European Monitoring Centre
for Drugs and Drug Addiction

SIRUS

2009 NATIONAL REPORT (2008 data) TO THE EMCDDA
by the Reitox National Focal Point

"NORWAY"
New Developments, Trends and in-depth information on selected issues

Norwegian Institute for Alcohol and Drug Research - SIRUS

Contents

Editor:

Odd Hordvin, SIRUS

Reference group: Astrid Skretting, Marit Edland Gryt, Anders Bryhni,Jostein Rise, all SIRUS.

Co-authors:

Chapter 1: Torbjørn Brekke, Ministry of Health and Care Services

Chapter 3: Maj Berger Sæther, Directorate of Health

Chapter 4: Ellen J.Amundsen, SIRUS

Chapter 6.1: Hans Blystad Norwegian Institute of Public health

Chapter 6.2: Einar Ødegård, SIRUS

Chapter 9.3 and 9.5: Rune Fjeld, Ministry of Justice and the Police

Chapter 10.3 Tormod Bønes, National Criminal Investigation Service

Authors of selected issues:

Chapter 11: Paul Larsson, The Norwegian Police University College

Chapter 12: Jørgen G. Bramness, The Norwegian Centre for Addiction Research

Translation: Allegro Language Services, Bergen

Summary –main findings

Main report – Part A

National policies and context

On 15 June 2009, the Norwegian parliament decided to make the temporary Act relating to injection rooms permanent. The injection room scheme will serve as a supplement in an overall chain of measures targeting those with major health problems who have difficulty quitting their drug use. Based on local needs, the individual municipalities can decide whether they wish to establish an injection room scheme. The legislative amendments with pertaining regulations enter into force on 17 December 2009.

The Government's action plan for the drugs and alcohol field was presented to the Storting in October 2007. It includes goals and measures for prevention, treatment and rehabilitation and entails a gradual escalation of funding in the period up until 2010. The Directorate of Health is responsible for implementing large parts of the drugs and alcohol policy. Moreover, it shall ensure that an overview of the drugs and alcohol situation is available at the regional and local level, and it will publish an annual status report.

According to the Directorate of Health, 115 of the Action Plan's 147 measures had been initiated at the end of 2008. Many of the measures are evaluated separately, and a comprehensive review of experience from the plan will be carried out.

A total of 19 drugs and alcohol advisers have been appointed by the 18 county governor offices. They will contribute to the implementation of the Action Plan in the municipalities. A three-year trial has started involving coordinating representatives in 30 selected municipalities. The aim of having such representatives is to help to ensure more coherent and individually-adapted services for people with drug or alcohol dependency, thus resulting in greater social inclusion and better life coping.

In connection with the Directorate of Health's grant schemes, great emphasis is placed on evaluating the measures and earmarking funds for this purpose. The goal is to help to improve quality and to support knowledge-based strategies and measures by ensuring continuity and local support.

Drug use among young people

The latest ESPAD survey among 15 to 16-year-old school students was carried out in 2007. The figures showed stability and, in part, a decline in relation to previous surveys. The decline is most pronounced in the use of cannabis. In 2007, around six per cent stated that they had ever used cannabis, while the corresponding figure for 2003 was nine per cent and, in 1999, 12 per cent. There were no significant changes for use during the last 30 days, however, which has been around two to three per cent in the last two surveys. The decline in cannabis use also reflects the tendency in Europe as a whole.

As regards the use of illegal substances other than cannabis, there have been minor changes in lifetime prevalence among young people under the age of 20. On the other hand, the proportion of young adults aged 21 to 30 who have ever used cocaine has tripled, from three per cent in 1998 to nine per cent in 2006. The proportion reporting that they have ever used amphetamine has increased from five per cent to ten per cent during

the same period. However, the proportion of young adults who have used amphetamine or cocaine during the last six months has remained stable at around two per cent.

There seems to be a clear connection between the use of cannabis and central stimulants among both youth and young adults. The proportion who had also used central stimulants increased in step with the number of times cannabis had been used. The majority of those who had used cannabis more than 51 times had also tried amphetamine or cocaine. The vast majority of those who stated that they had used central stimulants have previously used hash.

Among problem drug users

The number of injecting drug users in 2007 can be estimated to be between 8,600 and 12,600. This includes all injecting use. Heroin is the drug most commonly injected, but amphetamine is also injected.

In a new survey covering the years 2000 and 2008 it has been estimated how many people have used heroin in Norway, including those who have only smoked it. To be able to estimate the total consumption, the users were divided into categories according to frequency of use and how the drug is taken. Based on different methods, it is estimated that between 6,600 and 12,300 had used heroin regularly in 2008, a considerable reduction in relation to 2000 when the estimate was 9,550 to 17,750.

Treatment

In-patient treatment capacity has been stable since 2004, with a slight increase in the number of detoxification places and minor changes in the breakdown between short-term and long-term treatment. More people receive outpatient treatment, and there has been a significant increase in the number of people receiving substitution treatment. Figures from the Norwegian Patient Register show an increase of 16 per cent in new referrals to interdisciplinary specialist treatment from 2007 to 2008.

The national client mapping survey for 2008 shows that, except for alcohol, which still accounts for nearly half of the registrations on admission to treatment facilities and care services, heroin is most often reported as the most used intoxicant (18%). The percentage reporting heroin is in strong decline, however. In 2006, it was 24 per cent, while in the early 2000s it was around 35 per cent. The gender differences have evened out; the proportion of women reporting heroin was much higher a few years ago. There was no change for cannabis and central stimulants as the most used intoxicants from 2006 to 2008. The gender differences are also stable for both substance groups.

Health correlates and consequences

The incidence of HIV among injecting drug users in the group has remained at a stable, low level, with about 10 to 15 cases reported per year. The reason for this is not entirely clear, but a high level of testing, great openness regarding HIV status within the user milieus, combined with a strong fear of being infected and strong internal justice in the milieu, are assumed to be important factors.

Both the figures from Statistics Norway and the National Crime Investigation Service figures appear to indicate that a certain stabilisation of the number of drug-related deaths has occurred in the last 5-6 year period. The number of overdose deaths per year remains

high, however. Even though the number of clients in medication assisted treatment has increased strongly during the same period, this has not led to a marked decline in the number of deaths.

Drug crimes

In 2008, the police registered 37,531 drug offences, one of the lowest figures in the last ten years. The decline from 2007 was somewhat greater for drug offences that are regulated by the Act relating to medicines than for more serious drug offences regulated by the General Civil Penal Code. In 2007, which is the last year that such information is available, the total number of convictions for drug offences was 14,430. Only 1,220 convictions resulted in unconditional prison sentences. In 2008, the number of sentences started as an alternative to prison showed a marked increase on previous years.

Drugs market, availability and supply

The estimated consumption of heroin in Norway during the course of one year has been calculated for the first time. According to the survey, the quantity of heroin used in 2006 was estimated to be approximately 1,445 kilos, while consumption in the period 2000 to 2002 was estimated to be just over 2,000 kilos. The decline is mainly due to a decline in the number of problem users. The estimate for 2006 will probably also apply to 2007 and 2008.

Heroin sold in Norway mainly comes from Afghanistan through Turkey via two northerly routes through Bulgaria/Romania–Ukraine/Russia, and then on to Poland /Lithuania. Two southerly routes go through Greece/the Balkans to the Netherlands/Germany.

According to the customs service, most of the amphetamine and methamphetamine on the Norwegian market comes from illegal laboratories in the Netherlands, Poland and Lithuania. Lithuanian criminals have had a dominant role for several years as suppliers of synthetic drugs to Norway, and the proportion of amphetamine seized from Lithuania is increasing. However, the largest quantities of amphetamine seized now come from the Netherlands and Poland. The main routes go through Germany and Denmark via Sweden.

Cannabis seized in Norway mainly comes from Morocco via the Netherlands, while cocaine, as before, comes from South America to Africa and Spain and from there to the Netherlands and Germany before continuing up through Denmark to Norway.

Drug seizures

For the period 2000 to 2008, SIRUS has estimated that the total seizures by the police and the customs service amount to an average of only four per cent of the assumed total consumption of heroin in Norway per year. The highest proportion of seizures took place in 2004 (8% of annual consumption), while the lowest proportion was seized in 2007 (less than 3%).

In 2008, 19,619 drug cases and 23,835 seizures were registered. This represents a decline from 2007 of four and three per cent, respectively. However, there are big differences between the different types of drugs. While there were only small changes in the number of seizures of the most common drugs in 2007, the changes in terms of quantity were substantial.

While only 8.0 kg of heroin was seized in 2007, a number of medium-sized seizures of heroin were again made in 2008. Seizures of heroin in 2008 only accounted for approx.

five per cent of the total number of drug seizures in Norway. By comparison, this proportion was as high as 20 per cent in 1998.

The largest ever seizure of amphetamine in Norway, 112.3 kg, was made in 2008. Based on the number of seizures and verified analyses, the proportion of methamphetamine once again increased significantly in relation to amphetamine.

The amount of cannabis seized in 2008 was 1,732 kg, which breaks down into about 71% of cannabis resin, 9% of herbal cannabis and 20% of cannabis plants. One seizure of 401 kg of cannabis resin dominated in 2008. Many cannabis plantations, some of them large, were also uncovered in the first six months of 2008.

In 2008, less cocaine was seized than in 2007. Cocaine was seized in 26 of the country's 27 police districts, but there are relatively big differences between the districts. In Oslo, the number of seizures declined by 17 per cent, while Bergen, the second largest city, registered an increase of 63 per cent.

Selected issues – Part B

Cannabis market

The police often claim that the cannabis market has been dominated by a few major players who have been active for several decades. It is a well-known fact that these persons have connections with established organised criminal gangs that are involved in several types of crimes.

The market seems to be highly flexible and has ties to several quite distinct milieus. We have a fairly good overview of street-level sales. Knowledge about smugglers and couriers is also relatively extensive. On the other hand, we know little about the so-called ringleaders and wholesale dealers. The question is whether there are any clear ringleaders. There are many indications that there are few links in the chain between importation and the direct sale of hash to users. Price estimates suggest that sellers buy from persons who themselves have bought the drug from importers, or that there is one more link in the chain.

The flexibility in the importation of cannabis means that the market is open to many players. It is highly adaptable and will therefore be relatively unaffected if the police or customs service manages to catch one or more major players. In many cases, hash smuggling is combined with the smuggling of pills, amphetamine and ecstasy. On the other hand, there seems to be almost no connection whatsoever between those who are involved with heroin and those involved with hash. People who smuggle spirits very seldom have anything to do with hash.

The cannabis market is often linked to particular ethnic groups. It is assumed that Moroccans have come to play an important role in several European countries. In Norway, importation and distribution seems to be a largely multi-ethnic business. It is common to see teams of smugglers composed of persons from Norwegian, Asian and African backgrounds. Street-level sales have in recent years largely been dominated by groups of people from immigrant backgrounds.

Problem amphetamine and methamphetamine use

The main findings indicate that there has been an increase in the use of amphetamines in Norway for many years and that this increase has mostly concerned the use of methamphetamine. There is reason to believe that methamphetamine is currently more used than amphetamine. This represents something of a contrast to previous reports that indicate little use of methamphetamine in our part of Europe, while it confirms previous reports from EMCDDA indicating that Norway is the country in Europe with the quantitatively largest and highest number of seizures, and where the problems associated with methamphetamine can also be substantial.

The most remarkable finding in the survey presented is that most of the amphetamine used now appears to be methamphetamine. The increase in the proportion of methamphetamine has been a linear trend over many years in all the available data sources. As regards seizures, 2009 appears to be the year when the number of methamphetamine seizures exceeds that of amphetamine.

There is reason to believe that the trend has more to do with supply. New drug trading patterns have developed in step with the liberalisation of border controls in Europe, and there is reason to believe that the most important explanation for the shift from amphetamine to methamphetamine as the predominant substance in Norway is new producers and importers in the market, possibly production in the Baltic countries.

The combination of users not knowing whether they are using amphetamine or methamphetamine, the fact that the use of amphetamines is increasing and that methamphetamine has become the predominant amphetamine on the Norwegian market means that there is a clear danger that we will see more negative consequences of such use in Norway than in many other countries. The available road traffic data and data from psychiatric services are just two examples that point in that direction.

Part A: New Developments and Trends

1. Drug policy: legislation, strategies and economic analysis

1.1 Legal framework

On 15 June 2009, the Norwegian parliament, the Storting, decided to make the temporary Act relating to injection rooms (see NR 2008 Chapter 1.1) permanent. Making the act permanent means that municipalities that wish to establish injection rooms have a legal basis for doing so. The injection room scheme will not replace measures focusing on prevention and rehabilitation, but will serve as a supplement in an overall chain of measures targeting those with major health problems who have difficulty quitting their drug use. Based on local needs, the individual municipalities can decide whether they wish to establish an injection room scheme. The legislative amendments with pertaining regulations enter into force on 17 December 2009.

On 15 June 2009, the Oldelsting adopted an Act amending the Health Personnel Act. The amendment requires health personnel to help meet the need for information and necessary follow-up that minor children of parents with mental illnesses, drug/alcohol dependency or somatic illness or injury may have as a result of their parents' condition. The Ministry of Health and Care Services can issue regulations that specify the duties of health personnel pursuant to this provision.

1.2 Institutional framework, strategies and policies

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

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

1.2.1 Norwegian National Action Plan on Alcohol and Drugs

The Government's escalation plan for the drugs and alcohol field, hereinafter called the Action Plan, was presented to the Storting in October 2007. It includes goals and measures for prevention, treatment and rehabilitation and entails a gradual escalation of funding in the period up until 2010.

The Action Plan deals with both alcohol and drugs policy and national and international measures, and it is based on a policy with a clear public health perspective. The aim is to raise professional standards through research and by improving competence and quality. As regards services, the principle is that the ordinary services should also be available to people with drug or alcohol problems. Cooperation between the different bodies and administrative levels is emphasised, as is a user perspective.

The overriding goals are:

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

See NR 2007 Chapter 1 for a more detailed description of the performance goals in the Action Plan.

Implementation of policies and strategies

The involved ministries shall cooperate on follow-up of the Action Plan. The plan assigns chief responsibility for each measure to a specific body, which will be responsible for instigating relevant measures and involving affected parties. Separate reporting procedures have been adopted for the Action Plan that provide an overview of the progress and status of each individual measure and of the plan as a whole. In other respects, the general division of responsibility in the government administration will apply.

The key ministries in relation to implementation of the Action Plan are the Ministry of Labour and Social Inclusion, the Ministry of Children and Equality, the Ministry of Justice and the Police, the Ministry of Local Government and Regional Development and the Ministry of Education and Research. The respective directorates, the Norwegian Institute for Alcohol and Drug Research, AS Vinmonopolet, the Norwegian Institute of Public Health, the county governors and the regional drugs and alcohol competence centres all have important responsibilities in the field of drugs and alcohol policy. Good contact and cooperation between the different bodies is emphasised.

The Directorate of Health is responsible for implementing large parts of the drugs and alcohol policy. The Directorate has wide-ranging responsibility for the Action Plan, and it has chief responsibility for 58 of the 147 individual measures in the plan. Moreover, it shall

ensure that an overview of the drugs and alcohol situation is available at the regional and local level, and it will publish an annual status report.

During the period 2008 to 2009, a total of 19 drugs and alcohol advisers have been appointed by the 18 county governor offices. They will contribute to the implementation of the Action Plan in the municipalities. The drugs and alcohol advisers' responsibilities include the administration of grants, competence-building measures, advice and guidance, follow-up, regional meetings/ forums and the establishment of learning networks. Among other things, the county governor offices will help to ensure that more municipalities can avail themselves of government grant schemes aimed at providing users with individual follow-up and holistic services, and help to increase the proportion of users with individual plans.

The county governors are also responsible for following-up a trial scheme involving coordinating representatives (see Chap. 8.1.1). The county governors will also facilitate competence-building measures in the municipalities and administer funds for further education in the drugs and alcohol field for health and social service personnel and correctional service staff. In collaboration with the seven regional drugs and alcohol competence centres, regional drugs and alcohol forums and meetings will be organised. The county governors will also help to ensure that the municipalities practise user participation to a greater extent and that they offer services to family members of people with drug or alcohol problems.

Evaluation of policies and strategies

The measures in the Action Plan will be specified in more detail during the plan period. In order to ensure systematic further development and implementation, regular coordination meetings are held between affected ministries and relevant subordinate agencies. The Ministry of Health and Care Services is in charge of coordination, and it is also responsible for coordinating the escalation plan with other plans. Status and progress will be reported annually to the Ministry of Health and Care Services, and this reporting forms the basis for an annual status report on the progress of the measures and the attainment of goals. According to the report for 2008 (the Directorate of Health, 2009), 115 (78%) of the plan's 147 measures had been initiated at the end of 2008. Many of the measures are evaluated separately, and a comprehensive review of experience from the plan will be carried out.

In connection with the Directorate of Health's grant schemes, great emphasis is placed on evaluating the measures and earmarking funds for this purpose. The goal is to help to improve quality and to support knowledge-based strategies and measures by ensuring continuity and local support.

1.3 Economic analysis

Law enforcement
No comprehensive overview is available.

1.3.1 Public expenditures

In addition to the government's own operating expenses, the total allocation to the drugs and alcohol field consists of allocations via the Ministry of Health and Care Services' budget in the form of grant schemes, block allocations to the regional health authorities

and research allocations. Grants for competence and quality work, and to stimulate the development of methods, come in addition.

Important expenditures, in addition to the allocations via the Ministry of Health and Social Care Services' budget, include allocations to the customs service, the police, international projects, housing measures, employment qualification measures and preventive efforts aimed at children and young people.

Interdisciplinary specialist treatment for problem drug and alcohol use, i.e. responsibility for detoxification, diagnosis and specialist treatment (including medication assisted treatment – MAT), is by far the biggest item of expenditure in the Ministry of Health and Care Services' budget for combating drug and alcohol problems. Since the regional health authorities are financed through block allocations, it is difficult to ascertain precisely how much the health authorities allocate to interdisciplinary specialist treatment.

Municipal services for people with drug and alcohol problems are usually financed by the municipalities' free revenues.

Budget

The accounts for 2008 show that expenditure on interdisciplinary specialist treatment for alcohol and drug dependency amounted to EUR 331 million[1] (NOK 2.648 billion) of the regional health authorities' budgets. This amount includes the treatment of both alcohol and drug dependency and is related to specialist institutions for alcohol and drug dependency. The costs of treatment for drug and alcohol problems at other institutions, for example in the mental health care services, cannot be quantified and will therefore come in addition.

In the national budget for 2009, an additional EUR 37.5 million (NOK 307 million) was allocated to the drugs and alcohol field for following up and implementing measures in the Action Plan. In 2008: EUR 15.63 million. The allocations for 2009 break down as follows:

- EUR 1.25 million for implementation of the strategy for early intervention
- EUR 1.0 million for the preparation of municipal action plans in the field of drugs and alcohol policy
- EUR 0.75 million to strengthen controls of licences for selling and serving alcohol
- EUR 0.81 million to strengthen the Research Council of Norway's drug and alcohol research programmes
- EUR 62,500 to establish a register of drug-related deaths
- EUR 0.5 million to develop professional guidelines for interdisciplinary specialist treatment
- EUR 1.0 million (NOK 8 million) to strengthen GPs' competence in the drugs and alcohol field
- EUR 2.38 million for competence-building in municipal services
- EUR 7.5 million in increased grants for the development of municipal services
- EUR 1.0 million (NOK 8 million) to strengthen the Street Hospital
- EUR 4.38 million to strengthen Medication assisted treatment- MAT
- EUR 15 million to strengthen interdisciplinary specialist treatment
- EUR 0.63 million to establish units aimed at mastering drugs and alcohol problems in prisons
- EUR 0.63 million for improved cooperation and increased use of individual plans

[1] Conversion rate 1 EUR=NOK 8.00

- EUR 0.88 million for increased user influence and greater attention to the interests of family members through cooperation with voluntary organisations.

Funds for the general strengthening of the municipal sector and specialist health services come in addition, as well as EUR 3.75 million (NOK 30 mill) for the Church City Mission for the establishment of immediate measures for those with drug or alcohol dependency who are most in need of help.

Special grant schemes

In addition to the ordinary block grant funding allocated to municipalities and regional health authorities, funds are channelled to special-priority purposes through grant schemes that are largely administered by the Directorate for Health. The purpose of the grant schemes is to promote professional development and the development of methods in the municipalities' work on drug and alcohol problems in order to ensure that the users are offered services that are coherent, complex and available and that are adapted to individual's needs. This requires diverse and differentiated services with a high degree of local support. The grant schemes are divided between two items in the national budget:

Grants for municipal drug and alcohol measures – 2009: EUR 32.2 million *(*NOK 258 million). In 2008: EUR 21.58 million. Among other things, these grants shall be used to strengthen personal guidance and individual follow-up, low-threshold health services for alcoholics and drug addicts, a trial scheme for injection rooms, dental health services for people with drug or alcohol problems and street papers such as '=Oslo'.

Voluntary drug and alcohol prevention work etc. – 2009: EUR 16.1 million *(*NOK 129 million). In 2008: EUR 14.98 million. These grants are earmarked for follow-up, care and rehabilitation services run by voluntary organisations and private undertakings, self-help and interest groups and work among family members, measures aimed at prostitutes and the Street Hospital in Oslo.

The grant scheme *Measures among children and young people in large towns and cities* is administered by the Ministry of Children and Equality. Grants for youth measures are distributed between 23 urban municipalities and, in 2009, they amount to EUR 2.4 million (NOK 19.2 million). In 2008: EUR 2.1 million. These measures target youth groups and youth milieus that are deemed to be at risk. Young people from immigrant backgrounds face particular challenges, and measures that promote integration are given high priority. These measures will specifically target young people who make little use of existing cultural and leisure services and provide better opportunities for qualification, inclusion and coping.

Grants for *Voluntary work etc.* are administered by the Directorate for Health. Funding is given in the form of project and operating grants for voluntary organisations in the drug and alcohol prevention field. The purpose is to help organisations that work to reduce the consumption of and harm caused by drugs and alcohol to maintain and develop their efforts. The allocation for 2009: EUR 11.5 million *(*NOK 92.35 million). In 2008: EUR 11.3 million.

Research

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

Table 1: Grants for research and dissemination in 2009. In EUR (NOK) million. Figures for 2008 in italics.

SIRUS	4.564 (36.514) *4.373*
National Institute of Public Health*	1.250 (10.000) *1.250*
The Research Council of Norway. Programme for research and teaching in the drugs and alcohol field (including SERAF)	3.119 (24.950) *2.312*
Drugs and alcohol research conducted by the regional health authorities*	1.875 (15.000) *1.875*
Total*	10,808 (86,464) *9,810*

*Approximate figure

Source: The Ministry of Health and Care Services

Regional drugs and alcohol competence centres

Annual grants are paid to the seven regional drugs and alcohol competence centres in Norway. Allocation for 2009: EUR 12.38 million (NOK 99 million). 2008: EUR 8.25 million.

The competence centres are an important link between the state and municipalities and regional health authorities in connection with the dissemination and implementation of research-based knowledge and recognised methods. They have three main purposes:

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

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

International actions

Grant for 2009 to UNODC: EUR 3 million (NOK 29 million). Membership fees for the Council of Europe / the Pompidou Group, the EU's drug programme and EMCDDA come in addition, as well as aid funds, in particular to Afghanistan, of which a substantial proportion is drug-related.

1.3.2 Social costs

No adequate overview is available. The Directorate of Health is currently developing a statistics and documentation system that will provide better information about needs and the use or resources in the drugs and alcohol field and more health data regarding the drugs and alcohol situation in the municipalities – for example information about efforts aimed at homeless people and long-term social security recipients.

It is a challenge to quantify the status, needs, use of resources and service production in the drugs and alcohol field in the municipalities. This is partly due to the fact that the municipalities primarily register services provided according to needs, not diagnoses. Several measures have been initiated through the Action Plan[1] to provide better

[1] The measures include: commissioning Statistics Norway (SSB) to carry out primary mapping of the municipal efforts in the drugs and alcohol field in 2006, an external assignment to map the

documentation and statistics. These measures will form the basis for a long-term plan to improve documentation.

In 2008, for example, there were approximately 109,000 social security recipients. It is difficult to estimate the number of long-term social security recipients who have drug and alcohol problems, but it can be assumed that one in three long-term social security recipients are drug and/or alcohol users.

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

2.1 Drug use in the general population

The most recent survey of the general population's drug use was carried out by SIRUS in autumn 2004. The main results were discussed in NR 2005, Chapter 2.1). The next nationwide survey will be conducted in autumn 2009. Data and data analyses will be discussed in the national report for 2010.

2.2 Drug use in the school and youth population

2.2.1 The ESPAD survey 2007

ESPAD[2] surveys have been carried out among 15 to 16-year-old school students every four years since 1995. In 2007, the survey comprised more than 100,000 students in 35 European countries. In Norway, the survey comprised all the students from all ten years of primary and lower secondary school who were registered as of March 2007. The survey is based on questionnaires about smoking, the use of alcohol, illegal substances, medicinal drugs and other drugs. The ESPAD survey is coordinated by the Swedish Council for Information on Alcohol and Other Drugs (Centralförbundet för alkohol- och narkotikaupplysning i Sverige – CAN), which cooperates with the Pompidou Group, EMCDDA and researchers throughout Europe. As in previous years, SIRUS was responsible for the Norwegian part of the survey.

Among Norwegian school students who have tried illegal substances, the 2007 figures showed stability and, in part, a decline in relation to previous surveys. The decline is most pronounced in the use of cannabis. In 2007, around six per cent (boys: 7%, girls: 5%) stated that they had ever used cannabis, while the corresponding figure for 2003 was nine per cent and, in 1999, 12 per cent. There were no significant changes for use during the

municipalities' need for information in connection with their work in the field and to discuss the possibilities for future reporting and the production of statistics, good reporting procedures from the 202 municipalities that receive grant funding etc.

[2] European School Survey Project on Alcohol and Other Drugs

last 30 days, however, which has been around two to three per cent in the last two surveys.

As regards the use of illegal substances other than cannabis, there have been minor changes in lifetime prevalence; it was three per cent in both 2007 and 2003, but as high as six per cent in 1999.

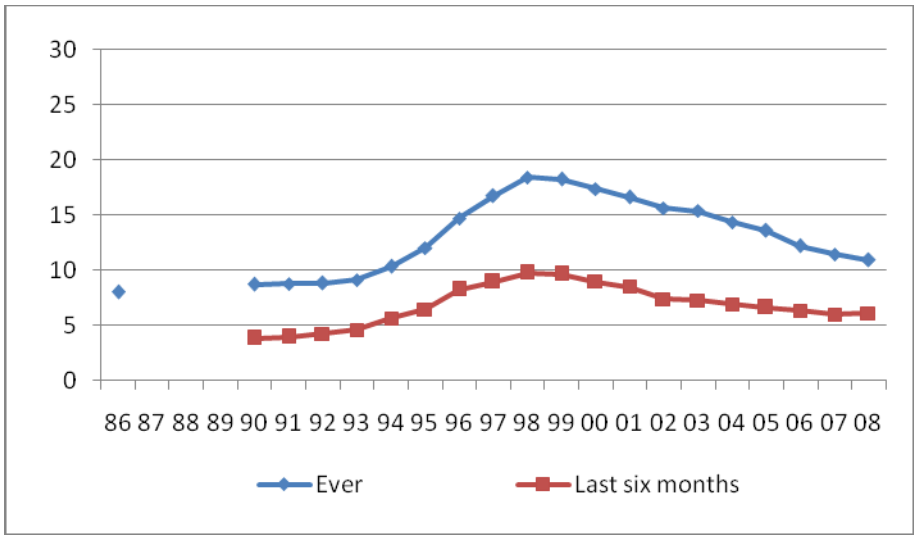
Compared with most other European countries, the prevalence of illegal substances in Norway is low. The decline in cannabis use also reflects the tendency in Europe as a whole. In 2003, the average lifetime prevalence in Europe among young people aged 15 to 16 was 21 per cent and, in 2007, 19 per cent. On the other hand, it looks like the use of inhalants has increased somewhat among Norwegian school students, from five per cent in 2003 to seven per cent in 2007, which is just slightly below the European average of nine per cent.

2.2.2 Drug use among youth aged 15 to 20

Data from SIRUS's annual questionnaire survey among youth aged 15 to 20 in 2008 have been analysed (Vedøy and Skretting, 2009). Since the division into age groups and questions about recent drug use in this survey are not in harmony with the division used by the EMCDDA (SIRUS: last six months, EMCDDA: past year and last 30 days), the data cannot be included in standard tables.

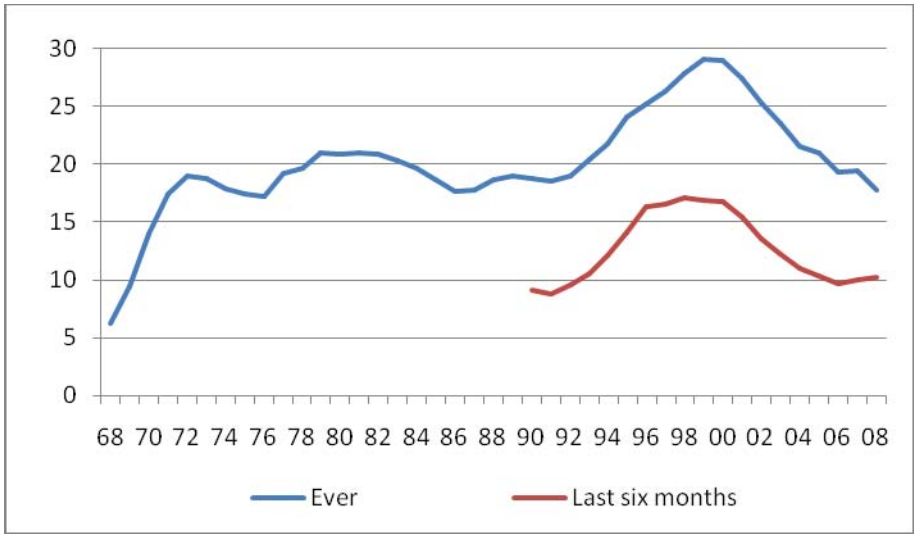
As with ESPAD, cannabis, primarily in the form of hash, is the drug most young people report having used, but this survey also shows a marked downward trend. At the turn of the millennium, less than 20 per cent nationwide and less than 30 per cent in Oslo reported that they had every used hash or marijuana. Since then, there has been a fairly pronounced decline to just over ten per cent nationwide and slightly less than 20 per cent in Oslo (Figure 1 and 2).

Figure 1: The percentage of youth between the ages of 15 and 20 in Norway who state that they have taken cannabis: ever and during the last six months, respectively, 1986 – 2008 (three-year sliding average).



Source: SIRUS

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



Source: SIRUS

A higher proportion in Oslo than nationwide stated that they had used cannabis during the last six months. The fact that having tried cannabis is not the same as regular use is illustrated by the fact that, during the period 2006-2008 as a whole, only three per cent of youth aged 15 to 20 nationwide and four per cent in the special Oslo sample reported having used cannabis more than five times during the last six months (Table 2).

Table 2: The number of times young people aged 15-20 have used cannabis during the last six months, NORWAY and OSLO (2006-2008 as a whole). As a percentage.

	Number of times during the last six months					
	0	1-4	5-10	11-25	26+	Total
Norway	93.8	3.3	0.7	0.5	1.7	100
Oslo	90.2	5.8	1.3	0.9	1.8	100

Source: SIRUS

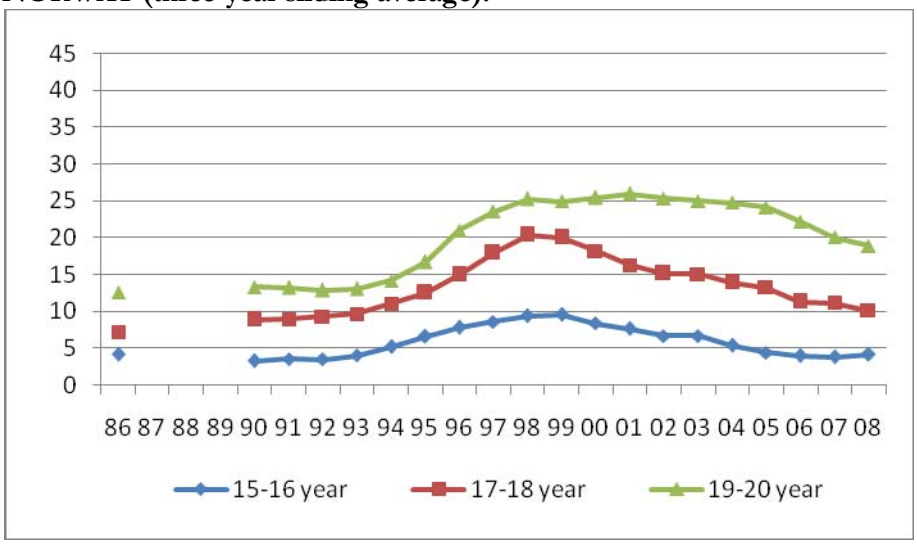
Gender and age

There was little or no difference between boys and girls with respect to experience of using cannabis. The proportion of boys in Norway who state that they have used cannabis was slightly higher than for girls up until the turn of the millennium, while in recent years, the proportion of girls appears to have been somewhat higher. However, the differences were not statistically significant. In the special Oslo sample, the proportion of boys who had used cannabis was generally higher than for girls, but on the whole the difference has not been statistically significant.

In a historical perspective, the proportion stating that they have used cannabis ever has (naturally) been lower among youth aged 15 to 16 than among those who are slightly older, but the relationship between the different age groups has changed somewhat over time. For the country as a whole, the proportion stating that they had used cannabis increased for all age groups from 1986 until the end of the 1990s (Figure 3). In the ensuing years, however, there appears to have been a decline among youth aged 15 to

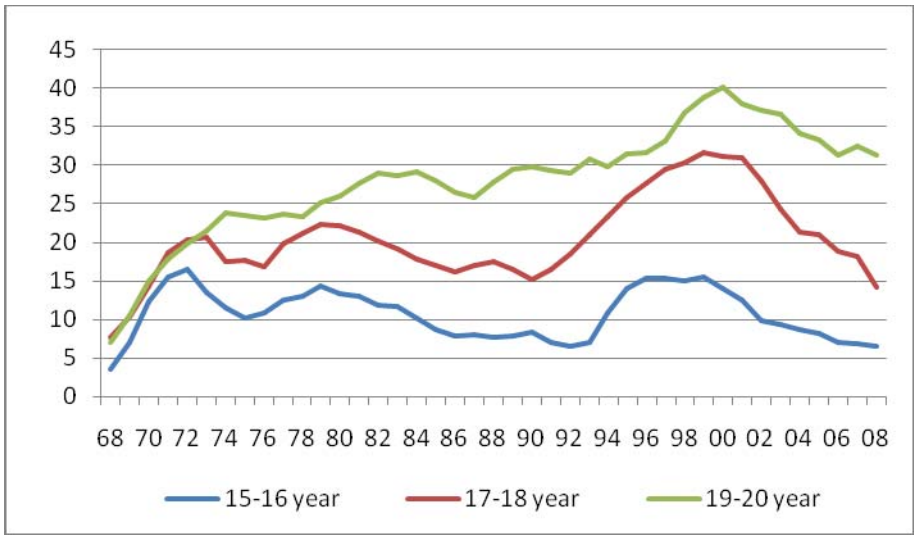
16 and 17 to 18, while the proportion of youth aged 19 to 20 remained at the same level until 2005. In recent years, the differences between the age groups have again decreased. In Oslo, the differences between the three age groups have also increased over time (Figure 4), but, unlike the country as a whole, there has been a marked decline in all age groups after 2000 in the proportion reporting that they have ever used cannabis.

Figure 3: Percentage of the different age groups reporting that they have ever used cannabis, NORWAY (three-year sliding average).



Source: SIRUS

Figure 4: Percentage of the different age groups reporting that they have ever used cannabis, OSLO (three-year sliding average).



Source: SIRUS

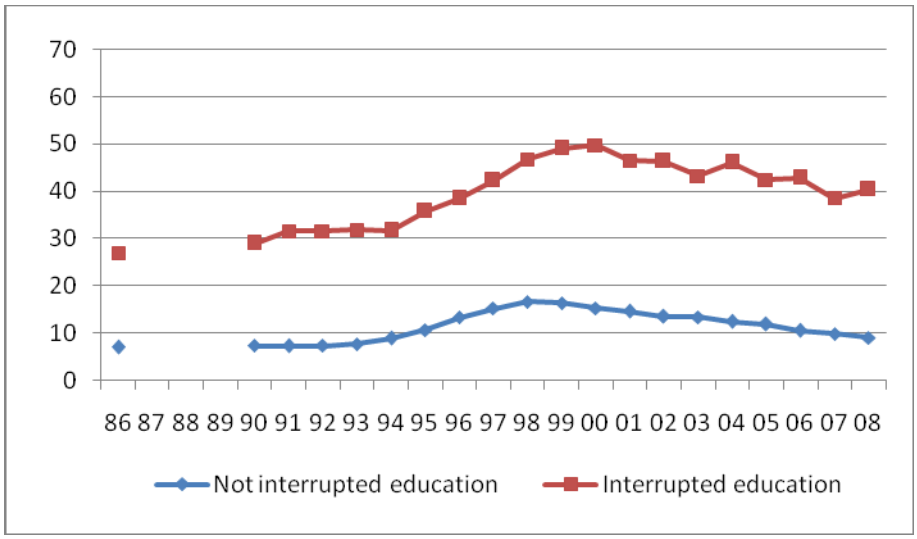
What characterises people who have used cannabis?

The questionnaire that is used contains few questions about background factors, and nor does it contain questions that can shed light on respondents' mental health. There are, however, some clear correlations. For example, whether young people live with both or just one of their parents seems to be significant. Nationwide, during the period 2006 to

2008 as a whole, seven per cent of those who lived with both their parents stated that they had ever used cannabis, while the corresponding figure for those who lived with just one of their parents was 15 per cent, and 24 per cent for those who had a different housing situation (living with other relatives, alone, with friends or a partner). The same pattern is found in Oslo.

There seems to be a clear relationship between interrupted education and the use of cannabis (Figure 5). The proportion stating that they had used hash was many times higher among those who had dropped out of school without taking exams than among those who had remained in school. There may be several reasons for this apparent relationship, and it may be difficult to separate cause from effect. On the one hand, the use of drugs may have led to expulsion or to the student having difficulty following classes, which, in turn, has led to him/her dropping out. Since the use of cannabis is not an entirely normal phenomenon among youth, it is not unlikely that young people using drugs become more easily marginalised and therefore experience more problems at school than other young people. Dropping out of school may in itself affect drug use. The relationship between interrupted education and the use of cannabis may be rooted in the same predisposing factors in terms of personality and milieu.

Figure 5: Percentage of youth aged 15-20 stating that they have ever used cannabis, among those who have dropped out of school and those who have not dropped out, NORWAY (three-year sliding average).



Source: SIRUS

The availability of cannabis

Two questions have been asked in the youth survey to shed light on the availability of cannabis:

'*Have you ever been offered marijuana or hash?*'

'If you wished to get hold of some marijuana or hash, do you believe you could obtain it in the space of two to three days?'

It is not specified whether the question concerns buying or an offer to try marijuana or hash free of charge.

Naturally, most of those who say they could obtain hash or marijuana have experience with the use of cannabis themselves. As Table 3 shows, for the period 2006 to 2008 seen as a whole, around 90 per cent of those who had used the drug between one and four times say that they could get hold of hash or marijuana in the space of two to three days. Among those who had used cannabis more than 11 times, the proportion was almost 100 per cent. The corresponding figure for those who had not used cannabis themselves was 46 percent nationwide and 56 per cent in Oslo ($p<0.001$).

Almost everyone who stated that they themselves had used cannabis reported that they also had friends or close acquaintances who have used the drug. This indicates that the use of hash or marijuana is linked to special milieus in these age groups. Regardless of whether they themselves have ever used cannabis, many young people in general state that they have friends or close acquaintances who have used cannabis. For the period 2006 to 2008 seen as a whole, this applied to 54 percent nationwide and 67 percent in Oslo.

The survey also asked whether the respondents had friends or close acquaintances who had been arrested for using cannabis. Again, this was primarily true of those who had used cannabis a certain number of times. For example, less than ten per cent of those who stated that they had never used cannabis said that they had friends or close acquaintances who had been arrested for using cannabis, while the corresponding figure was close to 40 per cent for those who had used the drug between 11 and 50 times and more than 70 per cent among those who had used cannabis more than 50 times (Table 3).

Table 3: The availability of cannabis and contact with users of cannabis among youth groups aged 15-20 who have used cannabis a various number of times (2006-2008 as a whole), as a percentage.

	Could obtain cannabis in two or three days		Friends or close acquaintances who use cannabis		Friends or close acquaintances who have been arrested for using cannabis	
	NORWAY	OSLO	NORWAY	OSLO	NORWAY	OSLO
0	46	56	48	60	8	9
1-4	90	91	97	98	27	22
5-10	96	95	99	98	40	38
11-50	99	97	99	98	46	41
51+	98	100	98	99	74	80
Total	52	63	54	67	12	15

Source: SIRUS

The use of other drugs among youth aged 15 to 20

The survey shows a clear relationship between the use of cannabis and other drugs. The proportion stating that they have tried different drugs is clearly much higher among those who have also used cannabis than among those who have never used this drug.

After cannabis, amphetamine is the second most used drug by young people. The proportion in the 15 to 20 age group in Norway stating that they had ever used

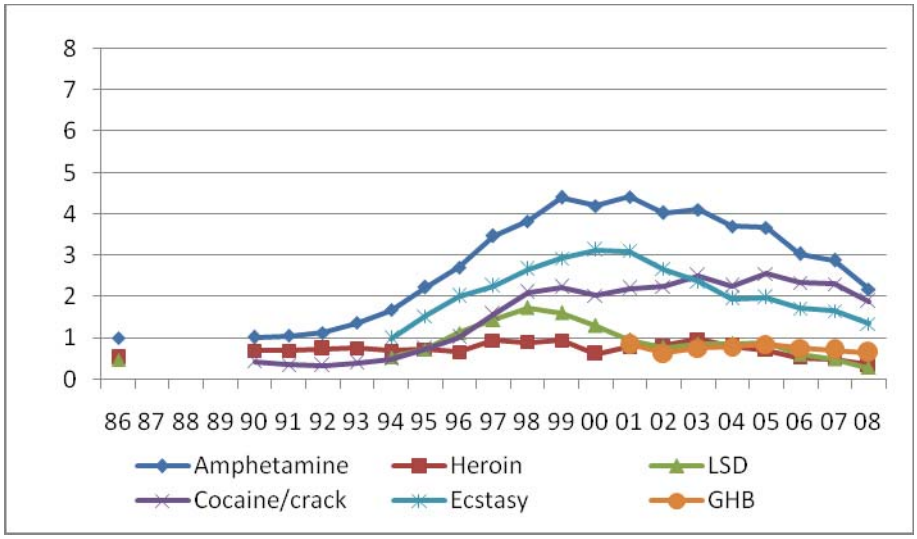
amphetamine increased up until the millennium to approximately four per cent, and then stagnated or declined. In Oslo alone, there was also an increase up until the millennium, when around seven per cent stated that they had ever used amphetamine. This was followed by a decline up until 2008, when around three per cent reported having used the drug.

The trend for cocaine has been somewhat different in that there has not been a similar decline in recent years. Nationwide, there was an increase in the 1990s from approximately 0.5 per cent to around two per cent at the turn of the millennium. The level has remained more or less unchanged since then. In Oslo, the proportion reporting that they had ever used cocaine increased from around one per cent in the early 1990s to approximately five per cent at the turn of the millennium, before levelling out. Nationwide, the level of cocaine use has approached the level for amphetamine in recent years and is now fairly similar. However, for the period 2004 to 2008, significantly higher proportions of cocaine use than amphetamine use were reported for Oslo.

The proportion stating that they have used other drugs has generally been around 0.5 to two per cent (Figures 6 and 7).

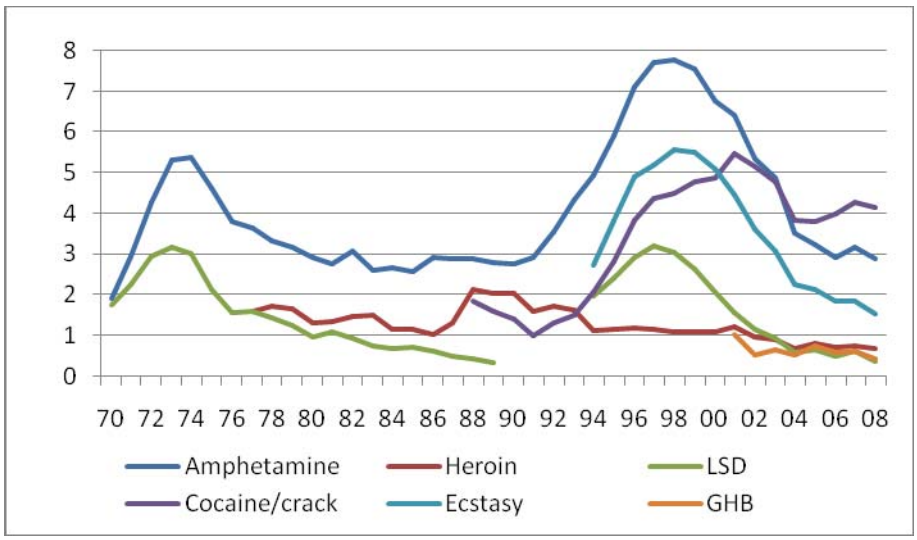
The proportion reporting use during the last six months is low for all drugs, except for cannabis. The proportion is highest for amphetamine at around one to two per cent.

Figure 6: Percentage of youth between the ages of 15 and 20 who state that they have ever used various drugs, NORWAY (three-year sliding average).



Source: SIRUS

Figure 7: Percentage of youth between the ages of 15 and 20 who state that they have ever used various drugs, OSLO (three-year sliding average).



Source: SIRUS

In recent years, less than six per cent in Norway report ever having sniffed solvents, while around two per cent state that they have used solvents during the last six months. Around four per cent state that they have ever used psychopharmaceuticals not prescribed by a doctor.

Statistical margins of error

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

From the start of the survey until the mid-1990s, around 70 per cent responded to the questionnaires. In the period since then, this response rate dropped, first to approximately 50 per cent, then to around 40 per cent. In an attempt to increase the response rate, the sample selected for the 2008 survey was given a choice of responding via traditional questionnaires or via the internet. However, the response rate dropped further to just above 30 per cent.

Because of the declining response rate, SIRUS no longer considers it justifiable from a professional perspective to continue these traditional surveys. The 2008 survey was therefore the last to be carried out. SIRUS has yet to decide whether other surveys will be initiated among young people to supplement the large population surveys that are carried out only every five years.

2.3 Drug use among young adults

The main results from SIRUS's questionnaire surveys among young adults aged 21 to 30 and among students were presented in NR 2007, Chapters 2.2.2 and 2.3.1. A recently published overview of amphetamine, cocaine and ecstasy use is based on data from these surveys, among others (Skretting and Vedøy, 2009).

The survey gives a picture of what different sources tell us about the use of central stimulants in Norway. The overview is based on four sets of questionnaire surveys about the use of drugs in different population groups: young people between the ages of 15 and 20, young adults between the ages of 21 and 30, students at the University of Oslo, and the adult population. In addition, it presents results from surveys among injecting drug users, problem drug and alcohol users receiving treatment, and other sources that shed light on the topic.

The proportion of young adults reporting that they have ever used amphetamine or cocaine has increased since the end of the 1990s, while use during the last six months has been stable. This suggests that more young adults have experimented with amphetamine and cocaine. However, the fact that the figures for recent drug use are stable at around two percent indicates that there has not been an increase in regular use.

Nationwide, the proportion of young adults who have ever used cocaine has tripled from three per cent in 1998 to nine per cent in 2006. The proportion reporting that they have ever used amphetamine has increased from five per cent to ten per cent during the same period. In Oslo, cocaine use increased from seven per cent to 14 per cent during the same period. The same tendency is found among students in Oslo. However, the proportion of young adults who have used amphetamine or cocaine during the last six months has remained stable at around two per cent.

The survey shows a clear connection between the use of cannabis and central stimulants among both youth and young adults. The proportion who had also used central stimulants increased in step with the number of times cannabis had been used. The majority of those who had used cannabis more than 51 times had also tried amphetamine or cocaine. The vast majority of those who stated that they had used central stimulants have previously used hash.

Drug use among targeted groups/settings at national and local level
No new information available.

3. Prevention

The Government's Action Plan (Chapter 1.2.1) includes efforts to raise professional standards in preventive work in Norway. One of the five main goals is a clear focus on public health. Information work will be strengthened, with more targeted information and more participation by young people and parents. Knowledge must be increased and attitudes changed in order to reduce the harmful effects. Public funding for the voluntary sector will continue as part of the effort to improve quality. Preventive measures will be coordinated and work on drug and alcohol prevention in the workplace will be intensified. The seven regional competence centres are key partners in coordinating and improving local prevention in the municipalities.

3.1 Universal prevention

3.2.1 School

For several decades, drug and alcohol prevention work has been based on various documents governing the school sector, such as legislation, national curricula and subject-specific curricula. A lot of research indicates that schools are important arenas for preventive work and that they form an important basis for preventive efforts. However, a number of research findings over several years suggest that universal school-based measures and programmes have very limited or no effect in terms of reducing the use of alcohol and drugs and their harmful effects (Babor et al. 2003; Foxcroft et.al. 2002; Giesbrecht 2007; Nordahl et al. 2006). It is therefore necessary to nuance the view that schools are good arenas for drug and alcohol prevention work.

In this light, the Directorate for Health, together with the Directorate for Primary and Secondary Education, started work in 2008 on producing a guide to schools-based drug and alcohol prevention work. The guide is scheduled for completion in 2009 and implementation will start in 2010.

3.1.2 Family

Parents' role in drug prevention

Much research identifies the home and family as crucial arenas affecting young people's behaviour as regards alcohol and drug use, although they are not by any means the only factors (Henriksen 2000, Kelly et al. 2007, Saether 2007).

One important aim of the Action Plan is to raise the general public's level of knowledge and to make people aware of the link between the age at which people start drinking and alcohol consumption in adult life. The initial target group consists of young people and parents, who are to be given a more active role as contributors to and mediators in local preventative work. One important goal is to help develop good, safe local communities.

Since the end of 2008, one of the regional resource centres for substance dependence problems has been dedicated to collecting more information and know-how about this theme. The centre is in the process of drawing up a plan for this work with a perspective of five years.

3.1.3 Community

Action plans in the field of drugs and alcohol policy

The Norwegian Alcohol Act requires the municipalities to prepare local drugs and alcohol policy action plans. A number of other acts also assign tasks to the municipalities in the drugs and alcohol field. Based on the intention of these acts and local needs, the municipalities are encouraged to pursue a coherent drugs and alcohol policy. For example, licensing rules and other preventive measures should be seen in conjunction with rehabilitation. Preparing a municipal *drugs and alcohol policy action plan* is a planning tool that should involve several municipal sectors, thereby ensuring coherence. The Directorate of Health, the regional competence centres and the county governors assist the municipalities in the development and implementation of such plans.

At the end of 2007, 254 municipalities (59%) had a coherent drugs and alcohol policy action plan. The corresponding figure for 2005 was 149 (34%).

Plan for competence-building

The Directorate of Health and the regional competence centres are cooperating on a competence-building plan. The county governors are also contributing to this work. The goal is to coordinate and strengthen local prevention efforts in the municipalities. Competence-building measures will be aimed at key personnel (administrative decision-makers, politicians, relevant sector managers, local school managers, teachers, health personnel), parents/guardians, the licensed trade, the police and voluntary organisations.

3.2 Selective prevention in at-risk groups and settings

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

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

The intention was to examine whether and to what extent youth from immigrant backgrounds need special measures to prevent the development of drug and alcohol problems, and whether or not various immigrant youth groups need separate early intervention measures in the drugs and alcohol field. A report was published in 2008 (Bergengen and Larsen, 2008). See also NR 2008, Chapter 3.2. Based on the report, there are plans to produce information adapted to youth from different ethnic backgrounds, for example through adapting drug and alcohol prevention programmes in lower secondary schools. The contents of the report will be spread among relevant groups.

About khat in particular

Khat was regulated as a narcotic substance in Norway in 1989, and its use and possession is therefore illegal pursuant to Norwegian law. The consumption of khat in some immigrant groups is alarming and a contributory factor to poor social inclusion. Measures across welfare sectors are therefore needed to meet this development. The khat problem must be seen in conjunction with employment and education, and close cooperation is required between public services and relevant immigrant organisations. With support from the Directorate of Health, the Oslo drug and alcohol competence centre

has produced a brochure targeting public services. It contains information about khat and its possible harmful effects.

A brochure aimed at khat users has also been produced in Somali. The Oslo competence centre and the Directorate of Health have allocated funds for a pilot project in Oslo aimed at obtaining employment for women whose husbands are part of a milieu in which khat is used. The pilot project was developed following a proposal from, among others, the Somali association SONORFUS. It was concluded in 2008, having achieved positive results. In 2009, the project was given funds for continued work and evaluation.

A large number of marginalised youth in Oslo from immigrant backgrounds have an income based on selling drugs, cannabis in particular (Sandberg and Pedersen 2006). There is reason to believe that certain groups of children and young people from immigrant backgrounds are at particular risk of developing a drug problem. A project supported by the Directorate of Health during the period 2006 to 2008 targeted young people from immigrant backgrounds who sell drugs in Oslo. The experience from this project will be followed up.

Outreach work

While outreach work among young people in high-risk milieus is part of the municipality's general responsibilities, it is not a statutory responsibility. Topics relating to outreach work are now part of further education programmes at several university colleges. A book of methods for use in outreach work has also been published under the auspices of the Oslo Drug and Alcohol Addiction Service Competence Centre. In April 2008, on assignment for the Directorate of Health, the Oslo Drug and Alcohol Addition Service Competence Centre organised a major international conference in Oslo on 'Outreach work'.

3.3. Indicated prevention

3.3.1 Early intervention

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

As part of this national strategy, the Directorate of Health has prepared the guide *From concern to action – A guide to early interventions in the drugs and alcohol field* (in Norwegian only*)*. The guide is part of a long-term programme of early intervention in the drugs and alcohol field. The aim is to increase knowledge about what public service managers and staff should look for in order to identify a nascent drug and/or alcohol problem in children, young adults or older people. The guide also provides concrete advice about what can be done to solve a potential problem as early as possible. The regional competence centres play a key role in implementing the guide and in contributing to greater knowledge about early intervention in the public services.

During the period 2007 to 2009, the competence centres have been given funding by the Directorate of Health to develop of a total of 25 early intervention projects, which can also lead to the development of new methods. Most of them target children and young people, who are a prioritised target group. Another priority group consists of pregnant women.

Funding has also been given to projects targeting arenas that are particularly well suited to early interventions, such as GPs, hospitals, the workplace and schools. Most of the projects run for several years.

3.4 National and local media campaigns

There are no new media campaigns aimed at the use of drugs in particular. On the other hand, several extensive information campaigns have been carried out in relation to alcohol in recent years. Over time, these campaigns have been given a more central and visible role in preventive work. The main goal of preventive efforts in Norway has been to reduce the harmful effects of drug and alcohol use on health and society by maintaining and increasing support among the general public for a restrictive alcohol policy. The campaigns have been one of the means to this end. They have targeted the general public and the municipalities. Information has also been aimed at selected groups in order to reduce problem behaviour such as harmful drinking or binge drinking among youth. To combat prenatal alcohol disorders (FASD), women of fertile age have been one of the target groups.

The information campaigns have been part of the Government's action plan to combat drug and alcohol-related problems (2004-2006) and the escalation plan for the drugs and alcohol field (2008-2010). Dedicated funds have been allocated to information measures in the national budget. The overall information effort has consisted of 'packages' of several measures, of which media and advertising campaigns for limited periods have been the most visible.

One example is the campaign *'Dare to set limits'* (2005-), which targets parents and young people with the aim of increasing parents' awareness of their responsibility as role models and setters of limits. The campaign encourages parents to address the issue of alcohol consumption and to set limits for their own children. The dedicated website http://www.settegrenser.no contains film clips and advice to parents. The campaign collaborates with schools in order to reach parents.

Norwegian authorities recommend that pregnant women do not drink alcohol. To inform women about this recommendation and the effects of alcohol on the foetus, an '*Alcohol-free pregnancy'* campaign was run in 2007 and 2009. The goal is to get as many women as possible to change their drinking habits when they are planning to become pregnant, and to abstain during the entire pregnancy. In addition to advertising, information about recent research is published in the media, online, at health stations, at GPs' offices etc. Courses and conferences are being held and screening tools are being developed to map alcohol consumption and improve cooperation between health authorities, child welfare services and social services in the municipalities.

4. Problem drug use

4.1 Prevalence and incidence estimates of PDU

See data in Standard tables 07 and 08.

In the EMCDDA context, problem use is defined as 'Injecting use of drugs *or* prolonged/regular use of opiates, cocaine and/or amphetamines.' In Norway, we primarily have figures for the group that injects drugs. However, in 2009, the number of problem heroin users was calculated based on a similar definition to the one EMCDDA uses. Chapter 4.1.2 deals with this in more detail.

4.1.1 Calculating the number of injecting drug users

For the period 2002 to 2006, the number of injecting drug users in Norway was calculated using three different methods: *the Mortality Multiplier, questionnaire surveys among the police and the social services in the municipalities, and the Multiple Indicator Method.* The methods are described in NR 2006, Annex 1. Since 2007, it is only possible to use the Mortality Multiplier, as questionnaire surveys among the police and the social services in the municipalities were discontinued. The Multiple Indicator Method used some of the data from the questionnaire surveys, and it was thus no longer possible to use this method either.

Table 4 shows estimates for the number of injecting drug users in Norway based on the Mortality Multiplier. Overdose death figures from the Norwegian Cause of Death Register, produced by Statistics Norway until 2007 and by the National Crime Investigation Service (Kripos) until 2008, provide an estimate of the number of injecting drug users in 2007. The estimate for 2006 has been adjusted slightly in relation to previous estimates for the same year. This is because calculations are based on a three-year sliding average and the preliminary estimate for 2006 has been replaced by 'final figures' for the same year. The estimate for 2007 will also be adjusted slightly when the figures from the Norwegian Causes of Death Register for 2008 are published. The trend as regards the number of injecting drug users showed an increase until 2001. This increase was followed by a decline until 2003 and a stable situation until 2008.

Table 4: Ranges for the number of injecting drug users in Norway 2002-2007, calculated using the Mortality Multiplier. The figures have been rounded off.

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

2007	8,600 – 12,000

Source: SIRUS.

In accordance with previous results when other methods were also used, it is assumed that the upper limit for the number of injecting drug users based on the Mortality Multiplier is approximately five per cent too low. The number of injecting drug users in 2007 can therefore be estimated to be between **8,600** and **12,600**. This includes all injecting use. Heroin is the drug most commonly injected, but amphetamine is also injected. In Oslo, for example, 12 per cent of those who obtained needles from the needle distribution service until 2004 stated that they mainly injected amphetamine. This percentage increased somewhat until 2008 (Bretteville-Jensen, 2005; personal correspondence Bretteville-Jensen 2009).

4.1.2 Problem heroin users

The consumption of heroin in Norway has been estimated in a survey covering the period 2000 to 2008 (Bretteville-Jensen and Amundsen, 2009). As a basis for the calculations, it was estimated how many people have used heroin in Norway, including those who have only smoked it. To be able to estimate the total consumption, the users were divided into categories according to frequency of use and the method of taking the drug: *experimental users, sporadic users and problem users*.

By *experimental users* in this context is meant persons who take heroin once or a few times and then stop. *Sporadic users* are persons who take heroin more or less regularly, but not as frequently as problem users and without as many negative consequences. These users can be referred to as controlled users, recreational users or moderate users (Stimson, Hickman, Quirk, Frischer, & Taylor, 1997; Stowe & Ross, 1991; Warburton, Turnbull, & Hough, 2005; Zinberg, 1984). *Problem users* are persons who use the drug more regularly, who experience withdrawal symptoms when they stop, and for whom the social, financial and health-related consequences can be great. These users can be referred to as addicts or heavy users. However, there is uncertainty attached to the calculations.

The size of the group of problem users of heroin *who inject the drug* is estimated using the Mortality Multiplier. The size of the group of problem users who *smoke* heroin is calculated on the basis of two surveys from Oslo. One is the Client Survey in Oslo from 2006, which was carried out among users of services provided by the Alcohol and Drug Addiction Service in Oslo (lodging houses, housing services, rehabilitation etc.). On the basis of this material, the proportion of a group of problem users who only smoke heroin can be estimated as a percentage of those who inject it. The other survey is carried out among users of the needle distribution service in Oslo, which provides information about the time that elapsed from the first time the relevant users smoked the drug until they injected it (Bretteville-Jensen, 2005). Based on this, a total estimated figure for the number of problem users of heroin in Norway who only smoke the drug can be calculated. The estimate is only based on information from Oslo, however.

Table 5 shows the estimates for the number of problem users of heroin for the years 2000 and 2008. The ranges have an uncertainty of 30 per cent. The decline from 2000 to 2008 is most probably due to a substantial increase in the availability of substitution treatment during the period.

Table 5: Estimate of problem heroin users in 2000 and 2008. National figures

	2000	2008
Problem users		
Only injection	9,150 (6,400-11.900)	6,300 (4,400-8,200)
Only smoking	2,100 (1,470-2,730)	1,450 (1,000-1,900)
Both injection and smoking	2,400 (1,680-3,120)	1,700 (1,200-2,200)
Total number of problem users	13,650 (9,550-17,750)	9,450 (6,600-12,300)

Source: SIRUS

4.2 Data on PDU from non-treatment sources

4.2.1 From the injection room scheme in Oslo

The injection room in Oslo opened in 2005 as a temporary arrangement. SIRUS evaluated the trial scheme in 2007 based on the two first years of its operation, from February 2005 to January 2007. See National report (NR) 2008, Chapter 7.1.1. In a new report (Skretting and Olsen, 2009), the evaluation has been updated for the period July 2007 to January 2009, after the injection room moved to its new premises. In April 2009, a permanent Act relating to injection rooms was adopted by the Storting. See Chapter 1.1.

Number of users of the injection room

In the first two years, 409 persons were registered as users, 383 of whom had actually used the service. As of 31 January 2009, the number had tripled to 1,276 registered users, 1,052 of whom actually used the injection room during the 19 months from July 2007 until January 2009. Because the first injection room had limited capacity, it was not possible to register new users during certain periods. After the move, new users could again be admitted, and the number has since increased steadily. In light of the fact that there are approximately 3,000 injecting drug users in Oslo, the number of actual users of the room is considered to be substantial.

Age and gender

The age limit for registration as a user of the injection room is 18. The number of newly-registered users over the age of 40 is slightly higher in the new injection room than in the old one. The average age of those who registered in the old injection room was 37, while it is 38 when those registered in the new room are included. As of January 2009, the gender distribution for registered users was 26 per cent women and 74 percent men (Table 6).

Very little is otherwise known about the users of the injection room with respect to their background and drug/alcohol history. This is because the Storting has stressed that the injection room scheme is intended as a low-threshold service, and only the gender and age of the users should therefore be registered.

Table 6: Number of registered users by age and gender in the old and new injection room

Number of registered users		Average age	Gender	
			% M	% F
Old injection room	409	37	71	29
New injection room	1276	38	74	26

Source: SIRUS

Frequency of use/ number of injections

The fact that the number of registered users has almost tripled has naturally led to an increase in the number of injections. In the period from July 2007 to January 2009, a total of 27,384 injections were registered, which means an average of 47 per day (based on the room being open for 580 days). Even though this is twice as many injections as during the first two years of operation, when there were an average of 24 injections per day (17,226 in total), 47 is nonetheless a low figure compared with the number of injections in Oslo every day, and it may not amount to more than approximately one per cent of the total.

Overdoses and overdose deaths

During the first two years of operation, 0.61 per cent of the injections in the injection room ended in an overdose. The proportion in the follow-up evaluation period was more or less the same. Overdoses defined as sub-acute are handled by the staff, while ambulance personnel take care of resuscitation when the overdose is regarded as acute. It is worth noting that none of the overdoses was fatal.

Intensive, frequent, long-term and other problematic forms of use
No new information available.

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

5.1 Strategy/policy

The four regional health authorities are responsible for ensuring that specialist health services also include the treatment of drug and alcohol problems. In the Act relating to specialist health services, the services are referred to as 'interdisciplinary specialist treatment for problem drug and alcohol use'. This means that the services have both a social and health-related component.

The Norwegian Action Plan on Alcohol and Drugs (2008-2010) focuses on strengthening both the quality and the quantity of the treatment services. Pursuant to the Action Plan, the quality and capacity of the services for patients with drug and alcohol problems must be improved. The national budget for 2009 specifies that there is still a need for greater growth in interdisciplinary specialist treatment than in somatic services. To increase capacity, the following seven measures will be implemented:

- Increase efforts and treatment capacity in interdisciplinary specialist treatment, including medication assisted treatment
- Ensure better procedures for holistic treatment to avoid interruptions to treatment
- Increase efforts and treatment capacity in mental health care services and ambulant services for people with both drug/alcohol problems and mental health problems
- Improve the service for patients with drug and/or alcohol dependency and mental health problems
- Amend the Patients' Rights Act to bring it into line with the Administrative Alcohol and Drugs Treatment Reform
- Complete professional guidelines for medication assisted treatment
- Consider issuing more detailed regulation for medication assisted treatment.

According to the status report for 2008 (the Directorate of Health, 2009), all these measures have been initiated. The regional health authorities have been asked to increase their capacity in the field of interdisciplinary specialist treatment, with particular emphasis on acute treatment, detoxification and ambulant teams, as well as medication assisted treatment. Everyone referred to interdisciplinary specialist treatment for drug and/or alcohol dependency will also be evaluated with respect to whether they need other services in the specialist health service. In addition, the efforts aimed at those with both drug or alcohol problems and mental health problems will be strengthened. Several sections in the Patients' Rights Act have also been amended.

In-patient treatment capacity has been stable since 2004, with a slight increase in the number of detoxification places and minor changes in the breakdown between short-term and long-term treatment. More people receive outpatient treatment, and there has been a significant increase in the number of people receiving substitution treatment. Figures from

the Norwegian Patient Register show an increase of 16 per cent in new referrals to interdisciplinary specialist treatment from 2007 to 2008.

Guidelines for medication assisted treatment of opioid dependency

In May 2009, the Directorate of Health and the Ministry of Health and Care Services distributed a consultative proposal for guidelines and regulations relating to medication assisted treatment (MAT) for opioid dependency. The deadline for submissions was 1 September 2009. The final guidelines and regulations will probably enter into force in 2010. The Directorate of Health gave the following reasons for the professional guidelines:

"The evaluation of MAT in 2004 showed that unfortunate regional differences have developed in the country as regards waiting times, rehabilitation efforts, the use of medication, organisation and the practising of the applicable guidelines. The criteria for receiving treatment and for being discharged from treatment differed. In addition, there were major differences with respect to municipal follow-up services such as housing, employment and financial support. The overriding objective for the work was to incorporate MAT as an integral part of interdisciplinary specialist treatment for drug addicts". (www.helsedir.no).

The proposed professional guidelines are largely a continuation of current practice, but some adjustments have been made as regards treatment indication and the basis for discharges. One particularly important change is that the minimum age for participating in the programme will be removed. It is currently 25 years. The main features of the proposal are:

- The treatment indication is opioid dependency, in accordance with the currently applicable diagnostic criteria. However, substitution treatment should not be the first choice of treatment unless it is the most appropriate and adequate treatment option based on an overall assessment.

- No minimum age is set, but the younger the patient, the greater the emphasis on drug-free treatment options.

- MAT must be viewed in conjunction with other available interdisciplinary specialist treatment options and the need for other specialist treatment for physical complaints and mental health problems.

- Treatment will start in the specialist health service. Tasks relating to the treatment, such as the ordering of medicinal drugs, may be delegated to the municipal health services, including GPs.

- The use of other substances will not result in patients being discharged, unless it entails an increased risk for the patient. Patients must only be discharged from treatment if the treatment is deemed to be unjustifiable or if the patient wishes to be discharged.

The guidelines must be viewed in conjunction with the regulations that regulate aspects of the treatment that are not regulated in other health legislation.

Treatment systems

No new information available.

5.2 Trends of clients in treatment and characteristics of treated clients

5.2.1 Data from the national client survey

Treatment demand data from treatment services are still only available at aggregate level. The inclusion of all admissions in the interdisciplinary specialist health service in the Norwegian Patient Register started from January 2009. It is possible that *individual-based data* can be reported from 2010, but a further delay may occur. Overviews from the current national client mapping system do not tell us how many individuals are included in the number of queries and admissions, which means that it is impossible to control for double registration. Moreover, the data basis does not distinguish between problem users of alcohol and drugs.

With these reservations, some preliminary data from the nationwide client mapping survey for 2008 are included below (Erik Iversen, the Bergen Clinics Foundation, personal communication). Comparisons are made with the corresponding survey from 2006, data from which were presented in NR 2007, Chapter 4.2.1.

In 2008, 34,944 requests for treatment were received from a total of 106 reporting services. The figures include outpatient services, in-patient treatment and care-based services. In 2006: 31,495 queries from 98 facilities. The number of admissions in 2008 was 24,422. In 2006: 21,987, while the number of concluded treatments was 15,889. In 2006: 13,250.

Most used intoxicant

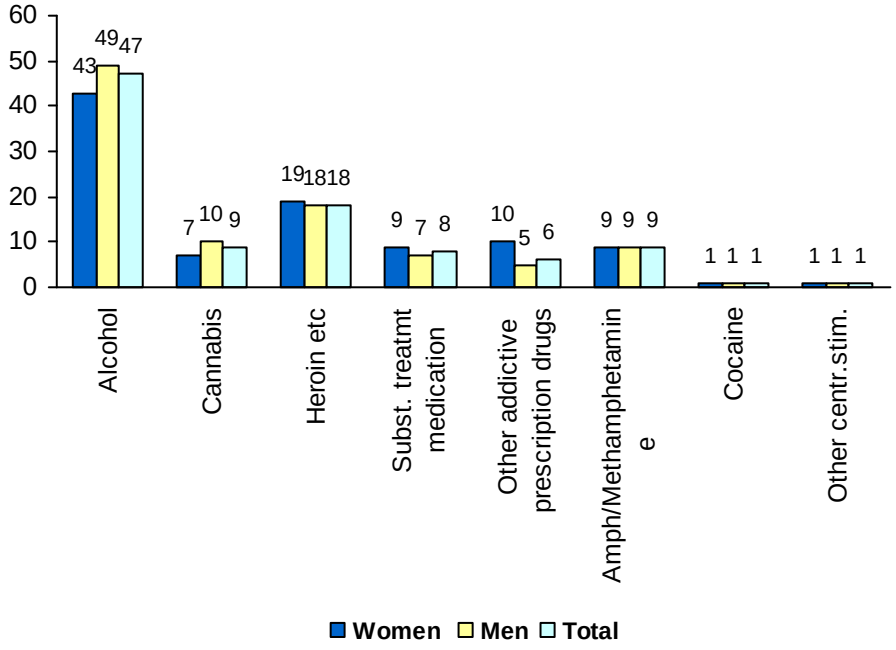
Figure 8 shows that, except for alcohol, which still accounts for nearly half of the registrations on admission to treatment facilities and care services, *heroin* is most often reported as the most used intoxicant (18%). The percentage reporting heroin is in strong decline, however. In 2006, it was 24 per cent, while in the early 2000s it was around 35 per cent. The gender differences have evened out; the proportion of women reporting heroin was much higher a few years ago.

The percentage reporting *addictive medicinal drugs*, including methadone and Subutex[3], has increased somewhat, from 11 per cent in 2006 to approximately 14 per cent in 2008. The corresponding figure in the early 2000s was only seven to eight per cent. The increase is probably largely due to substitution drugs, which accounted for about eight per cent in 2008. The significant differences between women and men, both in 2008 (19% and 12%) and in 2006 (16% and 9%), are probably due to the use of lawfully prescribed benzodiazepines. For substitution drugs, there is little or no difference between men and women.

There was no change for *cannabis and central stimulants* as the most used intoxicants from 2006 to 2008. The gender differences are also stable for both substance groups. In 2008, *cocaine* was registered separately, but only one per cent report it as being their most used intoxicant. *Amphetamine and methamphetamine* clearly predominate among the central stimulants.

Figure: 8. Most used intoxicant 2008. Percentage

[3] Total of both lawfully prescribed and illegally used Subutex and methadone



N=5,727/12,729/18,456
Source: Bergen Clinics Foundation

5.2.2 Profiles of clients in opioids substitution treatment

Clients in opioids substitution treatment are included in the nationwide client survey, but the probability of double registration is very small here since most of them stay in the same treatment system all year.

The Norwegian programme for medication assisted treatment (MAT) has been discussed in previous reports to the EMCDDA. See NR 2004 Chapter 5.3 in particular. Data are reported annually in the form of status surveys from the 14 regional centres that make up the MAT programme (SERAF, 2009). For 2008, a total of 4,172 forms were completed, while 4,913 persons were in treatment as of 31 December 2008. The average age of clients (for whom a form has been completed) was around 40, and the proportion of women was approximately 30 per cent, both figures more or less unchanged since 2005. Four-hundred and seventy-three patients concluded treatment during 2008, 39 of whom died.

The number of patients has increased rapidly and steadily by approximately 500 per year. In 2008, the total number of admissions was 831 nationwide, 59.5 per cent of which were first-time admissions. The percentage of first-time admissions has declined steadily in recent years, while the number of re-admissions is increasing.

Social condition

The status surveys have shown that a high proportion live in independent living arrangements, while a low proportion have been rehabilitated in relation to the employment market, and a significant percentage have disability benefit as their primary source of income. The percentage of people who are dependent on social security has varied considerably, also in 2008. Eight out of ten have their own house or apartment, two to three are in full or part-time employment and/or are in education/training, four in ten receive disability benefit and one to two in ten rely on social security as their main source of income. In other words, rehabilitation does not usually lead to paid work and financial

independence, but to disability benefit and social security benefits. In addition, many have been without work for years and have no qualifications. It is natural, therefore, that many are entitled to disability benefit.

State of health

The survey describes patients' status regarding infections and mental and physical health using rough and fairly uncertain measures. Just over two per cent are HIV positive. Those who are HIV positive mainly live in Oslo and Akershus, and partly in surrounding counties. More than a quarter, 27 per cent, suffer from illnesses or injuries that are sufficiently serious to affect their quality of life. Seventeen per cent show signs of serious depression and 21 per cent of serious anxiety. These findings are more or less unchanged from previous years and confirm that, as a group, patients in MAT are characterised by considerable morbidity, both mental and somatic. This largely involves enduring and, in part, chronic conditions.

Psychosocial treatment

The survey does not specify in detail the type of treatment measures the individual centres use beyond listing the services that the patient has been in contact with during the last 30 days. Active rehabilitation usually requires regular interdisciplinary contact. The survey shows that just over six in ten have been in contact with the social centre at least once, nearly six in ten with their GP and almost five in ten with an MAT consultant. Nearly five in ten have attended a meeting of the team responsible for them. This indicates fairly frequent interdisciplinary contact but says little about the quality. The system depends on competence in the first line and/or active follow-up by MAT. Contact with other specialist health services is infrequent. Less than one in ten has had contact with psychiatric health services, despite considerable comorbidity.

Drug use

The reporting was carried out by combining information about drug use and results from urine sample controls. The measure used is any use of other substances than those prescribed by the programme during the last 30 days, confirmed by at least one positive urine sample and/or information about use of the drug. The same person may test positive for more than one substance. The percentages are calculated separately for each substance. Figure 9 shows the distribution of the most common types of drugs.

About 13 per cent have used opioids and approximately 15 per cent have used other central stimulants in 2008. The use of cannabis is higher (32%), but the biggest problem is the use of benzodiazepines. More than 42 per cent have used such substances. Just under half of them (19%) had been legally prescribed the substance, while more than half obtained all such substances from illegal sources. The variation in this area is particularly great. One centre detected the use of benzodiazepines in 16 per cent of their patients, while the highest proportion at another centre was 53 per cent. A high proportion of legal prescriptions does not seen to prevent the use of medicinal drugs from illegal sources (SERAF, 2009).

6. Health correlates and consequences

6.1. Drug-related infectious diseases

See data in Standard table 09.

6.2.1 HIV and Aids

In 2008, 299 cases of HIV infection were reported to the Norwegian Notification System for Infectious Diseases (MSIS). Twelve of the cases were among injecting drug users: seven men and five women. The median age was 33 years (25 to 53 years). Five of the twelve who were diagnosed as HIV positive in 2008 were persons of foreign origin. They had been infected abroad before arriving in Norway for the first time. Four of them lived in Oslo. The number of HIV cases remains relatively low, and little new infection is detected in this group.

As of 31 December 2008, a total of 553 persons had been diagnosed as HIV positive with injecting use as a risk factor. This amounts to 14 per cent of all reported cases of HIV since 1984. Development into Aids has been reported in 149 of the cases (Table 7). No information is available regarding how many of the HIV positive injecting drug users are still alive.

Table 7: Percentage of injecting drug users of persons infected by HIV and Aids, with injecting risk behaviour, by year of diagnosis

	HIV total	HIV injecting drug use	Percentage HIV injecting drug use	Aids total	Aids injecting drug use	Percentage Aids injecting drug use
1984-89	894	315	35%	142	8	6%
1990	90	22	24%	60	13	22%
1991	142	16	11%	57	14	25%
1992	105	12	11%	52	8	15%
1993	113	13	12%	63	13	21%
1994	94	13	13%	74	19	26%
1995	105	11	10%	67	7	10%
1996	116	9	8%	56	11	20%
1997	114	11	10%	35	8	23%
1998	98	8	8%	36	4	11%
1999	147	12	7%	31	7	23%
2000	175	7	4%	35	5	14%
2001	157	8	5%	33	8	24%
2002	205	16	8%	34	4	12 %
2003	238	13	5%	53	6	11%
2004	251	15	6%	36	4	11%
2005	219	20	9%	32	4	13%
2006	**276**	**7**	**3%**	**32**	**4**	**13%**
2007	**248**	**13**	**5%**	**11**	**0**	**0%**

2008	**299**	**12**	**4%**	**18**	**2**	**11%**
Total	**4,086**	**553**	**14%**	**957**	**149**	**16%**

.

Source: Norwegian Institute of Public Health

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

6.1.2 Hepatitis

During the nationwide outbreak of hepatitis A from 1996 to 2000, 1,360 drug users were identified as having acute hepatitis A. Since then, only sporadic, individual cases of hepatitis A have been reported among injecting drug users.

Since 1996, there has been a considerable increase in hepatitis B among drug users. In 2008, 54 of a total of 103 reported cases of acute hepatitis B were among injecting drug users. During the period 1995 to 2008, the total number of reported cases of acute hepatitis B among injecting drug users was 1,924.

The monitoring of hepatitis C in Norway was intensified from 1 January 2008. The notification criteria were changed so that all laboratory-confirmed cases of hepatitis C must now be reported to MSIS. Previously, only acute illness had to be reported, and this provided a very inadequate overview of the real incidence of the disease in the country. In 2008, 3,411 cases of hepatitis C were reported. In about half of the reported cases, no information was provided about the presumed mode of transmission, but in the cases where the mode of transmission is known, 89 per cent (1,680/1,890) were infected through the use of needles. For the time being, data from MSIS cannot distinguish between cases involving new infection with hepatitis C and cases where the infection occurred many years ago. It is therefore not known whether new infection of hepatitis C among drug users has declined or increased in recent years.

In recent years, small-scale prevalence surveys have been carried out in connection with needle distribution in Oslo in order to register the incidence of, for example, hepatitis among injecting drug users. These surveys are the only prevalence surveys that are carried out regularly among a representative sample of drug users in Norway. The 2008 survey showed that 70 per cent of the 170 persons included in the survey had experienced a hepatitis A infection or been vaccinated against the disease, 41 per cent of the 172 persons included in the survey had had a hepatitis B infection and 68 per cent of the 171 persons included in the survey had experienced a hepatitis C infection. Forty-three percent had tags indicating that they had been vaccinated against hepatitis B.

Other drug-related health correlates and consequences
No new information available.

6.2 Drug-related deaths and mortality of drug users

See data in Standard tables 05 and 06.

Methodological considerations

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

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

WHO revised its coding of causes of deaths relating to drugs and alcohol in 2002. The revisions were implemented in the Norwegian Causes of Death Register as early as 2003, but they were not included in the Standard Tables until last year. The corrected figures show a higher estimate than previously reported by SSB.

Situation and development

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

Table 8: Drug-related deaths 1991-2008. Total number of deaths and broken down by gender. Figures from Kripos and Statistics Norway (underlying cause of death)

1991-2008	Number of deaths according to Kripos			Number of deaths according to Statistics Norway *		
	Men	Women	Total	Men	Women	Total
1991	74	22	96	66	22	88
1992	78	19	97	81	23	104
1993	77	18	95	76	17	93
1994	102	22	124	105	19	124
1995	108	24	132	114	29	143
1996	159	26	185	173	31	204
1997	149	28	177	160	34	194
1998	226	44	270	228	54	282
1999	181	39	220	191	65	256
2000	264	63	327	302	72	374
2001	286	52	338	327	78	405

2002	166	44	210	240	67	307
2003	134	38	172	193	62	255
2004	168	55	223	220	83	303
2005	146	38	184	176	58	234
2006	152	43	195	187	64	251
2007	162	38	200	217	58	275
2008	148	31	179	**	**	**

Source: Kripos and Statistics Norway

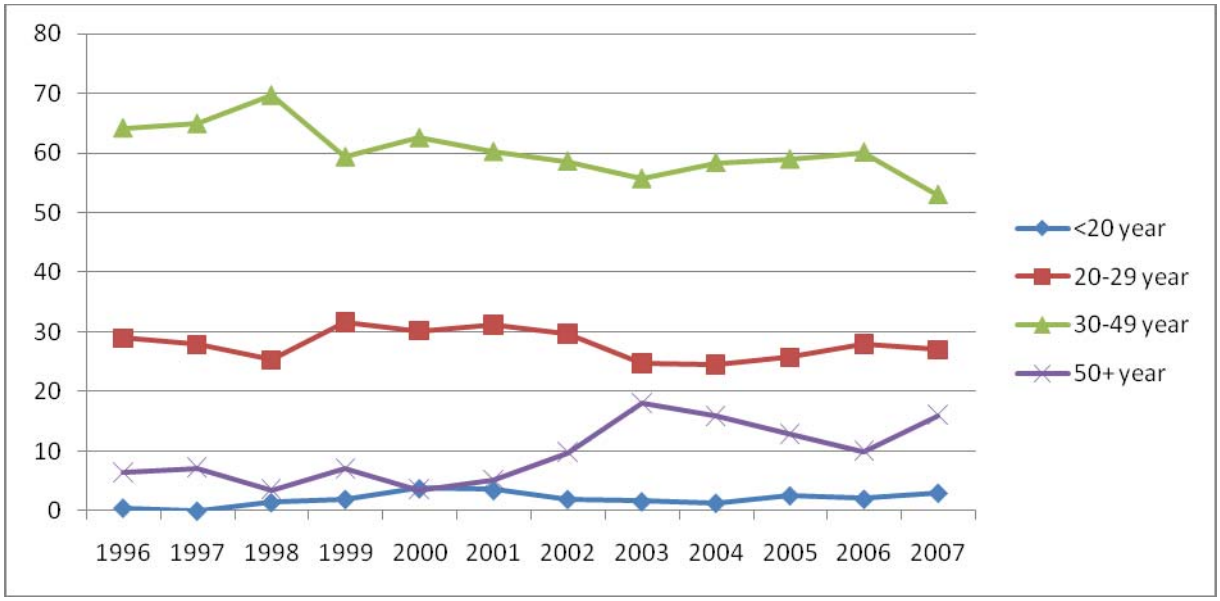
**The figures from 1996 and subsequent years are based on a revised inclusion criteria including a higher number of ICD-codes. Suicides in which narcotic substances were used are included from 1996.This results in higher estimated drug-related deaths. Hence the figures before and after 1996 are not directly comparable. Following WHO's classification instructions for certain drug-related deaths, Statistics Norway introduced a revised coding of causes in 2003. This also creates a higher rate of estimated drug- related from 2003 and subsequent years.*
*** Figures from Statistics Norway for 2008 are not yet available.*

According to the statistics from Kripos for 2008, 24 of 27 police districts had registered drug-related deaths. Oslo had most deaths (60), 34 per cent of the total. Very many of the deaths are believed to be due to extensive multiple use.

In the early 1980s, the proportion of drug-related deaths among those over the age of 30 was less than 20 per cent. The proportion has increased steadily, and in the 1990s it had reached 60 per cent according to SSB's statistics. The SSB statistics show that, for the years 1996 to 2007, the proportion of drug deaths in the 30 plus age group was approximately 70 per cent on average. During the same period, the proportion over the age of 50 appears to have increased. The youngest age groups' proportion of deaths remained stable during the period 1996 to 2007 (Figure 9.

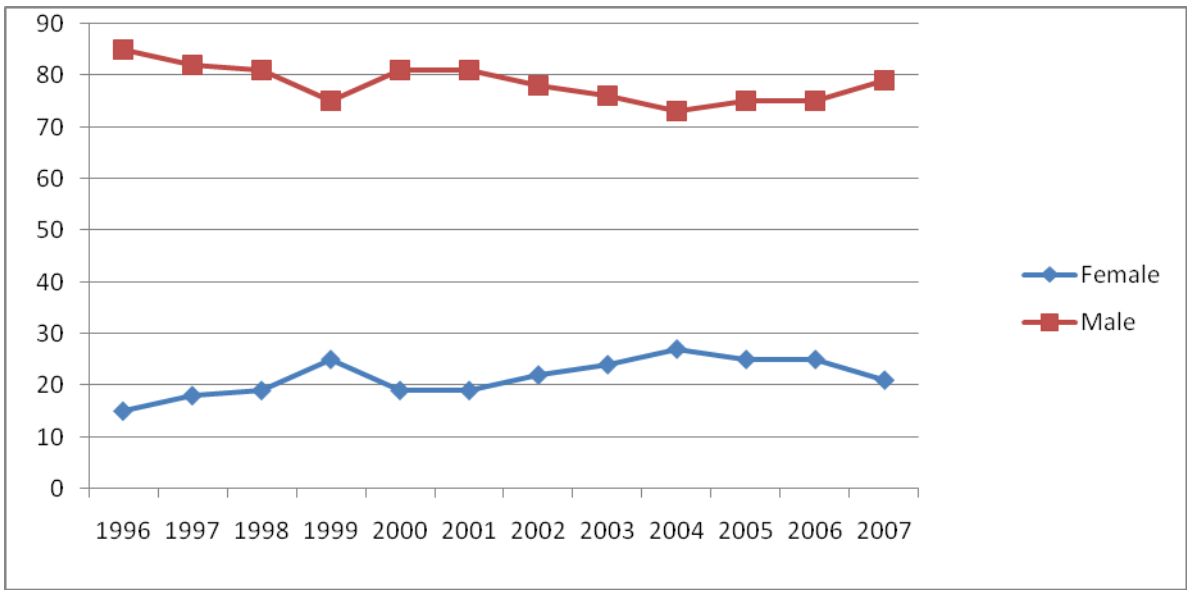
During the period 1996 to 2007, the proportion of women varied between 15 and 27 per cent, and was close to 22 per cent on average (Figure 10). During the period 1980 to 1990, the average proportion of women was also close to 22 per cent. Seen in a longer-term perspective, therefore, both the level and the variation seem to be within the 'normal range' for the proportion of women.

Figure 9: Drug-related deaths broken down by age group, 1996-2007



Source: SIRUS and Statistics Norway

Figure 10: Drug-related deaths broken down by gender, 1996-2007



Source: SIRUS and Statistics Norway

7. Responses to health correlates and consequences

Prevention of drug-related emergencies and reduction of drug-related deaths
Prevention and treatment of drug-related infectious diseases

No new information available.

7.1.1. Psychiatric and somatic comorbidity

Guidelines for serious mental health problems and drug and alcohol-related problems

The Directorate of Health has started work on drawing up national professional guidelines for diagnosing, treating and following up patients with serious mental health problems and concurrent drug and/or alcohol problems. The guidelines will deal with three main areas:

- Knowledge about concurrent serious mental health problems and drug or alcohol dependency/problem use
- Recommended methods for examination and diagnosis
- Recommended treatment and other follow-up.

The key elements in the proposed guidelines were discussed in NR 2008, Chapter 7.3.1. The guidelines were distributed for consultation early in 2009 and are expected to be completed by autumn 2009.

As part of the Action Plan (2008-2010), the efforts and treatment capacity of the mental health care services and ambulant services will also be increased for those with concurrent drug and/or alcohol problems and mental health problems (see Chap. 5.1). Those who are referred to interdisciplinary specialist treatment for drug and/or alcohol dependency will also be evaluated with respect to whether they need other services in the specialist health service. It is also a goal that users should become more involved in the work in this field. Psychiatric District Centres must have the competence and staff required to attend to individual and multiple treatment needs in all patients who are referred to mental health care services. The hospitals will be responsible for expert functions.

The Directorate of Health's reporting as of 31 December 2008 shows that all the health regions are working to improve services for patients with concurrent problems. For example, the South-Eastern Norway Regional Health Authority has placed great emphasis on strengthening its capacity in relation to acute measures and examinations in order to ensure that the needs of people with drug/alcohol dependency are assessed in relation to other specialist health services. Medical competence in the public sector part of interdisciplinary specialist treatment in Oslo has been considerably strengthened (the Directorate of Health 2009).

8. Social correlates and social reintegration

Social exclusion and drug use.

No new information available.

8.1 Social re-integration

New measures in the Action Plan (2008-2010) are discussed in Chapters 8.1.1 – 8.1.4.

8.1.1 Increased use of individual plans

As of 1 January 2004, the right to an individual plan for drug and alcohol users in need of long-term, coordinated services was laid down in the Act relating to social services (section 4-3a). The right to a plan based on individual treatment adaptation and further follow-up was already enshrined in the Patient's Rights Act in 2001. However, several reports show that few people with drug or alcohol dependency actually have an individual plan. The Action Plan therefore aims to ensure that more drug and alcohol users get their own plan.

Everyone who is in need of long-term, coordinated health and social services is entitled to an individual plan. The plan should include the appointment of a coordinator who is responsible for follow-up of the user and for the progress of the plan. There should also be a responsible team consisting of the user, the coordinator and other natural partners, such as the GP, family members or others. By having an individual plan, the user will have the benefit of a better overview of the services, more active participation and targeted cooperation. The support services will benefit in the form of better coordination of their services, a clearer user focus and more binding relations with the users.

The Directorate of Health is working to increase the use of individual plans for all groups who need or are entitled to such plans. Several measures have been initiated to ensure that more such plans are drawn up for problem drug and alcohol users. As mentioned in Chapter 1.3, the grant scheme for municipal efforts in the drug and alcohol field has been substantially strengthened in 2009. The aim is to encourage greater use of individual plans, including comprehensive follow-up before, during and after stays in institutions or in prison. Social inclusion and fewer relapses are other important goals. Increased use of individual plans is one of the main target areas of the grant scheme 'Municipalities' follow-up of problem drug and alcohol users' and in the trial scheme involving coordinating representatives.

8.1.2 Trial scheme involving coordinating 'representatives' for people with drug or alcohol dependency in the municipalities

A three-year trial has started involving coordinating representatives in 30 selected municipalities. The aim of having such representatives is to help to ensure more coherent and individually-adapted services for people with drug or alcohol dependency, thus resulting in greater social inclusion and better life coping. The representatives will follow users through the help services and ensure that they get the services they need, such as work/activity, medical help, housing, financial guidance, network-building, help in connection with crises etc. The municipalities can cooperate with voluntary organisations, but the offer must be based on the Social Services Act in order to comply with case processing requirements and ensure that users enjoy due process protection.

8.1.3 Qualification programme

The goal of the qualification programme is to strengthen efforts targeting persons with significantly impaired work capacity and earning ability who have limited or no National Insurance rights. The qualification programme will give people with drug or alcohol dependency a better opportunity to take part in the employment market and in other activities. The programme must be individually-adapted and work-related, so that it supports and paves the way for the transition to employment. The programme has been implemented in all municipalities with NAV[4] offices. The scheme will be nationwide from 1 January 2010.

The most recent reporting shows that, during the second half of 2008, far more applications for programmes were registered than in the first half-year, and the number of participants has increased significantly. At the end of 2008, the scheme was available in 276 municipalities. During 2008, a total of 5,279 applications were received. Of the applications that had been processed by the end of the year, 4,411 were granted and 160 were rejected. The number of participants at the end of the year was 4,133.

Work is being done to strengthen cooperation with NAV in order to ensure that more convicted persons who are serving prison sentences can find employment or join a qualification programme on their release. There are eight NAV advisers in prisons. They cooperate with the other NAV offices on prisoner releases. The goal is to increase the number of regional and local agreements between the correctional services and NAV.

8.1.4 Strengthen housing services for people with drug or alcohol dependency

The proportion of homeless people with a drug or alcohol problem was 59 per cent in 2008. In recent years, several housing and service models have been developed, such as the *Homeless people project* and *Obtaining housing for oneself*. The Action Plan specifies that these initiatives will be continued and that the experiences from them will be spread to more municipalities. The following four measures aim to strengthen housing services for people with drug or alcohol problems:

• Increase efforts to eradicate homelessness – with particular focus on homelessness in small municipalities
• Increase efforts to prevent homelessness, including reducing the number of evictions and temporary housing arrangements
• Develop methods and procedures for following up people in temporary housing arrangements so that they can be offered a permanent solution
• Introduce a new investment grant for nursing homes and sheltered housing.

All four measures were initiated in 2008. In addition, a trial project has been initiated to reduce the number of evictions and temporary housing arrangements. The Obtaining housing for oneself strategy will be evaluated, and a new survey was carried out in November 2008. These two reports will tell us whether smaller municipalities have also succeeded in putting homelessness on the agenda, without efforts decreasing elsewhere. They will also tell us something about the measures that did not work.

The correctional services have received funding from the Ministry of Local Government and Regional Development via the State Housing Bank to provide housing for inmates on their release from prison. Efforts are being made to draw up agreements with the

[4] Norwegian Labour and Welfare Service-NAV

individual municipalities. The correctional services have received grants to fund the appointment of seven housing advisers. At the end of 2007, a total of 44 cooperation agreements had been entered into between regions/prisons and the individual municipalities (the Directorate of Health, 2009).

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

9.1 Drug-related crime

9.1.1 Drug law offences

Reported drug crimes

In 2008, the police registered 37,531 drug offences. That is almost 3,300 fewer than in 2007 and one of the lowest figures in the last ten years, equivalent to the level during the period 2003 to 2005.

The decline from 2007 was somewhat greater for drug offences that are regulated by the Act relating to medicines (9%) than for more serious drug offences regulated by the General Civil Penal Code (7%). The number of reported violations of the two acts was almost equal, 19,191 and 18,340, respectively (Table 9). Figures for the number of *investigated* offences are not available from Statistics Norway after 2005.

Table 9: Number of reported drug crimes 2003-2008*

	2003	2004	2005	2006	2007	2008	
Drug crimes	15,009	15,671	16,163	17,966	17,779	16,475	
Aggravated drug crimes	1,143	1,143	955	1,190	1,307	1,072	
Other drug crimes	578	501	485	568	658	793	
Total pursuant to General Civil Penal Code, year 2008							18,340
Drugs, use	10, 547	10,925	11,259	12,635	12,806	11,585	
Drugs, possession	8,533	8,364	8,070	8,627	7,562	7,005	
Drugs, miscellaneous	901	715	731	747	659	601	
Total pursuant to Act related to medicines, year 2008							19,191
Total number reported	36,711	37,319	37,663	41,733	40,771	37,531	

* Number of cases

Source: Statistics Norway.

Penal sanctions

The most recent data from Statistics Norway, from 2007, are described in NR 2008, Chapter 8.2.1. Penal sanctions for drug crimes have increased most during the last decade and have contributed to a change in which groups of crimes result in penal sanctions. From 33 per cent in 1998, drug crime was the primary offence in 41 per cent of all criminal cases in 2007.

In 2007, the total number of convictions for drug offences was 14,430 (number of cases). Only 1,220 convictions resulted in unconditional prison sentences. Of these, 663 were sentenced to a combination of an unconditional prison sentence and a fine, while 358 cases resulted in both unconditional and suspended prison sentences. The number of fines was as high as 10,646, while community sentences were imposed in 446 cases.

9.1.2 Organised crime in Norway

A report published by the National Police Directorate in 2009 contains a strategic analysis of organised crime in Norway. See also Chapter 10.2.2. The purpose of the report is to

shed light on the complexity of organised crime and the challenges it poses for the police in relation to preventing and combating crime. The report is also intended to make it easier for the police to agree on a national strategy based on analyses and intelligence.

The main part of the report consists of an analysis of the five areas of organised crime that are seen as particularly challenging:

- A comprehensive effort in relation to cocaine
- Preventing and combating criminal gangs
- Efforts targeting crimes against property, with particular focus on receivers of stolen goods
- Uncovering the ringleaders behind human trafficking and smuggling
- Uncovering money laundering and confiscating the proceeds of criminal offences.

According to the report, "*Very few police districts mention organised crime as a threat in trend reports and analyses of the crime situation. One explanation may be that smaller operational units lack the knowledge, resources and expertise required to uncover and investigate organised crime. A number of police districts do not have analysis units with their own analysts. The strategic reports prepared by the police districts therefore vary greatly in terms of scope and quality. A lack of internal communication, experience and expertise in this type of reporting may be the reason for this. Previously, most of the cases that involved seizures of large quantities of drugs were followed up in order to uncover the rest of the drug network. Today, there is limited capacity for this".*

The report also provides an illustration of the current situation as regards seizures made along Norway's borders:

"*In a selected period of eight weeks from 1 September to 31 October 2008, 14 seizures were made on the Swedish border (Østfold police district). In terms of quantities, these seizures amounted to a total of 60 kg of drugs. Nine of the cases were big enough to be regarded as very serious drug offences pursuant to the General Civil Penal Code section 162 third paragraph. Of the 14 cases, the police only made efforts to uncover the receivers and ringleaders in three of the cases.*

Operation 'Green Lamp', targeting the Vietnamese cannabis plantations, highlighted some of the challenges described above. It was already known that such plantations constituted a big problem for the police in other European countries, but there was no intelligence information indicating a large number of plantations in Norway. The reason that the first plantation was uncovered was that someone had done a poor job when connecting the electrical system, which caught fire. Afterwards, it was revealed that the Norwegian police were aware of a radical increase in the number of marijuana seizures, but that the information had not been linked to the possible presence of illegal plantations" (the National Police Directorate, 2009).

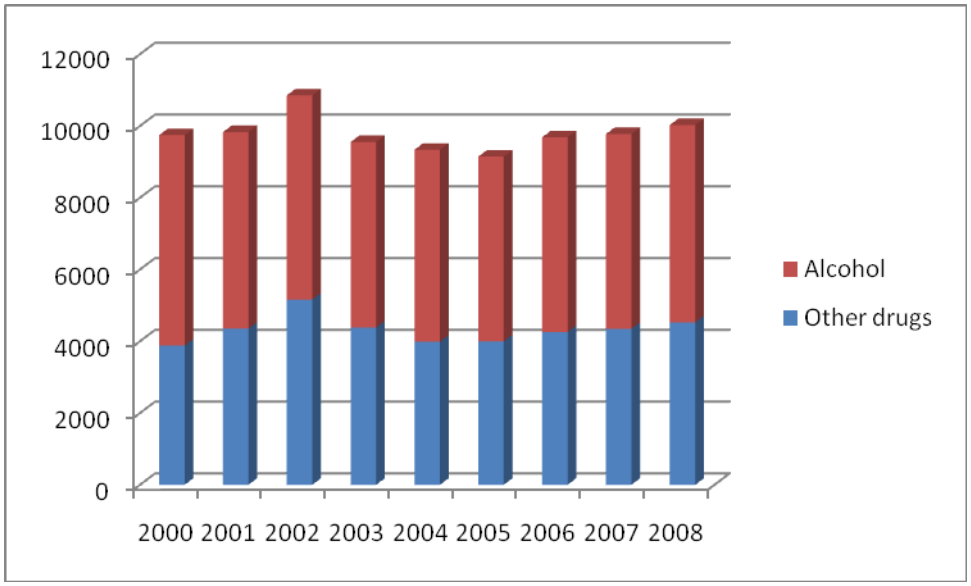
9.2 Other drug-related crime

9.2.1 Driving offences

In 2008, the Division of Forensic Toxicology and Drug Abuse at the Norwegian Institute of Public Health performed around 10,000 analyses of drivers suspected of driving under the influence. Of these, 4,500 were blood samples on which a broad analysis was carried out, i.e. analyses of alcohol and the most frequently found intoxicants (Figure 11). As a rule, several substances were found in the same blood sample. In the blood samples where a

broad analysis was carried out, an average of three intoxicants were found. In addition to alcohol, there is a high incidence of THC, diazepam, amphetamine and methamphetamine in the samples (Table 10 and Figure 12).

Figure 11: The number of road traffic cases received involving suspicion of being under the influence of either alcohol or other substances.



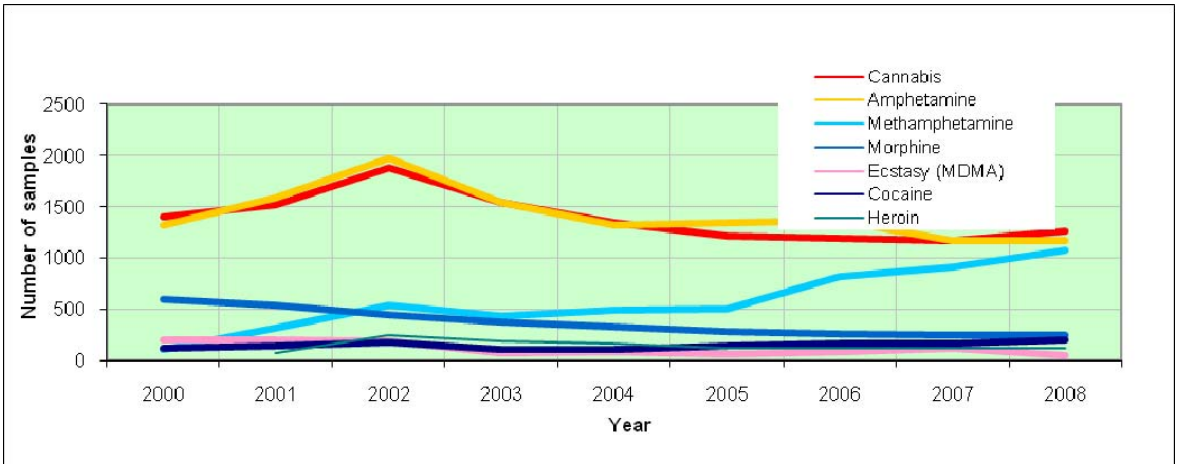
Source: Norwegian Institute of Public Health

Table 10: The most common finds of substances other than alcohol in blood samples from drivers suspected of driving under the influence in 2008. The number and percentage of blood samples on which a broad analysis was carried out.

	Name of substance	Example of name of medicine Explanation	Total number 4,525	Percentage
1	THC	Active agent in cannabis	1,305	29%
2	Diazepam	Valium ® Vival ® Stesolid ®	1,203	27%
3	Amphetamine		1,191	26%
4	Methamphetamine		1,098	24%
5	Clonazepam	Rivotril ®	715	16%
6	Nitrazepam	Apodorm® Mogadon®	319	7%
7	Alprazolam	Xanor®	306	7%
8	Oxazepam	Sobril® Alopam®	251	6%
8	Morphine	Heroin Dolcontin® Paralgin forte®	251	6%
10	Benzoylecgonine	Cocaine metabolite	201	4%
11	Flunitrazepam	Flunipam® Rohypnol®	188	4%
12	Codeine	Paralgin forte®	174	4%
13	Methadone		132	3%
14	Zopiclone	Imovane® Zopiclone®	102	2%
15	Zolpidem	Stilnoct®	69	1.5%

Source: Norwegian Institute of Public Health

Figure 12: Finds of illegal drugs in road traffic cases received 2000-2008. In numbers.



Source: Norwegian Institute of Public Health

In recent years, methamphetamine has been increasingly present in blood samples from drivers in Norway, while the trend for amphetamine appears to be slightly declining. This may indicate that amphetamine is increasingly being replaced by methamphetamine. However, some of the methamphetamine used metabolises into amphetamine in the body. Many of the blood samples that contain methamphetamine will therefore also contain amphetamine even if the person in question has not necessarily used both drugs. It is therefore misleading to simply add up the figures for methamphetamine and amphetamine. The relationship between amphetamine and methamphetamine in road traffic cases is investigated in more detail in Chapter 12.

The number of drivers caught with cocaine (benzoylecgonine) in the blood has increased during the last year. From slightly less than 150 drivers the year before, the number of drivers under the influence of cocaine registered last year was about 200. This is the highest number in eight years. Men living in Oslo and central parts of Eastern Norway stand out with most positive samples (Norwegian Institute of Public Health, 2009).

Prevention of drug-related crime
No new information is available.

9.3 Interventions in the criminal justice system

9.3.1 Alternatives to prison

Serving of sentences outside institutions pursuant to the Execution of Sentences Act section 12

So-called section 12 sentences are the most common alternative for convicted felons with drug or alcohol problems. See NR 2007 and NR 2008, Chapter 9.2, for more information. In 2008, the number of sentences started pursuant to section 12 of the Execution of Sentences Act was 505, which is a marked increase on previous years. Of these, 257 started alternative sentences immediately after conviction, while 248 felons were

transferred after serving the first part of a sentence in prison. The proportion of women was approximately 15 per cent. The number of days served pursuant to section 12 has also increased and amounted to almost 45,000 days in 2008 (Table 11).

Table 11: Number of days served pursuant to section 12, 2003-2008

	2003	2004	2005	2006	2007	2008
Men	31,673	26,302	34,474	37,137	37,835	40,150
Women	2, 729	2,235	3,786	4,347	4,224	4,841
Total	**34,402**	**28,537**	**38,260**	**41,484**	**42,059**	**44,991**

Source: The central administration of the correctional services

9.3.2 Other interventions in the criminal justice system

Alcohol treatment programme

In 2008, 485 suspended sentences were imposed on condition of alcohol treatment programmes, compared with 467 in 2007. Eighty per cent were completed without the conditions being breached or new crimes being committed.

Suspended sentence with Drug Courts

Drug Courts are an alternative to prison for people with drug and/or alcohol dependency who have been convicted of drug-related crimes. The participants regularly attend a day centre where rehabilitation is offered by an interdisciplinary service team. The programme was originally a three-year trial project in 2006 in Oslo and Bergen. The project has been prolonged until 2011 and is currently being evaluated by SIRUS. In 2008, 29 new sentences were implemented; 13 in Oslo and 16 in Bergen. Twenty-four suspended sentences were completed in 2008. Only (*editor's comment*) four sentences were completed without the conditions being breached, while the rest were interrupted, mostly because of new crimes being committed.

9.4 Drug use and problem drug use in prisons

See also Standard table 12.

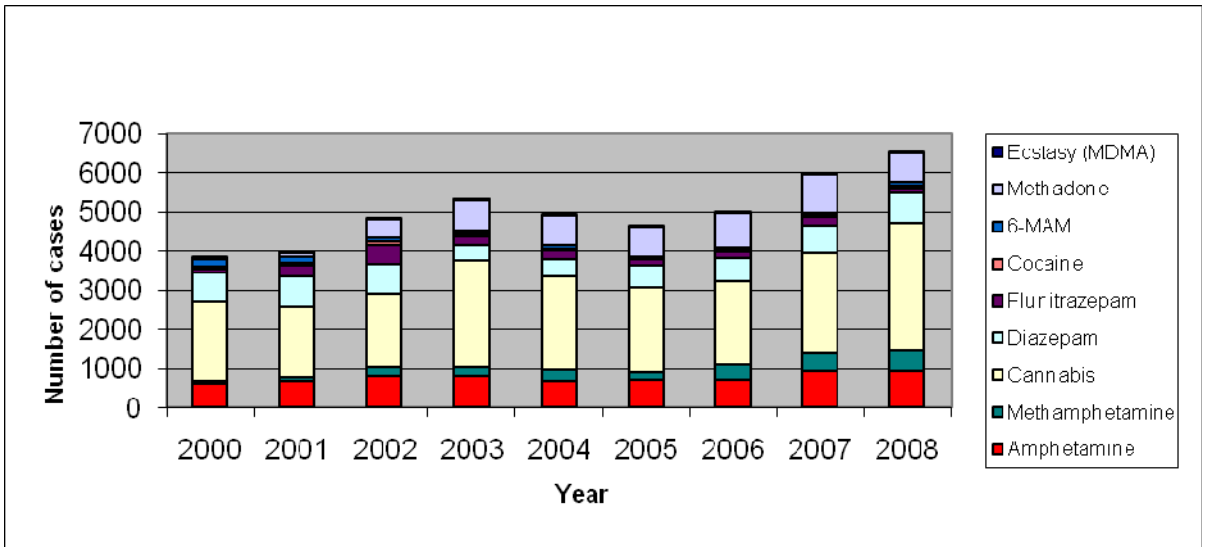
The use of drugs and alcohol and illegal consumption of medicinal drugs during the serving of sentences has been stable in recent years. Based on reports received by the central administration for the correctional services for 2008, it is evident that the number of seizures of drugs, alcohol and medicinal drugs has not changed significantly. The number of finds of user equipment and manufacturing equipment is also relatively stable

Urine samples to control drug use among inmates show that use is fairly stable compared with previous years. The National Institute of Public Health carried out analyses of almost 26,000 urine samples from prisons in 2008, approximately 1,500 more than in 2007. Drugs and tranquilisers were found in more than 6,500 of the samples, which is the highest number ever. After the samples had been quality assured to check whether there

had been any use of drugs or legal medication during the time the inmates served their sentences, just over ten per cent of all the samples were classified as illegal use. The other positive samples were due to the use of drugs before arrival in prison or following the use of legal medication.

Figure 13 shows that cannabis, amphetamine, methamphetamine[5] and various tablets are the most frequently discovered drugs. As regards methadone, it is not known to what extent it was used illegally. The number of inmates receiving legal medication from health personnel has increased. The prisons are cooperating with the health enterprises in connection with medication assisted treatment of inmates who are heavy drug addicts.

Figure 13: Drug finds in correctional service cases 2000-2008. In numbers



Source: Norwegian Institute of Public Health

9.5 Responses to drug-related health issues in prisons

Units for mastering drug and alcohol problems

The Ministry of Health and Care Services and the Ministry of Justice and the Police are working together to establish units aimed at mastering drug and alcohol problems in prisons. Units aimed at mastering drug and alcohol problems are a new rehabilitation service for inmates with drug and/or alcohol dependency who are entitled to interdisciplinary specialist treatment. The treatment is provided by the specialist health service, and staffing of the correctional services has also been strengthened in this connection. The aim is that a stay in a unit for mastering drug and alcohol problems will be followed up with outpatient treatment or treatment in an institution upon release. Three units opened in 2008 and six more will open during 2009, bringing the total number of prison units to nine. In addition, a new Pathfinder unit for female inmates was opened in 2008 in Bredtveit prison in Oslo (the central administration of the correctional service).

Reintegration of drug users after release from prison
No new information is available.

[5] The ratio between methamphetamine and amphetamine is studied in more detail in Chapter 12

10. Drug markets

10.1 Availability

10.1.1 Heroin use in Norway

In a new survey from SIRUS (Bretteville-Jensen and Amundsen, 2009), the estimated consumption of heroin in Norway during the course of one year has been calculated for the first time. According to the survey, the quantity of heroin used in 2006 was estimated to be approximately 1,445 kilos, while consumption in the period 2000 to 2002 was estimated to be just over 2,000 kilos. The decline is mainly due to a decline in the number of problem users. 2006 is the last year for which the data are good enough to stipulate the number of problem users. However, the estimate for 2006 will probably also apply to 2007 and 2008.

A bottom-up method has been used to calculate heroin consumption, which estimates the number of persons who have used heroin in the course of a year and multiplies it by the estimated quantity used. The assumption is that heroin users can be divided into three groups; problem users, sporadic users and experimental users. Chapter 4.1.2 contains a more detailed account of the classification of different user groups and the methods used to calculate the number of users.

For the problem user group, a distinction is also drawn between different methods of taking heroin, as this is thought to have a bearing on the quantity of heroin used. An estimated annual consumption has been calculated for problem users who only inject the drug, for those who only smoke it, and for those who both smoke and inject it. As regards sporadic and experimental users, the poor data basis means that a distinction cannot be drawn between the different methods of taking the drug.

The quantity of heroin used is mainly calculated on the basis of various special surveys among heroin users who provide information about their use and the quantity taken each time. There is great variation in the quantity of heroin used, both within the group of problem users and, not least, between the three user groups. Calculations indicate that problem users who inject the drug have an annual consumption of approx. 160 grams, that those who smoke the drug use about 118 grams, while those who both smoke and inject the drug on average use about 140 grams a year. Sporadic heroin users are assumed to use heroin twice a month, which means an annual consumption of 6.6 grams. Naturally, experimental users make the smallest contribution to total consumption. It is assumed that, on average, those who experiment use heroin twice, so that each user takes 0.3 grams per year.

Unsurprisingly, problem users account for the majority of the heroin used in Norway. If, for example, the number of sporadic users changes, or the assumed quantity of heroin used changes, by 20 per cent, the total amount only changes by plus/minus five kilos (1,440-1,450 kg). If the number or quantity changes correspondingly for experimental users, the effect is minimal. A 20 per cent increase in the number of problem users, however, will change the estimated consumption figures by 15 to 17 per cent (1,205-1,665 kg), and a corresponding change in consumption will change the estimated annual consumption by 16 to 20 per cent (1,160-1,730 kg).

10.2 Supply

10.2.1 Smuggling routes to Norway

According to the customs service, most of the *amphetamine* and *methamphetamine* on the Norwegian market comes from illegal laboratories in the Netherlands, Poland and Lithuania. Lithuanian criminals have had a dominant role for several years as suppliers of synthetic drugs to Norway, and the proportion of amphetamine seized from Lithuania is increasing. However, the largest quantities of amphetamine seized now come from the Netherlands and Poland. The main routes go through Germany and Denmark via Sweden. Cars with concealed cavities still seem to be the most frequently used method.

Cannabis seized in Norway mainly comes from Morocco via the Netherlands. From the Netherlands, hash is transported via Denmark and on to Norway by car, bus, train or plane. The customs service has uncovered large quantities of cannabis in passenger cars and heavy goods vehicles. The proportion of smuggled marijuana is increasing.

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

GHB and GBL are smuggled in shipments from the Netherlands, Poland and the UK. Most of the seizures are sent in the post and as courier shipments, while attempts are made to smuggle larger shipments by car.

Heroin sold in Norway mainly comes from Afghanistan through Turkey via two northerly routes through Bulgaria/Romania–Ukraine/Russia, and then on to Poland /Lithuania. Two southerly routes go through Greece/the Balkans to the Netherlands/Germany. From there, consignments destined for Norway are packed in hand luggage or passenger cars with concealed cavities. The number of couriers who smuggle heroin inside their bodies is increasing.

Khat is transported from production areas in Africa to Europe. It is smuggled on to Norway from the Netherlands and the UK by plane and car. Most of the seizures are made from airline passengers who arrive from the Netherlands and the UK. The largest quantities, however, are transported by road in cars from the Netherlands and Germany via Denmark and Sweden.

As before, *cocaine* comes from South America to Africa and Spain and from there to the Netherlands and Germany before continuing up through Denmark to Norway. Considerable quantities are also smuggled by airline passengers who arrive at European airports directly from South America. The cocaine is smuggled on to Norway in various ways. The customs service still uncovers many couriers smuggling the drug inside their bodies.

LSD is smuggled in the post and in courier shipments from Canada. The number of shipments is not high, but the trend is that the number is increasing (the customs service, personal communication).

10.2.2 Geographical regions that affect the crime situation

The report from the National Police Directorate on organised crime in Norway (see Chap. 9.1.2) claims that the Norwegian Police can expect an increased presence of international criminal networks. This view is shared by cooperating European police authorities, and, on Norway's part, this development is linked to three geographical regions:

The report states the following about these regions:

South America and West Africa
"According to reports from Europol, West African (Nigerian) criminal groups are increasingly involved in the smuggling of cocaine, organised prostitution and economic crime. The criminal networks are loosely organised and membership is based on religious, ethnic or geographical origin. It is thought that the groups are increasing their activities relating to the smuggling of cocaine to Norway. The transport routes for cocaine from Africa to Europe are often the same as for human trafficking and the smuggling of hash. Nigerian criminal groups are responsible for smuggling to Norway and they use the Netherlands for intermediate storage. Here, cocaine is divided, couriers are recruited and transport is organised. The smuggling takes place by land, sea and air. The criminal groups are based in the Netherlands, Germany and Belgium and in the Nordic capitals. The Netherlands' role as a contact/distribution point seems to be increasing.

Lithuania and Poland
'Organised criminal groups from Lithuania and Poland dominate the smuggling of amphetamine and methamphetamine to Norway. Criminal groups handle the production, importation and distribution of amphetamine. Baltic groups, and Lithuanians in particular, travel between the Nordic countries committing aggravated crimes against property and smuggling drugs. Aggravated violence is used both within the networks and against external victims. Organised crime from Lithuania has been highlighted as a threat by Europol and the Nordic countries. It is seen as likely that crime committed by Lithuanian and Polish criminals will increase in the time ahead. One example of what this threat may entail is an Estonian/Russian criminal group whose activities include armed robberies and the smuggling of drugs. The group committed murder and was involved in counterfeiting, kidnapping, car theft and human trafficking. The group's main activities have ties to Norway, i.e. robberies and the smuggling of cocaine. One of the group's (estimated to about 30 members) Estonian cocaine couriers has been arrested in Norway.'

The Balkans and Turkey
'Organised criminals from the Balkan countries (from Albania and Macedonia in particular) have been one of the Norwegian police's biggest challenges since the 1990s. The Balkan route is used for smuggling a number of goods. This affects the situation in Norway as regards the smuggling of heroin, human smuggling, document forgery, human trafficking and crimes against property. Organised criminals originating from the Balkans collaborate with a number of established criminal gangs in Norway. They are notorious for using extreme violence. The ringleaders control activities relating to heroin smuggling and human trafficking from their home countries. The networks are increasingly distributing cocaine and amphetamine. In Sweden, organised criminals from the Balkans have dominated the heroin market and aggravated robberies. They have used extreme violence to achieve their goals. They have central roles in established gangs in Swedish cities.
Turkey is of central importance to the Balkan route due to its position as the gateway to Europe."

The survey also mentions other geographical areas:

"Other players than before are getting involved, however, and this may affect the situation in Norway. OCTA 2008[6] refers to the fact that Nigerian organisations buy large quantities of heroin from Turkish ringleaders and arrange for the heroin to be transported from Turkey to other European countries, including the Nordic countries. They use Nigerian networks that are established in Europe/the Nordic countries, and thereby have a network

[6] Europols Organised Crime Threat Assessment 2008 (OCTA)

that is highly suitable for the distribution of heroin. Transport is often carried out using female couriers. Europol also points to increased activity among resourceful Pakistani criminal networks in Turkey.

There is reason to believe that an identified Kurdish group is involved in smuggling heroin from Turkey. The group is involved in the transportation of heroin to, for example, the Netherlands and Germany. The drug is transported on to drug dealers in the Nordic countries. Since the majority of Turks in Norway and the Nordic countries are Kurds, there is reason to believe that the smuggling of heroin in this network will be a threat in the future. It is probable that the same network is involved in human smuggling, document forgery and illegal currency exports". (The National Police Directorate, 2009)

10.3 Seizures

10.3.1 Proportion of heroin seized in relation to estimated annual consumption

The survey of the consumption of heroin in Norway (Chap. 10.1.1) also included calculations regarding the proportion of heroin seized in relation to estimated annual consumption. Apparently without a basis in the actual calculations, it has often been assumed that approximately ten per cent of the drugs that people try to import to the country are seized. The assumption has been widespread both in Norway and in other Western countries and has included seizures of heroin as well as other drugs.

For the period 2000 to 2008, it is estimated that the total seizures by the police and the customs service amount to an average of only *four per cent of the assumed total consumption* of heroin in Norway per year. The highest proportion of seizures took place in 2004 (8% of annual consumption), while the lowest proportion was seized in 2007 (less than 3%). Seizures made by the customs service for the period 2000 to 2008 amount to about two per cent of the estimated annual consumption of heroin. As a proportion of consumption, their seizures were highest in 2006 (6% of annual consumption) and lowest in 2007 (less than 1%) (Brettville-Jensen and Amundsen, 2009).

Of course, there is uncertainty attached to these calculations, and the estimated proportion that is seized could change if it were to emerge that the actual number of problem users or the average quantity of heroin used is more or less than assumed. In that case, the total consumption would decline or increase somewhat, and the proportion of seizures would be slightly higher or lower. Using examples from 2008 and a proportion of heroin seized of four per cent of annual consumption, it is evident that even a change of +/- 20 per cent in the number problem users or the annual quantity used would change the proportion of seizures by only one percentage point. Whether it is three, four or five per cent, the proportion seized is in any case low, especially in relation to the 'ten-percent rule' to which many people refer.

10.3.2 Seizure statistics for 2008

See also the data in Standard table 13.

Data basis and sources of error

The annual report from the National Criminal Investigation Service (Kripos) on the status of and developments in drug trafficking contains national data that include all seizures by the police, the customs service, the prisons and the Armed Forces. The data are based on

verified analysis results for use in ordinary criminal cases, as well as on information from the police districts when drug offences are decided locally through fines or by summary trial based on a plea of guilty. The latter categories are decided without the seizures being tested at the Kripos laboratory. In these cases, relevant information is usually given about what the seizures probably contain. The sources of error are not deemed to have a significant bearing on the main trends, but experience indicates that some of the minor seizures may include other types of drugs than those stated in statements to the authorities.

Main features of the drug statistics for 2008

In 2008, 19,619 drug cases and 23,835 seizures were registered. Nationwide, this represents a decline from 2007 of four and three per cent, respectively. However, there are big differences between the different types of drugs. It was also the case in 2008 that more drug cases were registered as having been decided by fines than ordinary criminal prosecutions. Of the total of 19,619 drug cases, 8,406 were analysed, while 11,213 were fixed-penalty cases.

The quantities seized will naturally vary considerably from one year to the next. As an indicator of the size of individual seizures, based on quantitative criteria for prosecution that meet the definition of aggravated drug crime in the General Civil Penal Code section 162 third paragraph, 38 such large drug seizures were made in both 2007 and 2008 (Table 12).

Table 12: Large drug seizures in 2007 and 2008

Drug type	Number of paragraph 3 cases 2007	Number of paragraph 3 cases 2008
Amphetamine and methamphetamine	28 (seizures over 3 kg)	14
Cocaine	6 (seizures over 3 kg)	4
Ecstasy	2 (seizures over 15,000 tablets)	0
Cannabis	1 (seizures over 80 kg)	3
Heroin	1 (seizures over 0.75 kg)	16
Benzodiazepines	0	1
Total	38	38

Source: Kripos

Table 13 shows the changes in the number of seizures during the period 2003 to 2008. Figure 14 shows the market share in 2008 for the most common substances.

Table 13: Number of seizures in the period 2003-2008 broken down by some types of drugs*.

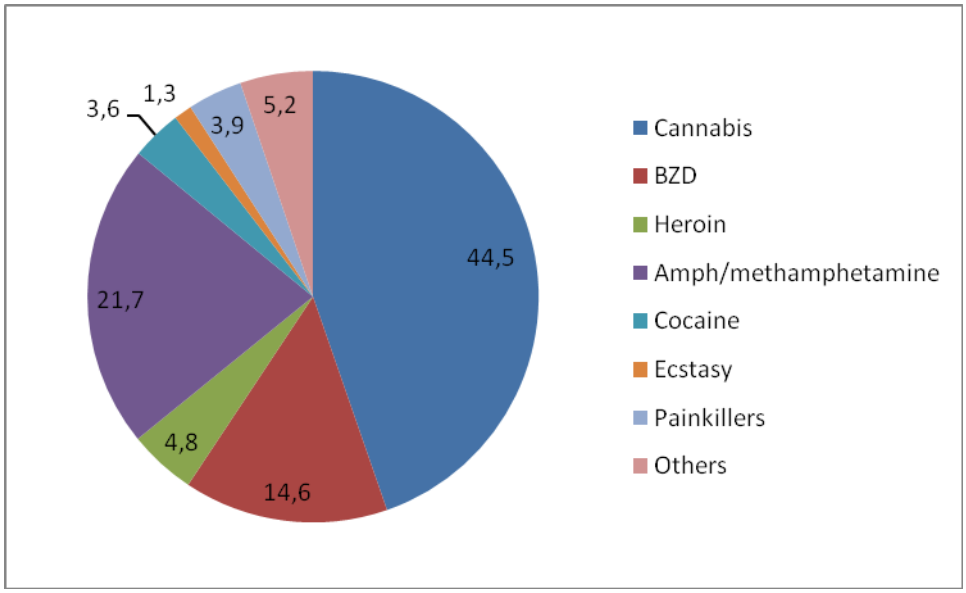
Drug type	2003	2004	2005	2006	2007	2008	% change 2007-2008
Cannabis	10.397	10.097	10.128	11.221	9.952	10.591	+ 6.5%
Amph/methamph	5.218	4.933	5.361	5.819	5.507	5.161	6.1%
Heroin	1.709	1.399	1.151	1.087	1.204	1.147	-4.6%
Benzodiazepines	4.700	4.358	3.929	4.551	4.088	3.490	-14.5%
Painkillers/ opioids	1.216	1.146	1.319	1.161	959	936	-2.4%

Cocaine	504	464	685	726	909	854	-6.0%
Ecstasy	405	452	341	411	421	310	-25.4%
LSD	31	30	34	28	13	15	+15.3%
GHB	120	28	46	65	163	134	-18.4%
Psilocybe mushrooms	89	77	75	82	77	54	-29.8%

**Some figures for 2003-2007 have been adjusted.*

Source: Kripos

Figure 14: Market share for different drugs in 2008. Number of seizures. Percentage



Source: Kripos

Heroin
While only 8.0 kg of heroin was seized in 2007, a number of medium-sized seizures of heroin were again made in 2008, amounting to a total of 55.2 kg. However, at 1,147, the number of seizures was somewhat lower than in the previous year. Heroin was seized in 24 of the country's 27 police districts, and more seizures were made in nine of the districts than in 2007. Oslo's share of the seizures was 38 per cent. Seizures of heroin in 2008 only accounted for 4.8 per cent of the total number of drug seizures in Norway. By comparison, this proportion was as high as 20 per cent in 1998.

Cannabis
The amount of cannabis seized in 2008 was 1,732 kg, which breaks down into about 1,234 kg of hash (71%), 151 kg of marijuana (9%), 347 kg of cannabis plants (20%) and 0.011 kg of cannabis extract. One seizure of 401 kg of hash dominated in 2008.

The number of cannabis seizures, 10,591, consists of about 82 per cent hash, 16 per cent marijuana and 2 per cent cannabis plants. The proportion of hash on the market is thus approaching the same level as before 2007, almost 90 per cent.

Many cannabis plantations, some of them large, were also uncovered in the first six months of 2008 (Table 14).

Table 14: Cannabis plants – number of seizures and quantities seized in 2008

	First half-year 2008	Second half-year 2008
Amount	324.5 kg	22.5 kg
Number of seizures	126	91

Source: Kripos

Amphetamine/methamphetamine
A total of 363.1 kg was seized, consisting of approximately 260 kg of amphetamine and 103.1 kg of methamphetamine. The largest ever seizure of amphetamine in Norway, 112.3 kg, was made in 2008. This exceeded the previous record from 1998 by 98.3 kg. Based on the number of seizures and verified[7] analyses, the proportion of methamphetamine once again increased significantly in relation to amphetamine (Table 15). See also chapter 12.

Table 15: Propotion of seizures of methamphetamine in relation to amphetamine.

Year	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
% Meth.	1.3%	1.8%	6.2%	10.8%	15.4%	21.1%	22.0%	26.0%	35.3%	43.6%

Source: Kripos

In 2008 as in previous years, seizures were made of tablets containing amphetamine, but the proportion is marginal compared with powder forms of the drug. Of illegally manufactured tablets with the same logo as ecstasy, 626 tablets were seized in seven seizures.

Cocaine
In 2008, 76.8 kg was seized in 854 seizures. As in 2007, cocaine was seized in 26 of the country's 27 police districts, but there are relatively big differences between the districts. In Oslo, the number of seizures declined by 17 per cent, while Bergen registered an increase of 63 per cent. Kripos does not distinguish as a matter of routine between cocaine hydrochloride and cocaine base ('crack').

Ecstasy
In 2008, around 31,000 tablets and over 0.5 kg of powder containing ecstasy were seized in 310 seizures. Seen from a historical perspective, these are small quantities, and the number of seizures has not been as small for ten years. The decline in the number of seizures from 2007 is all of 25 per cent. Again in 2008, two large seizures (a total of 19,410 tablets) explain most of the amount seized.

BZD
A total of 311,366 tablets and 1.8 kg of active agents were seized in 3,490 seizures. Demand for this type of medicinal drug appears to remain large on the illegal market. Looking at seizures of tablets in 2008 exclusively, there is a clear decline in both the

[7] A number of seizures of amphetamine have not been verified. Several of them probably contain methamphetamine.

number of seizures and the number of benzodiazepine tablets. However, the picture is rather different for seizures of active agents. The explanation for this is the substantial seizure of pure phenazepam and illegally-manufactured tablets containing fenazepam made in one county (Nord-Trøndelag). In addition to 28,580 tablets containing 1.6 mg of phenazepam, seizures were made of 1,756 g of phenazepam with a purity of 87 to 90 per cent. Based on a medicinal dose of 1 mg, this one seizure corresponds to over 1.5 million tablets. Phenazepam is a Russian benzodiazepine that is not in medicinal use in Norway.

Painkillers, medicinal drugs classified as narcotics
A total of 11,147 tablets were seized in 936 seizures. Both the quantity and the number of seizures has thus declined somewhat. There were no major seizures of these medicinal drugs in 2008. Several of the cases involved the illegal importation of such medicinal drugs via internet shopping, but the number of tablets in each seizure is relatively small. Based on the number of seizures, buprenorphine (Temgesic, Subutex and Subuxone) predominates, but the seizures are generally small. More tablets containing codeine were seized than any other substance.

GHB
Thirty-six litres of GHB were seized in 134 seizures in 2008. Even if we include seizures of the industrial chemicals GBL and 1.4-butandiol, substances that are not included on the Norwegian list of narcotic substances, the figures are deemed to be small, at 174 seizures in all, compared with other depressants. However, the risk of being detected can be smaller than for other substances. Since the appearance and effect of GHB and alcoholic beverages are similar, we cannot exclude the possibility that the seizure statistics do not reflect the actual prevalence of the drug.

LSD
Very few seizures of LSD are made annually, both in terms of number and quantity. In 2008: 245 doses in 15 seizures. Since LSD is easy to conceal, however, we cannot exclude the possibility that the seizure statistics do not reflect the actual situation.

Psilocybe mushrooms
The substance psilocybin has been included on the list of narcotic substances since 1971, but it was not until 2004 that all mushrooms containing psilocybin were regulated. It is mostly Psilocybe cubensis and Panaeolus Cyanescens that have been registered in connection with importation. Although these mushrooms have never figured prominently in the statistics, Kripos does receive some information that these hallucinogenics are still of interest as drugs. Among other things, the customs service and the police make seizures of cultivation media and spores from mushrooms containing psilocybin.

Other hallucinogenic drugs
A number of psychoactive substances were seized in several cases, first and foremost substances with a hallucinogenic effect, both substances that are included on the list of narcotic substances and substances not classified as narcotics. These include: PCP, DOET, DOB, DOM, DMT, 2,5-dimethoxy amphetamine, 4-chlorine-2,5-dimethoxy amphetamine, DPT, 5-MeO-DIPT and piperazine derivatives.

In the latter category, 1,(3-chlorphenyl)piperazine or mCPP should be emphasised. It first appeared as a tablet in 2005, the same year as the largest single seizure was ever made in Oslo (10,030 tablets). mCPP, which is not yet on the Norwegian list of narcotic substances, has no industrial or medicinal application. The tablets are usually colourful and have the same logo as traditional ecstasy tablets.

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

10. 4 Price of illicit drugs at retail level

The latest pricelist from the police, from October 2008, was presented in NR 2008:

For smaller quantities, the price level seems to have largely remained stable for most of the types of drugs since the last overview produced by the police in autumn 2006. In nominal terms, prices have probably fallen slightly rather than the opposite. The most striking development is that the price of cocaine appears to have fallen for typical sales doses. In 2006, the price for half a gram of cocaine was estimated to be approximately EUR 62.5[8] (NOK 500), while in 2008 it was approximately EUR 37.5 - 50 (NOK 300-400). By comparison, the market price for heroin in 2008 was estimated to be EUR 62.5 (NOK 500) for 0.5 grams and EUR 25 - 37.5 (NOK 200-300) for 0.2 grams. Cocaine is still expensive in relation to amphetamine. The price level for one gram is more than double the price level for amphetamine, and the differences seem to be even greater for large quantities. The prices for ecstasy, GHB and LSD are stable, while the price level for Rohypnol (per tablet, 100 mg) on the illegal market seems to have fallen since 2006.

Chapters 11 and 12 contain some price estimates for user doses of cannabis and amphetamines that differ in part from the overview for 2008. In addition, the prices of illegal drugs must naturally be treated with considerable caution.

10.5 Purity/potency/composition of illicit drugs and tablets

See data in Standard tables 14 and 15.

The average purity of *heroin* has been relatively stable in recent years, and in 2008 it was calculated to be 31 per cent. However, there is still great variation in purity from seizure to seizure. Paracetamol, caffeine and other intoxicating substances (benzodiazepines) are also found in relatively many seizures.

For *hash*, the average THC purity was around seven per cent; however, the results of measurements vary greatly. Based on the high number of hash seizures in Norway, there are therefore grounds for arguing that the average THC content in all types of hash seizures has not changed significantly. There was some focus on the THC content in connection with the discovery of relatively large cannabis plantations in 2008. A total of 150 quantitative measurements of THC were carried out, both for whole plants and for isolated top shoots. Whole plants usually contained three to seven per cent THC, and isolated top shoots usually 11 to 19 per cent. In one case, approximately 4 kg of isolated top shoots with a THC content of 22 per cent were seized, i.e. about three times more than in traditional hash. This is becoming more and more common in large parts of Europe.

[8] Conversion rate: 1 EUR=NOK 8.00

The average purity of *amphetamine* in 2008 is estimated to be roughly 34 per cent and 39 per cent for *methamphetamine*. This is somewhat lower than has been registered in recent years, but there is still considerable variation.

The *cocaine* content in seizures has fallen steadily, from more than 70 per cent over ten year ago to an average of 37 per cent in 2008. Cocaine hydrochloride of high purity was also seized in 2008. Fenacetine is still used as an additive.

For *ecstasy*, the proportion of MDMA in the seizures has declined significantly in relation to previous years and been replaced by other substances, such as chlorphenyl piperazines, but also by substances not classified as narcotics (Kripos 2009).

Part B: Selected issues

11. Cannabis markets and production

Paul Larsson, professor, the Norwegian Police University College

11.1 Markets

11.1.1 Cannabis domestic production

The hash that is used in Norway is mostly produced abroad. In recent years, the hash has mainly come from Morocco. The police estimate that between 80 and 90 percent comes from there. In addition, there are individual cases involving hash and marijuana from Thailand and Pakistan. On the other hand, there is reason to believe that a large proportion of the marijuana that is used in Norway is produced domestically. This type of production has been going on for a long time. The scale of the production varies greatly, from those who cultivate marijuana for their own use or for friends and acquaintances to those who cultivate the drug with the intention of selling it. Small-scale home production in lofts, basements or outdoors in flower beds is relatively widespread, as proved by frequent media reports about police seizures of this type.

From autumn 2007 onwards, the police discovered a number of marijuana plantations in private homes. This was something new in the Norwegian context. Few people had anticipated cultivation on such a scale taking place in large areas of Eastern Norway. Marijuana plantations had been uncovered previously, but not of the type found in these cases. The method is well-known abroad. You convert a house or an apartment into a production facility by installing watering systems and heating and lighting equipment. Usually, these houses were rented, and they were virtually gutted as a result of the installations.

The players were also largely unknown in the Norwegian context. Most of them were from Vietnamese backgrounds. There are many indications that these production facilities were established by persons who were familiar with this method of producing marijuana from other countries, but who were less familiar with Norwegian conditions. One of the reasons why many of these 'farms' were discovered was that they were often located in small towns or out of the way locations. Thus, they often quickly attracted the attention of the locals by keeping the lights on at all hours, plus the fact that the windows steamed up. Another question is the sale of the marijuana. How were they supposed to sell such large quantities (in the Norwegian context) as discovered here without drawing attention to themselves?

The fact that these 'farms' emerged at the same time, that they were run in the same way by people from the same ethnic backgrounds, and on such a scale, suggests that they were part of a larger and more organised scheme. This method is otherwise well-known from countries such as the Netherlands, Canada and England (Duyne and Levi 2005). Because of these 'farms', the total number of seizures of plants increased dramatically in 2007 and in the first six months of 2008 (Chapter 11.2.3).

11.1.2 Consumer markets share of different cannabis products

In Norway, the use and sale of cannabis is dominated by hash. Measured by the number of seizures, marijuana only accounts for 10 to 15 per cent (see Chapter 10.3.2). This proportion can also be an indication of the use of the drug.

11.1.3 Distribution of cannabis at national level

The police often claim that the cannabis market (i.e. the hash market) has been dominated by a few major players who have been active for several decades. A few people are said to have kept the business going – with the exception of periods spent in prison – since the 1970s. It is a well-known fact that these persons have connections with established organised criminal gangs that are involved in several types of crimes. Among other things, some of the largest seizures are linked to persons affiliated to motorcycle clubs, organised gangs and the so-called armed robbery milieu.

It is difficult to provide a simple description of the players involved in the smuggling and selling of hash in Norway, as it seems to be a highly flexible market that has ties to several quite distinct milieus. We have a fairly good overview of street-level sales. Knowledge about smugglers and couriers is also relatively extensive. On the other hand, we know little about the so-called ringleaders and wholesale dealers. The question, of course, is whether there are any clear ringleaders. There are many indications that there are few links in the chain between importation and the direct sale of hash to users. Price estimates suggest that sellers buy from persons who themselves have bought the drug from importers, or that there is one more link in the chain (Larsson 2006).

The cannabis market is often linked to particular ethnic groups. It is assumed that Moroccans have come to play an important role in several European countries. In Norway, importation and distribution seems to be a largely multi-ethnic business. It is common to see teams of smugglers composed of persons from Norwegian, Asian and African backgrounds. Street-level sales have in recent years largely been dominated by groups of people from immigrant backgrounds.

There are also clear differences between those who smuggle hash for their own use or for friends and acquaintances, those who operate on a small commercial scale and those who import large quantities. Most run a type of small-scale operation, on a kind of ‘cottage industry’ basis (Eck and Gersh 2000). There are many indications that those who import large quantities only do so a few times and that they are also involved in other types of crime.

Smuggling can be roughly divided into three parts. There are a relatively high number of people who smuggle for their own or for their friends’ use. They import small quantities. In an intermediary position, we find those who smuggle some tens of kilos. Many of the intermediate-level players are involved in several types of crimes, and importing hash is just one of many other offences. The degree of professionalism is fairly limited. In recent years, there have been a number of cases involving large quantities where several hundred kilos of hash have been imported. In many cases, professional carriers and couriers have been used. Importation on this scale can often be linked to established organised gangs. Some have been involved in importation for many years, but there are also a number of opportunists with a more short-term perspective. Large-scale importation of hash can be a profitable form of smuggling (Pedersen 2009).

This flexibility in the importation of cannabis means that the market is open to many players. It is highly adaptable and will therefore be relatively unaffected if the police or customs service manages to catch one or more major players. It is interesting to note that,

in many cases, hash smuggling is combined with the smuggling of pills, amphetamine and ecstasy. On the other hand, there seems to be almost no connection whatsoever between those who are involved with heroin and those involved with hash. People who smuggle spirits very seldom have anything to do with hash.

11.1.4 Cannabis prices

The price level for a normal sales dose of hash on the street has been stable for many years, at about NOK 100 (between 0.7 and 1 gram). This means that the price of hash has fallen relatively speaking. This price has also remained stable regardless of availability. Whether there has been a dry spell or a flood on the market has had little effect. All this suggests that it has not been a market price, but a price based on tradition and custom. If this is correct, it is very interesting in itself as it differs from the markets for other drugs that seem to be chiefly governed by supply and demand.

However, an unexpected change took place in summer 2009, when the street price of hash in Oslo fell to about EUR 6.25 [9](NOK 50) for 0.7 to 1 gram. The ordinary price of EUR 12.5 (NOK 100) suddenly no longer applied, and it was possible to buy cheap hash. Since autumn 2009, the price has been back at its previous level of EUR 12.5, and at times even higher. It has been said that the hash was often of relatively poor quality, but this had not affected the street price before. The sellers were often generous with the quantities. We can speculate about the explanation for these price variations. There are many indications that increased availability of hash could be an explanation for the low price in summer 2009. According to the police, large quantities are being smuggled by professional carriers, but increased availability alone cannot explain the price drop. Previously, the price elasticity of hash has proved to be poor. It has been suggested that Moroccans have now established themselves as major players in import and sales, which means that it is possible to reduce both the number of links and the price. As an explanation for why prices have again risen in autumn 2009, it is argued that increased border controls in Gibraltar and campaigns by the Moroccan authorities have influenced supply and the price level.

Buying large quantities quickly reduces the price. If you buy 10 grams, the price will often be halved, and if you buy, for example, one kilo, depending on the quality, the price may be EUR 3.1 to 3.8 per gram (NOK 25 to 30). The price level per kilo also seems to have declined from 2005 to 2008 in real terms. For example, the estimated price for one kilo of hash in 2008 was EUR 3,125 to 3,750 (NOK 25,000 - 30,000), while in 2005 it was NOK EUR 2,500 to 4,375 (NOK 20,000 – 35,000).

Typology of retail outlets for cannabis sale

Most sales are made between friends and acquaintances and in networks of which the police do not have a full overview. There are also street-level sales on a considerable scale, especially in Oslo, where the focus for some time has been on the open street market. Over the years, the sales market has changed location several times in Oslo city centre. In recent years, the sellers have mostly been teenage boys from immigrant backgrounds. Many of them are asylum seekers, often without residence permits in Norway (Sandberg and Pedersen 2006). Some of the sales also take place in connection with nightspots and pubs. Little is known about the market for marijuana. An open market hardly seems to exist, and to the extent that marijuana is available, it is sold among friends and in networks.

[9] Conversion rate 1 EUR= NOK 8.00

11.2 Seizures

11.2.1 Supply reduction organisation and activities

Since the turn of the millennium, the number of seizures of hash has varied somewhat, but it has mainly been around 10,000 per year (see statistics in Chapter 10.3.1). This tells us that the average seizures are small. In 1990, the average was 54 grams, while it was 220 grams in 2004. During the period 2000 to 2005, the number of big seizures increased significantly. This is confirmed by a number of cases involving seizures of 300 to 500 kilos of hash. Seizures of that size were very rare before 1995. In recent years, big (by Norwegian standards) seizures of this kind have declined. The biggest single seizure in 2008 was 400 kilos, however, while the biggest in 2007 was 169 kilos.

The explanation for this development is somewhat uncertain. There are many indications that the situation up until around 2005 was characterised by a great willingness among smugglers to take risks, and large quantities were imported. At the same time, however, it seems as if the police and customs service became better at tracing large quantities, for example through the use of new surveillance methods. During the last seven to eight years, the police have been allocated substantial funds to combating organised crime. Fighting drug crime has been a key element in this context. This also means that bigger cases, so-called paragraph three cases[10], are given priority. The number of such cases has increased significantly, from 55 in 2000 to 122 in 2007. There are no data about how many of these were related to cannabis.

11.2.2 Smuggling routes and modus operandi

A study of cannabis smuggling (Larsson 2006, 2009) showed that most of the seizures of cannabis on its way into the country by the police and customs, took place between Stavanger on the west coast, via key ports on the south coast of Norway to Oslo via Østfold and the Swedish border to Kongsvinger.

The smuggling routes are relatively simple. The hash is usually transported by boat from Morocco to Spain, some of it directly to other ports, for example in the Netherlands. From Spain, it is usually transported via the Netherlands to Norway, normally on the E6 motorway from Denmark via Sweden and Svinesund. Large consignments are either bought in the Netherlands or in Spain, very rarely in Morocco.[11]

The Netherlands stands out as a main country in the research material, which comprises 34 court judgments, mainly convictions for large quantities. Of 15 cases involving more than 100 kilos of hash, the hash was bought in the Netherlands in nine of them, while three were directly linked to Spain. The picture is equally clear when it comes to medium-sized cases (10 to 99 kilos), of which four of eleven involved hash from the Netherlands, two from Spain, two from Norway and one each from Denmark, Thailand and Sweden. Although the figures are not representative, they nevertheless indicate that most of the hash is bought in the Netherlands. There are many indications that, among other things, this is related to the good contact that exists with middlemen and suppliers in the country.

[10] Applies to cases pursuant to the General Civil Penal Code section 162 third paragraph, which concerns the most serious drug crimes.

[11] Even though the price level in Morocco is very low, the risk of being arrested as a 'white male' is considered to be high. Moreover, it must be assumed that very few people have contacts among suppliers in the country, which is crucial for a smuggler (Gross 1992).

Although transport by heavy goods vehicles seems to be most common way of importing large quantities, people are very inventive when it comes to smuggling methods. Norway has a long coastline, and a great deal is imported by ferry or boat. In addition, both large and small quantities are smuggled in many different ways, such as by plane, as 'legal' goods, in the mail, in containers, in camper vans and passenger cars (Larsson 2006). It appears that the vast majority of the hash goes via Oslo and is then spread to other parts of the country. The reason for this may be that most organised criminal networks are based in the Oslo area.

Large consignments have been brought in on small boats and stored temporarily in the island archipelago, as in the classic descriptions of the smuggling of spirits in the 1920s. However, the most common mode of transport is still by ferry or by road, depending on the size of the shipment. There are many semi-professional players who drive all the way to Amsterdam by car, where several persons, typically five or six, make up a team and where the quantities are somewhat larger. Among the more professional players are forwarding companies that hire out heavy goods vehicles that cannot be scanned, in addition to drivers. These services are not cheap and they can eat up a substantial part of the profit. Of course, the advantage is that it is possible to have the goods delivered relatively safely to central areas of Eastern Norway, while being less at risk if the shipment is stopped.

11.2.3 Seizures of plantations

Seizures of cannabis plants increased strongly in 2007 and 2008 compared with previous years (119 kilos/ 207 seizures and 347 kilos/ 217 seizures). This was mainly due to the discovery of cannabis plantations. So far, around 50 such plantations have been discovered. According to Kripos, the number of cannabis plantations will probably be greatly reduced in 2009.

11.2.4 Breakdown of cannabis seizures by product and by amount seized 2008

The amount of cannabis seized in 2008 was 1,732 kg, which breaks down into about 1,234 kg of hash (71%), 151 kg of marijuana (9%), 347 kg of cannabis plants (20%) and 0.011 kg of cannabis extract (see also Chapter 10.3.2). No detailed information is available about the breakdown of seizures by weight and type of product, but Table 16 provides an illustration of the thirteen biggest individual seizures made in 2008 and the type of cannabis involved.

Table 16: Individual seizures of cannabis in 2008 by amount and type of product

Police district	Amount	Product
Oslo	400.9 kg	Hash
Hedmark	145.4 kg	Hash
Oslo	121 kg	Hash
Oslo	39.1 kg	Hash
Hedmark	38.4 kg	Marijuana
Follo	26.7 kg	Cannabis plants
Oslo	25.6 kg	Hash
Gudbrandsdal	22.5 kg	Cannabis plants
Hedmark	21.4 kg	Cannabis plants
Follo	21.3 kg	Hash
Søndre Buskerud	21.2 kg	Cannabis plants
Oslo	19.7 kg	Hash
Romerike	14.9 kg	Cannabis plants

Source: Kripos

11.3 Offences

Police statistics do not distinguish between different types of drugs. In the registration context, a distinction is drawn by the size of the shipments that can be linked to defendants. Pursuant to the General Civil Penal Code section 162, a distinction is drawn between so-called paragraph one, paragraph two and paragraph three cases. The first paragraph covers small shipments, the second paragraph applies to medium-sized quantities, while the third paragraph applies to the largest quantities. The limit for cannabis is 80 kilos, a limit that was set following a case in which 80 kilos of marijuana were smuggled to Norway from Thailand. Use and possession of cannabis is mainly covered by the Act relating to medicines.

The seizure figures provide an indication of how large a volume the cannabis cases account for of the total number. Around 10,000 seizures of cannabis a year – of which most are minor seizures, typically use and possession – mean that a substantial proportion of registered drug crimes are hash cases. In 2007, approximately 20,000 formal complaints were brought pursuant to the Act relating to medicines section 31, and around 17,500 paragraph one cases pursuant to the General Civil Penal code section 162. It is not known how many of these concerned hash. The seizure figures are generally difficult to compare, because the persons reported are typically reported for several crimes at the same time, for example both use and possession.

12. Problem ampthetamine and methamphetamine use, related consequences and responses

Jørgen G. Bramness, Director of science / professor, Norwegian Centre for Addiction Research -SERAF

12. 1 Introduction

Norway is on the outskirts of Europe, not just geographically but perhaps also in terms of patterns of drug use. It has been reported in recent years (1, 2) that more amphetamine than cocaine is used in Norway and that methamphetamine has a large and increasing share of the illegal market for central stimulants. Others have claimed that, unlike in the USA (3, 4), Australia (5) and Asia (6), methamphetamine is not much used in Europe and that most of the use takes place in Central Europe based on production in the Czech Republic and Slovakia (7). In the following, we will use various data sources to study the prevalence of amphetamines (amphetamine and methamphetamine) and the relationship between the two substances in Norway in recent years.

12.2 Epidemiology of amphetamine and methamphetamine use

12.2.1 Trends and patterns of (meth)amphetamine use

In Norway, both amphetamine and methamphetamine are sold as white powder. In large areas of the world, methamphetamine is manufactured and sold as crystalline methamphetamine (‘ice’). This form of the drug is rarer in Norway. The powder is usually taken orally, snorted or injected, while the crystalline form can be smoked. Injection is more common in Norway (and Scandinavia) than in other countries where methamphetamine is used. This may be the reason why methamphetamine has achieved such an important place in Norway. However, many users, and perhaps also dealers, do not know whether they are dealing with amphetamine or methamphetamine. While some experienced users claim to ’know when they are given good or bad drugs’, it has not been confirmed that this indicates actual recognition of methamphetamine rather than amphetamine or whether it refers to other phenomena (such as purity), or whether it is simply a myth.

Surveys carried out among the general population do not contain separate questions about the use of methamphetamine. As regards more problematic use of amphetamine, frequency may be an indicator. Among young adults aged 21 to 30, three per cent said that they had used amphetamine 5 to 25 times, while three per cent had used the drug more than 25 times (overall proportion from surveys carried out in 2002 and 2006).

The use of methamphetamine among men who have sex with other men has been explored in a number of publications (16). American surveys show that this group is probably overrepresented among users, and that it is associated with other types of risk behaviour such as sex with unknown partners, unprotected sex and thereby with an increased risk of HIV transmission (17). Some anecdotal reports exist of such use among members of Norwegian gay club scenes (18). However, we do not have surveys from Norway corresponding to those from the USA, and it is important to keep in mind that, in practice, we are dealing with two different substances used in the two countries: smoking of ’crystal meth' in the USA and snorting or injecting powder in Norway.

Treatment demand for (meth)amphetamine use

In the annual nationwide client mapping of treatment and care facilities, information is provided about the two amphetamines combined (see Chapter 5.2.1). The proportion reporting methamphetamine/amphetamine as the most used intoxicant on admission has

increased over the last ten years from about five per cent to nine per cent. However, these are aggregated data that also include alcohol. Corrected for alcohol, the proportion reporting methamphetamine/amphetamine as the most used intoxicant was approximately 16 per cent in 2007, which is on a par with cannabis, but clearly behind heroin (37%) (personal communication Erik Iversen, the Bergen Clinics Foundation).

Production sites and laboratories, origin of products and trafficking routes, precursors seizures.

Information is scarce about the manufacturing of amphetamines in Norway. It is probably only small-scale production, at most. The most common smuggling routes are discussed in Chapter 2. According to the customs service, most of the *amphetamine* and *methamphetamine* on the Norwegian market comes from illegal laboratories in Russia, Poland and Lithuania. The largest quantities seized today, however, come from the Netherlands and Poland, through Germany and Denmark and via Sweden.

12.2.2 Epidemiological studies

Material and method

The Norwegian Centre for Addiction Research – SERAF – has collected data for a study from four different bodies:

The National Institute of Public Health (NIPH)
Three types of data were collected from the Division of Forensic Toxicology and Drug Abuse Research at the Institute of Public Health for the period 2000 to 2008:
The first source of data consists of blood samples from cases in which the police suspected driving under the influence of other substances than alcohol (the Road Traffic Act section 22 concerning driving under the influence). Every year, the police stop and test several thousand drivers suspected of driving under the influence (see also Chapter 9.2.1). On suspicion of other substances than alcohol, the person is question is brought before a doctor who takes a blood sample and performs a clinical examination (9, 10). For years, this data set has been a rich source of information about the use of medicinal drugs and narcotics (11, 12). Of course, there is a selection bias in this material in that it only includes those who drive and attract the attention of the police, but this bias has been constant for many years, and the data can nonetheless be used to shed light on developments over time.

The other source of data consists of urine samples from inmates in Norwegian prisons. Every year, around a thousand urine samples are taken from inmates in Norwegian prisons, partly as a matter or routine on admission and on return from leave, partly on suspicion of use (Chapter 9.4). As certain rules apply to the taking of urine samples that may lead to sanctions, these samples are also subjected to the same analyses using forensic toxicological methods. The procedures mean that nor is this material without selection bias, but again the bias has been relatively constant over a number or years, which means that it is possible to look at developments over time.

The third source of data from NIPH consists of results from autopsies in which forensic toxicological examinations have been performed post mortem. Between 1,500 and 2,000

such post mortem toxicological analyses are performed every year at NIPH. The National Institute of Public Health is not the only institution that performs such analyses in Norway, and, again, there could be selection bias, but like the other data, this material can also be used to observe developments over time.

All analyses performed by NIPH are carried out using chromatographic methods that ensure a high level of sensitivity and specificity when determining the use of different substances. It is possible, for example, to distinguish between amphetamine and methamphetamine, and these substances can also be distinguished from other medicinal drugs (such as ephedrine), which would otherwise be a problem if semi-quantitative methods were used (such as urine sticks). Since methamphetamine to some extent metabolises into amphetamine, amphetamine will usually also be present when methamphetamine has been used. All samples in which methamphetamine was found were therefore considered to be methamphetamine samples, regardless of how much amphetamine was found. This has probably led to an overestimation of the prevalence of methamphetamine cases, since, in some cases, there was so much amphetamine present in the methamphetamine sample that it could not be the result of using methamphetamine alone, i.e. amphetamine must have been used as well. However, we have kept these figures to avoid underestimating the proportion of methamphetamine, at the same time as we want to avoid giving the impression that the total number of cases is higher than it actually is. If the number of cases in each category had been counted, the total number of cases would have been too high because many samples contain both amphetamine and methamphetamine.

The National Crime Investigation Service (Kripos)
The seizure statistics from Kripos, particularly concerning the number of seizures, can be important in relation to describing how the situation in Norway has developed (see data in Chapter 10.3.2). The quantity of narcotics seized does not give as accurate a picture of the activity in the drugs market, since large individual seizures will affect the statistics disproportionately. The number of seizures, however, will better reflect the situation in the user milieus. Since there is often a strong connection between the priorities of the police and efforts targeting user milieus and the number of seizures, the number of seizures made during a year can vary greatly. The annual statistics from Kripos indicate the relative proportion of seizures of amphetamine and methamphetamine and the ratio between the two substances. These data have corresponded well with reports from NIPH. In the same way as NIPH, Kripos also uses chromatographic methods of analysis that ensure a high level of sensitivity and specificity. Not all seizures are analysed, however. This means that the published figures are minimum figures. The data from Kripos is from the period 1994 to 2008.

Emergency psychiatry
SERAF has carried out two surveys of emergency psychiatry services in Oslo: a pilot survey in autumn 2003 (13) and a new survey in autumn 2006 (unpublished data). All patients admitted during a specific period of time gave anonymous blood samples, and we used this material to shed light on the prevalence of amphetamine and methamphetamine in this group. Again, this sample is highly selective, as it consists of patients admitted to an emergency psychiatric department. This population is mainly dominated by acute psychoses characterised by uncontrolled behaviour and suicidality problems (14).

The Norwegian Institute for Alcohol and Drug Research (SIRUS)
Data from SIRUS are taken from the survey that is carried out twice a year at the central needle distribution facility in Oslo city centre. The participants are mainly injecting drug users. Those who come to the needle distribution facility probably belong to a more

marginalised group than the average users of both opiates and amphetamine, and may represent the abject group of users. Data from this survey have been supplemented by Anne-Line Bretteville Jensen at SIRUS.

12.2.3 Results

The National Institute of Public Health (NIPH)

Figures from NIPH and the three sources of data that constitute the material are presented in Figures 16-19. Here, the relative proportions of the samples that tested positive for amphetamine and methamphetamine are shown. Table 1 shows the total number of cases. For the period 2000 to 2008, the proportion of samples that tested positive for amphetamines was from 18 to 28 per cent in driving cases, from three to five per cent in the correctional services (urine samples) and from five to eight per cent in autopsy cases. For all the categories, the proportion of methamphetamine of all the cases involving amphetamine has gone from being almost zero around the turn of the millennium to as high as 69 per cent (Figure 15), 54 per cent (Figure 16) and 80 per cent (Figure 17), respectively, of all cases in 2008.

Kripos

Figure 18 shows the same development in the relationship between amphetamine and methamphetamine as for the number of seizures. In 2000, methamphetamine only accounted for six per cent of the total seizures of the two drugs, in 2008 the proportion was 44 per cent, and in the first six months of 2009 the proportion of seizures was as high as 68 per cent (data from 2009 are not shown in Figure 18).

Emergency psychiatry

One hundred patients were tested in autumn 2003. In this group, 22 patients had amphetamines in their blood, urine or both, which is a sign of relatively recent use of amphetamines (13). Of the 22, 14 (63%) had used methamphetamine, while eight of the 15 (53%) whose blood tested positive had used methamphetamine. A screening of 300 patients in 2006 revealed that 41 persons (14%) tested positive for amphetamine. In the 2006 survey, all the patients had used methamphetamine.

SIRUS

The users who visited the needle distribution facility in Oslo city centre stated that they were unable to distinguish between amphetamine and methamphetamine when purchasing the drug. The self-reported data therefore include figures for the use of both amphetamines. The data are not presented in any table or figure. In the period 1999 to 2008, SIRUS found that 63 per cent of the interviewees reported that they had used amphetamine during the last month (number of respondents n=2,219). The average number of days of use during the last month was 14.5 (n=1,394).

By splitting the responses into two five-year groups (group 1=1999 to 2003 vs. group 2=2004 to 2008), SIRUS found an increase in the proportion reporting that they had used amphetamine during the last month (59% compared with 68%). There was also an increase in the number of days that the amphetamine users reported having injected the drug (12.5 days compared with 16.6 days).

Of those who reported use of amphetamine during the last month, 77 per cent reported also having used cannabis in the same period (n=1390), while 75 per cent reported injection of heroin and 20 per cent reported having used cocaine.

12.3 Treatment for (meth)amphetamine use

Treatment of amphetamine dependency and methamphetamine dependency is a relatively unexplored area. Amphetamine users are often difficult to reach with therapeutic measures and they often do not seek help themselves. The most tested non-pharmacological technique is contingency management, which has proved to be effective. In addition, treatment with different pharmaceuticals, such as buporprione, stimulants (modafinil and methylphenidate) and antiepileptic drugs, has been tested, but a summary of the literature shows a lack of good studies of effective pharmacological treatment options (19), and that treatment is largely dependent on non-pharmacological interventions. The use of naltrexone has yielded promising results in a recent Swedish study, with respect to both actual use and perceived effect (20, 21).

Persons with amphetamine or methamphetamine in the blood are strongly represented among those admitted for emergency psychiatric treatment in Norway, and these substances are clearly the largest single group of drugs found among this group of patients (13). This corresponds well with what we know about the side-effects of amphetamine and methamphetamine use (8), even though the extent may be surprising. Most of the patients who were admitted for emergency psychiatric treatment had used a number of other substances. It is not known whether this was part of multiple use or whether depressants had been taken to end the period of intoxication. However, the high number of depressants may indicate that at least some were taken to end a period of drug abuse. When this period ended in psychosis and admission to emergency psychiatric treatment, it is an indication that we are dealing with members of a selected population who have been unsuccessful in their attempt to end a period of abuse in a constructive manner. Whether this has been made more difficult by the fact that we are dealing with methamphetamine is unknown, but we observe that all patients with amphetamine in the blood at the time of the last survey had used methamphetamine.

12.4 Discussion

None of the data sources used can give a complete picture of the prevalence of amphetamine and methamphetamine use in Norway. Instead, the data sources represent different signs of the use. However, the main findings indicate that there has been an increase in the use of amphetamines in Norway for many years and that this increase has mostly concerned the use of methamphetamine. There is reason to believe that methamphetamine is currently more used than amphetamine in Norway. Thus, the survey represents something of a contrast to previous reports that indicate little use of methamphetamine in our part of Europe (7), while it confirms previous reports from EMCDDA indicating that Norway is the country in Europe with the quantitatively largest and highest number of seizures, and where the problems associated with methamphetamine can also be substantial (1, 2).

The most remarkable finding in the present survey is that most of the amphetamine used now appears to be methamphetamine. The increase in the proportion of methamphetamine has been a linear trend over many years in all the available data sources. As regards seizures, 2009 appears to be the year when the number of methamphetamine seizures exceeds that of amphetamine. NIPH's laboratory analyses indicate that methamphetamine has been the dominant drug for many years already, but that may be due to the fact that, because of our method, we underestimate the incidence of amphetamine somewhat. This source of error probably increases in step with the exposure to the drugs. Thus, we see that the curves intersected first in autopsy cases, where most drugs are included, and last in prison cases, where the access to intoxicants is presumably lower. The figures from NIPH can nonetheless be used to confirm the almost linear increase for methamphetamine over a number of years.

In principle, we can envisage both supply and demand being contributory factors to such a development. Some users claim to be able to distinguish between 'good and bad amphetamine', implying that they know whether they have taken amphetamine or methamphetamine. The survey from the needle distribution facility, however, suggests that this is not common knowledge and that those buying drugs do not emphasis this. This is supported by reports from the courts (Jørg Mørland NIPH, personal correspondence), in which defendants in various cases do not know whether they have taken amphetamine or methamphetamine, and where biological tests show which of the drugs was taken. Despite the fact that defendants in such cases may have an interest in appearing ignorant of this difference, there is reason to believe that we must look to the supply side to find the explanation for the development. Similarly, it is possible that those who claim to be able to distinguish between 'good and bad amphetamine' wish to appear more experienced and knowledgeable than they actually are. Moreover, the purity of the two types of amphetamine will also vary (see Chap. 10.5), which may be the explanation for the difference between good and bad amphetamine. In other words, we cannot assume that demand is the reason why we have seen such a dramatic shift in which of the two drugs is found.

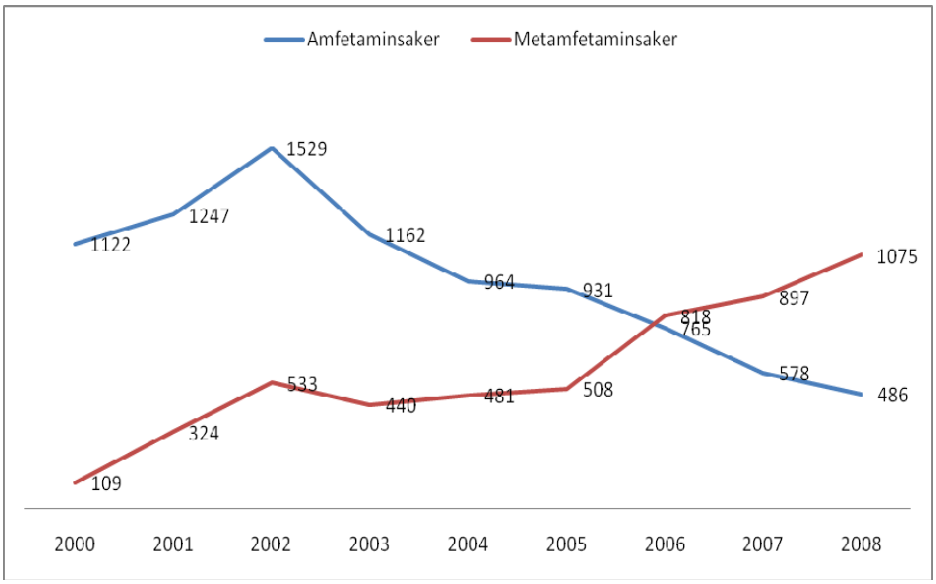
There is reason to believe that the trend has more to do with supply. New drug trading patterns have developed in step with the liberalisation of border controls in Europe, and there is reason to believe that the most important explanation for the shift from amphetamine to methamphetamine as the predominant substance in Norway is new producers and importers in the market, possibly production in the Baltic countries (2).

The combination of users not knowing whether they are using amphetamine or methamphetamine, the fact that the use of amphetamines is increasing and that methamphetamine has become the predominant amphetamine on the Norwegian market means that there is a clear danger that we will see more negative consequences of use in Norway than in many other countries. The available road traffic data and data from psychiatric services are only two examples.

Problem users of amphetamine and methamphetamine are not 'loyal' users who only stick to one drug. This is confirmed by data from, for example, the needle distribution facility. In part, they are addicted to more than one substance, and in part, they use a number of different pharmaceuticals to calm down after having used amphetamines for several days. This is a typical finding in the survey, which includes psychiatric patients who, among those with amphetamine or methamphetamine in their blood, tested positive for many substances. Because a period of amphetamine use will probably end if problems arise (admissions to hospitals and deaths), and the user at the same time tries to deal with these problems by taking depressants such as benzodiazepines or methadone, some analyses (hospital data or autopsy cases) may exaggerate the use of different drugs.

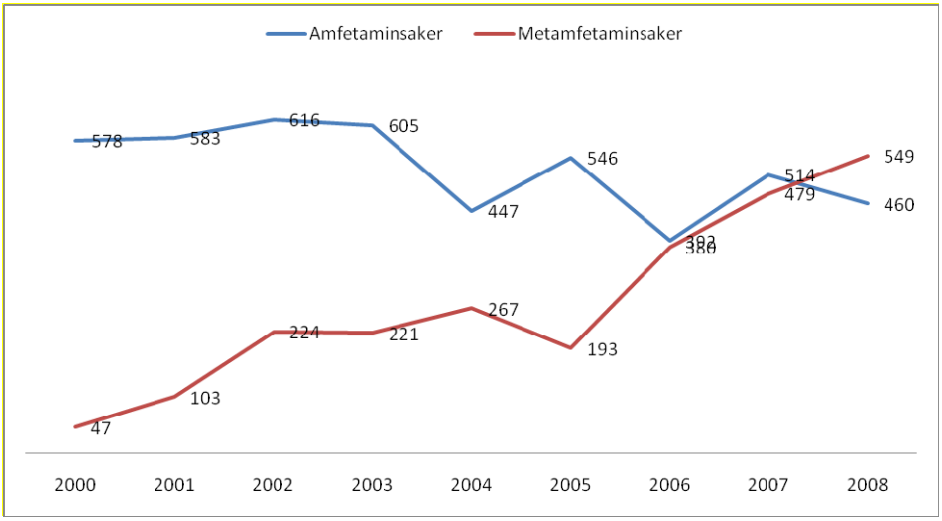
Future studies will have to follow the development of amphetamine use in the population and the proportion of methamphetamine users by utilising different sources of data. It is also necessary to find out whether the available Norwegian figures show a Norwegian trend only, or whether the same developments are also taking place in the other Scandinavian countries and possibly in Russia. Similarly, it will be important to study different negative consequences.

Figure 15: Findings of amphetamine and methamphetamine in cases of suspected driving under the influence of non-alcoholic drugs where forensic toxicological analyses have been performed.



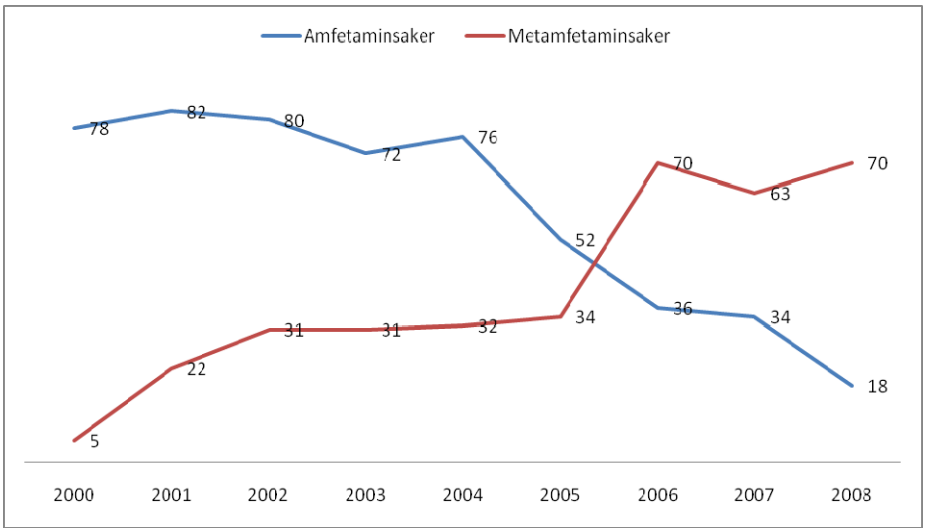
Source: Norwegian Institute of Public Health

Figure 16: Findings of amphetamine and methamphetamine in cases from the criminal justice system where forensic toxicological analyses have been performed. In numbers.



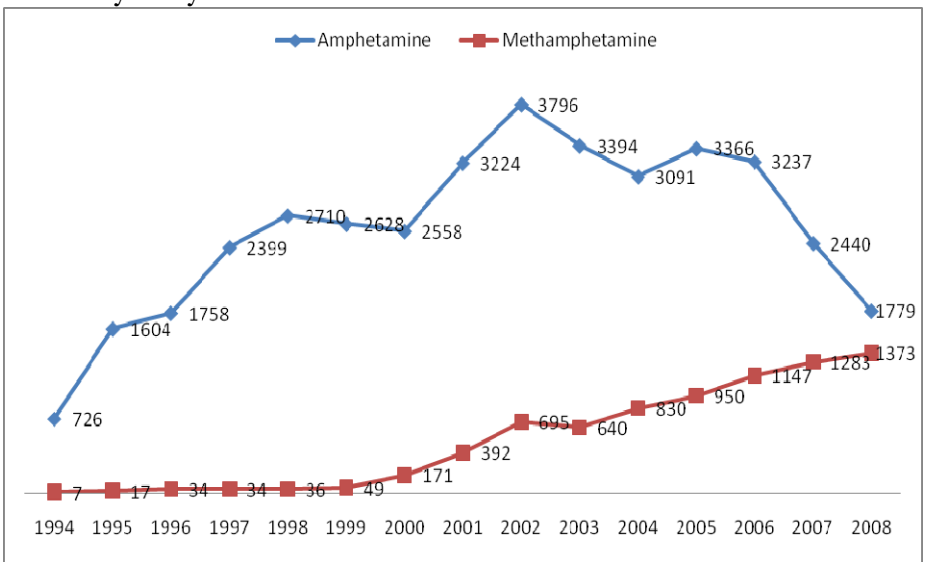
Source: Norwegian Institute of Public Health

Figure 17: Findings of amphetamine and methamphetamine in autopsies where forensic toxicological analysis have been performed. In number



Source: Norwegian Institute of Public Health

Figure 18: The number of seizures (both analyzed in laboratory and not analyzed in laboratory) that have been confirmed as containing amphetamine or methamphetamine by laboratory analyses.



Source: Kripos

Table 17: Number of forensic toxicological analyses in connection with autopsies 2000 to 2008, the number of cases of suspicion of driving under the influence of other substances than alcohol 2000 to 2008, the number of cases from the criminal justice system analysed at NIPH 2000 to 2008, and seizures made by the police and customs authorities 1994 to 2008.

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Forensic autopsies with toxicological screening							1855	1741	1768	1640	1645	1581	1579	1544	1659
Driving under the influence							3833	4314	5116	4379	4020	4050	4213	4296	4474
Criminal justice							20866	22561	23601	27061	23403	21572	22094	24302	25702

Seizures	8171	11357	11734	14812	17828	20141	21508	27649	30310	25210	24108	24118	26249	24568	23835

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Lists

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