



2005 NATIONAL REPORT (2004 data)

TO THE EMCDDA

by the Reitox National Focal Point

NORWAY

New development, trends and in-depth information
on selected issues

REITOX

Introduction

The Norwegian Institute for Alcohol and Drug Research (SIRUS) is the Norwegian Focal Point for the European Monitoring Centre for Drugs and Drug Addiction– EMCDDA. As an important part of its duties SIRUS has since 2001 produced annual reports on the national drug situation for use for the EMCDDA's purposes. This year's report has been prepared in accordance with guidelines that are common to all the 26 member states in the EMCDDA. The guidelines have been followed relatively stringently by focusing on "news" and important changes in epidemiology, legislation and organisation compared with last year's report. The special topics (chapters 11-13) are, moreover, new in this year's report. Many references have also been included to standard tables and structured questionnaires in special areas/topics without reproducing their contents. The tables and forms were sent to the EMCDDA in September 2005. The report may therefore seem a little fragmentary. However, our goal has not been to describe all aspects of prevention and treatment and pertaining measures that otherwise deserve to be discussed. The Ministry of Labour and Social Affairs' status report on the drug and alcohol situation in Norway in 2005 will be a useful supplement.

As in previous years, this report is based on textual contributions and data from central public institutions in Norway and other players in the drugs and alcohol field. These are listed as co-authors or mentioned in the reference list. The authors of the special topic chapters are also mentioned in the relevant chapters. The text and data have been reviewed and verified by an internal reference group in SIRUS. I would like to thank everyone who has contributed.

Although the report has primarily been produced for use by the EMCDDA, I believe that it may also be useful to other interested readers who wish to keep abreast of the drugs situation in Norway.

The whole report can be downloaded from www.sirus.no. A printed version can also be ordered, although only in English.

Oslo, November 2005

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Summary – Main trends and developments

Policies/strategies/organisation

The Minister of Health and Care Services has taken over responsibility for coordinating drugs and alcohol policy. In connection with changes in the structure of ministries made by the new government, the Section for Alcohol and Drug Policy will be transferred from the Ministry of Labour and Social Affairs to the Ministry of Health and Care Services. The change will be formally put into effect on 1. January 2006, but the Minister of Health and Care Services has taken over responsibility for these fields with effect from 17. October 2005. Both in terms of services for problem alcohol and drug users and in policy terms the field is now predominantly a health issue.

The government's new action plan to combat drug and alcohol-related problems (2006-2008) was presented on 17. August 2005. The action plan is in large part a prolongation of the action plan for 2003-2005. The government wishes to continue a comprehensive drugs and alcohol policy based on a long-term approach and continuity.

An interdepartmental working group put forward a proposal for a scheme for a "judge-led drug programme" (Drug Courts) in autumn 2004. The Act relating to changes in the penal code (trial scheme for a drug programme under court control) was adopted on 17 June 2005. The scheme is scheduled to enter into force in Oslo and Bergen at the turn of the year 2005/2006. The trial scheme will be evaluated before the Ministry of Justice and the Police decide whether to propose making it permanent.

Epidemiology

Prevalence:

On the basis of the most recent survey of the adult population carried out in 2004, it is clear that a steady, but not particularly marked, increase has taken place in lifetime prevalence for the use of cannabis. The proportions who report using cannabis during the last 12 months and the last 30 days have, however, been stable for the last ten years. As regards the use of other drugs, there has been no increase in reported lifetime prevalence.

The annual questionnaire surveys of young people in the 15-20 age group showed a clear increase in the latter half of the 1990s in the proportion who stated that they had ever used cannabis. However, the surveys for the last few years indicate that the increase has not continued but that it has declined compared with the top years 1998-2000. The same applies to the reported use of other drugs.

Patterns of use:

The registration of the drug situation in the municipalities shows that in 2002 and 2003 around half of the municipalities stated that no change had taken place in the drug situation since the previous year. However, the proportion of municipalities with a stable situation varies for the different types of drugs. For cannabis and amphetamine, approximately half of the municipalities reported an increase in the number of users for both years, and the illegal use of tranquillisers appears to be becoming more common.

Surveys from Oslo and Bergen indicate that the use of cocaine has become more common among young adults.

A new study, *Intravenous drug users in Oslo, a survey of a non-clinical population*, was part of a larger project aimed at studying the illegal drug market in general and the heroin market in Oslo in particular. It focused on buyers/users and was carried out by analysing a large number of interviews with intravenous drug users who contacted the needle distribution service in Oslo during the period 1993-2004. Central findings include: The average age on first injecting has risen by almost 10 years compared with those who started injecting in the 1970s. Among those who started injecting after 1995, 70 per cent had smoked heroin before injecting the drug. The average monthly consumption of heroin has more than doubled during the survey period, from slightly more than 8 grams to around 20 grams, while the average consumption of amphetamine has increased from 17 to 20 grams during the same period. Those who inject heroin and amphetamine state that they also indulge in extensive abuse of other intoxicants which are drunk, eaten, smoked or sniffed/snorted.

Drug-related deaths:

According to the statistics from the National Criminal Investigation Service, 223 persons died as a result of drug use in 2004. This is an increase compared with 2003, but seen in a five-year perspective, the trend is still downward. Twenty-two of the twenty-seven police districts reported drug-related mortalities. Oslo had one third of the mortalities. Very many of the deaths are due to extensive multiple use of heroin, amphetamine, benzodiazepines and methadone. The average age on death was 34 years for men and 36 years for women.

Drug-related infectious diseases:

The number of HIV cases among intravenous users remains relatively low, and little new infection is detected among this group. Only 15 of these cases (6 per cent) concerned intravenous users. The proportion that have developed AIDS is somewhat higher, but the number remains low and stable.

The hepatitis B outbreak continued in 2004, and 108 of a total of 188 cases involved intravenous users. During the period 1995-2004, there were 1 649 reported cases of acute hepatitis B among intravenous drug users.

Drug markets

Seizures:

The drug statistics from the National Criminal Investigation Service show a continued decline in the number of cases and the number of seizures. In 2004, 19 299 drug cases were registered and there were 24 108 seizures. This represents a decline of 5.0 per cent and 4.5 per cent respectively, compared with 2003. A decline was registered in most of the country's 27 police districts.

The reduction was greatest for heroin, benzodiazepines (including Rohypnol) and amphetamine. The number of seizures of heroin is the lowest for more than 10 years. The seizure figures indicate that heroin is less widespread and less used than previously. For most of the drugs, the statistics are within the normal range with respect to both the quantities seized and the number of seizures, but heroin and amphetamine/methamphetamine stand out in that record quantities of these drugs were seized.

Despite the decrease in the number of seizures, the statistics show that amphetamine and methamphetamine are still highly widespread. This is supported by the fact that all police districts made seizures of these substances in 2004.

The prevalence of ecstasy seems to have culminated and, in part, declined sharply since the top in 2001.

The number of seizures of Rohypnol and imitations has declined sharply. There is good reason to view this development in conjunction with the successful surveillance and investigative efforts aimed at Eastern Europeans among others.

In general, the price level on the black market has changed little since the reporting for 2004. However, in Oslo the price of heroin has fallen by 70 per cent since 1993, while the price of amphetamine has fallen by 60 per cent during the same period.

Part A: New Developments and Trends

1. National policies and context

1.1 Legal framework

The legal provisions and penalty frameworks were described in NR 2002 chapter 1.2.

1.1.1 Legislative changes in 2004/2005

The establishment of a trial scheme for injection rooms

The Act relating to injection rooms (Temporary Act no. 64 of 2 July 2004 relating to a trial scheme for premises for the injection of drugs (the injection room scheme) etc. and the Regulation relating to detailed rules for the injection room scheme entered into force on 17. December 2004. The Act enables the implementation of a three-year trial scheme which will subject to evaluation. The purpose of injection rooms is to enable an evaluation to be carried out of the effect of freedom from prosecution for the possession and use of drugs in injection rooms. Moreover, the scheme aims to provide more dignity for hardcore drug addicts, to provide an opportunity for contact and conversation between drug users and the support services, to contribute to preventing infections and the spread of infections and to reduce the number of overdoses and overdose fatalities. The target group consists of hardcore drug addicts over 18 years of age, and the injection rooms will be staffed by qualified health and social work personnel. The freedom from prosecution in injection rooms only applies to heroin. Municipal schemes for injection rooms are subject to approval.

Oslo municipality has been approved as a trial municipality, and it opened the first injection room on 1. February 2005. The scheme is to be evaluated by SIRUS. The evaluation will provide the government with a basis for deciding whether to propose to the Storting (parliament) that the scheme be introduced on a permanent basis.

Trial scheme for Drug Courts

An interdepartmental working group put forward a proposal for a scheme for a “judge-led drug programme” (Drug Courts) in autumn 2004. The Act relating to changes in the penal code (trial scheme for a drug programme under court control) was adopted on 17. June 2005.

The trial scheme applies to drug users who have been convicted for drug-related crime. The drug programme is a rehabilitation scheme adapted to individual needs that forms part of the penal reaction. The court can decide that convicted persons shall complete the programme as a condition for suspending the serving of a prison sentence. The goal of the programme is both to improve the practical help and treatment services offered to hardcore drug addicts and to prevent the commission of new crimes.

The scheme is scheduled to enter into force in Oslo and Bergen at the turn of the year 2005/2006. The trial scheme will be evaluated before the Ministry of Justice and the Police decide whether to propose making it permanent.

1.2 Institutional framework, strategies and policies

1.2.1 Organisation and coordination

Changes to be noted:

The Minister of Health and Care Services has taken over responsibility for coordinating drugs and alcohol policy with effect from 17. October 2005¹.

- In addition to its responsibility for coordinating drugs and alcohol policy, the Ministry of Health and Care Services is from 17.10.05 responsible for the Act on the sale of alcoholic beverages, the Wine Monopoly Act, Vinmonopolet AS and the Norwegian Institute for Alcohol and Drug Research (SIRUS).
- The Ministry of Health and Care Services has national responsibility for the whole range of treatment for people with drug and alcohol problems. This entails responsibility for the services offered and the overall range of interventions as described in the Act relating to social services, the Act relating to the municipal health services and the Act relating to specialist health services.

The Ministry of Health and Care Services thereby has national responsibility for following up problem drug and alcohol users, both in the municipalities and in the regional health authorities. The Ministry is also the owner of the regional health authorities.

The Ministry of Health and Care Services has administrative responsibility for the Directorate for Health and Social Affairs, although the Ministry of Labour and Social Affairs also has professional responsibility for the Directorate in relevant professional areas.

Pursuant to the Health reform of 2002, the state has overriding responsibility for providing necessary specialist health services to the public, including interdisciplinary specialist treatment for drug and alcohol abuse, cf. the Act relating to specialist health services section 2-1.

Five regional health authorities (established in 2002) are responsible for providing the necessary specialist health services to the population in their respective regions, cf. the Act relating to specialist health services section 2-1a), also including medically assisted rehabilitation.

The regional health authorities are also responsible for cooperating with municipal authorities on the preparation of individual plans and for ensuring adequate discharge procedures.

The municipal social services have an overall responsibility for problem drug and alcohol users. If the municipal support services are inadequate, it is the municipality, represented by a doctor or the social services, that is the agency responsible for referring individuals to interdisciplinary specialist treatment for drug and alcohol abuse.

The Directorate for Health and Social Affairs, which was established in 2001, is the government's primary advisor in health and social affairs matters. The Directorate is responsible for coordinating the national prevention strategy. As a responsible professional body, the Directorate shall monitor the situation in the health and social services and give advice and guidance about strategies and interventions to the authorities and the services. The Directorate's most important responsibility is to

¹ In connection with changes in the structure of ministries made by the new government, the Section for Alcohol and Drug Policy will be transferred from the Ministry of Labour and Social Affairs to the Ministry of Health and Care Services. The change will be formally put into effect on 1 January 2006, but the Minister of Health and Care Services has taken over responsibility for these fields with effect from 17 October 2005.

ensure that adopted health and social affairs policies are implemented in accordance with the Ministry's guidelines.

The National Police Directorate, the Directorate of Customs and Excise, the Directorate for Primary and Secondary education and the Norwegian Directorate for Children, Youth and Family Affairs are important partners in this context.

The County Governors, the government's representatives in the counties, shall endeavour to ensure that the Storting's decisions, goals and guidelines are followed up. The County Governors are responsible for following up work with problem drug and alcohol users in the municipalities, among other things by providing guidance and building competence. The County Governors also deal with appeals against individual decisions pursuant to the Act relating to social services, including decisions on interventions for drug and alcohol users. On assignment from the Norwegian Board of Health, the County Governors are responsible for supervising health services for problem drug and alcohol users.

The seven regional drug and alcohol competence centres are still important players in the implementation of drug and alcohol policies at the regional and local levels (NR 2003 chapter 9). The centres work together with the municipalities in their region, and provide continuing education, advice and guidance to frontline personnel as well as promoting the development of preventive measures. Moreover, they shall also contribute to the further development of interdisciplinary specialist treatment services. Each of the competence centres also has national responsibility for a specialised area:

- The Northern Norway drug and alcohol competence centre at the Nordland Clinic:
- *Drug and alcohol prevention in schools* (new area in 2005).
- The Central Norway competence centre: *Young drug users*.
- The Bergen Clinics Foundation: *Women and drug and alcohol use*.
- The Rogaland A Centre: *Drug and alcohol problems in families with school-aged children, drugs and alcohol in the workplace*.
- The Borgestad Clinic: *Pregnant drug/alcohol abusers and families with small children*.
- The Alcohol and Drug Addiction Service, Municipality of Oslo: *Youth and new patterns of abuse*.
- The Eastern Norway drug and alcohol competence centre: *Drug and alcohol abuse and mental health problems, gambling addiction*.

The competence centres cooperate through a Norwegian network function administered by the Directorate for Health and Social Affairs. The Norwegian network function is intended to meet the need for overall management and coordination.

The Ministry of Labour and Social Affairs followed up the ongoing action plan to combat drug and alcohol-related problems (2003-2005) by publishing an extensive status report on the drug and alcohol situation in Norway in July 2005.

1.2.2 New action plan to combat drug and alcohol-related problems (2006-2008)

The government's new action plan to combat drug and alcohol-related problems (2006-2008) was presented on 17 August 2005. The action plan is in large part a prolongation of the action plan for 2003-2005 (NR 2004 chapter 1.2). The government wishes to continue a comprehensive drugs and alcohol policy based on a long-term approach and continuity as described in the action plan for 2003-2005. The vision, main objective and the most important strategic goals are same for alcohol as for drugs.

Vision:

Freedom from drug and alcohol-related problems.

Main objective:

A considerable reduction in the harmful effects of drug and alcohol abuse on health and society.

Important strategic goals:

- the prevention of all forms of alcohol and drug abuse, with particular focus on preventive work among children and young people;
- improved availability of effective advisory services, help and treatment for persons with drug and alcohol-related problems, and the families of such persons;
- a significant reduction in the incidence of drug and alcohol-related harm to health and the number of drug and alcohol-related fatalities.

Special strategic objectives for the drug policy are:

- to reduce the supply of illegal drugs;
- to combat drug abuse, experimentation and recruitment, particularly among children and young people under the age of 18;
- to increase the proportion of drug addicts who, with the help of public and private treatment and rehabilitation services, succeed in overcoming their addiction or significantly improving their quality of life;
- to establish satisfactory alternatives that make it possible to close down and combat public areas used for the sale of drugs and as gathering places for drug abusers;
- to reduce crime resulting from drug abuse.

Focus will still be on the youngest and most hardcore users, but efforts aimed at early intervention, rehabilitation and treatment, research and international cooperation will be strengthened.

The action plan is a framework plan that sets out the government's priorities for the period 2006-2008. Chief responsibility for follow-up lies with the relevant individual ministries. The work will be coordinated by the Ministry of Health and Care Services.

A proposal for increased allocations or re-allocations between the various priority areas will be presented during the ordinary budget process. Close collaboration is planned between ministries and directorates in order to ensure that strategies and interventions are coordinated as well as possible.

1.2.3 National strategy for quality improvement in the drug and alcohol field

In 2003, on assignment from the then Ministry of Social Affairs, the Directorate for Health and Social Affairs began work on a project related to improving the quality of measures for problem drug and alcohol users. The work on quality in the drugs and alcohol field is part of the Directorate's national strategy for quality improvement in the social and health services: "... and we expect things to get better!"

The Directorate for Health and Social Affairs appointed a working group, which has drawn up a proposal for quality improvement in the social and health services for drug and alcohol users. The working group has also proposed quality indicators for the drug and alcohol field. The group has also proposed areas in which professional guidelines are required. The Directorate for Health and Social Affairs is responsible for preparing professional guidelines in the health and social services field, and it will also be in charge of the work on producing guidelines for the drug and alcohol field. A plan for the work will be prepared once the group's recommendations have been considered in more detail.

1.2.4 Knowledge base for drug and alcohol education in schools

Schools are an important arena for the prevention of drug and alcohol-related problems. In 2003, the Ministry of Health and Social Affairs started work on developing a knowledge base for drug and alcohol education in schools. The background to this was the existence of many different players and measures in the field, and the fact that the measures varied in their effectiveness. This has resulted in an unclear situation for schools and teachers, as well as uncertainty with respects to the results in terms of prevention.

The knowledge base will make recommendations about the use of effective strategies and measures, and about how they can best be implemented. The development of the knowledge base will take place in collaboration with the Directorate for Primary and Secondary Education and the regional drug and alcohol competence centres, and it is scheduled for completion in 2006.

1.3 Budget and public expenditures

Several ministries and directorates have budget allocations that are spent in part on preventive measures aimed at young people in particular and in part on measures aimed at people in difficult situations who also have a drug or alcohol problem. It is not possible to provide a comprehensive overview here. See also chapters 7.1 and 9.1.

In law enforcement: No comprehensive overview is available.

In social and health care: No new overview is available.

Research (alcohol, drugs and tobacco): SIRUS. Allocation for 2004: EUR 3.56 million² million in operating funds.

National strategies:

The action plan to combat drug and alcohol-related problems 2003-2005. *The regional project for improved prevention in nine municipalities:* Amount: EUR 1 million per year over a three-year period.

Campaign to influence attitudes to alcohol: Amount: EUR 1.88 million in 2004.

1.3.1 Funding arrangements

In addition to the normal funding of operations through block grants to the municipal sector and the health authorities, the Ministry of Labour and Social Affairs and the Ministry of Health and Care Services have extraordinary funds at their disposal for the development of special high priority efforts in the areas of epidemiology, research, prevention and treatment. These funds are channelled through SIRUS, the Directorate for Health and Social Affairs, the regional drug and alcohol competence centres and specialised centres for substitution therapy and low-threshold measures. Since funds are allocated to a large number of public bodies, institutions and organisations, either for the funding of ordinary operations or as project allocations, it is very difficult to provide exact figures for specific areas.

In 2004, EUR 23.83 million was allocated from the budget of the then Ministry of Social Affairs to drug and alcohol-related measures and EUR 15.01 million to voluntary drug and alcohol prevention work. Among other things, the allocations are spent on;

² Conversion rate: 1 euro=NOK 8.00

- measures to prevent and reduce the use of drugs and alcohol;
- treatment and rehabilitation of people with alcohol and drug problems and prostitutes;
- trial schemes and development work relating to the social services;
- voluntary organisations and private foundations that work for disadvantaged groups;
- voluntary preventive efforts to promote a drug and alcohol-free lifestyle and drug and alcohol-free milieus.

Funds for trial schemes and development work are not earmarked exclusively for drug and alcohol measures, but a large portion of the funds are spent on measures targeting drug and alcohol users. Moreover, a significant proportion is spent on measures that indirectly benefit the target group, for example measures targeting prostitutes or other measures aimed at the development of social services in general. The Directorate for Health and Social Affairs administers the grant arrangements for voluntary organisations whose goal is to prevent drug and alcohol-related problems (cf. the allocation of EUR 15.01 million).

In 2004, the Directorate for Health and Social Affairs allocated a total of EUR 7.55 million to the seven drug and alcohol competence centres. The allocations are intended to cover normal running expenses and the development of interventions.

The guidelines for grants to projects and interventions under the auspices of NGOs were changed with effect from 2004. The change follows an evaluation of the grant arrangements. The purpose of the change is to strengthen voluntary drug and alcohol prevention efforts at the national level. When allocating funds, preference will be given to projects and measures that can substantiate that they have a preventive effect, and which have goals that can be evaluated.

2. Drug use in the population

In this chapter, the main results of the nationwide survey of the Norwegian population's use of drugs, and data from the annual questionnaire survey of young people between the ages of 15 and 20 will be presented. The surveys were conducted by SIRUS.

On the basis of the survey of the adult population it is clear that a steady, but not particularly marked, increase has taken place in lifetime prevalence for the use of cannabis. The proportions who report using cannabis during the last 12 months and the last 30 days, however, have been stable for the last ten years. As regards the use of other drugs, there has been no increase in reported lifetime prevalence.

The annual questionnaire surveys of young people in the 15-20 age group showed a clear increase in the latter half of the 1990s in the proportion who stated that they had ever used cannabis. However, the surveys for the last few years indicate that the increase has not continued but that it has declined compared with the top years 1998-2000. The same applies to the reported use of other drugs.

2.1 Drug use in the general population

Background and methods

The last survey of the population's drug use was carried out in autumn 2004 (see the data in standard table 01)³.

The methods have been changed somewhat over the years, and the number of questions has been increased. The surveys were carried out as part of wider surveys that were mainly concerned with alcohol consumption and attitudes to alcohol policy issues. Data collection in these surveys is carried out in the form of face-to-face interviews, but the questions about drugs were answered on a separate sheet which the respondent gave to the interviewer in a sealed envelope. The data concerning drugs was later linked to the other data from the interview survey. Surveys containing questions about drug use were carried out using the same methods in 1985, 1991, 1994, 1999 and 2004.

The respondents were selected through a three-step procedure. After stratification of all Norwegian municipalities into 17 strata by region, number of inhabitants and main source of employment, a master sample of municipalities was first selected. In each municipality a random selection was made of a number of start addresses, and from each start address the interviewers went to four new addresses following a specified system. They endeavoured to interview the person over the age of 15 who had most recently had a birthday. The addresses where the interviewers did not succeed in carrying out interviews were not revisited, the interviewers just continued until the desired number of interviews had been completed. The number of interviews in each stratum had to be proportional to the number of inhabitants. The method is believed to give a virtually representative sample of the population aged 15 and over. During the analyses, the samples are nonetheless weighted on the basis of gender, age and type of municipality (stratum) in order to correct known biases in the sample.

³ All standard tables referred to in this report have been submitted to the EMCDDA separately

In line with the EMCDDA norm, “the normal population” is defined here as persons between the ages of 15 and 64. Other definitions and age groupings may be used in other presentations of these data.

Changes in prevalence 1985-2004

Table 1 shows the proportion that answered that they have ever tried cannabis has increased from 8.5 per cent in 1985 to more than 16 per cent in 2004. The increase in lifetime prevalence has increased from survey to survey, a fact that is not surprising given the cumulative nature of the variable: if you have taken cannabis once, you will always thereafter “have ever tried it”.

Table 1: Percentage of the population between the ages of 15 and 64 that has taken cannabis: ever, during the last year and during the last 30 days, respectively

Taken cannabis	1985	1991	1994	1999	2004
.. ever	8.5	9.6	13.1	15.4	16.2
.. last year	2.2	3.0	4.4	4.5	4.6
.. last 30 days	-*	-	1.9	2.5	2.2

*- = no data available

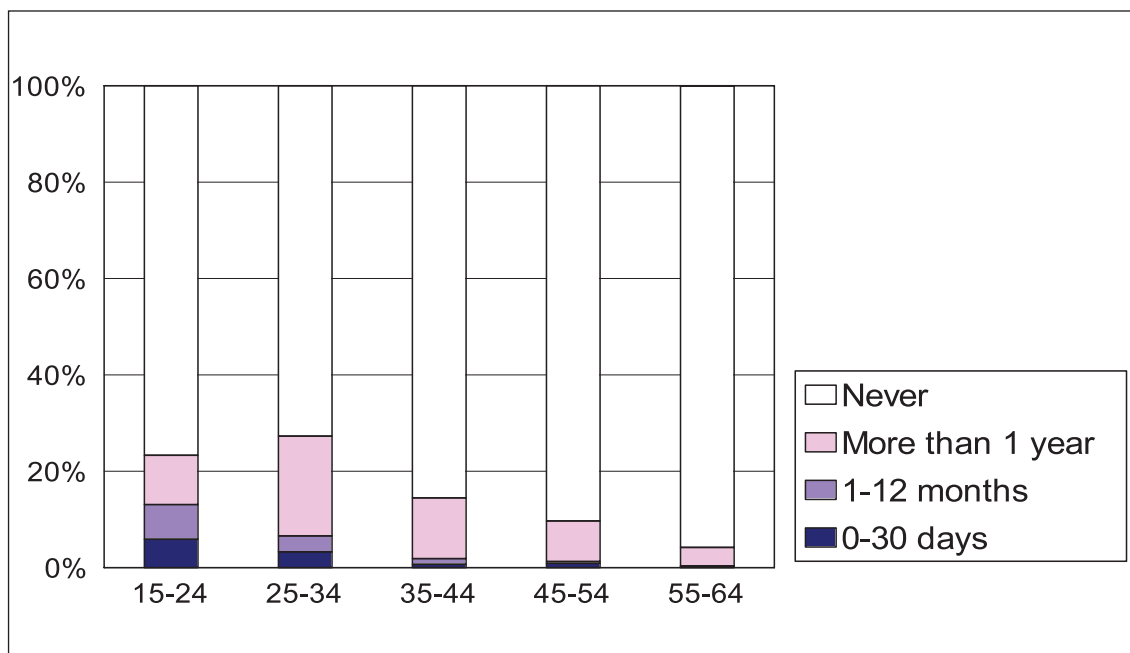
Source: SIRUS

A better measure of the actual use of cannabis is the proportion that has taken it during the past year. The table shows that this group increased from 1985 to 1994, but that it remained stable at around 4.5 per cent until 2004. Since 1994, we have also had data for the proportion reporting that they have taken cannabis during the past 30 days. This group appears to vary more, but the changes are not statistically significant.

Figure 1 shows how the proportions who state that they have taken cannabis: ever, during the last 12 months and during the last 30 days, varied with age. The whole coloured column represents lifetime prevalence, the two darkest fields represent the proportion that have taken cannabis during the last year and the darkest part shows the proportion that have taken cannabis during the last 30 days. The white part of the columns represents those who have never taken cannabis, and this group constitutes a large majority in all age groups.

The lifetime prevalence is greatest in the 25-34 age group, while both the proportion that have taken cannabis during the last year and the last 30 days is highest in the 15-24 age group. A more-detailed subdivision of the age groups shows that the proportion that have taken cannabis during the last year is highest between the ages of 20 and 24, and the same applies to the proportion who have taken it during the last 30 days.

Figure 1: Percentage in different age groups in 2004 who have taken cannabis: ever, during the last year and during the last 30 days, respectively



Source: SIRUS

The difference between the genders is relatively large with respect to the use of cannabis. Further analysis of the differences is presented in chapter 11.

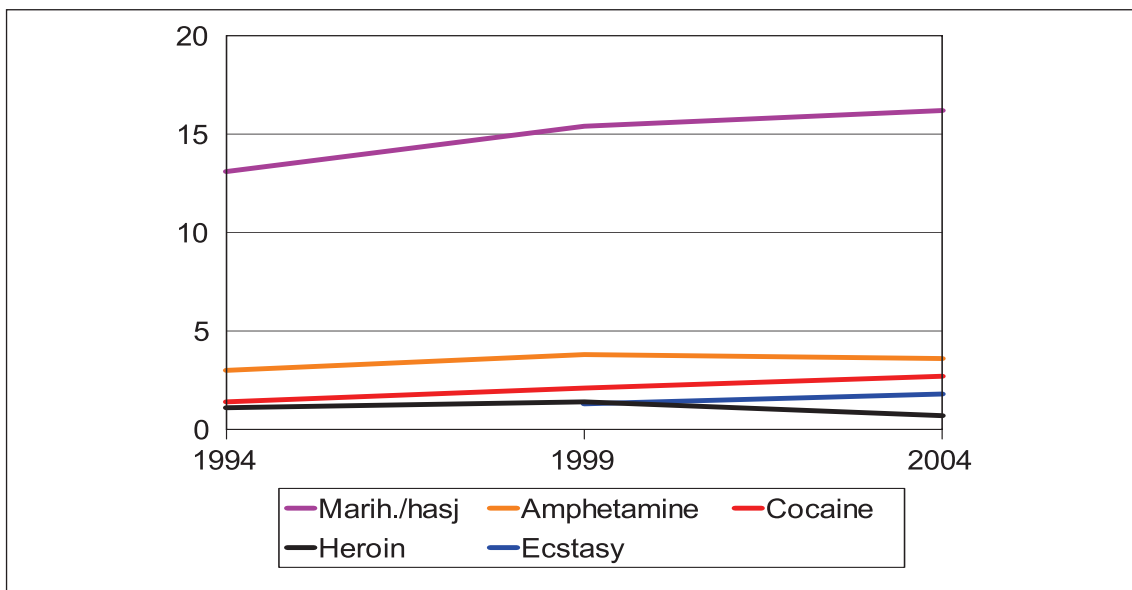
In the three last surveys (1994, 1999 and 2004) questions were also asked about the use of other drugs, and figure 2 shows the lifetime prevalence for these drugs. Cannabis has also been included for the purpose of comparison.

Figure 2 shows that the lifetime prevalence for all the drugs is much lower than for cannabis. While the lifetime prevalence for cannabis has increased during the whole period, it has remained more stable at a relatively low level for the other drugs. Prevalence is highest for amphetamine, which was as high as 3.8 per cent in 1999, but which was lower in 2004.

The proportions that state that they have taken the different drugs during the last year is shown in figure 3. Here too, the prevalence for cannabis has been included for the sake of comparison. We see that while the proportion of cannabis users appears to be very stable, the answers indicate that the proportions that have used the other drugs have largely tended to decrease. The numbers are very small however, and random factors may result in relatively large changes. With the exception amphetamine, which was as high as 1.4 per cent in 1994, all the preferences are under 1 per cent.

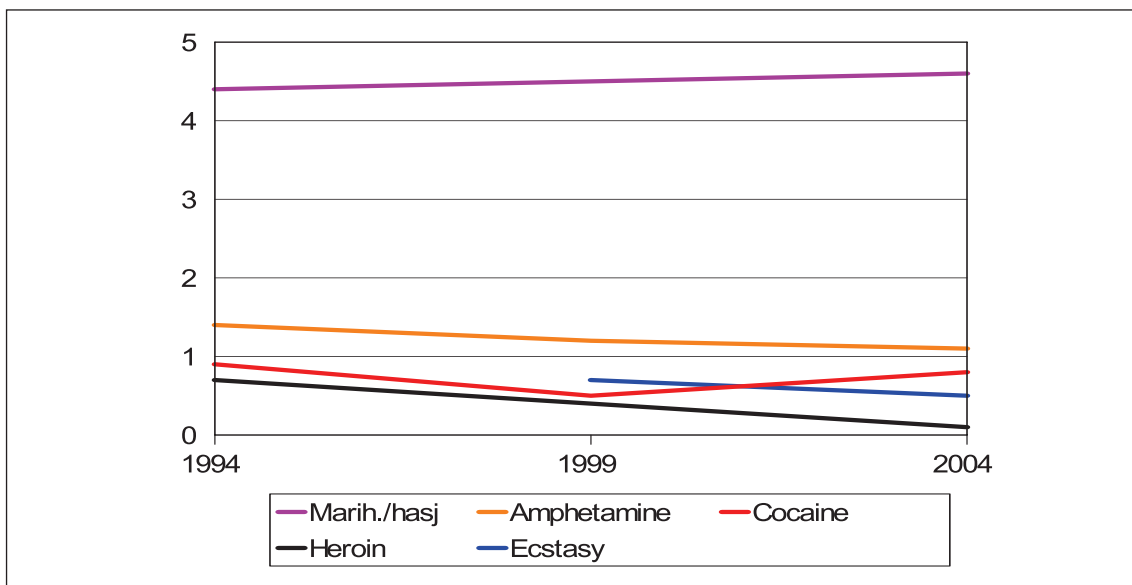
The figures for use during the last 30 days are so small for all the drugs (except for cannabis) that it is not possible to say anything about developments. In 2004, the figures were all below 0.3 per cent.

Figure 2: Percentage of the population between the ages of 15 and 64 that have ever used various drugs



Source: SIRUS

Figure 3: Percentage of the population between the ages of 15 and 64 that have used various drugs during the last 12 months



Source: SIRUS

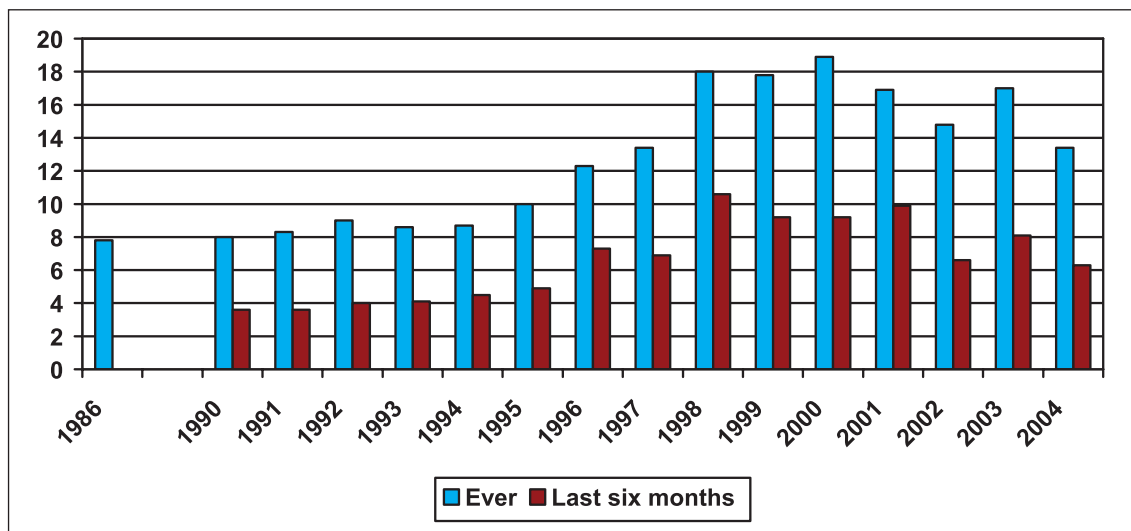
2.2 Drug Use in the youth and school population

No new nationwide schools surveys were carried out during the reporting period.

2.2.1 Annual youth survey 2004 – some main findings regarding the use of illegal drugs

The annual questionnaire survey for 2004 on the use of alcohol and drugs among youth between the ages of 15 and 20 shows that there has been a decline in the use of illegal drugs since the turn of the millennium. This applies first and foremost to the proportion that state that they have taken cannabis. In 2004, 13 per cent of the 15-20 age group in the whole country reported that they had ever taken cannabis. Similarly, 6 per cent reported that they had taken cannabis during the last six months (figure 4).

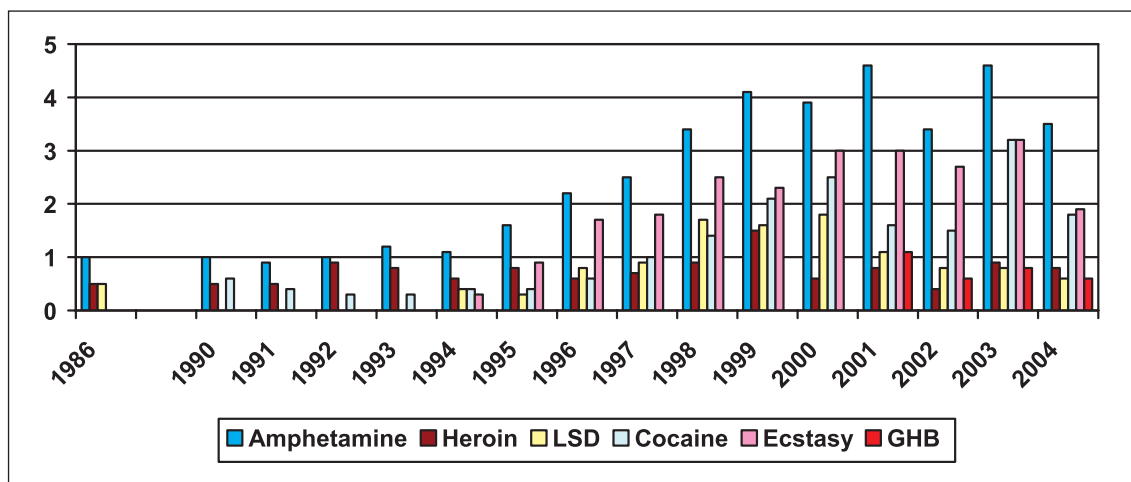
Figure 4: The percentage of youth between the ages of 15 and 20 who state that they have taken cannabis; ever and during the last six months, 1986-2004



Source: SIRUS

The proportion that state that they have used other drugs has also stagnated/ declined in recent years (figure 5). For example, the proportion of 15-20 year-olds stating that they have ever used amphetamine has been 4-5 per cent, while the proportion stating that they have ever used ecstasy has remained at around 2-3 per cent for several years.

Figure 5: Percentage of youth between the ages of 15 and 20 in Norway who have ever used various drugs, 1986 - 2004



Source: SIRUS

There does not seem to have been any increase in the availability of illegal drugs in recent years measured through questions about whether young people had been offered various drugs. The proportion of 15-20 year-olds who state that they have ever been offered cannabis has been around 40 per cent for the last five years, while the proportion who believe that they could obtain cannabis in 2-3 days if they so wished was around 60-65 per cent. The proportion who state that they have been offered amphetamine and ecstasy, was around 13-17 and 9-14 per cent, respectively.

Otherwise, the 2004 survey confirms the tendency we have seen in recent years that the proportion expressing a positive attitude to drugs is no longer increasing. During the last two to three years, approximately 10 per cent of 15-20 year-olds have expressed the opinion that it should be permitted to sell cannabis freely in Norway.

Statistical margins of error

The figures are subject to statistical margins of error and must be interpreted with care. Until the mid-1990s, approximately 70 per cent answered the questionnaire, but the response rate has fallen to slightly below 50 per cent in recent years. The falling response rate gives further reason to emphasise that there is uncertainty attached to the results from one single year. There is reason to believe that young people who regularly use drugs, either cannabis or stronger substances, will be underrepresented in the surveys. However, since the surveys have been carried out over many years, they represent time series that are of considerable value in measuring changes in trends (www.sirus.no).

2.3 Registration of the drug situation in Norwegian municipalities

SIRUS carried out the first surveys of the drug situation in all Norwegian municipalities (434) in 2002 and 2003. See also NR 2003 chapter 2.2.1.

Questionnaires were sent to the health and social services, police stations/rural police authorities and to outreach workers in municipalities with such services. The response rate from the health and social services and the police was good, 77-88 per cent in 2002 and 80-91 per cent in 2003. The response rate among outreach workers was low, on the other hand, 50 per cent on average. Everyone did not answer all the questions, however.

Table 2 shows that in 2002 and 2003 around half of the municipalities stated that no change had taken place in the drug situation since the previous year. However, the proportion of municipalities with a stable situation varies for the different types of drugs. For cannabis and amphetamine, approx. half of the municipalities report an increase in the number of users for both years, and the illegal use of tranquillisers appears to be becoming more common. The use of cocaine and solvents has increased least, and relatively many of the municipalities report that the occurrence of these substances cannot be proven in the municipality. The use of opiates and ecstasy is also increasing in some municipalities, but there is also a relatively large proportion of municipalities which report fewer users or that such drugs do not occur. It is characteristic that the police and social and health services evaluate the tendencies fairly similarly for most drugs, even though they have quite divergent views on the use of individual drugs, such as opiates and cocaine.

Table 2: The informants' assessment of changes in the number of users of selected drugs. 2002 and 2003

Type of drug	More users		No change		Fewer users		No users		Municipalities	
	HS*	P**	HS	P	HS	P	HS	P	HS	P
	Percentage								Number	
Cannabis										
2002	51	51	44	46	4	2	1	0	247	313
2003	45	42	49	55	3	2	3	1	314	377
Amphetamine										
2002	50	54	41	39	5	5	3	2	239	298
2003	42	42	46	49	5	5	7	4	296	363
Cocaine										
2002	9	20	57	37	4	3	30	40	164	208
2003	8	19	43	38	5	2	44	42	236	290
Opiates										
2002	27	16	53	62	12	10	7	12	215	250
2003	21	13	52	57	10	11	17	19	272	319
Solvents										
2002	5	3	64	54	13	17	18	26	152	167
2003	7	4	57	52	11	7	25	37	214	258
Tranquillisers										
2002	52	48	41	45	3	4	4	3	223	248
2003	43	28	49	62	3	3	5	6	276	316
Ecstasy										
2002	28	30	53	40	10	15	9	15	194	227
2003	15	11	52	44	12	20	21	24	247	296

* The health and social services

** The police

Source: SIRUS

A great deal of uncertainty will be attached to any attempt to estimate the extent of drug use in general, and intravenous drug use in particular, in a municipality and in Norway as a whole. In the survey, 'drug abuse' and 'drug users' were not defined, so that it is the respondents' own assessment that is used. The figures thus include more than just intravenous drug users.

Based on the estimates of the health and social services, the police and outreach workers, the number of drug users (again, in the respondents' opinion), has been calculated with a high degree of certainty to lie between 52 000 and 82 000 in 2002 and correspondingly between 53 000 and 90 000 in 2003. The breadth of the ranges reflects the great uncertainty pertaining to the figures. The median point in such ranges is often the best estimate, but for this type of data it is unclear whether this is correct. The figures for the big towns and cities will have a lot to say for the total figures, for which uncertainty is greatest.

Even though there is probably a certain amount of drug abuse in most municipalities, the problem seems to be of limited extent in most of them. More than half of the country's municipalities report that the number of drug users is less than fifty, and in approximately one fifth of them there are less than ten drug users. Since some municipalities have not provided such figures, these will be minimum figures. There are few municipalities that have reported more than 500 drug users. The ones that have are big towns and municipalities with large populations.

Comments on methodology

The data material is based on a lot of information and thorough work in connection with the completion of the forms. Nevertheless, the design and implementation of the survey and the response rate indicate methodological problems:

In many contexts respondents are asked for their assessment of the situation. The answers will often be coloured by the respondents' subjective perception of the situation. The respondent or the person responsible for returning the form is not necessarily the same person from year to year. If the form is completed by different persons, a more or less unchanged situation may be assessed differently. Certain concepts in the questionnaire can be perceived differently depending on the respondent's interpretation in the context in which the question is put. The definitions are not always unambiguous.

There may be different thresholds for reporting changes in the drug situation in the municipalities. It may also be deemed to be more unfortunate to underestimate problems than to overestimate them. Some of the respondents will probably overestimate the extent of the problems rather than estimating figures that are too low. On the other hand, drug abuse may occur that is as yet unknown to the respondents, and they may therefore underestimate the real problems. All in all, the results must be interpreted with a certain amount of caution and they should be seen in conjunction with other information. As we become more familiar with the strengths and weaknesses of such data and obtain longer time series, their utility value may increase and our knowledge of different aspects of drug abuse in Norway improve (Amundsen, Lalla 2005).

2.4 Mapping surveys in major Norwegian cities – Early warning systems

"Føre var" (earlier warning system) is a mapping system aimed at detecting new abuse patterns in drug and alcohol use (see the discussion in NR 2004 chapter 2.4).

The "Earlier warning system" has been established in the big towns Bergen, Oslo and Drammen (from 2005). The projects are primarily aimed at youth and young adults. Organisational features, such as the number and type of informants – formal and informal – vary between the three towns, but the methodology has many points in common. The focus is broad and directed at alcohol, drugs and the illegal use of prescription drugs. The use of tobacco is monitored in two of the towns.

Routine indicators are compiled, i.e. factual data and statistics, such as the sale of alcohol and statistics for seizures at town/municipality level etc, as well as more sensitive indicators: information from a variety of informants. These include professionals from different services/ agencies, adults who are in close contact with various youth subcultures and young people who are either users themselves or who there is reason to believe know about general drug and alcohol use and/or new trends among youth.

Bergen has published two six-monthly reports, in November 2004 and May 2005. Oslo's most recent report is from November 2004, while Drammen published its first trend report in June 2005.

Some main findings relating to the drug and alcohol situation:

Bergen (autumn 2004/ spring 2005):

- Stable situation or gradual increase in the use and availability of illegal drugs.
- Increase in the use and availability of central stimulants.
- A complex picture with respect to the abuse of prescription drugs.

(www.bergenclinics.no)

Drammen (spring 2005):

- Cannabis is the most common illegal drug.
- Cocaine appears to have become more widespread.
- Cocaine is smoked more than previously.
- Most drugs are used today in most social arenas.

(www.uteteamet.no)

Oslo (summer/ autumn 2004):

- Few changes in drug and alcohol use among young people.
- Alcohol and cannabis are of most concern to professionals.
- Young girls and drug and alcohol-related issues is an increasing source of concern.
- Fewer young people smoke cigarettes, more of them use oral moist snuff.

(www.rusmiddeletaten.oslo.kommune.no)

Since the “earlier warning” projects build on a mixture of secondary data and subjective points of view from informants, the data from the three towns cannot be directly compared. Several of the methodological weaknesses mentioned in connection with the survey of municipalities (chapter 2.3) will probably also be present here. The advantage of the “earlier warning” model is its ability to serve as a barometer, indicating changes in the situation in the towns in question. Personal contact with or between regular informants means that the information is relatively reliable. Moreover, the short interval between each publication means that the information is topical.

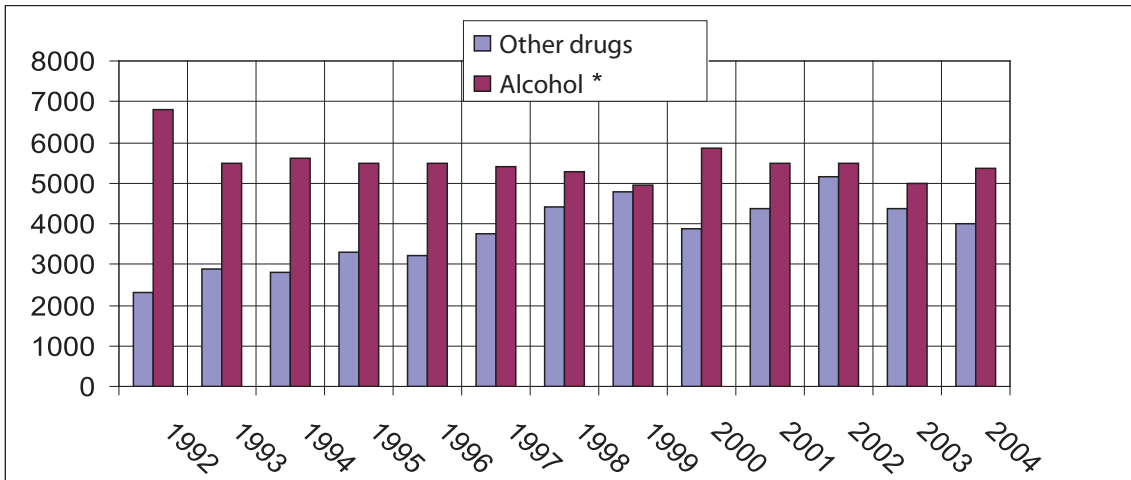
2.5 Drugs and driving

The statistics relating to driving under the influence are monitored by the Division of Forensic Toxicology and Drug Abuse at the National Institute of Public Health. The statistics relating to tests for the last two years show that the extent of detected driving under the influence of alcohol or other substances has been reduced somewhat (see also chapter 6.4.1).

In both 2003 and 2004, there was a certain decrease in the number of road traffic cases involving suspicion of driving under the influence of other substances other than alcohol (figure 6). This is unlikely to be due to fewer people driving with such substances in their bloodstream. The police, who have to cover the costs of drug analyses, may in some cases have refrained from ordering an analysis for budgetary reasons. These costs were previously covered by the Ministry of Justice and the Police.

For medicinal products the trend in analysis results for individual substances correlates well with the statistics from seizures registered by the Norwegian National Criminal Investigation Service (NCIS). One example is flunitrazepam (Rohypnol), for which the number of detections in traffic cases increased significantly during the period 1999-2002 (nearly doubling each year), whereas a significant decrease was registered in 2003 and 2004. A corresponding fall in seizures of Rohypnol was registered by the NCIS during the same period (chapter 10.2). The reason for the reduced availability of Rohypnol on the illegal market was probably the fact that the authorities succeeded in stopping the activities of an international criminal organisation that was responsible for most of its illegal transportation (Institute of Public Health).

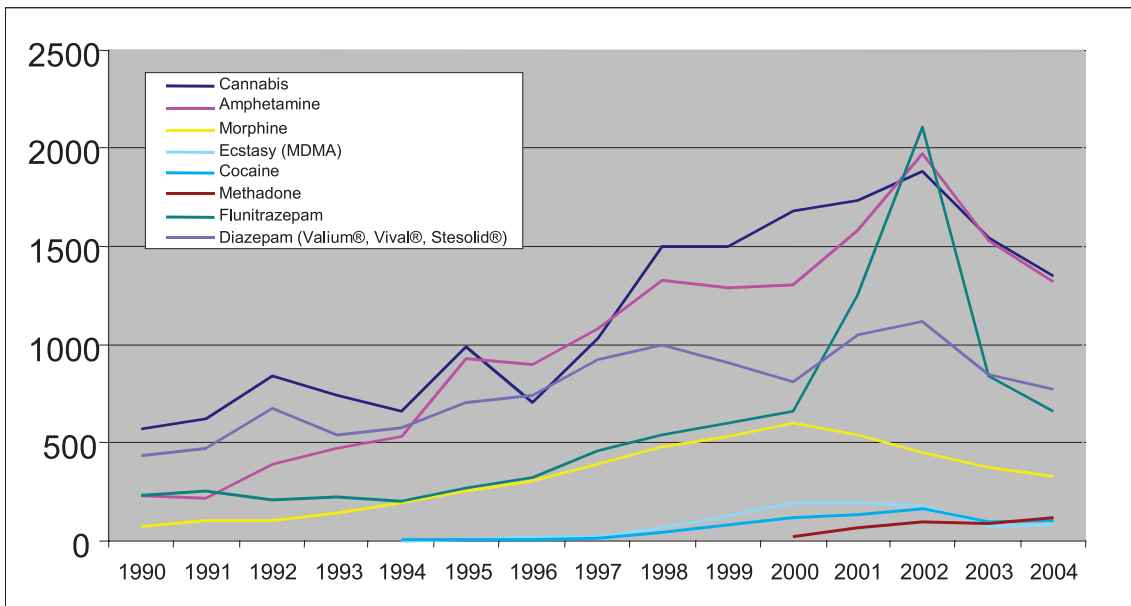
Figure 6: The number of road traffic cases received by the National Institute of Public Health 1990-2004 involving suspicion of being under the influence of either alcohol or other substances



* Approved breath tests conducted by the police using the analysis instrument Intoxilyzer 5000N are included (from 1995).

Source: Institute of Public Health

Figure 7: Drug finds (mainly illegal) in road traffic cases received 1990- 2004



Source: Institute of Public Health

3. Prevention

3.1 New national strategies and goals

In the government's action plan to combat drug and alcohol-related problems 2006-2008 (chapter 1.2.2) the prevention of all types of drug and alcohol-related problems, with particular focus on preventive efforts among children and young people, is mentioned as an important strategic goal. It is stated that the prevention of drug and alcohol-related problems must be viewed more in conjunction with general prevention. The methods used to prevent and intervene early against behavioural problems at school, such as bullying or smoking, or measures to prevent and intervene early against criminal behaviour, also prevent drug and alcohol-related problems. Drug and alcohol-related prevention efforts must therefore be integrated to a much greater extent with the rest of the preventive and support services.

Four target areas in the action plan:

- 1) The field of prevention will be reviewed, and a plan will be drawn up that describes how cooperation between the authorities and voluntary organisations can best be achieved.
- 2) In the action plan emphasis is placed on strengthening early intervention efforts aimed at children and young people at risk, children of parents with drug and alcohol problems and children and young people from immigrant backgrounds. The plan also maintains that it is necessary to focus more on prevention and early intervention in connection with drug and alcohol-related problems in the workplace.
- 3) The government believes that it is necessary to increase expertise in identifying children of drug and alcohol abusers, and increasing knowledge about the special needs of children who live with parents with drug and alcohol problems. A pilot project has been instigated for the systematic testing and development of interventions in selected municipalities in order to follow up children whose parents have drug and alcohol problems. Guidelines are also being prepared for agencies that provide services to adults with drug and alcohol problems and persons with mental health problems, to ensure that the children also receive the necessary help. The government will carry out systematic testing and development of interventions in treatment institutions in which children accompany their parents during treatment.
- 4) A research project will be instigated for children and young people from immigrant backgrounds in order to find out more about how MST (multisystemic therapy) works in such families. In our experience, such interventions have a good effect in relation to Norwegian families with children with behavioural problems (Ministry of Labour and Social Affairs, 2005).

3.2 Universal prevention

Interventions in schools

Schools are an important arena for preventive work in Norway. Drugs and alcohol education is based on a set curriculum and is an integrated part of ordinary tuition. It is a common feature of the school programmes and interventions that are implemented in schools that they primarily influence factual knowledge about drugs and alcohol, while it is difficult to identify any effect on behaviour. Roughly 90 per cent of schools implement one or more school programmes. Other measures which

schools have used in order to prevent serious behavioural problems and contribute to the development of social competence come in addition (structured questionnaire 22)⁴.

The Directorate for Health and Social Affairs is working on a knowledge base and on developing a strategy for bringing together and coordinating drug and alcohol prevention efforts in schools (see chapter 1.2.4).

The Directorate for Primary and Secondary Education has drawn up a comprehensive plan for the environment in which young people learn and grow up 2002-2005: "A secure and stimulating environment in which to learn and grow up". Preventive measures are one of three important target areas. The Directorate for Primary and Secondary Education has produced two brochures: "Serious behavioural problems – on prevention and mastery in schools". The brochures provide guidelines for school owners, school managements and teachers on work with children who are in the danger zone, in relations to drugs and alcohol, among other things.

Evaluation of the Drugs and Alcohol Helpline (RUStelefonen)

The Drugs and Alcohol Helpline is a service for those who wish to obtain factual information and advice about drugs and alcohol and related abuse, as well as advice about the treatment of such abuse. The main target group consists of young people who experiment with drugs and alcohol and their families. The helpline is run by the Oslo Drug and Alcohol Addiction Service on assignment from the Directorate for Health and Social Affairs. It is a three-year project scheduled to run from 2003 to 2005. During 2005, the Directorate for Health and Social Affairs will consider whether to continue the service and whether to make any changes in its operation.

The Drugs and Alcohol Helpline was evaluated by the University of Oslo in spring 2004. The evaluation includes a description of the system, an evaluation of goal attainment, user satisfaction and the population as a whole and the target group's familiarity with the service. The evaluation shows that 41 per cent of callers were men, while 59 per cent were women. Family members accounted for 36 per cent of the calls, while only 18 per cent fell into the category "young drug and alcohol abusers". Of the conversations, 4 per cent were described as support and guidance conversations with young people. The evaluation concludes that callers were satisfied with the conversation with the Drugs and Alcohol Helpline counsellors. Those who sought advice were most satisfied, while those who wanted factual information were less satisfied.

Evaluation of AKAN

AKAN – the Tripartite Committee for the Prevention of Alcohol and Drug Problems in the Workplace – which was established in 1963, is a tripartite collaboration between the Norwegian Confederation of Trade Unions, the Confederation of Norwegian Enterprises and the state. The purpose of AKAN is to combat drug and alcohol-related problems in Norwegian workplaces, to enable managers and employees to intervene in connection with risky drug and alcohol use, and to help employees with drug or alcohol problems to obtain assistance. Efforts are aimed at all workplaces in Norway both in the private and public sectors and in large and small enterprises. Almost two out of five employees work in enterprises with a drug and alcohol prevention service organised in accordance with the AKAN model, and AKAN is represented in all industries and business sectors.

AKAN's activities have been evaluated by the Work Research Institute on assignment from the Directorate for Health and Social Affairs. The main findings show that AKAN should continue with its basic model. In order to meet new challenges, AKAN should develop its service and play a more dynamic and proactive role. Establishing and running an AKAN service requires resources, and the

4 All structured questionnaires referred to in this report have been submitted to the EMCDDA separately

AKAN model is used less by small enterprises. AKAN should therefore develop its methods in order to reach new groups in the workplace (Frøyland, Grimsmo og Sørensen, 2005).

3.3 Local community-based prevention

See information in structured questionnaire 25.

The ongoing regional project is part of the government's action plan to combat drug and alcohol-related problems (2003-2005) (NR 2004 chapter 3). The overriding goal is to reduce the prevalence of drug and alcohol use and the harmful effects of the use/abuse of drugs and alcohol by strengthening preventive efforts at the local level. The project is based on a model for local community-based prevention that comprises a number of different measures and strategies that are adapted to local needs and instigated simultaneously. The project is unique in the Norwegian context. The Directorate for Health and Social Affairs has overall responsibility for the project, which is evaluated by SIRUS.

The evaluation consists of a process evaluation and an effect evaluation. The final evaluation report will be completed in spring 2007. On the basis of the evaluations, it will be considered whether it is desirable and expedient to extend the model used by the regional project to also include other municipalities. SIRUS has written a method memorandum on the evaluation.

School surveys are an important source of evaluation data in the regional project. The first school survey, which was conducted in autumn 2004, comprised all students in all years of lower secondary school and upper secondary school in both the project municipalities and the control municipalities. The students complete a questionnaire at school (during school hours). A corresponding questionnaire survey of all six school years is conducted one and two years after the baseline survey.

The process evaluation analyses how the signals from central decision makers are translated into practical action in the municipalities. Qualitative interviews, observation and document studies show how the professional and financial support provided to project municipalities results in local priorities. The process evaluation also focuses on how variation in local framework conditions results in differences in the design, implementation and maintenance of various preventive measures.

3.4 Selective/indicated prevention

See information in structured questionnaire 26.

The Government's action plan (2006 – 2008) emphasises the situation of children as a particularly important target area, and the Government wants to increase efforts to enable intervention to take place as early as possible. An overriding objective, and one of the main tasks in work with problem drug and alcohol users, is early intervention and in particular better efforts aimed at children and young people at risk.

National strategy for early intervention against problem drug and alcohol use

The Directorate for Health and Social Affairs has been assigned responsibility for drawing up a programme for prevention and early intervention. The programme is based, among other things, on experience from a research project into drugs and alcohol and the workplace and a report on "The responsibilities of the primary health service in drug and alcohol treatment and preventive drug and alcohol efforts". Together with the drug and alcohol competence centres, the Directorate for Health and Social Affairs will develop a national strategy for early intervention against problem drug and alcohol use. The strategy will be very similar to secondary or selective prevention, but the prevention will specifically target risk groups before drug and alcohol problems arise, and early intervention will be based on intervention in relation to an experienced or observed drug or alcohol problem.

Help for children of parents with mental health problems or drug and alcohol problems

The Directorate for Health and Social Affairs will draw up guidelines for agencies that provide services to adults with drug and alcohol problems and persons with mental health problems, to ensure that the children also receive the necessary help.

Systematic work with small children in risk families

In cooperation with the national childcare services, the Directorate for Health and Social Affairs will evaluate experiences from systematic work targeting families at risk with small children, in Norway and possibly in other countries, with a view to formulating recommendations for implementation on a national basis.

Multisystemic therapy (MST)

MST is a method of treatment that targets young people aged between 12 and 18. The method entails close follow-up of the individual youths involved, their families and local environment. The treatment is given through the child welfare and family welfare services. Training started in 1998, and so far the evaluation results are positive. Research from the USA shows a considerable reduction in behavioural problems, including drug and alcohol problems, both at home and in school.

MST has been developed as a method by MST Services and the Medical University of South Carolina in Charleston, USA. In Norway, the implementation and follow-up/quality assurance work is led by the Behavioural Centre – Unirand, which is wholly owned by the University of Oslo. The MST teams are organised under the child, youth and family services in the five regions.

MST is being evaluated in three counties. The purpose is to throw light on what young people between the ages of 12 and 17 with behavioural problems, and their families, gain from MST or child welfare measures under the auspices of the county authorities. The 100 young people involved and their families were randomly assigned to MST (N=62) and other measures under the auspices of the child welfare services (N=38). Data collection started in 2000, and the young people were registered on admission, and followed up after approximately six months and two years. The most important causes were crime, alcohol and drug abuse, unauthorised absence from school, running away from home and other serious behavioural problems. 44 per cent had three or more referral reasons and 39 per cent has previously been placed outside the home. The average age of participants in the project was 15 years, and 37 per cent were girls.

Participation in the evaluation project was voluntary, and the families were paid a small compensation for completing the questionnaires. 96 families took part in the follow-up after six months, while 89 took part after two years. The results of the evaluation have yet to be published.

Cause-for-concern interviews

The Ministry of Justice and the Police has drawn up guidelines for the police's carrying out of cause-for-concern interviews with children and young people, particularly with a view to involving parents when law breaking or other risk behaviour is discovered in children under the age of 15. The police's cause-for-concern interview with young people who behave in a way that empirically entails a great risk of law-breaking and negative developments is an important measure.

3.5 Prevention database

The database is part of the website www.forebygging.no, an interactive arena for prevention and health promotion work in Norway (see NR 2004 chapter 3.2.5). The database is intended to provide an overview of Norwegian drug and alcohol prevention measures, to document the use of various drug and alcohol prevention activities and to increase expertise in evaluation. The website will

highlight prevention measures that can document results of their work in order to focus on the good examples. The method used is an interactive registration form with a pertaining learning tool on evaluation linked to a searchable database. The development work will be completed in autumn 2005, but the website has already been in operation since January. So far, the database comprises 74 projects, 44 of which are national (www.forebyggingstiltak.no).

3.6 Continuing education

Continuing education for social workers and health personnel was discussed in NR 2002 chapter 9.4 and NR 2003 chapter 9.2.

Continuing education in outreach work was described in NR 2004 chapter 3.2.4. The education is a collaboration with Oslo University College, the National Association of Outreach Workers and the Oslo Drug and Alcohol Addiction Competence Centre. Its primary goal is to increase knowledge and skill levels in outreach work through comprehensive and systematic training. The first class – 17 students – completed the course in spring 2004. A new class with 25 students started in September 2005.

4. Problem drug use

4.1 Prevalence and incidence estimates

Based on statistics for overdose deaths, intravenous drug use in Norway was estimated in 2002 to involve between 11 000 and 15 000 persons. Work is being done with a view to changing the basis for calculating the so-called fatality indicator, but it has yet to be completed (see also NR 2004 chapter 4.1). There is therefore no such new estimate available for the reporting period.

SIRUS has continued its work to develop alternative methods of calculating the number of hardcore drug users based on surveys of the drug situation in the municipalities.

4.2 Profiles of clients in treatment

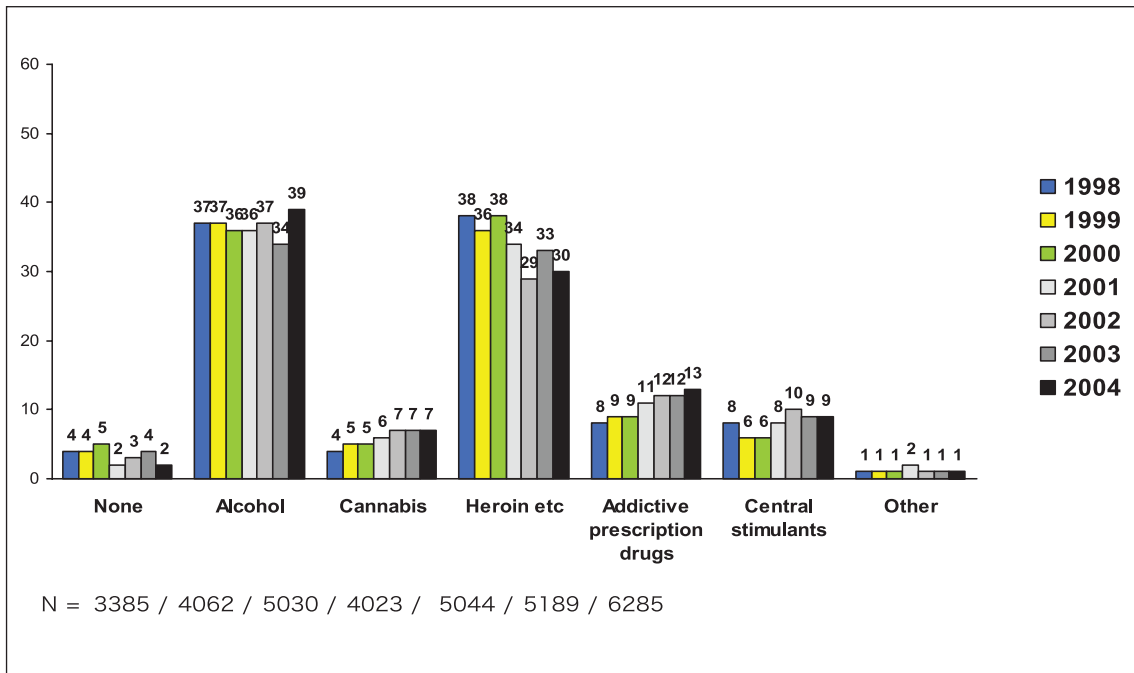
In cooperation with the Bergen Clinics Foundation, SIRUS operates a nationwide client registration system in Norway (NR 2003 chapter 3.1).

The data basis includes both alcoholics and problem drug users. Since the data is only available in **aggregate form**, the overviews do not tell us how many individuals are involved in the number of queries, admissions and conclusions, which means that it is not possible to check for duplicate registrations. The fact that the system is based on aggregate data also means that variables cannot be compared at the individual level. The individual variables can only be shown distributed by gender, geographical unit (region or county) and type of measure. It is also possible to show the variables distributed by combinations of gender, geographical unit and type of measure.

In 2004, 24 485 admissions were registered in treatment/ care measures. Seventy per cent of them were men, 30 per cent women. In 2003, the corresponding figure was 19 656 (69 per cent men, 31 per cent women). The increase is probably due to greater participation and more complete reporting.

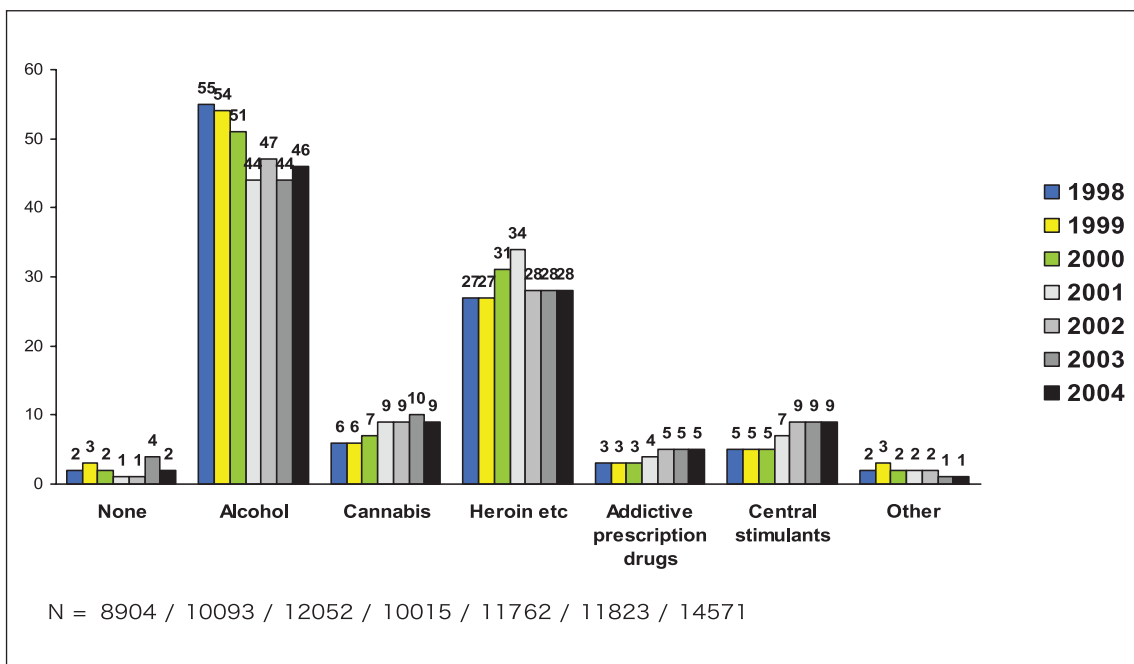
Figures 8 and 9 show the most used substance on admission for the years 1998 to 2004, for men and women separately (see also selected issue Gender differences chapter 11).

Figure 8: Most used substance on admission 1998-2004. Women. As percentage



Source: Bergen Clinics Foundation

Figure 9: Most used substance on admission 1998-2004. Men. As percentage



Source: Bergen Clinics Foundation

While there is reason to believe that the “most used substance” has been registered in a relatively uniform manner, the registration practice may have varied somewhat with respect to medicinal products containing opiates. They may have been registered under both “Heroin/ other opiates” and under “Addictive prescription drugs”. Alcohol and heroin dominate as the most used substances for both women and men.

Among women, the proportion stating that alcohol is the most used intoxicant has been approximately the same as the proportion stating that they use heroin (34 and 33 per cent respectively in 2003), while in 2004 a greater proportion of women stated that alcohol (39 per cent) was the most used intoxicant. Among men, alcohol was stated to be the most used intoxicant by the greatest proportion (46 per cent in 2004), while a somewhat lower proportion stated heroin (28 per cent in 2004). Among men, the tendency seems to be towards a decline in the proportion that have alcohol as their most used intoxicant and an increase in the proportion that have illegal substances other than heroin as their most used drug.

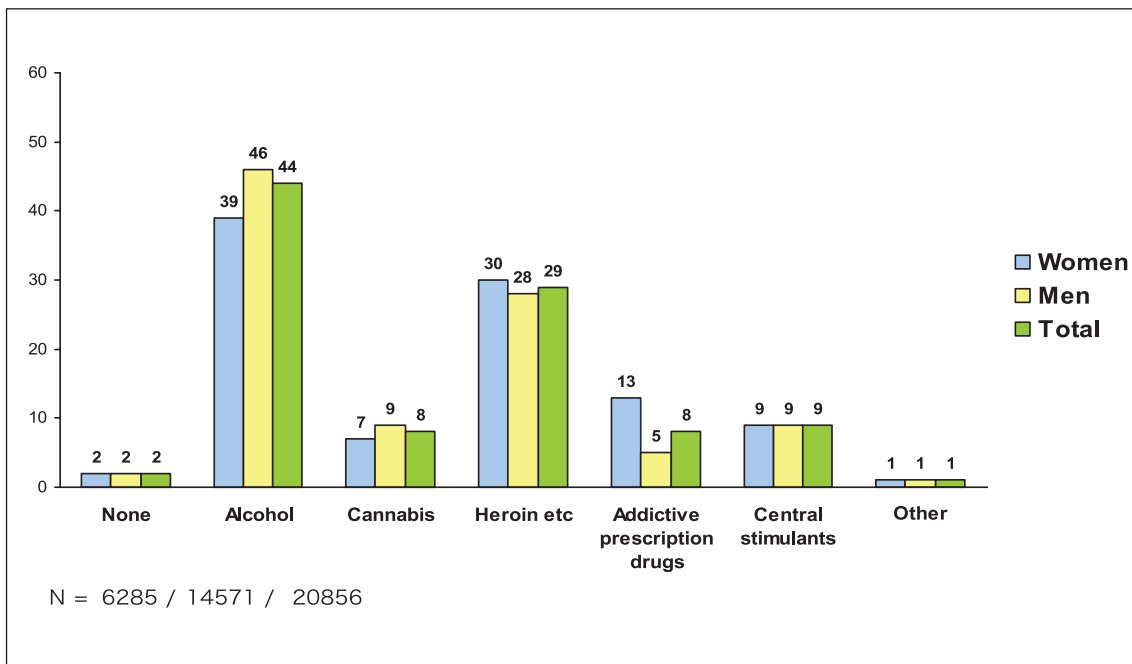
A clearly larger proportion of women (13 per cent in 2004) than men (5 per cent) reported addictive prescription drugs as the most used substance. This also includes patients/clients who have become addicted to prescription drugs which they have been given as part of normal medical treatment.

The proportion citing cannabis as the most used substance has increased somewhat in recent years, but it is still relatively low for both genders.

“No” drugs applies to a small number of patients/clients who state that they have not taken drugs or alcohol during the last six months, but who attend treatment/interventions to avoid a relapse.

Figure 10 shows a direct comparison of the percentages for women and men with respect to the most used substance in 2004. The gender difference is greatest with respect to alcohol and addictive prescriptive drugs.

Figure 10: Most used substance, 2004. Percentage



Source: Bergen Clinics Foundation

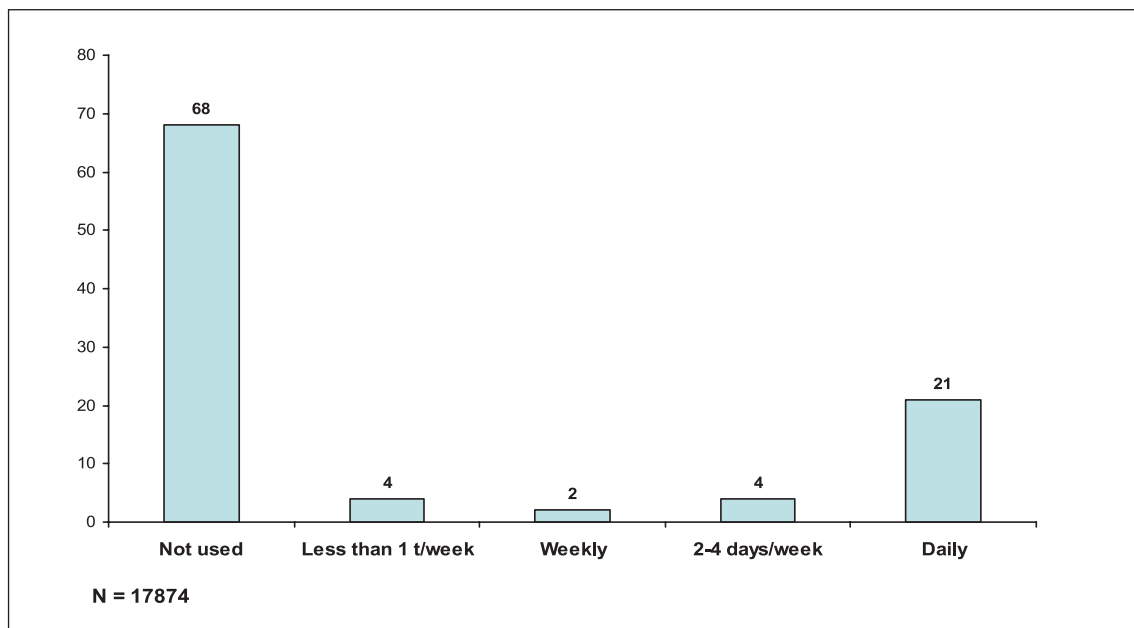
LSD, ecstasy and solvents are categorised under “other”. In 2004, “other” was the most used substance in 152 cases (1 per cent). Ecstasy was cited as the most used substance in 31 cases in 2004.

The use of more than one substance was not reported in a third of the admissions in 2004. A check of the data basis from individual measures shows that this applies overwhelmingly to persons who

cite alcohol and much less to those who cite addictive prescription drugs as the most used substance. Addictive prescription drugs were “the second most used substance” in the largest proportion of admissions (approx. a quarter), followed by cannabis and central stimulants. The situation was the same in 2001, 2002, 2003 and 2004. Alcohol and heroin are more seldom cited as the second most used substance.

Figure 11 shows that daily (or almost daily) injecting was normal among the majority of the 32 per cent who stated that they were intravenous users. There was a certain difference between those who attended treatment and care measures in the Oslo region and in the rest of the country. In the Oslo region, clients had injected in 38 per cent of admissions while the corresponding percentage for the rest of the country was 26 per cent.

Figure 11: Proportion of intravenous users. Percentage



Source: Bergen Clinics Foundation

Slightly less than 3 per cent of women admitted to the measures were registered as pregnant. These amounted to a total of 146 admissions in 2004. Questions about pregnancy were not registered in 1 419 admissions. In more than 2 470 cases in 2004 the patients/clients stated that they lived together with children under the age of 18.

The social background variables paint a picture of a group of problem drug and alcohol users who are not in employment and who are therefore dependent on public support. For more than 2 100 of the admissions in 2004 it was reported that the patients had been homeless for most of the time during the four weeks prior to admission. However, there is reason to believe that most of them have been living in hostels or institutions.

Those who are admitted to treatment/care measures constitute a group that clearly has limited financial means. The vast majority of them are unemployed and dependent on public support. There appears to be a decrease in alcohol being the most used substance for men admitted to treatment or care. It is also apparent that there is a clear and stable tendency for clients who are admitted to interventions for problem drug and alcohol users to have serious mental health problems, registered in this context as anxiety, depression and attempted suicide.

Table 3 shows the proportion of admissions in which the patient/client was a foreign national or of foreign descent. This applied to a greater proportion of the admissions in the Oslo region than in the rest of the country. In measures in the Oslo region, there was also a greater proportion of men than women who were of foreign origin. This was not the case to such an extent in the rest of the country.

Table 3: Proportion of admissions to treatment where the patient/client was a foreign national/of foreign descent, 2004. Percentage

Foreign national	3
Born outside Norway	6
Mother born outside Norway	7
Father born outside Norway	8

Source: Bergen Clinics Foundation

4.3 Main characteristics and patterns from non-treatment sources

A study: Intravenous drug users in Oslo, a survey of a non-clinical population

This study, recently published, is part of a larger project aimed at studying the illegal drug market in general and the heroin market in Oslo in particular. It focused on buyers/users of so-called heavy drugs. This is done by analysing a large number of interviews with intravenous drug users who have contacted the needle distribution service in Oslo during the period 1993-2004. In addition to describing characteristics of the drug buyers, emphasis is placed on the economic aspects of intravenous drug abuse.

The data in this report are unique in both the Norwegian and international context since they are based on many interviews conducted over a long period of time (n=3 829). The number of interviewees is lower than the number of interviews since some people have probably been interviewed more than once during the course of the survey.

The central findings from the study include:

- The average age on first injecting has risen by almost 10 years compared with those who started injecting in the 1970s (15.8 years compared with 25.1 years).
- Among those who started injecting after 1995, 70 per cent had smoked heroin before injecting the drug, while only approx. 15 per cent had smoked heroin first among those who started injecting before 1980.
- Roughly half of the sample started injecting regularly in the same year they first injected; slightly more than 80 per cent were regular intravenous drug users within three years of their first injection.
- 84 per cent of the sample mainly inject heroin, 12 per cent amphetamine, 3 per cent inject both and 1 per cent inject other drugs.
- The proportion citing heroin as their most used intravenous drug has increased during the survey period, from an average of 10 per cent for the period 1993-1999 to 17 per cent for the period 2000-2004.
- The average monthly consumption of heroin has more than doubled during the survey period from slightly more than 8 grams to around 20 grams, while the average consumption of amphetamine has increased from 17 to 20 grams during the same period.
- Those who inject heroin and amphetamine state that they also indulge in extensive abuse of other intoxicants which are drunk, eaten, smoked or sniffed/snorted.
- 25 per cent of respondents since 2002 (n=600) have tried methadone or Subutex during the last four weeks prior to the interview. 10 per cent state that they take the drugs daily or almost daily.

- 14 per cent of amphetamine abusers and 8 per cent of heroin abusers interviewed since 2002 are LAR patients (in medically-assisted rehabilitation).
- 65 per cent report having an overdose experience in which they required help from others to regain consciousness. On average, those with such experience had experienced 7 overdoses.
- More women than men report non-fatal overdoses and women under the age of 25 in particular appear to engage in high-risk behaviour. The data show that young women with overdose experience have experienced an average of 3.5 overdoses during the past year, while men of corresponding age have experienced 0.7 overdoses.
- The price of heroin has fallen by 70 per cent since 1993, while the price of amphetamine has fallen by 60 per cent during the same period.
- Methods of obtaining money have changed during the survey period. Fewer persons than previously state that they have used illegal sources of finance, such as crimes against property and the sale of drugs; the proportion with income from prostitution has also fallen. The proportion stating "other" has also declined.
- It is also the case that intravenous drug users alter their consumption if prices change. Analyses indicate that, if the price of heroin increases by 10 per cent, demand will probably fall by 12 per cent, 6 per cent among those who themselves sell drugs (Bretteville-Jensen, 2005).

5. Drug-related treatment

5.1 Treatment systems

The treatment system and organisational changes made in 2004 was described in NR 2004 chapter 5.1. Some data is provided in chapter 4.2. See also information in structured questionnaire 27.

The state, represented by the regional health authorities (RHAs), took over responsibility for the treatment of problem drug and alcohol users from 1 January 2004 (the Administrative Alcohol and Drugs Treatment Reform). Through this reform, 74 treatment units/institutions (in-patient institutions as well as out-patient units) were transferred to the state as represented by the RHAs. Forty-two of them were privately owned and run, while the other 32 were public. These institutions comprise both in-patient and out-patient units. As a result of the hospital reform effected from 1 January 2002, approximately 30 per cent of the intervention services had already been transferred before 2004 (psychiatric out-patient clinics, drug and alcohol clinics and certain in-patient institutions).

The new responsibility is defined as “interdisciplinary specialist treatment for problem drug and alcohol use” (cf. the Act relating to Specialist Health Services section 2-1a first paragraph subparagraph 5). An overriding goal of the Administrative Alcohol and Drugs Treatment Reform is to provide better and more comprehensive treatment, including ensuring better access to necessary health services.

The reform also lays the foundation for better utilisation of resources and improves the chances of transferring competence between somatic services, mental health care and drug and alcohol services. In addition to specific treatment for drug and alcohol problems, the specialist health service's responsibility for offering problem drug and alcohol users other health care is also emphasised.

The different treatment measures in interdisciplinary specialist treatment for problem drug and alcohol use were divided into four levels in 2004. They apply in all the five RHAs:

Level 1: Out-patient functions and assessment units, including day centres

Level 2: Detoxification and other services/abstinence treatment (in-patient services)

Level 3: In-patient treatment < 6 months (mainly health-related)

Level 4: In-patient treatment > 6 months (social and health-related measures)

In addition, the RHAs have designated institutions which have spaces for retention without the patient's/client's consent (sections 6-2,6-2a) and retention with the patient's/client's consent (section 6-3).

The RHAs are obliged to report every three months on activities in both in-patient institutions and out-patient clinics that fall under the definition of public and private service providers of treatment for problem drug and alcohol users.

The amendments to the Act relating to patients' rights introduced on 1 September 2004 set a time limit for assessments of 30 working days on referral to treatment for problem drug and alcohol use. An assessment of whether the patient is entitled to necessary health care or treatment must be made within the time limit. From 1 September, if the problem user is given status as a so-called

patient with rights, an individual time limit will be set for when health treatment must be given at the latest.

In cooperation with the Norwegian Patient Register, the Directorate for Health and Social Affairs will prepare a system for waiting list registration during 2005 that will take effect from 2006.

After responsibility for the treatment of problem drug and alcohol users was transferred to the specialist health services and the Act relating to patients rights was adopted, there is reason to believe that there has been an increase in referrals to the specialist health service for interdisciplinary specialist treatment for problem drug and alcohol use. Allocations of funds to the RHAs have also been increased in order to strengthen the service for problem drug and alcohol users.

A so-called requisition document issued by the Ministry of Health and Care Services to the RHAs for 2005 states that the weakest groups in society must be given priority, and particular reference is made to the need to improve services in mental health care and the treatment of people with drug and alcohol problems. The document emphasises that this priority must be reflected in practice in the allocation of resources and budgetary funds in the RHAs in 2005, to ensure that the percentage growth in drug and alcohol treatment and mental health care is greater than in somatic services.

In July 2004 the Minister for Health and Care Services sent a strategy document to the RHAs. The document outlines national perspectives and strategies for the development of the treatment services for problem drug and alcohol users. In particular the document underlines the need for cooperation between the specialist health service and the municipalities if they are to succeed in offering a good and comprehensive professional service to individual patients/clients. Cooperation and good procedures for cooperation after the completion of treatment are particularly important to people with drug and alcohol problems.

The Ministry of Health and Care Services has charged the Directorate for Health and Social Affairs with conducting an evaluation of the Administrative Alcohol and Drugs Treatment Reform. The evaluation report will be completed by the end of 2006.

Given their content, the activities at the centres for medically-assisted rehabilitation (the LAR centres) (chapter 5.3) must be regarded as interdisciplinary specialist treatment for problem drug and alcohol use, and the LAR centres are therefore part of the specialist health service (Ministry of Labour and Social Affairs, 2005).

5.2 Drug-free treatment

Drug-free treatment is still considered to be the most important treatment approach in Norway. The treatment varies from psychotherapeutic methods to simpler and more ideologically-based approaches, for example based on fundamental Christian principles, or on a combination of the two. Such treatment is mainly aimed at problem drug and alcohol use. Since interdisciplinary specialist treatment for problem drug and alcohol use became part the specialist health service, steps have been taken to improve coordination of the totality of services provided by the specialist health service to problem drug and alcohol users, particularly services in the mental health field and interdisciplinary specialist treatment for problem drug and alcohol use. This is also commented on in the requisition document to the RHAs for 2005.

No major new evaluations of treatment services have been conducted in 2005.

A study: Completion of long-term in-patient treatment of drug abusers, a prospective study from 13 different units

Completion of the treatment is an important predictor of subsequent positive development. In a prospective study from 13 Norwegian in-patient units, 307 drug abusers were followed from admission through to completion or drop-out. Six of the units were relatively large (24-40 places) and seven were relatively small (8-18 places). All the programmes had a drug-free life (abstinence) and full rehabilitation as their primary goals, and various forms of post-treatment follow-up were included. All the programmes offered both individual therapy and group therapy. Approximately three quarters of the clients were admitted on the basis of retention by own consent for a specific period (three weeks at a time). The methods/instruments used were EuropASI, MCMI II and SCL-25.

The average completion percentage for all the programmes was 40 (20-71 per cent), and there was no difference in terms of completion between first-time admissions (“debutantes”) and clients who have undergone several such stays (“veterans”). Among the debutants the number of years of daily or almost daily heroin use was a negative predictor of completion. Among the veterans, being older and being a frequent user of amphetamine were independent positive predictors of completion of the treatment, while suffering from one or more personality disorders and having several previous stays in institutions were negative predictors. Specific strategies are required for involving clients with personality disorders in treatment, and clients with three or more stays in institutions should be offered a different form of treatment, for example substitution therapy in combination with appropriate psychosocial measures (Ravndal, Vaglum, Lauritzen, 2005).

5.2.2 Drug and alcohol problems and mental health problems

There is a well documented connection between drug and alcohol problems and mental health problems. Problem drug and alcohol users with serious mental health problems are in a particularly difficult situation and require comprehensive and coordinated assistance from several agencies and levels. Out-patient psychiatric services comprise psychiatric out-patient clinics, social medicine out-patient clinics and psychiatric youth teams.

Psychiatric youth teams work especially with young people and young adults between the ages of 15 and 30 who have both drug or alcohol problems and mental health problems. It is a goal to strengthen help services for this group through the Administrative Alcohol and Drugs Treatment Reform, by making both the treatment of drug and alcohol problems and of mental health problems part of the specialist health service and part of the area of responsibility of the regional health authorities. The development of programmes will be carried out as part of the escalation plan for mental health. Among other things, competence-raising measures are required, both in drug and alcohol treatment and in mental health care. Regional educational programmes to increase competence relating to the combination of drug and alcohol and mental health problems have been carried out through the escalation plan (Ministry of Labour and Social Affairs, 2005).

5.3 Medically-assisted treatment

Medically-assisted treatment for drug abusers (LAR) was established as a nationwide service in 1998. As it is organised in Norway, this form of treatment presupposes close cooperation between the specialist health service and the municipal health and social services. The number of applications for such treatment has been much greater than originally calculated, and capacity has been under considerable pressure both in the municipalities and in the specialist health service (LAR centres). Methadone and buprenorphine are currently approved for this treatment. See also NR 2004 chapter 5.3.

Statistics

All clients are registered as patients in a regional unit that is approved for substitution therapy (LAR centre). This applies even though they take medication prescribed by a GP. The centres submit reports to the national centre in Oslo every four months regarding the number on waiting lists and the number of admissions and discharges. So far in 2005, there has again been a strong increase in the number of clients. On the most recent registration on 31. August 2005, there were 3 434 persons in treatment nationwide. 372 persons were either waiting for treatment or to have their application assessed (table 4).

Table 4: The number of patients in medically-assisted treatment and number waiting

Year	Number in treatment	Number waiting
1998	204	464
1999	719	713
2000	1 074	828
2001	1 503	649
2002	1 984	471
2003	2 431	550
2004	3 003	437
At 31.8 2005	3 434	372

Source: Unit for Addiction Medicine at the University of Oslo/MAR ØST

Each treatment facility submits a status report for each patient, prepared by the patient's main therapist in November each year. The report records the patient's social situation at the time of reporting and the type of treatment being given (medication and psychosocial treatment), drugs and/or alcohol use as assessed clinically and on the basis of urine test results for the past month. It also provides information about the number of drug and alcohol-free months, crime, suicides and overdoses during the year.

In 2004 reports were submitted for 2 633 patients. This corresponds to 88 per cent of the patients who were in treatment at the turn of the year 2004/2005. Of these, 12 per cent reported having injected at least once. Ten per cent were thought by their main therapist to have used opioids, and eleven percent had at least one urine test that was positive for opioids. Urine samples also showed that 26 per cent tested positive for cannabis, 28 per cent for benzodiazepines and 14 per cent for amphetamine or cocaine.

The situation varies somewhat between the different regions in Norway, but the general assessment was that eight to nine out of ten had not used illegal morphine substances, seven to eight out of ten had not used cannabis and six to eight out of ten had not used benzodiazepines in the month preceding status evaluation. 92 per cent submitted urine samples, 71 per cent regularly and most twice a week.

The survey showed better results outside Oslo, and it also indicates that decentralised treatment combined with rehabilitation based on social centres and prescriptions from GPs can achieve good results.

The survey also indicates satisfactory results in other areas. 7 per cent had been arrested, 6 per cent had been charged and 5 per cent had been fined and/or received a custodial sentence during the last year. 2 per cent had taken a quantity of a drug sufficient to be deemed an overdose and 2 per cent had attempted suicide. While this is significantly higher than in the general population, the figures show a significant improvement on the pre-treatment situation. 77 per cent owned or rent-

ed their own housing and an additional nine percent lived in stable conditions with their parents or with others. Only 1 per cent had no fixed abode and 4 per cent lived in hostels. 48 per cent had most social interaction with family or friends without drug or alcohol problems. Occupational rehabilitation, however, showed slow progress.

Evaluation

In 2004, medically-assisted treatment as it is organised in Norway was evaluated in two projects carried on assignment for the Directorate for Health and Social Affairs. Both projects referred to the rapid growth in the numbers in treatment and the fact that the treatment had become available throughout the country. It was emphasised as a positive element that the chosen model was based on collaboration between the social services and the health sector, and that LAR has won general acceptance in both political and professional circles. However, both projects also found considerable regional differences in the interpretation and practicing of the regulations and criteria, with the result that patients may be treated differently in different parts of the country.

One of the reports, which was prepared by a group of consultants (AIM consulting), also pointed out deficiencies in planning and a tendency to bureaucratise the treatment. At several units, admission and the start-up of treatment were made more on the basis of formal requirements than on professional assessments. It was also pointed out that in many places rehabilitation efforts have been reduced to a minimum.

The other report, prepared by the Unit for Addiction Medicine at the University of Oslo showed in particularly concrete terms how differences have developed in practice between the centres and that this to a large extent relates to ideological attitudes. It also pointed to the fact that retention in treatment is very high, both in the long and short term.

On the basis of the evaluations, the Directorate for Health and Social Affairs has drawn up a proposal for amended guidelines for medically-assisted treatment, particularly with respect to admission and discharge. The proposal is currently under evaluation by the Ministry of Health and Care Services.

Studies

SIRUS has conducted a prospective multi-centre study in which maintenance treatment was one of the treatments offered (Ravndal, Melberg, Lauritzen, 2003). A separate analysis has been published of those treated with methadone (Ravndal and Lauritzen, 2004). 75 opiate users at the methadone units in Oslo were interviewed on start-up of treatment and on two follow-up occasions. The main instruments were EuroASI and SCL-25 on admission as well as MCM-II. Five persons in the sample (7 per cent) died during the two-year observation period. A substantial reduction was registered in the use of opiates and in the incidence of crime and prostitution, while on the other hand there were no changes in other drug use and an increase in symptoms of depression. The data indicate that the rate of admission in Oslo has been at the expense of the psychosocial follow-up.

An analysis of the variations in treatment results indicates a lower success rate among patients in Oslo than patients in other places (Kornør and Waal, 2004). A study of a time-limited programme for young opiate addicts was initiated in March 2002 under the auspices of the Unit for Addiction Medicine at the University of Oslo. It showed that Subutex makes it possible to increase the compliance rate in out-patient psychosocial treatment but also that there is a minority that succeeds giving up buprenorphine. The study warns against stopping treatment unless this is clearly at the wishes of the patient and unless there is adequate follow-up by the treatment unit. Another project is studying the use of methadone for patients with psychoses and opioid addiction. A third project is studying the use of naltrexone implants for those who want a relapse prophylaxis following abstinence-oriented treatment.

5.4 Quality assurance - standards

Quality assurance is discussed in NR 2004 chapter 5.2.

See chapter 1.2.4 National strategy for quality improvement in the drug and alcohol field.

No significant changes have taken place during the reporting period.

6. Health correlates and consequences

6.1 Drug-related deaths and mortality of drug users

See the data in standard table 05.

There are two bodies in Norway that register drug mortalities. Statistics Norway and the National Criminal Investigation Service (NCIS). The NCIS bases its figures on reports from the police districts, while Statistics Norway prepares figures on the basis of the Cause of Death Registry (DAR). DAR codes information in medical examiners' post-mortem reports and death certificates pursuant to WHO's ICD-10 codes (NR 2004 chapter 6.1).

According to the NCIS statistics, 223 persons died as a result of drug use in 2004. This is an increase compared with 2003, but seen in a five-year perspective, the trend is still downward. Twenty-two of the twenty-seven police districts reported drug-related mortalities in 2004. Oslo had most mortalities (83). This is one third of the mortalities. Very many of the deaths are due to extensive multiple use of heroin, amphetamine, benzodiazepines and methadone. The average age on death was 34 years for men and 36 years for women. The 2004 figures from Statistics Norway are not yet available.

Methodological considerations

There have been considerable discrepancies between Statistics Norway's figures and the corresponding figures from the NCIS in recent years. Statistics Norway's figures are based on ICD-10 codes defined by the EMCDDA. This definition includes more than what has traditionally been classified as drug mortalities in Norway. The ICD-10 codes include suicide where certain illegal drugs are part of the picture and possible suicides (undetermined intent).

All the age categories are included in the ICD-10 codes. The highest age for several of the categories is 85 years. Figures from Statistics Norway show that deaths are thus included that most likely do not belong in the category drug mortalities.

The difference in the figures for drug mortalities between the NCIS's figures and Statistics Norway's figures based on the EMCDDA definitions is virtually eliminated if suicides and deaths among the elderly are removed.

Table 5: Drug-related deaths. Total number of deaths and broken down by gender. Figures from NCIS and Statistics Norway (underlying cause of death)

1991-2004	Number of deaths according to NCIS			Number of deaths according to Statistics Norway		
	Men	Women	Total	Men	Women	Total
1991	74	22	96	66	22	88
1992	78	19	97	81	23	104
1993	77	18	95	76	17	93
1994	102	22	124	105	19	124
1995	108	24	132	114	29	143
1996*	159	26	185	173	31	204
1997	149	28	177	160	34	194
1998	226	44	270	228	54	282
1999	181	39	220	191	65	256
2000	264	63	327	302	72	374
2001	286	52	338	327	78	405
2002	166	44	210	240	67	307
2003	134	38	172	174	49	223
2004	168	55	223	-**	-	-

Source: NCIS and Statistics Norway

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

** Figures for 2004 are not yet available.

An overview for Oslo for 2004 shows that only about a quarter of the overdose mortalities took place in public places. Approximately 80 per cent of the mortalities took place in private apartments, hostels or in various kinds of institutions.

Two studies

Two Norwegian studies which calculated the percentage of poisoning fatalities arrived at relatively similar estimates. Andersen et al. (1996) found that poisoning fatalities account for 63 per cent of the mortalities and Eskild et al. (1993) found that the percentage of poisoning fatalities in their sample was 67. The parameter value for the poisoning fatality percentage in the mortality multiplier, which is used to estimate the number of intravenous users in Norway, was stipulated at 65 per cent on the basis of these two studies.

The figures in these two studies were relatively small, however. This contributes to a certain uncertainty about the estimates. Another factor is that it must be assumed that the poisoning fatality percentage is not uninfluenced by circumstances that may change. For example, it would be reasonable to assume that the poisoning percentage will be reduced if the average age of the users, and thereby the risk of serious diseases, increases. Over time, therefore, it can be expected that the poisoning fatality percentage will decrease, and a later study arrived at a somewhat lower poisoning fatality percentage of 56 (Gjeruldsen et al. 2000).

As regards other causes of death uncovered in these studies, it is especially the category violent death (suicide, murder, accidents) at 20 per cent (Eskild et al. 1993), 22 per cent (Andersen et al. 1996), and 29 per cent (Gjeruldsen et al. 2000), respectively, that contributes to high mortality.

Norwegian register of drug-related mortalities

In 2002 the Division of Forensic Toxicology and Drug Abuse at the National Institute of Public Health was charged with establishing a register of drug-related deaths (see NR 2003 chapter 3.2).

One of the reasons for this was that Institute of Public Health carries out the forensic toxicology analyses for the vast majority of forensic post-mortem examinations in Norway and thus administers these data for requisitioners of reports and research. The institute thus has a good overview of available drugs and poisoning deaths. By including forensic toxicological findings in the reporting, the authorities and others who are dependent on good background data for this type of mortality will have a better basis on which to plan measures aimed at problem drug users so that the number of drug-related deaths can be reduced.

In order to test the feasibility of combining the forensic toxicology data from the Institute of Public Health with a sample taken from the Cause of Death Registry (DAR), it was decided that all poisoning deaths from the first quarter 2003 registered in DAR with the ICD code X40-X49 as an underlying or contributory cause of death should be combined with the forensic toxicological data from the Institute for Public Health for the same period. This may provide an answer to the question of how large a percentage of the poisoning fatalities can be said to be drug-related.

In the first quarter 2003, 90 per cent of all poisoning fatalities involving drugs (X42) were subjected to forensic toxicological examination. Some of the cases that were not examined at the Institute for Public Health may have been analysed at other laboratories.

Finds of drugs in 90 per cent of all drug poisonings in DAR show that most deaths in this category have been assigned the correct underlying cause. Drugs have also been found in cases coded as medication poisoning (2 cases) and poisoning by other substances (3 cases). It may be possible, therefore, that these five cases should have been coded as drug poisoning.

Reporting for the whole of 2003 is expected to be completed in 2005. The plan is to continue the reporting also for 2004 (Institute of Public Health).

6.2 Drug-related infectious diseases

See the data in standard table 09.

HIV and AIDS

The number of HIV-cases among intravenous users remains relatively low, and little new infection is detected among this group. The proportion that have developed AIDS remains low and stable.

In 2004, 252 cases of HIV infection were reported to the Norwegian Notification System for Infectious Diseases (MSIS). Only 15 of these cases (6 per cent) concerned intravenous users. Of the 15 cases in 2004, eight were men and seven women, and the average age was 34 years (23-45). Nine of the intravenous users were infected in Oslo, five were infected in other parts of the country and one case concerned an immigrant infected abroad before arriving in Norway.

As of 31 December 2004, a total of 501 persons had been diagnosed as HIV positive with injecting use as a risk factor. This constitutes 16 per cent of all reported cases of HIV since 1984. Development into AIDS has been reported in 144 (17 per cent) of the cases (table 6). There were four new cases in 2004 (12 per cent).

Table 6: Percentage of intravenous drug users of persons infected by HIV and AIDS, with injecting risk behaviour, by year of diagnosis

	HIV Total	HIV intravenous drug use	Percentage HIV intravenous drug use	AIDS total	AIDS Intravenous drug use	Percentage AIDS intravenous drug use
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	113	11	10 %	34	8	24 %
1998	98	8	8 %	39	5	15 %
1999	147	12	7 %	29	7	24 %
2000	176	7	4 %	38	6	16 %
2001	158	8	5 %	27	5	18 %
2002	205	16	8 %	33	3	9 %
2003	238	13	5 %	43	7	16 %
2004	252	15	6 %	34	4	12 %
Total	3 046	501	16.4 %	862	144	17 %

Source: Institute of Public Health

The reason for the stable, low incidence of HIV among intravenous users is not entirely clear, but a high level of testing, great openness regarding HIV status within the user milieu combined with a strong fear of being infected and self-imposed rules, are assumed to be important factors. In addition, many of the sources of infection in the drug-using milieu have disappeared due to overdose deaths or been rehabilitated through substitution therapy or other forms of rehabilitation. However, the extensive outbreaks of hepatitis A and B in recent years, and the high incidence of hepatitis C, show that there is still extensive needle sharing. The situation as regards HIV is therefore deemed to be very unpredictable.

Hepatitis

During the national outbreak of hepatitis A from 1995 to 2000, 1 360 intravenous drug users were identified as having acute hepatitis A infection. Since then, only isolated, sporadic cases of hepatitis A have been reported among intravenous users. The hepatitis B outbreak continued in 2004, and 108 of a total of 188 cases involved intravenous users. During the period 1995-2004, there were 1 649 reported cases of acute hepatitis B among intravenous drug users.

The high incidence of hepatitis B among intravenous drug users in recent years has resulted in increased sexual transmission, often to younger women in the user milieu. The outbreaks have demonstrated that intravenous drug use is no longer limited to the big towns and cities, but that it has also spread to smaller municipalities all over the country. These outbreaks have resulted in hepatitis A vaccination being offered free to all users of illicit drugs in Norway. Hepatitis B vaccinations have been offered free to problem drug users since 1984. In 2003, an estimated 800 drug users in Norway were vaccinated for hepatitis A and 900 for hepatitis B. No vaccination data are available for 2004.

In recent years, in connection with needle distribution in Oslo, small-scale prevalence surveys have been carried out to register the incidence of, for example, hepatitis among intravenous drug users. The 2004 survey showed that 59 per cent of the 264 persons included in the survey had had a hepatitis A infection, 42 per cent a hepatitis B infection and 68 per cent a hepatitis C infection. In Norway, hepatitis C is not monitored to the same extent as hepatitis A and B, and hence the number of new cases of drug users being infected with the hepatitis C virus is not known. These Oslo surveys are the only prevalence surveys to be conducted regularly among drug users in Norway.

Other infections among problem drug users

Syphilis, gonorrhoea and other sexually transmitted diseases are very seldom reported among drug users in Norway. No outbreaks of tuberculosis have been registered among drug users in the country. Skin infections and abscesses are not uncommon. In certain cases these can develop into serious septic/toxic infections. Infectious endocarditis is a well-known consequence of injections. Every year, a small number of cases of such infections is reported among drug users, but it is clear that such infections are under-reported to the Norwegian Notification System for Infectious Diseases.

An increased incidence of tetanus has been reported among drug users in the UK. In light of this, antibody tests were also conducted for tetanus during the prevalence survey among drug users in Oslo in 2004. They showed that only approximately 10 per cent were inadequately protected against tetanus. The results indicate that protection against tetanus is good among drug users and that separate vaccination campaigns targeting tetanus are not necessary (Institute of Public Health).

6.3 Psychiatric co-morbidity (dual diagnosis)

Co-morbidity was thoroughly dealt with in NR 2003 chapter 16.

6.4 Other drug-related health correlates and consequences

Driving and accidents

A new survey shows the incidence of alcohol and other drugs among drivers killed in traffic in the Nordic countries.

The report has been prepared by a Nordic working group on assignment from the Nordic Council of Ministers. All the participating countries have processed the tests in accordance with the same analysis program and joint guidelines. In total, the material covers more than 1,900 drivers killed during the period 2001-2002.

The biggest difference between the countries is related to the proportion of accidents investigated, which varied from 90 per cent in Sweden and Finland to approximately 70 per cent in Norway and less than 20 per cent in Denmark.

When comparing alcohol and drug-related accidents, particular focus has been given to single-driver accidents in which the cause of the accident can be attributed to the individual driver. Alcohol and/or other drugs were a contributory factor in almost 2/3 of single-driver accidents in Norway, Sweden and Finland. Alcohol alone was detected in relatively more of the accidents in Sweden and Finland compared with Norway. The combination of alcohol and other drugs was more frequent in Norway than in Sweden and Finland.

The incidence of illegal drugs and prescription drugs with a warning triangle was highest in Norway. The most commonly detected drugs in addition to alcohol were tranquillisers and soporific drugs (benzodiazepines etc.), cannabis and amphetamine. In the Norwegian cases, alcohol and benzodi-

azepines were detected in approximately the same number of deceased drivers. The majority of the deceased drivers among whom drugs or alcohol were detected were in the age group from 20 to approximately 35 years.

The Norwegian material has been compared with a corresponding survey from 12 years ago, and it shows an increase in drug-related single-driver accidents of approximately 10 per cent. The incidence of other drugs, alone or in combination with alcohol, has more than doubled (Institute of Public Health).

7. Responses to health correlates and consequences

7.1 Low-threshold health services

A total of 38 municipalities will receive a total of EUR 6 million⁵ in government funding in 2005 for low-threshold health services for hardcore problem drug and alcohol users. EUR 1.25 million of this amount has been allocated to the Salvation Army's street hospital in Oslo. The street hospital in Oslo will provide specialised health and care services to problem drug and alcohol users with an extensive need for help.

Through low-threshold health services, problem drug and alcohol users are offered medical check-ups, follow-up of overdose cases and referral to specialist treatment. The municipalities report that these services have an effect. The services are at street level and accessible, they reach hardcore problem users, contribute to improving the health of this group and probably contribute to reducing the number of overdose fatalities. The municipalities report an increase in the number of queries and consultations, and extensive health problems are also uncovered among many problem users through these services.

7.2 Prevention of drug-related deaths

Information about policies and priorities is provided in structured questionnaire 29. See also NR 2004 chapter 7.1-7.2.

Several of the low-threshold services in the big towns and cities operate an overdose prevention service. One good example is the Strax House in Bergen, whose staff are ready and qualified to receive and provide appropriate help to persons brought to the Strax house following overdoses. The overdose emergency response service is operative 17 consecutive hours a day, five days/nights of the week. The personnel who staff the emergency response service are trained and ready to receive persons following overdoses. In 2004, 10 persons were brought to the Strax House following overdoses, compared with five in 2003. The service is little used viewed in relation to the number of call-outs of the ambulance service in connection with overdoses. Users of the Strax House report that they very seldom wish to be taken anywhere immediately after resuscitation. The ambulance service points out the importance of being able to offer supervision and care to persons who have been given emergency help due to an overdose.

The Strax House also gives first aid training to drug addicts, both through conversations and through direct training of this user group. A first aid course in basic cardiopulmonary resuscitation has been organised for this user group for several years. The training is given by health personnel at the Strax House. The course has been given the name "Save a friend". A course certificate/diploma is awarded on completion of the training.

It is difficult to measure the effect of this information and training, but the feedback has been very positive. Users say that they benefit directly from the training. Ambulance personnel often experience that users have already started administering first aid when the ambulance arrives (Annual report 2004, the Strax House).

⁵ Conversion rate: 1 euro=NOK 8.00

The injection room in Oslo city centre

The injection room opened on 1. February 2005 as a three-year trial scheme (chapter 1.1). See also NR 2003. Interest in the room has been very great, and the upper limit on the number of users has already been reached. In order to be registered as a user of the injection room, users must be hard-core heroin users and must be at least 18 years old. Freedom from prosecution is limited to bringing and injecting one user dose of heroin.

Some data as of the end of August 2005: There are 300 registered users. 213 of them are men and 87 women. A total of 5 145 injections have been made, which means an average of 24 injections per day. An ambulance has been called out on 27 occasions. The opening hours are from 9.30 to 15.30 every day. The availability of the service is thus limited.

The injection room trial scheme will be evaluated by SIRUS. The evaluation will attempt to establish whether and to what extent the various goals of the trial scheme can be said to have been attained, the characteristics of users of the injection room and how they use the service etc. The evaluation will also examine the role of the employees and how the police deal with such a service. It will also be relevant to examine the effect of the injection room on the surrounding area, and to what extent it becomes a hang out for problem drug users. One important issue in the evaluation will be to examine how the staff handles the provision that freedom from prosecution only applies to one user dose of heroin and how the police deal in general with various problems that can be expected to arise around such a service. The trial scheme will be monitored through observation, interviews with users, staff and the police. Another important source of data will be the information that is registered by the staff in connection with use of the injection room.

7.2 Prevention and treatment of drug-related infectious diseases

See NR 2004 chapter 7.2

The Alcohol and Drug Addiction Service in Oslo intensified its infection prevention efforts in 2004. Through a new project targeting young intravenous drug users, the field health care service and the outreach service hope that they can succeed in vaccinating at least 150 users under the age of 25 against hepatitis A and B.

It is also a goal to increase awareness of infection situations among intravenous users under the age of 25. The service is directed at the user group with whom the outreach service are in contact, and which is recruited via outreach service personnel. The field health care service has assigned a nurse to the project, the outreach service provides premises, and the cost of vaccines is covered by the National Insurance Service pursuant to the applicable rules.

In recent years, the Health Service, the Alcohol and Drug Addiction Service and the National Institute of Public Health have carried out various vaccination campaigns, checked immune system status and offered x-ray examinations in connection with needle distribution in Oslo. Needle users are offered vaccination against hepatitis A and B, x-ray examinations and examinations for hepatitis A, B and C, and HIV (chapter 6.2). Examinations were also conducted in 2004 to protect against tetanus.

7.3 Interventions related to psychiatric co-morbidity

This topic was thoroughly discussed in NR 2003 chapter 16.

New regional competence centre for the dual diagnosis drug and alcohol problems and psychiatry.

The Eastern Norway Regional Health Authority has established a competence centre for the dual diagnosis drug and alcohol problems and psychiatry. The centre will gather and develop competence in the field, and focus primarily on the development of clinical methods, on increasing knowledge and disseminating information. The aim is to contribute to strengthening treatment for persons with the dual diagnosis, both qualitatively and quantitatively. The centre opened in April 2005.

An updated overview of dual diagnosis services, both at the municipal and specialist level, will be drawn up in 2005. The overview will comprise services that explicitly work on both patients' drug and alcohol problems and their mental health problems. As regards second-line measures, it will also be examined whether such measures use integrated treatment methods.

8. Social correlates and consequences

8.1 Homelessness

Based on those persons who were in contact with the help services in a certain week in December 2003, the Norwegian Building Research Institute studied and calculated the extent of homelessness in Norway. The study and calculations were carried out in the same manner as in a previous survey in 1996. It shows that the extent of homelessness was reduced by approximately 1 000 from 1996 to 2003. In 1996, 6 200 homeless persons were registered compared with 5 200 in 2003. The most recent study shows that the number of homeless people with drug or alcohol-related problems has increased in the group as a whole.

Approximately 70 per cent of homeless people had drug or alcohol problems. There are no surveys of the extent of housing problems among problem drug and alcohol users in general, but several surveys show that problem drug and alcohol users stand out as the group in the worst situation in the municipalities' social housing efforts (Ministry of Labour and Social Affairs, 2005).

8.2 Drug related Crime

Due to changes in Statistic Norway's registration system, statistics are only available for 2004 for reported drug crimes (pursuant to the Penal Code, section 162 and the Act relating to Medicines). Figures for investigated drug crimes are currently unavailable for the years after 2001. Figures for penal reactions are not available after 2003 (NR 2004 chapter 8.2).

Following two years with a reduction in the number of reported crimes involving drugs, the total number of registered drug crimes was approximately the same in 2004 as in 2003 (standard table 11). The number is nonetheless 20 per cent lower than in 2001, when drug crimes accounted for more than 15 per cent of all reported crimes. For the country as a whole drug crime accounted for roughly 13 per cent of all reported crimes in 2004.

The number of cases reported for the use of drugs increased by almost 4 per cent. The possession of small amounts of drugs (regulated by the Act relating to medicines etc.) fell by 2 per cent, while drug crimes pursuant to the Penal Code increased by more than 4 per cent. The total number of serious drug crimes remained unchanged from 2003 to 2004. In the last two years, however, more cases involving the most serious kind of drug crimes have been registered (the Penal Code section 162 third paragraph) than in the preceding decade.

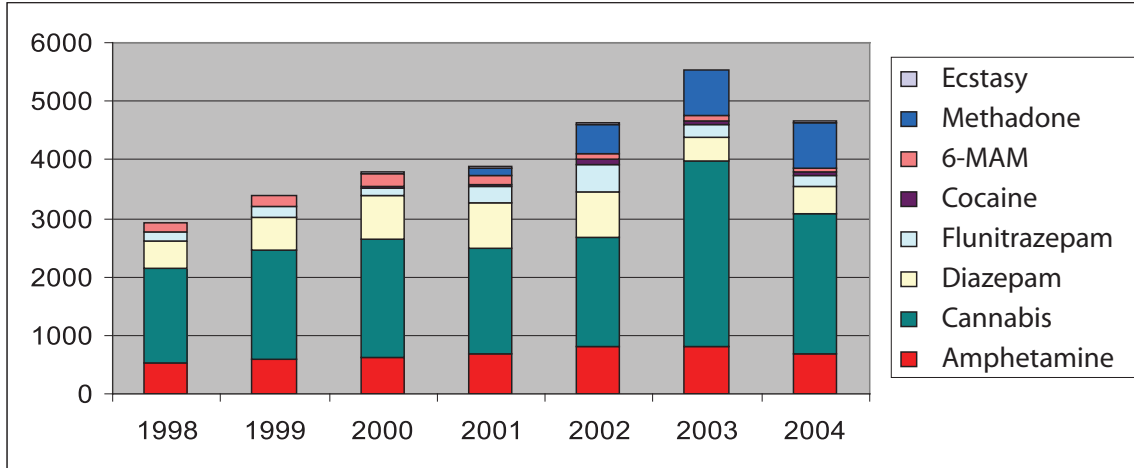
There are relatively pronounced differences between the different counties with respect to the crime situation. For example, there were approximately 11 reported drug crimes per thousand inhabitants in Oslo, the lowest figure since 1996 (Statistics Norway).

8.3 Drug use in prison

Roughly the same number of analysis cases were sent from the correctional service to the National Institute of Public Health as in 2002 (standard table 12). Not surprisingly, cannabis is by far the most frequently detected drug in urine tests of inmates in prisons and open institutions, although the pro-

portion has fallen since 2003. A substantial proportion of methadone was also registered in these tests in 2004. No exact figure is available for how many positive findings for methadone relate to persons in treatment and how many are in connection with illegal use.

Figure 12: Drug finds in correctional service cases received during the period 1998-2004



Source: Institute of Public Health

9. Responses to social correlates and consequences

9.1 Social re-integration

See information in structured questionnaire 28.

9.2 The homeless people project

The homeless people project was a four-year development project carried out from 2001 to 2004. The project was carried out as a collaboration between the then Ministry of Social Affairs, the Ministry of Local Government and Regional Development, the State Housing Bank and the Directorate for Health and Social Affairs. Seven urban municipalities and three voluntary organisations took part. The objectives of the project were to develop methods and models for preventing homelessness, to provide an opportunity to test comprehensive local solutions, to create a basis for and provide experience of a concerted national effort and to communicate experience and knowledge. The State Housing Bank was in charge of the project.

The final report shows that 31 measures have been established for a total of 412 persons, mainly homeless people with drug and alcohol problems. Housing has been provided for many more homeless persons. Most of the measures will be continued after conclusion of the project. A broad range of housing solutions has been employed, ranging from ordinary municipal rented accommodation at one end of the spectrum, via co-located housing, bedsits with shared facilities and communal housing/shared accommodation, to places in nursing homes at the other.

The project was allocated EUR 1.31⁶ million in 2004 from the Ministry of Social Affairs' budget and EUR 0.75 million from the State Housing Bank for project management in municipalities, voluntary organisations and central administration of the project. Government grants from the State Housing Bank for obtaining housing, and grants for follow-up services from the Directorate of Health and Social Affairs come in addition.

Municipalities that have not participated in the homeless people project have also received government grants for the establishment and follow-up of housing measures for people with drug and alcohol problems. Some of these municipalities have been able to realise projects as a result of the Action plan to combat poverty.

Grants for residential follow-up services

In connection with the Action plan to combat poverty a grant scheme aimed at the municipalities was established in 2003 for the purpose of strengthening and developing residential follow-up services. In 2004, more funds were made available to the grant scheme bringing the total available to EUR 5.25 million. As of 31. December 2004, a total of 45 municipalities and urban districts were receiving grant funding. An estimated 1 600 persons have received support in 2004 as a result of the scheme. Oslo accounts for approximately one third of those receiving assistance.

⁶ Conversion rate: 1 euro=NOK 8.00

In connection with its consideration of White Paper no. 23 (2003-2004) *Om boligpolitikken – On housing policy*, the Norwegian Storting decided to continue these efforts and to utilise the experience from the homeless people project through the strategy "Obtaining housing for oneself". All municipalities are invited to take part in this collaboration in which prevention will be given greater emphasis.

The White paper on housing policy states that the government will take steps to ensure people with drug and alcohol problems the same right to individual assessment as other groups (Ministry of Labour and Social Affairs, 2005).

9.3 The treatment of inmates and convicted persons with drug or alcohol problems

There are approximately 1 800 persons with drug or alcohol problems in prison at any given time. The nationwide survey "Levekår blant innsatte – Living conditions among inmates" (2004) shows that 60 per cent of the prison population has a drug or alcohol problem. The majority of them used opiates or central stimulants on an almost daily basis prior to incarceration. Most of the inmates with drug or alcohol problems have a chronic illness and many of them have mental health problems. A majority of the recidivists in prison are people problem drug and alcohol users. The survey documents the strong correlation between drug abuse and crime and shows that it is necessary to improve the rehabilitation of inmates with drug or alcohol problems.

The correctional service has for several years run a scheme for the serving of sentences aimed at inmates with drug and alcohol problems in particular. Various programmes are offered that address problems relating to the drug and alcohol problems of convicted felons. In recent years, a Canadian drug mastery programme called "Drug Prevention in Prisons" has been organised in a number of prisons. These programmes are followed up by the probation service, through the "My choice" programme among others, a programme aimed at reducing the relapse rate.

Convicted persons are entitled to specialist health services on a par with other people. Being able to serve sentences pursuant to section 12 of the Execution of Sentences Act is important to inmates who need to stay in a treatment or care institution. In 2004, 28 537 sentences were served pursuant to section 12 compared with 34 402 in 2003 and 35 397 in 2002.

The reduction is largely due to the fact that the former institutions run by the probation service, which were for the most part section 12 institutions, were converted into prisons with lower levels of security. The figures concern both rehabilitation in institutions for drug and alcohol problems and other institutions. Many of this group of inmates have drug and alcohol problems. The Ministry of Justice and the Police wishes to increase the number of sentence days served under section 12 conditions, particularly in institutions under the regional health authorities. This must be achieved in close consultation with the correctional service and the health and social services (Ministry of Labour and Social Affairs, 2005).

9.4 Collaboration between the correctional service, the health service and the social services

The Ministry of Justice and the Police and the Ministry of Health and Care Services appointed a working group in 2004 as part of the efforts to improve access to effective counselling, help and treatment for inmates and convicted persons who have drug or alcohol problems. The group will draw up a joint circular concerning the allocation of responsibility for inmates and convicted persons who have drug or alcohol problems between the correctional service, the health service and the

social services. The intention is that binding and qualitatively good collaboration at the central level will be followed up by collaboration at the regional and local levels. This applies in particular to inmates and convicted persons who have a combination of mental health problems and drug or alcohol problems.

In cooperation with the health and social service sector, the prisons and the probation service will take steps to ensure that those with relevant needs will have their right to health assistance assessed. Steps will be taken to ensure that those who need and are entitled to interdisciplinary specialist treatment for drug and alcohol problems, including medically-assisted treatment, shall be given an opportunity to undergo such treatment also during the serving of sentences. For problem drug and alcohol users who have a right to an individual plan, it must be ensured that the plans are implemented also during the serving of sentences.

The establishment of drug and alcohol coordination teams in all the major prisons has started. These teams will have a particular responsibility for information and coordination of work on drug and alcohol problems and for taking initiatives to increase competence in the field. Drug and alcohol programmes, social environmental programmes and plan work shall be included in the overall services available to problem drug and alcohol users in prisons.

Together with other involved ministries, the Ministry of Justice and the Police has instigated trial projects under the title "TURN young offenders around in time – a joint responsibility for the state, municipalities and the local community". This measure will focus on binding administrative collaboration, both at the central and local levels.

Three measures are aimed at young problem drug and alcohol users in particular:

"Ung-firer'n" in Trondheim prison, *"Stifinneren jr."* in Oslo prison and *"From prison to the municipality; a follow-up programme for problem drug and alcohol users released from Bergen prison"*. The model is based on close, binding collaboration between the municipality, the specialist health service and other relevant bodies. Responsibility groups are established and the participants closely followed up in order to address the needs of the individuals involved.

9.4 Programme for drug courts

The topic is discussed in chapter 1.1

10. Drug markets

10.1 Availability and supply

Several factors must be emphasised when describing any changes in availability. Seizures of illegal substances by the police and customs authorities are an important parameter in this context. However, the number of actual seizures and the quantities involved are affected by the internal priorities of and resources available to the police and customs authorities, and by surveillance methods and international cooperation. The statistics may therefore show significant fluctuations from one year to the next, without this necessarily meaning that corresponding changes have occurred in terms of actual availability. It is therefore a matter for debate to what extent seizure statistics is a good tool in connection with such assessments.

The National Criminal Investigation Service (NCIS) nonetheless believes that major changes in the figures for certain substances reflect real changes in their supply and use. However, the NCIS states that the reduction in the number of seizures is nonetheless not a sure indication that the drug problem has decreased in Norway. When the police and customs authorities have succeeded in seizing large quantities of drugs, this may have had an effect on the spread of the drugs, thus helping to explain the reduction in the number of seizures.

This applies to heroin in particular, of which an individual seizure of 61.3 kg was made in 2004. When such considerable quantities of heroin are seized, it may be the result of the police having given priority to the investigation of major drug cases with international connections and concentrating their efforts less on dealers and user milieus. However, the statistics show that the number of seizures of heroin is the lowest for more than 10 years. The seizure figures indicate that heroin is less widespread and less used than previously.

The seizure figures for cannabis indicate that cannabis is as prevalent as previously and that the police focus strongly on the sale and use of the drug.

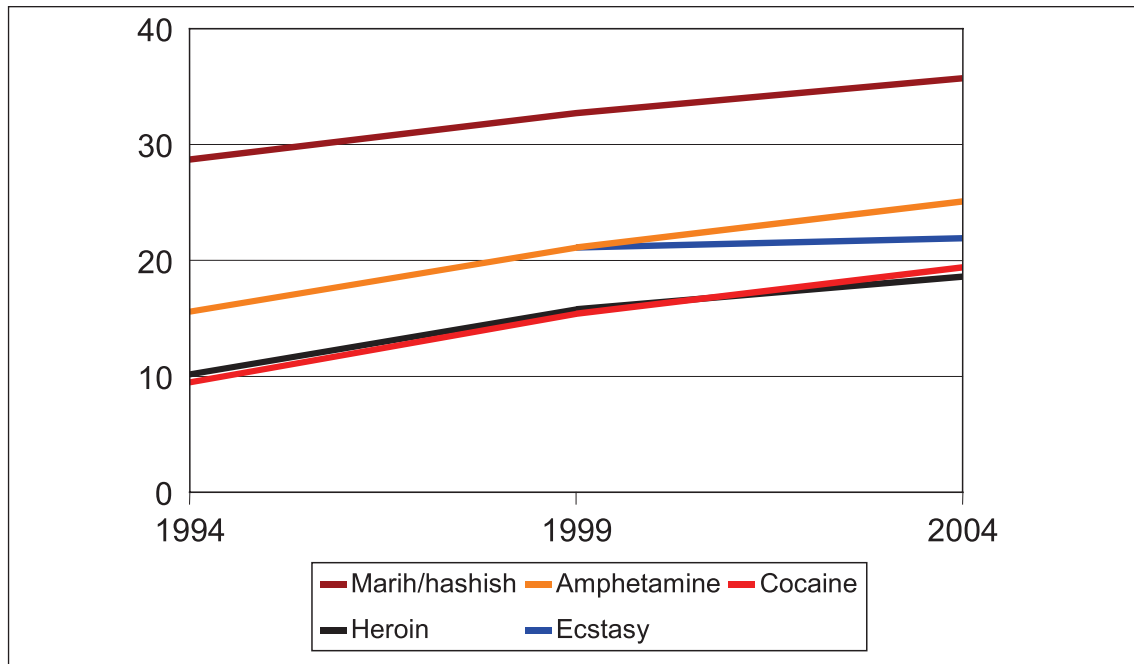
Despite the decrease in the number of seizures, the statistics show that amphetamine and methamphetamine are still highly widespread. This is supported by the fact that all police districts made seizures of these substances in 2004.

The prevalence of ecstasy seems to have culminated and, in part, declined sharply since the top in 2001.

The number of seizures of Rohypnol and imitations has declined sharply. There is good reason to view this development in conjunction with the successful surveillance and investigative efforts aimed at Eastern Europeans among others (Annual Report 2004 NCIS).

In SIRUS's population studies from 1994, 1999 and 2004 (chapter 2.1), respondents were asked whether they would manage to obtain various substances in the space of 2 to 3 days (figure 13). The answers show that people believe it is easiest to obtain cannabis, more difficult to obtain amphetamine and ecstasy and most difficult to obtain cocaine and heroin. A more interesting finding is that availability appears to have increased relatively strongly during the period. Relatively speaking, the increase is greatest for cocaine and heroin. In 2004 twice as many people as in 1994 stated that they could obtain these drugs in the space of 2 to 3 days.

Figure 13: Percentage “yes” answers to the question: Do you believe that you could obtain any of the following substances in the space of 2 to 3 days?



Source: SIRUS

10.2 Seizures

The statistical data from the NCIS are based on information from the police districts in connection with requisitions of analyses or destruction (fixed penalty cases) or on verified analysis results. Destruction and analysis cases are thus included jointly in the statistics. The figures also include all seizures made by the customs authorities.

The statistics are based on figures that include many seizures of drugs that have not been analysed. These seizures relate to 8 157 fixed penalty and destruction cases, as well as seizures of drugs for which chemical analysis had not commenced at the time the statistics were prepared. These possible sources of error are not deemed to have a significant bearing on the main trends in the presentation, but experience indicates that some of the minor seizures may include other types of drugs than those stated in statements to the authorities.

Main trends

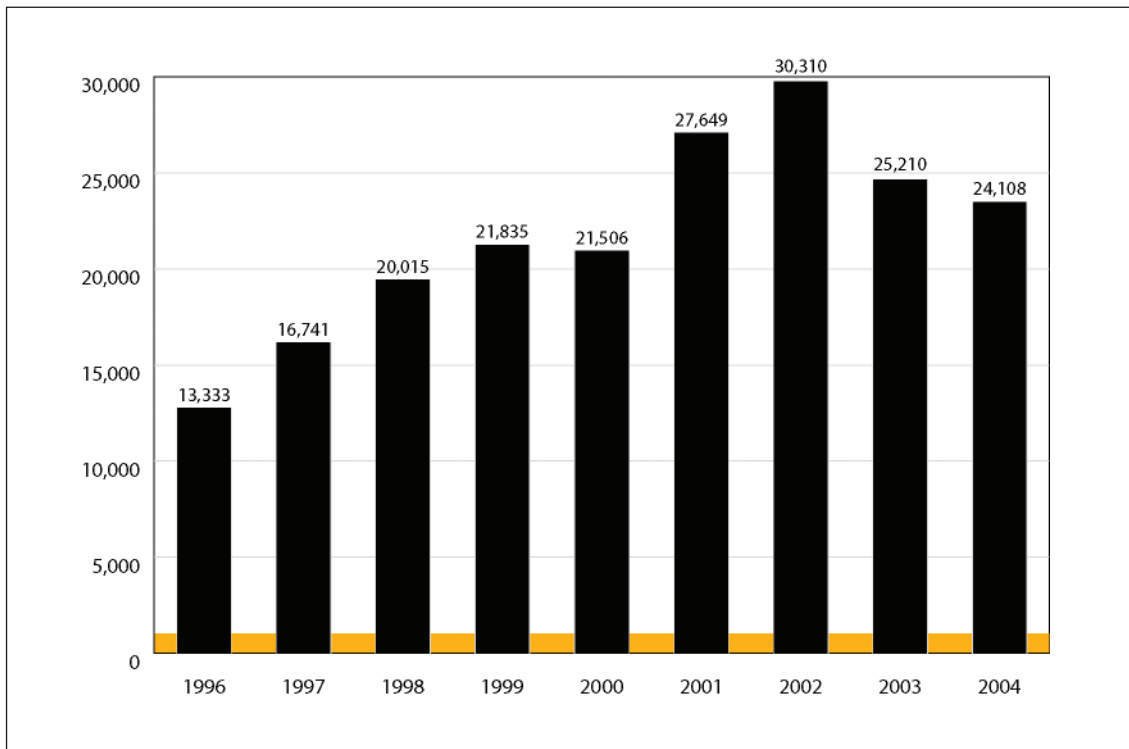
The drug statistics show a continued decline in the number of cases and the number of seizures (table 7). In 2004, 19 299 drug cases were registered and there were 24 108 seizures. This represents a decline of 5.0 per cent and 4.5 per cent respectively, compared with 2003. A decline was registered in most of the country's 27 police districts.

In 2004, 1 100 fewer seizures were made than in 2003. The reduction was greatest for heroin, benzodiazepines (including Rohypnol) and amphetamine. For most of the drugs, the statistics are within the normal range with respect to both the quantities seized and the number of seizures, but heroin and amphetamine/methamphetamine stand out in that record quantities of these drugs were seized.

The prevalence of amphetamine and methamphetamine, on the other hand, appears to still be very high and growing. In no previous year have such large quantities been seized – almost 300 kg (standard table 13).

Figure 14 shows the changes in the number of drug seizures during the period 1996 – 2004.

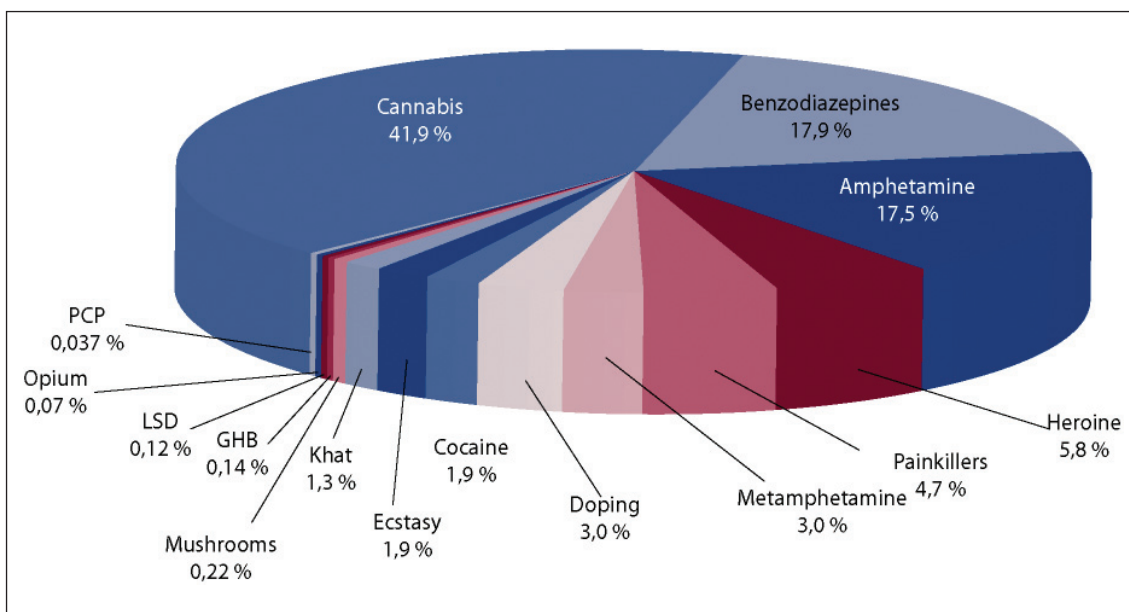
Figure 14: Total number of drug seizures 1996 – 2004



Source: NCIS

The pie chart, figure 15, illustrates the market share of each substance based on the parameter: number of seizures.

Figure 15: Market share for each substance in 2004



Source: NCIS

Table 7: The number of seizures during the period 2001 – 2004 for the most discussed types of drugs

Type of substance	2001	2002	2003	2004	Percentage change from 2003
Cannabis	10 838	10 921	10 397	10 097	- 2,9
Amphetamine	4 283	5 037	4 578	4 213	- 7,9
Methamphetamine	392	696	640	720	+ 12,5
Heroin	2 501	1 906	1 709	1 399	- 18,1
Benzodiazepines	6 006	8 058	4 700	4 358	- 7,2
Painkillers	1 109	1 237	1 216	1 146	- 5,7
Doping	643	697	726	716	- 1,3
Cocaine	496	577	504	464	- 7,9
Ecstasy	836	693	405	452	+ 11,6
Khat	198	238	249	305	+ 22,4
LSD	52	15	31	30	- 3,2
GHB	81	75	120	34	- 71,6
Opium	21	14	7	18	+ 157,0
Psilocybe mushrooms	45	46	71	53	- 25,3
PCP	-	-	6	9	+ 50,0
Others	-	-	94	94	0

Source: NCIS

Heroin

The amount of heroin seized was 129 kg. This is by far the largest quantity of heroin seized in Norway in any one year, and it is mainly due to a seizure in Oslo of 61.3 kg. The number of heroin seizures (1 399) on the other hand is the lowest for more than 10 years.

Cannabis

The amount of cannabis seized, 2 242 kg, was very high, and there was only a marginal decline in the number of seizures from 2003. As usual, cannabis was seized in all the police districts in Norway, and more seizures were made in 14 of the districts in 2004 than in 2003. The seizures comprise 2 084 kg of hashish, 125 kg of cannabis plants, 33 kg of marihuana and 14 grams of cannabis extract. Twenty-six cases were registered involving seizures of more than 10 kg of hashish.

Amphetamine/methamphetamine

The amounts of amphetamine and methamphetamine seized were 230.7 kg and 63.1 kg, in 4 213 and 720 seizures, respectively. In total, as much as 293.7 kg of these substances was seized in 4 933 seizures. The quantity seized is greater than ever before, but the combined decline in the number of seizures of these two substances is 3.3 per cent since 2003. All police districts made seizures of these substances in 2004.

For amphetamine, five cases were registered that involved amounts of more than 10 kg.

The strength of mixtures containing amphetamine has declined during the last year, but there are still great differences. The average in 2004 was approximately 40 per cent. Amphetamine base was seized for the first time in Norway in 2004. The seizure involved as much as 6.1 kg, which corresponds to 8.4 kg of pure (100 per cent strength) amphetamine.

There has been a significant increase in methamphetamine, both in terms of the amount seized and the number of seizures. Eighteen police districts made more seizures of methamphetamine than in 2003.

Five seizures were registered that involved amounts in excess of 4 kg.

Ecstasy

Despite a slight increase in the number of seizures, the statistics show that there has been a very sharp decline in the number of tablets seized. A total of 53 561 tablets were seized in 452 seizures, all containing the active agent MDMA. MDEA in combination with MDMA was only detected in one seizure.

Ecstasy seizures were made in all of the country's police districts, but ecstasy accounted for only 1.9 per cent of the total number of drug seizures in Norway in 2004. Fifty new tablet types of previously unregistered appearance and logo were seized. In addition, nine seizures were made of tablets similar in appearance to ecstasy, but containing other narcotic substances than MDMA. The substances detected in these tablets include amphetamine, methamphetamine, PCP and acetyl codeine. The opioid acetyl codeine was found in one tablet, the third find in 35 years.

Other hallucinogenic substances that are often mentioned in conjunction with ecstasy, for example 2C-B, DOB, 2C-T-2, 2C-T-7, 4-MTA, PMA, PMMA and mescaline were not detected in 2004. However, 5-metoxy-DMT, which can occur naturally in plant material, was detected.

Benzodiazepines

A number of major seizures of benzodiazepines were made in 2004, primarily of Rohypnol and imitations of Rohypnol, with 360 000 tablets being seized in 2 100 seizures. The proportion of Rohypnol and Rohypnol imitations was the lowest for several years.

While the amounts remain large, the number of seizures of both benzodiazepines, in general, and of Rohypnol and imitations, in particular, have declined sharply.

As regards prescription drugs containing diazepam, both the number of seizures and the amounts seized have been in clear decline for several years. In 2004, 56 000 tablets were seized in 1 177 seizures. As with Rohypnol, most of the seizures were made on the basis of illegal imports.

New benzodiazepine

Fenazepam is a benzodiazepine from Russia that is not in medical use in Norway, but large quantities of it were found both in 2003 and 2004. In 2003, 10 062 tablets containing fenazepam were seized in Norway in 11 seizures, while as many as 45 495 tablets were seized in 32 seizures in 2004.

Alprazolom (the active agent in the prescription drug Xanor) was also found to a much greater extent than in previous years. Alprazolom is also used as the active agent in illegally-manufactured tablets as a component in drug mixtures containing heroin. The number of seizures of the prescription drug Xanor is also increasing.

Cocaine

A total of 38.3 kg of cocaine was seized in 2004 in 464 seizures. The seizures were evenly distributed throughout the year and all the seizures are related to persons. The amount of the drug is regarded as average in a wider perspective, while the number of seizure is falling somewhat. Cocaine accounted for 1.9 per cent of the total number of drug seizures in 2004.

Other substances

Khat

More than 3.6 tonnes of khat were seized in 2004 in 305 seizures. This was 1.2 tonnes less than in 2003, while the number of seizures was the highest ever.

LSD

Seizures were small and our data give no indication that LSD's market share is growing. A total of 579 doses were seized in 30 seizures.

Opium

Both the amount seized and the number of seizures of opium are very small compared with heroin and medicinal painkillers. In 2004, 7,9 kg were seized in 18 seizures.

Medicinal painkillers

In 2004, a total of 14 396 tablets were seized in 1 164 seizures. This is roughly the same situation as registered in previous years. It is primarily medicinal drugs containing morphine, buprenorphine and methadone that dominate the statistics, with a total of 1 100 seizures.

No particularly large seizures of tablets were made. The biggest seizures were of 700 tablets containing codeine, 300 tablets containing buprenorphine and 190 morphine tablets. Even though the figures are far lower than for heroin, it is nonetheless worth noting that the frequency of seizures of buprenorphine (Subutex and Temgesic) and of methadone (drugs used, among other things, in medically-assisted treatment of heroin addicts) is higher than in any previous year.

GHB

Since the first year it was registered in the drug abuse context, the number of seizures of GHB has been small compared with other established drugs. As the table shows, the number of seizures has fallen to one quarter compared with 2003, and the total amount of liquid mixture containing GHB was approximately one kilo. Even if one includes the seizures of GBL and 1.4-butandiol, substances in the same category in terms of their effect, the figures are nonetheless marginal, with only 63 seizures. It should nonetheless be mentioned that more than 28 kg of 1.4-butandiol, a substance that is not classified as a narcotic, was seized.

Other hallucinogenic drugs

PCP

In Oslo police district, 15 tablets were seized towards the end of 2003 in 5 seizures of phencyclidine hydrochloride (PCP), popularly called "angel dust". Seven seizures of the substance were made in Oslo and one in Follo during the period January – February 2004. The biggest single seizure consisted of 937 tablets. In addition, 4.5 grams of powder containing an unquantified amount of PCP were seized. Thus, in 2004, a total of 1 776 tablets containing PCP were seized in nine seizures in three police districts. It can, in addition, be mentioned that small quantities of the hallucinogenic substances 2-CI and 5-MeO-DMT were also seized. None of these substances has been included on the list of narcotic substances.

Psilocybe mushrooms

It was also the case in 2004 that psilocybe mushrooms did not have a prominent place among the seizures made. During the first six months of the year, 224 grams were seized in 24 seizures, and for the whole year 945 grams were seized in a total of 53 seizures.

Since 15 April 2004, all fungi containing psilocybin have been classified as narcotic substances, including *Panaeolus cyanescens* (“Blue meanies”) and *Psilocybe cubensis* (“Mexican mushrooms”). In 2004, 751 grams of these species were seized in 16 seizures. Over and above these three species one seizure was made of another fungus containing psilocybin. It weighed 169 grams.

Several intoxicating plants and parts of plants that are not classified as narcotic substances were the subject of considerably increased interest last year. This can probably be explained by the fact that such substances can be purchased and imported via the internet.

10.3 Prices

See data in standard table 16.

Drug prices are based on information from drug users and dealers at different levels collected by police officers in Oslo police district.

The stipulation of prices for drugs is a very inexact science since prices can vary strongly depending on quality, contacts and the quantity purchased. In general, the price level has changed little since the reporting for 2004. A certain reduction in the price of cannabis can, however, be detected. The price of the most common prescription drugs is also relatively constant. It is normal to pay the same unit price for ten tablets as for one, while purchases of larger quantities result in strong price reductions. The price of Rohypnol, the most popular pill, varies strongly. This is primarily due to the highly variable availability of this medicinal drug.

10.4 Purity

See the data in standard tables 14 and 15.

Heroin

The average percentage strength of heroin is at roughly the same low level as in 2003, but there are major variations. They are illustrated in table 8.

Table 8: Percentage strength of heroin in major individual seizures

Police district	Quantity of heroin	Percentage strength
Oslo	61.3 kg	Approx. 44
Oslo	19.9 kg	Approx. 27
Østfold	6.4 kg	Approx. 18
Vestfold	6.0 kg	Approx. 22
Follo	5.4 kg	Approx. 20

Source: NCIS

Amphetamine

The strength of mixtures containing amphetamine has declined during the last year, but there are still great differences (table 9). The average strength was approximately 40 per cent in 2004.

Table 9: Percentage strength of amphetamine in major individual seizures

Police district	Quantity of amphetamine	Percentage strength
Romerike	25.7 kg	24-50
Oslo	19.7 kg	5
Østfold	19.0 kg	40
Østfold	10.9 kg	83
Østfold	10.1 kg	8

Source: NCIS

Methamphetamine

The average strength of methamphetamine has been calculated at approx. 50 per cent. This is the same percentage as in 2003.

Cocaine

Previously, the strength of cocaine was usually more than 80 per cent, while in 2003 it was stipulated to lie between 30 and 60 per cent. In 2004, the average strength of cocaine was stipulated at 58 per cent. Neither coca leaves nor cocaine base (crack) were seized in 2004. It was in the last six months of the year in particular that lower strengths were registered.

Ecstasy

No exact calculations have been made, but it appears that the average amount of the active agent is continuing to fall slightly. In the 12 biggest cases, the amount of MDMA in each tablet varied from 44 mg to 102 mg, but amounts of MDMA of 120 mg were also registered.

PART B: Selected issues

11. Gender differences

Astrid Skretting, researcher SIRUS

11.1 Introduction

Traditionally, there have been clear differences between women and men with respect to both the use of drugs and alcohol and various problems associated with such use. Men, for example, have always had a higher consumption of alcohol than women, and naturally men are therefore more involved in various injuries in connection with the consumption of alcohol. We have recently registered an increase in alcohol consumption, and the relative increase is greater among women than among men. This applies both to the adult population and to youth. As regards the use and abuse of drugs, the gender differences among young people are not particularly pronounced if we examine what we usually refer to as experimental use of cannabis, for instance. However, a clearly larger proportion of men than women among the older age groups state that they take cannabis. There is also a clearly larger proportion of men than women in the group who develop hardcore abuse of both alcohol and drugs. In the following, we will examine the relationship between men and women/boys and girls as illustrated in various data sets relating to the use/abuse of drugs and alcohol.

11.2 Surveys

SIRUS carries out regular surveys on the use of drugs and alcohol among both the adult population (15 years +) and among youth (15-20 years). The purpose of the surveys is to monitor developments in alcohol consumption, drinking patterns and the experimental use of various drugs. In order to establish an overview of the abuse of different drugs, however, it is necessary to utilise other data sources.

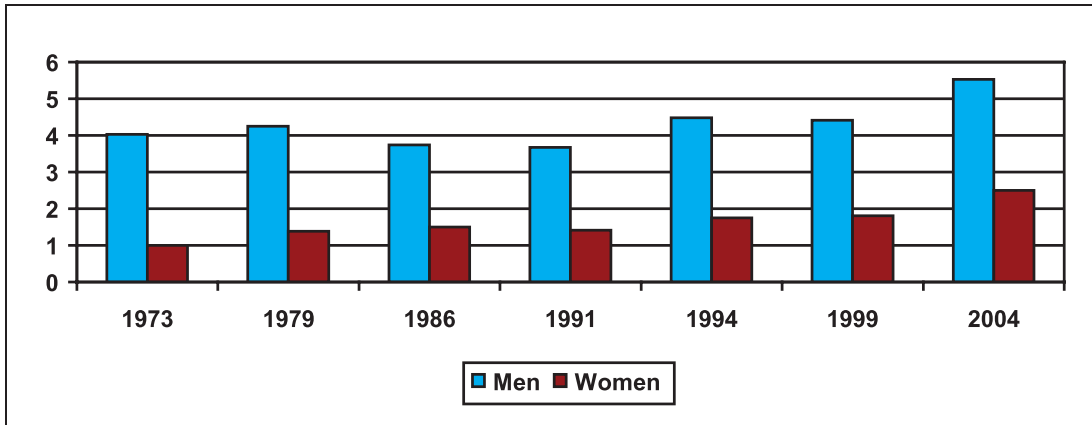
11.2.1 In the general population

Surveys on the use of drugs and alcohol among the 15 + population are carried out roughly every five or six years (see also chapter 2.1).

Alcohol.

The surveys provide a basis for calculating the population's average annual consumption of alcohol. Experience shows that the estimated alcohol consumption is, for various reasons, always lower than the registered consumption. However, the surveys provide a basis for saying something about drinking patterns and the distribution of consumption between different groups in the population, for example between women and men, and developments over time. Following a decline in both the registered and the reported consumption of alcohol during the first half of the 1990s, both the registered and reported consumption of alcohol have increased. As shown in figure 16, the absolute increase is roughly the same for both genders, while the relative increase in the estimated alcohol consumption is much greater for women than for men. While alcohol consumption among women has more than doubled from the 1970s/1980s to the 2004 survey, the corresponding increase among men is approximately 30-40 per cent.

Figure 16: Estimated average annual consumption of alcohol in litres of pure alcohol among women and men (15 +)



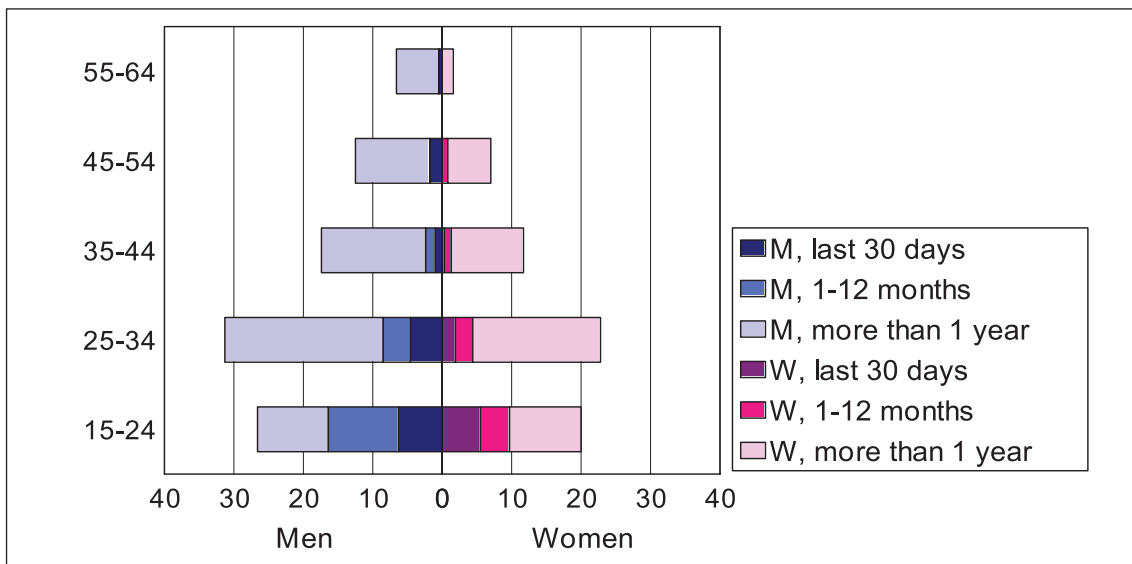
Source: SIRUS

Illegal drugs

Figure 17 shows the proportion of women and men in different age groups in the 2004 survey who state that they have taken cannabis: ever, during the past year and during the past 30 days.

The difference between the genders is relatively large with respect to the use of cannabis. For the whole age group between 15 and 64, 13 per cent of women and almost 20 per cent of men answer that they have ever taken cannabis. 3.2 per cent of women and 6 per cent of men stated that they had taken cannabis during the past year, and 1.5 per cent of women and 2.9 per cent of men say that they have taken it during the past thirty days.

Figure 17: Percentage in different gender and age groups who have taken marihuana/hash: ever, during the past year and during the past 30 days, respectively.



Source: SIRUS

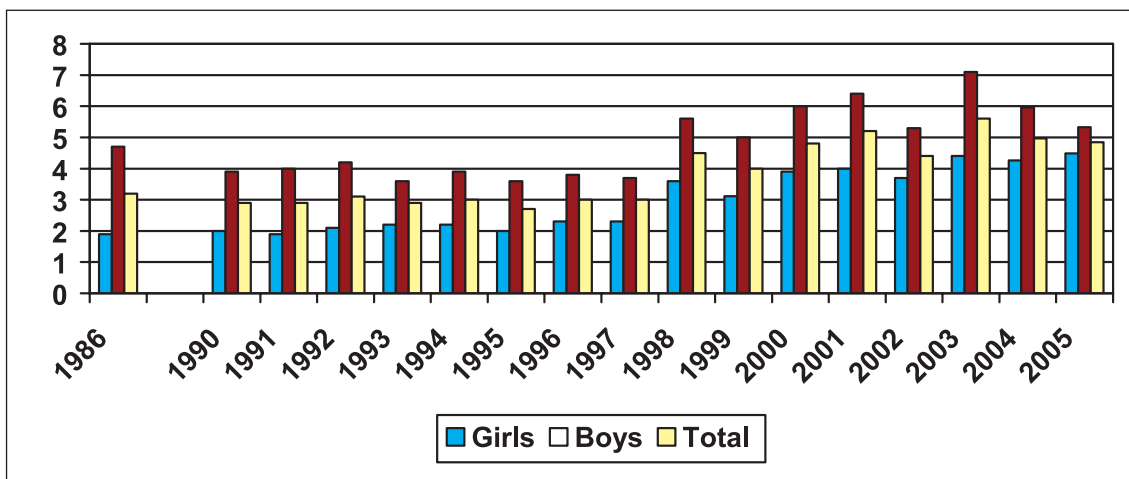
Figure 17 shows that lifetime prevalence (the entire coloured columns) is higher among men than among women in all age groups. The same applies to the percentages who have taken cannabis during the past year (the two darkest areas of the columns) and during the past 30 days, except for the fact that no one in the oldest age group had taken cannabis during the past year, and that the figures for both women and men are small for everyone over the age of 35. In the 15-24 age group, however, the percentage that has taken cannabis during the past 30 days is almost as large among women as among men.

The figures are so small for other drugs that gender differences are not statistically significant.

11.2.2 Young people

Questionnaire surveys are carried out among the 15-20 age group every year. Calculations of the average annual consumption are shown in figure 18 and show that the reported alcohol consumption among girls has increased relatively more than among boys. While, roughly speaking, boys previously drank twice as much as girls, this ratio has changed during the past decade. As shown in figure 18, the difference in alcohol consumption between boys and girls is now much less than it was found to be during the first half of the 1990s.

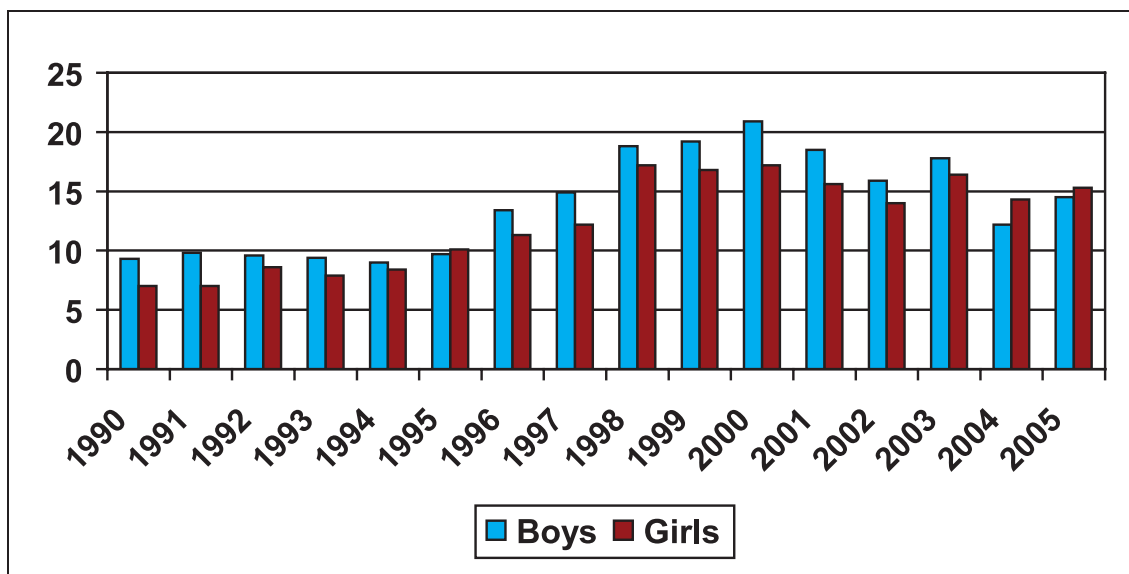
Figure 18: Estimated average alcohol consumption in litres of pure alcohol among boys and girls aged 15-20 in Norway, 1986 – 2005



Source: SIRUS

Unlike the situation among the adult population, there is little difference between boys and girls in the 15-20 age group with respect to the use of cannabis and other illegal drugs. However, figure 19 shows that while there previously was a slightly higher proportion of boys than girls who reported that they had ever taken cannabis, the proportion was slightly higher in 2004 and 2005 among girls. It should be mentioned, however, that the differences are for the most part not significant.

Figure 19: Percentage of boys and girls in Norway who state that they have ever taken cannabis



Source: SIRUS

With respect to use during the past six months in 2005, the proportion was 8 per cent among boys and 6 per cent among girls, while, in 2004, 6 per cent of both boys and girls stated that they had taken cannabis during the past six months.

Nor is there any difference between girls and boys with respect to the proportion reporting that they have ever taken amphetamine, roughly 3-4 per cent among both boys and girls in both 2004 and 2005.

In the same way as the annual surveys of the 15-20 age group, the ESPAD surveys also show that, while in 1995 and 1999 a slightly larger proportion of boys than girls reported having taken cannabis, there was no such difference in the 2003 survey.

11.3 Mortality and drug-related deaths

Men also account for a much larger proportion than women of drug-related deaths. In recent years, men have accounted for 75-80 per cent of drug-related deaths, while women account for approximately 20-25 per cent (chapter 6.1).

11.4 Infectious diseases

HIV

In 2004, there were only 15 new cases of HIV among intravenous drug users (chapter 6.2). Eight of them were men, seven women. The corresponding figures for 2003 were 16 new cases of HIV, 11 men and 5 women.

Hepatitis

An overview is only available for hepatitis B (standard table 09). The gender distribution among newly infected cases has been relatively stable during the period 1997-2004. The proportion of men varied from 71 (2001) to 78 per cent (1999), while the proportion of women varied from 22 (1999) to 29 per cent (2001). While it is true that the differences in the last two years were among the most pronounced during the period, we have chosen not to attach too much weight to this.

11.5 Treatment and care

Most Norwegian treatment facilities admit both women and men. However, some facilities admit only women or only men. This applies both to treatment units and to care-based institutions. Some treatment facilities are also organised for pregnant women and problem drug or alcohol users with children (family departments). These facilities are dominated by women with drug or alcohol problems, since the husband/father has often disappeared from the scene. Even though the treatment facilities admit both women and men, many of them nonetheless have special women's or men's groups as an integrated part of the treatment.

The gender distribution in so-called clinical populations of problem drug users has for several years been approximately 30 per cent women and 70 per cent men. This applies both to drug-free treatment facilities and to substitution treatment. The average age of men in treatment is higher than for women, and the proportion of women in treatment/ care facilities for problem drug or alcohol users is higher among younger age groups than among older age groups. See also chapter 4.2 Profiles of clients in treatment.

11.6 Penal reactions

Men dominate clearly with respect to penal reactions for various forms of drug crime. In 2002, men accounted for 84 per cent of those receiving penal reactions for drug crimes (illegal importation, selling), while 79 per cent of those who received penal reactions for violations of the Act relating to medicines (use, possession) were men. More recent figures are not yet available.

11.7 Other aspects

An injection room was opened in Oslo on 1 February 2005 on a trial basis (see chapters 1.1 and 7.2). For capacity reasons the number of registered users has been limited to 300, 29 per cent of whom are women and 71 per cent men.

A study: Intravenous drug users in Oslo, a survey of a non-clinical population

Since 1993, SIRUS has conducted regular interviews with persons who contact the needle distribution programme in Oslo (see also chapter 4.3). The goals of the project include adding to knowledge about the drugs market and the financial aspects of intravenous drug use. The interviews were conducted monthly the first year, then quarterly until 1997 and thereafter every six months. So far, 3 800 interviews have been registered. The interviews are anonymous and some individuals have probably taken part more than once. The sample can probably be regarded as relatively representative for intravenous drug users in Oslo.

As in other studies of drug users, we find that approx. one third of the sample are women. However, there are major differences in the percentage of women in the different age groups (table 10).

Table 10: Percentage of women in different age groups

	<20	20-24	25-29	30-34	35-39	≥40	Totalt
Proportion of women	68	46	36	28	26	18	31
Total number of interviews	75	526	889	957	796	576	3819

Source: SIRUS

While two out of three persons among those under the age of 20 are women, the percentage of women falls to below 20 among those over the age of 40. There may be several reasons for this; it has among other things been claimed that it is easier for women to quit the abuse situation and that more men than women start injecting after the age of 30. The average age of the interviewees rose by almost five years during the survey period, from 29.1 years in 1993 to 33.8 years in 2004. The women are on average three years younger than the men. The sample has a relatively low educational level (approx. 2 years over and above lower secondary school on average), and more than 90 per cent are of Norwegian origin.

There are clear gender differences in that the total reported consumption among women is greater than among men. While female heroin addicts report an average consumption of 20.3 grams per month, the corresponding figure for men was 17.2 grams. This finding is surprising in light of the fact that female problem drinkers always report a lower consumption than male problem drinkers (Bretteville-Jensen, 2005).

11.8 Summary

Even though women and young girls still have lower alcohol consumption than men/ boys, the difference is smaller today than previously.

There is little difference between girls and boys with respect to what we call experimental use of illegal drugs. Among older age groups, however, there are more men than women who report having taken cannabis.

In the group “hardcore” drug addicts, different data sets show with certain variations a gender distribution of approximately 30 per cent women and 70 per cent men. The proportion of women is higher among younger than among older addicts. As a result of the fact that the price of heroin has fallen in Oslo, individual users have increased their consumption, and the increase is greater among women than among men.

12. European drug policies: extended beyond illicit drugs?

Torbjørn Brekke, senior adviser. Ministry of Labour and Social Affairs

12.1 Official endorsement of the National Drug Strategy

The Norwegian Government's *Action Plan to Combat Drug and Alcohol-related Problems 2003-2005* (The Action Plan) was proposed in October 2002. See NR 2003 chapter 1.1. A new Action Plan for the years 2006-2008 was proposed in August 2005. The new plan is largely a prolongation of the previous plan (chapter 1.2.2).

One of the main strategic objectives of the Action Plan 2003-2005 is to prevent all types of substance abuse, particularly among children and young people. The substances to which the alcohol and drug policy refers are all substances which cause intoxication by affecting the brain. They include alcohol, illegal drugs (cannabis, amphetamine, heroin, etc.), solvents and certain legal substances (sleeping pills, sedatives).

There are also a number of substances and/or behavioural disorders which are related to alcohol and drug issues. This concerns in particular the use of tobacco and doping substances, and addictive disorders such as compulsive gambling. In some cases, the prevention and treatment of these problems will overlap and in others special methods and expertise will be required. The Government has high ambitions for its efforts to prevent smoking, and these may also have a positive effect on its work to prevent substance use and abuse. With the exception of doping substances, the Government has nevertheless chosen not to include work specifically addressing these problems in this action plan, but it will seek to coordinate efforts where expedient. The sale and use of doping substances outside sporting contexts has shown a disturbing increase in recent years. The Government will consider whether doping as a social problem should be linked more closely to efforts to combat substance abuse.

The Government advocates a holistic approach to the social and health-related problems that are associated with alcohol, drugs, tobacco, doping and other related factors. A long-term, goal-oriented programme to reduce these problems is planned. A sector-overlapping approach at all levels, including the international level, will ensure a sustainable and more effective policy. The targets set must, at the same time, be realistic ones.

Children and young people are at risk as regards the use of alcohol and drugs and their negative consequences. They are more vulnerable than adults and have less chance of influencing their own life situation. Children and young people have a right to be shielded from the negative consequences of their own and other people's substance abuse. Alcohol and drug-related problems can be significantly reduced by delaying the onset of drinking by young people and by preventing their initial drug use. Preventive work among children and young people is therefore an important part of the Action Plan.

12.2 Genesis and rationale

Norwegian alcohol and drug policy has traditionally been based on regulation/control (alcohol) and prohibition (drugs). This has been combined with appropriate help and treatment services for those affected. During the last two decades or more, Norway has taken a broad approach including both alcohol and drugs in policy documents, reports to the Storting (parliament) etc. as well as in meas-

ures implemented. This has been the situation with respect to prevention in particular, though there have been examples of local plans addressing alcohol and drugs separately. The first national action plan including both alcohol and drugs was launched in 2002 (chapter 12.1).

Other countries have often regarded the official Norwegian policy as restrictive. Norway's approach has probably produced some positive results, particularly at the national level. The percentage of the population suffering from alcohol and drug-related problems is lower in Norway than in other European countries. However, those who are affected have serious problems, and the high number of overdose fatalities in the last decade has caused particular concern. The Government will continue to prohibit drugs and to regulate the sale and consumption of alcohol in order to reduce alcohol-related problems.

Doping has traditionally been regarded as a problem limited to performance-enhancing drugs used in sports. Developments in recent years have shown that the abuse of doping substances in more and more areas is a problem on a scale approaching that involving traditional intoxicants. In the context of the Action Plan, doping substances are understood to be testosterone preparations and anabolic/androgenic steroids.

There has been growing focus on and concern about gambling as a social problem since the late 1980s, and gambling is now to some extent regarded as an addiction, similar to drug addiction. Treatment for gambling was originally included in the treatment system for drug and alcohol-related problems. This is still the situation, but some institutions have built up specific competence on this issue. Preventing gambling is included in the holistic approach though special efforts, and regulatory steps have been taken. One of the seven regional competence centres has been assigned special responsibility for know-how on the issue. Several articles has been published in recent years on compulsive gambling and its link to addiction in general.

12.3 Responsibility and coordination

Norwegian alcohol and drug policy is interdepartmental. Seven ministries are directly involved and the Ministry of Health and Care Services is from 17.10.2005 responsible for coordination (chapter 1.2.1). Each ministry has one or more directorates which are responsible for implementing the Action Plan.

The Directorate for Health and Social Affairs is responsible for coordination of the plan at directorate level. This involves monitoring health and social conditions, as well as the development of health and social services. On this basis, the Directorate provides advice and guidance on strategies and measures to the central government, municipalities, the regional health authorities, as well as to NGOs and the general public. Furthermore, the Directorate compiles knowledge and experience relating to professional issues and serves as the normative national body for services in selected areas.

Seven regional competence centres on alcohol and drug-related questions have been established in order to serve regional authorities and municipalities (chapter 1.2).

The five regional health authorities are responsible for specialist interdisciplinary treatment (chapter 1.2).

Budgets at ministry level are always related to objectives, mainly allocated as block grants that do not distinguish between different types of substances. For preventive purposes, however, parts of budgets may be allocated to certain defined (risk) behaviour.

13. Developments in drug use in recreational settings

Henning Pedersen & Dag B. Grødal, special consultants. The Alcohol and Drug Addiction Services's Competence Centre, Oslo

13.1 Introduction

We have chosen to focus especially on developments in the recreational use of illegal drugs in Oslo, and in connection with nightlife and the club scene in particular. We have also gathered some information from other towns – Bergen, Trondheim, Stavanger and Tromsø – which are the largest towns in different regions in Norway. In addition, we have collected information from Drammen which is the biggest town near Oslo. By recreational use in this context is meant use of illegal drugs that is more extensive than experimental use but where the use has not been established as a regular, compulsive pattern. We have attempted to describe developments in terms of the following:

- New observations, tendencies, trends or findings relating to recreational use.
- The milieus and arenas in which illegal drugs are used in the recreational context.
- The consequences which changes in the pattern of use will have for the users themselves and for the recruitment of new user groups.
- The responses established to prevent abuse or reduce harm caused by use.

13.2 Method

We have employed a twofold method involving both a qualitative and a quantitative approach. We have distributed open questionnaires to the outreach service in Oslo and to outreach workers in the other towns. We have also carried out a focus group interview with all the outreach workers in the different wards in Oslo. Eight employees/managers at selected bars/nightclubs in Oslo have been interviewed. In addition, we have also interviewed the emergency childcare service in Oslo, the police and six young people from different subcultures associated with the recreational use of drugs. The collection of information has taken place over a period of two months from August to October 2005.

We have based ourselves on sources who we believe are capable of telling us something about young people at risk or about the nightlife/club scene in Oslo. The qualitative findings presented here cannot therefore be generalised. They must be understood as expressing the opinions of those who have consented to being interviewed or who have completed a questionnaire.

13.3 Previous research and reports

The youth survey

SIRUS's annual youth survey provides data about youth between the ages of 15 and 20 in Oslo and the rest of Norway (chapter 2.2.2). Only the figures concerning Oslo will be used in this context. The youth survey shows that the use of illegal drugs appears to have been decreasing during the last five years. The biggest decline is reported in relation to the lifetime prevalence of cannabis, amphetamine and ecstasy. Cannabis use declined from 28 to 23 per cent, while amphetamine use decreased from 7 to 5 per cent and there was a decline from 5 to 3 per cent in the proportion who reported having ever taken ecstasy. A decline was also reported in the use of all other illegal drugs with the exception of cocaine. For cocaine, there was a slight increase, from 5 to 6 per cent, in the proportion reporting that they had ever taken the drug.

A significant weakness of this survey in relation to our purpose is that it is limited to those between the ages of 15 and 20. We assume that it is in the 20-35 age group that the largest group of recreational users of illegal drugs are to be found.

The “Føre Var (Earlier warning system)” reports

The “Earlier warning system” projects report on local trends in the drugs field. See chapter 2.4 for a more detailed discussion. Earlier warning projects have been established in several large towns in recent years. In our context, we have used the reports from Oslo, Bergen and Drammen. The six-monthly reports published in spring 2005 have been used for Bergen and Drammen, while we have used the report published in December 2004 for Oslo, since Oslo has not published a more recent report.

The “Earlier warning” reports show certain common characteristics. One main common feature is that no major changes in drug and alcohol use have been registered in these towns/cities. Minor increases in the use of cocaine have been reported, however, in both Oslo, Bergen and Drammen. It is particularly informants from the nightlife scene who report increased use of cocaine. The “Earlier warning” reports have previously reported a decline in the use of ecstasy. This decline appears to be confirmed by police seizure figures which show that the quantity of ecstasy seized has been halved from 2000 to 2004. Moreover, the “Earlier warning” reports also describe increased use of anabolic steroids among young boys and men. Subject to the validity of the data, the following tendencies emerge:

- No major changes in the use of drugs and alcohol.
- A slight increase in the use of cocaine.
- A decline in and stabilisation at a low level of the use of ecstasy.
- Increased use of anabolic steroids.

Two publications

The book “Partydop og ungdomskultur” describes the general cultural framework for experimentation and the recreational use of drugs.

“Traditionally, young people’s drug use has been described as a response to a difficult background, mental health problems or similar. However, the use of party drugs is probably also largely a response to a subcultural orientation in which the use of drugs forms part of a “style package” (...). We believe that it is particularly important to study in more detail the recreational use of drugs which forms part of “cultural style packages” in order to identify the motivational patterns and “stages” in the development of drug abuse” (Moshuus et al. 2002).

This publication focuses on various subcultures as driving forces behind drug use among young people. It describes the development of different patterns of use as an adaptation to and marker of belonging to specific subcultural scenes. It highlights popular alternative youth subcultures such as house, techno and hip hop, music scenes in which the use of particular drugs can form an important part of the style package.

In a literature study published in 2002 on youth who take ecstasy and other party drugs, the media-created image of users of party drugs as successful, normally-functioning youth is challenged. It concludes as follows:

“The positive image of young people who “pop E” or who take other typical party drugs probably only applies to rare exceptions. Findings from various studies of young people in the normal population point exclusively in one direction. In other words, it still seems to be the case that illegal drugs, and ecstasy and other heavier drugs in particular, are most prevalent among youth who have problems in different areas of life. Furthermore, the situation is that there is a total lack of documentation that the opposite is true (...). It is not only imprecise and misleading to claim that it is normal,

resourceful youth from “nice” homes who take ecstasy or other party drugs. Such normalisation also has a seductive effect and potentially promotes sales” (Pape, 2002).

Our evaluation

We have conducted interviews with key informants among young people and employees in the nightlife sector in order to try and form an impression of the use of drugs in these milieus today. Our informants provide information that supports the conclusion (Moshuus et al.) that the house, techno and hip hop cultures have changed from being expressions of young people’s own culture to become more commercial and easily accessible consumer cultures. This provides an opening for the spread of drug use to new groups of young people who identify with these forms of cultural expression. However, it appears that the commercialisation of these cultures in Norway has resulted in the splitting up and differentiation of these cultures into countless local styles. Our informants describe how younger youths use these subcultures less than before as central elements in the construction of their own identity. The young are increasingly using local reference points such as local networks of friends to confirm and clarify their own identity. This may mean that these previously relatively extensive subcultures have lost some of their effect as motivating factors and driving forces behind young people’s use of new illegal drugs.

The literature study (Pape 2002) focused mainly on ecstasy, the drug which was perhaps the foremost symbol of the rave culture. It is reasonable to assume that the trendsetters who took the drug in the late 1980s in Norway are not necessarily identical with the users of the drug from the mid-1990s to the present day.

In our mapping of the situation, we have received information from sources on Oslo’s nightlife scene who describe the use of cocaine among new groups of resourceful youth. Although the basis for our conclusion is weak, the reports we are receiving from people in the nightlife sector are in conflict with the literature study, which states that the recreational use of illegal drugs only occurs among, well-integrated and resourceful young people in exceptional cases. In our material, recreational use of cocaine on the nightlife scene is associated with relatively prosperous groups of young adults (25-34 years) with attractive jobs in the media, advertising and IT sectors. However, we know nothing about the background of these user groups or about what problems they may have outside the workplace and their active role on Oslo’s nightlife scene. The literature study also confirms that there are major gaps in the research with respect to the recreational use of drugs. *“Knowledge is particularly limited as regards the use of illegal drugs among those who are in the borderline area between “prolonged youth” and the established adult world.”* There should therefore be reason to examine more closely the recreational use of illegal drugs among young adults in future studies.

In the data collected for this study the *users’ local neighbourhood, open drug milieus in town centre areas* and the *nightlife scene* emerge as the most important arenas for the recreational use of illegal drugs. In the following, we will take a closer look at the three arenas for recreational use of illegal drugs that emerge from the reports from our informants.

13.4 Drug use in users’ local neighbourhood

Among younger youths (under the age of 20), informants reported a strong connection between the use of alcohol and the recreational use of illegal drugs. There are local milieus in most areas of Oslo which young people can visit or contact in order to buy illegal drugs. These milieus are, to a lesser extent than previously, visible, youth milieus with fixed bases. Most of the informants report that the purchase and sale of drugs takes place via contacts among users’ network of friends and that agreements for buying and selling are entered into by mobile phone or via the internet.

Among younger youths, recreational use primarily involves the use of cannabis. Most of the informants report changed attitudes in the direction of greater acceptance of the use of cannabis among

young people who do not use cannabis themselves. The following statement by an outreach worker is a good description of the situation many of our informants report: *“We register a change in attitude among youth, whereby large sections of the youth population display the attitude that “everyone is the architect of his own fortune”. Everyone is responsible for his/her own life – I look after myself, and everyone else can do what they like.”*

Most outreach workers have reported that cannabis has become a more visible intoxicant at home-alone parties than previously. In the eastern areas of Oslo, where young people do not have their own flats or basement rooms in their parents’ houses at their disposal to any great extent, the use of cannabis is more visible and open in public areas. Many outreach workers report changes in the direction of increased openness from young people about their own use of cannabis. Several outreach workers report that increasing numbers of young people are experiencing dependency problems in relation to cannabis use. Moreover, the outreach services report increasing distance between those who take and those who do not take illegal drugs. The majority of the youth group still distance themselves from the use of illegal drugs, but, as already mentioned, they increasingly define the issue as a matter of personal choice.

The reports from outreach workers on young people’s use of other illegal drugs largely concern marginalized youth groups. Most outreach workers in Oslo’s wards know of local milieus among younger and older youths who regularly take illegal drugs. However, there is disagreement with respect to whether their use of illegal drugs can be defined as recreational use or whether it borders more on problem use. It is a widespread view that it is from these local drug milieus in users’ local neighbourhoods that young people are recruited to more serious abuse.

Several outreach workers point out that increasing numbers of young people, and young boys in particular, are interested in anabolic steroids. We do not have statistics to prove increased use of such substances, but our mapping indicates that the use of anabolic steroids should be given more attention in future research. The situation reported from Oslo with respect to drug use in users’ local neighbourhoods is largely in accord with the situation reported from other towns we have included in the study.

Responses

The municipalities are responsible for drug and alcohol prevention efforts. All municipalities make a certain effort through preventive programmes in schools. 77 (of 434) municipalities have established outreach services or other municipal outreach activities aimed at youth at risk. These are mostly municipalities with a certain urban character and high populations by Norwegian standards. The City of Oslo has established outreach services in the inner city and in 11 of the city’s 15 wards. Municipal outreach services largely involve obtaining an overview of hidden groups of youth at risk and helping to create positive change among these youths through establishing contact between them and the established support services, the workplace, schools or other inclusive social arenas.

13.5 Drug use in town centre areas

In Oslo city centre there are two relatively visible and well-known marketplaces for the sale of illegal drugs. Heroin and other drugs for which there is demand among opiate abusers are bought and sold in an area around the lower section of the city’s main street, Karl Johans gate (see also NR 2004 chapter 1.4). The core of this milieu primarily consists of established, adult opiate abusers who are not part of the target group for the present study. However, according to the outreach service, the milieu is also visited by other users who are not established opiate abusers. Among others, young people from the nightlife scene previously only known to the outreach service as users of central stimulants now also visit this milieu to buy drugs.

In 2004, a study was carried out of young people who hang out in the vicinity of this milieu. Among other things, the study focused on the importance of the open drug milieu for the recruitment of ordinary youth to drug abuse. At the time, this milieu hung out in the “Plata” area outside Oslo’s main railway station, roughly 100 metres from where the milieu is based today. There is nonetheless reason to believe that its findings are still relevant after the milieu has been moved. The summing up of the study states:

“Our data indicate that the wards outside Oslo city centre and the belt along the Akerselva river have long been more important arenas for sale and recruitment than Plata. Even though Plata did not act as a recruitment arena, it did act as a sales centre – mostly for hardcore drug addicts, but also for emergency use by hidden abusers and young people with established abuse. But for ordinary youth in Oslo city centre it does not seem to have played an important role” (Pedersen, Sandberg, 2005).

There is also another area further east in Oslo city centre where the sale of illegal drugs takes place visibly and in the open. In this area, it is primarily hash, pills and cocaine that are sold. According to reports from the outreach service, the sale and use of cannabis and cocaine in these milieus has increased. Counts carried out by the outreach service during summer 2005 show that there are up to 90 per cent boys in this milieu and that the milieu is dominated by youth from minority backgrounds. Between 70 and 80 per cent of youth registered in this milieu are from non-Norwegian ethnic backgrounds. Many of them identify with heroes from the Gangsta rap scene⁷. Those who occasionally buy drugs in this milieu stand out clearly from those who sell and hang out in the milieu over time. Such persons make brief visits, buy drugs and then leave the area.

Responses

Action plans have been drawn up for both these open milieus in Oslo city centre, and substantial funding has been allocated, both government and municipal funding, for preventive and harm-reduction responses aimed at these open drug milieus (see NR 2004 chapter 7). Together with a more intense police presence, outreach work, improved treatment services, the establishment of injection rooms and the coordination of support services have been the most important strategies employed in these efforts.

13.6 Drug use in nightlife arenas

Through its outreach efforts, Oslo’s outreach service has focused in particular on drug use on Oslo’s nightlife scene. *Future* is a drug prevention project organised by Oslo’s outreach service which targets the club scene and the nightlife scene in particular. The project is a collaboration between voluntary personnel recruited from the house and techno scenes and the outreach service in Oslo. Their work involves being present in pubs and bars, at festivals and other major events. Despite great efforts from both field workers and voluntary personnel, *Future* is only able to visit a limited number of these arenas. The amount of information obtained is nonetheless large, among other things through contact with voluntary project personnel who are very active on the nightlife scene and with young people who seek help for drug or alcohol-related problems. *Future* is therefore a good source for reporting on developments in drug use on the nightlife scene.

Previously, the outreach service and *Future* concentrated to a large extent on nightclubs and bars etc. that played house and techno music. According to the police and the outreach service in Oslo, the use of illegal drugs was widespread in these milieus. Today, the outreach service and *Future*

⁷ Gangsta rap is a subgenre of hip hop music which involves a lyrical focus on the lifestyles of inner-city thugs, criminals and gangsters. “ www.en.wikipedia.org

report that there is no particular club scene that stands out with respect to the widespread use of illegal drugs. They describe a situation in which styles and musical genres are more often mixed and in which the use of illegal drugs takes place at many different bars, pubs, clubs etc. The outreach service believes that they can notice an increase in the availability of cocaine, particularly among persons over the age of 25 who go out a lot to bars/nightclubs etc. The outreach service and Future see this in conjunction with lower prices for cocaine, the increased availability of the drug and the fact that most people have become more prosperous so that they can afford to use cocaine.

In their reporting, the outreach service and Future emphasise the fact that the use of central stimulants is no longer linked to a specific subculture or specific genres of electronic music, as was the situation described a few years ago. This is also confirmed by all our informants who know the Oslo scene well. Drug use is linked more to established networks of friends who frequent various bars, nightclubs etc. in Oslo. Ecstasy and GHB are reported to be less visible on the scene, while most of our informants believe that cocaine has become more visible and accepted by more people than before.

The outreach service in Oslo has worked on a number of clubs and events for homosexuals and lesbians. They believe that more alcohol is drunk and that there is more experimentation with illegal drugs in these milieus than in other nightlife venues. This is also supported by other informants on the nightlife scene in Oslo. We have also found support for this finding in new research. One report concludes that young homosexuals have a higher consumption of both legal and illegal drugs than other youth.

“One main conclusion is that those lesbians, bisexuals and homosexuals who belong to the core groups in the lesbian/homosexual milieus in Norway display much poorer health behaviour with respect to the abuse of alcohol and drugs than the homosexual population in general.” (Ulstein Moseng, 2005).

This may be an indication that young homosexuals who are active at high-profile nightlife venues for homosexuals in Oslo are a group in which the recreational use of illegal drugs is more widespread than in the rest of the population.

“Finally, it must be concluded that, as shown in previous representative Norwegian and international surveys, the drug and alcohol survey, Gay Days 2003, shows that homosexual women and men are a particularly vulnerable group with respect to drug and alcohol problems. Seen in this light, it is disturbing that in Norway there is at present no drug and alcohol prevention work or strategies based on research results relating to the unique risk factors that can explain the uneven distribution of healthy behaviour with respect to drugs and alcohol between homosexual women and men and the majority population in general.” (Ulstein Moseng, 2005)

In the long term, trend-setting groups' drug and alcohol behaviour may have a decisive influence on other sections of the nightlife scene. Groups of homosexuals have been viewed as trendsetters and important pioneers on the nightlife scene. Nevertheless, we also know of no national drug and alcohol strategies to prevent drug and alcohol use in these milieus.

Information from employees in the nightlife sector may indicate that there is a certain increase in the recreational use of illegal drugs. Cocaine has been mentioned in particular. The manager of a popular bar whose clientele mainly consists of young middle class adults describes the situation as follows:

“More people than before are now using drugs as instant recreation in order to switch off from the day-to-day demands and stress of their jobs without having to experience the Monday morning hangover that results from binge drinking. I notice that a larger proportion of cocaine users have become open about their use, and they are keener than before to get friends who are not users

involved. I believe that people's increased openness about cocaine use can help to make it seem more harmless and lower the threshold for new users." ("Markus' 31)

Through these informants, we have learned that small milieus exist in which the recreational use of illegal drugs is relatively widespread. This applies to several small groups who are clearly distinguishable from more mainstream-oriented youth groups.

One example is the music milieu referred to as the "psytrance scene". It consists of somewhere in the region of 200-300 persons. Its most important characteristics are the musical style and its focus on an organic lifestyle such as vegetarian food, organic intoxicants and woodland parties. The milieu largely consists of persons between the ages of 25 and 40 from the lower social strata of the population. Our informants estimate that more than fifty per cent of those who belong to this milieu take cannabis. Alcohol is the most used intoxicants at parties, but also cannabis and psilocybe mushrooms are taken by a significant proportion of the participants. The milieu gets together at special events at nightclubs in Oslo or at woodland parties that are convened by email, internet radio or mobile phone. According to our sources, other illegal drugs are also taken, such as amphetamine and LSD, but not to a greater extent than at other nightlife venues in Oslo. The milieu is described as relatively stable, with little turnover and recruitment of new members. According to our sources, young people under the age of 25 regard this milieu as peculiar and not very attractive. Our sources believe that no great changes have taken place in drug and alcohol use in this milieu during the past five years. On the other hand, they point out that groups who are better off financially than themselves have changed their habits:

"If you are not completely out of it and commit crimes to get money for drugs or are rich, money is actually a pretty important factor. I can't be bothered spending a thousand kroner on one gram of cocaine, I prefer to buy some good hash topped off with some mushrooms and good whisky." ("Peter' 32)

Other sections of the techno and house milieus also organise open-air happenings at which there is extensive use of illegal drugs, according to reports we have received. One source from the techno scene describes the situation as follows:

"At some of the parties most of the participants are high on illegal drugs, particularly at open-air events. GHB and ecstasy are on the way out, cocaine is on the way in." ("Sara' 26)

The bar manager and concept developer at a large restaurant and nightclub in Oslo states that they have experienced some problems with drunkenness. Otherwise, he emphasises cocaine use and dealing in and around the club as a major challenge. He said the following about their strategies to meet these challenges:

"It is a problem for us that we have attracted several people who we know to also be heavily involved in selling cocaine. It is a challenge to discover them and get rid of them, particularly since those who sell cocaine are often the most pleasant and polite towards the staff, and as a rule they usually have their own "court" consisting of other pleasant and attractive guests. We do not want to be a venue associated with drugs and dealing. In my experience it is bad for business in the long run. We have therefore implemented a number of measures:

- *The shelves in the toilets have been covered in plaster in order to give them an uneven surface that is unsuitable for taking cocaine.*
- *High openings between the floor and the doors to the toilet stalls which make it easier for security guards to find out what is going on in the stalls.*
- *The disabled toilet is locked with a separate key that has to be obtained from the bar. It is only given to people with a genuine need for a disabled toilet.*

- *Personal contacts in the police have contributed to relatively frequent patrols both inside and outside.*
- *Floodlighting of the park surrounding the bar at nights.*
- *An explicit zero-tolerance policy with respect to illegal drugs among staff; two people have been given immediate dismissal so far after being caught breaking this prohibition.*
- *Guests discovered taking cocaine are thrown out.” (‘Gøran’ 35)*

On the basis of our survey, there no longer seems to be any significant subcultures on the nightlife scene that recruit new young people to the use of illegal drugs. The house and techno culture has lost a lot of its support and it recruits few new young people to such parties or nightclubs in Oslo. The Youth Base (outreach service) in Trondheim has nonetheless reported that a number of techno events are still held that attract relatively many young people. There is thus good reason to believe that there may be regional differences with respect to the prevalence and popularity of such subcultures. It is commonly believed that subcultures first appear in large towns and then spread to smaller places throughout the country.

The recreational use of illegal drugs takes place at different nightlife venues with different images, such as mainstream venues and venues with more limited target groups from the rock, metal, house, techno and hip hop scenes. Cannabis is the most common illegal drug used, while cocaine emerges as the illegal drug that is most on the increase on the nightlife scene. Ecstasy is less used now than it was previously. Homosexuals are one group on the nightlife scene who stand out because of their high consumption of drugs and alcohol.

Responses

As regards responses aimed at the recreational use of illegal drugs on Oslo’s nightlife scene, it is primarily Future that has spearheaded these efforts. It has produced information specially adapted to target groups on the nightlife scene and uses peer education as a central method in its work. It has developed a number of group and self-help responses aimed at party drug users. Only two other cities in Norway have established similar responses, Trondheim and, in part, Bergen.

Central framework for the regulation of the nightlife scene

The most important regulatory mechanisms for pubs, bars, nightclubs etc. are found in the Act on the sale of alcoholic beverages etc. – the Alcohol Act. The Alcohol Act contains regulatory provisions relating to the sale and serving of alcohol, and it is the municipal councils that are the licensing authorities. Licences can be revoked in the event of breach of the licence conditions or if requirements for licence holders are not satisfied. Note: An alcohol licence can also be revoked in the event of the repeated sale of drugs on the licensed premises.

Pursuant to the Police Regulations, the police are responsible for security at events in public places and at events to which the general public has access. Organisers of events are obliged to notify the police about the time, place and size of the event. Security arrangements and guard duties are often solved in cooperation between private security companies and the police, whereby the security companies draw up a plan for how the event can be secured and then obtain police approval for the plan. In a security plan it will, among other things, be relevant to include body searches before admission to big concerts or festival areas so that illegal objects and drugs can be confiscated.

13.7 Summary

In this study we have described in brief the recreational use of illegal drugs in three different arenas: users' local neighbourhoods, public areas in Oslo city centre and the nightlife scene. Our main conclusion is that no dramatic changes have taken place in the use of illegal drugs. We have not registered any strong subcultural trends that promote the use of particular illegal drugs. Nor, in light of the statistics on which we have based ourselves, has there been any significant increase in young people's use of illegal drugs. On the contrary, there appears to have been a decline in the number of young people who try illegal drugs. Outreach workers report a relatively stable situation with respect to young people's consumption of illegal drugs.

However, the fact that the strength of cannabis appears to have been increasing in recent years represents a challenge (Ramstrøm 2004). This may help to explain outreach workers' reports that more young people experience dependency problems in connection with cannabis use, without it necessarily being the case that more young people are taking the drug. There is a certain amount of concern attached to groups of marginalized youth who take a lot of drugs, but this does not appear to represent a new trend. On the other hand, the outreach workers report a new and more liberal attitude among young people to the use of anabolic steroids. There is a lack of reliable information and appropriate support services in this area. We have referred to documentation that may indicate that young homosexuals who are active on the nightlife scene are a group with a particularly high consumption of both illegal drugs and legal intoxicants.

Our sources on the nightlife scene report more visible use of cocaine in nightclubs and pubs, bars etc. in Oslo. The increase largely involves relatively well-established young adults (25 to 35 years old) who are active on the nightlife scene. Several of our informants from the nightlife scene call for responses and effective strategies to prevent the increased use of illegal drugs in pubs, bars, nightclubs etc. It appears that ecstasy, GHB and other party drugs that have traditionally been associated with rave parties are less used today on the nightlife scene than previously.

One main challenge in drug prevention work in the time ahead may be the fact that more and more young people who are active on the nightlife scene will have to take an active stance with respect to other guests' use of cocaine. According to our nightlife sources, this drug is seen as "the drug for successful people", in the same way that ecstasy was portrayed in the media. Today, cocaine appears to be regarded as an exclusive drug with a difference that stands out from other drugs which are associated with problem drug use and marginalized groups in society. A great deal of uncertainty does, however, attach to the reports we have received in this area. If our information about cocaine use and new user groups nevertheless proves correct, it will probably have consequences for the spreading and prevalence of cocaine in Norway in the long run.

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