s, the proportion of cocaine seizures increased to four per cent in 2007. The proportion has since fallen every year, and it was 2.5 per cent in 2011.

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-chlorphenylpiperazine), 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 2011 show that MDMA is once again on the increase in Norway. In addition to tablets, seizures have also been made of approximately 380 grams of MDMA in powder form.

GHB and GBL: Although the number of seizures of GHB and GBL does not account for more than approximately 1.5 of the total, there

has been a considerable increase in both the amounts 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.

Benzodiazepines-BZD: Bigger quantities of active agents have not been seized in 2011, as has been the case in previous years. However, alprazolam and diazepam are found relatively often in seizures of powder in combination with heroin. There is little doubt that demand for this type of medicinal drug is still great on the illegal market.

PMMA: In addition to traces of the substance in drug mixtures containing amphetamine and methamphetamine, 7.1 kg of drug mixtures containing pMMA and 730 tablets were seized in 148 seizures, which is a decrease in quantity but almost a twofold increase in the number of seizures in relation to the year before. In 2010, 79 seizures were made containing a total of 24.6 kg, which was largely due to one big case, and 28 tablets.

10.4 Price of illicit drugs at retail level

The latest overview of estimated drug prices from Oslo Police District as of May 2010 was presented in the National Report for 2010. Compared with the previous overview from October 2008, the nominal price of a typical user dose in the Oslo area has remained relatively stable: EUR 25 (NOK 200) for 0.2 grams of heroin, EUR 12.5 (NOK 100) for 0.2 grams of amphetamine, EUR 37.5–50 (NOK 300–400) for 0.5 grams of cocaine, and EUR 12.5 (NOK 100) for 0.7 grams of hash.⁹

⁹ Conversion rate: 1 EUR = NOK 8.

However, there seems to have been a marked drop in price for quantities of up to five grams for both heroin and cocaine in the same period. The price of one gram of heroin is now estimated to be EUR 87.5–100 (NOK 700–800), compared with EUR 125 (NOK 1,000) in 2008, and the price of five grams is now EUR 225–375 (NOK 1,800–3,000) (2008: EUR 313–438). For cocaine, the price of five grams has dropped from EUR 438 to EUR 313. For hash and amphetamine, the changes are only marginal.

The price also seems to have dropped for purchases of ten grams. The estimated price of ten grams of heroin was between EUR 450 and EUR 688 in 2010 (NOK 3,600 and NOK 5,500). In 2008, the price level was EUR 625–750 (NOK 5,000–6,000). The price of ten grams of cocaine and amphetamine is also markedly lower, approximately 18 per cent lower for cocaine and as much as 25 per cent lower for amphetamine. There are no such changes in relation to hash.

As regards ecstasy, the price level as a whole has remained stable. The price per tablet is around EUR 12.5 (NOK 100), while a certain reduction can be seen in the price of 100 tablets.

Naturally, a price list of this kind must be treated with considerable caution. However, since the data have been collected from the same source for several years, some comparison is possible.

10.5 Purity/potency/composition of illegal drugs and tablets

Table 15 shows that the average purity of heroin base continues to fall. An average purity of 15 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
Purity percentage	26 %	30 %	36 %	31 %	25 %	21 %	15 %

Source: Kripas

The average purity of amphetamine was about 25 per cent, and 38 per cent for methamphetamine. For amphetamine, this is the same percentage as in 2010, while it is lower for methamphetamine (2010: 44 %). As in previous years, the purity in analysed seizures varied greatly in 2011, from less than one per cent to 96–99 per cent.

As reported for several years now, the purity of seized cocaine has been declining steadily, from 69 per cent in 2000 to 25 per cent in 2009. The purity increased again to 37 per cent in 2010, and then declined again to 31 per cent in 2011. There are still great variations, ranging from one per cent to 97 per cent in the individual seizures in 2011. Phenacetin, xylocain and caffeine are often found as additives.

As regards the THC content in the cannabis seizures, there are still great variations for both marijuana and hash. Full-grown plants usually contain three to seven per cent THC, and isolated top shoots usually contain 11 to 22 per cent. For hash, which dominates the Norwegian market, the average THC content has remained at

Table 16: Average purity of cocaine 2000 and 2004–2011.

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

Source: Kripas

around seven per cent for several years, but analyses from recent years indicate that this average has increased to eight per cent. In a few individual cases, which concerned the smuggling of dark balls of hash inside couriers' bodies, a THC content of as high as 25–35 per cent was found in 2011, the highest ever measured in Norway.

In 2010, the proportion of seizures of MDMA only accounted for 19 per cent, while in 2011, this proportion had increased substantially to 62 per cent.

PART B

Selected issues

11. Residential treatment for drug users

Astrid Skretting, the Norwegian Institute for Alcohol and Drug Research

11.1 History and policy frameworks

11.1.1 The history of residential treatment

As early as 1961, Norway had established one of the first specialist clinics in Europe for problem drug users (the National Clinic for Drug Abusers). Initially, the majority of the patients were so-called 'classic' drug addicts, or adult patients who abused morphine or other opioids. The clinic worked on the basis of a psychiatric/medical model. Based on the new client groups that subsequently emerged as a result of young people's use of illegal drugs, the clinic was reorganised in 1979 into a more social-educational institution with the emphasis on school, work training and rehabilitation.

As a need grew for treatment measures for an increasing number of young people and young adults who had developed problems relating to the use of drugs, it was emphasised that the treatment should not be developed as a separate care service, as had been the tradition in the care for alcoholics. It therefore became a goal early on that the help and treatment services should be developed as part of the ordinary treatment system. In the early 1970s, emphasis was therefore placed on establishing treatment services within the framework of mental health care. The most important reason why the mental health care services were allowed to take responsibility for people who developed drug problems was that the use of drugs was regarded as one of several symptoms of mental health and social problems. Secondly, experience showed that gathering a large number of drug users in the same institution made treatment more difficult. It therefore seemed to be most expedient to treat drug users

together with other patient groups (Ministry of Social Affairs, 1976).

Moreover, a separate care service for the treatment of drug users alone would give the impression that this was a very unique and limited illness. The general public would thereby find it more difficult to see the connection between social and economic factors and drug abuse (ibid.).

It became clear relatively quickly, however, that traditional mental health services were not equipped to deal with this new category of patients. Many of the young people who sought treatment for their drug problems needed measures that the psychiatric services could not provide. During this period, political and professional schools also emerged that led to a change in views on how young drug users should be handled. From the early 1980s, more systematic efforts were therefore made to develop special in-patient services for long-term treatment. One important element was that social and mental health problems were not to be treated within the framework of an authoritarian medical-psychiatric understanding. Instead, a psychological, social-educational approach was adopted that focused on equality of status between client and helper and on social network-building. In other words, drug use went from being perceived as a traditional illness to being understood more in social-psychological terms. Based on the recognition that problem drug use among young people is a complex problem that requires untraditional approaches, what are known in the Nordic countries as communal residential and work facilities were established. Other treatment institutions also gradually emerged that were based on different professional approaches, for example what are known as 'greenhouses', which are developed as therapeutic communities. The initiatives largely came from groups or individuals,

who established the institutions with the help of public funding.

The HIV/Aids epidemic among injecting drug users in the mid-1980s highlighted the need for greater treatment capacity. Substitution treatment was not regarded as an option at this stage. The most important reason for the opposition to this type of treatment was the idea that heroin users, like everyone else, were capable of changing their behaviour. It was claimed that methadone treatment meant abandoning this fundamental belief in change and society's obligation not to give up, but to try again and again. Treatment optimism could be said to have predominated on behalf of medication-free treatment of heroin users (Skretting, 1997). The then Ministry of Social Affairs presented a dedicated action plan for the development of in-patient treatment, with the goal of establishing 300–350 new in-patient places for problem drug users (Ministry of Social Affairs, 1988). All the county authorities in Norway were invited to present plans for the development of treatment measures for drug users, and, as a result of financial assistance from the state, around 400 new in-patient places were established.

Overall responsibility transferred to the county authorities

Initially, it was the county authorities that were responsible for treatment institutions for problem drug users, while the state was responsible for corresponding institutions for alcoholics. This was changed by the Act relating to Social Services, which entered into force on 1 January 1993. As a result of the new Act, the county authorities were assigned overall responsibility for the treatment of both patient groups.

The foundations for the organisation of treatment measures for drug and alcohol users by the county authorities were laid in the Act relating to the County Authorities' Responsibility for Institutions for Alcoholics etc. of 1984. The Act relating to Social Services went one step further by assigning overall responsibility for treatment measures for drug and alcohol users to the

county authorities. The Act relating to Social Services gave the county authorities responsibility for ensuring that a sufficient number of places in institutions were available to cover the need at all times (responsibility for 'ensuring' this). The emphasis on the municipalities' responsibility for providing help in the local community instead of leaving drug or alcohol users to be treated in institutions was followed up by a funding arrangement whereby stays in county institutions were co-financed by the municipalities and the county authorities. The county authorities could own and run the treatment units themselves, or choose to enter into operating agreements with or buy individual places from private providers. The units were largely regulated by the Act relating to Social Services, but the county authorities could also fulfil their treatment responsibility by using treatment measures regulated by other acts (the Hospitals Act). In practice, this primarily applied to outpatient treatment units originating in the psychiatric services (e.g. the psychiatric youth teams), but also to some in-patient units.

Norway carried out major health policy reforms in the years following the turn of the millennium. As a result of the Regular GP Reform of 2001, all the country's inhabitants were assigned a regular GP. Through the Hospital Reform, which entered into force in 2002, responsibility for and ownership of hospitals and other specialist health services was transferred from the county authorities to the state. Five state-owned regional health authorities were established (reorganised as four from 1 January 2009) that shall ensure that adequate specialist health services are available to the population in the respective health regions.

In 2004, the Hospital Reform was followed up by the Administrative Alcohol and Drugs Treatment Reform. Through this reform, responsibility for treatment for drug and alcohol problems was also transferred from the county authorities to the state represented by the regional health authorities. It thereby became part of the state specialist health service. The reform formed the

organisational basis for viewing treatment for drug and alcohol problems in conjunction with the other specialist health services in somatic health care and mental health care. The municipal health and social services still have overall responsibility for covering needs that are not covered by the specialist health service.

Residential treatment for drug users has primarily been organised as long-term treatment periods of one to three years. This is in contrast to institutions that provided treatment for alcohol problems, which have focused to a greater extent on shorter stays in clinics. After treatment for drug and alcohol problems became part of the specialist health service, a gradual shift towards shorter stays in institutions also applies to the treatment of problem drug users. The idea is that treatment will be provided to a greater extent as outpatient treatment, in combination with shorter stays in institutions when this is considered necessary, and in combination with the municipal health services.

11.2 Strategy and policy frameworks for residential treatment

The regional health authorities' new responsibility was defined as 'interdisciplinary specialised treatment for drug or alcohol use', and legislative regulation of relevant treatment units was transferred from the Act relating to Social Services to the Act relating to Specialist Health Services. The Ministry of Health and Care Services has explained in a circular what the amendments entail (Ministry of Health, 2004a). The circular also provides an interpretation of the provisions of the Patients' Rights Act and how they apply to interdisciplinary specialised treatment.

The Patients' Rights Act entitles patients to free choice of hospitals. Correspondingly, drug and alcohol users are entitled to free choice of treatment facility. They can choose between treatment facilities anywhere in Norway that are part of the regional health authorities' services. In

other words, the right to free choice is not limited to the health region that the patient 'belongs' to. The right to free choice of treatment facility does not apply to the choice of treatment level, however. For example, a patient who has been granted a right to receive treatment for his/her drug or alcohol use cannot choose residential treatment if he/she has been granted a right to outpatient treatment. Nor can a patient who is deemed to be in need of short-term treatment (up to six months) choose a treatment programme of longer duration. A list of institutions/units that provide interdisciplinary specialised treatment is available at www.frittisykehusvalg.no. The list is divided into detoxification, outpatient treatment, 'short-term in-patient treatment' and 'long-term in-patient treatment'. Most of the institutions included offer both short-term and long-term in-patient treatment.

The Ministry has also prepared a strategy document aimed at the regional health authorities. It outlines national perspectives and strategies for the Administrative Alcohol and Drugs Treatment Reform (Ministry of Health, 2004b).

The goals of this reform are ambitious. It is emphasised that drug and alcohol users with concurrent problems shall receive better services. The treatment shall focus on comprehensive, individually-based approaches, with the emphasis on both a social and health-related perspective (ibid). The reform is intended to ensure that problem drug and alcohol users' patient rights are better promoted and safeguarded, and that they, as patients, receive the specialised health services that are necessary in order to reduce their somatic and mental health complaints, in addition to receiving treatment for their abuse. The need to ensure better services for problem drug and alcohol users with concurrent mental illnesses is emphasised in particular (ibid). The guidelines in circulars and policy documents concern both in-patient and outpatient treatment.

Help and treatment services for problem drug and alcohol users in Norway have traditionally

had a large proportion of private service providers, many of which had operating agreements with one or more county authorities. When the Administrative Alcohol and Drugs Treatment Reform was introduced, the regional health authorities took over the county authorities' agreements with private providers of treatment services. It is emphasised that the regional health authorities must give private providers an opportunity to compete on equal terms with public providers of treatment services. At the same time, however, the same quality requirements must apply to private and public treatment services. Now that treatment for problem drug and alcohol use is part of the specialist health service, there is reason to believe that both public and private providers will find that they are subject to more stringent requirements as regards quality and results.

Residential treatment for drug and alcohol problems under the auspices of the state specialist health service is funded by the state and is free of charge for the individual patients. No estimate is currently available of the costs per patient per day.

11.3 Availability and characteristics

National availability and accessibility

Because treatment for problem alcohol and drug use is uniformly organised in Norway, it is difficult to quantify how many in-patient institutions or units only provide treatment for problem drug use. In addition, organisational factors mean that some institutions are big and have several departments, for example units that are part of a hospital department. Based on the list at www.frittisyekehusvalg.no, 65 units/institutions state that they provide in-patient treatment for patients with drug problems. Of these, 28 are units affiliated to hospitals, 11 are therapeutic communities/communal residential and work facilities, and 26 are other types of in-patient institutions. While therapeutic communities/communal residential and work facilities primarily provide

treatment for drug problems, most of the other units also provide treatment for alcohol problems. The number of in-patient places is estimated to around 1,900 (Statistics Norway). It is not known how many of these places are used to treat patients with drug problems, however. The number will vary from year to year.

As regards the length of different forms of residential treatment, it often varies greatly – from short-term treatment programmes of four to six months to long-term programmes of up to three years. Because the same in-patient institutions in many cases provide both short-term and long-term treatment (in Norway, the distinction is drawn between ≤ 6 months and >6 months), it is not expedient to provide an overview of the number of units that provide short-term and long-term treatment programmes, respectively.

As long as treatment for problem drug and alcohol use was regulated by the Act relating to Social Services, referrals were made via the municipal social services, and the municipality paid part of the costs for each person undergoing in-patient treatment. When this type of treatment became part of the specialist health service, the right to make referrals was transferred to GPs, as is the practice for the specialist health service in general. However, because many problem drug and alcohol users have little contact with the ordinary health service, the Storting decided that the social services and the GPs shall have equal right to make referrals to interdisciplinary specialised treatment in and outside institutions. The social services' right to make referrals does not include specialised health services in somatic health care and mental health care, however.

Referrals for treatment are considered by an assessment unit that decides whether the referred patient shall be granted a right to treatment in the specialist health service. The assessment units consist of the different outpatient clinics in interdisciplinary specialised treatment and mental health care. A guide has been prepared for the assessment of such referrals (see Chapter 1.3). The guide covers the assessment of referrals to all

types of treatment for problem drug and alcohol use. It is the assessment unit that decides whether the referred patient shall be granted a right to treatment and whether the right shall include inpatient treatment (short-term or long-term), outpatient treatment or substitution treatment (Directorate for Health and Social Affairs, 2007). The assessment shall be carried out within 30 working days of receipt of the referral. In cases where a patient is granted a right to treatment, an individual deadline shall be set for when the patient shall receive the necessary treatment at the latest.

11.4 Types and characteristics of residential treatment units

Residential treatment in Norway is diverse and includes different approaches, such as therapeutic communities, family treatment, various psychodynamic methods, communal residential and work facilities, 12-step programmes etc.

There are some big differences between the different residential institutions and between what is included in the treatment programme. For example, it varies whether the treatment institutions themselves carry out detoxification of the patients, or whether patients must have gradually reduced their use of drugs or alcohol or not be under the influence of drugs or alcohol on admission to treatment. It also varies whether education and vocational training are offered as part of the treatment. While residential institutions that provide long-term treatment usually offer such services (communal residential and work facilities and therapeutic communities), this is naturally less common in more short-term treatment programmes. As regards various forms of somatic health care (including testing for HIV, HCV etc.), this is included as an integral part of the treatment programme in residential institutions.

In Norway, substitution treatment is mainly provided as an outpatient service. However, most residential institutions admit patients for

different forms of psychosocial treatment as a supplement to the substitution treatment.

As regards various forms of social follow-up/aftercare, this is in principle the municipalities' responsibility. However, such services are sometimes offered by residential institutions as an integral part of long-term treatment.

Although most residential institutions in Norway are not age/group-specific, some units are reserved for young problem users. There are also a few dedicated units for women and families, respectively. There are no special units for ethnic minorities so far.

When a patient who is discharged from residential treatment for drug or alcohol use is assessed as needing help from the municipal social services, the social services will be notified in good time if the patient so wishes. The discharge will then be planned and prepared in cooperation between the social services and the specialist health service.

Drug users in need of long-term, coordinated services are also entitled to an individual plan. The plan is intended to be a tool for cooperation between the patient and various service providers. It shall also contribute to strengthening coordination between the relevant service providers to ensure that the patient gets the help he/she needs. This includes services from the health service, social services, education and employment etc.

11.5 Quality management

Availability of guidelines and service standards for residential treatment

The regional health authorities are responsible for ensuring that there are adequate treatment services for different patient groups. As regards treatment services for patients with drug or alcohol problems, the individual health regions have prepared strategy plans for how to fulfil their responsibilities and what the treatment services

shall comprise. The regional plans contain guidelines for which treatment services will be provided. They apply to units operated by the health authorities themselves as well as to treatment services purchased from private service providers. Requirements specifications are prepared in connection with purchases from private service providers, which the relevant providers must comply with.

As of 2012, there are no uniform national guidelines for interdisciplinary specialised treatment over and above what is set out in the above-mentioned circulars and policy documents. This means that there is currently no national standard for staffing and what qualifications staff must have. However, the inclusion of treatment for problem drug and alcohol use in the specialist health service has led to greater focus on health professionals in such treatment than before. Moreover, the Directorate of Health is working on guidelines for the treatment of problem drug and alcohol users that will apply to both residential treatment and outpatient treatment. The following guides/guidelines relating to treatment for drug or alcohol use are also available:

- Guide to the assessment of referrals to interdisciplinary specialised treatment for drug or alcohol problems (2007). It applies to both residential treatment and outpatient treatment.
- National guidelines for opioid substitution treatment for opioid dependency (2011).
- National guidelines for pregnant women in opioid substitution treatment and follow-up until the children reach school age (2011).
- Guidelines for the treatment of patients with concurrent drug or alcohol problems and mental illness (2011).

(The guidelines have been discussed in previous national reports to the EMCDDA. See NR 2009–2011).

As regards documentation, interdisciplinary specialised treatment units are required to report

patient data to the Norwegian National Patient Register, in line with the rest of the specialist health service. These data form the basis for the annual reporting to the EMCDDA's Treatment Demand Indicator on patients who start treatment. The register of individual-based data was not established until 2009, so the data that are reported are still somewhat inadequate. Work is under way, however, on improving both the quality and the level of coverage. Inadequate reporting has not had any financial consequences for the individual treatment units so far.

11.6 Discussion and outlook

Based on information from the Norwegian National Patient Register, demand for treatment for drug and alcohol problems appears to be increasing. The inclusion in the patient register of patients who seek treatment for drug or alcohol problems is relatively recent, however, which makes it difficult to say for certain how many patients have sought such treatment in recent years compared with the first years of the new millennium.

There is also concern among many treatment providers about the fact that, whereas it used to be possible to offer residential treatment lasting one to three years, the responsible authorities now see shorter admissions as more desirable and want municipalities to take more responsibility for many of the services that were previously included in the treatment. This applies to education, work training, residential follow-up etc.

Since treatment for drug and alcohol problems became part of the state specialist health service, we have also seen increasing concern about the greater emphasis that is placed on the medical part of the treatment through increased use of medication, which may be at the expense of social aspects of treatment. We also note a trend whereby in-patient institutions are being ordered to admit patients in substitution treatment to a greater extent. This is a development that

personnel at some in-patient institutions are sceptical about, based on the view that drug users who, for different reasons, are not suited for or do not want substitution medication should be given an opportunity to take part in a treatment programme in which there are no patients receiving such medication.

As mentioned, the trend is towards shorter periods of in-patient treatment, a trend that is also being questioned. While stays of one to three years in institutions were common before, the trend is now for increased use of short-term residential stays and increased emphasis on outpatient treatment. Part of the background to this is that long-term residential treatment has traditionally included social components such as

training in living skills, education, employment etc. This is a responsibility that, in principle, rests with the municipalities and other service providers outside the specialist health service. It is therefore a goal that in-patient and outpatient treatment in the specialist health service be seen in conjunction and be combined with different municipal services, such as health-related follow-up, social services in the form of adequate housing, employment etc. Whether such a reorganisation from long-term to short-term residential stays will have the expected results will basically depend on whether the municipalities can actually provide the necessary services for the patient group in question, and whether treatment in the specialist health service is coordinated with the other services.

12. Case study: Oslo the capital city.

Key features of the city's drugs policy

Arne Schanche Andresen, The municipality of Oslo, Agency for Welfare

12.1 The City of Oslo's drugs and alcohol policy and most important agencies

The City of Oslo's supreme political body is the City Council and its subordinate committees. Political responsibility for drug and alcohol-related matters mainly rests with the Standing Committee on Health and Social Welfare. Oslo has a parliamentary form of government with City Government Departments that serve as the City Council's secretariat. The departments have subordinate agencies that have executive responsibility. *The Department for Health and Social Services* is responsible for various measures in the alcohol and drugs field.

On 1 January 2004, responsibility for what we in Norway call interdisciplinary specialised treatment for drug and alcohol problems was transferred to the state. See NR 2010 Chapter 5.1. As part of this, responsibility for detoxification and treatment, including mandatory treatment, was transferred to the South Eastern Norway Regional Health Authority pursuant to the Act relating to Social Services. This means that the City of Oslo is largely responsible for social, preventive and harm-reduction work relating to drug and alcohol use, and for providing suitable housing, recreational measures etc.

Establishment of the Agency for Welfare

In order to coordinate and rationalise drug and alcohol-related work and other health care and social work, a dedicated *Agency for Welfare* was established on 1 January 2012 by merging the Oslo Alcohol and Drug Addiction Services and the Health and Welfare Service. The new Agency

for Welfare is now the City of Oslo's executive body in the drugs and alcohol field. Relevant tasks for the agency are:

'The Agency for Welfare's main areas of activity are city-wide support functions in relation to social services and the use of social housing instruments, city-wide measures for problem users of drugs and alcohol, adapted housing arrangements and institutions. The agency is also responsible for procurements and contract administration in its own area, and it has a special responsibility for work targeting negative city centre milieus.' (www.velferdsetaten.oslo.kommune.no)

The new agency is organised in four departments.

The Institution and Housing Department manages all in-patient drug and alcohol measures in two relatively similar sections, both providing low-threshold, rehabilitation and care services. In addition, the department has a section for adapted housing for people with mental disabilities and young people, among others. As of August 2012, the Agency for Welfare had a total of 697 in-patient places for problem drug and alcohol users at its disposal, 217 of which were provided by private owners. The agency also administers City Council grants to 13 foundations and projects that are directly linked to work with people with drug or alcohol problems.

The City Centre and Urban Department is responsible for outpatient measures such as follow-up of Opioid substitution patients (OST), the outreach service, the field health care services, low-threshold health services, the injection room and the ambulant team. Harm-reduction measures are largely carried out at the field nursing stations, which provide advice and guidance to injecting drug users, a needle distribution service and referrals to the help services.

The Procurement and Grants Department is responsible for purchasing places in private drug and alcohol programmes, among other things. In 2012, agreements were entered into with 11 private programmes.

The Department for Social Issues and Social Housing includes the KOR-Oslo competence centre, one of seven regional competence centres for the drugs and alcohol field. KOR-Oslo is largely publicly funded, and the Directorate of Health is its primary client. The department is also responsible, among other things, for the comprehensive social services based in Oslo's city wards and the Drugs and Alcohol Helpline.

Budget

During the period 2006–2011, the budget available for drug and alcohol-related work in the City of Oslo has increased steadily and significantly. The number of full-time equivalents in ordinary positions has also increased, from 414 in 2006 to 491 in 2011. The increase is related, among other things, to the action plans for the city centre and low-threshold services.

12.2 Action plans for breaking up the drug milieus in the city centre

Since the end of the 1960s, there have been drug scenes in public places in Oslo where drugs have been sold and used more or less openly. During the same period, the City of Oslo, the police and various private players have endeavoured in different ways to solve the problems relating to the sale and use of drugs in open drug scenes. The most hard-core drug scenes have moved from the Royal palace park, down the main street Karl Johans gate, via Egertorget square, and ended up in an area in the lower part of Karl Johans gate/the central railway station/Skippergata. In recent years, scenes have also emerged along the Akerselva river/the Grünerløkka area, and in the Vaterland and Grønland areas.

The first coordinated plan, *The action plan for alternatives to the drug scene in the centre of Oslo*, was prepared by the Department for Health and Social Services for the period 2003–2005. The plan was a collaboration between affected ministries, the police and the City of Oslo. The primary intention was to break up the city centre milieus by intensifying rehabilitation and care work for the target group. The goal was to stop the extensive, open sale and use of drugs and, not least, to prevent the recruitment of young people to these hard-core scenes in and around the area near the central railway station known colloquially as 'Plata'. The measures were intended as 'active help services for individual users, and not contribute to legalisation or be perceived as or appear to be «social cleansing»'. Emphasis was to be placed on the extensive sale of drugs, and on not contributing to further stigmatisation of individual users. The measures were also aimed at obtaining a good overview of the scenes and the users' need for help. The steering committee also planned what became known as the 'Plata campaign' to eradicate the drug scene in this area. The police could no longer turn a blind eye to the use and sale of drugs there.

However, the measures did not help to improve the situation, and in June 2004, the police issued a statement announcing that, from a given date, they would no longer accept the on-going trading in and use of drugs. The police campaign led to extensive coverage in the media and an at times heated debate between public bodies and services, on the one hand, and voluntary organisations, on the other. The latter were of the opinion that the campaign was illegal and that drug addicts could not simply be chased around the city centre. The municipal services, on their part, were not sufficiently prepared to receive clients expelled and/or referred by the police. The milieu did not disappear, however, but moved to surrounding streets and areas. A new campaign was launched, among other things following complaints from businesses in the area. The open drug scene, and undisguised injection in particular, became less visible.

The city centre plan has been evaluated by SIRUS (Olsen and Skretting, 2006). The evaluation concluded that, although it did not lead to the break-up of the milieu, it led to an improvement of services for hard-core drug users, among other things by establishing an injection room in 2005, an increase in the provision of OST, housing measures with follow-up, referrals to treatment, funding of travel home for users not originally from the city, the serving of meals etc. For a while, the milieus became more dispersed, and counts also showed that the number of users decreased, but this trend was gradually reversed and the number of sellers again increased.

The evaluation also pointed out that the establishment of day shelters and health services near the city centre and the distribution of user equipment in the city centre have cemented the situation and hardly contributed to the break up of such scenes. Although some agencies, including some people in the police, believed it was useful to have an overview of the milieu and the trade in drugs by having a concentrated, open drug scene in the city centre, the situation became unacceptable during the course of 2004–2005. Businesses and the general public saw the situation as very unpleasant and also detrimental to commerce in the area. Although a coordinated police effort led to a reduction in the number of users in the most hard-core city centre milieus, it also caused some of the dealers and users to move to other areas near the city centre.

The first city centre plan was formally discontinued in 2009. The main purpose, i.e. to break up the drug dealing milieu and put an end to the open use of drugs, cannot be said to have been achieved. A lot of the work initiated during the plan period was continued, however, and is now being carried out under the auspices of the Agency for Welfare. Measures that were developed as a direct consequence of the plan have become a permanent part of the help services. They include the injection room and the establishment of several day shelters, some of which also offer meals/cafés. Increased access to low-threshold health services is also the result of the

first plan, and, not least, work has been strengthened on sending home people who are not resident in Oslo by referring them to the social services in their home municipalities.

Some of the drug problems in the city centre are due to the fact that Oslo, like most capital cities, has special ‘big-city’ problems relating to marginalised groups and individuals seeking ‘anonymity’ in cities. Certain groups of asylum seekers without legal residence in Norway and cases of organised crime and human trafficking are additional factors. Furthermore, it is part of the challenge that people with drug or alcohol dependency and serious mental problems often have problems making use of the help services that are available. This underlines the need for stronger integration of the help services and different professional groups in a longer-term perspective.

The City of Oslo’s action plan for city centre work 2012–2015 – Open drug abuse in Oslo city centre

The situation in Oslo in 2012 is that, despite plans and many years of efforts by the police, the municipality and voluntary organisations, open drug scenes in the city centre are still a considerable problem. The police council (crime prevention partnership between the police and the municipality), which was established in 2007, has had the open drug scene on its agenda from the start, and the police have worked actively to maintain the peace in and around these milieus. In connection with its action plan for 2011, the police council asked the Department for Health and Social Services to submit proposals that could contribute to bringing the open drug scene under control by developing measures that would improve conditions for those who are part of these scenes. On 16 February 2011, the City Council considered Report No 1/2010 to the City Council on drug and alcohol care in the City of Oslo. It passed the following resolution:

The City Council is requested to enter into a dialogue with voluntary organisations, the police and the health authorities with the

intention of finding measures for combating open drug dealing scenes.

This means that there is now broad political agreement on a joint, overriding goal of combating open drug scenes in Oslo. On the basis of this resolution, a new action plan has been prepared: *Open drug abuse in Oslo city centre – The City of Oslo's action plan for city centre work 2012–2015* (in Norwegian only). The plan is based on experience from the action plan 2003–2005 and on SIRUS's evaluations. In particular, greater emphasis is now placed on experience from big European cities that have largely succeeded in bringing open drug scenes and dealing cultures under control in the city centres.

In cooperation with one city ward and the accident and emergency service represented by the department for social and ambulant services, the Agency for Welfare has drawn up the new action plan in detail. Together with the police, these agencies will have chief responsibility for the practical coordination and implementation of the city centre plan. Both politicians and experts have been on study trips to enable them to benefit from transferable success factors and conclusions from corresponding work in Zurich, Lisbon, Vienna, Amsterdam and Frankfurt, among other cities. In its report 'Open Drug Scenes and Overdose Mortality – What to do?' (SERAF, 2011), the Norwegian Centre for Addiction Research has drawn up a list of success factors common to cities that have succeeded in reducing or eliminating open drug scenes:

- Combining control measures with help and care services
- Changing and mutually adapting the roles of the police, helpers and users
- Developing high availability of low-threshold services, usually through methadone programmes
- Closing, or actively preventing open drug scenes from developing, and making long-term active efforts to prevent these scenes from re-emerging

- Contributing to dispersing the use and sale of drugs, as opposed to such activities taking place in concentrated areas
- Developing a fundamental acceptance of users, including those who are unable or unwilling to stop using illegal drugs
- Not permitting destructive behaviour, developing a dialogue with the users that involves making demands on them
- Zero tolerance for disturbance of the peace, but nonetheless developing tolerance for users and finding methods for coexistence between society and users of illegal drugs.

These points form the basis for efforts in the city centre and serve as governing, strategic principles for work during the plan period.

A lot has already been accomplished in 2012. In addition to the continuation of measures that have proven to be effective, a new central reception centre for drug and alcohol users was opened in the city centre in April that is tasked with assessing the condition of and following up clients. The Prindsen reception centre, where the injection room is now also located, is responsible for coordinating the city centre work. It is a key factor in this work, and a great deal will depend on the centre succeeding in its tasks. The first phase of this work is a 24-hour residential facility with 17 rooms available for both men and women. As a rule, the time spent here will be limited to one or two days. Requests for emergency accommodation will go via Oslo accident and emergency service, the social ambulant emergency service.

Preventing the recruitment of young people to the hard-core drug scenes in the city centre continues to be an important goal. By providing financial assistance to travel home, clients from elsewhere will still be ensured local follow-up in their home municipality. Before the police initiated its city centre plan in July 2011, figures showed that about 50 per cent of those who were part of the open drug scenes in the city came from other municipalities. Systematic work has therefore been carried out in relation to the

social services in other districts to ensure follow-up of those who receive help to travel home.

Motivational work in relation to this group of clients will be strengthened and the overdose problem in Oslo will be followed up. A survey that sheds light on the overdose problem in Oslo 2006–2008 points to inadequate coordination, exchange of information and coordination in the help services (Gjersing et al., 2011). The report points out that the high overdose figures are largely due to the special user culture, which is characterised by multiple injection use, with heroin as the dominant drug. The proposals were described in detail in NR 2011 Chapter 7.1.1.

The number of heroin addicts in Oslo is estimated to be between 3,000 and 4,000, the majority of whom are injecting users. From time to time, various people have argued in favour of motivating users to switch to smoking heroin, but, so far, this has had little or no effect on these milieus.

About ten years ago, Oslo had its own overdose team. Considering the fact that the overdose problem still exists, it is surprising that the new action plan does not propose re-establishing such a team. It is possible, however, that the new reception centre and strengthening of the collaboration with the accident and emergency service will be sufficient to achieve a reduction in the number of overdose fatalities in Oslo city centre.

12.3 The city centre work and the responsibility of the city wards

Although the police's activity and presence in the city centre in recent years have led to a reduction in the number of visible problem drug users in the area around Oslo central station, a more lasting result will depend on expedient measures being developed in the city wards/ home municipalities.

Oslo is divided into 15 wards that have all prepared their own drugs and alcohol policy action

plans. In addition to preventive work and early intervention, the wards shall also provide local services and follow up clients before, during and after treatment, and strengthen employment-related and recreational services. Emphasis is also placed on greater user involvement. Housing measures with various forms of follow-up in the clients' local community will be prioritised. This concerns both adapted housing measures with varying degrees of follow-up and employment-related and recreational services that can include different activities and more work-related measures. This entails great challenges for the wards in areas that will be decisive if the city centre plan is to succeed in achieving its goals.

The Agency for Welfare and others have succeeded to some extent in developing work-related measures of this kind, but there is a need for more and especially adapted measures in the wards outside the city centre. If such measures are not established locally and are not seen as appropriate by those concerned, the problems in the city centre areas will largely persist in the years to come.

As before, the 'not in my backyard' attitude remains an obstacle to the establishment of expedient measures for hard-core drug users outside the city centre. This attitude is manifested, for example, in the form of neighbourhood campaigns against lodging houses and low-threshold services. This is a challenge that must be addressed by both the chief executives in the city wards and employees at grass-roots level. Close cooperation with both the user organisations and not-for-profit organisations involved in the drugs and alcohol field in Oslo city centre is essential. It must be an aim to hold regular meetings with voluntary organisations that work with drug addicts in the city centre in order to ensure better coordination of the efforts. Cooperation with government agencies and/or other municipalities that are responsible for people without legal residence and unaccompanied minor asylum seekers must also be systematised and strengthened.

12.4 Local policing strategies against drug scenes/drug trafficking

In parallel with the municipality's plan, the police have now developed their own plan for specific efforts targeting the open drug scenes. As far as possible, the plan will be coordinated with the municipal action plan, so that health and social services are included in continuation of the police's efforts. To get this to work satisfactorily, regular arenas have been established, and cooperation between the municipality and the police has been strengthened. The police focus on the following areas in particular:

- Open crime (the sale and use of drugs) shall be prevented and stopped
- A visible, permanent police presence in the open drug scenes near Oslo central station and in surrounding areas from 10.00 to 22.00 (every day)
- Prevent new recruitment – especially children and young people under the age of 18
- Eradicate criminal networks involved in the open drug scenes
- Clarify the identity of the most active foreign sellers with a view to deporting them to their home countries
- Take a repeat criminal approach to the most active foreign sellers who cannot be deported.

(Source: *The City of Oslo's action plan for city centre work 2012–2015*)

The city centre work is challenging and extensive on many levels. In their interdisciplinary work targeting hard-core users who are part of the open drug scenes, the municipality and the specialist health service must act swiftly, flexibly and unbureaucratically and have a clear division of responsibility and labour. In light of earlier actions and plans and other initiatives implemented by the municipality, the police and the public help services, emphasising coordination, communication and exchange of information will be decisive.

The outreach service has carried out social work in the drug milieus in the city centre since 1969. This service has been strengthened with two additional positions in connection with the new city centre plan and the work on adults with concurrent problems. One of the positions is held by a psychologist. This means better clinical competence at street level and it can also contribute to improving communication with and referrals to the specialist health service. The outreach service is out on the street and accessible for the target group seven days a week. The outreach service thereby plays a crucial role in city centre work in general and in the implementation of the city centre plans in particular. It must also be mentioned that the outreach service, which the police regarded for many years as unwilling to cooperate, now cooperates actively with the police who are involved in the city centre work – through frequent, regular cooperation meetings aimed at achieving the common goals enshrined in the plans. In June 2012, the outreach service conducted an average of 36.4 patrols per week, both during daytime and in the evenings, and at night at weekends. Each patrol consists of two people.

The police define five drug scenes in the central areas of Oslo:

- Oslo central station, including side streets and the lower part of Karl Johans gate, is a high-priority area. It is also relatively hectic at night, with drunkenness, violence and prostitution in addition to the sale of drugs.
- The Vaterland area, where cannabis is sold and where West African asylum seekers in particular are active sellers.
- The Grünerløkka area, where cannabis also dominates and is sold by the same groups as in Vaterland.
- The Grønland area is a key area for the sale of khat in the Somali community. This is serious for families whose main breadwinner is involved, because the family's finances usually collapse as a result of the person buying, selling and using khat.

The police are now present in the city centre milieu 16 hours a day, divided between two shifts. Since the plan was implemented in June 2011, the police have expelled approximately 210 persons per week on average who have been involved in the sale and/or open use of drugs. Each expulsion is logged systematically with respect to who, where and when, and which police officers were involved. This is important, among other things because urban myths sometimes circulate about police interventions and what has been referred to, especially by voluntary organisations, as ‘chasing and persecuting sick drug addicts in Oslo city centre.’ However, there appear to be fewer stories in the media with this kind of angle, which is probably related to the use of logs. The police underline that they are still in the initial phase of the plan, and that this is long-term work that, in addition to specific measures, also involves changing attitudes, values and ethics among officers at all levels in relation to working with such a vulnerable and problem-ridden target group.

The ECAD network

Oslo is a member of the ECAD (European Cities Against Drugs) network. ECAD’s main goal is to work towards a drug-free Europe. Only cities that support this main goal and thereby pursue a restrictive drugs policy aimed at combating liberal distribution of drugs and alcohol can become members. With reference to the establishment of the injection room and the extensive distribution of needles/user equipment free of charge, the question of whether Oslo is entitled to be a member has been raised from time to time, without this leading to it being excluded or resigning. All in all, it seems that participation in

ECAD over the years has probably been an important factor in preventing municipal authorities from adopting a more liberal drugs policy.

12.5 Monitoring system

For many years, the outreach service has conducted daily counts of people who are present in the open drug scenes in Oslo city centre. They are carried out at fixed times of the day and in the evenings. Although the counts cannot be regarded as research, they are nonetheless good indications of the size of the user groups that hang out in the city centre. The outreach service’s report on key figures for July 2012 states that:

‘In total, the outreach service registered contact with 497 different persons, 333 of whom were men and 164 women. This is somewhat lower than in June this year, but a clear increase compared with June last year.’

Of 43 new registrations, only 12 persons came from Oslo. Eighteen came from other municipalities, and thirteen were foreigners. Summer counts for the past three years show a marked reduction in the number of people who are present in the drug scenes in the city centre (Table 17).

There is still considerable activity in the city centre, however, also at night. The outreach service will therefore intensify its counts/observations at night on some weekdays to obtain a comparable picture of the situation.

Table 17: Average number of persons present in the drug scenes in Oslo city centre, summer 2010–2012

Area	June			July			August		
	2010	2011	2012	2010	2011	2012	2010	2011	2012
City centre – daytime	78.5	68.2	18.6	64.3	11.9	36.5	56.9	9.6	38
City centre – evening	92.9	86.3	20.4	75.8	17.2	37.5	65.8	8.8	41.4
City centre east – daytime	23.9	24.5	8.5	21.4	30.3	14.9	28.9	24	18.3
City centre east – evening	46.5	48.1	18.8	54.8	59.2	35.1	60.1	39.7	36.5

Source: Outreach service, the City of Oslo

The work of sending people back to their home municipalities and providing follow-up in collaboration with local social services in their home municipality is an important part of the outreach service's activities, but it has often proven difficult to establish adequate help measures locally. Many of those who have used the return travel scheme reappear in the open drug scene in Oslo after a short time.

Interventions in recreational nightlife settings

Measures targeting the city's nightlife, pubs and bars are largely focused on the serving of alcohol to people who are already drunk, the sale of alcohol to minors, and the extent to which the sale of beer by bars/pubs and supermarkets is in accordance with the Alcohol Act and municipal regulations. From time to time, however, the police take action against pubs, bars and clubs where they know, through undercover work etc., that drugs are used and sold.

12.6 Low-threshold services for problem drug users

Detoxification is the state's responsibility. It takes place at the emergency admissions department at Oslo accident and emergency service, in close collaboration, however, with the municipal reception centre, the municipal outreach services and the police. The low-threshold services are primarily municipal services. The City of Oslo has a total of 160 low-threshold places, including for clients actively using drugs. Forty-eight places are reserved for women. Twenty places in private low-threshold services come in addition. Not-for-profit organisations (the Church City Mission, the Salvation Army and the Fransiskus-hjelpen foundation) have also established similar services. The low-threshold services (day shelters) offer meals, showers, clothes etc. Since the infection control service and field nursing service are now established at the new reception centre, it is now possible for the centre to provide good follow-up for its clients. The emergency accommodation service is frequently used, and

collaboration with the city wards and other municipalities is working well.

There are eleven places in Oslo that distribute syringes/needles (six low-threshold housing facilities, the injection room, needle distribution facilities at the Prindsen reception centre, Café Trappa, the Pro Centre and the mobile nursing service). In 2011, the municipality handed out a total of 1,826,569 needles free of charge from the regular distribution facilities. In addition, 44,670 needles were distributed by outreach services/mobile units.

The LASSO project (harm-reduction substitution treatment in Oslo) offers quick start-up on Suboxone. Since the project started in 2011, 40 persons have been transferred to ordinary OST treatment. For a more detailed description, see NR 2011 Chapter 7.1.4.

One factor that probably contributes to drug addicts continuing to congregate in the city centre is the fact that most of the low-threshold services/day shelters and the needle distribution services are established in the city centre or in the immediate vicinity. This makes it difficult to prevent addicts from congregating in the city centre and to put a stop to the open use and sale of illegal drugs. Even though the municipality now has plans to move services for this target group somewhat further away from the city centre, it is difficult to get private organisations to do the same. Some claim that the target group will not be reached if low-threshold services offering free food etc. are not established where they hang out, which is in the city centre. In this context, we can perhaps discuss what came first – the chicken or the egg. The problems relating to the location of low-threshold services will be further assessed during the plan period. The Agency for Welfare has already decentralised needle distribution, and work is also under way on getting more pharmacies in the city wards to accept responsibility for needle distribution.

12.7 Current issues in Oslo – policy concerns

Both the municipality and the police are satisfied with the cooperation on the city centre plan. They believe that it works well both at street level and at the management level. In a memo of 13 July 2012 to the Standing Committee on Health and Social Welfare, the Vice Mayor for Health and Social Services gives some examples of this cooperation:

The cooperation between the outreach service, the child welfare emergency service and the police is an example of good cooperation in day-to-day work. When minors or parents with children are seen in or near the drug scenes or in an intoxicated state by the outreach service, the child welfare emergency service and the police are alerted. This helps to prevent new recruitment to the drug scenes and to ensure that children who live with parents who use drugs are taken care of. Another example is when the police meet people in need of help. On several occasions, the police have contacted the outreach service or escorted people to the accident and emergency service for further help and assistance.

The City of Oslo, represented by the Agency for Welfare and the Agency for Health, takes part in regular two-weekly meetings with the police, the Salvation Army, the Church City Mission, the «=Oslo» street paper and the Fransiskushjelpen foundation. The meetings focus on exchanging information and further development of the collaboration. The participants inform each other about their work and can raise situations or topics they consider relevant to the city centre work. It is also possible to raise complaints from users about police interventions in individual cases. The participants at the meetings have stated that they see the meetings as useful and as contributing to improving the collaboration.

The social ambulant emergency service (SAA) at the accident and emergency service, part of the Agency for Health, reports that it will implement new procedures for its social service tasks. The reception facilities will be rebuilt so that a complete conversation service will be permanently staffed and in continuous operation. This will ensure capacity and result in a more time-efficient service. In addition, the SAA will redeploy some of its resources to the weekend, in order to reduce vulnerability in periods of great demand. This will benefit users of the service, for example people looking for emergency accommodation.

The overriding goal of the Young people and drugs/alcohol project («Prosjekt Ungdom & Rus») is to prevent young people under the age of 23 who come to the accident and emergency service in an intoxicated state or under the influence of drugs from developing drug or alcohol problems*. During the project period, some individuals have repeatedly been in contact with the project and arrived at the accident and emergency service in an intoxicated state on several occasions. On this basis, the project will increase its focus on these repeat arrivals and, in particular, endeavour to establish appropriate measures for them, through follow-up and referral to local help services and the specialist health service. The project will be continued and will be implemented in the social ambulant emergency service from 2013.

* See more information in Chapter 7.1.1.

12.8 Discussion

The above description gives grounds for hoping that the City of Oslo, the police and important not-for-profit organisations could succeed in bringing the problems under control for the first time since the problems relating to the open use and sale of drugs in the city centre first arose in the late 1960s. One of the most important reasons for this is probably that the current plan has

broad political support. It is not least positive that both municipal and private organisations and institutions in the drugs and alcohol field are involved, that they appear to have developed a shared 'ownership' of the plan, and that they at least agree that none of the parties involved wants open drug scenes in which the use and sale of drugs flourish in public places. This is a particularly important precondition if we are to succeed in preventing different or conflicting strategies or measures aimed at the target group from developing. In order to achieve even broader support for this, it is important to involve the user organisations to a greater extent.

While the goals are largely shared by all the participating agencies, there is still some disagreement about the means to this end. Police efforts alone are not enough. Unless expedient measures for the target group are developed in parallel, preferably outside the city centre, it is probable that the situation could return to what it was like after the first plan for the period 2003–2005 was launched, namely that the situation in the city centre largely returned to square one.

It takes time to develop help services, change attitudes among user groups and establish new alliances for cooperation etc. When assessing the situation in the city centre, it must therefore be taken into consideration that the city centre plan to combat the open drug scenes has a long-term perspective, initially until 2015. Following conversations with leading police officers, the City of Oslo Department and the Agency for Welfare, as well as municipal personnel and employees of not-for-profit organisations, there is now reason to claim that a certain optimism prevails in relation to the ongoing work and the plans that have been adopted for the time ahead.

One factor that causes concern, and that could be an obstacle to success, is the fact responsibility for the situation in the city centre is being shifted from the city centre to the city wards. It is probably unrealistic to believe that the city wards, and, not least, other towns and municipalities, will manage to take responsibility locally

for this target group and provide expedient care and housing measures with various forms of follow-up, and employment-related and recreational measures. Unless the operation of both public and private low-threshold services is strengthened and, not least, coordinated as regards opening hours etc. to ensure efficient use of resources, future work could be unnecessarily difficult. Grants for such measures should be ensured and seen in conjunction with the plan, also in relation to the not-for-profit organisations.

Again, this is a question of ideals and realities in the Norwegian public debate. The fact is that, in Oslo as in all big cities, there will be a 'residual group' of drug or alcohol addicts and other down-and-out people in the city centre, and we need to find out how to address this situation. The provision of night shelters and short-term housing arrangements will probably also have to be strengthened for this group. They have to be someplace. So far, this can seem to be a case of too little, too late. It is not realistic to believe that the health and social services in the city wards and other towns or municipalities can take full responsibility for these people.

Despite all that remains to be done, a lot of promising work is being carried out. There may be disagreement about the means to the end, and there may be different motives, but having a common goal could prove to be the decisive factor if Oslo is to succeed in the long term in creating a city centre where everyone, including drug addicts and alcoholics, can be present without being a nuisance.

Note: Important informants for this chapter have been the management and staff of the Department for Health and Social Services, the Section for Social Services, the Agency for Welfare, the Salvation Army, the Church City Mission, the Fransiskushjelpen foundation, and employees of SIRUS.

Appendix 1.

Legal limits for driving under the influence of other drugs than alcohol

With effect from 1 February 2012, the Storting decided to introduce 'drug driving limits' for 20 narcotic substances and potentially intoxicating medicinal drugs. The Norwegian Institute of Public Health has provided the scientific basis for the new limits.

Since 1936, Norway has had a drink driving limit that defines when you are under the influence and thus not permitted to drive a car or operate other motor vehicles (cf. the Road Traffic Act). The limit was originally 0.5 mg/ml, but it was lowered to 0.2 mg/ml in 2001. The sentencing depends on the concentration of alcohol in the blood. No such limits have existed for illegal narcotic substances or intoxicating medicinal drugs. An individual assessment has therefore been required in each case. It has been necessary in such cases to use experts to assess whether the driver was under the influence. The experts have, among other things, considered individual tolerance levels and carried out a discretionary comparison of the degree of intoxication compared with what is normally associated with a given blood alcohol level.

Fixed limits

Legal limit corresponding to a blood alcohol level of 0.2 mg/ml

For 20 intoxicating substances, it has been documented that use entails an increased risk of a road accident. Concentration limits corresponding to a blood alcohol level of 0.2 mg/ml have been adopted for these substances.

Sentencing limits corresponding to 0.5 mg/ml and 1.2 mg/ml

For 13 of the 20 substances, sentencing limits have been adopted that correspond to the intoxication normally associated with a blood alcohol level of 0.5 and 1.2 mg/ml, respectively. There is documentation that intoxication becomes more pronounced at higher concentrations of these substances. As for alcohol, the development of tolerance to such substances is not taken into consideration.

The limits are linked to one individual drug, and not to combinations of drugs. If several substances are found in a case, and the concentration of one of the drugs is higher than the highest sentencing limit, it will not be necessary to carry out an individual (expert) assessment.

Sentencing limits have not been adopted for some drugs because the connection between the concentration of the drug in the blood and the degree of intoxication is highly variable. The drugs for which sentencing limits are lacking can result in very considerable intoxication, however, also at low concentrations. In such cases, an individual expert assessment will still be necessary to determine the degree of intoxication. Table 18 below shows the limits that apply from 1 February 2012.

Table 18: Legal limits for driving under the influence of other drugs than alcohol

SUBSTANCES	Legal limit corresponding to 0.2 mg/ml (micromol per litre of whole blood)	Limit corresponding to 0.5 mg/ml (micromol per litre of whole blood)	Limit corresponding to 1.2 mg/ml (micromol per litre of whole blood)
Benzodiazepines and similar substances			
Alprazolam	0.010	0.020	0.050
Diazepam	0.200	0.500	1.200
Phenazepam	0.005	0.015	0.030
Flunitrazepam	0.005	0.010	0.025
Clonazepam	0.004	0.010	0.025
Nitrazepam	0.060	0.150	0.350
Oxazepam	0.600	1.500	3.000
Zolpidem	0.100	0.250	0.600
Zopiclone	0.030	0.060	0.150
Cannabis			
THC	0.004	0.010	0.030
GHB	100	300	1,200
Hallucinogens			
Ketamine	0.200	0.500	1,200
LSD	0.003	*	*
Opioids			
Buprenorphine	0.002	*	*
Methadone	0.080	*	*
Morphine	0.030	0.080	0.200
Stimulants			
Amphetamine	0.300	*	*
Cocaine	0.080	*	*
MDMA	0.250	*	*
Methamphetamine	0.300	*	*

* Sentencing limits have not been adopted because the connection between the concentration of the drug in the blood and the risk of accidents/impaired driving skills is highly variable, or insufficiently documented. Pronounced intoxication can for example be seen at low concentrations, especially some time after taking large doses of amphetamine/methamphetamine.

Appendix 2. Sales and licensing hours

The municipalities decide sales and licensing hours based on the limits set out in the Alcohol Act. When the Alcohol Act was amended in 1989, ‘normal hours of operation’ and ‘maximum hours of operation’ were introduced for the sale and serving of alcohol. Normal hours for the sale of beer (more than 2.5 per cent alcohol by volume) are from 8.00 to 18.00 on weekdays and from 8.00 to 15.00 on days before Sundays and public holidays. The maximum hours are until 20.00 and 18.00, respectively. The maximum opening hours for Vinmonopolet (‘the wine monopoly’)¹ are from 8.30 to 18.00 on weekdays and from 8.30 to 15.00 on days before Sundays and public holidays.

The normal hours for serving spirits laid down in law are from 13.00 to 24.00 on weekdays, while the maximum hours are from 13.00 to

3.00. The normal and maximum hours for serving beer and wine are from 8.00 to 1.00 and from 6.00 to 3.00, respectively, on all days of the week.

Age limits

There are age limits for both the serving and sale of beer, wine and spirits. It is not permitted to serve or sell alcohol to persons under the age of 18.

- Alcoholic beverages containing more than 22 per cent alcohol by volume can only be sold or served to persons above the age of 20.
- Alcoholic beverages containing less than 22 per cent alcohol by volume must not be sold, served or supplied to anyone under the age of 18.
- Alcoholic beverages containing 22 per cent alcohol per volume or more must not be sold, served or supplied to anyone under the age of 20.

¹ Vinmonopolet is run by the state, but each municipality decides whether it wants to have an outlet and where, in such case, it will be located. Vinmonopolet must therefore apply to the municipality for permission to establish an outlet, but the initiative for the application can also come from the municipality itself.

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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=134,112_387&_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>