

**Annual National Report
on the Drug Situation in Norway
2001**

**National Institute for Alcohol and Drug Research (SIRUS)
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Introduction

This annual report on the drug situation in Norway was compiled during the autumn of 2001 by the National Institute for Alcohol and Drug Research (SIRUS) for the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

The EMCDDA is an independent, decentralised EU agency. The centre is charged with collating and analysing information and knowledge about drugs and political issues related to drugs. The aim is to better equip the member states to develop effective measures against drugs and drug related problems within a national or common European framework. Norway joined the centre 1.1.2001, and at the same time SIRUS was connected with the European Information Network – REITOX as a national Focal Point.

For the most part the proposed guidelines and framework for the national report have been carefully followed, with two exceptions: The key issue “ Poly drug use” has been integrated into the main report; key issue “Successful treatment” is limited to medically assisted rehabilitation. Since this is the first time Norway has delivered such a national annual report, we have chosen in some cases to provide information relating to specific measures and projects that were initiated prior to 2001. This is also true for the comparable statistical data and survey results presented.

Part I. National strategies: institutional & legal frameworks has been mainly written by the Ministry of Health and Social Affairs. All other sections, have been prepared in their entirety by SIRUS internally and by staff who function as the Norwegian Focal Point, where Norway’s representative to the Scientific Committee of the EMCDDA also has played a central role. Information in the report is largely based on information and data collected from central Norwegian institutions and actors in the drug field. I would like to thank all external contributors, in particular the translator and staff who, often under the pressure of short timelines, have contributed to the report in its current form.

Oslo, December 2001

Knut Brofoss
Director
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Summary. Main trends and developments

Norwegian drug policy is based on a comprehensive, multidisciplinary approach, in which prevention, treatment and rehabilitation efforts balance and reciprocally reinforce supply side measures and control efforts. Ever since the use of drugs became a social problem among youth in the late 1960's, Norway has pursued a restrictive drug policy, banning both the possession, use and trafficking of drugs.

Despite all efforts made, drug abuse still constitutes a considerable health and social problem. There is a greater access to and availability of drugs than ever before. Increased drug trafficking and new patterns of abuse imply significant challenges to all services involved as well as demanding extensive efforts.

Over the years, the Government has stressed the importance of further developing a comprehensive “substance abuse policy”, with regard to prevention, care and treatment efforts. One reason for this is the extent and sophistication of research results and knowledge accumulated over the last few decades concerning the relationship between substances. We now know that where we find illicit drugs we also find alcohol and tobacco. Supporting and reinforcing efforts to obtain knowledge in the substance abuse field and raising the level of competence among key professional groups is a major priority.

There still seems to be a general consensus among experts, politicians and the general public that any proposals that could potentially lead to the liberalisation of drugs should be rejected. It is also worth noting that a vast majority of Norwegian youth still opposes any use of illicit drugs. This despite the sharp increase in use of cannabis and of ATS (amphetamine type stimulants), in particular ecstasy among young people under 21.

Surveys among young people 15- 20 years of age suggest that there has been a distinct increase in the use of different substances in recent years. While until the mid 1990s less than 10 per cent of young people across the country from 15-20 years of age reported that they had ever used cannabis, this estimate grew to 17 per cent in 2001.

Among those who report a use of other illegal drugs, 1-2% report that they have used substances such as LSD, heroine, cocaine and ecstasy at some time. For amphetamines, there has been an increase from approximately two per cent during the mid-1990s to approximately four percent during the last 2-3 years (Figure 2).

Lifetime use of cannabis among those 15-64 years of age shows that the percentage has risen from 9.6% in 1991 to 15.4% in 1999. The proportion of those who reported having used cannabis during the last year rose from 3.0% to 4.5%. During 1999, 3.8% of the same age group reported having ever used amphetamines, 1.3% reported use of ecstasy, 2.1% cocaine and 1.4% heroine.

Other surveys show that a substantial increase has also taken place with respect to more long-term abuse. Calculations made by the National Institute for Alcohol and Drug Research show that the number of intravenous drug users in Norway has grown from 4-5 000 at the end of the 1980s to 9-12 000 during the late 1990s. Surveys show that most intravenous drug users inject heroine. The proportion of those who primarily inject amphetamines is estimated to be approximately 10 per cent.

The abuser population has grown older over time. There is reason to believe that this trend will continue. From at one time being a youth problem, it is currently on the verge of becoming a social problem that is increasingly related to middle-aged abusers. Moreover, it appears that more recruiting is taking place among the older age groups, particularly among men. One possible explanation for this is that those who have traditionally abused alcohol have now become heroine addicts.

There also seems to have been an increase in the consumption of heroine, which is related not only to the fact that there are more abusers, but also to the fact that the dosage size per injection has grown.

There has been a dramatic increase in the number of drug-related deaths during the 1990s. In 1990, 75 people died as a result of an overdose, while the figure for 2000 was 327, the greatest number ever. The rise in mortality has no easy explanation, and we continue to lack information in this area.

Along with growing older, the group of heavy drug users has become more physically and mentally debilitated. There is wide access to heroine as a result of falling prices, which in turn has contributed to larger doses for individual users. Mixed abuse, whereby heroine is taken together with alcohol and/or other prescription drugs such as Rohypnol, are becoming increasingly common. Moreover, many drug addicts appear to be more resigned to their problem and more self-destructive after several rounds of treatment in various institutions and rehabilitation programmes. The high mortality rate can be related to a more widespread drug injection culture in Norway when compared to other countries, including Nordic neighbours.

The number of new cases of HIV infection among intravenous drug users in Norway is low. This is also the case for the number of new intravenous drug users who develop AIDS.

As of 31 December 2000, 448 individuals were diagnosed as HIV-positive, with intravenous drug use as a risk factor of. Among those who had developed AIDS as of 31.12.2000, 119 were intravenous drug users or 17% of the total number of AIDS cases. The outbreak of Hepatitis A and B appears now to be in retreat, although 176 new cases were reported in 2000.

Hepatitis C still need not be reported except in the case of acute infection, and the number of reported cases does not represent the real incidence rate. The number of reported cases is very low, although it is known that large numbers of drug users have been infected with Hepatitis C.

The number of drivers arrested under suspicion of driving under the influence of drugs other than alcohol has more than doubled during the 1990s.

Narcotics and/or medicines have been detected in slightly less than 70% of tests where the primary suspicion is such substances. Cannabis and amphetamines are the most commonly detected drugs. For these drugs the number of positive tests during the period has doubled many times over. The prevalence of heroine, benzodiazepines and ecstasy has also shown a similar increase.

Developments in seizures of drugs largely indicate a growing tendency with respect to both number and amount.

However, there have been broad variations for all substances from one year to the next. Cannabis is the dominant drug seized. During the last five years, the number of seizures has risen from 4 296 in 1996 to 9 225 in 2000. The number of seizures of amphetamines has risen from 1 775 in 1996 to 3 077 in 2000. Seizures of heroine have remained relatively stable, at approximately 2 300-2 600 seizures during the last five years.

The number of seizures of ecstasy has grown from 198 in 1996 to 783 in 2000, while the number of seized doses has risen from nearly 13 000 to nearly 15 000. As in other countries, new types of tablets and capsules are continuously registered, although MDMA dominates, accounting for 97 per cent of seizures. The remaining 3 per cent includes MDA, MDEA, amphetamines, cocaine and ephedrine.

LSD and other hallucinogenic substances have never gained a foothold in Norway, and were absent from the market for quite some time. However, in 1995 LSD made a comeback in the wake of ecstasy. The number of seizures of LSD is, however, low (88 in 2000). The volume confiscated has also been relatively modest.

While there has been a relatively large increase in the number of cocaine seizures (from 75 in 1996 to 390 in 2000), cocaine amounts to a small portion of the total number of seizures of narcotics in Norway. However, large single seizures have been made in some years, such that the total volume confiscated has been relatively large (92.7 kilos in 1998, 60.2 kilos in 1999).

Seizures of GHB are rare, although they have become more frequent; from 2 in 1998, 38 in 1999 to 83 in 2000. In July 2000 GHB was classified as a narcotic substance in Norway. One of the raw materials used in the production of GHB – gammabutyrolakton (GBL), which otherwise is used in the removal of “tagging” – was classified as a drug in January 2000.

The general goal of treatment is full rehabilitation of substance abusers. This is viewed as compatible with an acceptance that harm-reduction measures directed at reducing the damaging effects of drug abuse to the abusers themselves, to their families and to the society are needed.

However, controversy has arisen in relation to the need for new harm-reduction measures, particularly proposals for establishing public injecting rooms in protected

environments. Before resigning in October 2001, the former Government concluded that since no means should be left untested in the struggle to reduce deaths caused by overdose, public injecting rooms could legally be established in a limited number of municipalities on a strictly controlled trial basis. The new Government will await comments to the proposal before deciding its position.

The issue of substitution treatment has also been controversial. This is part of a larger debate on the quality and effect of treatment offered, a debate initiated by users as well as those working in the rehabilitation field. Since the conclusion of a pilot methadone project in 1997 that involved 50 clients, the number of clients receiving substitution treatment has risen dramatically, and is estimated to reach 1 600 by the end of 2001. Investing in substitution treatment does not disregard the ethical dilemmas associated with offering a form of treatment that replaces a life-long addiction to one narcotic drug with another, but acknowledges a moral duty to improve the lives of those suffering as a result of extensive drug abuse.

The national drug prevention field under the Ministry of Health and Social Affairs has recently been reorganised.

A major objective of this action is to support local communities' ability to prevent and tackle drug abuse, and to strengthen the after-care system for drug addicts who have gone through specialised treatment programmes. Furthermore, the reorganisation is intended to strengthen the areas of research and education within the drug field. As of 1 January 2001 three central environments for substance abuse prevention were involved in the reorganisation. These operate within the areas of research and documentation, education and competence, and administrative tasks and are as follows:

- the National Institute for Alcohol and Drug Research (SIRUS)
- the Norway-Net consisting of seven regional centres of competence
- the remaining Norwegian Directorate for the prevention of alcohol and drug problems.

Through this reorganisation the Ministry has ensured broad and current access to knowledge and experience as a basis for strategic planning and policy development.

The establishment of seven regional centres of competence in Norway represents a substantial contribution towards strengthening the development of competence within the drug field among health and social workers.

The competency centres are to provide up-grading education for key personnel within municipalities, further develop specialised services for drug abusers and support schools. Following the reorganisation of state efforts within the drug field, the centres are also expected to cooperate with the municipalities, fuel the further development of methods and contribute to raising the level of competence within the drug prevention field. Each centre of competence has been delegated one or several speciality areas. Norway-net is the collective network for the regional drug centres of competence.

PART 1

NATIONAL STRATEGIES: INSTITUTIONAL & LEGAL FRAMEWORKS

1. Developments in Drug Policy and Responses

1.1 Political framework in the drug field

a. Objective and priorities of the national drug policy

Norwegian drug policy is based on a comprehensive, multidisciplinary approach, in which prevention, treatment and rehabilitation efforts balance and reciprocally reinforce supply side measures and control efforts. Ever since the use of drugs became a social problem among youth in the late 1960's, Norway has pursued a restrictive drug policy, banning both the possession, use and trafficking of drugs.

Awareness of the fact that the drug problem is increasing, rather than the reverse, has inevitably led to discussions on the effect and purpose of the restrictive orientation of Norwegian drug policy. Both the Government's and the Storting's position in relation to this issue has been, and still is, clear. As stated in Report No 16 to the Storting on Drug Policy (*St meld nr 16 (1996-97) Narkotikapolitikken*), liberalisation would first and foremost imply that society no longer considers drugs to be a serious problem and most likely lead to an increase in the availability of drugs and thus, leading to increased abuse. In its response the Storting emphasised the importance of maintaining the existing restrictive drug control policy.

The same statements can be found in the follow-up Proposition to the Storting in an action plan for reducing the use of psychoactive substances (*St prp nr 58 Handlingsplan for redusert bruk av rusmiddel (1998-2000)*). The Government declared that the ambitious goal of a drug-free society would be firmly upheld, as a necessary expression of attitude towards drugs. The Storting confirmed its negative attitude towards legalisation or decriminalisation, while also stressing that greater emphasis must be given to prevention, and not least prevention carried out within the framework of NGOs (*Innst.S.nr.40 (1998-99)*).

Despite all efforts made, drug abuse still constitutes a considerable health and social problem. There is a greater access to and availability of drugs than ever before.

Increased drug trafficking and new patterns of abuse imply significant challenges to all services involved as well as demanding extensive efforts. The practical implementation of the national drug policy is therefore focused on reducing supply and demand, most importantly through preventive measures.

Over the years the Government has viewed the further development of a comprehensive "substance abuse policy" with regard to prevention, care and treatment efforts with great importance. One reason for this is the extent and sophistication of research results and knowledge accumulated over the last few decades concerning the relationship between substances. We now know that where we find illicit drugs we also find alcohol and tobacco. Supporting and reinforcing efforts to obtain knowledge in the substance abuse field and raising the level of competence among key professional groups is a major priority.

International cooperation - both at sub-regional, regional and global level - is considered one of the main pillars of Norwegian drug policy, and an important part of a comprehensive approach to drug abuse. At the European level, Norway is a member of and participates in the work of the EMCDDA and the Council of Europe's Pompidou Group. Norway has also ratified the three relevant UN conventions, and in addition to our participation in and support of the UNDCP, Norway is currently the chair of the regional section of the Dublin Group covering the three Baltic States, and has been a member of this group since 1993.

b. Basic elements of drug policy at national, regional and local level

In general, a major challenge and priority is to maintain and reinforce negative attitudes towards drugs through preventive measures. Focus is particularly on reducing the use of illicit drugs like cannabis, ecstasy and other new synthetic drugs among youth and young adults.

Primary responsibility for drug policy issues, hereunder prevention, care and treatment, rests with the Ministry of Health and Social Affairs, under the Minister of Social

Affairs. Due to the multidisciplinary nature of the drug problem and the need for extensive cooperation with other ministries, the Ministry of Health and Social Affairs has appointed a drug policy panel to survey the drug situation and co-ordinate specific drug policy efforts in different sectors. The panel meets yearly and consists of members from the Ministry of Justice and the Police, the Ministry of Education, Research and Church Affairs, the Ministry of Children and Family Affairs, the Ministry of Defence and the Ministry of Foreign Affairs, in addition to the Ministry of Health and Social Affairs.

The national drug prevention field under the Ministry of Health and Social Affairs has recently been reorganised. A major objective of this action is to support local communities' ability to prevent and tackle drug abuse, and to strengthen the after-care system for drug addicts who have gone through specialised treatment programmes. Furthermore, the reorganisation is intended to strengthen the areas of research and education within the drug field. As of 1 January 2001 three central environments for substance abuse prevention were involved in the reorganisation. These operate within the areas of research and documentation, education and competence, and administrative tasks and are as follows:

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Through this reorganisation the Ministry has ensured broad and current access to knowledge and experience as a basis for strategic planning and policy development.

The municipalities are responsible for prevention measures and the rehabilitation of substance abusers, according to advice and guidelines provided by the national level. A point of departure for this is that services are to be anchored in the local communities where the problems exist.

Treatment of people with drug problems is predominantly based on the principles of voluntary, drug-free rehabilitation. Moreover, measures should be appropriate to the

different needs of different groups, such as drug abusers with children and those who are pregnant. Priority is also given to further developing low threshold health services for drug abusers.

Substitution treatment for hard-core intravenous drug users has been available on a nation-wide basis since 1998. The system is anchored in specialised regional centres, but the municipal health and social services are otherwise responsible for follow-up. However, practical problems have surfaced in relation to the necessary participation of local doctors and social services. A significant effort has been made to clarify the issues of organisation, responsibility and financing in order to make the system more effective, and Parliament has now approved a revised model that more clearly integrates substitution treatment into the ordinary municipal health and social services as of 1 July 2001. This is expected to expand system capacity from approx. 1 100 clients (31.12.2000) to an estimated 1 600 by the end of 2001.

Cooperation with other local services and sectors is vital. It is not only necessary to coordinate social services for substance abusers, but also their relationship with the mental health services, the child care services and the primary health sector. In addition, close cooperation with the housing system, the labour market and the educational system is necessary. Voluntary organisations make a valuable contribution, owning and operating several residential institutions, most often with support from public funds.

The police, under the Ministry of Justice and the Police, work to prevent drug-related crime through two important angles. First, by means of an effective police force that investigates cases and impedes and therewith reduces the supply of drugs. Second, the police spread information about the adverse consequences of drug abuse. An active information service for different youth groups, parent groups and schools is enforced, whose strategy is to prevent the recruitment of new youth groups to the drug scene.

1.2 Policy implementation, legal framework and prosecution

- a. Law and regulations (drug-related issues about health, social affairs, youth, justice, drug control, etc.)

There are no separate laws dealing with drugs only in Norway. Legislative responsibility is divided between the Ministry of Justice and the Police (the Civil Penal Code) and the Ministry of Health and Social Affairs (the Act on Medicinal Products and the Social Services Act).

All illicit dealings with drugs are covered by the Norwegian Civil Penal Code of 22 May 1902, with the exception of the use and possession of minor quantities of drugs, which is covered by the Act on Medicinal Products etc, of 4 December 1992. As far as control policy is concerned, Norwegian legislation allows the maximum penalty of 21 years of imprisonment to be applied for serious drug crimes.

Legal provisions for care and treatment are laid down in the Social Services Act of 13 December 1991, No 81.

Legal framework in the area of care and treatment

As stated in section 3-1 of the Social Services Act, the municipal social services have an obligation to make efforts to prevent and combat substance abuse, and according to section 6-1 have a comprehensive responsibility for care and treatment. Section 6-1 states in full:

"By means of advice, guidance and practical assistance, cf. Sections 4-1 and 4-2, the social services shall help individuals to stop abusing alcohol and drugs. Advice, guidance and help shall likewise be given to the families of the persons in question.

When necessary and when the client so wishes, the social services shall provide for a course of treatment. Such a course of treatment may among other things comprise the appointment of a support contact, the establishment of a support network at work, and contact with the primary health services or specialist services.

Should such assistance outside institutions prove insufficient, the social services shall provide a place in a suitable institution for care and treatment. If the need for such a place at an institution cannot be met, the social services shall if necessary see that temporary measures are adopted.

The social services shall follow up the client through the course of treatment in conversations and if necessary on home visits, and by making arrangements for the measures required on the termination of a stay, if any, at an institution."

According to section 7-1, the counties are responsible for establishing and running institutions with specialist services associated with them for the care and treatment of

alcohol and drug abusers. The counties may own and operate the institutions themselves or enter into an agreement with private institutions. While responsibility for specialist services currently falls under the Social Services Act this will in due time be assumed by the state as a result of the ownership reform already in force for specialised services falling under the new Act on Specialised Health Services.

The Social Services Act sets forth legal provisions for compulsory treatment of drug addicts. From 1996 these provisions also include pregnant drug abusers. Section 6-2a states that a pregnant drug or alcohol abuser can, without her consent, be admitted to an institution and be detained there throughout the pregnancy, provided that the abuse is of such a nature that it will in all probability have a harmful effect on the child, and provided that voluntary assistance is not sufficient. The purpose of this practice is to prevent or limit the likelihood of harm coming to the child. During her stay, attention shall be given to offering the woman satisfactory help for her drug or alcohol abuse and enabling her to take care of her child.

The Ministry of Health and Social Affairs has issued circulars on the organisation and operation of substitution treatment programmes at regional and local levels.

Legal framework in the area of justice and drug control

The *General Civil Penal Code* and the *Act on Medicinal Products* do not define the term “drugs”. The *Act on Medicinal Products* in section 22 empowers the King to determine which substances shall be regarded as narcotic drugs. The King in turn has delegated this task to the Director of Health (as from 1 January 2001 the Norwegian Medicines Agency) who has laid down a detailed list of narcotics, cf. the regulation relating to narcotics etc. (The Narcotics’ List of 30. June 1978, No 8). Included in the national narcotic drug list are all the psychotropic substances (cf. Convention on Psychotropic Substances) and narcotic drugs (cf. Single Convention on Narcotic Drugs) under international control and a few additionally substances/plants, which are only under national control. Salts and derivatives of the substances listed in the national narcotic drug list, and any isomers, esters and ethers of the substances or their salts are also considered narcotic drugs.

Regulations issued on 19 December 1997 concerning Certain Substances that can be used in the Illicit Manufacture of Narcotic Drugs and Psychotropic Substances, precursors, implements the European Community Directive n° 92/109 of 14 December 1992.

The General Civil Penal Code, section 162 first paragraph, sets forth the main provision with regard to drug felonies. It relates to anyone who intentionally (cf. Section 40 of the General Civil Penal Code) "manufactures, acquires, imports, exports, stores, sends or conveys" narcotic drugs. *The penalty* for drug offences pursuant to section 162, first paragraph is fines and/or imprisonment of up to 2 years. *Aggravated drug felonies*, however, are punished by a term of imprisonment not exceeding 10 years pursuant to the second paragraph of this provision. Whether an offence is to be considered aggravated depends on an evaluation of each case by which, according to statutory provisions, the sort of substance involved will be regarded as significant, as well as the quantity and the nature of the offence (i.e. whether the substance has been systematically sold to groups that are considered to be especially vulnerable, such as pupils, inmates in prisons and clients in social institutions).

The third paragraph increases the penalty to a term of imprisonment of no less than three and not more than 15 years if "a very considerable quantity is involved in the offence". According to the intentions behind this provision, it shall only be applied in very exceptional cases. Under "very aggravating circumstances", a term of imprisonment not exceeding 21 years (which is the maximum penalty according to Norwegian penal laws) may be imposed pursuant to the second paragraph, item 2. Given the legislative history behind this provision, it is clear that it was primarily intended to impede the really large organisers of international drug trafficking involving the most dangerous drugs.

The legal status of use and possession of small amounts of drugs was reclassified from a misdemeanour to crime in 1984. Use and possession of small amounts do not, however, fall under section 162 of the General Civil Penal Code, but under the more lenient provisions of the Act on Medicinal Products of 4. December 1992, no 132, Section 31 second paragraph, cf. Section 24. The punishment is fines or imprisonment of up to 6 months. The same applies to complicity. Attempted infringement is to be punished as an accomplished offence cf. Section 31, last paragraph.

In 1988, Section 162a relating to profit derived from a drug felony was introduced. The objective of this provision was to impede the economic interests invested in drug trafficking. In 1993, the provision was repealed and replaced by the amended Section 317 of the General Civil Penal Code, which was formulated in such general terms that profiting from drug trafficking, for instance acts involving the laundering of drug money, also falls under this provision. The fourth paragraph of section 317, however, still prescribes a special penalty scale for the intentional involvement with proceeds from a drug offence. Under very aggravating circumstances a term of imprisonment up to 21 years may be imposed. Otherwise a penalty of fines and/or imprisonment with a term not exceeding three years shall be imposed when a crime relating to the proceeds of a criminal act is of a more general nature.

Property crime committed by a drug user to finance his/her drug addiction falls under the general rules in the Penal Code on theft, robbery, etc. Furthermore, the proceeds of the offence may be confiscated by applying the general rules on confiscation in Section 34 in the Penal Code. There are no specific provisions regarding property crimes for the financing of drug abuse. However, in Section 317 of the Penal Code regarding profit from a criminal act, there are specific provisions that may lead to a more severe penalty if the offence is drug related.

Section 162 of the General Civil Penal Code covers all forms for distributing drugs. Again, the severity of the penalty depends on the drug type and the quantity.

The Prison Act of 12 December 1958, No 7, Section 12, allows treatment to be substituted for a prison sentence. The decision to transfer the convicted person to a treatment institution is made by the governor of the Prison Service Institution, or in cases involving serious crimes, by the Prison Service Administration. In special cases, it may be decided that the execution of a sentence is to commence in a treatment institution. Transferral to a treatment institution as an alternative to serving the sentence in a Prison Service Institution is voluntary in accordance with section 12 of the Prison Act.

- b. Prosecution policy, priorities and objectives in relation to drug addicts, occasional users, drug related crime

Practice shows that the penalty for drug felonies to a large extent depends on the substance and quantity involved. Involvement with cannabis is subject to more lenient sentencing than involvement with more dangerous substances. Also a very important issue with regard to sentencing is the nature of the involvement that the convicted felon has had with the substance. Greater leniency is shown in cases involving the import and purchase of drugs intended for personal consumption than in cases where the act was motivated by profit.

In three recent court decisions (Rt. 1999, p.33 and p.1504 and the Supreme Court Ruling of 6. September 2000), the Supreme Court very strongly expresses the need to draw a distinct line between the purchase and storing of drugs intended for private consumption and the purchase and storing of drugs intended for sale. In the Supreme Court Ruling from September 2000, the first voting justice stated that this decision, in his opinion “must be perceived as an indication of a change of practice” compared to earlier. As such, it appears that the Supreme Court would like to move further than it previously has, towards creating a distinction between involvement with drugs intended for private consumption and involvement with drugs intended for sale.

- c. Any other important project of law or other initiative with political relevance to drug related issues

The Minister for Social Affairs has recently appointed a research commission to summarise existing knowledge in the field of substance abuse, evaluate the need for further research and indicate policy dilemmas and options in the years to come. The Commission is to submit a report by 1 July 2002.

1.3 Developments in public attitudes and debates

There still appears to be a general consensus among experts, politicians and an overall majority of the public that any proposals that could lead to liberalisation of drugs should be rejected. It is also worth noting that a vast majority of Norwegian youth still opposes any use of illicit drugs. This despite the sharp increase in use of cannabis and of ATS (amphetamine type stimulants), in particular ecstasy among young people less than 21 years of age.

Although the legalisation debate has been limited in Norway, criticism has nonetheless been raised against the existing drug policy. The media have in recent years focused in particular on the dramatic increase in the number of drug related deaths and requesting more effective measures in order to prevent such mortality.

Critics also point to what they argue is an uneven balance between the seriousness of the crime and the framework according to which different drug-related crimes are punished. The general level of sentencing for criminality in Norway is regarded as rather low, while the level of punishment for drug-related crimes is high.

Individual citizens and lawyers have also raised doubts about how effective the current penal system is with respect to preventing drug abuse. Questions have been posed as to whether the restrictive Norwegian control system creates more problems than it solves.

The general goal of treatment is full rehabilitation of substance abusers. This is viewed as compatible with an acceptance that harm-reduction measures directed at reducing the damaging effects of drug abuse to the abusers themselves, to their families and to the society are needed. However, controversy has arisen in relation to the need for new harm-reduction measures, particularly proposals for establishing public injecting rooms in protected environments. Before resigning in October 2001, the former Government concluded that since no means should be left untested in the struggle to reduce deaths caused by overdose, public injecting rooms could legally be established in a limited number of municipalities on a strictly controlled trial basis. The new Government will await comments to the proposal before deciding its position.

The issue of substitution treatment has also been controversial. This is part of a larger debate on the quality and effect of treatment offered, a debate initiated by users as well as those working in the rehabilitation field. Since the conclusion of a pilot methadone project in 1997 that involved 50 clients, the number of clients receiving substitution treatment has risen dramatically, and is estimated to reach 1 600 by the end of 2001. The reason why Norway now channels increasing resources into medically assisted rehabilitation programmes is that we have seen limited results from other rehabilitation programmes for hard-core injecting drug users. Investing in substitution treatment does

not disregard the ethical dilemmas associated with offering a form of treatment that replaces a life-long addiction to one narcotic drug with another, but acknowledges a moral duty to improve the lives of those suffering as a result of extensive drug abuse.

No recent relevant research has been conducted on media presentation and imaging of drug use, and therefore nothing specific can be said about this matter at the moment.

1.4 Budget and funding arrangements

The principle of decentralisation characterising the Norwegian health and social services means that the administrative level responsible for implementing the various services is also responsible for the funding of those services, supported by block grants from the State.

In a report published in February 2001, The Ministry of Health and Social Affairs has calculated the total amount spent on measures for drug and alcohol abusers at the administrative level during the last decade (figures are given in EUR at an exchange rate of 1 EUR to 8.045 NOK.) In 1999 the figure was EUR 203.3 million. The amount spent has more than doubled since 1990. However, the figures do not include costs related to consultation and treatment by general medical practitioners or treatment in somatic and psychiatric hospitals.

In addition to block grants, the Ministry of Health and Social Affairs has at its disposal extraordinary budgetary funds for the development of special high priority efforts in the areas of epidemiology, research, prevention and treatment. Such funds are channelled through SIRUS, the Norwegian Directorate for the Prevention of Alcohol and Drug Problems, the regional centres of competence, specialised centres for substitution treatment and low-threshold services. As funds are granted both via and to a large number of authorities, institutions and organisations, and often either as operational funding or on a contributory basis, it is very difficult to present the exact figures in relation to specific areas of interest. In the mid 1990`s The Norwegian Directorate for the Prevention of Alcohol and Drug Problems attempted to estimate the total annual costs related to prevention efforts at national and local level, and found that these roughly amounted to EUR 20 million. In the area of research, SIRUS is allocated a total

of EUR 2.6 million in operational expenditure for 2001, and some contributory research funds (approx. EUR 600 000) are granted also to the Norwegian Research council and the regional centres of competence.

PART 2

EPIDEMIOLOGICAL SITUATION

2. Prevalence, Patterns and Developments in Drug Use

2.1 Main developments and emerging trends

Norway has experienced a low prevalence of use and abuse of drugs when compared with other European countries and the United States. In these countries both the proportion of heavy users and the proportion of those whose use is more experimental in nature has traditionally been more extensive than in Norway. This has apparently been related to the fact that alcohol use has also been traditionally more restricted in Norway than in most other countries (Alcohol and Drugs in Norway 2001, *Rusmidler i Norge 2001*). This is also true for legal prescriptions for sedatives.

Recent research and reports from social workers and the police indicate, however, that this picture is about to change. As in other western countries, the number of young persons reporting that they use cannabis has increased during the latter half of the 1990s. More young people than earlier also report that they have used ecstasy and amphetamines. This picture is confirmed by other studies. Surveys of the adult population show that there is also a growing proportion among those aged 20 and older who report that they have used cannabis at some point, which is to some extent due to a cohort effect (SIRUS).

While heavy use and dependency on amphetamines and heroine have traditionally been linked with social and personal problems, there are indications that the more experimental use of cannabis, amphetamines as well as newer substances such as ecstasy, cannot be one-sidedly linked to such underlying factors. Drug use seems to be part of different youth scenes that have not traditionally used such substances.

Young people who are active in environments where cannabis, amphetamines and ecstasy are used do not necessarily develop a long-term dependency. At the same time, there are grounds for carefully monitoring such developments. Although there is no direct route from use of one narcotic substance to another, there are reasons to believe that the barrier against also trying other substances can be weakened. As a greater number of young people experiment with different narcotic substances, there is also reason to fear that more young people will be recruited into heavy abuse. Yearly surveys also show that opinions about drugs among young people have developed in a more liberal direction (SIRUS).

New calculations indicate that the number of intravenous drug users has doubled during the 1990s. The number of applicants for medically assisted rehabilitation has been far greater than the initial prognoses envisioned (Waal et al 2001). The number of overdoses has also increased dramatically during the 1990s. Figures from the National Bureau of Investigation (KRIPOS) and the court system show that there has simultaneously been a clear increase in seizures of narcotic substances and similarly the number of cases and persons who have appeared before the courts has grown.

The fact that drugs, and especially heroine, now are more widely available in Norway, is likely related to global developments that have led to an increase in production and smuggling. While there were periods during the 1980s when it was difficult to obtain heroine, this is apparently no longer the case.

2.2. Drug use in the population

General population

In 1999 interviews were conducted with a representative country-wide sample of the Norwegian population in which respondents were asked to provide written anonymous responses to questions regarding their personal use of drugs. A similar study was also conducted in 1991, but with a more limited battery of questions concerning drug use. Among persons aged 15-64 years old the percentage of those who had at one time tried cannabis rose from 9.6% in 1991 to 15.4% in 1999. In the same population 3.8% in 1999 indicated lifetime use of amphetamines, 1.3% of ecstasy, 2.1% of cocaine and 1.4% of heroine (SIRUS).

School and youth population

The yearly survey of young people

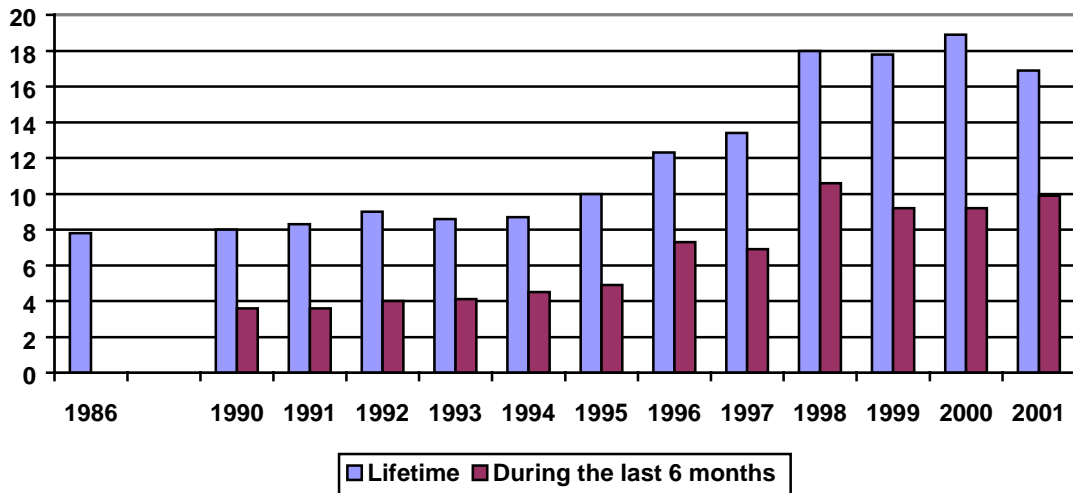
The National Institute for Alcohol and Drug Research (SIFA/SIRUS) has conducted yearly surveys to study drug use among young people in Oslo since 1968. In 1986 a comparable study was conducted for the first time nation-wide, and from 1990 both the Oslo-survey and the national survey have been conducted annually. These surveys are conducted such that the same questionnaire is sent by post to representative samples of young people from 15-20 years old; one sample includes young people registered with an Oslo address only, and the other includes the entire country as well as Oslo. In this context we will refer to the yearly national survey. While the response rate over the years has been at approximately 70%, this has dropped to approx. 50% in recent years (Skretting 2000, Rusmidler i Norge 2001).

ESPAD

Norway participates in the European School Survey Project on Alcohol and Other Drugs – ESPAD among 15 and 16 year olds, providing data for 1995 and 1999 (Hibel et al. 2000).

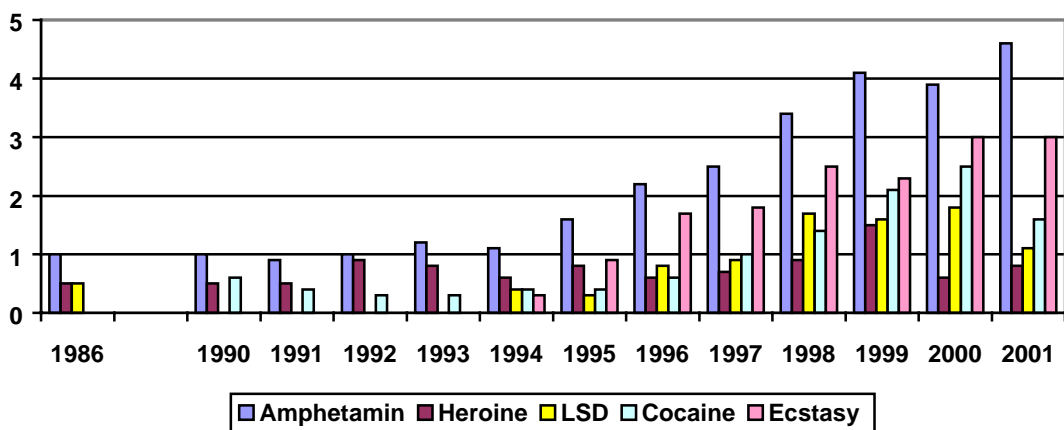
Figure 1 shows the development in the proportion of 15-20 year olds who indicate that they have used cannabis at some time during the last 6 months. For the years 1990-95 this number was between 8 to 10 per cent among this age group, while the proportion has risen to 18 per cent during the last half of the 1990s, and now appears to have stabilised. With respect to use of cannabis during the last 6 months, the proportion during the first half of the 1990s was about 4 per cent. Thereafter the figure rose to approx. 7 per cent in 1996-97 and 10 per cent in 1998. However, there has not been a further increase.

Figure 1. Percentage of young people from 15-20 years old in Norway who report lifetime use of cannabis and use during the last six months 1986-2001.



With respect to the percentage of those aged 15-20 years who report use of other drugs, there has been between 1 and 2 per cent during recent years who report that they have used substances such as LSD, heroine, cocaine and ecstasy at some time. Among those who report having used amphetamines at some time, we see an increase from approx. 2 per cent during the mid-1990s to approx. 4 per cent during the last 2-3 years (Figure 2).

Figure 2. Percentage of young people aged 15-20 years who report lifetime use of different drugs.



The Norwegian ESPAD survey among 15 and 16 year olds shows that while in 1995 6 per cent of those surveyed reported they had tried cannabis, this has now risen to 12 per cent in 1999 (Table 1). Likewise the survey shows that an increase in the number of those who have used cannabis during the last 12 months and last 30 days has taken place.

Table 1. Percentage of 15-16 year olds (ESPAD) who report lifetime use of cannabis and use during the last 12 months and last 30 days.

	Lifetime	During last 12 months	During last 30 days
1995	5.9	4.7	2.7
1999	12.3	9.1	4.1

With respect to other drugs, the ESPAD survey from 1999 shows that 3 per cent reported to have tried amphetamines, ecstasy and heroine. Likewise, 2 per cent have tried LSD/hallucinogenic drugs and 1 per cent have tried cocaine. 6 per cent of young people have tried solvents at some time, while 2 per cent have used solvents during the last 12 months (Hibel et al. 2000).

Drug use in prison

In *Stortingsmelding nr 16* (1996-1997) “On drug policy” it is noted that prison authorities report that 40-60% of inmates use drugs once or several times while serving their sentences. In 1999, slightly less than 30% of the 2 695 inmates in Norwegian prisons were sentenced for different forms of drug-related crimes. The prison board concludes that the drug problem is extensive among those incarcerated (see key issue).

2.3 Problem drug use

Calculations are available for intravenous drug users only. Such calculations have been made on three occasions, in 1989, 1999 and 2001. While the number in 1989

was estimated to be between 4 000 and 5 000, it had risen to 9 000- 12 000 in 1999. In 2001 estimates indicate that this figure is between 10 500 and 14 000 people, in other words a doubling during the last 10 years (Skog 1990, SIRUS).

Heroin is clearly the predominant drug that is injected.

There appears to have been an increase in the level of consumption of heroin that is not only related to the greater number of abusers, but also to the fact that the dosage per injection has increased. A survey of intravenous drug users by the needle bus in Oslo shows that the average heroin use per occasion has grown since 1993.

Calculations made in 1999 also gave estimates by age group. One estimates that 10% of drug injectors are under 21 years of age, 45% between 21 and 30 and 45% are 31 or older. Most drug injectors are men. The percentage of women is estimated to approx. one-third .

The abuser population has grown older over time. There is good reason to believe that this development will continue. From at one time being a youth problem, it is currently on the verge of becoming a social problem that is increasingly related to middle-aged abusers. Moreover, it appears that more recruiting is taking place among the older age groups, particularly among men. One possible explanation for this is that those who have traditionally abused alcohol have now become heroin addicts.

Additionally there is a greater geographic spread among intravenous drug users in Norway, even if the capital Oslo continues to be the main base. It is assumed that recruitment of intravenous drug users will continue to grow and that the demographic recruitment potential will expand. At the same time, the recruitment to intravenous drug use may also increase due to the increased use of 'lighter' drugs that has been recorded during the 1990s (Bretteville-Jensen and Ødegaard 1999).

Risk behaviours

On several occasions so-called user surveys have been conducted among the clients of the needle bus in Oslo. According to the 1997 survey, only 4% reported that they had used a second hand needle on their last injection. The majority of those who reported using a needle that someone had used before them indicated that the person who had

used the needle was their steady partner. One should note that given the interview context, a certain degree of underreporting might have taken place.

3. Health Consequences

3.1 Drug treatment demand

Norway has established a registration system for drug abusers in treatment where “core items” in The Treatment Demand Indicator are included. The system includes both alcohol and drug abusers. Due to legislation on confidentiality information is available only at the aggregated level. This means that it is not possible to distinguish between persons with alcohol and drug problems. However, work is currently being done to create a codification system that would be acceptable to the authorities, such that the registration system can also be used to analyse the individual level and therewith to report data on drug abusers in treatment to the EMCDDA.

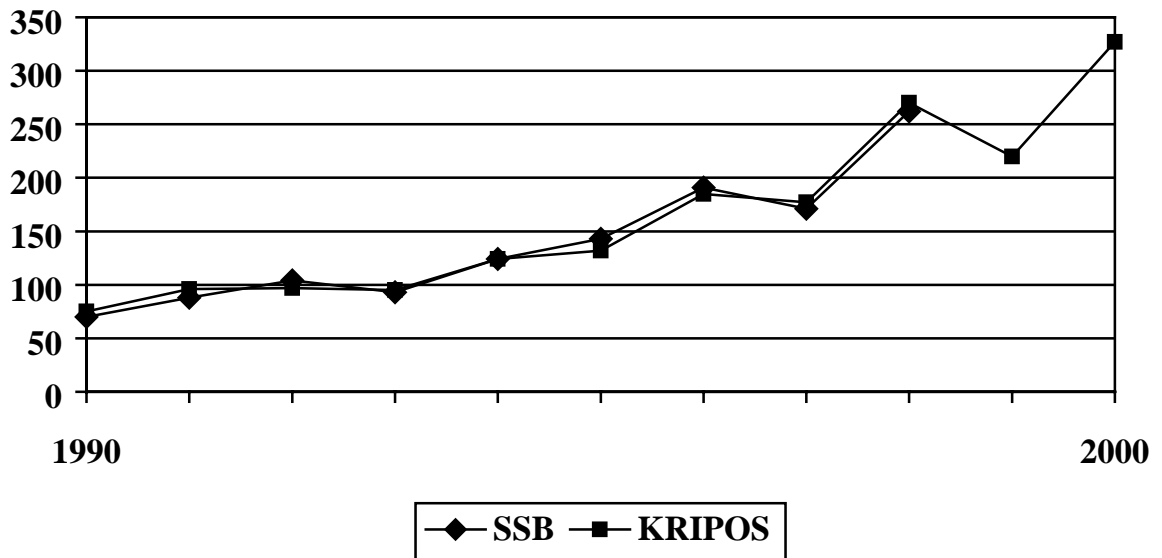
3.2 Drug-related mortality

There are two authorities in Norway who register drug-related mortality, the National Bureau of Statistics (SSB) and the National Bureau of Investigation (KRIPOS). SSB’s figures are based on the medical examiner’s reports, autopsy reports and doctors’ declarations of death. SSB codes cause of death according to a Norwegian copy of the international classification of diseases, accidents and injuries (ICD). Deaths registered in these statistics are related to the determination of *underlying cause*, in other words, that drug use has directly led to death.

KRIPOS’s registration system is based on reports received from police stations around the country. Generally, the inclusion criteria appear to be less restrictive as the data is not based strictly on a medical diagnosis.

Despite the different means of attaining data, the two sources are similar for the period 1990-1998 (SSB has not yet published figures for the period after 1998). Both series show a sharp rise in mortality.

Figure 3. Number of drug-related deaths registered by the National Bureau of Statistics (SSB) and National Bureau of Investigation (KRIPOS) for the 1990-2000 period. Note: SSB's figures are for 1998 only.



According to KRIPOS there were 75 drug-related deaths in 1990, while the figure for 2000 was 327.

The rise in mortality has no simple explanation, and we still lack information in this area. The group of heavy drug users has grown older and they are deteriorating both physically and mentally. There is wide access to heroine and prices are falling, a situation that in turn has led to larger doses among individual drug abusers. Mixed abuse, whereby heroine is taken together with alcohol and/or prescription drugs such as Rohypnol is becoming more common. Moreover, many drug addicts appear to be more resigned to their problem and more self-destructive after several rounds of treatment in various institutions and rehabilitation programmes. And of significance: The high mortality rate can be related to a more widespread drug injection culture in Norway when compared to other countries, including Nordic neighbours. In Norway heroine is taken by and large via injection (Sosial- og helsedepartementet 2000).

In Oslo municipality a working group has provided an analysis of the background for the rise in drug-related mortality. Among other things, the group identified the following:

It is first and foremost heroine that leads to death by overdose. Tolerance to opiates is radically reduced, e.g. after rehabilitation or prison, which increases the danger of overdose after prolonged abuse. Alcohol and benzodiazepines (e.g. Rohypnol) play an important role. Prescriptions for habit inducing medicines by physicians (without close follow-up) increase mortality. The majority of deaths due to overdose occur in private homes/shelters. Drug abusers with poor somatic and/or mental health are particularly at risk. Men face a greater risk than women. As one ages the chance of overdose is also greater.

The police provides the additional information:

- There is a correlation between the number of deaths and the availability of drugs. Active attempts to limit availability are thus of particular importance.
- Today a greater number of overdoses are reported in “non-traditional areas, such as upper-middle class areas on Oslo’s Westside, than was the case earlier.
- 25-30% of individuals of those afflicted by a drug-related death in Oslo are non-locals. More precise and thorough registration routines for such mortality can provide more precise information on the problem. Poly-drug use related to alcohol/benzodiazepines is on the rise.

Oslo municipality is responsible for a EU financed project to reduce overdose mortality, a project involving Oslo, Frankfurt, Copenhagen and Amsterdam. The goal is “to gather and ensure further knowledge about why intravenous drug addicts die from overdoses, analyse how this knowledge may be of practical use by health planning officials and design monitoring devices which provide officials with feedback to the choices made”. The final report will be available Winter 2002.

Mortality among heavy drug addicts in Norway is calculated in several follow-up studies. However, it is problematic to generalise from group-specific mortality rates to the entire population. Bretteville-Jensen and Ødegård (1999) also emphasise the uncertainty associated with the estimate they make on the basis of a literature review, stipulating that the yearly mortality rate among intravenous drug users is between 3 and 4%. The estimate indicates an increase in mortality. Estimates for 1990 showed that the yearly mortality rate was between 2 and 2.5% based on available literature (Skog 1990).

At the present time it is impossible to calculate mortality estimates based on client data due to the restrictions cited earlier (see point 3.1).

3.3. Drug-related infectious diseases

HIV and AIDS

As of 31 December 2000, 448 individuals were diagnosed as HIV-positive, with a risk factor of intravenous drug use. Among those who had developed AIDS as of 31.12.2000, 119 were intravenous drug users or 17% of the total number of AIDS cases. The number of new cases of HIV infection among intravenous drug users in Norway is low. This is also the case for the number of new intravenous drug users who develop AIDS. A large proportion of drug injectors who have developed AIDS are already dead. Moreover, a relatively large number of HIV-positive drug addicts died of other causes. Studies show that more than 90 per cent of intravenous drug addicts report that they have been tested, most of them several times. Therefore, the unrecorded population is likely relatively small.

Table 2. The number of intravenous drug users among persons registered as infected with AIDS and AIDS at risk due to intravenous drug use, according to year of diagnosis.

	HIV Total	HIV- Intravenous drug user	Percentage of HIV- intravenous drug user	AIDS Total	AIDS Intravenous drug user	Percentage of AIDS- intravenous drug user
1984-89	894	315	35	144	8	6
1990	90	22	24	59	13	22
1991	142	16	11	59	16	27
1992	105	12	11	50	8	16
1993	113	13	12	64	13	20
1994	94	12	13	74	19	26
1995	105	11	10	67	8	12
1996	116	9	8	56	12	21

1997	112	11	10	34	8	24
1998	98	8	8	36	5	14
1999	147	12	7	21	3	14
2000	177	7	4	38	6	16
Totalt	2 194	448	20	703	119	17

Source: National Institute for Public Health.

Hepatitis

An outbreak of hepatitis A and B among intravenous drug users was registered in 1995. During the period 1995-2000 a total of 1 162 intravenous drug users with hepatitis B were identified. However, the outbreak appears now to be in retreat, even if 176 new cases were reported in 2000.

Hepatitis C still need not be reported except in the case of acute infection. Therefore the number of cases reported does not represent the real incidence rate. However, 13, 17, 15 and 11 cases of acute hepatitis C infection were reported among intravenous drug addicts for the years 1997, 98, 99 and 2000, respectively. There are a number of factors that make these a rather unreliable picture of the real incidence of the disease. Among other things, the majority of newly infected persons do not experience symptoms and therefore do not seek medical treatment such that the condition can be diagnosed and reported. Additionally, when one does diagnose hepatitis C, it is seldom possible to identify when infection took place. The prevalence of hepatitis C in Norway can neither be defined with certainty. However, it is known that a large number of drug addicts have been infected with hepatitis C. Several prevalence studies have shown that 50-80% of drug addicts in Norway have tested positive to anti-HCV (National Institute for Public Health - Folkehelsa).

3.4 Other drug-related morbidity

Non-fatal drug emergencies

Reliable data covering the incidence does not exist. Therefore figures cannot be provided.

Psychiatric co-morbidity

During the period 1998-99 persons who suffered from both a serious mental illness and heavy use of intoxicating substances were tracked (The Norwegian Board of Health - Statens helsetilsyn 2000). The study concluded that approximately 4 000 people who abuse alcohol and/or drugs also suffer from a mental disorder of such calibre that they are in need of special treatment for their mental problems, above and beyond what is available to them today. 2/3 of these individuals were men and the average age was 31 years old. Approximately half, or 2 000, were drug addicts. The study identified a clear pattern: patients with mental disorder tended to abuse cannabis and amphetamines, while patients with personality disorders were over-represented among opiate abusers.

Drugs and driving

Statistics covering drug-related traffic accidents are not maintained in Norway. However, statistics are available for the number of positive blood tests taken from those suspected of using drugs other than alcohol in traffic-related incidents. The number of drivers arrested under suspicion of driving under the influence of drugs other than alcohol has more than doubled during the 1990s (Table 12 in the appendix). Drugs and/or other medicines are detected in nearly 70% of the tests conducted where the primary suspicion is related to such substances. Cannabis and amphetamines are the most common substances found. For these drugs, it was discovered that the number of positive tests had doubled fourfold during the period. A similar trend was also shown for heroine, benzodiazepines and ecstasy. Ecstasy and related substances nonetheless account for a significantly smaller percentage of the positive test results. The number of positive drug tests has sharply increased from one year to the next, except during 2000, and the number is nearly at the same level as the number of tests for those suspected of driving under the influence of alcohol. However, it is difficult to draw definitive conclusions based on the available data with respect to the level and development. This is because the tests are determined by the police and their frequency can be influenced by the police's focus and resources.

The typical driver driving under the influence of drugs other than alcohol is a man between 20-39 years of age, who often combines several substances; illegal substances/medicines, sometimes in addition to alcohol. This driver has often been arrested for similar behaviour previously and will likely be detained again. Use of several substances simultaneously appears to be on the rise. In 1991, two or more substances were identified in approx. 50% of tests, while after 1995 this has risen to 60-70%, not including alcohol. In approx. 95% of tests in which benzodiazepines were detected, one also found these combined with other substances (National Institute of Forensic Toxicology - Statens retts toksikologiske institutt).

The large increase in the number of positive test results taken from drivers can be related to new routines for controls and the development of new tests, as well as increased attention paid to the problem of drug use among drivers. Nonetheless there is reason to believe that there has been a real increase in the use of drugs in traffic.

4. Social and Legal Correlates and Consequences

4.1 Social Problems

Different studies of Norwegian drug users show an extensive over-representation of different social problems. Many live under poor housing conditions, in environments with extensive crime, violence and prostitution. A study of users of the so-called "needle bus" in Oslo showed, for example, that more than 4/5 received economic assistance or social security, while only approx. 10% were in paid work. Over half of the women earned their income through prostitution (Bretteville-Jensen 2000).

Collectives of drug users of varying sizes can be found congregated in squares, parks or other public places in Oslo as well as in other Norwegian towns. Similarly, drug addicts who panhandle along the streets have become a common element of the Oslo street scene. Although citizens generally regard this with distaste, experience has shown that chasing addicts away from such sites for congregating does not solve the problem as they soon find new meeting places.

4.2 Drug offences and drug-related crime

Legislation

The Norwegian Civil Penal Code § 162 and the Act on Medicinal Products § 31, Section 2 jf § 24, Section 1 regulate drug-related crimes. The penal code regulates the more serious crimes, while the latter act provides guidelines for punishing what are regarded as misdemeanours. (See Part I for a closer examination of this issue).

In Norway, statistics are maintained for crimes reported, investigated, prosecuted and convictions related to drug-related crimes. However, information is not provided on what type of substance is involved .

Table 3. Number of drug crimes reported and investigated.

	Civil Penal Code § 162		Act on Medicinal Products		Total	
	Reported crimes	Investigated crimes	Reported crimes	Investigated crimes	Reported crimes	Investigated crimes
1985		1 137		3 666		4 803
1986		1 794		2 789		4 583
1987		2 364		2 244		4 608
1988		3 624		2 605		6 229
1989		4 266		3 837		8 103
1990		4 697		4 394		9 091
1991	7 377	5 328	5 711	4 621	13 088	9 949
1992	7 692	6 250	6 328	5 059	14 020	11 309
1993	7 640	6 458	6 432	5 281	14 72	11 739
1994	8 005	6 458	6 759	5 384	14 764	11 842
1995	11 911	8 044	11 420	7 629	23 331	15 673
1996	13 669	10 310	13 786	10 442	27 455	20 752
1997	16 169	11 639	18 376	12 360	34 545	23 999
1998	17 276	13 809	21 498	16 489	38 774	30 298
1999	17 820	16 041	23 167	20 135	40 987	36 176

Source: *Crime statistics, Statistics Norway(SSB)*

*Information on drug-related crimes is available from 1991.

Crime statistics reveal a clear rise in drug-related criminality. During the period 1990 to 2000 the number of crimes against the medicinal act has nearly quadrupled. The number of arrests for breaches of the paragraph 162 of the penal code, which regulates more serious drug crimes, has nearly tripled during the same period. Compared with other crime forms, the statistics covering drug-related crime clearly reveal the sharpest increase.

During the 1990s the number of investigated cases and number of convictions doubled. In 1996 20 752 cases were investigated compared with 36 176 in 1999. The number of persons involved in drug-related crimes has risen by approx. 43% from 1996 to 1999. Statistics on the number of convictions show a similarly sharp rise.

Table 4. Number of persons charged with drug crimes

	Straffeloven §162	Legemiddeloven	Totalt
1985	609	1 332	1 941
1986	825	1 150	1 975
1987	915	1 021	1 936
1988	1 260	1 064	2 324
1989	1 367	1 690	3 057
1990	1 511	1 821	3 332
1991	1 584	1 993	3 577
1992	1 974	1 929	3 903
1993	2 282	1 508	3 790
1994	2 143	1 303	3 446
1995	2 496	1 442	3 938
1996	2 878	1 577	4 455
1997	3 424	1 764	5 188
1998	4 056	2 430	6 486
1999	4 891	3 111	8 002

Source: Crime statistics, Statistics Norway(SSB)

4.3 Social and economic costs of drug consumption

In 1999 the public sector spent EUR 203.3 million on measures related to drug addicts (see 1.4). This includes measures for both alcohol and drug addicts (Sosial og Helsedepartementet 2000).

5. Drug Markets

5.1 Availability and supply

Naturally there has not only been an increase in the percentage of the population that has used different substances during recent years. Various data sources also point to a parallel increase in availability. This is true for the entire country and is reflected in part in the confiscations made by the police and customs authorities, and in part in the drop in prices for different substances, and in part in surveys that measure respondents' estimates of availability.

The Drug section of the Oslo Police Force assumes that approximately 80% of all drugs that are smuggled into Norway are headed for Oslo and are spread to the rest of the country from there. Developments indicate that drugs are being spread to an even greater number of police districts. Drugs are often smuggled through natural ports of entry such as the Swedish border and ferry ports. New substances largely arrive in Oslo and the central east part of the country first. Once a market has been established for such drugs, they are then spread to other areas of Norway.

Both the frequency of seizures and the increasing mortality rate indicate that use and abuse of most illegal drugs have become more common throughout the country. Although cannabis has been confiscated for a number of years in all of the 54 police districts around the country, other substances are now found in an increasing number of districts (Table 5). For example, heroine was confiscated in 19 police districts in 1989, but this number had grown to 50 in 2000.

Table 5. Number of police districts who have seized different drugs (of total possible 54 police districts).

	1989	1994	1995	1996	1997	1998	1999	2000
Heroine	19	39	41	43	48	46	52	50
Amphetamines	39	45	52	49	53	52	54	54
Cannabis	53	54	54	54	54	54	54	54
Ecstasy	-	7	27	26	26	26	38	47
LSD	3	4	12	15	22	17	21	24

Cocaine	9	11	14	16	17	33	33	35
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Source: KRIPOS

The growing mortality rate confirms, for example, that heroine is increasingly abused throughout the country. While drug-related deaths were reported in 16 of the country's 54 police districts in 1989, this number had risen to 36 in 2000.

The fact that different drugs are more readily available is also apparent in surveys. For example, the yearly survey of 15-20 year olds shows an increase in the proportion who have been offered cannabis from 25 per cent during the first half of the 1990s to approximately 40 per cent in recent years. Similarly the percentage who report that they would be able to obtain cannabis within 2-3 days has increased from approximately 55 per cent to approximately 70 per cent. The ESPAD survey points in a similar direction, as 25 per cent reported that it was quite easy or very easy to obtain cannabis in 1995 to 38 per cent in 1999.

In the general population study from 1999, results show that 33 per cent report that they would be able to obtain hash within 2-3 days. Comparable figures from a survey in 1994 showed 31 per cent. Figures for amphetamines show an increase from 18 per cent in 1994 to 21 per cent in 1999, while the proportion who reported that they would be able to obtain cocaine and heroine has risen from approx. 11 per cent in 1994 to 16 per cent in 1999 (SIRUS).

5.2 Seizures

KRIPOS registers drug seizures made by the police and customs authorities. In this way double-registration is avoided in cases in which both the customs authority and the police are involved. The number of seizures is defined based on the number of times a substance is identified and is quantified according to the type of substance, the time of seizure and how it was carried out. In other words, multiple seizures are registered for the same case if different types of substances are confiscated. The same holds true if the seizure is conducted at different locations or at different points in time.

Developments in the seizure of drugs largely show a growing trend in both number and volume. Cannabis accounts for most of the drugs confiscated. During the last five years, the number of seizures has risen from 4 296 in 1996 to 9 224 in 2000 (Table 13 in the Appendix). With respect to the quantity confiscated, the registry shows that there have been substantial variations that are largely due to the fact that there have been large single seizures some years. As already noted, cannabis is seized in all police districts in the country.

The number of seizures of amphetamines has increased from 1 775 in 1996 to 3 077 in 2000, while there have been large variations in the amount seized. Among other factors, the greater number of seizures may be related to the increase in illegal production and therewith a greater availability and lower street price. Moreover, amphetamines and similar central nerve stimulants in pill form have become popular as recreational drugs among young adults outside of traditional user scenes. Pills that are sold as ecstasy are sometimes shown in fact to be amphetamines.

With respect to heroine, the number of seizures has remained relatively stable at around 2 300 – 2 600 cases during the last five years, while the amount confiscated during the same period ranged from 74.1 kg in 1996 to 37.4 kg in 1998 (51.5 kg in 2000).

The number of ecstasy seizures has risen from 198 in 1996 to 783 in 2000, while the number of seized doses has risen from just under 13 000 to just under 50 000. As in other countries, new types of tablets and capsules are continuously registered, although MDMA dominates, accounting for 97 per cent of seizures (KRIPOS, midterm report 2001). The remaining 3 per cent includes MDA, MDEA, amphetamines, cocaine and ephedrine.

LSD and other hallucinogenic substances have never gained a foothold in Norway, and were absent from the market for quite some time. However, in 1995 LSD made a comeback in the wake of ecstasy. The number of seizures of LSD is, however, low (88 in 2000). The volume confiscated has also been relatively modest.

While there has been a relatively large increase in the number of cocaine seizures (from 75 in 1996 to 390 in 2000), cocaine amounts to a small portion of the total number of

seizures of narcotics in Norway. However, large single seizures have been made in some years, such that the total volume confiscated has been relatively large (92.7 kilos in 1998, 60.2 kilos in 1999).

5.3 Price/purity

Prices for different narcotic substances are attained from information from the Drug section of the Oslo Police Force (Table 16 in the Appendix). The price per gram is calculated in relation to the user dosage. Prices for the different substances vary in accordance with the size of the quantity purchased, such that the price per gram will be cheaper for one gram than for one dosage. Price developments are also followed in a study in Oslo on the price elasticity of narcotic substances (Bretteville-Jensen 2001). The price of cannabis has been stable over a five-year period, while there has been a noticeable price drop for amphetamines, heroine, LSD, cocaine and ecstasy. The price fall for heroine had begun already during the early 1990s and has continued to show a steady decline. While the price per gram for purchasing a user dose was approximately 750 Euro in 1996, this costs is approximately 250 Euro today (Oslo police deapartment).

Information on the purity of different substances is derived from the Central Bureau of Criminal Investigation, which conduct a limited number of chemical analyses of confiscated narcotics. For example, it is not common to analyse the THC content in cannabis. With respect to brown heroine, the purity level in 2000 is reported to be between 1 and 70% with an average of 40-45%, and is based on an analysis referred to as so-called heroine-based mixture of drugs. The purity of white heroine, heroine chloride, is reported to be between 5-95%, with an average of 60% and cocaine is between 50-100% with an average of 85%. Information is not available on the purity of other narcotic substances (KRIPOS).

6. Trends per Drug

Cannabis

There has been an increase in the use of cannabis during the 1990s. This is apparent, among other means, through surveys and analyses of blood tests from drivers suspected

of driving under the influence. Similarly, the number of seizures has increased, particularly over the last four years. At the same time, the price of cannabis has remained relatively stable. That cannabis has become more available in Norway is also illustrated through data from surveys showing that an increasing proportion of the population report that they are offered cannabis or that they are able to obtain cannabis should they wish to use it. Surveys also show that opinions on cannabis have become more liberal.

Synthetic drugs

Amphetamines are taken either by way of injection, or orally. Although amphetamines have not occupied the same position among intravenous drug users as for example in neighbouring Sweden, amphetamines are widely used among established users, particularly outside the Oslo area. Together with ecstasy, and to some extent LSD, amphetamines are part of a drug culture that is to some extent associated with “house and rave scenes” in the large townships, and to some extent an element of a party culture practiced in some youth scenes. Different data sources, such as seizures, surveys, drivers who test positive for ecstasy and amphetamines point towards an increase in the use of synthetic drugs and a broader user base.

Heroin/opiates

Estimates of the number of intravenous drug users indicate a doubling during the 1990s, from 4-5 000 to 10-14 000. The majority of these users inject heroin. Similarly, a dramatic increase in the number of drug-related deaths has also taken place and an increase in the number of seizures. At the same time heroin is increasingly confiscated across the country. In other words, all available data sources indicate that Norway is facing a serious expansion of heroin use.

Cocaine/crack

According to survey data, cocaine is not used to any great extent. However, there has been an increase in the number of seizures and although cocaine seldom seems to make an appearance in user environments, it is reported that cocaine, like ecstasy and amphetamines, is used as part of isolated party scenes to a greater extent than previously. It is not known whether crack has been used in Norway.

Multiple use

Data derived from treatment studies and reports from clinics show that the majority of abusers use several substances. Alcohol is the most common element in the picture, either in combination with a drug or as an alternative substance. The extensive use of other narcotic substances other than heroine is a major problem in work with medically assisted treatment.

7. Discussions

From the early 1990s Norway could claim relatively limited problems related to use and abuse of drugs, when compared to other countries. This picture has been altered during recent years. All available data sources point to an increase in the use of illegal substances among the general population, at the same time as the number of intravenous drug users has doubled. There has been a dramatic increase in the number of drug-related deaths and many intravenous drug addicts report poor health. One tool in this context is a major focus on substitution treatment (see key issue).

There are apparently several factors that contribute to an explanation of this negative trend. On the one hand, the last decade has been a period characterised by major changes in international drug trafficking, with more and new actors emerging. This has provided a basis for increased smuggling and a geographic spread of substances, a fall in prices and therewith an increase in availability. On the other hand, this is also a time in which opinions towards drugs appear to be moving in a more liberal direction than earlier, and in which the use of drugs has become a part of social currents that have a major influence on youth scenes to a greater extent than previously.

7.1 Consistency between indicators

It is a great deal of consistency between the different indicators with respect to developments in drugs in Norway. As indicated, there has been a consistent expansion of both seizures and the number of drug-related crimes, the proportion of the population that has used different substances, etc. Developments concerning 'ecstasy' are perhaps one possible exception. While seizures of ecstasy have increased and prices have fallen - two trends that point to increased availability, the proportion of young people from 15-20 years of age who report lifetime use of ecstasy has remained relatively stable during recent years.

7.2 Implications for policy and interventions

The Ministry of Health and Social Affairs presented an action plan for reducing drug use in 1998 for the period 1998-2000. The action plan focused, among other things, on the relationship between an early alcohol and tobacco debut and later problematic use of illegal narcotic substances. Measures aiming to postpone young people's alcohol debut and thereby contribute to reducing the risk that they will use narcotics, was proposed as one of several measures. This was developed into an opinion-building campaign directed at parents, children and adults generally for postponing the age of debut and therewith contributing to reducing drug use among young people.

Other efforts were directed at enabling parents to detect their children's drug use, guidelines for how to relate to young people's use of drugs and similar information. Educational intervention in schools was emphasised as a means of influencing the opinions of young people and their parents. Non Governmental organisations that work actively to reduce drug use and change opinions continue to be regarded as making an important contribution and are given support (St.prp. 58 1997-98).

The dramatic increase in the number of intravenous drug users and drug-related deaths provided a backdrop for the major emphasis on medically assisted rehabilitation and the establishment of low threshold health care alternatives for drug users. Moreover, the expansion of drug problems has been a contributing factor for the development of political measures based on new investigative methods in criminal cases, e.g. giving the police permission to engage in raids and confiscation without first informing the parties involved, and the use of anonymous witnesses in court cases.

7.3 Methodological limitations and data quality

For Norway's part, several of the indicators provided by EMCDDA are inadequate. This is particularly true with respect to data on clients in treatment, estimates on mortality and the extent of drug use in the prison system. In the case of drug-related deaths, data based on the ICD 10 classification system is not updated for the previous year, although practices will be changed from 2001 such that data will be available earlier. Norwegian reporting of data covering arrests for drug-related crimes, intravenous drug users with

hepatitis, HIV and AIDS deviates from the guidelines provided. This is due to national routines for reporting this information.

There is also some uncertainty concerning data on the prevalence of drug use. For example, a low response rate for the yearly youth surveys makes them non-representative. The illegal nature of the different substances can also contribute to a statistical underreporting. Moreover, it might also be the case that young respondents have fewer qualms about providing information about their use of drugs than older respondents, thereby contributing to a greater reporting rate by younger than older respondents.

Estimates of the number of intravenous drug users have been calculated using a multiplication method based on a registry of the number of drug-related deaths. This method takes its point of departure from the relationship between the number of drug-related deaths and the number of abusers. Possible errors may have incurred if these figures are not as reliable as has been assumed. The estimates are calculated, among other means, using the registry of drug-related deaths maintained by the National Bureau of Investigation. A scientific evaluation of these showed that they are relatively reliable (Bretteville-Jensen and Ødegård 1999). Nonetheless one can sometimes question on what grounds the police register a death as drug-related. Some of the cases might have been mistakenly defined as death-related since the person was a drug user although the individual died of other causes.

Drug-related crimes are "crimes without victims" and are seldom reported by others. The numbers of crimes that are investigated and convicted are therefore largely dependent on the efforts of the police and customs authorities. Changes from one year to the next or variations between different districts are therefore entirely or at least partly traceable to differences in the intensity of control activity, without this necessarily involving an actual change in the number of crimes committed.

Also seizures of drugs, both the number and the amount seized, vary according to the priorities and efforts of the police and customs authorities. Among other things, the amount seized says very little about the actual volume of substances that are on the

market and illegally used. The number of seizures can also be influenced by legislative changes.

Oslo police force reports information on the price of illegal drugs. An average price estimate is based on information provided by a relatively random sample of drug dealers, users and others. The data is limited to reports in Oslo. Prices are also calculated based on a representative sample.

PART 3

DEMAND REDUCTION INTERVENTIONS

8. Strategies in Demand Reduction at National Level

8.1 Major strategies and activities

In order to describe the primary elements constituting national strategies for fighting drug abuse, it is necessary to provide a short review of the documents put forth by the Ministry of Health and Social Affairs (SHD) over the last few years. A report to the Storting, “Measures directed at drug addicts” (*Stortingsmelding nr.69, “Tiltak for rusmiddelmissbrukere”* 1991-92), provides for the development of the rehabilitation sector for drug addicts and provides a framework for organising treatment, intervention measures and the division of responsibility, including the establishment of regional centres of competency focused on the drug field. The centres of competence and the Norwegian network in this field will be further described below.

A second report to the Storting, “The Drug Policy” (*Stortingsmelding nr.16”Narkotikapolitikken”* (1996-97)) describes the development of the drug situation and presented goals and measures. In the report, the Government emphasised the need to strengthen prevention work, to further strengthen the collective assistance and rehabilitation apparatus for drug addicts, to expand the restrictive drug policy already in place as well as Nordic and international cooperation against drugs.

In 1998 SHD presented an action plan for reducing drug abuse. The backdrop for the plan was an increased use of alcohol in Norway, coupled with research that showed that illegal substances were gradually gaining ground in youth environments. The plan contained strategies and defined areas for intervention that would strengthen measures directed at opinion-building and prevention work. The main goals of the plan with respect to drugs are as follows:

- The reduction of abuse of illegal substances among youth and young adults.
- Raise awareness of the links between use and abuse of different substances.
- Strengthen negative opinions of drug use.

- A better and more effective treatment, low threshold health service and treatment alternative for drug addicts, including those with children and pregnant women.

In order to achieve these goals one looked to:

- Cooperation with homes, schools and leisure time activities within the framework of opinion-building work.
- A broad mobilisation of voluntary efforts, organisations and youth groups.
- Allowing municipalities, the local police and local community play a central role in prevention work.
- A long-term perspective for prevention work.
- Directing measures towards the entire population and to risk groups.
- Ensuring that the rehabilitation and treatment measures operate in cooperation with voluntary organisations, groups and individuals.
- Strengthen after- care.

One of the measures contained in the action plan was the establishment of a drug policy panel that was to act as a reference group for the Minister of Social Affairs. The panel is a bridge between the authorities, labour groups, the business community, insurance industry and organisations working with drug policy. The panel is to operate until 01.01.02.

During 2000, a reorganisation of state intervention in the prevention field was conducted. The aim was to strengthen local and regional work and prevention measures, the production of knowledge and spread of information within the drug field and the creation of a more effective administration practice (see also 1.1.b).

As a consequence of this reorganisation, the National Institute for Alcohol and Drug Research -SIRUS (*Statens institutt for rusmiddelforskning*) was established 1.1.2001. SIRUS is responsible for conducting research and spreading results and documentation on drug issues, giving particularly attention to social scientific aspects. The institute employs 26 persons. Research conducted can be divided into 5 main areas: the drug market, drugs and drug culture, prevention techniques, consequences, rehabilitation and care. The institute is also Norway's Focal Point for the EMCDDA.

Centres of competence – “Norway-net”

“Norway Net” is a collective network for the seven regional centres of drug competence. The centres are responsible for increasing competency and spreading knowledge within the drug field among health- and social workers. They are to provide up-grading education for key employees of the municipalities, further develop specialised services for drug users and provide schools with prevention assistance. Following the reorganisation of state intervention in the drug field, the centres have as of 2001 also been awarded responsibility for contributing to raising competency levels within the drug prevention arena in general. Moreover, they are to provide the Ministry of Health and Social Affairs with advice concerning the expansion of the national drug policy, and via Norway-net to cooperate with SIRUS and the Norwegian Directorate for the prevention of alcohol and drug problems in common areas of responsibility. Each centre has been delegated one or several special areas. The following is an overview of the centres in different areas of the country and their speciality areas:

Region Nord (Northern Norway)

Counties covered: Nordland, Troms and Finnmark

Centre: Nordland’s Clinic – www.nordlansklinikken.no

Speciality area: A group-based therapeutic approach to drug issues

Region Midt-Norge (Central Norway)

Counties covered: North- and South-Trøndelag, Møre and Romsdal

Centre: Central Norway competency centre for drugs – www.mnk-rus.no

Speciality areas: Youth and drug use, young drug addicts

Region Vest (Western Norway)

Counties covered: Sogn og fjordane, Hordaland and Rogaland

The region has two competency centres:

Rogaland A-centre - no website

Speciality areas: Family and school-aged children, drugs in workplace

The Bergen Clinics Foundation – www.bergenclinics.hl.no

Speciality areas: Women and addiction, female drug addicts

Region Øst (Eastern Norway)

Counties covered: Oppland, Hedemark, Akershus and Østfold

Centre: Sanderud Hospital, Drug ward - www.sanderud-sykehus.no

Speciality areas: double-diagnoses – psychiatry and addiction, gambling addiction

Oslo

Oslo has its own centre of competence.

Centre: Alcohol and Drug Addiction Service-Municipality of Oslo
www.rusmiddeletaten.oslo.kommune.no

Speciality area: New usage trends among youth

Region Sør (Southern Norway)

Counties covered: Aust- and Vest-Agder, Telemark, Buskerud and Vestfold

Centre: Borgestad Clinic – www.borgestadklinikken.no

Speciality areas: Pregnant addicts and addicts with small children

9. Intervention Areas

9.1 Primary prevention

There are no sharp divisions between alcohol, medication and drugs within the prevention field in Norway. Drug prevention is the responsibility of the municipality as outlined in the law on social services. The municipal social services are to use information and active outreach work to prevent and work against abuse of alcohol and other substances and spread information on the harm caused by such abuse (NOU: 1998:18 “*Det er bruk for alle*”).

Drug prevention work is largely based on local measures that emphasise cooperation between the home, school and social- and health services sectors, as well as the leisure- and cultural sectors. Voluntary organisations active in the drug policy field have an important position within prevention work.

The State, through the Norwegian Directorate for the prevention of alcohol and drug problems, contributes economic support to activities and measures with drug prevention aims through these organisations, as well as through associations, companies and municipalities. For the year 2000, the Norwegian Directorate for the prevention of alcohol and drug problems distributed 56.3 million Norwegian crowns (approx. EUR 7 million) to be utilised for such causes.

9.1.1 Infancy and Family

The centre of competence for Southern Norway (Region Sør) is responsible for the speciality area, “Pregnant drug addicts and families with children”. The centre works to develop and spread competency within this area by way of participation in projects, and the development and implementation of training and education programmes.

A separate action plan was developed in 1994 in accordance with *St.meld 69* (1991-92), which identified work with pregnant drug addicts and addicts with small children as an area for extra intervention. Financial support was directed to a number of measures and projects aimed at this group, including the establishment of a number of trial projects in three counties. The aims were to prevent drug abuse among pregnant women; the early identification of drug problems among women in the risk zone as well as intervention; identifying the extent of the problem; increasing competency and establishing routines for solid cross-disciplinary cooperation. Experiences from the nine pilot municipalities

have been published (“*Graviditet, barn og rusmidler* [Pregnancy, children and drugs]” Borgestad-klinkikken, 2000).

A book of methodology for drug prevention work by primary health care services has been created, to be used as a tool for health care workers who are in contact with pregnant women and parents of small children. The book is an encyclopaedia of information about drugs and advice for how health care professionals can provide information on the consequence of drugs as well as suggestions for how to handle situations in which one suspects drug use during pregnancy (Melkeraaen 1997). In the wake of this book, a course has been held for paediatric nurses.

In conjunction with the action plan, a handbook has also been created for social- and child welfare services at the municipal level. The handbook is a guide for how the different municipalities can organise their work in relation to pregnant drug addicts and addicts with small children (Rusmiddeldirektoratet 1999).

Different voluntary organisations are also engaged in the issue of drug use during pregnancy and parents’ approach to different drugs. Among others, the Blue Cross has developed a prevention program, “*Children in the danger zone*” (*Barn i faresonen*), which aims to educate those in a child’s network to see, understand and act when children are neglected by an adult. The program provides various forms of assistance to the primary health services, child care centres, elementary schools and middle schools, as well as co-operative work involving different authorities such as churches and cultural centres. The message is directed to adults, but is about children (Blue Cross website- www.bks.no).

9.1.2 School programmes

Schools play a central role in prevention work. Drug education is embedded in the national educational framework and integrated in the regular curriculum. As one measure in the aforementioned reorganisation of the national drug sector, the regional centres of competence were distributed resources for providing advice to primary and secondary schools on drug-related questions. The centres are to support schools with information, education and opinion-building measures. This means that as of 2001 state

responsibility for prevention has been shifted from the Norwegian Directorate for the prevention of alcohol and drug problems to the regional competency centres.

Examples of the school programmes earlier developed by the Norwegian Directorate for the prevention of alcohol and drug problems is the educational tool, “*Some fairytales you write yourself*” (*Noen eventyr skriver du selv*), which was developed in conjunction with a national campaign against drugs in 1998. This tool is for youth from 16-19 years of age, and consists of a video, factual brochures, group work and a guidebook for teachers. It is aimed at increasing awareness and instigating a critical perspective on drugs.

The school campaign, “*Youth and hash*” (*Ungdom og hasj*), was completed in 2000 and aimed to give youth the strength to say no to cannabis and give parents a structure for how to raise the issue with their children. The materials consist of a brochure for parents, instructional materials for teachers with transparencies and a student workbook. It is prepared as a means of assisting teachers who wish to raise the topic at parent meetings. The student materials are currently being scientifically evaluated.

NGO’s are extensively involved in activities directed at schools, with support from the Norwegian Directorate for the prevention of alcohol and drug problems. Two examples of school campaigns developed are described below:

For many years Lions Quest has provided schools with the teaching packet, “*It is my choice*” (*Det er mitt valg*) for 1st-7th graders. It is grounded in humanistic pedagogy and focuses on developing social competence. Teacher training is an important element in this. Lions Quest has now translated the materials and adapted them for secondary school levels as well. Materials have also been developed for parent meetings and a book for parents: “The important years” (*De viktige årene*).

For many years now, the youth organisation Juvente has run a programme called “*Free style*”, “*Action against drugs*” [*Fristil, Handling mot rusgift*], whereby nearly 1 000 students in the ninth grade receive education for four days and thereafter create activities for their classmates. The programme is evaluated. Juvente’s musical theatre group “*Kolon*”, which is aimed at high school level students, reaches a yearly audience of nearly 40 000 students.

The local police authorities also run prevention work against drugs in schools among other means, by offering a two-hour educational programme at each class level in elementary schools. For this, the Ministry of Justice has developed course material titled, “*The police binder*” (*Politiets skoleperm*), consisting of three educational packets for the different grade levels with information and materials on work by the police in this area. The aim is crime prevention. The educational packet functions as a guide for the local police authorities on how to conduct prevention work in schools. The police binder was developed together with the teacher packet “*Live well*” (*Lev vel*) under the auspices of the National Council for Crime Prevention (KRÅD), which is administratively linked to the Department of Justice). The approach consists of guidelines for teachers, a student manual, video, CD, pictures, playing cards and a play. The educational presentation focuses on harassment, ethics, drugs, racism, violence, the mass medial and social isolation.

Other school programmes include a three-year (2000-2002) competency-development programme (SAMTAK) for individuals tied to the pedagogical-psychological services (PPT) and leadership in elementary and high school education. Primary emphasis is upon increasing competency in relationship to reading and writing problems, learning disabilities and socio-emotional problems. It is possible to address issues related to drug use among children and youth as a part of the local introduction of the programme (Sosial-og helse departementet 2000).

9.1.3 Youth programmes outside schools

Outreach work by child and youth service workers under the auspices of the public sector were established in Norway during the late 1960s. This began with the Outreach Section in Oslo, and outreach work has now been established in many municipalities, with approximately 60 entities today. Activities span several prevention measures involving older children and youth, as well as outreach and provision of rehabilitation for youth and young people who have developed drug abuse problems.

The project “*Stop the drugs, not the dancing*” (*Stopp dopet ikke dansinga*) was initiated in Oslo in 1995 as a cooperative effort between the Outreach section of the Alcohol and Drug Addiction Service (Municipality of Oslo) and young people from the

“house culture”. The party patrol, which is one element in these activities, consists of young people in voluntary work together with employees from the outreach services. The party patrol is present at house parties and distributes information and is available to young people. At present the project has changed its name to “Future” and currently exists in Bergen, Trondheim and Oslo and is connected to other outreach activities.

Municipalities run leisure clubs for children and youth, and some are run by voluntary organisations in cooperation with the municipality. However, the municipality finances most of these.

The Ministry of Children and Family Affairs administers a fund, “Youth measures in larger townships” (*Ungdomstiltak i større bysamfunn*), whereby townships can apply annually for financial support for projects and investments in improving living conditions for youth from 12-25 years of age.

An overview of the different drug prevention measures by the municipalities has been created, RUFUS. The database was established in 1995 and approximately 300 projects and measures have been registered to date. In addition to providing an overview of existing measures, the database is intended to spread information and encourage an exchange of experiences between municipalities.

9.1.4 Community programmes

Different community based projects exist around the country. One example is “*Live together*” (*Lev i lag*), which was initiated in 1987. The project targets young school children, and the aim is to give young people greater understanding and a sense of security that will allow them to make independent choices. Weekend meetings are organised, which emphasise that actions and choices should be based on knowledge and respect for others rather than pressure, ignorance and misunderstanding.

“*The night ravens*” (“*Natteravnene*”) is a project that involves adults patrolling the downtown streets during weekend evenings and nights. Their mission is to be visible and available to young people. The idea is that their presence will reduce the likelihood of violence and harm. Such groups exist in 250 locations around Norway.

9.1.5 Telephone help lines

National wide public telephone help lines to which one can turn with questions related to drugs do not exist. However, there are contact help lines for children and youth who need to speak with an adult about drug issues. Two examples are the Red Cross contact line and IOGT's "Teleteddy" (Telebamsen). The National Parents Organisation Against Drug Abuse has a support line primarily intended to provide assistance for those who have children or other family members with a drug problem.

9.1.6 Mass media campaigns

The Norwegian Directorate for the prevention of alcohol and drug problems is responsible for conducting national information- and opinion-building campaigns. In 1998 the directorate launched the campaign, "*Some fairly tales you write yourself*". The target group was of 16-19 year olds and the campaign consisted of three 40-second films based on H.C. Andersens fables. Additionally, educational materials have been devised for schools. The films have been shown at cinemas and on television. This effort was Norway's contribution to the European Drug Prevention Week in 1998.

In 1999 the Directorate released the campaign "*Narko - what a T.R.I.P*" in cooperation with UNDCP. The campaign was directed at raising the social awareness of youth who flirted with illegal substances and tried to apply a solidarity perspective to drug use. The campaign consisted of educational efforts at the high school level, a series of articles in the daily press, a video with inserts from the national broadcasting station NRK and a handbook for teachers.

In October 2001, the Directorate launched the campaign "*Only you can take care of your brain*" (*Det er bare du som kan passe på hjernen din*). The goal is to reach young people at risk for drug use. The campaign fully utilises the Internet, and cooperation with youth organisations is a central element. Young people over 16 years of age are the target group, and the campaign is sent over the Internet, television, cinema, postcards, billboards and youth magazines.

The municipality of Oslo has run two campaigns in recent years:

”Don’t mess with your brain” (*Ikke kødd med hjernen*). The campaign pointed to the uncertain future that ecstasy users face and included advertising slots on television and at the cinema as well as teaching packets for high schools.

”Stoned for four hours. Slow for four weeks” (*Stein i fire timer. Sløv i fire uker*) is a campaign in which the main goal is to prevent the increasing acceptance of cannabis among young people. The campaign consists of two parts, with short films at the cinemas and brochures distributed at secondary schools, clubs for young people, cinemas, etc. The campaign was repeated the same year, at which time it was also supplemented with informational efforts, directed especially at parents.

9.1.7 Internet

There are numerous websites that treat the topic of illegal drugs in different ways. During recent years the Internet has also become a medium for conducting drug prevention campaigns. One example, is the before mentioned campaign, “Only you can take care of your brain”. www.dopinfo.no

Forebygging.no – <http://www.forebygging.no> is an information database and interactive arena for prevention and public health work. The net service has been developed through a broad cooperation among professional groups in Norway and is financed by SIRUS. The homepage can be used as a textbook on prevention and public health work, methods and other knowledge on prevention. Links and presentations of “Norway’s net” and the seven drug centres of competence can also be found there.

On SIRUS’s homepage (www.sirus.no) one finds information on the institute’s work, research reports, drug statistics, as well as information on research activities. The site also publishes public statistics on alcohol and drugs as well as studies.

SIRUS also maintains a national library. The library is specialised in literature treating the alcohol and drug field. In addition to books and journals, the library has access to search engines for international databases. It is also possible to order books and articles from around the world through the library’s website.

The Norwegian Directorate for the prevention of alcohol and drug problems - <http://www.rusdir.no/> includes factual information on the different narcotic substances and national campaigns, among other kind of information.

The Alcohol and Drug Addiction Service (Municipality of Oslo) <http://www.rusmiddeletaten.oslo.kommune.no/> provides information on the different departments, publications, campaigns and meetings.

9.2 Reduction of drug related harm

9.2.1 Outreach work

Outreach work is a part of the municipal social services and is based on the target group's own environment and network. (See 9.1.3 on outreach work as a part of child and youth work).

Outreach work and coordinated services (OKT) in Oslo works with individuals with acute drug-related problems, focusing especially on those most afflicted. OKT is responsible for maintaining a systematic oversight of the city's drug scene, aiming to provide contact and assistance alternatives, preventing overdoses and follow-up of potential overdose cases. They conduct home visits and meet and accompany users to help facilities upon referral by citizens, police and other co-operative partners. Moreover, they are to have an ongoing overview available capacity for acute and low threshold alternatives, and to assist the public, clients and co-operative partners when they need information about relevant acute and low threshold alternatives. They are also supposed to assist those most afflicted homeless drug abusers.

9.2.2 Low threshold services

During recent years the State has distributed earmarked funds to low threshold services to 14 of the country's municipalities where the greatest number of drug-related deaths have been registered. "*Feltpleien*" ("Field Nursing) in Oslo is an example of such a low threshold service. The service was established in February 1999 as a trial project

aimed at providing drug abusers with a low threshold health service. The service is directed first and foremost to those who for various reasons, do not seek help from established health service centres in Oslo. Doctors and nurses are involved in the service. Drug addicts are offered general health check-ups, treatment for abscesses and sores, hepatitis vaccinations, x-rays, assistance with hospital admittance when necessary, referrals and accompaniment to municipal and private medical centres.

”Pro Sentret” (*The Pro Centre*) in Oslo is a centre of competence for prostitution (more fully described in point 9.6). Among other tasks, the centre is charged with providing outreach work in known prostitution areas. The main goal is to provide health education and prevention. Additionally, the centre runs a shelter that acts as a meeting place for receiving care and motivation. Environmental measures are also introduced, aiming to improve the health of those who use the centre. Similar services are found in most larger municipalities.

Both NGO’s such as the Salvation Army and **”Kirkens bymisjon”** (Church city mission) and the public sector run low threshold services for drug abusers, including shelters, soup kitchens, food distribution, clothing distribution, etc.

“Nadheim” and **“Natthjemmet”** are services offered to women who have experience from prostitution and abuse, under the auspices of the *“Kirkens bymisjon”* in Oslo. *Nadheim* runs outreach work in prostitution areas, and services involving cultural activities, home visits, institutional visits and support or accompaniment to the social services office, court or to a doctor. At *“Natthjemmet”* women can receive food, a shower, wash clothes and speak to someone in addition to shelter for the night. Similar measures exist in other municipalities. **“Strax huset”** (*“Strax-house”*) in Bergen offers services to those over 18 years of age, with a history of heavy drug use. They have a shelter for those in acute need, a day centre, evening/night time services and offer individual follow-up.

The socio-medical centre in Tromsø is a cooperative project involving the municipality, county and University in Tromsø. The centre consists of a health centre, social services office, and an open health clinic that offers assistance to those with social and health problems such as abuse and sexually transmitted diseases.

9.2.3 Prevention of infectious diseases

In 1988 an AIDS information bus (*Sprøytebussen*) was established in the municipality of Oslo. The bus was initiated in response to the fact that drug-injecting abusers are a group that is particularly at risk for contracting diseases as a result of needle sharing. By providing access to clean needles and condoms, and information about the risk of contagion, the AIDS information bus is to reduce the risk behaviour of this group. Several municipalities outside of Oslo have begun distributing needles, from vending machines in combination with them being sold in pharmacies.

Hepatitis is common among drug-injecting abusers in Norway. In 1995 an epidemic of hepatitis A and B broke out among this group, but following substantial efforts by the municipality to provide abusers with information and vaccinations, in addition to assuring access to clean needles, further spread of disease has been curbed.

9.3 Treatment

9.3.1 Treatments and health care at National level

Municipalities, via the social services, have an overarching responsibility for introducing measures for drug abusers. The counties are responsible for the establishment and operation of specialised treatment services. This includes specialist services such as public institutions and privately owned institutions with a county-agreement, psychiatric hospitals, departments of social medicine and child protection services. Additionally, the counties purchase individual rehabilitation slots in private rehabilitation institutions.

Treatment is largely voluntary, but the law on social services does provide for withholding an addict in an institution for up to 3 months upon the recommendation of the County Council for social cases. Those who are voluntarily admitted can enter into an agreement allowing them to be withheld in treatment for up to three weeks. The use of compulsory treatment is intended to encourage the client to accept further treatment.

A vast array of treatment and rehabilitation services has been developed in Norway with different professional and ideological approaches. Treatment alternatives vary from the

professional psychotherapeutic approach to a more simplistic approach based on a lifestyle built around a central Christian message.

The open psychiatric alternative consists of child- and youth psychiatric clinics, open social medicine clinics, and a youth psychiatry team. The child- and youth psychiatric clinic offers children and youth less than 18 years of age a treatment alternative for all types of mental illnesses and problems. There are approximately 70 child and youth psychiatric clinics and approximately 100 adult psychiatric clinics across the country. Some adult clinics have employed personnel who are dedicated to working with drug abuse and mental disorders.

The youth psychiatric team works especially with youths and young adults between 15 and 30 years of age who have both drug problems and psychiatric disorders. There are 28 psychiatric youth teams in the country, distributed across 15 counties. Rather than specific youth teams, four counties have specially reserved “abuse spaces” at adult psychiatric clinics.

Institutes with 24-hour services span everything from minimal intervention with only a few employees to treatment places within large institutions with many different wards. Ownership varies; they can be owned by the county, by public or private foundations, corporations or privately. Approximately 2/3 of the 24 hour services available to drug abusers are in private hands. However, organisations such as “Kirkens bymisjon”, “Stiftelsen Pinsevennes Evangeliesenter”, the Blue Cross and Salvation Army, etc. contribute more than a supplement to that offered by public institutions. Common to all these treatment alternatives is that they are generally open to those with problems involving alcohol, medications and drug use and are primarily financed by public funds.

Emergency and detoxification institutions offer detoxification and referrals for admittance to other rehabilitation services. The emergency institutions can be separate entities or a part of a treatment institution or other service that focus on rescue services in crisis situations.

In addition to the measures described above, there are also a number of purely care-related measures; that is, alternatives that accept downtrodden abusers, who show little potential for rehabilitation and offer them general help/care and a drug-free

environment. Other measures include half-way houses, which aim to improve their residents' situation.

Costs

While the state, counties and municipalities collectively spent EUR 82.5 million within the rehabilitation sector for drug abusers in 1990, this price tag was raised to more than EUR 187.5 million in 1998. This is an increase of 94% over a time span from 1990-98 (Sosial-og helsedepartementet).

9.3.2 Substitution and maintenance programmes

See key issue.

9.4 After-care and re-integration

After-care and re-integration is a municipal responsibility described in the Law on Social Services. However, different rehabilitation measures are associated with different after-care and re-integration approaches.

9.5 Interventions in the Criminal Justice System

See key issue – Drug users in prison.

9.6 Specific targets and settings

Gender-specific issues

As previously mentioned Pro Sentret is a national competency centre on prostitution and is responsible for providing systematic information, distributing knowledge, providing guidelines for the social assistance apparatus, authorities and public. The centre conducts outreach work in areas known for prostitution and attempts to provide health-related information and prevention. Pro Sentret is competent in the area of prostitution widely defined, in other words, child prostitution as well as male and female prostitution.

The social work consists of work with individuals through counselling and advising on economic, legal or social-and health-related questions. Additionally, the centre runs a shelter, which is a meeting place based on care and motivation. Environmental measures have also been initiated that focus on improving health. Other services available to

prostituting women are *Nadheim* and the “*Bymisjon*”, which are described in point 9.2.2.

Parents of drug users

Parents Against Drug Abuse (*Landsforbundet mot stoffmisbruk*) is a nationwide organisation whose primary goal is to provide the families of drug abusers with help to self-help and to help abusers return to society. The organisation maintains 50 local associations. Courses, seminars, meetings, support work and a hotline are arranged.

Drug use at the work place

AKAN, the Norwegian Tripartite Committee for the Prevention of Alcohol and Drug Problems in the Workplace is aiming to prevent drug problems in Norwegian work places, as well as helping employees with drug abuse problems find help. The central AKAN committee (the board) consists of representatives from the Norwegian Confederation of Trade Unions, the Confederation of Norwegian Business and Industry and from the Ministry of Social Affairs. These parties are also the financial contributors to the activities of AKAN.

AKAN's work is conducted according to an independent charter based on the specific conditions the tripartite cooperation creates. AKAN does not seek to promote a politically motivated abstention, as do other organisations and institutions. AKAN offers work places individually tailored support programmes for employees with drug problems. The programme is structured and can include efforts both within the company and outside, e.g. in cooperation with a clinic or treatment institution.

AKAN has largely focused on alcohol abuse, but in recent years illegal drugs in working life have also entered into the picture, and in the autumn of 2000 cooperation with the Norwegian Industrial Security Council (*Arbeidsmiljøseneteret*) and The Centre for Working Environment (*Næringslivets Sikkerhetsorganisasjon*) was established. The goal is to offer training in the form of a one-day course for resource persons who work with drug questions within the companies. The course curriculum takes up: factual knowledge about narcotic substances, work environment issues, current statistics,

AKAN's experiences with drug cases and projects directed at young employees – such as methods for preventing the development of a drug problem.

Self-help groups

Narcotics Anonymous - NA (*Anonyme Narkomaner*,) is an international, fellowship-based organisation of drug addicts in recovery. In Norway, NA is a self-driven support group that follows the AA (Alcoholics Anonymous) model. There are groups across the country.

10. Quality Assurance

10.1 Quality assurance procedures

Information is not available.

10.2 Treatment and prevention evaluation

There are no consistent quality control procedures for either treatment or the prevention field. SIRUS is, however, currently conducting a project that treats the benefits and costs of different treatment forms and different combinations for different groups of drug abusers. The project is titled, “*To what benefit, for whom, and at what cost*” and is a prospective multi-centre study of abusers in treatment. The project was launched in 1997, and is to be concluded in 2003.

10.3 Research

In Norway drug research is conducted in several settings. Research takes place in research institutes, at the university, colleges and individual competency centres.

In addition to SIRUS, drug research is conducted at NOVA (Norwegian Social Research). Administratively, the institute falls under the Ministry of Education, Research and Church Affairs. The institute's aim is to conduct research and developmental work that can contribute to increasing knowledge on social conditions and change processes. Issues such as the life course, and living conditions, quality of life, as well as social welfare initiatives and services are addressed.

The National Forensic Institute of Toxicology (SRI) is a division under the Ministry of Health and Social Affairs, which works with conducting biological analysis of drugs, medicines and poisons, as well as interpreting results from such tests and providing expertise. Based on blood and urine tests submitted in connection with traffic incidents, different epidemiological studies are carried out. Moreover, research and development work is carried out as well as education and information work.

The HEMIL centre (Centre for research on health promotion work, environment and lifestyle) at the University of Bergen, is a multi-disciplinary institute charged with initiating, coordinating and conducting research, education and other activities of importance to health prevention work.

The Bergen Clinics Foundation maintains an independent research department that cooperates with the College in Bergen, with two faculties at the University of Bergen and with the HEMIL centre on different research projects in the drug field.

Competency Centre Vest (Rogaland A-senter), Rogaland psychiatric hospital, Department for drug-related psychiatry, Rogalands Research and the College in Stavanger cooperate to offer research, development and educational projects within treatment and drug prevention work.

Rogalands Research is a research institute that conducts research upon assignment by the business community. Within the drug field, the institute has had research projects on topics such as cultural economic dependency, the role of pills in abusive environments and different projects related to work life and abuse.

HENÆR is a centre of competence within health promotion and prevention work in the local environment at the College in Vestfold, with drug prevention work as one of the main areas. The centre cooperates with the Borgestad Clinic and the Nordland's Clinic with respect to evaluation and counselling in the drug field.

10.4 Training for professionals

The University in Bergen offers a 2 year master's program in health promotion work, in addition to coursework in health under the department for health psychology and health promotion work, for which drug use is included as a subject area. The University of Tromsø has a master's program in Public Health Science. Several colleges offer further education in drug prevention and drug related issues.

The seven regional centres of competence are expected to contribute to increasing knowledge among personnel working in the drug sector. In particular, they are to conduct education and counselling in drug prevention work(see 8.1.).

Part 4 – Key issues

11. Substitution treatment, its clients and effectiveness¹

Background, history

Until the mid 1980s, there was broad consensus in Norway, both politically and among those working in the treatment apparatus, that methadone should not be used in the rehabilitation of drug abusers. However, with repeated reports on the dire state of the oldest drug abusers, and a considerable rise in the number of drug-related deaths, greater numbers gave voice to using methadone. In 1991 a trial project with maintenance treatment for HIV-positive clients with long-term immune deficiency was initiated under the auspices of the Municipality of Oslo, without raising mentionable criticism.

The question, however, was whether maintenance treatment with methadone should be available regardless of HIV status. In this respect, a considerable debate took place among workers within the treatment apparatus network, in the media and in different professional and political environments. Arguments were complex and varied. For example, what can be called ethical arguments were central for both proponents and opponents of methadone treatment. Opponents posited that they did not wish to label drug abusers as hopeless and that giving them methadone could be interpreted as a signal that it was not possible to become drug-free. Many have felt that the use of methadone symbolically indicates that drug abusers are passive victims of their own abuse, and would not be able to manage on their own. Another argument has been that methadone is habit-forming in the same way that heroine is. In treating drug abusers one should not replace one narcotic substance for another. It has also been suggested that the acceptance of methadone could be interpreted to mean that drug-free treatment is of no use.

Spokesmen for methadone have argued that it is a treatment form that could "save" drug abusers from humiliation and early death. By giving them access to methadone they would be able to achieve a better quality of life. The need to commit crimes and engage

¹ Note: The key issue on successful treatment: The effectiveness of the interventions, has been limited to medically assisted rehabilitation only

in illegal dealings would be reduced, potentially increasing the possibility that an abuser would remain in a rehabilitation programme (Skretting 2001).

A three-year trial with methadone-assisted rehabilitation was initiated in 1994 with 50 opiate addicted users in Oslo. The project followed a Swedish model, with strict inclusion criteria. Among other things, clients were to have had an opiate addiction for at least ten years and be over 30 years of age.

In June 1997 the Storting concluded that Norway would develop a national programme for using methadone in the treatment of drug addicts. The target group was to consist of patients for whom progress had not been achieved in drug-free treatment. During preparatory work and in the parliamentary debate, emphasis was placed on the fact that the primary aim of the programme should be rehabilitation. Medical treatment is to be integrated with collective efforts to improve the individual's standard of living and ability to function. Guidelines for treatment are described in a circular issued by the Ministry of Health and Social Affairs.

Admission criteria were re-evaluated in 2000 and are now less restrictive:

The applicant shall be at least 25 years old, be heavily addicted to opiates despite a reasonable amount of treatment, and have been addicted for several years. Special criteria are applied when methadone is necessary in order to provide treatment of life-threatening illnesses.

A national centre has been established in Oslo as well as regional coordinating agencies in four health regions. Treatment is based on frontline co-operation between social centres and physicians, and the programme must be approved by the regional centres. The individual patient applies through his or her social centre with an action plan that outlines individual goals and necessary measures. Each county shall have an admissions agency that assures the quality of applications and ensures the necessary cooperation and drug rehabilitation services and other special services are available.

These alternatives were established during 1998, based on an expected 600 patients. By the end of 2000, 1 072 patients were in treatment. However, demand for these services has proven to be even greater and waiting lists remain long. The goal is to increase the number of available spaces to approximately 1 600 patients by the end of 2001 (Waal et al.2001).

In other words, expansion in Norway has been rapid. Sweden, in contrast, which initiated this type of treatment in 1996, and which has provided a model for methadone treatment in Norway, has limited the number of clients to 800. This rather dramatic change in policy with respect to heavy drug users in Norway is largely the result of massive pressure by public opinion/media and politicians. Similarly the issue has been raised in the Storting on repeated occasions. This far, it could be said that the arguments presented by both politicians and in public opinion/the media build on the perception that use of methadone and/or buprenorphine more or less represents “the solution” to drug use. That medically-assisted rehabilitation is now emphasised, must be seen in relation to the fact that the success of drug-free rehabilitation measures has been limited.

Although one can be sceptical to the rapid growth in medically-assisted rehabilitation, from just under 100 patients in 1997 to nearly 1 100 three years later, there is little evidence that the demands presented by politicians and the mass media to increase capacity are based on a desire to increase control. First and foremost the basis for growth appears to be a genuine concern for the general misery one sees among long-term drug users and the many drug-related deaths (270 in 1998, 220 in 1999, and 327 in 2001). However, such a rapid expansion has naturally led to problems with respect to the expected quality of treatment. Many would also posit that rehabilitation is a far too ambitious and unrealistic goal for the group of users who are potential candidates for medically-assisted rehabilitation. Given the extent of the problem, one could argue that the primary goal of treatment with methadone and buprenorphine should be harm reduction, and that one should not expect the abandonment of all use of illegal drugs (Skretting 2001).

Organisation of treatment

The organisation of treatment has been tailored to local conditions in the different counties. In particular, the degree of decentralisation varies. There are separate treatment centres in Oslo, Bergen and Trondheim. In Oslo and Bergen, one has largely based treatment on daily visits to the centres, while in Trondheim treatment is organised through the pharmacies. Administration of medication has largely been conducted at the centres during the initiation and stabilisation phases, and then later at a pharmacy. In some counties treatment is based on prescriptions by general physicians with

administration at a pharmacy, or by a home health care worker. There has been some hesitation among general physicians, but there appears to be an increasingly positive attitude towards this form of treatment in most locations, although unclear payment schemes have created substantial difficulties (Waal et al.2001).

How is the patients' progress?

Maintenance treatment is not curative. Most individuals must continue taking medication over a long period of time, in many cases for the rest of their lives. A Swedish study showed that only 5% manage to quite using methadone without a relapse into abuse. This percentage should be seen in relation to the strict selection criteria associated with this form of treatment in both Sweden and Norway. Only those who fail in other forms of treatment are admitted. In Norway patients are on average above 35 years of age and often began their abuse career during puberty. Many have used heroine since they were 15 to 25 years of age and face problems in many areas of life. This makes it necessary to always maintain a long-term perspective.

A common criterion for successful treatment is a high level of retention. During 2000, 171 individuals completed treatment, largely due to a weak effect of the treatment. Some of these had begun during the same year while others began much earlier, such that the calculated retention rate is only approximate. The number who completed treatment amounts to less than 25% of those who were in treatment at the beginning of the year. This gives a rough yearly retention rate of 75%. By international comparison this is a good result. A partial explanation is probably that this alternative is a "rare good". In the event that treatment was easier to attain, retention would fall. Moreover, one sees that the number of those who are discharged from treatment is increasing.

Of course, retention is not in and of itself a sufficient goal. Therefore the regional centres also must report on the degree of drug use, patient satisfaction and the degree of rehabilitation. This reporting system is not fully developed, but reports thus far and evaluations indicate that nearly all patients have drastically reduced their drug use. This is especially true with respect to the use of opiates (Waal et al.2001).

Mortality and morbidity

Intravenous heroine abusers have a high mortality level, primarily due to overdoses. But, other conditions also contribute to serious illness and often death. HIV infection and virus hepatitis, for example, lead to immune deficiency and chronic hepatitis. Depression and anxiety are also common.

It is usual to find a yearly mortality rate of 2-3% in follow-up studies of abusers. This is confirmed by the applicant list to the centre in Oslo. When one compares the police department's list of names in overdose cases in Oslo with the applicant list to the Oslo centre, it is evident that 12 of 321 applicants died in 1998 (3%), 8 of 375 (2.1%) in 1999 and in 2000 12 of 418 (2.9%) died. However, over the last year 106 patients participated in a trail project with Subutex. None of these died, and this has reduced the collective overdose mortality of the list.

In order to evaluate the effect of treatment, all regional centres have reviewed their lists. All together 1 400 have been or are in treatment. It is reported that one patient died of unknown causes, likely due to an irregular heart rhythm. One patient knowingly reduced his intake and died of an overdose that is regarded as an intentional suicide. In one case an overdose occurred while increasing the dosage before stabilisation could occur. There was also a case of overdose during involuntary reduction. Two died of accidental drowning. Other cases of mortality are related to the level of other illnesses affecting the group, particularly immune deficiency and liver disease. Hence, it can be stated that overdose mortality has nearly been eliminated during treatment. However, after treatment is concluded mortality once again increases, probably to the same level indicated by the applicant list cited above (Waal et al.2001).

Criminality

Criminality is widespread among intravenous drug users. A project in Oslo showed that very little crime was reported during treatment. Moreover, self-reports show a drastic reduction. Systematic data covering the development of criminality in the different regions is not available, but a clinical review of treatment workers' knowledge indicates a similar dramatic reduction. However, the centres are often aware of new criminality leading to imprisonment, and always in cases when this leads to an interruption in treatment. Such criminality has been minimal(Waal et al.2001).

Towards more and better methods?

Until recently treatment models were referred to as methadone-assisted treatment. Today, Subutex, high-dosage buprenorphin, is also approved for this application. There have been test projects with Subutex. The results of these will be available during 2001. Moreover, outside the projects medication is more modestly used in clinical settings, and experience indicates that the drug can be used effectively. Another alternative is LAAM, a methadone-like medication with an especially long half-life. The drug is of interest, but reports on deaths related to the extended QT-time make a cautious approach natural. In some countries one has chosen to try heroine as a maintenance drug. Morphine-sulphate and codeine have also been used. These medications do not seem to be a natural choice, but there are grounds to expect a greater variety of pharmaceuticals in the future. The guidelines describing the use of these medications for this type of treatment have therefore renamed it from “*methadone-assisted*” to “*medically-assisted*” rehabilitation.

The Norwegian model emphasizes the rehabilitation concept. This does not necessarily mean that the patient is returned to working life, but that everyone should aim towards an improved quality of life, social functioning and ability to cooperate to solve one’s own problems. The Law on Social Services regulates the form of rehabilitation. Together, these conditions place the social sector at the heart of treatment.

As physicians have increasingly entered the treatment arena, demands for a greater and more independent role for physicians have become clearer. Not all physicians find it natural to work as part of an interdisciplinary team, not even as a leader of that team. Moreover, some patients do not have as great a rehabilitation need as others. In some situations, rehabilitation goals should be deferred until the patient has recovered from the critical phases of an illness. In such cases, the demand to give social services a primary role in rehabilitation is experienced as a barrier.

Other areas of treatment will also need to be evaluated. Many, nearly all, experience a substantial improvement in their situation and quality of life, including those who to varying degrees use non-opiate drugs. The number of overdoses is also a growing problem in Norway. Together these factors shed light on the goals and choices

associated with medically-assisted rehabilitation. Evaluations and analysis are therefore important (Waal et al.2001).

Research

The Unit for Addiction Medicine is a newly established research unit organized under the Department Group of Psychiatry (University of Oslo, Faculty of Medicine). The aim is to initiate and coordinate research concerning the medical treatment of drug addiction and the integration of medical and psychosocial interventions. Besides being structurally organized under the University of Oslo, the unit is closely connected to *Centre for Medication Assisted Rehabilitation* (MARIO). MARIO constitutes the scientific and clinical base for evaluation and development of methodology in the treatment of opioid dependence. The centre will in addition act as adviser for governmental authorities. Within this framework, the University-section will be responsible for securing a scientific approach to the questions raised.

Tentative conclusions

In Norway medically-assisted rehabilitation is a treatment form that is established and developing according to a fruitful cross-functional professional model. Opposition to treatment is currently being replaced by a consensus concerning the positive and negative aspects. A well-functioning regional system has been built with municipal/county cooperation.

In time the choices and dilemmas will need to be evaluated and perhaps revised. Among other things, it might prove necessary to re-evaluate the division of labour within the cross-functional professional cooperation in place at present, although the main emphasis upon interdisciplinary cooperation seems to be appropriate. There has long been a strong need for better cooperation between the health and social services both on the frontline and thereafter. This seems to be occurring in medically-assisted rehabilitation. Experience thus far indicates that cooperation largely contributes to greater mutual trust between health care workers and social care workers and creates respect for their different professional backgrounds. This can be to the benefit of not only patients with drug problems, but also other groups with complex problems.

It is too early to provide a final status of the overall effect of this treatment. Experience to date indicates that one has achieved a substantial reduction in overdose mortality and patients are better empowered to cooperate so that their other illnesses can be treated. Most individuals clearly experience an improvement in their social functioning and quality of life. Criminality is definitively reduced. Problems related to continued abuse of drugs, especially benzodiazepines, and partly alcohol and cannabis, remain. Somewhere between 20 and 40 per cent achieve full mastery of their drug problem, and an equal number experience a clearly improved situation. This concerns a target group that has otherwise proven to be treatment-resistant with an apparently chronic dependency. Nearly all patients reduce their heroine use substantially. (Waal et al.2001).

12. Drug users in prison

The drug situation in Norwegian prisons

The inmate population reflects and presents a concentrated picture of the problems that exist outside prison walls. The proportion of inmates who are serving sentences for crimes against drug legislation has been growing and corresponds to the growth in such problems in Norway in general. In 1999, 777, or slightly fewer than 30% of the total 2 695 inmates in Norwegian prisons, were serving sentences for different types of drug-related crimes. In addition to these, were those who are convicted of crimes that have a direct relationship to drug use, but which are not reflected in the statistics. Typical examples are theft or robbery committed in order to finance drug use.

The prison authorities suggest that 40-60% of inmates in Norwegian prisons use drugs once or several times while serving their sentences (Stortingsmelding nr 16(1996-1997) Narkotikapolitikken). This estimate builds on previous studies conducted in prisons, with anonymous surveys among inmates, reports submitted by prison and visitation officials to the prison board, as well as various scientific studies that have been conducted.

Smuggling and use of narcotic substances is a problem in some Norwegian prisons. The possibility of detecting smuggling and use is related to a consideration of the inmate's situation in the prison. Searches of private property, cell inspections and body searches of the inmates are regarded as degrading and insulting, and further impinge on the inmate's freedom. The harmful effects of further impinging upon freedom are to be prevented or limited and wide use of cell inspections and other searches could have a reverse effect. This is therefore a matter for consideration. Today facilities are legally empowered to require urine tests and conduct body searches when there is concrete suspicion of drug use or storing drugs (in body cavities).

Table 6 shows that the number of body searches has been significantly reduced from 1992-2000. In 1992 152 body searches were carried out, and drugs were discovered in 32 of these. In 2000 only 23 searches of this nature were conducted, and drugs were discovered in 14 of them. Collectively the number of discoveries of drugs and user equipment has increased from 1992 to 2000. In 1992 drugs were discovered 216 times, and user equipment 632 times. In 2000 drugs were found 494 times and user equipment

1 097 times. This increase is due to the spread of drugs in prisons as well as use, but can also be linked to changes in control routines.

The number of urine tests that have shown positive for drug use have increased from 1 267 in 1992 to 2 412 in 2000. In other words, there has been a doubling in the percentage of positive tests. Most results indicate cannabis and different pills. This corresponds to the seizures that have been conducted. The number of urine tests conducted has been somewhat reduced, from 1992 to 2000, even if there was a slight increase in the number of tests in 1993.

Table 6
Drugs in Norwegian prisons

1992-2000

	Number of drug seizures	Seizures of user equipment	Number of body searches	Number of seizures from body searches	Number of positive urine samples
1992	216	632	155	32	1 267
1993	252	541	28	8	1 535
1994	267	740	41	22	1 541
1995	275	873	33	13	1 782
1996	236	825	26	18	1 814
1997	284	1 194	36	6	2 150
1998	325	1 090	27	5	1 921
1999	391	1 128	21	10	2 328
2000	494	1 097	23	14	2 412

Source: The Prison board

Prevention and rehabilitation efforts

For several years now criminal care facilities have worked to direct inmates to correctional programmes that address their problems and criminal profile, hereunder referred to as drug problems and drug-related criminality. During and after sentences have been served, the inmates with drug problems are presented with opportunities to participate in various programmes that deal with dependency issues. Such programmes include:

- Contract sentences
- An alternative sentence in accordance with paragraph 12 of the prison law
- Drug dependency programmes
- Life mastery programmes
- The establishment of networks
- Probation groups
- Work experience within an institution
- Education
- Leisure activities
- Participation in the prison system's work-furlough programme

all of which constitute means of releasing prisoners and following them up after their release.

A majority of the prison system's measures touch upon issues that directly or indirectly address the convicted individual's relationship to drug dependency. Over the last two years, Canadian drug mastery programmes have been conducted in facilities, under the name "Drug Prevention Programmes in Prison" (*"Rusprogram i fengsel"*). These programmes will be followed up after release from prison, with the programme "*Mitt valg*" (my choice), whose goal is to reduce the likelihood of a relapse.

Contract sentencing aims to combat drug use among inmates. It builds on an agreement, or contract, between the inmate and the facility by which he or she agrees to refrain from drug use during incarceration. The contracts are entered into on an individual basis in regular facilities or in conjunction with being transferred to a contract ward or contract prison. There are usually no demands placed upon the inmate to participate in other rehabilitation beyond the agreement to remain drug-free and consent to urine tests. Contracts are also utilised during parole periods, whereby the contracts can also contain conditions and requirements to refrain from drug use, a set frequency of meetings with a parole officer, participation in education, training in various everyday activities, participation in discussion groups and work with personal life planning.

Serving sentences according to the prison law, §12.

The prison law §12 gives inmates with a drug problem the opportunity to be transferred to a half-way house or other treatment institutions. The institution must be able to offer a treatment programme that meets the individual's needs. The law specifically requires that mitigating circumstances are present if a convicted person is to serve his/her entire sentence in an institution. Here, the law is directed to cases in which the convicted is so in need of treatment that the entire sentence should be carried out within a treatment institution. In practice, this decision is strictly applied for alternative sentencing for drug users only.

The prison system does not operate according to specified overviews or approval codes for potential paragraph 12 institutions, but evaluates each concrete case according to whether one can offer an appropriate alternative. To fulfill the restrictions placed on such alternative sentencing, the chosen institutions must offer secure conditions under which the sentence can be served. Pure care facilities are generally not accepted as treatment institutions according to paragraph 12. Transfers can only be to institutions that lie within national borders. The inmate is to be subjected to total prohibition of alcohol and other substances as long as the sentence is being carried out. This prohibition is also applicable under any furloughs, leisure activities, etc.

As a rule of thumb, the opportunity to carry out a sentence in a treatment institution/half-way house is not granted if the expected time until release exceeds 12 months.

The "*Stifinner project*" ("*Path-finder project*") is a rehabilitation approach that is run in cooperation with the Oslo prison authority and the Tyrili Foundation, a rehabilitation facility. This alternative is directed to heavier drug users and currently has a yearly capacity of 18 treatment spaces. Participants are placed for 8 months in the "*Stifinner*" house in association with an Oslo prison where they undergo an introduction phase and a motivation phase. They are transferred thereafter to sentencing under paragraph 12 of the Prison Law, under the Tyrili Foundation's treatment continuation programme, which includes life and work training.

So-called "*influence programmes*", such as violence and crime watch groups as well as probation groups are also important. These are based on crime prevention motives. They

take their point of departure from the social and personal problems that are assumed to contribute to criminal acts.

The criminal care services cooperate with a number of organisations with humanitarian, religious, sports, cultural or drug prevention goals. These make a major contribution through outreach work and measures that promote skills, improve self-esteem and integrate former inmates into active leisure activities. Intentions are to strengthen this cooperation by, among other means, drawing voluntary organisations into work more directly related to activities during the actual sentence being served. Here, special attention is given to building networks and helping the individual establish him- or herself in drug-free environments even before being released.

The development of the HIV/AIDS problem involves major challenges for the prison system. An important aim is to ensure that staff and inmates are guaranteed the greatest degree of safety with respect to exposure to HIV. There are relatively large number of intravenous drug users in prisons, and despite the frequency of strict controls, needles are used. In order to prevent the spread of disease by needle-sharing among inmates, the State Health Authority has required that prisons make chlorine available in prisons, such that inmates are able to clean used needles.

Note: There is no needle distribution programme in Norwegian prisons.

Access to substitution treatment is provided to inmates that have already begun such treatment, such that they can continue while serving their sentence. In principle, substitution treatment could also begin while carrying out a sentence if the inmate fulfils the admission criteria for the programmes.

References:

- Borgestadklinikken (2001): Graviditet, barn og rusmidler
- Bretteville-Jensen, A.L. & Ødegård, E. (1999): Injeksjonsmisbrukere i Norge, SIFA-rapport, 4/99.
- Bretteville-Jensen Anne-Line: Kjønnforskjeller i bruksmønster og helse blant intravenøse heroinmisbrukere i Oslo. Tidsskrift for Norsk Lægeforening nr. 2, 2000.
- Bretteville-Jensen A.L. & Biørn E.: Estimating addict's price response of heroin: A panel data approaches based on a re-interviewed sample, UiO memorandum 8/2001,
- Hibell , Bjørn et al.: The 1999 ESPAD Report. CAN. Stockholm 2000.
- Kriminalpolitisen (KRIPOS): Årsrapport 2000, halvårsrapport 2001.
- Melkeraaen, H: (1997). Forebyggende rusmiddelarbeid i helsestasjonen
- NOU 1998:18: "Det er bruk for alle"
- Rusmiddelstaten, Oslo kommune: Årsmelding 2000
- Rusmiddelstaten, Oslo kommune: Kampanjemateriell
- Rusmiddeldirektoratet (1999): Gravide rusmiddelmisbrukere og misbrukere med små barn
- Rusmiddeldirektoratet: Årsmelding 1998, 1999,2000
- Rusmiddeldirektoratet: Kampanjemateriell 2001
- Skog, O.-J., 1990, Utviklingen av intravenøst narkotikamisbruk - Anslag for insidens og prevalens, SIFA-rapport nr. 1/99, Oslo
- Skretting Astrid. : Legemiddelassistert "rehabilitering" i Norge, Behandling-omsorgskadereduksjon-kontroll?(Nad publikasjon nr.40 2001)
- Skretting A: Ungdom og rusmidler 2000, Rusmiddeldirektoratet
- Sosial- og helsedepartementet(2000): Offentlige utgifter til helse og sosiale formål. 1980-1998.
- Sosial- og helsedepartementet (2000): Narkotikaproblemene i Norge 2000. Rapport om situasjonen og tiltak.
- Statens helsetilsyn. 10-2000: Personer med samtidig alvorlig psykisk lidelse og omfattende rusmisbruk..
- Statens institutt for folkehelse: MSIS.
- Statens institutt for rusmiddelforskning (SIRUS): Rusmidler i Norge 2001
- Statens institutt for rusmiddelforskning (SIRUS): Data fra surveyundersøkelser.
- Statens rettskikologiske institutt(SRI): Årsmelding 2000
- Statistisk sentralbyrå (SSB): Kriminalstatistikken.

Stortingsmelding 1992/93: 69: Tiltak for rusmiddelmissbrukere. Sosial- og helsedepartementet

Stortingsmelding 1996/97:16: Narkotikapolitikken. Sosial- og helsedepartementet

Stortingsmelding 1996/97:25: Åpenhet og helhet. Sosial- og helsedepartementet

Stortingsproposisjon nr 58 (1997-98): Handlingsplan for redusert bruk av rusmiddel (1998-2000) .

Waal, Helge et al. :Medikamentassistert rehabilitering i Norge. Oslo kommune 2001.