

The Drug Situation in Norway 2008

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

Acknowledgements

Since 2001, SIRUS has been the Norwegian Focal Point for the European Monitoring Centre for Drugs and Drug Addiction - EMCDDA. All member countries submit an annual national report and, in addition, a number of standardised tables, mainly epidemiological data. In 2008, two comprehensive questionnaires have also been completed, on treatment programmes and on prevention of health-related harm associated with drug use. They have been submitted separately to the EMCDDA.

As in previous years, this 8th annual national report on the drug situation in Norway has been drawn up in accordance with the reporting guid-

elines common to all member states in the EMCDDA. Since the report is intended to be brief and to primarily cover important development trends, it may appear rather fragmentary. Little of the information provided in last year's report will be repeated in this report. References are included instead. However, we hope that the report will prove useful to readers who wish to familiarise themselves with the drugs situation in Norway. SIRUS wishes to express its gratitude to all experts, external partners and public institutions that helped in the preparation of the report. Our thanks go in particular to the co-authors who have made textual contributions and to the author of the selected topic.

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Summary

Main findings

National policies and context

A temporary Act relating to injection rooms applies until 16 December 2009. On 31 October 2008, a consultation proposal was distributed in which it is proposed to make the Act permanent. The proposal means that it will be up to the individual municipalities to establish injection rooms as part of their overall services. It is proposed to discontinue the state grants that were available as part-financing during the trial period. The Regulations that have been issued will largely be continued in their present form in order to enable the measure to be defined as a health service.

In October 2007, the Government presented an action plan to the Storting (Parliament) for the drugs and alcohol field. It includes goals and measures for prevention, treatment and rehabilitation and entails a gradual escalation of funding in this field in the period up until 2010. The plan includes alcohol and drugs policy as well as national and international measures. The plan aims for a policy with a clear public health perspective. The aim is to raise professional standards through research and by strengthening competence and quality. As regards services, the principle is that the ordinary services should also be available to people with drug or alcohol problems. Cooperation between the different bodies and administrative levels is emphasised, as is the user perspective.

Drug use in the population

The annual questionnaire survey among young people aged between 15 and 20 in 2007 shows that cannabis, primarily hash, is still the drug most young people report having used. However, after peaking at the turn of the millennium, a clear reduction has been registered in recent years. The proportion who state that they have used other drugs also increased in the late 1990s before stagnating/ declining in recent years. The

decline appears to be somewhat greater among young people in Oslo than in the country as a whole.

Among young adults in their twenties, the figures are substantially higher, both for ever having used and recent use. In a survey from 2006, lifetime prevalence among the 21–30 age group had increased considerably in the preceding eight years, both for cannabis and other commonly used drugs. However, the prevalence for recent use, during the past six months, has been quite stable overall.

The next nationwide survey among the population as a whole is scheduled for 2009.

Injecting drug use

The trend for the number of injecting drug users remains largely unchanged; the figure increased until 2001, then fell until 2003 before levelling out. Summarising estimates from two methods, it was calculated that there were approximately 8,500 to 12,500 injecting drug users in Norway in 2006.

Treatment

Data from treatment services are still only available at aggregate level. The inclusion of all admissions to the interdisciplinary specialist health service in the Norwegian Patient Register will start on 1 January 2009.

A waiting list guarantee for children and young people entered into force on 1 September 2008. The waiting list guarantee is intended to ensure that no one who is entitled to necessary medical help shall have to wait for more than maximum 65 working days for treatment, and everyone will be entitled to an evaluation within 10 working days (as opposed to 30 working days for those

over the age of 23). In connection with the amendment of the law, a practice guide and a prioritisation guide are being issued that are intended to ensure uniform, good professional practice in the services.

Health correlates, consequences and responses

In Norway, there are two bodies that register drug-related deaths. According to preliminary statistics from the *National Criminal Investigation Service* (Kripas) for 2007, the number of drug-induced deaths was 200, an increase of 5 on 2006. Very many of the deaths are believed to be due to extensive polydrug use.

The most recent data from *Statistics Norway* are from 2006. They show a total of 251 drug-related deaths. Suicides in which narcotic substances were used are included here. There is reason to believe that the data from Statistics Norway are more reliable since this body prepares figures on the basis of medical examiners' post-mortem examination reports and death certificates in accordance with the WHO's ICD 10 codes.

In 2007, 248 new cases of HIV infection were reported. Only 13 of these cases were among injecting drug users. The number of HIV-cases has remained relatively low for a number of years, and little new infection is detected in this group.

Since the turn of the millennium, only sporadic, individual cases of hepatitis A have been reported among drug users. On the other hand, there has been a considerable increase in hepatitis B since 1996. In 2007, 60 of a total of 118 reported cases of acute hepatitis B were among injecting drug users.

In Norway, hepatitis C is not monitored to the same extent as hepatitis A and B, and the number of new cases of drug users being infected is therefore not known. From 1 January 2008, the notification criteria for hepatitis C have been changed, so that we can expect a better overview of the incidence among injecting drug users next year.

Medically assisted treatment (MAT) can undoubtedly be argued to be an important factor in the effort to prevent overdoses. The design of and participation in the Norwegian programme probably contribute to reducing the annual number of overdose deaths to a considerable extent. The MAT programme is big in the Norwegian context, and the number of clients is steadily increasing. By the end of 2007, the programme included more than 4,500 persons, mostly injecting drug users.

Oslo is the only municipality that has made use of the trial scheme for injection rooms. On assignment for the Ministry of Health and Care Services, the Norwegian Institute for Alcohol and Drug Research has evaluated the trial scheme in Oslo in its first two years of operation, February 2005-February 2007. The report was published in January 2008.

The state gave grants to low-threshold health services for substance abusers in 34 municipalities in 2007. A comprehensive evaluation was carried out of the services in 2007. The overriding goal was to answer the question of whether the services contribute to establishing an adequate service for substance abusers, mostly hardcore drug addicts, who do not use or are not reached by the ordinary health services. In the report, it is stated that, in general, the services appear to succeed in providing good help for 80 per cent of the users, while 20 per cent do not get sufficient help for various reasons.

Reported drug offences

Following an increase from 2005 to 2006, the number of reported drug offences fell in 2007. The use of drugs and drug crimes pursuant to the General Civil Penal Code were as frequent as in 2006. Thirteen hundred cases of the most serious type of drug crimes were registered in 2007, slightly up on previous years.

The number of arrests in 2007 on suspicion of driving under the influence of alcohol or other substances shows little change in relation to previous years. The number of cases in which drugs

and other intoxicating medicinal drugs were found in blood samples has remained stable for the last five years, at approx. 4,000 cases.

Tetrahydrocannabinol (THC) is one of the most frequently found substances in blood samples from arrested drivers, besides alcohol. The proportion of cases in which THC is found appears to be relatively stable, at around 30 per cent of the samples received. In recent years, methamphetamine has been increasingly found in blood samples from arrested drivers, while the trend for amphetamine appears to be declining.

Drug markets

The most striking development in 2007 was the large reduction in the amount of heroin seized. While the number of seizures again increased somewhat after a steady decline during the last six to seven years, much less heroin was seized in 2007 than in the preceding years, eight kilos – compared with 93 kilos in 2006. Even though the quantity seized is a less reliable indicator of prevalence than the number of seizures, it is nonetheless the case that so little heroin has not been seized since 1990. The reduction most probably does not reflect availability to the same extent. The price level has remained more or less unchanged, and no reports have been received of a heroin drought of any length. In the first half of 2008, the situation has changed in that several large seizures have been made and the number of seizures is again increasing.

Record amounts of amphetamine and methamphetamine were seized in 2007. In terms of the

number of seizures, the proportion of methamphetamine is increasing substantially in relation to amphetamine. It was approximately 35 per cent in 2007. There is no evidence to indicate that the importation and distribution of amphetamine and methamphetamine has changed, and Norway is probably still a substantial market for these two drugs in the European context.

While both the number of seizures and the amount of cannabis seized declined, the cultivation of cannabis plants was uncovered on an extensive scale. During the last six months of 2007 and into 2008, the police uncovered a large number of «plantations» in rented houses, particularly in Eastern Norway. The vast majority of the «gardeners», and probably also the ringleaders, are of Vietnamese origin.

As for prices, the price level for smaller quantities in 2008 seems to have largely remained stable for most of the types of drugs since the last overview produced by the police in 2006. In nominal terms, prices have probably fallen slightly, rather than the opposite. The most striking development is that the price of cocaine appears to have fallen for typical sales doses. Naturally, prices for drugs on the illegal street market are far from accurate and thus must be treated with considerable caution.

PART A

New developments and trends

1. National policies and context

1.1 Legal framework

The temporary Act relating to injection rooms¹ (discussed in NR 2007, Chapter 1.1) applies until 16 December 2009. On 31 October 2008, a consultation proposal was distributed in which it is proposed to make the Act permanent. The proposal means that it will be up to the individual municipalities to establish injection rooms as part of their overall services. It is proposed to discontinue the state grants that were available as part-financing during the trial period. The Regulations that have been issued will largely be continued in their present form in order to enable the measure to be defined as a health service.

Waiting list guarantee for children and young people

In April 2007, the Government presented Proposition No 53 to the Odelsting (2006–2007) in which it proposed authorising the issuing of regulations containing a statutory waiting list guarantee for children and young people under the age of 23 with mental illnesses and substance abuse. The proposition was adopted in December 2007 and the regulations entered into force on 1 September 2008. The waiting list guarantee is intended to ensure that no one who is entitled to necessary medical help shall have to wait for more than maximum 65 working days for treatment, and everyone will be entitled to an evaluation within 10 working days (as opposed to 30 working days for those over the age of 23). See also Chapter 5.1.

On 22 April 2008, the Ministry of Health and Care Services distributed a proposal for consultation that will make it a statutory requirement for health personnel to contribute to attending to

the needs of children when parents, as a result of mental illness, drug addiction/alcoholism, serious somatic illness or injury, are not capable of or are unable to provide a child with the necessary help and care. The purpose of the amendments to the law is to ensure that the children of such patients are identified and taken care in a better and more systematic way than at present. The children and parents will be given information and guidance, and they will be consulted. Among other things, this will require changes in the duty of confidentiality to which health personnel are subject. It is also proposed that the specialist health service shall, insofar as necessary, have health personnel with particular responsibility for following up children.

1.2 Institutional framework, strategies and policies

The Minister of Health and Care Services has overall responsibility for drugs and alcohol policy in Norway and for coordinating efforts in the field. Drugs and alcohol policy involves several different sectors and requires cooperation and coordination across ministry and agency boundaries. Moreover, there is a tradition in Norway for pursuing a holistic alcohol and drugs policy, and there will therefore be one integrated action plan for the whole field.

In addition to the Ministry of Health and Care Services, the most involved ministries are the Ministry of Labour and Social inclusion, the Ministry of Children and Equality, the Ministry of Justice and the Police, the Ministry of Local Government and Regional Development and the Ministry of Education and Research. The respective directorates, the Norwegian Institute for Alcohol and Drug Research, AS Vinmonopolet, the county governors and the regional drugs and alcohol competence centres all have important responsibilities in the field of drugs and alcohol

¹ Temporary Act No 64 of 2 July 2004 relating to a trial scheme for premises for the injection of drugs (the injection room scheme)

policy. Good contact and cooperation between the different bodies is emphasised.

1.2.1 Norwegian National Action Plan on Alcohol and Drugs

In October 2007, as part of Proposition No 1 to the Storting (2007–2008) for the Ministry of Health and Care Services, the Government presented an escalation(action) plan for the drugs and alcohol field. It includes goals and measures for prevention, treatment and rehabilitation and entails a gradual escalation of funding in this field in the period up until 2010.

The plan includes alcohol and drugs policy as well as national and international measures. The plan aims for a policy with a clear public health perspective. The aim is to raise professional standards through research and by strengthening competence and quality. As regards services, the principle is that the ordinary services should also be available to people with drug or alcohol problems. Cooperation between the different bodies and administrative levels is emphasised, as is the user perspective. The overriding goals are:

- A clear public health perspective
- Better quality and increased competence
- More accessible services and greater social inclusion
- Binding cooperation
- Increased user influence and greater attention to the interests of children and family members

See NR 2007 Chapter 1 for a more thorough description of the performance goals in the escalation plan.

Implementation of policies and strategies

The involved ministries shall cooperate during the plan period on continuous follow-up of the National Action Plan for Alcohol and Drugs. The plan assigns chief responsibility for each measure to a specific body. That body will be responsible for instigating measures and involving affected parties. Separate reporting procedures have been developed for the escalation plan that provide an

overview of the progress and status of each individual measure and for the plan as a whole. In other respects, the general division of responsibility in the public administration will apply.

The Directorate of Health (formerly the Directorate for Health and Social Affairs) is an executive and advisory body in the drugs and alcohol field. It is responsible for implementing large areas of the drugs and alcohol policy. The Directorate has wide-ranging responsibility for the escalation plan and it has chief responsibility for 58 of the 147 individual measures in the plan. Moreover, it shall ensure that an overview of the drugs and alcohol situation is available at the regional and local level, and it will publish an annual status report.

Responsibility for interdisciplinary specialist treatment has been assigned to the four regional health authorities. Norwegian drugs and alcohol policy is decentralised to a great extent, and the municipalities have been delegated considerable responsibility for prevention, rehabilitation and reintegration of substance abusers in the local community.

Evaluation of policies and strategies

Many of the measures in the escalation plan will be specified in more detail during the plan period. In order to ensure systematic further development and implementation, a system of coordination meetings between affected ministries and relevant subordinate agencies has been established. The Ministry of Health and Care Services will be in charge of coordination, and it will also be responsible for coordinating the escalation plan with other plans. The status and progress of the different measures will be reported annually to the Ministry of Health and Care Services, and this reporting will form the basis for an annual summary of the attainment of goals and the progress of the measures.

In connection with the Directorate of Health's grant schemes, great emphasis is placed on evaluating the measures and earmarking funds for such evaluations. The goal is to contribute to im-

proving quality and supporting knowledge-based strategies and measures by ensuring continuity and local support.

1.2.2 New research centre

The Norwegian Centre for Addiction Research - SERAF, which was established in autumn 2007, is located in the same premises as the Medication Assisted Rehabilitation centre for South-eastern Norway and the department of specialist outpatient clinics in the Clinic for Drug Abuse and Dependence at Aker University Hospital.

The Centre (www.seraf.uio.no/eng) will primarily focus on clinically relevant drug research. The Centre shall have a national role in recruitment and education, functioning as a network builder for drug research in Norway.

SERAF shall have an intra-faculty function and multidisciplinary composition, and it shall represent sound expertise at international level in clinically relevant drug research. The research will be organised in four research groups:

- 1 Vulnerability to and development of dependency conditions
- 2 Drug-related and co-morbid conditions
- 3 Interventions – treatment and prevention
- 4 Health service research.

The research centre will be evaluated after five years and, provided that the evaluation is positive, it will be maintained for a further five years.

1.3 Budget and public expenditure

Law enforcement

No comprehensive overview is available.

Social and health care

Alcohol and drug-related tasks are part of the ordinary services. Isolating and quantifying costs from the social and care services that relate to drug problems is very complicated, and such figures can therefore often be misleading.

In 2007, the cost of interdisciplinary specialist treatment for problem drug and alcohol users amounted to EUR 287.5 million² (NOK 2.3 billion) of the regional health authorities' budgets. The figure includes the treatment of both alcoholics and drug addicts. However, the estimate only includes institutions specifically aimed at drug addicts and alcoholics. The costs of treatment of drug and alcohol problems at other institutions (for example in the mental health care services) cannot be quantified, and it will therefore come in addition.

In the national budget for 2008, an additional EUR 15.63 million (NOK 125 million) was allocated to the drugs and alcohol field for following up and implementing measures in the escalation plan. The allocations break down as follows:

- EUR 5.75 million (NOK 46 million) to boost acute treatment, detoxification and MAT
- EUR 1.5 million (NOK 12 million) for the establishment of a system of drugs and alcohol advisers at the county governor offices
- EUR 2.88 million (NOK 23 million) for trial schemes with «special coordinators» in the municipalities
- EUR 0.88 million (NOK 7 million) for prevention and early intervention
- EUR 0.88 million (NOK 7 million) for dental health services for persons in MAT
- EUR 0.38 million (NOK 3 million) to boost drugs and alcohol research
- EUR 0.25 million (NOK 2 million) to strengthen the regional drugs and alcohol competence centres
- EUR 2.13 million (NOK 17 million) for municipal measures in the drugs and alcohol field
- EUR 1 million (NOK 8 million) for the Pathfinder prison project

² Conversion rate 1 EUR=NOK 8.00

The strengthening of the municipal sector and the specialist health service comes in addition. In the national budget proposal for 2009, it is proposed to increase the allocation to the drugs and alcohol field by EUR 37.5 million (NOK 300 million).

Special grant schemes

In addition to the ordinary block grant funding allocated to municipalities and health authorities, funds are channelled to special-priority purposes through grant schemes that are largely administered by the Directorate for Health. The grant schemes are divided between two items in the national budget:

Grants for municipal drug and alcohol measures - 2008: EUR 21.59 million (NOK 172.7 million). Among other things, grants shall be used to strengthen personal guidance and individual follow-up, low-threshold health measures for alcoholics and drug addicts, a trial scheme for injection rooms, dental health services for people with drug or alcohol problems and publications such as «Oslo».

Voluntary drug and alcohol prevention work etc. - 2008: EUR 14.98 million (NOK 119.8 million). Grants are earmarked for follow-up, care and rehabilitation services run by voluntary organisations and private undertakings, self-help and interest groups and work among family members, measures aimed at prostitutes and The street hospital in Oslo. In addition, EUR 444,425 (NOK 3.55 million) is channelled through the regional drug and alcohol competence centres in order to stimulate efforts by the municipalities and specialist health service.

The grant scheme *Measures among children and young people in large towns and cities* is administered by the Ministry of Children and Equality. Grants for youth measures are given to 23 urban municipalities and, in 2008, they amount to EUR 2.1 million (NOK 16.8 million). These measures should target youth groups and youth milieus that are deemed to be at risk. Young people from immigrant backgrounds face particular

challenges, and measures that promote integration are given high priority. These measures will specifically target young people who make little use of existing cultural and leisure services and provide better opportunities for qualification, inclusion and coping.

Grants for *Voluntary work etc.* are administered by the Directorate of Health. The grants are given in the form of project and operating grants for voluntary organisations in the drug and alcohol prevention field. The purpose is to help organisations that work to reduce the consumption and harm caused by drugs and alcohol to carry on and develop their efforts. The allocation for 2008: EUR 11.3 million (NOK 90.4 million).

Research

State funding is allocated annually to the Norwegian Institute for Drug and Alcohol Research-SIRUS and other research milieus (Table 1).

Table 1: Grants for research and dissemination in 2008. In EUR (NOK) million.

SIRUS	4.373 [34.982]
The Behavioural Centre	0.375 [3]
National Institute of Public Health*	1.250 [10]
The research programme – Research Council of Norway/SERAF	2.312 [18.5]
Drugs and alcohol research conducted by the regional health authorities**	1.875 [15]
Total*	9.810 [81.482]

*Approximate figure

** Approximate figure for 2007

Regional drugs and alcohol competence centres

Annual grants are paid to the seven regional drugs and alcohol competence centres in Norway. Allocation for 2008: EUR 8.25 million (NOK 66 million).

The competence centres are an important link between the state and municipalities and regional health authorities in connection with the dissemination and implementation of research-bas-

ed knowledge and recognised methods. They have three main purposes:

- to stimulate the development of preventive measures in the municipalities
- competence-building in the municipalities and the specialist health service
- to develop national areas of expertise

The most important users of the centres' services are employees in municipal services and the specialist health service.

International actions

Grant for 2007 to UNODC: EUR 3 million (NOK 24 million).

1.4 Social and cultural context

Mass media campaigns

In order to increase awareness about the damage alcohol can result in and to increase knowledge about which methods work best, the Directorate of Health also ran the campaign – www.settegreenser.no in 2008. Such campaigns are followed up at the local level, among other things through cooperation with the parents council for primary and lower secondary schools. Young people and parents are particularly important target groups and there must be agreement between the information aimed at these two groups. In addition, people from immigrant backgrounds and pregnant women are given priority. More emphasis will be placed on adapting information to suit the section of the population at which it is aimed. Moreover, the Directorate's information efforts should support and strengthen the understanding that a restrictive alcohol policy is necessary.

2. Drug use in the population

2.1 Drug use in the general population

No new information available. The most recent survey of the general population's drug use was carried out by SIRUS in autumn 2004. The main results were discussed in NR 2005, chapter 2.1. The next nationwide survey is scheduled for 2009.

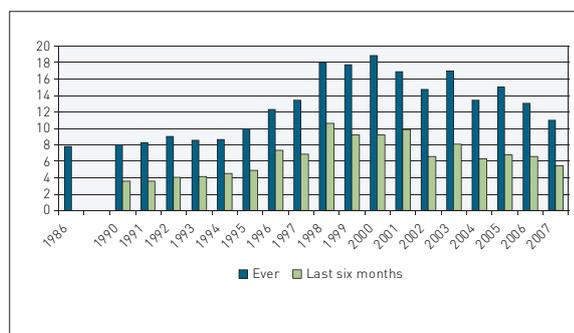
2.2 Drug use in the school and youth population

2.2.1 Drug use among youth aged 15–20

Data have been analysed from the annual questionnaire survey among young people aged between 15 and 20 in 2007. Since the division into age groups and questions about recent drug use in this survey are not in harmony with the division used by the EMCDDA, the data cannot be included in standard tables.

Cannabis, primarily in the form of hash, is the drug most young people report having used. After peaking at the turn of the millennium, a reduction has been registered in recent years (Figure 1).

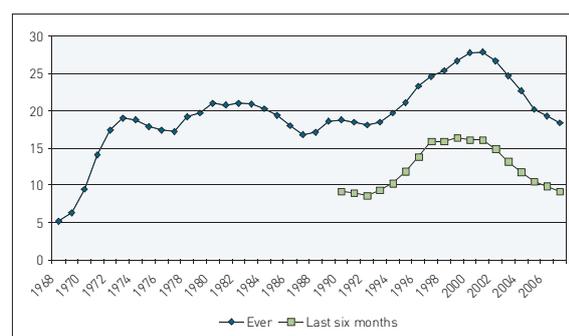
Figure 1: The percentage of youth between the ages of 15 and 20 in Norway who state that they have taken cannabis: ever and during the last six months, respectively, 1986 - 2007.



Source: SIRUS

The percentage of 15–20 year-olds in Norway who state that they have ever used hash or marijuana has been around 11 to 13 per cent during the last few years, while the proportion reporting having used the drug during the last six months has been around six per cent. The corresponding percentages around the turn of the millennium were approximately 18 and 9–10 per cent, respectively. If we look at the same age group among those who live in Oslo, there has also been a steady reduction in the proportion who report ever having used cannabis. In the last few years, slightly less than 20 per cent report having used cannabis, while around nine per cent report having used cannabis during the last six months. The corresponding percentages around the turn of the millennium were approximately 28 and 16 per cent, respectively (Figure 2).

Figure 2: The percentage of youth between the ages of 15 and 20 in Oslo who state that they have taken cannabis: ever and during the last six months, respectively, 1968 - 2007 (three-year sliding average).



Source: SIRUS

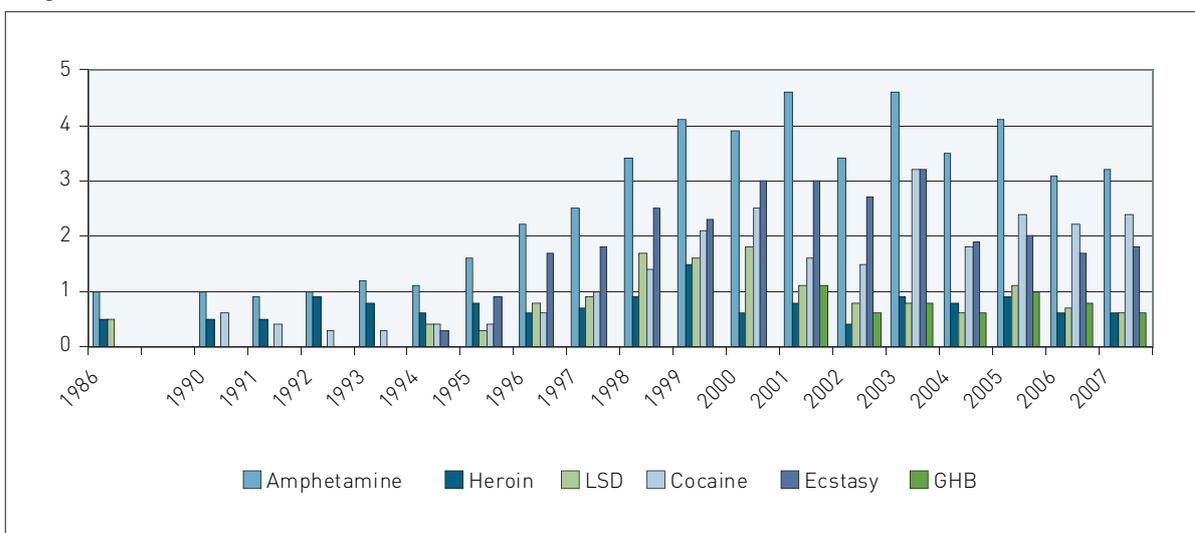
The proportion who state that they have used other drugs also increased in the late 1990s before largely stagnating/ declining in recent years (Figures 3 and 4). For example, the proportion of 15–20 year-olds in the country as a whole who state that they have ever used amphetamine has been around three to four per cent in the last two to three years, while the proportion stating that they have ever used ecstasy has remained at

around two to three per cent for several years. The corresponding figures for Oslo are two to four per cent for amphetamine and the same for ecstasy. The decline appears to be somewhat greater among young people in Oslo than in the country as a whole.

There does not seem to have been any increase in the availability of illegal drugs in recent years as

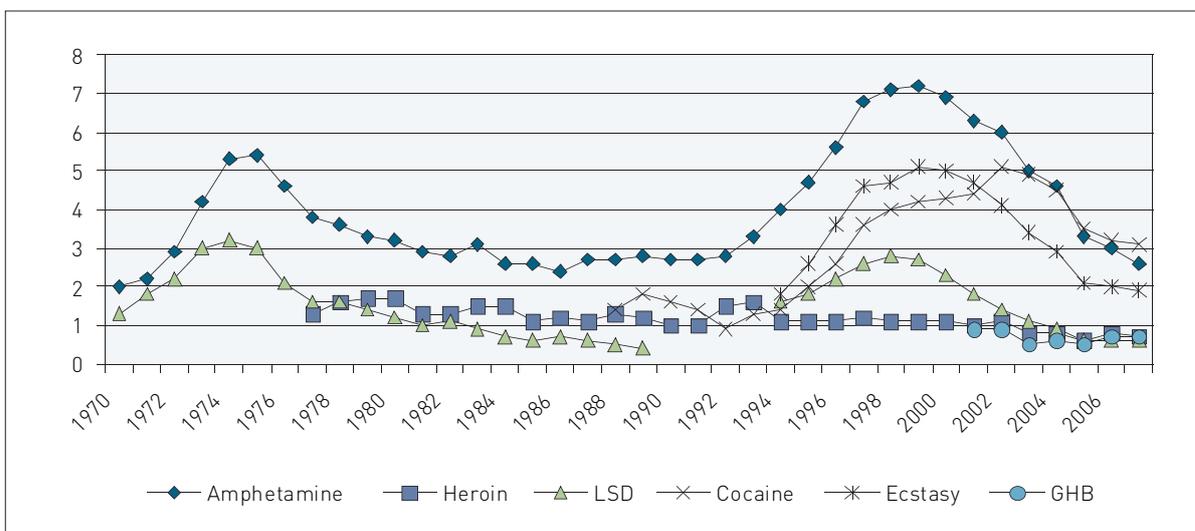
measured by questions about whether young people had been offered various drugs, or believed they could obtain them. The proportion of 15 to 20 year-olds in the country as a whole who state that they have ever been offered cannabis has been around 30 to 40 per cent for the last five years, while the proportion who believe that they could obtain cannabis in two to three days if they so wished has been around 50 to 65 per cent. In

Figure 3: Percentage of youth between the ages of 15 and 20 in Norway who have ever used various drugs, 1986 – 2006.



Source: SIRUS

Figure 4: Percentage of youth between the ages of 15 and 20 in Oslo who have ever used various drugs, 1970 – 2007 (three-year sliding average).



Source: SIRUS

the country as a whole, the proportion who state that they have been offered amphetamine, cocaine and ecstasy has been around 7 to 13 per cent in the last two to three years.

If we look at 15 to 20 year-olds in Oslo alone, the proportion who state that they have been offered cannabis is around 40 to 50 per cent, while slightly more than 60 per cent believe they could obtain cannabis in the space of two to three days. In Oslo, the proportion who state that they have been offered amphetamine, cocaine or ecstasy has been around 10 to 15 per cent in the last two to three years.

Otherwise, the 2007 survey confirms the trend we have seen in recent years that the proportion expressing a positive attitude to drugs is no longer increasing. During the last two to three years, approximately six to eight per cent of 15 to 20 year-olds in the country as a whole and seven to ten per cent in Oslo have expressed the opinion that it should be permitted to sell cannabis freely here in Norway.

Statistical margins of error

Note that the figures are subject to statistical margins of error and must be interpreted with great care. Moreover, it is important to bear in mind that questionnaire surveys are always susceptible to certain sources of error (not everyone responds, some responses may contain deliberate or inadvertent errors etc.), and that the surveys referred to here target young people in general. There is reason to believe that young people who regularly use drugs, either cannabis or stronger substances, will be underrepresented in the surveys.

In the annual youth surveys up until the mid-1990s, approximately 70 per cent answered the questionnaire, but the response rate has fallen to between 40 and 50 per cent in recent years. This is worrying, and it is probably related to the fact that very many questionnaire surveys have been carried out among young people in recent years. It is not unlikely, therefore, that a certain 'fatigue' arises among respondents. On the basis of the

falling response rate, there is further reason to emphasise that there is uncertainty attached to the results from one single year. The purpose of the surveys is primarily to serve as a tool for examining trends over time. Given that the youth surveys have been carried out for so many years, they represent time series that are relatively unique in the international context, and they are therefore assumed to be useful even though the response rate has been relatively low in recent years.

2.2.2 Hash use among young adults

Data from SIRUS's questionnaire surveys among young adults aged between 21 and 30 were presented in NR 2007 Chapter 2.2.2.

A study

A representative sample of young women and men have, since they were in their teens in 1992 until they became adults in 2005, answered a questionnaire about cannabis on four occasions (Pedersen, 2008). They were also asked about their parents' education and social class, about their own education and position in the employment market, about whether they have received social security or welfare benefits, and about their income. In addition, various measures of marital status/partnership and starting a family were examined. The study is based on *Young in Norway – a longitudinal study*, which is described in detail by Strand and von Soest (NOVA 2006). A sample of 2,819 persons answered the questionnaire on all four occasions, which means an accumulative response rate of more than 70 per cent for all the surveys.

Results

At the age of 15 to 16, less than ten per cent had experience of using cannabis, but quite a few made their debut with the drug in their late teens and also during their twenties. At the end of their twenties, 40 per cent of the men and 29 per cent of the women had used cannabis at some time, and 18 per cent of the men and eight per cent of the women has used cannabis during the past year (both differences between the sexes $p < 0.001$).

In the teenage years, there were no significant differences between the sexes as regards the use of cannabis. Use in the teenage years was not associated with social marginality and low social class among parents, but, during their twenties, the cannabis users were increasingly young, single men with interrupted education who were outside the employment market.

Many respondents, particularly among the young men, make their debut with cannabis in their twenties. It is surprising that as many as 30 per cent of young men in their late twenties who live in Oslo have used cannabis during the past year. In the group with low education and among those who are outside the employment market, the proportion who use drugs is much higher than this. However, it must be pointed out that most respondents in the sample report low-frequent use of cannabis.

Moreover, the study shows that the recruitment base during the respondents' early teens is not characterised by low social class or social marginality among the parents. On the other hand, however, a pattern develops with increasing age whereby young adults who have dropped out of school and who have failed to find a foothold in the employment market are more likely to become cannabis users. Those who do not marry or form partnerships during their twenties are also at increased risk. A single man, resident in the Oslo region, with an interrupted education and not in permanent employment who lives off social security or welfare benefits will have a high probability of being a cannabis user.

The study is assumed to be representative and has a good response rate. It forms a good basis for studying the prevalence of cannabis use among the young adult population in Norway. However, there is an accumulated dropout rate of 30 per cent for the four data collections. Previous analyses show that dropping out is selective in a manner that means that there are probably more cannabis users among the dropouts than in the sample as a whole. It must be assumed, not least, that regular use of cannabis entails a very

high probability of dropping out of the study (Pedersen, 2008).

The study complements the picture provided by other studies carried out in recent years. This applies in particular to *Drug use among young adults aged 21 to 30* (discussed in NR 2007, Chapter 2.2.2) in connection with which SIRUS have collected data. In this study, the proportion who have ever used cannabis in Norway increased from 22 per cent in 1998 to 34 per cent in 2006, while the proportion reporting recent use (here: The last six months) did not increase from 2002 to 2006 (Table 2). The 21 to 25 age group was highest here, with 12 per cent both years, while approximately nine per cent in the 26 to 30 age group reported use during the last six months. The incidence among men is more than double that among women. A low and falling response rate is a problem in connection with this study as well, and this can be assumed to result in underestimation of use.

Table 2: The percentage between the ages of 21 and 30 in Norway who state that they have used cannabis during the past six months. By age group, gender and survey year.

Year Age		NORWAY		
		Women	Men	All
1998	21-25	5	12	9
	26-30	4	9	6
2002	21-25	7	17	12
	26-30	5	11	8
2006	21-25	8	15	12
	26-30	4	13	9

Source: SIRUS

2.3 Drug use among specific groups

2.3.1. Drug use among persons from immigrant backgrounds

Quantitative research carried out on large populations shows that immigrant youth as a group use drugs less than Norwegian youth. Qualitative surveys also indicate that the use of alcohol and drugs is smaller and more controlled than

among youth from Norwegian backgrounds. At the same time, however, since the turn of the millennium, an open drugs and alcohol scene that is dominated to a great extent by teenage boys and young men from immigrant backgrounds has emerged along the Akerselva river in Oslo city centre. In addition, there are signs that there has been an increase in the numbers of immigrant youth in the hardest drug milieus in Oslo, and that the use of drugs and alcohol and problem use is greater among immigrants and immigrant youth than previously assumed (Bergengen and Larsen, 2008).

Quantitative surveys

Since 2004/2005, SIRUS has asked respondents about their own and their parents' birthplace in its questionnaire surveys. This provides an opportunity to report on drug and alcohol use among groups of persons from immigrant backgrounds (Vedøy and Amundsen, 2008).

Data from seven surveys has been used to describe the use of alcohol, cigarettes, oral moist snuff and cannabis among young people and adults with backgrounds from different countries, in both Oslo and Norway as a whole. Based on Statistics Norway's definition of immigrants, figures have been presented for the different continents. This is because categorisation by country of birth would result in many categories often containing a small number of cases. For the surveys carried out among adults, the continent was decided by the respondents' country of birth. Among young people, the continent was decided on the basis of the father's place of birth.

Statistics Norway defined the immigrant population as «persons with two parents born abroad: first-generation immigrants who have migrated to Norway, and persons born in Norway with two parents who were born abroad». Respondents' own country of birth is defined as the mother's country of residence when the respondent was born.

About hash in particular

Five of the surveys contained questions about the use of hash.

Adults 2004: SIRUS's nationwide survey of drug and alcohol use among adults in 2004 included 3,191 persons in the age group 15 and above (see NR 2005 Chapter 2.1 for more information).

Young adults 2006: SIRUS's survey of drug and alcohol use among persons aged between 21 and 30 from 2006 included a total of 4,193 persons (see NR 2007 Chapter 2.2.2 for more information).

Attitudes (HoldRus): The survey was carried out by SIRUS and the Alcohol and Drug Addiction Service to study drug and alcohol use and attitudes to the use of drugs and alcohol among students at lower secondary schools in Oslo. The survey's gross sample included students at six schools in the Oslo area who completed the seventh, eighth and ninth forms in 2002. The survey was repeated among the same students in the four following years. A total of 4,396 questionnaires were completed, and the response rate varied between 86 and 90 per cent.

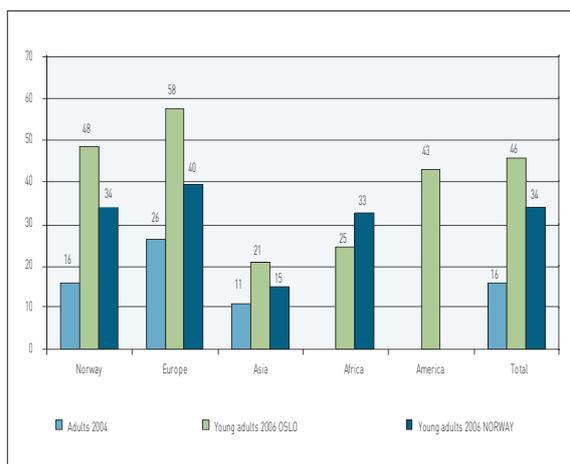
Youth 2006/2007: SIRUS's annual survey on the use of drugs and alcohol among young people covers the 15 to 20 age group. See Chapter 2.2.1. Questions about immigrant background were included from 2006. In order to strengthen the sample, the figures from the 2006 and 2007 surveys are shown combined. The total number of respondents for the two years was 8,108.

The Schools Survey 2004: SIRUS's survey of drug and alcohol use and its consequences in connection with the evaluation of the Regional Project – see Chapter 3 for more information. The gross sample in the survey consisted of all students in lower and upper secondary schools in 16 selected municipalities outside the big towns and cities in Norway. The gross sample for 2004 consisted of 25,872 students from 91 schools. A total of 20,703 forms were completed. The response rate was 80 per cent.

Among adults from immigrant backgrounds

The survey shows that it was more common to have smoked hash among adults from immigrant backgrounds born in Norway or Europe than among persons from immigrant backgrounds from Asia and Africa. In all the surveys, we also found that a larger proportion of persons born in Europe had tried hash than of persons born in Norway (Figure 5). We also found that the proportion was higher among young adults than in the Norwegian population as a whole. In addition, the use of hash among young adults was more common in Oslo than in the rest of the country.

Figure 5: Percentage of adults who have ever smoked hash grouped by place of birth.



Source: SIRUS

Among youth

On the basis of the four surveys, we find that the use of hash among lower secondary school students varies somewhat with national background, but there is great variation between the surveys and the results point in several different directions. The main tendency is that the use of hash is greater among youth in Oslo than in the rest of the country and that young people with fathers from Europe are least abstemious in relation to hash use.

If we look at the surveys together and examine the use of hash by father's country of birth, the main tendency was that young people with

fathers born in Asia or Africa were more restrictive with respect to the use of hash. The category that uses hash most is boys from Norway and Europe. We also find that youth in Oslo are less restrictive in terms of using hash than youth in the rest of the country.

The use of hash varies to a certain extent with national background, and it is among people from Norwegian and European backgrounds that we find the largest proportion who state that they have tried hash. However, it appears that the differences between the surveys, i.e. between the different age groups, are greater than the differences between persons from different national backgrounds.

Among ethnic Norwegians, the figure for ever having used hash is clearly higher among young adults than among adults as a whole. The same cannot be claimed to apply to persons from immigrant backgrounds from Asia and Africa, partly because the differences are less than for ethnic Norwegians and partly because the number of respondents is too low. So, again with all the necessary reservations, immigrants from Asian backgrounds do not seem to be picking up Norwegian (bad) habits as regards the use of hash. The higher risk of non-Western immigrants being offenders in drug crimes is not reflected in hash use as measured in population surveys.

Few of the surveys in this report enable more thorough analyses to be carried out of how drug and alcohol use varies with, for example, socio-economic status, degree of assimilation or integration etc. There are also few of the surveys that include so many persons that it is possible and meaningful to carry out quantitative analyses of specific drug/alcohol cultures.

Statistical sources of error

In population surveys, there are some marginalised groups that do not take part. Heavy drug and alcohol use among persons of no fixed abode or who move frequently, for example in and out of treatment, will therefore not be reported. In

school surveys among young people, those who are frequently absent without reason because of antisocial tendencies and who probably have higher drug and alcohol use will not take part. Moreover, most people will have a tendency to be somewhat biased in their reporting in the direction of the norms for and social desirability of drug and alcohol use within their own culture/social group. Ethnic Norwegian youth may well over-report drug and alcohol use, while ethnic Norwegian adults and Muslims regardless of age may well under-report such use (Vedøy and Amundsen, 2008).

Other surveys

The Oslo Drug and Alcohol Addiction Service Competence Centre has produced an overview of what is known about drug and alcohol use among immigrant youth (Bergengen and Larsen, 2008). In the summary of various self-report surveys, several of which have already been mentioned, it is confirmed that a large proportion of immigrant youth report less drug and alcohol use than ethnic Norwegian youth, but there are exceptions.

As part of the overview of current knowledge, experience-based material was also collected from 34 selected municipalities (of 53 asked) and 14 wards in Oslo. In terms of the information reported by the individual municipalities, there appear to primarily be differences between town and country. Naturally, Oslo clearly stands out, because it is the biggest city and has the largest proportion of immigrants³. The main impression is that, except for Oslo and some of the big towns and cities, immigrant youth and drug and alcohol use is not much of an issue. The figures for the other municipalities are so small that it is a matter of individuals rather than groups.

Immigrant youth as a group use drugs and alcohol less and their use is more controlled than among Norwegian youth, although there has been an increase in the number of immigrant youth in the hardest drug milieus in Oslo. The differences between boys and girls' use of alcohol are small among youth from Norwegian backgrounds. Among immigrant youth, there is a clear preponderance of boys among those who have drunk alcohol. The differences between youth from Norwegian backgrounds and youth from immigrant backgrounds are smaller in relation to the use of other drugs than alcohol.

³ As of 1 January 2006, 36 per cent of the non-Western immigrant population lived in Oslo. If the neighbouring county of Akershus is included, 46 per cent live in what is normally referred to as the Oslo area www.ssb.no.

3. Prevention

The Government's escalation plan for the drugs and alcohol field in Norway (discussed in Chapter 1) includes efforts to raise professional standards in preventive work in Norway. Information work will be strengthened, with more targeted information and more participation by young people and parents. Knowledge must be built and attitudes changed in order to reduce the harmful effects. Public support for the voluntary sector will continue as part of the quality boost, preventive measures will be coordinated and the work on drug and alcohol prevention in the workplace will be intensified (the Ministry of Health and Care Services, 2008).

3.1 Universal prevention

The Youth & Alcohol project – a process evaluation

The preventive measure Youth & Alcohol (discussed in NR 2006 Chapter 3) is based on a social cognitive strategy that focuses on children and young people's attitudes and norms in relation to alcohol. Central teaching methods include problem-based learning and the use of information and communications technology. The target group consists of eighth form students, teachers and parents/guardians, with follow-up in the ninth form. The programme has been process evaluated with the focus on initiation and implementation of the programme in lower secondary schools in Oslo in the 2006/2007 school year. The purpose was to identify factors that influence initiation and implementation in schools, and to further develop and improve the web solution and implementation strategies.

The evaluation methods consisted of observation of implementation, group interviews with selected students and teachers at selected schools, document analysis, conversations with various par-

ties and a questionnaire survey at all the lower secondary schools in Oslo and among parents.

The study shows that most schools, roughly 75 per cent, implement the programme in full. The reason why some schools did not implement all the components has to do with the high proportion of foreign language speakers among students or that the schools were already involved in other preventive programmes in the field. The results of the evaluation showed that the following factors are important in connection with implementation:

- *Support must be ensured for the programme.* In Oslo this was done through a decision of the City Council stating that an alcohol prevention programme was mandatory.
- *Raising competence is decisive. In Youth & Alcohol, this means providing courses for teachers and group leaders.* The Educational Service and Oslo Drug and Alcohol Addiction Service Competence Centre followed up the decision by organising a seminar for teachers and helping to finance the training of group leaders.
- *The schools' management must follow up the decision to implement the programme.* In Oslo, this meant that those in charge of schools had to ensure that information about Youth & Alcohol was mandatory and was received by all teachers. The decision also had to be followed up by sending teachers on courses.
- *Structural factors at individual schools are important.* In Oslo, factors such as sufficient time, technical equipment, finances, planning work and the proportion of students from multicultural backgrounds proved to be important.
- *Individual participants' motivation and competence in relation to the different parts of the programme.* The analyses show that

the schools' management, teachers, parents/guardians and students are generally positive to the programme. The evaluation also revealed that schools with a high proportion of students from multicultural backgrounds face special challenges relating to linguistic and cultural barriers in relation to alcohol as a topic (Steinkjer, 2008).

Evaluation of the Regional Project

In order to encourage coordination and cooperation in the municipalities, the Regional Project was started in nine pilot municipalities in 2004 (discussed in NR 2005, Chapter 3.3). The main goal was to develop effective preventive measures and to further develop existing measures with a view to limiting the use of drugs and alcohol and harm caused by drugs and alcohol, with the main focus on children and young people.

The project was evaluated by SIRUS in 2007 (Baklien, Pape, Rossow and Storvoll, 2007). The analyses are based on extensive data, including data from interviews with players at the central and local levels, observations of meetings and the implementation of measures, questionnaire surveys of 40,000 school students and attempts to buy alcohol in shops that sell beer.

According to the evaluation report, the Regional Project's main goal of reducing the use of drugs and alcohol and limiting drug and alcohol-related harm among young people was not achieved during the period covered by the evaluation (2004–2006). Nor did the project contribute to limiting young people's access to alcohol. The report points to several possible explanations for the lack of results. Only a few of the measures the directorate recommended to the municipalities had a documented effect on drug and alcohol use and drug and alcohol-related harm. Many of the measures had a long time perspective, and some of them were implemented in incomplete «light» versions.

On the other hand, the project has resulted in some municipalities setting up new multidisciplinary collaborations, both internally and bet-

ween municipalities. As regards adaptation and further development of preventive measures, local expertise has also increased. The organisation of the project in the municipalities has been functional, and the project has had good political and administrative support locally.

The report points out that none of the municipalities in the Regional Project has implemented the most effective strategies in drug and alcohol prevention, such as restricting the availability of alcohol and stricter enforcement of the regulations for the sale and serving of alcohol.

3.2 Selective prevention

Measures aimed at immigrant youth's use of drugs and alcohol

In 2006, the then Directorate for Health and Social Affairs gave the Oslo Drug and Alcohol Addiction Service Competence Centre the task of mapping available knowledge about immigrant youth and their use and problem use of drugs and alcohol.

The intention was to examine whether and to what extent youth from immigrant backgrounds need special measures to prevent the development of drug and alcohol problems, and whether or not various immigrant youth groups need separate early intervention measures in the drugs and alcohol field. See also Chapter 2.3.1, Other surveys. A report was published in 2008 (Bergengen and Larsen, 2008). The report contained the following proposals:

- Measures aimed at youth from immigrant backgrounds should be based on
- existing measures.
- There should be greater focus on violence-related problems and problem behaviour that can conceal problem drug and alcohol use.
- There should be greater awareness of problems relating to the migration experience.
- Greater focus should be placed on the resources that exist in immigrant milieus

that can protect against the development of destructive drug and alcohol use.

- There should be greater focus on poverty-related problems in relation to dealing.
- We need more knowledge about the use of drugs and alcohol among youth from immigrant backgrounds, about immigrant girls' use of drugs and alcohol, marginalised groups of youth from immigrant backgrounds, students and older youth from minority backgrounds and youth with one foreign and one Norwegian parent.

3.3 Indicated prevention

3.3.1 Early intervention

On assignment for the Ministry of Health and Care Services, the former Directorate for Health and Social Affairs drew up a proposal for a national strategy. The proposals were presented in the report 'Early intervention in the drugs and alcohol field. Central perspectives - relevant target groups and arenas', which was published in June 2007 (discussed in NR 2007, Chapter 3).

In 2007, 12 different intervention projects were initiated under the auspices of the regional competence centres and financed by the Directorate for Health and Social Affairs. Most of them were projects that will run over several years and will receive further funding aimed at the designated target groups and arenas. One of the interventions, 'Children in families with drug or alcohol problems – early intervention', has been evaluated by SIRUS. See below.

Evaluation of the project 'Children in families with drug or alcohol problems – early intervention'

The project *Children in families with drug or alcohol problems – early intervention* was developed and implemented by the Borgestad clinic's competence centre in 2006 and 2007. The goal was to increase the action competence of staff in schools, nursery schools, the social services and the child welfare services. The intention was to enable those involved to identify as early as possible

children growing up in families with problem drug or alcohol use, and to give them adequate follow-up and help as early as possible. As part of the project, approximately 160 teachers and nursery school staff from four municipalities in two counties (Telemark and Vestfold) have taken courses. The project has been evaluated by SIRUS (Baklien and Wejden, 2008).

The intention of the project was to create change, both at the individual level and the collective level. The evaluation attempts to track these change processes. The most important source of data consisted of extensive qualitative interviews with a total of 60 course participants and other key persons. The evaluation is also based on a questionnaire survey and document analysis.

The proportion who state that they have sufficient competence to identify signs that a child is suffering because of problem drug or alcohol use in the family has increased considerably during the project period. The course has created enthusiasm and a moral obligation in relation to children who need help. The participants state that they have become more secure and more observant. There are still many who are reluctant to conduct the necessary conversation with the parents, but the informants find that the course has provided them with methods that to a certain extent make it easier to talk to the parents. In other words, there is reason to believe that at least some children will receive speedier and better help as a result of the project.

The project also had ambitions of creating structural and relational changes. The goal was to develop a model that could coordinate efforts between those who meet children who are subjected to problem drug or alcohol use in the family and those who meet parents who have drug or alcohol problems. This goal was not achieved. One important reason appears to be that it was unclear whose responsibility it was to initiate this coordination. The project did not take sufficient account of the preconditions and framework conditions that must be met if one is to succeed in developing new models for cooperation. Efforts primarily targeted changes at the individual level.

4. Problem drug use and the treatment population

4.1 Prevalence and incidence estimates of PDU

See the data in Standard Tables 07 and 08⁴.

The EMCDDA defines problem use as «Injecting use of drugs or prolonged/regular use of opiates, cocaine and/or amphetamines.» In Norway, we only have information about the group that injects drugs. The estimated number of injecting drug users in a given year will also include persons in treatment or in prison if they inject one or more times during the year.

So far, we lack good data sources that can provide figures for prolonged/regular use of opiates, cocaine and/or amphetamines. Including all admissions to interdisciplinary specialised treatment for drug problems in the Norwegian Patient Register will gradually provide a much better overview of the number of persons in this group who apply for and are admitted to treatment.

The number of injecting drug users in Norway is calculated using three methods that are described in detail in NR 2006, Appendix 1:

- the Mortality Multiplier
- questionnaire surveys among the police and the social services in the municipalities
- the Multiple Indicator Method

There are insufficient figures for 2006 for the latter method to be used. Table 3 shows the estimates for the three methods. The figures in the Mortality Multiplier have been adjusted up slightly in relation to previously published figures for 2003 to 2005. This is because the basis for the calculations from Statistics Norway Causes of Death Register in previous reports included too few deaths. The World Health Organisation (WHO) revised the coding of causes of death relating to drugs in 2002, and the changes were already implemented in the Causes of Death Register in Norway in 2003. This change has not been incorporated into our calculations until now. The revised figures for drug-related deaths in 2003 to 2005 are shown in Chapter 6.1.

The trend for the number of injecting drug users in Norway is unchanged; the figure increased until 2001, then fell until 2003 before levelling out. Summarising estimates from two methods, it was presumed that there were approximately 8,500 to 12,500 injecting drug users in Norway in 2006⁵.

Table 3: The number of injecting drug users in Norway 2002–2006. Three methods.

	The Municipal Survey*	The Multiple Indicator Method*	The Mortality Multiplier.
2002	15,465 (12,375 – 19,001)	15,527 (11,956 – 19,098)	10,386 – 14,023
2003	15,554 (13,105 – 18,575)	16,462 (15,048 – 17,876)	9,213 – 12,756
2005	17,210 (13,403 – 22,076)	14,680 (13,606 – 15,854)	8,857 – 12,400
2006	16,467 (12,830 – 19,183)	-	8,524 – 11,933

* The figures for Oslo calculated using the Mortality Multiplier have also been adjusted up somewhat.

Source: SIRUS

⁴ All the Standard tables referred to have been submitted to the EMCDDA separately.

⁵ The estimate has an upper limit that is higher than that resulting from the Multiplier Method, but lower than that resulting from the Multiple Indicator Method and the Municipal Survey. This is because the latter two methods probably produce figures that are too high.

4.2. Treatment demand indicator

Data from treatment services are still only available at aggregate level. The inclusion of all admissions in the interdisciplinary specialist health service in the Norwegian Patient Register will start on 1 January 2009. It is expected that it will be possible to report *individual-based data* to EMCDDA from 2010. Overviews from the current client mapping system run by SIRUS do not indicate how many individuals are included in the number of queries and admissions, which means that it is impossible to control for double registration. Moreover, the data basis does not distinguish between problem users of alcohol and drugs.

Several characteristics of the clients, such as gender, age, education, income and most used intoxicant, taken from the client survey in 2006, were presented in NR 2007, Chapter 4.2.1. Since only small changes take place from one year to the next and the data are, as mentioned, only at the aggregate level, this will not be discussed further in this report. Instead, Chapter 4.2.2 will focus on data and profiles for clients in medically assisted treatment/rehabilitation. They are included in a nationwide client survey, but the probability of double registration is small here since most of them stay in the same treatment system all year.

4.2.1 Profiles of clients in medically assisted treatment

See also the data in Standard Table 24.

The Norwegian programme for medically assisted treatment (MAT) has been discussed in previous reports to EMCDDA. See NR 2004 chapter 5.3 in particular.

Data are reported annually in the form of status surveys from the 14 regional centres that make up the MAT programme. For 2007, a total of 4,014 forms were completed, while 4,542 persons were in treatment as of 31 December 2007. A total of 562 persons had concluded treatment during the year, 32 of whom had died. Forty-six persons were discharged in connection with mo-

ving house and are now in treatment elsewhere. The data basis includes both those who were in treatment at the turn of the year and those who concluded treatment during the year. The percentage basis is therefore the sum of the two. The survey covers approx. 80 per cent of the clients, a slightly larger proportion than in 2006.

The average age is stable and was 40.1 years in 2007 (2006: 39.9 years, 2005: 39.8 years). The same applies to the gender distribution. The proportion of women was approximately 30 per cent in 2007, the same as in 2005 and 2006. The differences between regions and centres are small. There is no indication that there are more younger clients, even though it has been made clear that it is permitted to admit patients younger than 25 (note: The formal lower age limit for admission to the programme is still 25 years).

Retention

According to the status survey for 2007, 91 per cent of the patients were in treatment, while 9 per cent had been discharged. However, it is possible that there are a greater number of discharged patients among the dropout group (those for whom a status form has not been submitted). The same type of survey for 2006 showed 92 per cent retention. Retention is thus at a stable high rate, but there are moderate but clear differences between the centres. The dosage level of methadone and Subutex may be one of the reasons why so many remain in treatment. Higher dosages are used in treatment in Norway than in some other countries. The average dose in 2007 was 109 mg of methadone per day. Two counties have an average of between 120 and 130 mg. The dosage of buprenorphine is unchanged or has increased slightly to an average of 18.6 mg in 2007.

Social function

Correspondingly, the survey shows a high proportion of benefit recipients. Thirty-nine per cent of the patients were benefits recipients, a slight increase on 2006 (37 %). Seventeen per cent had social security as their most important source of income, while this proportion was 19.5

per cent in 2006, and 20 per cent in 2005. The proportion on medical/occupational rehabilitation benefit was 40 per cent in 2007 (31.5% in 2006 and 34% in 2005). All in all, this indicates a certain transition to disability benefit and slightly less use of social security benefits, without this being the result of more active use of rehabilitation. However, closer study of the pattern shows considerable differences between the centres.

Housing conditions

The proportion in their own rented or owned housing is surprisingly high, roughly eight out of ten in most centres. Oslo stands out with a lower proportion.

Health conditions

The survey's questions about health show that slightly more than a quarter (27%) have a somatic illness that is so serious that it affects how they live their lives and their life quality. There is also a considerable proportion with chronic infections such as HCV. Nationwide, the proportion of patients with HIV is three per cent. In Oslo, the proportion was seven per cent. In addition, the proportion suffering from depression and/or anxiety is high.

Additional misuse

The reporting was carried out by combining information about drug and alcohol use during the last four weeks and information from urine tests. Use is thus reported if there is one urine finding or information about at least one instance of the drug in question having been taken. Considerable uncertainty attaches to all the reports because the proportion stated as unknown is around 10 per cent for all the different types of drugs. On the other hand, there are major differences between the centres as regards the proportion of unknowns.

Opioids

In 2007, the proportion of patients who had used a morphine-based drug in addition to the MAT medication during the last four weeks was 14 per cent for all the centres (2006: 13%). There are considerable differences between the centres.

Most centres in the Eastern Norway region, including Oslo, score particularly high. However, the findings are low in the international context.

Cannabis

Almost a third have used cannabis at least once during the last four weeks, the same proportion as in 2005 and 2006.

Benzodiazepines

The use found in the survey includes both prescribed benzodiazepines and illegally obtained benzodiazepines. The survey for 2007 shows that 42 per cent have used such drugs in the last month (2006: 41%). Less than half (18%) come from prescriptions. Roughly one in every four patients has thus used illicitly acquired benzodiazepines. The use of this substance appears to be increasing. The increase is found in most of the centres.

Central stimulants

There is less additional misuse of such drugs. Nationwide, the proportion with proven use during the past four weeks was 16 per cent, roughly the same as in 2006. This involves both amphetamine derivatives, and partly also cocaine, but cocaine is not checked regularly. It appears that the prevalence of central stimulants is greatest in Western Norway, where the use of buprenorphine in treatment is particularly high. There is certainly nothing to indicate that this reduces the use of central stimulants.

The goal of the treatment is rehabilitation. In this context, the survey indicates moderate success. While it is true that a large majority live in either own rented or owned housing, the proportion who neither have a job nor are in education is high, and many of them have been without work for years prior to MAT, while some of them have never been in employment. The health questions show that more than a quarter have a somatic illness that affects how they live their lives and their life quality. Since many seems to progress via reduced criminality and ordered finances towards a life on welfare benefits, this may be the most realistic rehabilitation goal. There are still many

whose most important source of income is social security benefit, but a growing proportion receive regular National Insurance benefits (Waal, Clausen, Håseth and Lillevold, 2008).

4.3 PDUs from non- treatment sources

SIRUS follows trends in the type of drugs injected and other characteristics of injecting drug users in Oslo in a continuing survey that started in

1993. However, no new figures are available since this was last discussed in NR 2005 (Chapter 4.3). In the surveys in recent years, attempts have been made to map who is or has been in treatment during the last year in order to enable characteristics to be described. This work continues.

5. Drug-related treatment

See also information in Structured Questionnaire 27 part I: Treatment programmes and part II: Quality assurance.

5.1 Treatment systems

Changes in the treatment systems in Norway have previously been discussed in NR 2004–2006. The evaluation of the Administrative Alcohol and Drugs Treatment Reform was discussed in NR 2007 Chapter 5.1.1. No new system changes have been introduced in the treatment area.

A waiting list guarantee for children and young people entered into force on 1 September 2008. See Chapter 1.1. In connection with the amendment of the law, a practice guide and a prioritisation guide are being issued that are intended to ensure uniform, good practise in the services.

The escalation plan for mental health (1998–2006) and the building-up of mental health care for children and young people in the municipalities will have consequences for the services offered to children and young people who are at risk of developing or have developed drug and alcohol problems. At least 20 per cent of earmarked funds for the municipalities from the escalation plan for mental health will be used on measures aimed at children and young people. The municipalities shall develop low-threshold services for examining, treating and following up children and young people with mental health problems, irrespective of cause and background. The guide to mental health care for children and young people in the municipalities has been published. It provides the municipalities with advice and guidance about the development of services for children and young people at risk and about the prevention of mental health problems and drug and alcohol dependency (the Ministry of Health and Care Services, 2008).

5.1.1 Guide to processing referrals to interdisciplinary specialist treatment for drug and/or alcohol use

In 2008, the Directorate of Health has revised a guide that describes the processing of referrals to interdisciplinary specialised treatment for drug and/or alcohol use. It also provides advice about how this can be dealt with professionally in accordance with the currently applicable professional and legal frameworks. One goal is to ensure equal treatment in the whole country.

The primary target group for the guide consists of those who assess referrals to interdisciplinary specialised treatment for drug and/or alcohol use. In practice, this will be the bodies appointed by the health enterprises to carry out such assessments. The guide will also be useful for social centres and first-line medical practitioners, as well as staff in the specialist health services. The document is not binding on service providers. However, the guide sets out the national health authorities' views on good practice and correct interpretation of the regulations. If the service chooses a different practice than that proposed in the guide, it should therefore be based on a concrete assessment. The courts and supervisory authorities normally base their decisions on such assessments.

Pursuant to the Patients' Rights Act, section 2–2, patients are entitled to an evaluation of their state of health on referral. Referrals to interdisciplinary specialised treatment for drug and/or alcohol use can be made by the social services, the child welfare service, GPs, specialist physicians in private practice, physicians in other parts of the specialist health services, physicians in the prison health service or other health personnel who are entitled to refer patients to the specialist health service. Referrals must contain the infor-

mation that is important in terms of evaluating the patient's state of health.

The main conditions for the right to necessary medical help

Three main conditions in the Prioritisation Regulations section 2⁶ shall be assessed individually and together.

The *Seriousness* criterion requires an evaluation to be made of the patient's condition and of how the patient will most probably develop if medical help from the specialist health service is postponed. The main topic for assessment will be the degree of drug and/or alcohol use and dependency, and the impact the problem use can be assumed to have on the patient's expected length of life and life quality.

When sufficient insight has been gained into the patient's condition, it shall be assessed how the patient's condition will develop if medical help from the specialist health service is postponed in relation to the patient's expected condition if medical help is provided. In order for the criterion of seriousness to be met, it must be assumed to be most probable that the patient's length of life will be shorter or quality of life poorer if the medical help is postponed than would be the situation if the patient receives the medical help. The following factors, which are partly linked to problems relating to problem use, will be relevant in the assessment:

- Danger to life and health/self-destructiveness
- Suicidality
- Pregnancy
- Crises and serious life events in connection with problem use
- Problem use at a young age
- Co-morbidity, somatic health
- Co-morbidity, mental health
- Care and control of small children

- Social factors with considerable negative consequences for prognoses
- Other factors

The *Usefulness* criterion requires an assessment of whether the medical help from the specialist health service will improve the patient's condition or prevent deterioration. Medical help includes actions that have preventive, diagnostic, treatment, health-preserving, rehabilitating or nursing and care purposes and that are carried out by health personnel. The main point is whether the medical help will lead to an improvement in the patient's length of life and/or life quality of a certain duration or prevent deterioration. Usefulness is also present if the possibilities for treatment will be lost if the medical help is postponed. In connection with usefulness, it must be assessed what a relevant course of treatment will be for the individual patient. Factors that are relevant in relation to the seriousness criterion should be compared with the following additional factors:

- The desire for change/ commitment
- Experience of treatment
- Problem use of short duration
- Cognitive functioning
- Degree of co-morbidity

The criterion of *Cost-efficiency* means that the costs of treatment must be in reasonable proportion to the expected effects of the treatment, in terms of both improving the patient's state of health and preventing a deterioration of his/her state of health. Costs incurred in connection with previous treatment of the same patient shall be disregarded. The conditions for the right to necessary medical help are based on the main conditions being interconnected and on their being weighted in relation to each other (the Directorate of Health, 2008).

⁶ Cf. the new section 4 in Regulations No 1208 of 1 December 2000 on the prioritisation of health services, the right to necessary medical help from the specialist health service, the right to treatment abroad and about the appeals board, amended by Regulations No 833 on 25 July 2008.

5.2 Drug-free treatment

No major new evaluations or studies were carried out in 2007.

5.3 Pharmacologically-assisted treatment

The evaluation of medically assisted treatment (see NR 2005, Chapter 5.3) shows that waiting times vary between the health regions. Treatment and rehabilitation services vary both between and within municipalities and regions. As part of the follow-up of the evaluation, it has been decided (Proposition No 53 to the Odelsting (2006–2007)) to authorise the issuing of regulations relating to medically assisted treatment. The regulations could include the purpose, crite-

ria for admission and discharge, a requirement for an individual plan, follow-up teams and requirements for urine testing. Professional guidelines and, if issued, regulations will replace the currently applicable circular relating to medically assisted treatment, thus helping to make medically assisted treatment a better service. The Ministry of Health and Care Services is said to be planning to present Regulations relating to medically assisted treatment in autumn 2008.

Based on the contents of the draft regulations from the Ministry, the Directorate of Health is working on proposals for new guidelines for *the medically assisted treatment and rehabilitation of opioid addicts* and guidelines for *the treatment of pregnant women in MAT and assistance to families up to school age*. The proposals will be sent for consultation with a view to a decision being made in spring 2009.

6. Health correlates and consequences

6.1 Drug-related deaths and mortality of drug users

See the data in Standard Tables 05 and 06.

Methodological considerations

In Norway, there are two bodies that register drug deaths, Statistics Norway (SSB) and the National Crime Investigation Service (Kripós). Kripós bases its figures on reports from the police districts, while Statistics Norway prepares figures on the basis of medical examiners' post-mortem examination reports and death certificates in accordance with the WHO's ICD 10 codes.

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 Kripós. 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 are largely identical in both series of figures, however.

Table 4: Drug-related deaths 1991–2007. Total number of deaths and broken down by gender. Figures from Kripós and Statistics Norway (underlying cause of death).

1991–2007	Number of deaths according to Kripós			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	174 193**	49 62**	223 255**
2004	168	55	223	171 220**	60 83**	231 303**
2005	146	38	184	142 176**	48 58**	190 234**
2006	152	43	195	187**	64**	251**
2007	162	38	200	***	***	***

Source: Kripós 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.

** Figures based on WHO's revised coding of causes of death.

*** Figures for 2007 are not yet available.

WHO revised its coding of causes of deaths relating to drugs and alcohol in 2002. The revisions were implemented in the Norwegian Causes of Death Register as early as 2003, but they were not included in the Standard Tables until this year. The corrected figures show a higher estimate than previously reported by SSB. In order to highlight the discrepancy, both series for the period 2003–2006 are reported in Table 4. For the three years, the new figures represent an average increase in the estimate of slightly more than 20 per cent. The corrected figures for 2003–2006 are now directly comparable with the years 1996–2002.

Situation and development

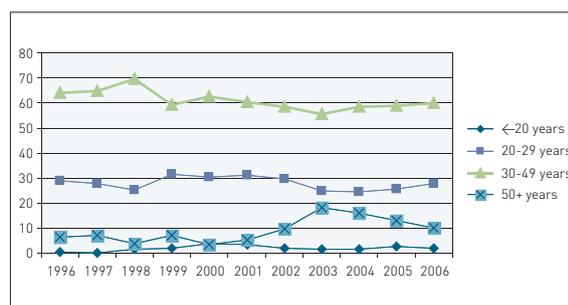
The figures from both SSB and Kripis peak in 2000/2001. In the ensuing years, there has been a considerable reduction in the number of registered drug deaths. The reduction since the turn of the millennium is most probably due to the strong increase in the number of clients on medically assisted treatment. Both the SSB figures and the Kripis figures appear to indicate that, after the reduction following the peak years of 2000 and 2001, a certain stabilisation of the number of mortalities has occurred.

According to the statistics from Kripis for 2007, 26 of 27 police districts had registered drug-induced deaths. Oslo had most deaths (65), 33 per cent of the total. Very many of the deaths are believed to be due to extensive polydrug use.

In the early 1980s, the proportion of mortalities among those over the age of 30 was less than 20 per cent. The proportion has increased steadily, and in the 1990s it had reached 60 per cent according to SSB's statistics. The SSB statistics show that, for the years 1996 to 2006, the proportion of drug deaths in the 30 plus age group was approximately 70 per cent on average. During the same period, the proportion over the age of 50 appears to have increased. If we compare the period 1996–2000 with the period 2001–2006, we find that the proportion in the first period was approx. 5 per cent as opposed to more than 11 per cent in the latter period ($p < 0.001$). For the 30 to 49 age group, on the other hand, we find that there has been a

reduction if we compare the same two periods. In the first period, the proportion was 64 per cent, while it was just under 59 per cent in the latter period ($p = 0,003$). The youngest age groups' proportion of deaths has remained stable during the period 1996 to 2006 (Figure 6).

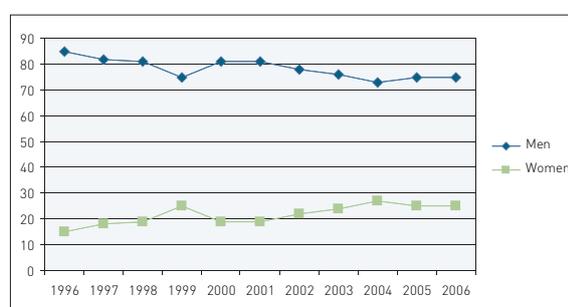
Figure 6: Drug-related deaths broken down by age group, 1996–2006



Source: SIRUS and Statistics Norway

During the period 1996 to 2006, there has been a certain increase in the proportion of women among mortalities (Figure 7). During the period 1996 to 2000, the proportion of women was 19.5 per cent according to the SSB statistics, while it had increased to 23.5 per cent in the period 2001 to 2006 ($p = 0.008$). Seen in a longer perspective, however, this variation seems to be within the «normal range» for the proportion of women. During the period 1980 to 1990, the average proportion of women among the mortalities was close to 22 per cent.

Figure 7: Drug-related deaths broken down by gender, 1996–2006



Source: SIRUS and Statistics Norway

6.2 Drug-related infectious diseases

See the data in Standard Table 09.

6.2.1 HIV and AIDS

In 2007, 248 cases of HIV infection were reported to the Norwegian Notification System for Infectious Diseases (Table 5). Thirteen of these cases were among injecting drug users, ten men and three women. The median age was 39 years (24 to 48 years), all of whom were men. Five of the drug users had been infected in Oslo. The number of HIV-cases remains relatively low, and little new infection is detected in this group.

As of 31 December 2007, a total of 541 persons had been diagnosed as HIV positive with injecting drug use as a risk factor. This amounts to 14 per cent of all reported cases of HIV since 1984.

Development into AIDS has been reported in 147 of these cases.

The incidence of HIV among injecting drug users in the group has remained at a stable low level over the last decade, with about 10 to 15 cases of HIV infection a year. The reason for this is not entirely clear, but a high level of testing, great openness regarding HIV-status within the user milieu, combined with a strong fear of being infected and strong internal justice in the milieu, are assumed to be important factors. In addition, many of the sources of infection in the milieu have disappeared due to overdose deaths or been rehabilitated through substitution therapy or other forms of rehabilitation. However, the extensive outbreaks of hepatitis A and B in recent years, and the high incidence of hepatitis C, show that there is still extensive needle sharing. The HIV situation is therefore still unpredictable.

Table 5: Percentage of injecting drug users of persons infected by HIV and AIDS, with injecting risk behaviour, 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
1984-89	894	315	35 %	142	8	6%
1990	90	22	24 %	60	13	22%
1991	142	16	11 %	57	14	25%
1992	105	12	11 %	52	8	15%
1993	113	13	12 %	63	13	21%
1994	94	13	13 %	74	19	26%
1995	105	11	10 %	67	7	10%
1996	116	9	8 %	56	11	20%
1997	114	11	10 %	35	8	23%
1998	98	8	8 %	36	4	11%
1999	147	12	7 %	31	7	23%
2000	175	7	4 %	35	5	14%
2001	157	8	5 %	33	8	24%
2002	205	16	8 %	34	4	12%
2003	238	13	5 %	53	6	11%
2004	251	15	6 %	36	4	11%
2005	219	20	9 %	32	4	13%
2006	276	7	3 %	32	4	13%
2007	248	13	5 %	11	0	0%
Total	3,787	541	14 %	939	147	16%

* The figures for some years have been corrected. The total number of new AIDS cases among injecting drug users has thus also been corrected. The percentage is the same, however.

Source: Norwegian Institute of Public Health

6.2.2 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 sporadic, individual cases of hepatitis A have been reported among drug users. Since 1996, there has also been a considerable increase in hepatitis B among drug users. In 2007, 60 of a total of 118 reported cases of acute hepatitis B were among injecting drug users. During the period 1995–2006, the total number of reported cases of acute hepatitis B among injecting drug users was 1,871.

In recent years, small-scale prevalence surveys have been carried out in connection with needle distribution in Oslo in order to register the incidence of, for example, hepatitis among injecting drug users. These Oslo surveys are the only prevalence surveys that are carried out regularly among a representative sample of drug users in Norway. The 2007 survey showed that 69 per

cent of the 222 persons included in the survey had experienced a hepatitis A infection or been vaccinated against the disease, 45 per cent had had a hepatitis B infection and 64 per cent had experienced a hepatitis C infection. Forty-eight per cent had tags indicating that they had been vaccinated against hepatitis B. In Norway, hepatitis C is not monitored to the same extent as hepatitis A and B, and the number of new cases of drug users being infected with the hepatitis C virus is therefore not known. From 1 January 2008, the notification criteria for hepatitis C have been changed, so that we can expect a better overview of the incidence of hepatitis C among injecting drug users next year.

6.3 Psychiatric co-morbidity

No new information available.

7. Responses to health correlates and consequences

7.1 Prevention of drug-related deaths

In Structured Questionnaire 23/29⁷, a brief overview is provided of the coverage rate for interventions that can be seen as preventing acute drug-related deaths, including some data concerning the injection room in Oslo. In Chapters 7.1.1 and 7.1.2, an evaluation is presented of two types of intervention in which the prevention of overdoses is one of several goals.

Medically assisted treatment (MAT) can undoubtedly be argued to be an important factor in the effort to prevent overdoses. The design of and participation in the Norwegian programme probably contribute to reducing the annual number of overdose deaths to a considerable extent. The MAT programme is big in the Norwegian context, with more than 4,500 patients, mostly injecting drug users. According to the status report for 2007, some three per cent of the patients experienced one or more non-fatal overdoses during the year. Slightly less than two per cent have attempted suicide. Some of the cases are assumed to be overdose cases without a clear suicidal intent. An average level of three per cent is not unreasonable in a population with drug problems with a high incidence of depressive complaints, anxiety problems and difficulties in life. Thirty-two individuals who were part of the programme died during 2007. The causes of death were not stated, but it must be assumed that several of the deaths are not due to overdoses (Waal et al., 2008)

7.1.1 Evaluation of the trial scheme for injection rooms

The City of Oslo opened an injection room on 1 February 2005 after the Storting had passed a temporary act relating to a trial scheme for injection rooms (NR 2004 Chapter 1.1). Oslo is the only municipality that has made use of the trial scheme. The temporary act was originally intended to apply until December 2007, but it was subsequently prolonged by two years (see NR 2007 Chapter 1.1). One reason for the prolongation was that the trial scheme was under evaluation and that the Ministry of Health and Care Services wished to study the evaluation carefully before arriving at a permanent decision. In Chapter 1.1, an account is given of the Ministry's position in relation to the Storting with respect to a permanent act. On assignment for the Ministry of Health and Care Services, SIRUS has evaluated the trial scheme in Oslo. The report became available in January 2008 (Olsen and Skretting, 2007). Some key data and an excerpt of the main conclusions of the report are presented below.

In its first two years of operation, February 2005 to February 2007, 409 persons were registered as users, and 383 of them used the injection room on one or several occasions. Of the 383, 71 per cent were men and 29 per cent women, 23 per cent were aged 30 or younger, 41 per cent were between 31 and 40 years old, and 37 per cent were older than 40.

A total of 17,226 injections took place, i.e. an average of 24 injections a day. There are large variations in terms of how often the registered users have used the injection room scheme. Only 10 per cent have used the injection room scheme more than six times on average per

⁷ All Structured Questionnaires have been submitted to the EMCDDA separately.

month. Two-thirds have used the scheme two or fewer times a month on average during the period they have been registered.

Eighty per cent of the users reported injecting 0.2 to 0.25 grams of heroin (a «quarter»). Most users injected in their arms (64 %). Other body parts used for injections were the groin (19%), legs (15%) and neck (2%). Only 0.6 per cent of all injections in the injection room resulted in an overdose. Eighteen per cent of the users have experienced overdoses in the injection room. None of the overdoses was fatal.

Main conclusions

The target group for the injection room scheme is «hardcore heroin users over the age of 18». The aims of the trial scheme are, in numerical order:

- 1 To assess the effect of freedom from prosecution for the possession and use of drugs in a limited area.
- 2 To contribute to more dignity for hardcore drug addicts.
- 3 To provide a better opportunity for contact and dialogue between drug users and the help services.
- 4 To contribute to preventing infections and the spread of infections.
- 5 To reduce the number of overdoses and overdose deaths.

1. The police have loyally supported the trial scheme. The provision on freedom from prosecution must be said to have had the effect that, from a legal perspective, it is practically possible to run an injection room scheme, even if it is impossible for staff to check that only one user dose of heroin is brought in. However, freedom from prosecution has also had the unintended effect that the possession of small amounts of heroin has in practice been further decriminalised in Oslo city centre.

2. In general, the users of the injection room express great satisfaction with the service pro-

vided. Virtually no one has any objections to the guidance given in connection with injections, how they are treated by staff or the equipment offered. The main changes they would like are an extension of the opening hours and permission to inject pills together with heroin. Insofar as it possible to operationalise the dignity concept, the scheme can be said to have contributed to increased dignity for the target group in question. The scheme can be said to have provided greater dignity for drug addicts in the broadest sense in that it recognises the need to inject drugs in a manner that entails as little risk as possible. The scheme can also be said to provide a form of dignity for individual users in the way that the users are treated by the staff.

3. Professional health and social service follow-up of the users has only been registered in eight per cent of all visits. However, such follow-up is dependent on adequate staff levels. Expedient premises that provide an opportunity for private conversations would also improve the possibilities for follow-up.

4. There is a limited basis on which to conclude whether the injection room scheme has contributed to preventing infections and the spread of infections. However, the users have to comply with clear hygiene rules. They are also given concrete advice about how they can inject in a way that causes as little harm as possible with respect to sores and abscesses. They are given guidance on injecting in 13 per cent of the total number of injections, and 81 per cent of the users have received such guidance on one or more occasions. It must be assumed that the users take some of these «lessons» with them when they inject drugs elsewhere. Users also state that they have become generally more aware of hygiene when they inject.

5. There are no grounds for concluding that the injection room scheme has contributed to a reduction in overdoses/overdose deaths in Oslo. If the scheme is to be capable of making such a

contribution, it must have sufficient capacity to cover a substantial proportion of the total number of injections that take place.

The evaluation makes no recommendation with respect to whether the trial scheme should be made permanent. However, it points out that a permanent injection room scheme must involve setting requirements for municipalities that wish to establish such a service. The premises must be expedient and guarantee the safety of staff. Staff training and working conditions must also be better than in the trial scheme. In July 2007, the injection room was moved to larger and more suitable premises in Storgata in Oslo city centre. The number of users has increased and the professional follow-up by health and social services seems to have improved.

7.1.2 Evaluation of low-threshold health services

The state gave grants to low-threshold health services for substance abusers in 34 municipalities in 2007. The services are aimed at persons who use drugs particularly extensively and who need complex and concurrent services from different agencies, but who are not capable of availing themselves of ordinary health services. In the Government's action plan to combat drug and alcohol-related problems 2003–2005 (NR 2005, Chapter 1), low-threshold health services are highlighted as important focus areas in terms of reducing various kinds of damage to health relating to the use of drugs and alcohol, improving health and care services for addicts and preventing overdoses.

An evaluation was carried out of the services in 2007. The final report became available in January 2008 (SINTEF, 2008). The overriding goal was to answer the question of whether the services contribute to establishing an adequate service for drug addicts who do not use or are not reached by the ordinary health services.

The organisation and contents of the services were studied on the basis of the questionnaires distributed to representatives of 33 low-thres-

hold health services. Thirty of the services answered the first part of the questionnaire, while 23 services answered the follow-up questionnaire in autumn 2007. The final report is also based on two survey rounds carried out at intervals of six months among 400 users. Moreover, a new user survey was conducted in which 691 users filled in a form, and a survey of experiences in the rest of the services based on focus group interviews in some municipalities.

The users of the low-threshold health services are largely hardcore drug addicts who get high often and who have been drug addicts for many years. The average age is approximately 39 years, while ten per cent of the users are under the age of 26. The most commonly used drugs are opioids, benzodiazepines, amphetamine and cannabis. There are many combinations of different drugs and many people who use combinations that entail a high risk. For example, 95 of 400 users use a combination of heroin and Rohypnol and 80 per cent use heroin in combination with alcohol. Alcohol is stated to be the only intoxicant by 13 users. Many of them have major health problems. Many have particularly serious problems relating to dental health. There are also very many who have problems with their mental health, housing situation and contact with their families.

Mapping twice during a six-month period provided a picture of the situation for the users over time. More than half the users had not experienced any change that was picked up on in the questionnaire. The other half had experienced a change in their life situation, in either a negative or positive direction. Positive changes include users receiving treatment either in a treatment institution (roughly 10%) or mental health care (5%), being admitted to medically assisted treatment (5%) or having stopped using drugs (1%). Negative changes include the user being in prison (5%) or dying (1%).

For the users, needle distribution, dialogue/guidance and nutrition are the most important rea-

sons for using the low-threshold services. These are also the services most often provided to users. The low-threshold services provide a very wide range of services. In addition to health-related services such as improving general health, they include dental health and follow-up of various illnesses and dressing of sores, motivation to reduce drug use and to use ordinary services and the provision of general care. On the other hand, emergency preparedness in relation to overdoses seems to be given lower priority. Only six services state that this is very important, while almost half answer that overdose emergency response is not part of the service. These are low figures. The high incidence of overdoses was central when the state decided to earmark funds for low-threshold health services for drug addicts.

In the report, it is stated that, in general, the services appear to succeed in providing good help for 80 per cent of the users, while 20 per cent do not get sufficient help for various reasons. The exceptions are needle distribution and condom distribution where few users do not get sufficient help. There can be many different reasons why help does not reach all users to the same extent. There are many whom it is particularly difficult to help because they are in a very difficult life situation in which their ability to care for themselves is poor, and they have difficulties keeping appointments with other services that are brought in to help users.

On the basis of the in-depth interviews with users, one can get the impression that low-threshold services are the part of the health and social services that the users feel most satisfied with. A critical methodology comment on the results could be: The interviews were carried out in the premises of the low-threshold services and the informants knew that it was only the low-threshold service, and not other services, that was to be evaluated. They may therefore have been more cautious of criticising the service because they are so dependent on it.

7.2 Prevention and treatment of drug-related infectious diseases

In Structured Questionnaire 23/29, a brief overview is provided of the coverage rate for services that can be regarded as preventing drug-related infectious diseases. No other new information is available.

7.3 Interventions related to psychiatric co-morbidity

7.3.1 National professional guidelines for examining, treating and following up persons with serious mental health problems and concurrent drug or alcohol problems.

As mentioned in NR 2007 Chapter 7.2, the Directorate of Health (formerly the Directorate for Health and Social Affairs) is charged with preparing professional guidelines for examining, treating and following up persons with serious mental health problems and concurrent drug or alcohol problems. The draft, which will be distributed for consultation in autumn 2008, is expected to be implemented in spring 2009. The guidelines will deal with three main areas:

- Knowledge about concurrent serious mental health problems and drug and alcohol problems
- Recommended methods for examination and diagnosis
- Recommended treatment and other follow-up

The guidelines will be based on the best existing research and experience-based knowledge in the area. The different issues will be discussed and recommendations made to the relevant services. The recommendations shall be as concrete as possible and practicable in different situations. The basis for the recommendations must be documented and prioritised.

The target group of patients consists of persons with serious mental health problems and concurrent drug or alcohol problems (dual diagnosis⁸) from the age of approximately 15 upwards.

The definition of «serious mental health problem»: By serious mental health problem in this context is meant⁹:

Schizophrenia and schizophrenia-like psychoses, bipolar disorder, serious depressions and chronic long-term drug or alcohol-induced psychoses. Serious personality disorders such as schizoid, paranoid, anti-social and emotionally unstable personalities are included, in addition to serious behavioural disorders among young people. Some other diagnoses may be relevant if the problem leads to a significant loss of function, for example persons with prolonged anxiety problems that are present irrespective of the drug and/or alcohol use.

Definition of «drug /alcohol problems»:

By drug or alcohol problems is meant addiction, prolonged harmful use or abuse of in toxicants with the exception of tobacco¹⁰. The terms drug/alcohol problems and problem drug and alcohol use will be used interchangeably when discussing problems in connection with the use of intoxicants. Both terms include both medical and social consequences of problem drug and alcohol use and drug/alcohol problems.

The target group for the guidelines:

- Those who provide treatment/process cases in the social services and primary health services in the municipalities.

- Those who provide treatment/process cases in the specialist health service. The guidelines may also be important for other agencies that come into contact with the target group.

The performance goal for the guidelines:

- Referrals from the first line service shall as far as possible contain an overall assessment of the patient's situation as regards both drug and alcohol history and mental state.
- The patients' mental health problem and problem drug or alcohol use shall be examined on a broad basis.
- The co-morbid condition shall be treated at the same time, either by the same treatment entity or through cooperation with different entities if dual competence is not available in one place.
- Individual plans shall be prepared that contribute to treatment of the patient as a whole.
- Professionals in mental health care and interdisciplinary specialised drug/alcohol treatment must have good qualifications for and skills in working with this group of patients.
- The measures that are initiated shall, in as cost-efficient a manner as possible, lead to a reduction in mental health symptoms and problem drug and alcohol use, as well as improving users' life quality and functional level (the Directorate for Health and Social Affairs, 2007).

⁸ Dual diagnosis is primarily a system-related concept used to describe persons with serious mental health problems who also have a drug or alcohol problem. A broader concept is co-morbid condition or persons with serious mental health problems and drug or alcohol problems.

⁹ In the ICD-10 diagnosis system, this means the codes F20 to F 29, F30, F31, F32.2, F32.3, F33.2, F33.3, F 60.0 to F 60.3, F91, F92.

¹⁰ ICD-10 codes F10 to F19 with the exception of F17, and «substance abuse» in DSM-IV.

8. Social correlates and consequences

8.1 Social exclusion

No new information available.

8.2 Drug-related crime

8.2.1 Drug offences

Reported drug offences

Following an increase from 2005 to 2006, the number of reported drug offences fell to 40,771 in 2007 (Table 6). The number of official complaints for the possession of small amounts of drugs (regulated in the Act relating to medicines) is 12 per cent lower than in 2006, and this contributes most to the reduction in the number of reported drug offences overall. The use of drugs (12,806) and drug crimes pursuant to the General Civil Penal Code (17,779) were as frequent as in 2006. Thirteen hundred cases of the most serious type of drug crimes were registered in 2007, slightly up on previous years.

Penal sanctions

Drug crime results in more penal sanctions than other types of crime. Penal sanctions for drug crimes have increased most during the last decade and have contributed to a change in which groups of crime result in penal sanctions. From 33 per cent in 1998, drug crime is now the primary offence in 41 per cent of all criminal cases. Eighty-seven per cent of all penal sanctions for crimes were imposed on people of Norwegian nationality, and eight per cent on people with European nationality. The proportion of foreign nationals was highest in connection with crimes against property and drug crimes, at 18 and 12 per cent, respectively. See Chapter 11 Sentencing statistics for more information about penal sanctions.

8.2.2 Driving offences

Statistics relating to driving under the influence are prepared by the Norwegian Institute of Public Health. The number of arrests in 2007 on suspicion of driving under the influence of alcohol or

Table 6: Number of reported drug crimes 2002–2007*

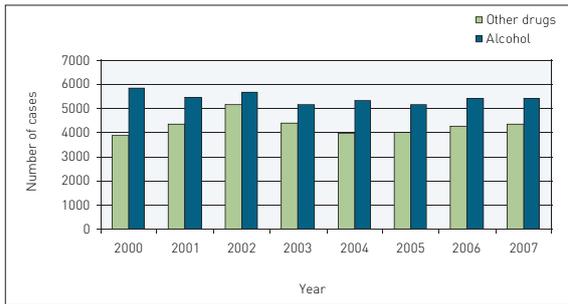
	2002	2003	2004	2005	2006	2007
Drug crimes	18,047	15,009	15,671	16,163	17,966	17,779
Aggravated drug crimes	1,247	1,143	1,143	955	1,190	1,307
Other	545	578	501	485	568	658
Drugs, use	13,377	10,547	10,925	11,259	12,635	12,806
Drugs, possession	10,930	8,533	8,364	8,070	8,627	7,562
Drugs, miscellaneous	1,015	901	715	731	747	659
Total number	45,161	36,711	37,319	37,663	41,733	40,771

* Number of cases

Source: Statistics Norway.

other substances shows little change in relation to previous years. The number of cases in which drugs and other intoxicating medicinal drugs were found in blood samples has remained stable for the last five years, at approx. 4,000 cases (Figure 8). More information and data, including about penal sanctions, is provided in Chapter 11.

Figure 8: The number of road traffic cases received involving suspicion of alcohol/other substances 2000–2007.



Source: Norwegian Institute of Public Health

Table 7 shows which drugs/intoxicating medicinal drugs that were most frequently (proportion of more than 10%) found in blood samples of drivers arrested by the police in 2007 on suspicion of driving under the influence. The percentage shows the proportion of blood samples for which a broad analysis was ordered in which the individual substances were found. Both illicit

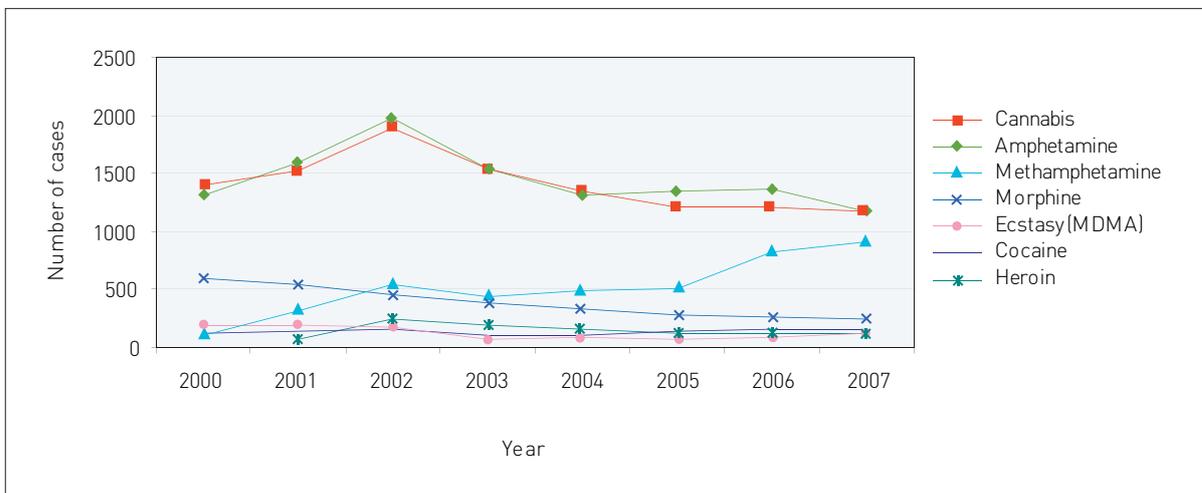
drugs and medicinal drugs that can be prescribed (e.g. morphine and diazepam) are included. The analysis findings do not necessarily answer the question of whether or not the drug was taken illegally. As a rule, several substances were found in the same blood sample. The Institute of Public Health finds an average of three intoxicating drugs per sample.

Table 7: The five most common findings of substances other than alcohol in blood samples from drivers arrested on suspicion of driving under the influence in 2007. The number and percentage of blood samples in which a broad analysis was carried out.

	Name of substance	Example of name of medicine Explanation	Total number	Percentage
1	Diazepam	Valium ® Vival ® Stesolid ®	1,257	29%
2	THC	Active agent in cannabis	1,171	27%
3	Amphetamine		1,168	27%
4	Methamphetamine		914	21%
5	Clonazepam	Rivotril ®	574	13%

Source: Norwegian Institute of Public Health

Figure 9: Finds of illegal drugs in road traffic cases received 2000–2007. In numbers.



Source: Norwegian Institute of Public Health

Cannabis

Figure 9 shows that tetrahydrocannabinol (THC) is one of the most frequently found substances in blood samples from arrested drivers. The proportion of cases in which THC is found appears to be relatively stable at around 30 per cent of the samples received. Since 2002, the substance has been among the three most common intoxicants among arrested drivers. 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 24 hours.

Amphetamine/methamphetamine

In recent years, methamphetamine has been increasingly found in blood samples from arrested drivers, while the trend for amphetamine appears to be declining. This may indicate that amphetamine is being replaced by methamphetamine in some cases. Some of the methamphetamine is converted into amphetamine in the body. Many of the blood samples that contain methamphetamine will therefore also contain amphetamine even if the person in question has not necessarily taken both drugs. 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.

Cocaine

The number of blood samples that tested positive for cocaine in 2007 is more or less identical to the figures for the two previous years. The body converts cocaine into the inactive metabolite benzoylecgonin, a substance that does not have any effect. However, finding benzoylecgonin is definite proof that cocaine has been taken during the previous 24 hours (Norwegian Institute of Public Health).

8.3 Drug use in prison

A study

A survey (Ødegård, 2008) that covered all Norwegian prisons showed that two-thirds of the in-

mates (69%) had used drugs in the period prior to their imprisonment. Almost half of the inmates (45%) were what is described as «hardcore» drug users in the period prior to imprisonment. A quarter of the inmates (26%) were regular and frequent injecting drug users in the period prior to their imprisonment. Just under a third (29 %) of the inmates had used drugs in connection with their current prison sentence. Cannabis was the drug most inmates reported having used. It was followed by amphetamine, then heroin.

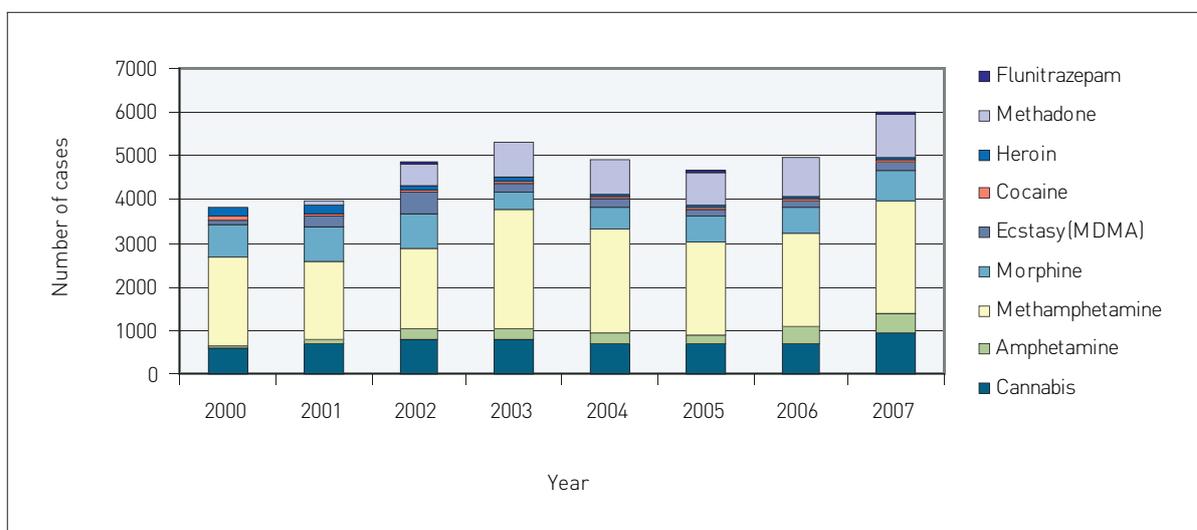
The data on which the analysis is based are data reported by the inmates themselves. In December 2002, all inmates at all the 52 Norwegian prisons were given a questionnaire in which they were asked about their demographic characteristics, criminal history and use of alcohol and drugs.

At the time when the survey was carried out, there were 2,687 inmates in Norwegian prisons. It was estimated that between 1,700 and 1,900 of them had used drugs during the period prior to their imprisonment. Between 1,100 and 1,300 had a serious drug problem, and between 600 and 800 were injecting drug users.

Drug controls in prison

Regular urine sample tests are the most common indicator of the extent of use and of which substances are used in prisons. The National Institute of Public Health has national responsibility for the securing of evidence, analysis and interpretation of drugs, medicines and poisons in samples taken from persons for whom the analysis results may have consequences in criminal law or corresponding consequences.

Around 24,000 cases are received annually from the Correctional Services. Figure 10 shows an overview of the number of cases from prisons in which illegal narcotic substances or medicinal drugs were found. The number of such cases has increased from around 5,000 in recent years to almost 6,000 cases in 2007. Cannabis is the most common illicit drug. The number of cases involving amphetamine and methamphetamine con-

Figure 10: Drug finds in correctional service cases. In numbers 2000–2007

Source: Norwegian Institute of Public Health

tinues to increase. Findings of methadone have increased most over a period of five to six years, and it was found in almost 1,000 cases in 2007. However, it is not possible to distinguish between lawful prescribed and illegally obtained methadone. Methadone-assisted treatment is approved in prisons as a means of rehabilitating inmates with an opiate addiction.

8.4 Social costs

No new information available. No major surveys or studies were carried out in 2007.

9. Responses to social correlates and consequences

9.1 Social re-integration

No new information available.

9.2 Prevention of drug-related crime

9.2.1 Assistance to drug users in prison

There are many indications that services are less available to inmates with a drug or alcohol problem than to others. The goal of the escalation plan for the drugs and alcohol field (the Ministry of Health and Care Services, 2008) is for more inmates with drug or alcohol problems to be given an opportunity for better treatment and rehabilitation while serving prison sentences or serving sentences in other ways. This requires close cooperation between the prisons and the regional health authorities, and between the prisons and the municipalities.

The Ministry of Health and Care Services and the Ministry of Justice and the Police have produced a circular that clarifies the responsibilities, tasks and coordination between the municipalities, the specialist health services and the Correctional Services as regards inmates and convicted persons who are drug addicts/alcoholics. The circular is intended to improve and intensify cooperation and ensure follow-up and continuity in the services. Steps will be taken to ensure that relevant services arrive at good solutions for cooperation and joint plans at the regional and local level. The need for cohesion in services before, during and after sentences are served means that special care services should not be developed for persons in correctional service institutions.

In 2006, 41,484 days were served in prison pursuant to the Execution of Sentences Act section 12 (alternative serving of sentences) by a total of 439 persons. It will be assessed whether more inmates with drug and or alcohol problems can serve part of their sentences in institutions pursuant to section 12. Increased access to this form of serving of sentences is desirable. The financing of such measures is to be reviewed.

More units aimed at mastering drug and alcohol problems are to be established in Norwegian prisons. In 2006, there were three units of this kind: in Oslo, Bergen and Trondheim. In 2007, units aimed at mastering drug and alcohol problems were established in three new prisons. The purpose of the units is to improve the service to inmates and convicted persons who are drug addicts or alcoholics and who need treatment and rehabilitation. Staff at the units should have both health and social work and prison service backgrounds. The treatment and rehabilitation that is started in prison must be followed up after release. Steps have therefore been taken to facilitate good cooperation with the probation service and the municipal services already during the serving of sentences.

There is a particularly strong need to improve services to inmates during the release phase. Cooperation between the involved parties must start in good time before the transition from prison to freedom. Cooperation with voluntary organisations such as WayBack is important during this phase.

Drug programme under court control

A system of suspended sentences with a drug programme under court control started in 2006 as a three-year trial scheme in Oslo and Bergen in order to offer convicted persons with drug or

alcohol problems an alternative means of serving their sentences. The participants regularly attend a day centre where rehabilitation is offered by an inter-service team. Through this scheme, experience is being gained of inter-service cooperation on the follow-up of convicted persons. The trial scheme will be evaluated by SIRUS and then considered for continuation and expansion.

In 2007, 56 personal assessments were carried out (64 in 2006). Of these, 28 were found to be suitable for such a sanction. During 2007, 21 cases were concluded, one of which was discontinued because of death, 19 were discontinued because of new criminality or breach of special conditions, and the last case was discontinued because the convicted person withdrew consent. Thirty-one new sentences were implemented in 2007, compared with 23 in 2006 (the Correctional Services, 2008).

10. Drug markets

10.1 Availability

Various factors that influence the availability of drugs were discussed in NR 2007 Chapter 10.1. No new analyses have been carried out, but the situation in 2007/2008 is probably fairly similar. In the police's view, there are indications that cocaine, like amphetamine and methamphetamine, is being distributed and used more than before. In a historical frame of reference, the data show that the proportion of cocaine seizures in relation to all other drugs has increased from approx. 0.5 per cent to four per cent in ten years.

However, the most striking development in 2007 was the large reduction in the amount of heroin seized. While the number of seizures increased somewhat after a steady decline during the last six to seven years, much less heroin was seized in 2007 than in the preceding years, eight kilos – compared with 93 kilos in 2006. Even though the quantity seized is a less reliable indicator of prevalence than the number of seizures, which is illustrated by the fact that the quantities have varied a great deal in recent years, it is nonetheless the case that so little heroin has not been seized since 1990. The reduction does not reflect availability to the same extent. The price level has remained more or less unchanged, and no reports have been received of a heroin drought of any length. The low seizure figures for 2007 raise three questions that have yet to be answered:

- Has the supply of heroin to Norway been reduced?
- Is the regular use of heroin based on previously imported supplies?
- Is heroin being imported via entirely new routes and/or using new techniques?

The Customs Service has initiated cooperation with SIRUS with a view to obtaining a broader analysis of the drugs market with respect to the

use of heroin. A project has been initiated with a view to estimating the hidden figures for how much heroin there actually is on the Norwegian market. The project will also include the collating of interview data from interviews with injecting drug users in Oslo. The aim is for the project to be completed and a final report produced by the end of February 2009.

10.2 Production, sources of supply and trafficking patterns

Most of the *amphetamine* and *methamphetamine* on the Norwegian market comes from illegal laboratories in Russia, Poland and Lithuania. Lithuanian criminals have had a dominant role for several years as suppliers of synthetic drugs such as amphetamine, methamphetamine and Rohypnol to Norway. Lithuania still has a central role, but the biggest quantities now come from the Netherlands and Poland. The main routes run through Germany and Denmark to the Øresund Bridge and on through Sweden to Norway. Cars prepared with concealed cavities seems to be the most frequent method used.

As before, *cannabis* mostly comes to Norway from Morocco via two main routes – from Spain and Italy up to the Netherlands/Germany and on to Denmark and Norway. The customs service has uncovered large quantities of cannabis in passenger cars and heavy goods vehicles.

Ecstasy tablets that are sold in Norway are largely produced at illegal laboratories in the Netherlands and Poland. The customs service makes most seizures in connection with drugs sent by post, while the biggest seizures are made from cars at Norway's borders.

Heroin comes from Pakistan and Afghanistan via two northerly routes via Bulgaria/Romania –

Ukraine/Russia, and then on to Poland /Lithuania. Two southerly routes go through Greece/the Balkans to the Netherlands/Germany. From there, consignments destined for Norway are stowed in hand luggage or passenger cars with concealed cavities.

As before, *cocaine* comes from South America to Africa and Spain and from there to the Netherlands and Germany before continuing up through Denmark to Norway. Substantial quantities are also smuggled by airline passengers who arrive at European airports direct from South America. The cocaine is smuggled on to Norway in many ways. The Norwegian customs service recently experienced a growing wave of couriers smuggling drugs inside their bodies at Norwegian airports.

Khat is transported from production areas in Africa to Europe. The drug is smuggled on to Norway from the Netherlands and the UK by plane and car. Most of the seizures are made from airline passengers who arrive from airports in the Netherlands and the UK. However, the biggest quantities are transported by road via Denmark and Sweden (the customs service, personal communication).

10.3 Seizures

The data basis

The annual report from the National Criminal Investigation Service (Kripos) about status and developments in drug trafficking contains national statistics that include all seizures by the police, the customs service, the prisons and the Armed Forces. Two variables are always reported – the quantity seized and the number of seizures. The data are based on verified analysis results for use in ordinary criminal cases, as well as on information from the police districts when the drug offences are decided locally by writs with the option of a fine (destruction cases).

Main features of the drug statistics for 2007

In 2007, 20,419 drug cases were registered and 24,139 seizures made. The total number of cases and drug seizures thus declined slightly compared with 2006, but there are big differences between the different types of drugs.

Such large quantities of amphetamine, methamphetamine and khat have never been seized in Norway before, 556.7 kg amphetamine and methamphetamine and more than 7.7 tonnes of khat.

Moreover, 95 kg of cocaine were seized in 886 seizures. Both the quantity seized and the number of seizures indicate that the use and availability of cocaine is on the increase.

Large seizures were also made of ecstasy (79,133 tablets) and benzodiazepines (708,293 tablets), while only modest quantities of cannabis (842 kg) and doping substances (343,000 units) were seized.

The amount of heroin seized in 2007 was only 8.1 kg. Seizures of heroin only accounted for approximately five per cent of the total number of seizures in Norway. By comparison, this proportion in 1998 was as high as 20 per cent.

While both the number of seizures and amount of cannabis seized declined, the cultivation of cannabis plants was uncovered on an extensive scale. During the last six months of 2007, the police uncovered a large number of «plantations» in rented houses, particularly in Eastern Norway. The vast majority of the «gardeners», and probably also the ringleaders, are of Vietnamese origin.

Tendencies during the first six months of 2008

Large quantities of hash have been seized. Four hundred and one kilos were seized in one seizure, the third biggest ever made in Norway. The large seizures involve hash that is probably produced in North Africa. As regards the number of seizures, it is primarily cannabis plants and marijuana that have increased substantially.

For amphetamine and methamphetamine, both the quantities seized and the number of seizures remain high. The most striking seizure was of 112.3 kilos, the biggest single seizure ever made. Kripas has no evidence to indicate that the importation and distribution of amphetamine and methamphetamine has changed, and Norway is still seen as a substantial market for these two drugs in the European context.

On the basis of the seizure figures, Kripas has no grounds for supposing that there has been a reduction in the importation and use of cocaine.

For heroin, the situation has changed since 2007 in that several large seizures have been made and the number of seizures is again increasing.

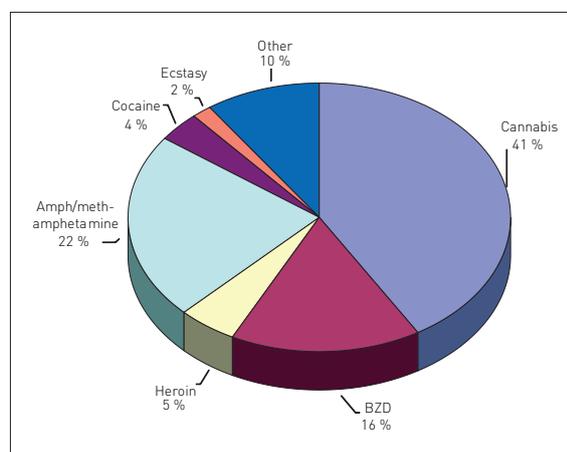
10.3.1 Seizures and purity of different types of drugs

See the data in Standard Tables 13, 14 and 15.

Table 8 shows the total number of seizures by the police, the customs service, prisons and the Armed Forces in 2007 broken down by the most common types of drugs. It also shows developments in recent years and the percentage change since 2005. The pie chart below illustrates the

market share of each drug based on the number of seizures.

Figure 11: Market share for the different drugs in 2007. Percentage.



Source: Kripas

Heroin

Only eight kilos of heroin were seized in 2007. Despite the small quantities, the number of seizures increased slightly compared with the two preceding years. The number of seizures, 4,222, increased slightly in 2007 after several years of steady decline. However, the number of seizures is only half the number in 2001. There are big

Table 8: Number of seizures in the period 2001–2007 broken down by type of drugs*.

Drug type	2001	2002	2003	2004	2005	2006	2007	% change 2006–2007
Cannabis	10,838	10,921	10,397	10,066	10,128	11,221	9,953	-11.3%
Amphetamine	4,283	5,037	4,578	4,149	4,410	4,680	4,222	-9.8%
Methamphetamine	392	696	640	830	950	1,139	1,284	+12.7%
Heroin	2,501	1,906	1,709	1,390	1,151	1,087	1,204	+10.8%
Benzodiazepines	6,006	8,058	4,700	4,393	3,928	4,552	4,088	-10.2%
Painkillers/ opioids	1,109	1,237	1,216	1,179	1,319	1,161	959	-17.4%
Cocaine	496	577	504	489	685	726	908	+25.1%
Ecstasy	837	693	405	456	341	411	421	+2.4%
Khat	198	238	249	305	210	220	376	+70.9%
LSD	52	15	31	31	34	28	14	-50%
GHB	81	75	120	28	46	65	163	+150.8%
Opium	21	14	7	18	16	23	19	-17.4%
Psilocybe mushrooms	59	66	89	77	75	82	77	-6.1%

*The figures for 2007 have been adjusted as of September 2008.
Source: Kripas

variations between the police districts. Heroin was seized in 24 of the country's 27 police districts and, in 14 of the districts, more seizures were made than in 2006.

The average purity of the heroin has increased from 26 per cent to 36 per cent in two years, but there are big variations from seizure to seizure. Paracetamol and caffeine, as well as other intoxicating substances (benzodiazepines), are also found in very many seizures.

Cannabis

Since 2006, the amount of cannabis seized has been almost halved and the number of seizures has been reduced by 11 per cent. The decline in the number of seizures and quantities seized applies to the big towns and cities in particular. Even though the decline is relatively large for the country as a whole, nine police districts have made more seizures than the year before. It is a striking development in 2007 that the proportion of marijuana and cannabis plants has increased, both as regards the amount and the number of seizures, in relation to hash.

The amount of cannabis seized in 2007 was 863.9 kilos. The amount consists of approx. 668 kg of hash (77%), 76 kg of marijuana (9%), 119.9 kg of cannabis plants (14%) and 0.013 kg of cannabis extract.

Of the total number of cannabis seizures (9,964), hash accounted for four-fifths. The reduction in the number of seizures from 2006 is more than 17 per cent. As regards marijuana and cannabis plants, on the other hand, there was an increase of 29 per cent. In terms of quantities, the seizures amounted to approx. 140 kilos, as much as 119

kg of which was seized in the last six months of the year alone.

For hash, the average THC purity is around seven per cent as it has been for many years. The results of measurements vary greatly, however. Based on the high number of hash seizures here in Norway, there are therefore no grounds for claiming that the THC content in all types of hash seizures has changed significantly on average. Based on the analyses carried out of cannabis products in recent years, it is only in some of the cultivation cases that the top shoots of cannabis plants have had high, and sometimes unusually high, THC values.

Amphetamine/methamphetamine

Record amounts of amphetamine and methamphetamine were seized in 2007, and 2006 is the only year in which more seizures were made than in 2007. A total of 559.4 kg were seized in 5,506 seizures. Preliminary analyses show that the total seizures consist of 392 kg of amphetamine and 167 kg of methamphetamine. For both substances, the amounts are greater than the year before. Based on the number of seizures, the proportion of methamphetamine is increasing substantially in relation to amphetamine. It was approx. 35 per cent in 2007. Table 9 shows developments in the last ten years.

All the police districts have made seizures of both amphetamine and methamphetamine. Six districts made more seizures than in 2006.

The average purity in 2007 is estimated to be roughly 38 per cent for amphetamine and 44 per cent for methamphetamine. This is somewhat lower than registered in recent years.

Table 9: Proportion of seizures of methamphetamine in relation to amphetamine 1998–2007. Percentages.

Year	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Metamph.	1.4%	1.3%	1.8%	6.2%	10.8%	15.4%	21.1%	22.0%	26.0%	35.3%

Source: Kripas

Cocaine

Nine hundred and eight seizures of cocaine were made in 2007, the highest number of seizures of cocaine ever made in Norway. With the exception of the years 1998 and 2005, when very large quantities of cocaine were seized that were not intended for the Norwegian market, 2007 was also a record year in terms of the amount seized, 95 kg.

Cocaine was seized in 26 of the country's 27 police districts and 16 police districts made more seizures than the year before. Oslo's share of the cocaine seizures has been reduced from 62 per cent to 36 per cent over the last 11 years, while the rest of the country's share has naturally increased.

Kripos does not distinguish as a matter of routine between cocaine hydrochloride and cocaine base («crack»). In 2007, however, one seizure was made of 482 grams of a mixture of substances containing cocaine base (33–37%).

The cocaine content in the seizures has fallen steadily, from more than 70 per cent 10 years ago to 38 per cent in 2006 and 2007. Cocaine hydrochloride of up to 100 per cent purity was seized also in 2007. Fenacetin is often used as an additive.

Ecstasy

In 2007, nearly 79,000 tablets were seized in 421 seizures. It is only in 2002 and 2003 that larger amounts of ecstasy have been seized than in 2007. The number of seizures, on the other hand, remains stable. As described in previous years, it appears that the illegal traffic in ecstasy culminated at the turn of the millennium. However, as the seizures show, ecstasy has not disappeared from the market. The number of seizures, however, indicates that ecstasy's market share is no greater than it has been for this class of substances in recent years. The high number of tablets seized is explained by two large seizures. Historically, they rank as the second and fifth biggest seizures ever.

No other substances than MDMA were found in the seizures in 2007.

Apart from seven minor seizures of tablets containing amphetamine and equipped with an ecstasy logo, no other hallucinogenic, synthetic substances often mentioned together with ecstasy were found in 2007. However, 0.86 grams of a powder containing 2C-B was found in four seizures, and on one occasion MDEA was found in combination with MDMA. Neither MDA, MBDB, PCP, DOB, 2C-T-2, 2C-T-7, 4-MTA, DMT, PMA nor PMMA, all of which have been identified previously, were registered in any seizures in 2007. On the other hand, ketamine (4.6 grams) was found in two seizures. However, this substance, which is an ingredient in the Norwegian-registered medicinal drug Ketalar, is not included on the list of narcotic substances.

Benzodiazepines (BZD)

More than 730,000 seized tablets in 4,084 seizures show that this class of medicinal drugs has in no way disappeared from the illicit market, even though the number of seizures has been halved in relation to the peak year of 2002. During the period 2001 to 2003, it was primarily Rohypnol that dominated this class of substances with more than 6,500 seizures, while the figure five years later has fallen to roughly 800 seizures.

Based on the number of seizures parameter, it is diazepam that is increasing its «market share» at the expense of flunitrazepam. Rohypnol and Flunitrazepam were reclassified from class B to class A drugs with effect from 1 January 2003, and Rohypnol was de-registered as a medicinal drug in Norway on 1 August 2004. All the Rohypnol seizures must therefore come from illegal import.

Other BZD substances

Other benzodiazepines that can be mentioned include fenazepam, a benzodiazepine from Russia that is not in medical use in Norway. Even though this drug has never been very common in Norway, it has nevertheless attracted a lot of attention. The substance was first seized in 1993 in a small seizure in Finnmark. There were no more seizures until 2003. In recent years, the prevalence of fenazepam appears to have been on the decline. A total of 2,030 tablets were seized in 2007.

Painkillers, drug-classified medicinal drugs

A total of 17,354 tablets were seized in 959 seizures. The number of seizures has thus declined somewhat, while the amount seized remains relatively stable compared with recent years. Several of the cases involved illegal import of such medicinal drugs via internet shopping, but the num-

ber of tablets in each seizure is relatively small. Based on the number of seizures, buprenorphine (Temgesic and Subutex) predominates, although the quantities seized are generally small. More tablets containing codeine were seized than any other substance.

Table 10: Seizures of painkillers, drug-classified medicinal drugs. Number of tablets/units and percentage.

Drug	Substance	% (number) of seizures	Number of tablets/units
Temgesic, Subutex	Buprenorphine	45.2% (449)	4,256 tablets
Paralgin forte etc.	Codeine	26.9% (267)	7,463 tablets
Dolcontin etc.	Morphine	17.1% (170)	4,256 tablets
Methadone	Methadone	7.8% (77)	844 units
Ketorax, Fentanyl	Other	3.0% (29)	2,200 tablets

Source: Kripas

GHB

Fifty-eight litres of GHB were seized in 163 seizures in 2007. The number of seizures of GHB increased radically in 2007. Even if we include seizures of the industrial chemicals GBL and

1.4-butandiol, substances that are not included on the list of narcotic substances, the figures are nonetheless deemed to be small compared with other depressants.

Table 11: Seizures of GHB, GBL and 1.4 butandiol 1998–2007. Number.

Substance	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
GHB	2	45	82	81	74	120	28	57	65	163
GBL	-	-	-	-	8	21	11	3	11	24
1.4-BD	-	-	-	-	17	7	24	7	10	0

Source: Kripas

Table 12: Amounts seized of GHB, GBL and 1.4 butandiol 2004–2007. Litres.

	2004	2005	2006	2007
GHB	3.5 litres	8.5 litres	18.2 litres	58.0 litres
GBL	5.4 litres	0.9 litres	14.2 litres	30.4 litres
1.4-BD	45.3 litres	7.4 litres	18.1 litres	-

Source: Kripas

Khat

Khat is included on the Norwegian list of narcotic substances. A total of 7.747 kilos of khat was seized in 2007 in 376 seizures. This is a much larger amount and the number of seizures is also mark-

edly higher than the year before. However, only 13 police districts (out of 27) made seizures of khat.

LSD

Based on the figures for the number of seizures, LSD does not appear to have become more widely available in 2007. The opposite would actually appear to be case. Since LSD is easy to conceal, however, we cannot discount the possibility that the seizure statistics do not truly reflect the situation.

Other hallucinogenic drugs

Two hallucinogenic drugs were found for the first time in 2007, but neither of them is on the list of narcotic substances. One of them is bromo-dragonfly. This substance was seized in very small quantities of one gram/five doses and 0.6 grams/three doses, respectively. The other substance found was *3,4-methylenedioxymethcathinone* or *methyline* in the form of 2.6 grams of powder.

Psychoactive plants and plant parts that are not classified as drugs are regularly seized on the grounds that their importation is not normally permitted. Much of this traffic is probably the result of information and offers on the internet. Kripos has noted in particular seeds of *Argyrea nervosa* (Hawaiian Baby Woodrose), *Salvia divinorum*, *Peganum harmala*, seeds of peyote cactus and peyote cactus containing mescaline.

In 2005, tablets appeared containing the synthetic substance *1.3-chlorphenyl piperazine*, a hallucinogenic that is also called mCCP. The substance, which is not yet on the list of narcotic substances, has no industrial or medicinal application. The largest single seizure was made in Oslo in 2005, and consisted of 10,030 tablets together with 20 kilos of amphetamine. The distribution of this drug has clearly been in Southern and Western Norway. All the tablets seized had the same appearance and logo as traditional ecstasy tablets.

10.4 Prices

See the data in Standard Table 16.

A new 'pricelist' for narcotic substances is available as of October 2008. The list has been produced by Oslo police district on the basis of information from internal police sources. Naturally, the prices on the illegal street market must be treated with considerable caution and should preferably also be checked against sources outside the police. Moreover, as regards large quantities, the variation in prices is particularly great for several of the types of drugs.

For smaller quantities, the price level seems to have largely remained stable for most of the types of drugs since the last overview produced by the police in autumn 2006. In nominal terms, prices have probably fallen slightly rather than the opposite. The most striking development is that the price of cocaine appears to have fallen for typical sales doses. In 2006, the price for half a gram of cocaine was estimated to be approximately EUR 62.5¹¹ (NOK 500), while in 2008 it was approximately EUR 37.5 - 50 (NOK 300-400). By comparison, the market price for heroin in 2008 was estimated to be EUR 62.5 (NOK 500) for 0.5 grams and EUR 25 - 37.5 (NOK 200-300) for 0.2 grams. Cocaine is still expensive in relation to amphetamine. The price level for one gram is more than double the price level for amphetamine, and the differences seem to be even greater for large quantities. The prices for ecstasy, GHB and LSD seem stable, while the price level for Rohypnol (per tablet, 100 mg) on the illegal market seems to have fallen since 2006.

¹¹ Conversion rate: 1 EUR=NOK 8.00

PART B

Selected issue

11. Sentencing statistics - Norway

11.1 Options available in the country – penal sanctions in Norway

11.1.1 The general system of sanctions

The question of which penal sanctions are to be used in criminal cases in Norway is initially decided by the prosecuting authorities. Instead of prosecuting an offender in the courts, the prosecuting authority can conclude the case on its own. One option is waiver of criminal charges, which means that the prosecuting authority waives prosecution on condition that the offender in question does not reoffend during a probationary period of two years and meets any other requirements set by the prosecuting authority. The prosecuting authorities can also issue a writ with the option of a fine, which means that the offender can choose to accept the stipulated fine instead of having his or her case tried in the courts. Waiver of criminal charges was previously frequently used in less serious cases, but it is used relatively rarely today, also in drug cases. Instead, the use of writs with the option of a fine has increased strongly.

The prosecuting authorities also have the option of referring a case to a mediation board. This is the only form of «diversion» in Norwegian law. Referral to a mediation board means that the prosecuting authority – or, if applicable, the court as a condition for a suspended sentence – can transfer the case to a mediation board at which the offender and the victim meet and, if possible, agree on how the conflict between them can be resolved. Hearings by mediation boards are used in minor cases in particular, often when young offenders are involved. However, in cases where there is no victim, as in the case of driving under the influence of drugs or illegal association with drugs, a hearing by a mediation board will rarely be an option.

In principle, the police are not entitled to decide a case, although informal warnings are probably used in some relatively trivial cases. However, the lower prosecuting authority is integrated with the police. Lawyers are employed at all the police stations in the country who, in addition to ordinary police duties, are also authorised to take certain decisions regarding prosecution in minor cases, including waiving prosecution, issuing writs with the option of a fine, referring to a hearing by a mediation board or bringing charges before the courts. In the exercise of their duties as prosecutors, however, they are subject to the Director General of Public Prosecutions, not the Ministry of Justice and the Police.

If the prosecuting authorities bring a case before the courts, a number of different penal sanctions can be imposed. A person found guilty can be sentenced to pay a fine or to a prison sentence, which can either be unconditional or suspended on condition that the person in question complies with certain conditions during a stipulated probationary period. Fines and prison sentences can be combined. A court can also sentence the offender to a community sentence, which means that the offender must perform certain tasks for a certain number of hours for the community. In the case of serious crimes, the offender can be sentenced to preventive detention if there is high risk of the person in question committing new, serious crimes.

In cases that involve drug crimes, it can be set as a condition for both a waiver of prosecution and a suspended sentence that the offender in question refrains from using alcohol or other intoxicating or narcotic substances, or undergoes treatment to combat the use of such substances, in an institution if necessary. This latter condition is rarely used since it is deemed to be an intervention by the court in the area of responsibility of the treatment sector. Normally, such a condi-

tion will only be set if the person in question is already in treatment or has already been granted admission to a treatment institution at the time the decision to waive prosecution was made or the judgment was handed down. If the court finds that a suspended sentence cannot be imposed, it will be possible to reduce the length of the prison sentence in many cases if the offender is a drug user who, since the offence, has started treatment or has been assigned a place in a treatment institution.

Through an amendment of the law in 1995, a scheme was introduced whereby it is possible to impose a suspended sentence on persons with alcohol problems who are convicted of driving under the influence on condition that they undergo an approved alcohol treatment programme under supervision of the Correctional Services. In 2005, a trial scheme was introduced in the two biggest cities in Norway consisting of a drug programme for drug users who have been convicted of drug-related crimes, but this is not limited to driving under the influence of drugs. Treatment in an institution can also be included as part of the programme. The programmes are administered by the probationary service, which is also responsible for following up the convicted offender.

11.1.2. Penal provisions for drug crimes

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 covers all kinds of association with drugs other than use and possession for own use, such as the manufacture, importation, exportation, acquisition, storage, sending or conveying of drugs. However, 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 re-

spects. 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 after the repeal of life imprisonment in 1981. This means that drug crimes – except for driving a motor vehicle under the influence of drugs – fall into one of five categories of gravity:

- 1 The Act relating to medicines section 24: The use and possession of drugs (for own use). Fines or imprisonment for up to two years.
- 2 The General Civil Penal Code section 162 first paragraph: Drug crimes Fines or imprisonment for up to two years.
- 3 The General Civil Penal Code section 162 second paragraph: Aggravated drug crimes. Imprisonment for up to ten years.
- 4 The General Civil Penal Code section 162 third paragraph first sentence: Aggravated drug crimes that involve a large quantity. Imprisonment for between three and 15 years.
- 5 The General Civil Penal Code section 162 third paragraph second sentence: Aggravated drug crimes that involve a very large quantity and where there are other particularly aggravating circumstances.

The General Civil Penal Code does not contain any provisions specifying what drugs or what quantities are required for the different punishment alternatives to be applicable, or what other circumstances are to be given weight. In a circular from the Director General of Public Prosecutions (Circular 1/1998 part II – Drug cases: The importance of quantity in the legal assessment and use of writs with the option of a fine), however, instructions are given for when the prosecuting authority shall decide cases by writs with

the option of a fine or which sentencing claims are to be entered in drug cases that are heard in the courts. In the circular, it is stipulated that in cases involving possession and storage where the aim is not resale, it shall be possible to issue writs with the option of a fine if the quantity does not exceed one to two user doses of heroin, amphetamine, cocaine or LSD, five grams of cannabis – increased to 15 grams in 2006 – five kilos of khat, one to two ecstasy tablets or 25 to 30 tablets containing benzodiazepine.

If the case involves importation or distribution or exceeds these limits, the case must be brought to court. In such cases a claim shall be entered for punishment for a drug crime pursuant to the General Civil Penal Code section 162 first paragraph if the case involves up to 15 grams of cocaine or amphetamine, 350 ecstasy tablets or one kilo of cannabis.

If larger quantities than this are involved, a claim shall be entered for punishment for an aggravated drug crime pursuant to the General Civil Penal Code section 162 second paragraph if the case involves between approx. 15 and 750 grams of heroin, between approx. 50 grams and three kilos of amphetamine and cocaine, between approx. 350 and 15,000 user doses of LSD and ecstasy, or between approx. one and 80 kilos of cannabis. If the quantity is even greater, a claim shall be entered for punishment pursuant to the General Civil Penal Code section 162 third paragraph first sentence. Punishment pursuant to section 162 third paragraph second sentence requires that further aggravating circumstances are present.

Although the claims entered by the prosecuting authorities are not binding on the court, the sentence will often not deviate much from the claim. This is due, not least, to the fact that the claim in an individual case – and the instructions in the Director General of Public Prosecutions' circular – are largely based on case law from the Supreme Court, which has precedential effect and is therefore largely followed by the lower courts.

11.1.3. Penal provisions for driving under the influence of drugs

In Norway, the first penal provisions for driving motor vehicles under the influence of alcohol were introduced in the early 1900s. In 1936, a fixed limit for the blood alcohol level of 0.5 mg/ml (which in 1988 was lowered to 0.2 mg/ml) was introduced, and the right to take blood samples was also introduced at the same time. Until 1959, the law only applied to driving under the influence of alcohol, but from then the prohibition was extended to also cover the influence of «other intoxicating or narcotic substances», and the right to take blood samples was also extended to such cases.

However, the prohibition against driving a motor vehicle under the influence of other substances than alcohol was virtually a dormant provision for many years. Only in exceptional cases were blood samples examined with a view to establishing whether the driver had used substances other than alcohol, and in the event that such substances were found, there was great uncertainty in case law about whether the driver could be described as being under the influence. The result was that hardly anyone was prosecuted for driving under the influence of substances other than alcohol.

In 1958, the police were given the right to use a so-called breathalyser test on suspected drivers of motor vehicles with a view to establishing whether there was alcohol in their exhaled breath and thus grounds for taking a blood sample of the driver to establish guilt. However, drivers were not obliged to take such tests. Through an amendment of the law in 1981, however, the police were given the right to carry out breathalyser tests of drivers as a matter of routine in connection with road accidents, on suspicion of certain road traffic offences and in connection with ordinary road traffic controls. In 1988, a fixed limit was also introduced for punishable alcohol content in exhaled air. Because sufficiently reliable measuring instruments were not available, however, breathalyser tests were first seriously

introduced as proof of being under the influence of alcohol with effect from 1996.

While breathalyser tests were initially only used to a modest extent, their use increased as the 1980s progressed. Even if the influence of substances other than alcohol could not be detected by such breathalyser tests, it could be indicated indirectly. If a driver appeared to be under the influence despite the breathalyser showing that he or she was not under the influence of alcohol, this could indicate that he or she was under the influence of other substances. In such case, the police could ensure that a blood sample was taken and that it was specially analysed with a view to establishing whether the person in question was under the influence of substances other than alcohol. Moreover, a gradual development took place on both the technical and methodological level as regards the chemical analyses that were carried out to establish the presence of other such substances. This gradually resulted in a strong increase in the number of blood samples sent for so-called extended analysis, in which the sample is also analysed with a view to establishing the influence of substances other than alcohol. However, saliva samples with a view to establishing whether a driver has used other substances are still not used by the police.¹²

The current penal provisions concerning driving under the influence of alcohol or other intoxicating or narcotic substances are found in the Road Traffic Act sections 22 and 31. Pursuant to section 22, a driver of a motor vehicle shall be deemed to be under the influence in the sense of the Act if his or her blood alcohol level is over 0.2 mg/ml or more than 0.1 mg alcohol per litre air in exhaled breath. As regards influence from other substances, on the other hand, there are no fixed limits – it is up to the courts to decide whether a driver shall be deemed to have been under the influence, often by obtaining a written or oral statement from an expert.

Pursuant to section 31, the punishment for driving under the influence of alcohol varies with the degree of influence: a fine and a suspended prison sentence for a blood alcohol level of less than 1.0 mg/ml, a fine and a suspended or unconditional prison sentence for a blood alcohol level of 1.0 to 1.5 mg/ml, and a fine and unconditional prison sentence if the blood alcohol level is over 1.5 mg/ml. Pursuant to the directions from the Storting and the Ministry of Justice and the Police, the fine should normally be equivalent to one and a half months' gross income. For driving under the influence of substances other than alcohol, the punishment shall also vary in the same way, but because there are no corresponding units of measurement that can be used, the decision is left to the discretion of the court.

11.2. Data collection systems

11.2.1. Crime statistics

Data about crimes are published in annual crime statistics prepared by Statistics Norway (SSB). The statistics are first published on SSB's website (www.ssb.no/emner/03/05) and then published as an annual printed publication (Crime Statistics), which also contains an English text. Both Norwegian and English are used on the website and in the printed version. The crime statistics are available on the website one to two years, and in printed form two to three years, after the reporting year.

The crime statistics consist of police statistics that include all registered offences and those charged in these cases, sanctions statistics that provide information about the penal sanctions imposed and, finally, imprisonment statistics that provide information about the prison population. The police statistics are based on the police's central registration system in which all offences are registered, also if they have been committed by the same accused person. The sanctions statistics are based on the central criminal record and police information system (SSP), which provides information about which

¹² A comprehensive test project on saliva samples was carried out in Norway in 2005/2006. www.fhi.no

sanctions have been imposed on those who have been given penal sanctions. The imprisonment statistics provide information about the prison population as of 1 January in the statistical year, and admissions to and departures from prisons during the year, and they are based on SSP, supplemented by information from the Correctional Services' registration system.

11.3 Data collected

In addition to the primary offence of which they have been found guilty, the information relating to persons in the crime statistics – i.e. persons charged, sentenced and the prison population – includes the primary offence they have been found guilty of, their gender and age, and for charged and sentenced persons, also their county of residence. For persons charged, additional information is provided about the location where the crime was committed (county), the number of offences covered by the charge and the number of accomplices, and whether the person in question had previous convictions during the last five years. For sentenced persons, information is provided about where the crime was committed (county), nationality, the length of any prison sentence, the size of optional fines and imposed fines, in addition to the conditions set for waiving prosecution and suspended prison

sentences. The different personal data at the different stages of a case are presented in Table 13.

It is not possible on the basis of the crime statistics to trace the same person through the different stages in the criminal law process. Moreover, registration is linked to the section or sections of the Penal Code that have been violated, with no additional description of the offence. This means that as regards, for example, drug offences, there is no information about which drugs and which forms of unlawful association with drugs are involved, and, in the case of driving under the influence, there is no information about whether the person in question was under the influence of alcohol or another substance.

11.4 Results available

11.4.1 Statistics for drug crimes

In 2005, which is the last year for which such statistics are available, a total of 39,634 drug cases were investigated. Of this total, 4,487 cases were dropped as unsolved or because the perpetrator could not be held criminally liable because of his or her age or because of absconding. How the remaining 35,084 cases were decided is shown in Table 14.

Table 13: Personal data at the different stages of a case

Charged*	Sentenced*	Prison inmates*
Number of offences		
Number of accomplices		
Previous convictions		
Age	Age	Age
Gender	Gender	Gender
Location of the offence (county)	Location of the offence (county)	
Place of residence (county)	Place of residence (county)	
	Nationality	
	Length of prison sentence	
	Size of fine	
	Conditions for conditional sanctions	

*For primary offence
Source: SIRUS

In 2007, a total of 14,194 sanctions were imposed where a drug offence was the primary offence, and Table 15 shows the distribution of the different sanctions. Some of those convicted received a prison sentence where part of the sentence was suspended. They are included in the table under unconditional prison sentence. Moreover, some of the convicted persons in the table categorised under suspended or unconditional prison sentence were also sentenced to pay a fine.

11.4.2 Statistics for driving under the influence of drugs

According to the police statistics for 2005, which is the last year for which we have data, 8,605 cases were investigated that concerned driving un-

der the influence of alcohol or other substances. Of these cases, 1,122 cases were dropped as unsolved because the person in question had left the country, was a minor or could not be held criminally liable for other reasons. Of the remaining 7,483 cases, 451 (6.0%) were decided by a writ with an option of fine and 192 (2.6%) by waiver of prosecution, while 6,840 (91.4%) were prosecuted as criminal cases before the courts.

As mentioned, no information is available about how many of these cases involved driving under the influence of substances other than alcohol. The crime statistics do not distinguish between persons who are investigated for, charged with or sentenced for driving under the influence of al-

Table 14: Persons charged with drug offences 2005

	General Civil Penal Code				Medicines Act					
	Aggravated drug crime		Drug crime		Possession of drugs		Use of drugs		Other drug crimes	
	No	%	No	%	No	%	No	%	No	%
Waiving of prosecution etc.	23	2.3	1,159	7.6	881	12	876	7.6	27	49.0
Writ with option of fine	1	0.1	3,758	24.7	3,488	47.6	5,029	43.6	20	36.4
Mediation board	0	0	1	0	0	0	2	0	0	0
Charge	995	97.6	10,283	67.7	2,961	40.4	5,627	48.8	8	14.6
Total	1,019	100	15,201	100	7,330	100	11,534	100	55	100

Source: Statistics Norway, Crime Statistics

Table 15: Penal sanctions for drug offences by type of sanction 2007

	General Civil Penal Code				Medicines Act					
	Aggravated drug crime		Drug crime		Possession of drugs		Use of drugs		Other drug crimes	
	No	%	No	%	No	%	No	%	No	%
Waiver of prosecution	0	0	70	.0	28	1.1	99	2.5	1	16.7
Writ with option of fine	4	0.6	4,441	63.8	2,506	94.8	3,499	88.9	4	66.7
Fine by judgment	0	0	100	1.4	60	2.3	73	1.9	1	16.7
Community sentence	63	9.7	351	5.0	4	0.2	24	0.6	0	0
Suspended prison sentence	20	3.1	1,172	16.8	25	0.9	86	2.2	0	0
Unconditional prison sentence	561	86.6	826	11.9	20	0.8	156	4.0	01	0
Total	648	100	6,960	99.9	2,643	100.1	3,937	100.1	6	100

Statistics Norway, Crime Statistics

cohol and driving under the influence of other substances. However, there are data about suspected drivers who have been subjected to a blood test for alcohol and an extended blood test (possible supplemented by a urine test) which are compiled by the National Institute of Public Health. It is the only institute in Norway that analyses blood samples for use in such cases, and data from the analyses is published annually on the website www.fhi.no and in the statistical publication: Alcohol and Drugs in Norway (www.sirus.no).

According to these statistics, in 2005 a total of 2,243 drivers of motor vehicles were proven to have been under the influence of alcohol through tests of their exhaled breath, and a blood sample was therefore not taken. In addition, blood samples were taken of a total of 6,225 drivers suspected of driving under the influence of alcohol or other substances, for 4,257 or 68 per cent of whom an extended analysis was carried out of the blood sample. There are no data about how many of these persons were found to be under the influence of substances other than alcohol, but estimates from the institute indicate that approximately 2,500 to 3,000 persons per year are found guilty of driving under the influence of substances other than alcohol (Christophersen

and Mørland, 2006). This means that slightly more than a third of all the 7,483 persons punished for driving under the influence in 2005 were under the influence of other substances, possibly in combination with alcohol.

For those drivers of motor vehicles where other substances are found, either in an amount that means they are deemed to be under the influence or smaller amounts, the National Institute of Public Health provides an overview of which substances are involved. In all, 25 substances or groups of substances are examined, and, in many of the tests, several different substances are found.

In 2005, amphetamine was found in 1,343 blood samples, which is 32 per cent of all the 4,257 samples that were subjected to extended analysis, and methamphetamine was found in 509 samples (12%). Cannabis substances were found in 1,215 (29%) of the samples. As regards benzodiazepines, diazepam was found in 967 (23%) of the samples, clonazepam in 542 (13%), and other benzodiazepines were also common. Of opiates, morphine was found in 270 (6%) of the samples, the metabolite of heroin in 117 (3%) and methadone in 197 (5%). Cocaine was found in 142 (3%) of the samples and ecstasy in 63 samples (1%).

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List of Structured Questionnaires submitted in 2008.

- Str.Q 27(part I&II): Treatment programmes(part I);Quality assurance treatment(part II)
- Str.Q 23/29: Prevention and reduction of health-related harm associated with drug use

Links to 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:

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