

# The Drug Situation in Norway 2011

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

## Foreword

As in previous years, this 11th<sup>th</sup> national report on the drug situation in Norway has been drawn up in accordance with the reporting guidelines common to all member states in the EMCDDA. In addition to the annual report, we have submitted separately a number of standardised tables, mainly epidemiological data, as well as several comprehensive questionnaires in the fields

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

Oslo, December 2011

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## Summary. Main findings – Part A

### Legal framework

In 2011, *the Act relating to municipal health and care services* replaced the Act relating to the municipal health services and the Social Services Act. It clarifies the municipalities' overall responsibility for ensuring health and care services, but without requiring the municipalities to organise the services in a particular manner. The municipalities have the same duties, but they are formulated in more general and professionally neutral terms. The act does away with the legal distinction between health services and care services. The new act aims to ensure better coordination within the municipality and between the specialist health service and municipal health and care services.

Amendments were also adopted to *the Road Traffic Act* in 2011. The amendments concern the Road Traffic Act's provisions concerning driving under the influence, mainly related to driving under the influence of substances other than alcohol. The primary purpose of the legislative amendments is to improve traffic safety and reduce the number of traffic injuries and fatalities. The amendments also aim to create greater correspondence between the provisions on drink driving and the regulation of driving under the influence of other substances.

### Consultation on alternatives to punishment

In June 2011, a working group submitted the report *Alternative reactions to less serious drug offences, intervention programmes and motivational interviews* to the Ministry of Justice and the Police and the Ministry of Health and Care Services. It proposed that persons arrested for minor drug offences be offered motivational interviews or a more long-term intervention programme as a special condition for a conditional waiver of prosecution or a conviction. The reaction will normally not be registered in the person's criminal record. The target group primarily

consists of young people, but no upper age limit is proposed. The purpose is rehabilitation. The Minister of Justice and the Police underlines that 'the proposals do not entail any form of legalisation, decriminalisation or lessening of criminalisation of drug offences. It is more a question of punishing people in a way that works, by tailoring a reaction that addresses the cause of the crime/ drug use'. The report and the proposals have been distributed for consultation.

### White paper in progress

A white paper on drug and alcohol policy, originally scheduled for presentation in 2011, has been postponed until 2012. The white paper will summarise experience of the Action Plan (2008–12) and identify the main challenges and strategies for the drug and alcohol policy in future. Prevention, comprehensive and coordinated services and emphasis on the role of the municipalities will be guiding principles in relation to the contents of the report. The white paper will deal with alcohol, drugs, medicinal drugs and doping outside organised sport. The provision of services for older people with drug and alcohol problems will be assessed, including palliative treatment and care in the final phase of life. User participation and the situation of next-of-kin will be emphasised.

### The question of introducing heroin-assisted treatment

In June 2009, the Storting asked the Government to organise a so-called consensus conference at which both expert communities and user organisations could discuss professional, ethical and priority-related aspects of offering heroin-assisted treatment to drug addicts in Norway. On assignment for the Ministry of Health and Care Services, the Research Council of Norway organised a conference of this kind in June 2011. The appointed panel submitted its report to the Ministry in September. It recommended

not initiating a trial scheme for heroin-assisted treatment. The panel concluded that the overall knowledge basis for introducing heroin-assisted treatment in Norway is still too weak. The Ministry will make a recommendation on this issue in the coming white paper.

### **Decline in the use of cannabis**

The most recent survey among the general population was carried out in 2009. The survey showed that the proportion of respondents who answered that they had ever tried cannabis had fallen from approx. 16 per cent in 2004 to less than 15 per cent in 2009. What was more surprising was the relatively strong decrease since 2004 in the proportion that had used cannabis during the last 30 days in the under-35 age group. In 2004 it was 4.5 per cent, while in 2009 it was reduced to less than the half. Furthermore, the last-year prevalence had also decreased in the 15–34 age group, from a proportion of 9.6 per cent in 2004 to seven per cent in 2009.

In another survey addressing young adults that was conducted in 2010, preliminary analyses show that lifetime prevalence for the use of cannabis is declining in the 21–30 age group compared with the 2006 survey for the same age category. The decline found among the general population thus seems to be confirmed by this survey.

The 2010 survey, which included people aged 18–30 years, showed that cannabis is still the illegal drug that most young people report having tried (29 %). Significantly fewer have tried amphetamine and cocaine (approx. 6 % for both). Ecstasy and sniffing have been tried by nearly four and three per cent, respectively, while around one per cent of this age group report ever having used LSD, GHB and heroin.

### **Injecting users – stable situation**

The number of injecting users in Norway has probably been quite stable since 2003. In 2009, it was estimated to be between 8,800 and 12,500. The figure includes all injecting use. Heroin is still the most common drug injected, but, for

around 17 per cent, amphetamines are the main drug injected.

### **Problem users of cocaine**

SIRUS has in 2010/2011 participated in a project in which the amount of cocaine used in Oslo was calculated using three different methods. The Norwegian Institute for Water Research has carried out measurements of cocaine in wastewater, while the Norwegian Institute of Public Health has carried out measurements of cocaine among drivers suspected of driving under the influence. SIRUS has used a method based on the reporting of the frequency of cocaine use in four different surveys, both population-based and among inmates in prisons and injecting users. The results of the surveys have not yet been published, however.

In the questionnaire surveys, the respondents were also asked how often they used cocaine. It is thus possible to calculate an annual average number of cocaine users and the number of persons who used the drug more than once a week or more (problem users). On average for 2000–2009, there were approximately 1,800 problem users of cocaine per year in Oslo and 10,200 others who used the drug more rarely. The majority of the cocaine users, almost 50 per cent, were experimental users who had only used the drug one to four times during the last 12 months, while 35 per cent were recreational users (limited use). No corresponding estimates have been carried out so far at the national level.

### **Drug-related treatment**

During the first half of the 2000s, extensive administrative and organisational changes took place with regard to the treatment of drug and alcohol problems. Through the hospital reform of 2002 and the Administrative Alcohol and Drugs Treatment Reform of 2004, responsibility was assigned to the state-run specialist health service. This reorganisation has led to increased focus on diagnostics, medication and the use of commercial principles in the treatment context. This change has been criticised in several different quarters. It has been argued, for example,

that the reorganisation threatens to undermine the diversity of treatment options. Resources appear to be increasingly channelled to so-called evidence-based interventions, the establishment of outpatient clinics, shorter treatment programmes and more medication. There now seems to be a tendency to prioritise short-term measures and substitution treatment in tender criteria at the expense of social-pedagogical long-term measures and aftercare.

One new set of guidelines, *For pregnant women in opioid substitution treatment (OST) and follow-up of families until the children reach school age*, entered into force in the course of 2011.

The goal is to provide clear, knowledge-based recommendations for the treatment and follow-up of OST patients during pregnancy and while in hospital in connection with the birth, and for follow-up /treatment of the child and the family until the child reaches school age. The target group consists of women in OST during pregnancy, their partners, children who have been exposed to methadone or buprenorphine at the foetal stage, and their families. The guidelines address all professional groups in the municipalities and in the specialist health service that have responsibility for following up these patients. This applies to the health services, but also to social services, child welfare services, kindergartens and the school psychological service.

### **Treatment provision**

In a report for 2009, the Directorate of Health describes the health services offered to patients in interdisciplinary specialised drug or alcohol treatment by the sector itself and by the mental health care service for adults. The data basis consists of information reported by the institutions about patients who have received treatment in the interdisciplinary specialist treatment sector. In all, 40 per cent of the patients in this sector received in-patient treatment in 2009, more men than women. Drug problems caused by the use of cannabinoids were more often treated on an outpatient basis, while problems caused by the use of tranquillisers and depressants,

stimulants or multiple substances were more often treated through admission.

### **Psychiatric and somatic co-morbidity**

Very many patients in mental health care in Norway have drug or alcohol problems, and very many patients in interdisciplinary specialised treatment for drug or alcohol use have psychiatric and somatic disorders.

Counts of patients in mental health care for 2010 show that 23 per cent of those who are admitted to mental health care, have or are given a drug or alcohol diagnosis. This is a decline from 2007, when the proportion was 29 per cent. The presence of drug or alcohol problems in addition to another primary condition increases the likelihood of readmission to mental health care. Although they are readmitted more often, patients with concurrent drug or alcohol problems and mental health problems nonetheless spend fewer days in treatment than other patients. These patients make more use of in-patient treatment than other patients in mental health care and less use of outpatient services. Behaviour disorder is the most common psychiatric diagnosis among those who are readmitted with concurrent psychiatric and drugs or alcohol-related diagnoses.

The treatment period is shorter and the contact with specialists in mental health problems more sporadic for these patients than for others. This makes it difficult to establish the patient's needs and how drug/alcohol treatment and mental health care can be integrated to provide better treatment.

### **New patient register in force**

The Norwegian National Patient Register (NPR) is authorised by the regulations of 2009 to collect personally identifiable information about patients in the specialist health service. The purpose is to facilitate quality development and management of treatment provision, and to strengthen evaluation and research activities. The personally identifiable register also enables NPR to quantify the number of patients who



receive treatment in the specialist health service. The 'new' way of counting patients is based on encrypted personal identification numbers, not just institution numbers and patient numbers. This means that the new calculation method avoids patients being counted more than once.

All entities that offer interdisciplinary specialised treatment are required to report to the NPR. The reporting of activity data from entities that offer interdisciplinary specialised treatment has been mandatory since 1 January 2009, and it also includes registering the patient's situation at the start of treatment. Patient data for interdisciplinary specialised treatment are still incomplete. Deviations between patient data and overall reports to Statistics Norway indicate that some areas remain to be clarified. This also applies to under-reporting, which is most common in the outpatient sector.

#### **HIV stable– high incidence of HCV**

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

#### **Drug-related deaths. Large proportion caused by other opioids than heroin**

In 2009, 285 persons died of drug-related causes in Norway, an increase of 22 compared to 2008. Of the total number that were recorded by Statistics Norway, 255 deaths involved opioids with or without additional drugs, 137 were deaths due to heroin, 39 deaths were recorded with methadone poisoning as the underlying cause, and 61 with other opioids, either as poisoning or dependency. Thirty-nine of the deaths were coded as suicides, which is probably a conservative estimate of the suicide rate.

The proportion of drug-related deaths among those over the age of 30 has increased steadily. In 2009, this age group accounted for 76 per cent of the deaths. The proportion over the age of 50 appears to have increased as well. In 2009, this age group accounted for 25 per cent of the total number of deaths. Five of the deaths were in the 65 years or more age group. The youngest age groups' proportion of deaths has remained relatively stable, but nine deaths under the age of 20 years in 2009 is the highest number ever registered.

#### **Drug markets**

The number of cases and seizures has increased to record levels in 2010. However, with the exception of GHB and GBL, the big increase in cases has not led to seizures of record amounts of drugs.

The number of seizures of heroin is the highest since 2003. The number is far lower, however, than in the period 1995–2003. Moreover, the purity of heroin base has sunk to a historically low level, 21 per cent in 2010 on average, declining further to 17 per cent in first half of 2011.

The total seized amount of all cannabis products is not particularly high, which can be explained by the relatively small amount of hash seized. On the other hand, the number of cultivation cases and the number of seizures of marijuana have again increased strongly. Both the quantities and the number of seizures substantially exceed those in the years 2007 and 2008, which were registered as record years until 2010.

In total, the number of seizures of amphetamine and methamphetamine has increased relatively strongly in 2010 compared with the period 2006–2009.

Although 2007 is the only year in which more seizures of cocaine were made than in 2010, cocaine nonetheless appears to have a somewhat smaller market share during the last three years compared with seizures of other drugs.

The seizure figures are very low for ecstasy, both in terms of the amount seized and the number of seizures. Among tablets with logos, MDMA has largely been replaced by other drugs, primarily mCPP (1,3-chlorphenylpiperazine).

Both the number of seizures and the number of tablets of benzodiazepines have increased since 2008, a trend that was reinforced in 2010. Only in two previous years have greater quantities been found and more seizures made than in 2010. It is clonazepam (Rivotril) and diazepam (e.g. Valium) in particular that dominate the user market.

Of the new stimulants that were introduced to the user market in 2010, it is mainly PMMA that stands out. According to the National Institute of Public Health, PMMA has so far (end of September 2011) been linked to 20 overdose cases with fatal outcomes.

The customs service is uncovering an increasing amount of drugs sent in the post and by courier. This applies in particular to narcotic tablets ordered online. As regards tranquillising narcotic tablets, the smuggling of Rivotril and Subutex appears to have increased in particular.

The customs service has also registered an increase in the smuggling of new drugs. New versions of synthetic cannabinoids and other synthetic substances are being uncovered all the time. The challenge is that many of these substances are difficult to stop as they are not yet on the list of narcotic substances. Eight synthetic cannabinoids were listed with effect from 21 December 2011, however.

# PART A

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## New Developments and Trends

# 1. Drug policy: legislation, strategies and economic analysis

See also information in Structured Questionnaire 32.

## 1.1 Legal framework

In 2011, two new acts were passed and amendments were made to one act, all of which have a bearing on drug and alcohol policy.

*The Norwegian Act relating to municipal health and care services*<sup>1</sup> replaces the Act relating to the municipal health services and the Social Services Act. It clarifies the municipalities' overall responsibility for ensuring health and care services, but without requiring the municipalities to organise the services in a particular manner. The municipalities have the same duties, but they are formulated in more general and professionally neutral terms. The act does away with the legal distinction between health services and care services. Patient and user rights relating to municipal health and care services are continued, but they are now set out in the Patients' Rights Act. This entails more unambiguous and comprehensive rights for patients and users. The new act aims to ensure better coordination within the municipality and between the specialist health service and municipal health and care services.

*The Norwegian Act relating to public health work (the Public Health Act)*<sup>2</sup> replaces, among other acts,

the Act concerning the county municipalities' public health duties and certain provisions of the Act relating to the municipal health services. The act is intended to contribute to developing society in a manner that promotes public health and evens out social differences in health and living conditions. The municipalities' responsibility for maintaining an overview of health conditions and impact factors is specified, thus providing the individual municipalities with a clearer picture of local health challenges.

Amendments to the *Norwegian Road Traffic Act*.<sup>3</sup> The amendments concern the Road Traffic Act's provisions concerning driving under the influence, mainly related to driving under the influence of substances other than alcohol. The primary purpose of the legislative amendments is to improve traffic safety and reduce the number of traffic injuries and fatalities. The amendments also aim to create greater correspondence between the provisions on drink driving and the regulation of driving under the influence of other substances.

### Alternatives to punishment

A working group has looked more closely at the question of alternative reactions to less serious drug-related crime. In June 2011, the working group submitted the report *Alternative reactions to less serious drug offences, intervention programmes and motivational interviews* to the Ministry of Justice and the Police and the

<sup>1</sup> Act relating to municipal health and care services. Proposition 91 L (2010-2011) to the Storting, Recommendation 424 L (2010-2011) to the Storting, Legislative decision 63 (2010-2011).

<sup>2</sup> The Act relating to public health work. Proposition 90 L (2010-2011) to the Storting, Recommendation 423 L (2010-2011) to the Storting, Legislative decision 64 (2010-2011).

<sup>3</sup> Amendments to the Road Traffic Act concerning driving under the influence. Proposition 9 L (2010-2011) to the Storting, Recommendation 105 L (2010-2011) to the Storting, Legislative decision 26 (2010-2011).

Ministry of Health and Care Services. It proposed that persons arrested for minor drug offences be offered motivational interviews or a more long-term intervention programme, as a special condition in a conditional waiver of prosecution or a conviction. The reaction will normally not be registered in the person's criminal record. The target group primarily consists of young people, but no upper age limit is proposed. The purpose is rehabilitation. The Portugal model of dedicated commissions has been a source of inspiration.

Motivational interviewing (one to three sessions) is intended for persons who have only used drugs a few times. The idea is that the interviews will have a preventive effect. The intervention programme (three to six months) is intended for addicts or persons in danger of becoming addicted. If the arrested person does not consent, or repeatedly violates the conditions for the alternative reactions, he/she may risk fines or imprisonment, which is the current practice.

The Minister of Justice and the Police underlines that the proposals 'do not entail any form of legalisation, decriminalisation or lessening of criminalisation of drug offences. It is more a question of punishing people in a way that works, by tailoring a reaction that addresses the cause of the crime/ drug use'. The report and the proposals has been distributed for consultation in autumn 2011.

## 1.2 National action plan, strategy, evaluation and coordination

The Government's overriding goal for its drug and alcohol policy is to reduce the negative consequences of drug and alcohol use for individuals and for society as a whole. The policy, for which the Ministry of Health and Care Services has overall responsibility and which it coordinates, is enshrined in the National Action Plan on Alcohol and Drugs 2008–2012, hereinafter called the Action Plan.

The allocations for the Action Plan have so far increased by more than EUR 125 million<sup>4</sup> (NOK 1 billion) during the course of the plan period. In the proposal for the national budget for 2012, the allocation is continued at the same level as in 2011 in the Ministry of Health and Care Services' budget. Strengthening the municipalities' finances and the basic allocations to the four regional health authorities come in addition. This is intended to contribute to the continuation and strengthening of services for drug addicts and alcoholics. The Action Plan has helped to increase the focus on prevention, competence and quality in the municipalities and in specialised interdisciplinary drug and alcohol treatment.

A white paper on drug and alcohol policy was originally scheduled for presentation in 2011, but it has been postponed until 2012. The white paper will summarise experience of the Action Plan, follow up the Stoltenberg Committee's<sup>5</sup> report and identify the main challenges and strategies for the drug and alcohol policy in future. Prevention, comprehensive and coordinated services and the emphasis in the Coordination Reform<sup>6</sup> on the role of the municipalities will be guiding principles in relation to the contents of the report. The white paper will deal with alcohol, drugs, medicinal drugs and doping outside organised sport. The provision of services for older people with drug and alcohol problems will be assessed, including palliative treatment and care in the final phase of life. User participation and the situation of next-of-kin will be emphasised.

<sup>4</sup> Conversion rate 1 EUR = NOK 8.00

<sup>5</sup> In spring 2009, the Government appointed a committee that was tasked with assessing how drug addicts and alcoholics most in need of help can receive better help – the so-called 'Stoltenberg Committee'. The committee submitted its report in June 2010. It contained 22 concrete proposals ranging from prevention to treatment. A narrow majority of the committee's members support carrying out a trial project whereby treatment with heroin will be included in OST.

<sup>6</sup> Proposition no 47 (2008-2009) to the Storting. The Coordination Reform. The right treatment in the right place at the right time.

### 1.2.1 Status of implementation of the Action Plan

The plan has five main goals:

- a clear public health perspective
- better quality and increased competence
- more accessible services and greater social inclusion
- more binding cooperation
- increased user influence and greater attention to the interests of children and family members.

The plan includes 147 concrete and relatively extensive measures that address the challenges in the drugs and alcohol field. Almost all the measures have been initiated.

#### A clear public health perspective

A public health perspective in the drug and alcohol policy is considered crucial. The extent of negative social and health-related consequences increases in step with the use of drugs and alcohol. It is therefore a challenge that alcohol consumption is increasing among adults. On the other hand, surveys show a certain decline in the use of alcohol and cannabis among young people.

Grants for drug prevention projects and activities are awarded annually, as well as operating grants for drug and alcohol policy organisations. The Directorate of Health runs information campaigns and engages in attitude-building work.

#### Better quality and increased competence

One of the goals of the Action Plan is to strengthen research and teaching in the field of drug and alcohol problems, to initiate measures to enhance the quality of preventive work and services and to raise employees' competence.

One main focus is the Research Council of Norway's drug and alcohol research programme. The programme's overriding goal is to contribute to the development of new relevant knowledge and to promote research in the drugs and alcohol field. An important instrument is funding of

the Norwegian Centre for Addiction Research (SERAF) at the University of Oslo. In spring 2011, the Research Council concluded an evaluation of the centre's activities. The evaluation recommended that SERAF be granted funds for a new period. A preliminary summary has also been produced of existing knowledge in the projects in the programme. The main impression is that the quality of the projects is generally good, and that there is great variation in research questions and methods.

Other important research communities in the drugs and alcohol field are the Norwegian Institute for Alcohol and Drug Research (SIRUS), the Institute of Public Health and important treatment institutions in the health authorities.

The Directorate of Health is in the process of preparing a series of guidelines and guides for the drugs and alcohol field, with the aim of contributing to more knowledge-based practice. The seven regional drugs and alcohol competence centres and the county governors are tasked with maintaining, developing and disseminating expertise in the field, and with initiating and implementing government measures in the individual regions. The competence centres collaborate with the county governors on measures adapted to the needs in the municipalities, among other things by providing continuing and further education, interdisciplinary networks/arenas in the regions and courses to raise the level of basic knowledge about drug and alcohol problems.

Quality shall also be raised in the public and voluntary sector through making the grant schemes more performance-oriented. In addition, continuous efforts are being made to develop better statistics for municipal services for persons with drug or alcohol problems and better reporting of treatment data from the Norwegian National Patient Register.

The Directorate of Health has been tasked with assessing systems for relevant reporting on drugs and alcohol-related work and mental health care in the municipalities. The goal is to obtain good

data on the service recipients, assistance and service needs, and the use of resources in municipal work on drug and alcohol problems.

The Uni Rokkan Centre has carried out an evaluation of the provisions on forced treatment in the Social Services Act in relation to drug addicts and alcoholics.<sup>7</sup> The report addresses the question of whether it is necessary to change the rules, and it points out that a need to revise the rules on certain points has been identified. The Directorate of Health has been tasked with following up the evaluation.

### **More accessible services and greater social inclusion**

In 2011, grants totalling EUR 50.88 million (NOK 407 million) were awarded to municipal drug and alcohol work to around 300 municipalities.

The Action Plan is intended to contribute to improving services for people with drug and alcohol problems and to support the work on the Coordination Reform. The goal is to provide the users with comprehensive services characterised by quality and accessibility. In line with the Coordination Reform, the services and the municipalities' competence in early identification of drug and alcohol problems and early intervention, especially in relation to children and young people, must be improved. See Chapter 3 for a more detailed description of measures. The capacity of the services for people with drug and alcohol problems has increased, both in the specialist health service and in the municipalities. In 2010, around 23,000 patients received interdisciplinary specialised drug and alcohol treatment. The figure includes both patients with alcohol problems and patients with drug problems.

A waiting list guarantee was introduced in 2008 for children and young people under the age of

23 with mental health problems and/or drug or alcohol problems. The waiting list guarantee means that all assessments must be made within ten working days and that all treatment must have commenced within 65 working days. This has resulted in more people receiving treatment within the deadline.

The voluntary sector has also been strengthened (see Chapter 1.3). Activities cover the whole range of measures, with the main emphasis on rehabilitation, follow-up/motivation and social participation /aftercare. Grants are also awarded to a number of projects and organisations run by and for users.

The correctional service has adopted a comprehensive drugs and alcohol strategy to ensure better rehabilitation and treatment of inmates and convicted persons with drug or alcohol problems. The strategy and the measures are described in more detail in Chapter 11.

Through the Action Plan, the collaboration between the correctional service, the health services and other services has been strengthened. The number of inmates serving their sentence in an institution, either in the specialist health service or in other institutions, is increasing. Work is also under way on strengthening coordination between the services upon release, cf. the Government's return-to-society guarantee, and on increasing the number of people who receive an individual plan and on the trial scheme of suspended sentences with drug courts. The scheme is currently being evaluated by SIRUS.

In 2010, 511 persons were transferred to serving sentences pursuant to the Execution of Sentences Act section 12. It is an express goal that far more inmates shall receive this offer than today. The individual measures in the prisons are described in Chapter 11.

### **Binding cooperation**

The Directorate of Health has allocated grant funding for the testing of models that ensure a continuous and coherent treatment

<sup>7</sup> The use of force in relation to drug addicts and alcoholics. Evaluation of the Act relating to social services sections 6-2, 6-2a and 6-3 (June 2010).

and rehabilitation process. Grants have also been allocated to mapping/raising competence in relation to coordination problems and different target groups' need for comprehensive services and interdisciplinary cooperation between health and care services and other sectors. Work and activity have been emphasised in particular. The use of individual plans must be increased in order to ensure more coordinated services for users.

Municipal drug and alcohol policy action plans are intended to help to ensure better coordination of drug and alcohol policy. About three-quarters of the Norwegian municipalities have now drawn up such action plans. In 2011, SIRUS conducted a study in selected municipalities to investigate the effect of these plans. The report emphasises the importance of political involvement and support, but it points out that much work remains to be done before the intentions behind the action plans have been achieved (see also Chapter 3.1.1).

Next-of-kin, and especially children, are a vulnerable group whose problems will be better addressed through the Action Plan. In 2011, the Institute of Public Health has established that many children live in families in which there is mental illness and/or drug or alcohol problems, and studied the consequences of this.

Children as next-of-kin of problem drug and alcohol users have been given a stronger entitlement to follow-up. The child welfare service has been strengthened, and several conferences have been held on the topic of children as next-of-kin. In 2011, the Directorate of Health established an online next-of-kin portal containing information about services for and the rights of next-of-kin and, if relevant, users. A training package will also be produced for services that target next-of-kin.

The user perspective is important in all work in the drugs and alcohol field, and the user organisations have been strengthened through the Action Plan. User participation is a requirement

in grant schemes, and the county governors and the competence centres are working together with the user organisations to develop measures/projects.

Self-organised self-help is an important focus area. In 2010, the nodal point for self-help, *Selvhjelp Norge*, focused on the drugs and alcohol field in particular. The strategy is regarded as being a success, and the drugs and alcohol field will be an integrated part of the work on self-organised self-help in the years ahead.

### **1.3 Work organised by voluntary organisations etc.**

In 2011, EUR 20.6 million (NOK 165 million) was awarded to 103 measures. The allocation covers grants for the follow-up, care and rehabilitation of people with drug/alcohol addiction and/or with experience of prostitution, organised by voluntary and charitable organisations. Self-help groups and interest groups and work with next-of-kin will also receive funding.

The purpose of the funding is to support the work of voluntary and charitable organisations in relation to people with drug or alcohol problems. The intention is that the initiatives that receive funding will supplement public services and contribute to improving and coordinating the overall efforts aimed at the target groups. Emphasis will be placed on the organisations' ability to document cooperation with the municipality, and on the establishment of a system for user participation.

The grant recipients cover the whole range of measures, with the main emphasis on rehabilitation, follow-up/motivation and social participation /aftercare. Grants are also awarded to a number of projects and organisations run by and for users. The grant scheme was evaluated in 2010 by the International Research Institute of Stavanger . The evaluation recommended drawing a clearer distinction when allocating funding between operating grants for institutions that



provide in-patient treatment and more short-term projects and measures. This will be achieved by adopting different grant regulations for the different target groups. Further follow-up of the evaluation will also be a topic addressed in the upcoming white paper.

### **Regional competence centres for the drugs and alcohol field**

For 2011, a total of EUR 16 million (NOK 128 million) was allocated to the seven regional drug and alcohol competence centres. The grants aim to strengthen organisation, competence and quality development in the drugs and alcohol field. The grants will be used:

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

Each competence centre has been assigned responsibility for one or two national areas of expertise. In 2010/2011, the centres have focused on three priority areas in particular:

- better coordination of the municipalities' work in the drugs and alcohol field based on drugs and alcohol policy action plans,
- boosting the municipalities' competence in relation to local preventive measures,
- raising competence in early intervention.

A number of method development projects were carried out in the period 2007–2010. The projects target children of parents with mental health problems and drug or alcohol problems, at-risk youth, pregnant women, employees at work, students in schools, patients at GPs and in hospitals. The projects will be reviewed and experience communicated to other regions. See also Chapter 3. An evaluation of the competence centres will be completed by the turn of the year 2011/2012.

## **1.4 The question of introducing heroin-assisted treatment**

In June 2009, the Storting asked the Government to organise a so-called consensus conference at which both expert communities and user organisations could discuss professional, ethical and priority-related aspects of offering heroin-assisted treatment to drug addicts in Norway.<sup>8</sup>

On assignment for the Ministry of Health and Care Services, the Research Council of Norway organised a conference of this kind in June 2011. The appointed panel submitted its consensus report to the Ministry in September. It recommended not initiating a trial scheme for heroin-assisted treatment. The panel concluded that the knowledge basis for introducing heroin-assisted treatment in Norway is weak, especially because of the following factors:

'A large proportion of those who constitute the intended target group for heroin-assisted treatment are not included in the international studies of such treatment. The intended target group consists of problem users of heroin who do not make use of other treatment and who are capable of adapting to the stringent regime that heroin-assisted treatment represents. Little knowledge is available about how this group might benefit from an offer of heroin-assisted treatment. A clearer definition of the target group for a measure of this type is in any case required, so that the treatment is adapted to the patients, and not the other way round.

The panel finds that the effects of heroin-assisted treatment are only moderately better than the effects of other substitution treatment (with methadone or buprenorphine). International studies show a high drop-out rate in the course of a few years of the treatment. There are indications that the drop-out rate is greatest among patients with a weak social network, poor health and poor

<sup>8</sup> Document no 8:93 (2008/2009), cf. Recommendation no 326 (2008/2009) to the Storting.

social functioning. There is much to indicate that the effects of heroin-assisted treatment are weakest for those in the target group who are in greatest need of an alternative or extended offer of substitution treatment.’

The Ministry will follow up the question of heroin-assisted treatment in the coming white paper on drugs and alcohol policy.

## 1.5 Economic analysis

It has proven difficult to calculate the costs to society of drug and alcohol use. This is partly because problems caused by use and abuse of alcohol and drugs are difficult to translate into monetary terms, and partly because of different views of what cost components should be included in such a cost estimate. Calculations that have been carried out vary with respect to what costs are included, and the studies are not very comparable. Over and above establishing that the costs are significant, we do not find it

justifiable to stipulate a more specific amount before a reliable calculation model exists.

The Norwegian welfare model is largely based on universal design, rights and integrated solutions. Drug and alcohol problems and costs relating to such problems are difficult to isolate, and coming up with a figure that only relates to drugs and alcohol is very difficult in practice. It is common to describe drug and alcohol problems as complex and to say that they must be seen in conjunction with other closely-related areas. This applies to both prevention and treatment. For example, early intervention will address the incipient stages of drug or alcohol use and form part of a broader preventive strategy that does not limit itself to drug and alcohol prevention alone. The same applies to the treatment of addiction, which often involves somatic health care, psychiatry and social issues.

## 2. Drug use in the general population and among specific targeted groups

### 2.1 Drug use in the general population

SIRUS has conducted surveys of the Norwegian population's use of alcohol and drugs since 1968. The surveys are normally carried out every five years. The most recent survey was carried out in autumn 2009, and the data were presented in the National report for 2010, Chapter 2. The drugs questionnaire was part of a more comprehensive survey that was mainly concerned with alcohol consumption and attitudes to alcohol policy issues. Data collection in these surveys is carried out in the form of face-to-face interviews, but the questions about drugs were answered on a separate sheet that the respondent gave to the interviewer in a sealed envelope. The data concerning drugs were later linked to the other data from the interview survey. Main features from the 2009 survey:

The proportion of respondents who answered that they had ever tried cannabis had fallen from approx. 16 per cent in 2004 to less than 15 per cent in 2009 (Table 1). The fact that lifetime prevalence has fallen during the past five years is somewhat surprising given the cumulative nature of the variable.

Lifetime prevalence is highest in the 25–34 age group, while both the proportion that have taken cannabis during the last year and the last 30 days is highest in the 15–24 age group. This applies to both 2004 and 2009. What is more surprising is

the relatively strong decrease since 2004 in the proportion that have used cannabis during the last 30 days in the under-35 age group. In 2004 it was 4.5 per cent, while in 2009 it was reduced to 2.1 per cent. This percentage seems to have increased among those over the age of 35. Furthermore, the last year prevalence has also decreased in the 15–34 age group, from a proportion of 9.6 per cent in 2004 to seven per cent in 2009. The decline in the youngest group could also be a sign of a change in the longer term and it may be a contributory factor to the above-mentioned observed decline in lifetime prevalence at the population level (Figure 1).

For the other drugs, the lifetime prevalence has been more stable and at a relatively low level. In 2009 the prevalence for amphetamine is highest, almost four per cent, followed by cocaine at 2.5 per cent. The figures are very small, however, which means chance can result in relatively large changes. In 2009 the prevalence of any drugs, except for cannabis did not exceed one per cent.

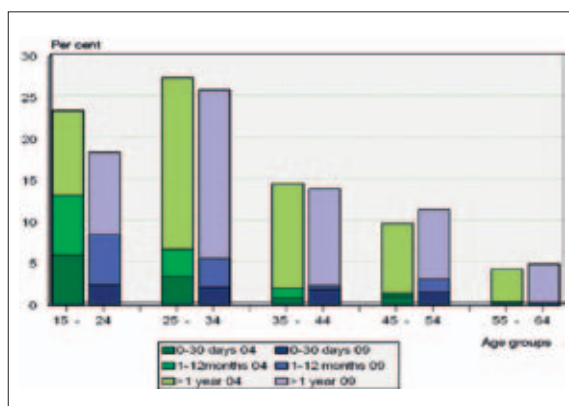
**Table 1: Percentage of the population between the ages of 15 and 64 that have used cannabis: ever, during the last year and during the last 30 days, respectively.**

Used cannabis	1985	1991	1994	1999	2004	2009
.. ever	8.5	9.6	13.1	15.4	16.2	14.6
.. last year	2.2	3.0	4.4	4.5	4.6	3.8
.. last 30 days	-*	-	1.9	2.5	2.2	1.6

\* - = no data available

Source: SIRUS

**Figure 1: Percentage in different age groups in 2004 and 2009 who have taken cannabis: ever, during the last year and during the last 30 days, respectively.**



Source: SIRUS

## 2.2 Drug use among young adults.

### Main findings of a questionnaire survey conducted in 2010 in the 18–30 age group.

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

### Methodology and sampling

The 2010 survey, which forms the basis for the results that are presented here, was conducted in a corresponding manner to previous surveys, based on systematic samples of the population register with the aim of ensuring a representative sample for this age group (Bretteville-Jensen,

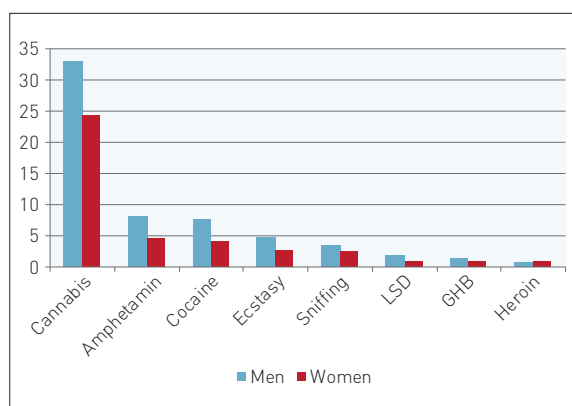
2011). The 2010 survey has been changed on two points, however: 1) the age group was extended to include people aged 18–20 years, and 2) a sample of 2,005 persons recruited via *TNS Gallup's* web panel for the relevant age group was included in addition to the ordinary sample. Some minor changes were also made to the questionnaire.

The sample consists of 4,956 persons in total. Unless otherwise stated, the findings are based on the whole sample, i.e. 18, 19 and 20-year-olds are included. This means that the results here are not directly comparable with the previous three surveys. A report based on comparable data (corresponding sample type and age group), which focuses on changes over time in particular, is being prepared and is expected to be completed by the end of 2011. Preliminary analyses show that lifetime prevalence for the use of cannabis is declining in the 21–30 age group, compared with the 2006 survey for the same age category. The decline found among the general population thus seems to be confirmed by this survey.

### 2.2.1 Data

Figure 2 shows the proportion of young adults who say that they have used various illegal substances *ever* and *during the last six months* prior to completing the questionnaire. As in previous studies, cannabis is the illegal drug that most young people report having tried (28.8 %). Significantly fewer have tried amphetamine and cocaine (approx. 6 % for both). Ecstasy and sniffing have been tried by 3.8 and three per cent, respectively, while around one per cent of this age group report ever having used LSD, GHB and heroin.

**Figure 2: The proportion who report having tried different substances, ever and during the last six months, aged 18–30**



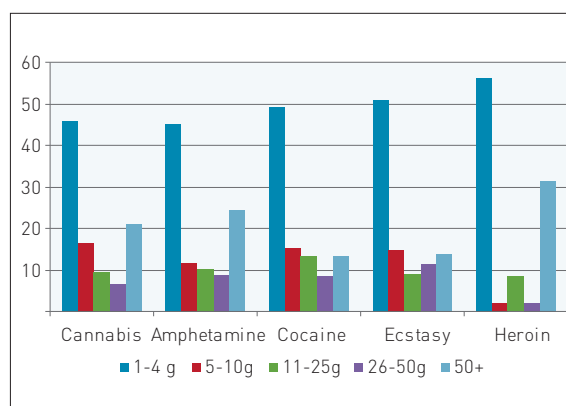
Source: SIRUS

As Figure 2 shows, the number reporting more recent use is significantly lower than the number who have ever tried the different substances. About a third of those who report having experience of the different types of drugs, report that they have used them during the last six months. Nine per cent of the entire sample report relatively recent use of cannabis, less than two per cent have used amphetamine or cocaine and less than one per cent of the respondents report that they have used the other substances during the last six months.

### Frequency of use

Although almost 30 per cent of the sample report having tried at least one illegal substance, the data show that the majority only try this drug a few times (Figure 3). The proportion who have used the different substances once or just a few times is highest for heroin and lowest for cannabis, but even here, 46 per cent of the cannabis users report having used the drug one to four times and 63 per cent report having used it ten times or less. Two out of ten cannabis users report having used the drug more than 50 times during their lives. Heroin deviates somewhat from the other drugs in that more than 30 per cent of those who report use state that they have tried the drug more than 50 times. The number of persons who report heroin use is nonetheless very small (n=45).

**Figure 3: Frequency of use among those who report having tried different substances, as a percentage, aged 18–30**

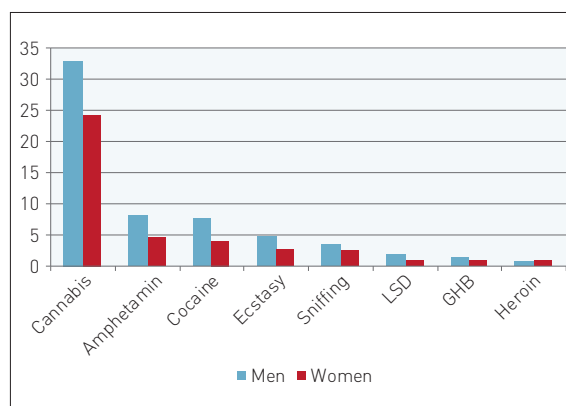


Source: SIRUS

### Gender and age distribution

More men than women state that they have tried different drugs (Figure 4). The difference between women and men is statistically significant for cannabis, amphetamine, cocaine, ecstasy and LSD. This means that the gender differences are greater than can be ascribed to random differences resulting from our using samples instead of total population figures. Nine percentage points more men than women report having used cannabis, and almost twice as many men as women report having used amphetamine and cocaine.

**Figure 4: The proportion aged between 18 and 30 years who report having tried different substances in Norway, among women and men**

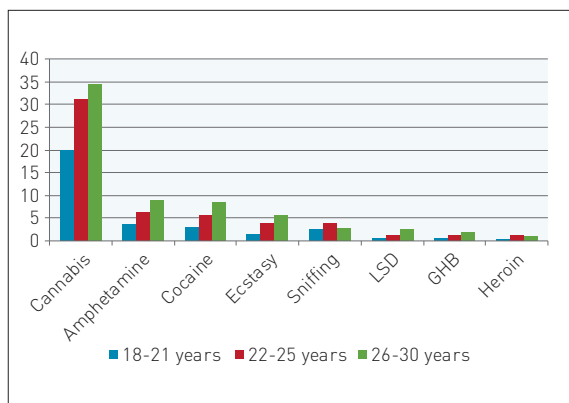


Source: SIRUS

Figure 5 clearly shows that persons in the oldest age category (26–30 years) have more experience

of drug use than the younger age groups. This is to be expected, as the former have had more years to try drugs. For cannabis, for example, we see that, while 20 per cent of the youngest age group (18–21) report having tried the drug, the proportion is 31 per cent among those aged 22 to 25, and 34 per cent in the oldest age category. The difference between the youngest cannabis users and the slightly older ones is nonetheless so great (11 and 14 percentage points, respectively), that it may indicate that the younger users have a lower tendency to try the drug. This is in line with other surveys that show declining cannabis use in the youngest age group (Vedøy & Skretting, 2009, Hibell et al., 2007). It is only in relation to the sniffing of solvents and use of heroin that the proportion among those aged between 22–25 is somewhat higher than in the other age groups, but these differences are not statistically significant.

**Figure 5: The proportion who report having tried different substances in Norway, in different age groups**

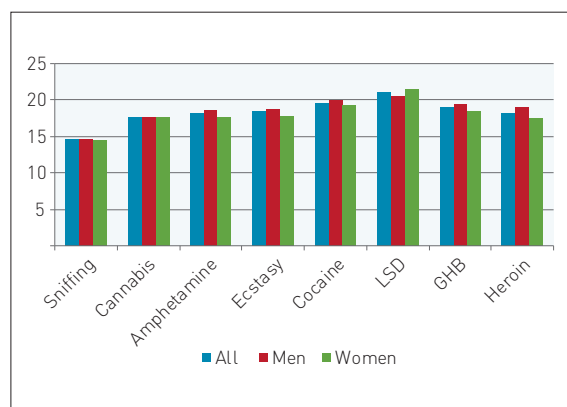


Source: SIRUS

## Debut age

The lowest average debut age in this age group is found for the sniffing of solvents, namely 14.6 years, followed by cannabis (17.7), amphetamine (18.2) and ecstasy (18.4). It is only for the latter two that there is a statistically significant difference between the genders, with women starting somewhat earlier than the men who try these drugs. LSD has the highest average debut age (21 years), followed by cocaine (19.7). The average debut ages for GHB and heroin are 19.0 and 18.1, respectively (Figure 6).

**Figure 6: Debut age for different substances, for men and women separately. Age group 18–30 years**



Source: SIRUS

## 3. Prevention

### Introduction

Preventive work in Norway is based on a long-term, continuous perspective. In recent years, prevention in Norway has been rooted in the Government's Action Plan. The plan 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 harmful effects. Public support of 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. It is a goal that preventive work in the drugs and alcohol field (and in mental health) shall be a natural part of the municipalities' work on health promotion. The Norwegian Directorate of Health's task is to contribute to local implementation of preventive measures that are in line with official policy. The seven regional competence centres for alcohol and drug tasks are key partners in coordinating and improving local prevention in the municipalities. Preventive work of various kinds and on a varying scale is ongoing in all municipalities.

### 3.1 Universal prevention

#### 3.1.1 Community

##### Competence-raising in the municipalities

The Directorate of Health and the seven regional drug and alcohol competence centres cooperate with the aim of increasing the municipalities' competence in drug and alcohol prevention work in general. The county governors also contribute to this work. The municipalities are responsible for quality assuring and developing a local drugs and alcohol policy that helps to reduce the negative consequences of drug and alcohol use for

individuals and society. One important goal is to coordinate and strengthen local prevention efforts. Competence-raising measures target key personnel in the municipalities (administrative decision-makers, politicians, relevant sector managers, the retail and licensed trades, the police, health personnel, local school managers, teachers, parents/guardians and voluntary organisations).

One example of local competence-raising measures is PREMIS, a programme for coordinating drug and alcohol prevention work that was initiated by a regional competence centre in Central Norway. The programme is linked to the intersectorial partnership in health in two of the counties in Central Norway. It aims to contribute to raising competence in the municipalities, the implementation of knowledge-based measures and network-building between the municipalities. The main goals of PREMIS are:

- To reduce the incidence of binge drinking among youth
- To raise the debut age for alcohol use
- To reduce the use of drugs among young people

All the municipalities in the region are invited to join PREMIS for a period of three years. The programme has certain fixed, overriding elements relating to the implementation of the process, but the participating municipalities are free to organise the local work themselves and to choose preventive measures based on local needs. Each municipality appoints a local interdisciplinary working group and a coordinator. The municipalities are offered free courses, access to a 'toolbox' of methods and measures, professional guidance and follow-up, and opportunities for network building with other municipalities. The programme was first developed, implemented and evaluated as a pilot project in the period 2006–2008.

In order to learn from experience of this way of working, the evaluation focused on how the work was carried out in the municipalities. The evaluation did not focus on measuring the effects of the measures.

Different disciplines and agencies have been represented in the local PREMIS groups. This has helped to give those involved greater insight into, understanding of and respect for each other's work situations. An important success criterion for the work on PREMIS was good backing from the municipality, i.e. support at different levels in a municipality, from both politicians and experts. This was important in order to win acceptance for preventive measures.

The evaluation indicated that PREMIS has contributed to raising the competence of people in the municipalities, strengthened interdisciplinary/inter-service cooperation, helped with the systematisation of existing measures and, not least, laid a foundation for further work on drugs and alcohol prevention. Four out of five pilot municipalities are still running measures that were implemented when they participated in PREMIS, three years after the end of the PREMIS period. Since its start-up in 2005, 24 municipalities have participated or are participating in PREMIS.

### **Action plans in the field of drugs and alcohol policy**

Pursuant to the Norwegian Alcohol Act, the municipalities are required to prepare alcohol policy action plans. Several other laws also assign the municipalities tasks in the drugs and alcohol field. Based on the intentions of the act and the municipalities' own needs, the municipalities are encouraged to pursue a coherent drugs and alcohol policy, and to have a plan for this work in which drugs and alcohol policy challenges are seen in conjunction with licensing arrangements, other preventive efforts and rehabilitation. The Directorate of Health, the regional competence centres and the county governors assist the municipalities in the development and implementation of such plans. Just under three-quarters of

the 430 Norwegian municipalities now have drugs and alcohol policy action plans, compared with about a third in 2004. In other words, there has been a considerable increase in the number of municipalities with such plans.

On assignment for the Directorate of Health, SIRUS has carried out an in-depth study consisting of qualitative interviews, participatory observation at meetings and document analyses in eight selected municipalities in order to shed light on the importance of such plans (Baklien & Krogh, 2011). The report covers both the process in connection with the plan, the actual plan itself and what effects the action plans seem to have had.

The evaluation points out that, for those involved, the plan processes generate enthusiasm, increase awareness and knowledge, and put the topic of drugs and alcohol on the agenda. When the plan gets as far as to the municipal council, however, the outcome is often that not very much happens. To the extent that there is debate, it usually concerns sales and licensing hours. Care and rehabilitation initiatives are seldom the subject of political debate. How far politicians feel ownership to the plans varies a great deal. It is the practitioners who feel the clearest ownership to the plans and who use them actively. As a whole, the plans have probably failed to have the big and noticeable effect on municipal drugs and alcohol policy that was hoped for. There is basically not much politics involved in the processes, products and consequences. This indicates that a lot remains to be done for the intention behind the drugs and alcohol policy action plans to be realised.

The selection of municipalities was based on including different regions, municipalities of different sizes and political colour, that varied in terms of organisation and the degree of involvement of the competence centres. Questions can nonetheless be raised about representativeness, since the study only covers a small minority of the municipalities that have prepared such action plans.



### **The municipalities' control of the sale and serving of alcohol**

Norwegian legislation relating to alcohol contains many provisions aimed at limiting accessibility, including a licensing requirement, age limits for the sale and serving of alcohol, sales and licensing hours, and restrictions on serving/selling alcohol to people who are clearly under the influence of alcohol or drugs. It is the municipalities' responsibility to enforce the provisions of the law in this context. Surveys show that municipal control of the sale and serving of alcohol is not good enough. On the basis of a project carried out by the Directorate of Health in collaboration with the regional competence centres in 2009/2010, the directorate is now preparing a guide to inspections aimed at municipalities and sales and licensed premises inspectors. One of the goals is to establish a national norm/standard for good inspections and procedures. The guide is being developed in collaboration with the National Police Directorate. A number of competence-raising measures have also been carried out for the municipalities.

#### **3.1.2 Family**

##### **Parents' role in drug prevention**

One important aim of the Action Plan 2008–2012 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 is young people and parents, who are to be given a more active role as contributors and mediators in local preventative work. One important goal is to help develop good, safe local communities.

One of the regional competence centres is dedicated to collecting more information and knowledge about this topic. The centre follows a five-year plan for this work. Conferences, seminars and various programmes will contribute to spreading information and involving parents more in preventive work. During the past year, the competence centre has, among other things, worked on translating the Swedish Örebro Prevention Programme into Norwegian and

adapting it to Norwegian conditions. Various local projects have also been initiated in several municipalities to strengthen the work.

#### **3.1.3 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. Based on recent relevant research in the field, the Directorate of Health and the Directorate for Education and Training will publish a new, electronic guide in autumn 2011 for schools' preventive work in the drugs and alcohol field.

The guide is intended to help to spread new knowledge about how schools can best contribute to drugs and alcohol prevention work and to provide national recommendations for the whole country. The guide focuses on important elements that form the basis for coherent, knowledge-based prevention: a good learning environment, cooperation between the home and school, adapted tuition, social competence, methods that activate pupils and authoritative classroom leadership. The efforts that are implemented must be theoretically well-grounded, have a clear implementation strategy and a long-term perspective. The guide is linked to the national curriculum, which, in some subjects and for selected years, contains clearly defined competence goals relating to drugs and alcohol. The home/parents and the school health service are key partners.

### **3.2 Selective prevention, at-risk groups and settings**

Pursuant to the Government's Action Plan, services shall be available to children and young people who are particularly at risk of developing drug or alcohol problems.

Six measures in the plan are intended to contribute to early intervention and greater accessibility of services for children and young people:

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

Work on all the measures is under way. Among other things, a training package has been developed for staff in relevant services. The guide *Fra bekymring til handling* (From Concern to Action) (see NR 2010 Chapter 3.3.1) was launched in autumn 2009. It makes an important contribution to early intervention efforts by providing guidance for service staff and managers.

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

A study was carried out in 2010 of the prevalence of mental health and drug and alcohol problems among young people and their further treatment and follow-up needs. The final report is expected to be completed by the end of 2011.

### 3.2.1 At-risk groups

About 30 methodology development projects have been initiated in different municipalities. The projects largely target at-risk young people aged between 11 and 23, children of problem

drug and alcohol users and parents with mental illness, and early intervention in relation to pregnant women and parents of infants and small children. Work is currently under way on summarising the results of the project, which will be used to identify 'best practice'.

### Continuation of the 'Ut av tåka' (Out of the fog) quit smoking hash course in Oslo

The course is a continuation of the Outreach Service's quit smoking hash course in Oslo in 2006/2007. See NR 2010 Chapter 3.2.1. It is based on intersectorial support and cooperation, and on the systematic development of local methodological competence based on experience from Sweden and Denmark. There are two target groups: youth aged between 15 and 25 who are motivated to stop using cannabis, and first-line employees in the city wards whose day-to-day work involves contact with these young people. The initiative has helped professionals to develop their competence so that they are able to offer young people in their ward an opportunity to stop on a group and individual basis. Young people are reached earlier than before.

The Outreach Service, the Oslo Drug and Alcohol Addiction Service Competence Centre and the SaLTo secretariat (SaLTo – Model for collaboration between the City of Oslo and Oslo Police District on crime-prevention work among children and youth) have produced a description of an initiative outlining an offer to young people with an addictive relationship to cannabis. It includes the 'Ut av Tåka' programme. The offer is comprehensive and is based on high accessibility to the target group and unbureaucratic referral procedures.

The goal is to:

- Establish an offer for young problem users of cannabis
- Establish and develop an intervention in all interested city wards
- Spread knowledge about the method, the initiative and cannabis addiction
- Seek contact with Norwegian and Swedish networks in the prevention and rehabilitation of problem cannabis use.

Great demand has been registered for know-how about cannabis and the treatment of cannabis problems. There is reason to believe that courses aimed at weaning people off cannabis reach young people who would not otherwise seek help for their drug problems. Increased focus on and knowledge about cannabis in the help services will also help more young people to seek help for their problems at an earlier stage.

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

In cooperation with the City of Oslo's Health and Welfare Service, the Oslo Drug and Alcohol Addiction Service Competence Centre has carried out a project where ICDP groups focus on the topic of drugs and alcohol (described in more detail in NR 2010 Chapter 3.2.1). The aim of ICDP (the International Child Development Programme) is to influence the carer's positive experience of the child/youth in order to get the carer to more readily identify and empathise with him or her. The ICDP courses have been completed and the report is in preparation. The feedback from ICDP counsellors indicates that the project has produced good results in terms of participation and a mutual increase in knowledge. There were challenges during the start-up phase relating to the recruitment of participants, but there were no drop-outs once the course got started. The preliminary conclusion is that the courses seem to have had a positive effect on the participants in relation to network building, strengthening of the role of parent and increasing knowledge about society and drug problems.

### **3.2.2 At-risk families**

Children of parents with drug or alcohol problems and/or mental health problems and children who have been exposed to violence or traumatic experiences are particularly at risk of developing drug or alcohol problems themselves. It is important to ensure that everyone who is at particular risk of developing such problems and people with incipient drug or alcohol problems are discovered at an early stage and that they are offered the correct help as early as possible. Early intervention in relation to children often involves intervening in relation to the adults in the child's life, while early intervention in relation to youth, adults and older people is often about getting to grips with risky alcohol consumption.

The guide 'Fra bekymring til handling' (From Concern to Action) has been implemented in many municipalities during 2010. See the description in NR 2010 Chapter 3.3.1. The recommendations in the guide are followed up by competence-raising initiatives in the municipalities organised by the regional competence centres. Link:

([http://www.helsedirektoratet.no/vp/multimedia/archive/00334/IS-1742\\_Engelsk\\_Eng\\_334559a.pdf](http://www.helsedirektoratet.no/vp/multimedia/archive/00334/IS-1742_Engelsk_Eng_334559a.pdf))

### **Competence raising**

In collaboration with the regional competence centres, the Directorate of Health contributes to raising competence in use of the 'early intervention' method in the municipalities and the specialist health service, among other things through increased use of mapping tools with follow-up conversations (mini-interventions).

In 2010, the Directorate of Health and the Directorate for Children, Youth and Family Affairs developed a national training programme that provides training in mapping tools (TWEAK – uncovering risky consumption of alcohol, and depression and violence in close relationships) and conversation methods targeting pregnant women and parents of small children. The programme is offered to the municipalities free of

charge. The training programme is being tested in five municipalities (one municipality in each region – North, Central, Eastern, Southern and Western Norway) and it is offered to relevant employees/services (doctors, midwives and health visitors, kindergartens/schools/NAV). The training programme is approved by the Norwegian Medical Association as conferring formal competence. The training programme is being evaluated by SIRUS. The report will be available in 2012.

### Website

The Norwegian Electronic Health Library runs a website on behalf of the Directorate of Health and the Directorate for Children, Youth and Family Affairs: *Screening and mapping tools for use in work with parents, pregnant women and children of parents with mental health problems and/or drug or alcohol problems.*

<http://www.helsebiblioteket.no/microsite/Kartleggingsverktøy>

## 3.3. Indicated prevention

### 3.3.1 Early intervention

From 2010, all the competence centres in the drugs and alcohol field have three trained instructors in MI (motivational interviewing), which is a knowledge-based method (for change). They will contribute to competence-raising in municipalities that work on early intervention in particular. The interviewing method is suitable in many contexts when it is desirable to encourage another person to change his/her behaviour and it is very suitable for conversations about lifestyle changes in the health and care sector.

### Self-help programmes

There are many digital self-help programmes aimed at people who wish to change their use of or addiction to alcohol, cocaine or cannabis. The programmes are freely available on the internet. Self-help programmes are aimed at people with mild to moderate drug or alcohol problems, who live in stable living conditions and have contact

with friends, relatives or colleagues. The course/self-help is not suitable for persons with a long history of problem drug or alcohol use.

Links: The Bergen Clinics Foundation/ the Bergen Drug and Alcohol Addiction Service Competence Centre: *Online self-help programmes, alcohol, cannabis and cocaine.*

<http://www.bergenclinics.no/index.asp?strUrl=1001996i&topExpand=&subExpand>

AKAN's *Balance, Alcohol:*

<https://program.changetech.no/ChangeTech.html?Mode=Trials&P=H8V8X8&C=HJ04HX>

### 3.3.2 Outreach work

There is long-standing tradition for outreach work targeting young people. It is an important part of the preventive efforts in Norway. The main focus is on early intervention. In this context, early intervention means reaching youth in high-risk milieus as early as possible. While outreach work among young people is part of the municipality's general responsibilities, it is not a statutory responsibility.

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

The Norwegian Association for Outreach Work With Youth (LOSU) represents most of the country's 60 outreach workshops, counting some 250 street educators. Link: [http://www.losu.no/index.php?option=com\\_content&view=category&layout=blog&id=102&Itemid=55](http://www.losu.no/index.php?option=com_content&view=category&layout=blog&id=102&Itemid=55)

In 2010, LOSU has, among other things:

- Organised four regional conferences for outreach services in Norway to strengthen the professional preventive approach in outreach methodology
- Prepared and distributed a professional guide for small outreach services
- Prepared and distributed a professional guide for outreach social work on the internet
- Contributed to the development of an international methodology textbook for outreach social work
- Had close contact with central authorities concerning social and legal challenges relating to unaccompanied minor asylum seekers and young people who are victims of human trafficking
- Taken part in international cooperation. LOSU is a key member of the global association for outreach social work, Dynamo International, which is based in Brussels
- Helped to organise a big international conference in Oslo. The topic was 'Perspectives on Outreach Work in Europe'. Plans are under way for a new conference in 2012. These conferences are organised under the auspices of the Oslo Drug and Alcohol Addiction Service Competence Centre.

The biggest outreach services come together in a dedicated network twice a year to exchange information and experiences from work in the big cities and towns in Norway. Bergen Outreach Service has adapted the *Rapid Assessment & Response* method as an analytical approach to social issues in outreach work. The method was originally developed by the World Health Organisation (WHO). The use of this method is on the increase in the outreach field.

Work on tacit know-how and the use of so-called reflecting teams is now well established in the outreach services in Oslo and Bergen. Reflecting teams are a method whereby the members of the outreach team are given an opportunity to focus

on tacit know-how in their work. Both services have given lectures on the method both in Norway and abroad – often in collaboration with the Oslo Drug and Alcohol Addiction Service Competence Centre. Part of the method consists of reflecting team sessions being held 'live', linked to a specific situation that the field workers or others bring with them from their work.

### **Motivational interviewing as a method in outreach work**

In 2010–2011, the Oslo Drug and Alcohol Addiction Service Competence Centre carried out a pilot group project with the aim of systematically testing the use of motivational interviewing (MI) in outreach work. Ten former students with further education in outreach social work who now work in six different outreach services were given the chance to take part in a guidance group in which experience of the use of MI in outreach work was to be reviewed and further developed. The evaluation of the pilot group indicates that MI is a highly expedient approach to outreach work, but it also seems to be the impression that implementing MI requires relatively extensive training and support in the process of changing one's own practice. The Oslo Drug and Alcohol Addiction Service Competence Centre is starting a new guidance group in MI for outreach services staff this autumn. There is great interest in participating.

### **Further education at university college level**

Topics relating to outreach work are now part of further education programmes at several university colleges. At the university colleges in Oslo and Akershus counties, the Oslo Drug and Alcohol Addiction Service Competence Centre has established a dedicated further education programme in outreach social work (street-based youth work). To be eligible for participation, the students must have a relevant education from a university or university college and be employed in an outreach service. The study programme lasts for one year and is worth 30 credits. This year's class consists of 26 students, 14 of whom are Norwegian field workers, while the

rest are field workers employed in Swedish and Finnish municipalities.

### **The European Correlation Network**

A report from the network on early intervention is currently in preparation. This is a European collaboration network in which one of the focus areas is how to reach at-risk youth at an early stage. The report and the project will be completed in autumn 2011. The Oslo Outreach Service and outreach workers in two city wards have been part of the project, which has also involved collaboration with partners in several European countries.

### **Online registration tool**

With support from the Directorate of Health, the Oslo Drug and Alcohol Addiction Service Competence Centre has worked during 2010 and 2011 on creating a new online registration tool for outreach services. The programme, which will be tested in ten municipalities, could lead to new procedures for the documentation of practice in outreach services. At the same time, it

results in better information security in connection with the registration of personal data (patient records etc.), and the submission of statistics to local and central authorities, and it creates new possibilities for improved registration and handling of governing data for the development of the services. During 2011, the new registration tool will be introduced in ten pilot municipalities throughout Norway. The project is to be evaluated in 2012–2013, and the possible continuation and wider introduction of the tool in more municipalities will be considered in this connection.

## **3.4 National and local media campaigns**

No recent media campaigns have been aimed at the use of drugs in particular. There have been several extensive national information campaigns in connection with alcohol, however. These campaigns were described in the national report for 2009. They were continued in 2010.

## 4. Problem drug use

### 4.1 Prevalence and incidence estimates of PDU

See data in Standard tables 07 and 08.

#### Definitions

The EMCDDA defines problem use as ‘Injecting use of drugs *or* prolonged/regular use of opiates, cocaine and/or amphetamines’. Opioids is used as a generic term for natural opiates (such as opium, dolcontin), semi-synthetic opiates (heroin) and synthetic opioids (such as methadone, buprenorphine). This means that everyone undergoing substitution treatment who is prescribed methadone and Subutex are problem users according to the EMCDDA’s definition. Including such groups can appear strange in Norway, where the intention of opioid substitution treatment (OST) is to get people who have used heroin for a prolonged period to begin a life without using illegal drugs, subject to follow-up and rehabilitation.

In the Norwegian context, however, it might be natural to look at a subgroup of patients in OST as problem users. Around 12 per cent of OST patients report using morphine substances in addition to OST medication during the last 30 days, and 17 per cent have been found to use stimulants. There has also been an increase in the number of persons who move in and out of OST, and who thus may have periods of heroin use between treatment periods (Waal et al., 2011).

In addition to the general definition of problem use, the EMCDDA also uses two underlying definitions: injecting drug users and problem users of opioids or heroin.

In Norway, we primarily have figures for the group that injects drugs, but the number of problem users of heroin in the period 2000 to 2008 has also been estimated (see NR 2009 Chapter 4.2.1 and Bretteville-Jensen & Amundsen, 2009).

Work is being done to calculate how many problem users we have according to the general definition. Figures from the Norwegian National Patient Register for the number of persons who have started treatment for drug-related diagnoses will be a new source of data. See more details in Chapter 5.

#### Calculating the number of injecting drug users

Table 2 shows estimates of the number of injecting users in Norway, calculated using the Mortality Multiplier. The estimates include figures for overdose fatalities from the Norwegian Cause of Death Register supplied by Statistics Norway and from the National Crime Investigation Service (Kripes) up until 2009. Provisional calculations for 2009 from last year’s report have been adjusted upwards to the same level as in 2008. The estimated number of injecting users in Norway increased from the 1970s until 2001, followed by a reduction up until 2003. The figure has since remained stable.

**Table 2: Ranges for the number of injecting drug users in Norway 2002–2009, calculated using the Mortality Multiplier\***

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

\*Round figures  
Source: SIRUS.

The figures include all injecting use. Heroin is still the most common drug injected, but, for some, amphetamine is the main drug injected. The proportion of injecting users in Oslo who inject amphetamine has been increasing and it

was around 17 per cent in the period 2000–2004 (Bretteville-Jensen, 2005).

### Problem users of cocaine

SIRUS has participated in a project in which the amount of cocaine used in Oslo was calculated using three different methods. The Norwegian Institute for Water Research (NIVA) has carried out measurements of cocaine in wastewater, while the Norwegian Institute of Public Health has carried out measurements of cocaine among drivers suspected of driving under the influence. SIRUS has used a method based on the reporting of the frequency of cocaine use in four different surveys, both population-based and among inmates in prisons and injecting users.<sup>9</sup> The results of the surveys have not yet been published (Reid et al.). SIRUS's work on this project can also be used to estimate the number of problem users of cocaine.

The EMCDDA's definition of problem users of cocaine includes persons who have used cocaine or crack over a prolonged period and regularly. SIRUS chooses to define 'prolonged and regularly' to mean having used cocaine at least once a week for at least six of the last 12 months. Recent use of cocaine (during the last six or twelve months) seems to have changed little during the 2000s, and average figures from several different surveys have therefore been used to ensure low statistical uncertainty.

In the questionnaire surveys, the respondents were also asked how often they used cocaine. It is thus possible to calculate an annual average number of cocaine users and the number of persons who used the drug more than once a week or more (problem users). The results for Oslo for the period 2000–2009 are shown in Table 3. On

average, there were approximately 1,800 (interval 1,600–2,000) problem users of cocaine per year in Oslo and 10,200 (9,100–11,300) others who used the drug more rarely.

The majority of the cocaine users, almost 50 per cent, were experimental users who had only used the drug one to four times during the last 12 months, while 35 per cent were recreational users (limited use). Overall, it was thus estimated that 15 per cent of a total of 12,000 persons (10,700–13,300) were problem users of cocaine.

Some marginalised users who use little cocaine may be big consumers of other hard drugs and therefore be included in the general definition of problem users, but on the basis of their use of other substances. No corresponding estimates have been carried out so far at the national level.

**Table 3: Last-12-months cocaine users in Oslo. Annual average 2000–2009**

	Problem users	Other users	Total
Number of cocaine users	1,600–2,000	9,100–11,300	10,700–13,300

Source: SIRUS

**Table 4: Last-12-months cocaine users in Oslo. Annual average 2000–2009. Percentage of the population 15–64 years old**

	Problem users	Other users	Total
15–30 years old <sup>1</sup>	0.4	4.3	4.7 (4.3–5.2)
31–64 years old <sup>2</sup>	0.3	1.3	1.7 (0.6–2.8)
Marginalised users <sup>3</sup>	0.1	0.1	0.2 (0.0–0.4)
Total	0.4	2.5	2.9 (2.6–3.2)

<sup>1</sup> Based on population surveys among 15 to 20-year-olds in 2006–2008 and among 21 to 30-year-olds in 2006 and 2010

<sup>2</sup> Based on population surveys among persons aged 15 year and older in 2004 and 2009

<sup>3</sup> Based on sample surveys among prison inmates in 2002 and among injecting drug users in 2000–2004

Source: SIRUS

<sup>9</sup> The following surveys were used: Surveys of the 15–20 age group in 2006–2008; the 21–30 age group in 2006 and 2010; the population aged 15 and older in 2004 and 2009. In addition, the results are based on a survey conducted among prison inmates in 2002 and among injecting drug users in 2000–2004.



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

Additional information can be found in Structured Questionnaire 27, Treatment programmes, Standard table 24, Access to treatment, and in Standard table 34 Treatment Demand Indicator.

### 5.1 Strategy/policy

During the first half of the 2000s, extensive administrative and organisational changes took place with regard to the treatment of drug and alcohol problems. Through the hospital reform of 2002 and the Administrative Alcohol and Drugs Treatment Reform of 2004,<sup>10</sup> responsibility was assigned to the state-run specialist health service. This reorganisation has led to increased focus on diagnostics, medication and the use of commercial principles in the treatment context. This change has been criticised in several different quarters. It has been argued, for example, that the reorganisation threatens to undermine the diversity of treatment options. Resources appear to be increasingly channelled to so-called evidence-based interventions, the establishment of outpatient clinics, shorter treatment pro-

grammes and more medication. There now seems to be a tendency to prioritise short-term measures and substitution treatment in tender criteria at the expense of social-pedagogical long-term measures and aftercare.

### 5.2 Quality assurance

Two guidelines have entered into force in the course of 2010/2011:

#### **National guidelines for pregnant women in opioid substitution treatment (OST) and follow-up of families until the children reach school age**

On assignment for the Ministry of Health and Care Services, the Directorate of Health has produced professional guidelines for pregnant women in OST and for the follow-up of families until the children reach school age. The guidelines entered into force in May 2011.

The goal is to provide clear, knowledge-based recommendations for the treatment and follow-up of OST patients during pregnancy and while in hospital in connection with the birth, and for follow-up /treatment of the child and the family until the child reaches school age.

The guidelines contain recommendations relating to the whole course of a patient's development. The treatment includes several different areas in both the first-line service (health, social and child welfare services) and the specialist health services (obstetrics, neonatal medicine, child and youth psychiatry and drug and alcohol treatment), and the roles and responsibilities of these services are described in the guidelines.

<sup>10</sup> The state, represented by the regional health authorities (RHAs), took over responsibility for the treatment of problem drug and alcohol users from 1 January 2004 (the Administrative Alcohol and Drugs Treatment Reform). Through this reform, 74 treatment units/institutions (in-patient institutions as well as out-patient units) were transferred to the state as represented by the RHAs. Forty-two of them were privately owned and run, while the other 32 were public. These institutions comprised both in-patient and out-patient units. As a result of the hospital reform effected from 1 January 2002, approximately 30 per cent of the intervention services had already been transferred before 2004, (psychiatric out-patient clinics, drug and alcohol clinics and certain in-patient institutions).

The target group consists of women in OST during pregnancy, their partners, children who have been exposed to methadone or buprenorphine at the foetal stage, and their families.

The guidelines address all professional groups in the municipalities and in the specialist health service that have responsibility for following up these patients. This applies to the health services, but also social services, child welfare services, kindergartens and the school psychological service.

### **National guidelines for opioid substitution treatment of opioid dependency**

The guidelines entered into force in February 2010 and were described in NR 2010 Chapter 11.2. The aim is to provide advice and recommendations in connection with substitution treatment for persons who are addicted to heroin or other opioids.

The guidelines and pertaining regulations replace the framework that was developed when substitution treatment was established as a nationwide service in 1998. The objective is to normalise OST and integrate it with the general health service, to ensure that OST patients receive comprehensive treatment, and, as far as possible, to help to ensure that the treatment offered is the same throughout the country. The guidelines have been prepared on the basis of collated international research on substitution treatment and on clinical experience from Norway.

## **5.3 Treatment systems and organisation**

Treatment for drug and alcohol problems became part of the state specialist health service in 2004. It was designated 'Interdisciplinary specialised treatment for problem drug and alcohol use'. This type of treatment is either provided as part of the specialist health service in the four regional health authorities or at private drug and alcohol institutions that have an agreement with the health authorities for the provision of such services. Interdisciplinary

specialised treatment is organised differently in the different regions. In one of the regions (Central Norway), the treatment is organised in a separate health enterprise, while in the other three regions, the treatment is divided between different health enterprises to a varying extent. About half of the in-patient treatment capacity is provided by private non-profit organisations.

Several of the entities that offer treatment for drug and alcohol problems are organised as part of the mental health care service. The two sectors are closely linked organisationally. There may be professional, organisational or resource-related reasons for this, such as access to professionals. However, not all patients who receive treatment for their drug or alcohol problems are treated in the interdisciplinary specialist treatment sector. Care-based services and low-threshold services are largely defined as a municipal responsibility. On the other hand, there are also patients in the interdisciplinary specialist treatment sector who receive treatment for a mental health problem that is not related to drugs or alcohol.

The Norwegian National Patient Register (NPR), which is a department in the Directorate of Health, is authorised by the regulations of 2009 to collect personally identifiable information about patients in the specialist health service. The purpose is to facilitate quality development and management of treatment provision, and to strengthen evaluation and research activities. The personally identifiable register also enables NPR to quantify the number of patients who receive treatment in the specialist health service. The 'new' way of counting patients is based on encrypted personal identification numbers, not just institution numbers and patient numbers. This means that the new calculation method avoids patients being counted more than once.

### **5.3.1 Treatment provision for patients in interdisciplinary specialised drug or alcohol treatment**

A report for 2009 (the Directorate of Health, 2011) describes the health services offered to patients in interdisciplinary treatment by the sector

itself and by the mental health care service for adults. The presentation of the treatment offered is based on the level of care, and a distinction is drawn between in-patient treatment and outpatient contact.

The data basis consists of information reported by the institutions about patients who have received treatment in the interdisciplinary specialist treatment sector. In all, 40 per cent of the patients in this sector received in-patient treatment in 2009. More men than women received in-patient treatment. Drug problems caused by the use of cannabinoids were more often treated on an outpatient basis, while problems caused by the use of tranquillisers and depressants, stimulants or multiple substances were more often treated through admission.

Patient data for interdisciplinary specialised treatment for 2009 showed that about 60 per cent of completed in-patient stays were followed by outpatient contact. Half of these contacts took place in the course of the first two weeks following discharge, and two-thirds had started outpatient follow-up within 30 days.

In all, 30 per cent of the interdisciplinary specialised treatment patients were also treated by the mental health care service for adults. As regards in-patients, more than 40 per cent were treated by both sectors. It was the youngest patients in particular who were treated by both sectors. While 45 per cent of the patients aged 18–22 were treated in both sectors, the proportion was less than 20 per cent for the oldest patients.

Patients in interdisciplinary specialised treatment who were treated by the mental health care service were younger and more predominantly male than other patients in mental health care. More than 40 per cent of patients in interdisciplinary specialised treatment who were treated by the mental health care service were admitted, while the rest only had outpatient contact with this sector. More drugs/alcohol patients were treated at hospitals when they were admitted to mental health care. Patients in interdisciplinary

specialised treatment accounted for as many as ten per cent of all in-patients treated by the mental health care service, but, because their stays were short, they accounted for a somewhat smaller proportion of in-patient days. Overall, patients in interdisciplinary specialised treatment accounted for about five per cent of patients treated by the mental health care service in 2009.

All entities that offer interdisciplinary specialised treatment are required to report to the NPR. The reporting of activity data from entities that offer interdisciplinary specialised treatment has been mandatory since 1 January 2009, and it also includes registering the patient's situation at the start of treatment (situation data). Personal ID numbers were reported in almost all cases in both 2009 and 2010 (99.6 % and 99.4 %, respectively).

Patient data for interdisciplinary specialised treatment are still incomplete. Deviations between patient data and overall reports to Statistics Norway indicate that some areas remain to be clarified. This also applies to under-reporting, which is most common in the outpatient sector.

### 5.3.2 Waiting times

The Norwegian National Patient Register publishes statistics every four months of waiting times for treatment and violations of treatment guarantees. In interdisciplinary specialised treatment, the average waiting time was 76 days for patients who were entitled to prioritised medical help in 2010, a reduction of two days from 2009, but five days more than in 2008. In the waiting list statistics, a patient can be referred several times since the patients are referred to different discipline areas. This means that the same patient is counted more than once, which leads to the NPR registering more referrals than the number of patients.

## 6. Health correlates and consequences

### 6.1. Drug-related infectious diseases

See data in Standard table 09.

#### 6.1.1 HIV and AIDS

In 2010, 258 cases of HIV infection were reported to the Norwegian Surveillance System for Communicable Diseases (MSIS). Eleven of the cases were among injecting drug users: eight men and three women. The median age was 38 years (26 to 52 years). Five of the eleven who were diagnosed as HIV positive in 2010 were persons of foreign origin. They had probably been infected abroad before coming to Norway for the first time.

As of 31 December 2010, a total of 575 persons had been diagnosed as HIV positive with injecting use as a risk factor. This amounts to 12 per cent of all reported cases of HIV since 1984. Development into AIDS has been reported in 153 of the cases (Table 5). No information is available regarding how many of the HIV-positive injecting drug users are still alive.

The incidence of HIV among injecting drug users has for many years 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 drug user community, combined with a strong fear of being infected and strong internal justice in the milieu, are assumed to be important factors. In addition, many of the sources of infection in the milieu have disappeared due to overdose deaths or have been rehabilitated through substitution therapy or other forms of rehabilitation. However, the extensive outbreaks of hepatitis A and B in the late 1990s and early 2000s, and the high incidence of hepatitis C, show that there is still extensive needle sharing 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.

**Table 5: Notifications of HIV infection and AIDS, Norway 1984–2010. Percentage of injecting drug users by year of diagnosis**

	HIV total	HIV injecting drug use	Percentage HIV injecting drug use	AIDS total	AIDS injecting drug use	Percentage AIDS injecting drug use
1984–99	2,018	442	22 %	675	112	17 %
2000	175	7	4 %	35	5	14 %
2001	157	8	5 %	33	8	24 %
2002	205	16	8 %	34	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 %
2009	282	11	4 %	18	1	6 %
2010	258	11	4 %	22	3	13 %
<b>Total</b>	<b>4,626</b>	<b>575</b>	<b>12 %</b>	<b>999</b>	<b>153</b>	<b>15 %</b>

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

Hepatitis A vaccine has been offered to IDUs free of charge since 2000.

In the period 1995–2008, a considerable increase in hepatitis B among drug users nationwide was reported to the Norwegian Surveillance System for Communicable Diseases. In 2010, only 5 of a total of 27 reported cases of acute hepatitis B involved injecting drug users. During the period 1995–2010, the total number of reported cases of acute hepatitis B among injecting drug users was 1 952. Hepatitis B vaccine has been offered to IDUs free of charge since the mid-1980s.

The monitoring of hepatitis C in Norway was intensified from 1 January 2008. The notification criteria were changed so that all laboratory-confirmed cases of hepatitis C must now be reported to MSIS. Previously, only acute illness had to be reported, and this resulted in a very inadequate overview of the real incidence of the disease in the country. In 2010, 1,792 cases of hepatitis C (both acute and chronic cases) 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, 85 per cent were infected through the use of needles. For the time being, data from MSIS cannot distinguish between cases involving new infection with hepatitis C and cases where the infection occurred many years ago. It is therefore not known whether new infection with hepatitis C has declined or increased among drug users in recent years.

Among OST patients, the status survey for 2010 from the Norwegian Centre for Addiction Research shows that, for the country as a whole, 59 per cent of the clients were hepatitis C antibody positive, roughly the same proportion as in 2009. This is lower than expected, and the explanation is probably that the percentage with unknown status was as high as 16 per cent. In two regions where the percentage with unknown status was low, the proportion of hepatitis C-infected was almost 70 per cent.

Since 2002, small-scale prevalence surveys have been carried out in connection with needle distribution in Oslo in order to register the prevalence of several infectious diseases among injecting drug users. These surveys are the only prevalence surveys that are carried out regularly among a sample of drug users in Norway. The 2010 survey showed that 70 per cent of the IDUs tested had experienced a hepatitis A infection or had been vaccinated against the disease, 34 per cent had had a hepatitis B infection and 67 per cent had experienced a hepatitis C infection. Twenty-seven per cent had hepatitis B markers indicating that they had been vaccinated against hepatitis B.

### 6.1.3 Bacterial infections

In the period 2000–2010, six cases of botulism have been notified among injecting drug users. In addition, one case of anthrax and one case of *Clostridium novyi* were reported in injecting drug users in the same period. In recent years, five to ten cases of methicillin resistant *Staphylococcus aureus* (MRSA) have been reported annually among drug users. There are insufficient data about the incidence of other bacterial infections among drug users in Norway. Tuberculosis is very rarely seen in drug users in Norway.

## 6.2 Other drug-related health correlates and consequences

### 6.2.1 Psychiatric and somatic co-morbidity

Very many patients in mental health care in Norway have drug or alcohol problems, and very many patients in interdisciplinary specialised treatment for drug or alcohol use have psychiatric and somatic disorders.

Studies from Norwegian emergency psychiatric services show a prevalence of drug or alcohol problems of between 20 and 47 per cent (Vaaler et al., 2006, Mordal, 2010). Biological tests show that many patients have taken more than one drug upon admission. Potentially addictive medication was found in about 50 per cent of the

patients, alcohol in 10 per cent and illegal substances in 30 per cent. Findings/traces of illegal substances are most common among men aged 18–36, with amphetamine being found in 40 per cent. (Mordal, 2010).

Counts of patients in mental health care for 2010 (the Directorate of Health, 2011) show that 23 per cent of those who are admitted to mental health care have or are given a drug or alcohol diagnosis. This is a decline from 2007, when the proportion was 29 per cent. The presence of drug or alcohol problems in addition to another primary condition increases the likelihood of readmission to mental health care. Although they are readmitted more often, patients with concurrent drug or alcohol problems and mental health problems nonetheless spend fewer days in treatment than other patients. These patients make more use of in-patient treatment than other patients in mental health care and less use of outpatient services. Behaviour disorder is the most common psychiatric diagnosis among those who are readmitted with concurrent psychiatric and drugs or alcohol-related diagnoses.

The treatment period in mental health care is shorter and the contact with specialists in mental health problems more sporadic for these patients than for others. This makes it difficult to establish the patient's needs and how drug/alcohol treatment and mental health care can be integrated to provide better treatment.

Reports for 2010 show that in 17 per cent of all decisions to forcibly commit people to mental health care institutions, pursuant to the provisions on compulsory mental health care in the Norwegian Mental Health Care Act, the patients had a drugs or alcohol-related diagnosis. In total, there are 1,200 forcible admissions annually of persons with drugs or alcohol-related disorders in the mental health care sector (the Directorate of Health, 2011). There is also an option pursuant to social services legislation of detaining people with drug or alcohol problems without their consent. Forty per cent of those who were forcibly committed pursuant to the Social

Services Act in 2009 had a concurrent mental health problem, but this represents a relatively low number of patients (Lundeberg et al., 2010).

Persons with concurrent drugs/alcohol and mental health problems receive illness-triggered social benefits, such as disability benefit, less often than other patients, and they often lack daily activation measures (Gråwe and Ruud, 2006). The group has a high risk of experiencing homelessness. In the most recent survey of homelessness in Norway (2008), over 6,000 persons were registered as homeless. Twenty-three per cent – i.e. almost 1,500 persons – are assumed to have concurrent drug or alcohol problems and a mental health problem. (Dyb and Johannessen, 2009). This is an increase of 15 per cent from a corresponding survey ten years earlier. The increase may be related to the fact that treatment facilities have poor discharge procedures, and to the downscaling of in-patient provision that is taking place in the mental health care sector without a corresponding increase in residential and follow-up services in the municipalities (Skog Hansen & Øverås, 2007). Surveys of homeless persons with concurrent drug or alcohol problems and mental health problems show that they are often more ill, more down-at-heel and have a longer history of living in marginalised environments than other homeless people.

A Norwegian follow-up survey among 482 clients at 20 different treatment facilities for drug users that was carried out during the treatment and ten years later (SIRUS, 2003) showed a stable and substantial reduction in the clients' drug/alcohol problems, but less experienced improvement in mental health. This may indicate that many people who receive treatment for drug or alcohol problems have under-diagnosed chronic physical and mental problems and that they are therefore not receiving adequate treatment. The problems can become more noticeable as they stop using drugs/alcohol to the same extent as before.

### 6.3 Drug-related deaths and mortality of drug users

See data in Standard tables 05 and 06.

#### Methodological considerations

In Norway, there were two bodies that registered drug-related deaths, Statistics Norway and Kripas (the National Crime Investigation Service). Kripas based its figures on reports from the police districts, while Statistics Norway prepared figures on the basis of medical examiners' post-mortem examination reports and death certificates in accordance with the WHO's ICD 10 codes. Kripas has unofficially announced that it will stop releasing figures for drug-related deaths. Hence, the 2009 figures will probably be the last year of reporting from that source.

With effect from 1996, Statistics Norway's figures have been based on EMCDDA's definition of drug deaths. This broadened the inclusion

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

The WHO revised its coding of causes of deaths relating to drugs and alcohol in 2002. The corrected figures from 2003 onwards show a higher estimate than previously reported by Statistics Norway.

#### Situation and development

Table 6 shows that the figures from both Statistics Norway and Kripas peaked in 2000/2001. In the ensuing years, there has been a considerable reduction in the number of registered drug deaths.

**Table 6: Drug-related deaths 1991–2009. Total number of deaths and broken down by gender. Figures from Kripas and Statistics Norway (underlying cause of death).**

1991–2009	Number of deaths according to Kripas			Number of deaths according to Statistics Norway		
	Men	Women	Total	Men	Women	Total
1991	74	22	96	66	22	88
1992	78	19	97	81	23	104
1993	77	18	95	76	17	93
1994	102	22	124	105	19	124
1995	108	24	132	114	29	143
1996*	159	26	185	173	31	204
1997	149	28	177	160	34	194
1998	226	44	270	228	54	282
1999	181	39	220	191	65	256
2000	264	63	327	302	72	374
2001	286	52	338	327	78	405
2002	166	44	210	240	67	307
2003**	134	38	172	193	62	255
2004	168	55	223	220	83	303
2005	146	38	184	176	58	234
2006	152	43	195	187	64	251
2007	162	38	200	217	58	275
2008	148	31	179	210	53	263
2009	146	38	184	222	63	285
2010	n.a	n.a	n.a	***	***	***

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

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

\*\*\*Figures for 2010 are not yet available.

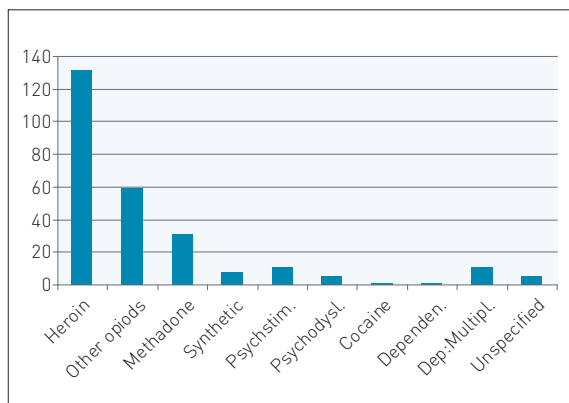
Source: Kripas and Statistics Norway

The reduction since the turn of the millennium is most probably due to the strong increase in the number of clients on opioid maintenance treatment. Both the Statistics Norway 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 mortalities has occurred. The number of mortalities remains high, however.

Concerning the 285 drug-related deaths in 2009 that were recorded by Statistics Norway, 255 deaths involved opioids with or without additional drugs (Figure 7), 137 were deaths due to heroin (X42, X44, X62, X64 + T401), 39 deaths were recorded with methadone poisoning as the underlying cause (X42, X44, X62 + T403), and 61 with other opioids, either as poisoning or dependency (X42, X44, X62, X64 + T402, F112). The remaining 48 deaths broke down as follows: 18 other synthetic narcotics (X42, X44, X64 + T404), four other/unspecified psychodysleptics (X42 + T409), seven psychostimulants (X41, X44, X61 + T436), three unspecified narcotics (X42, X44 + T406), 16 dependence other stimulants and dependence multiple/other (F152,F192), and no deaths from cocaine (X44 + T405).

In 2009, 39 (14 %) of the deaths were coded as suicides, which is probably a conservative estimate of the suicide rate.

**Figure 7: Drug-related deaths in 2009 broken down by specific death. Numbers**



Source: SIRUS and Statistics Norway

In 2009, Kripos recorded 184 deaths, 11 of which were of non-Norwegian citizens. This was the same level as the year before. Many of these deaths are believed to be due to extensive multiple-drug use. In 60 per cent of the deaths, the heroin-specific metabolite monoacetylmorphine was detected, and morphine was found in a further 15 per cent of the deaths. Methadone was detected in 16 per cent of the deaths, while amphetamines and/or methamphetamines and/or cocaine were detected in 28 per cent of the deaths.

In 2009, there were 5,383 patients in opioid substitution treatment (OST) in Norway, 56 per cent of whom were on methadone and 44 per cent on buprenorphine. The 39 deaths due to methadone in 2009, is a somewhat higher number than in 2008 (31). The majority of methadone-related deaths occur among persons not enrolled in the OST programme, and multiple drugs were typically involved. This fact illustrates that it is necessary to strike a balance between access to OST and the need for control measures to limit the 'leakage' of methadone from the OST programme. Additionally, it is generally a challenge to differentiate between deaths caused by methadone and deaths where methadone was present in the blood at the time of death, but not necessarily the cause of death.

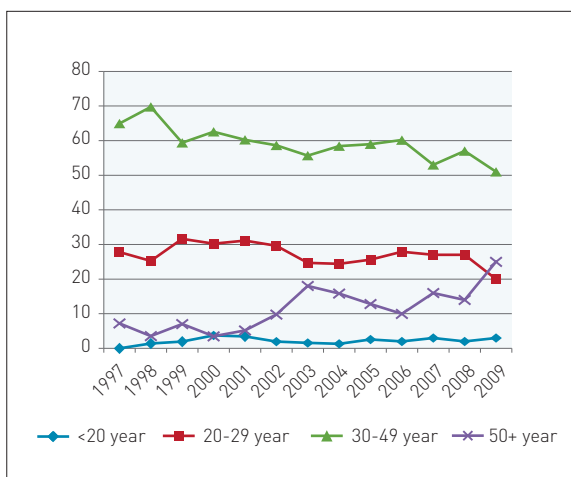
### Age -increasing

Figure 8 shows that the proportion of drug-related deaths among those over the age of 30 has increased steadily. In the 1990s, it had reached 60 per cent according to Statistics Norway statistics. The Statistics Norway statistics show that, for the years 2000 to 2009, the proportion of drug deaths in the 30-plus age group was approximately 70 per cent on average. In 2009, this age group accounted for 76 per cent of the deaths (217 persons). During the same period, the proportion over the age of 50 appears to have increased. In 2009, this age group accounted for as many as 25 per cent of the total number of deaths (71 persons). Five of the deaths were in the 65 years or more age group. The youngest age groups' proportion of deaths has remained relatively stable,



but nine deaths under the age of 20 years in 2009 is the highest number ever registered.

**Figure 8: Drug-related deaths broken down by age group 1997–2009. Per cent**

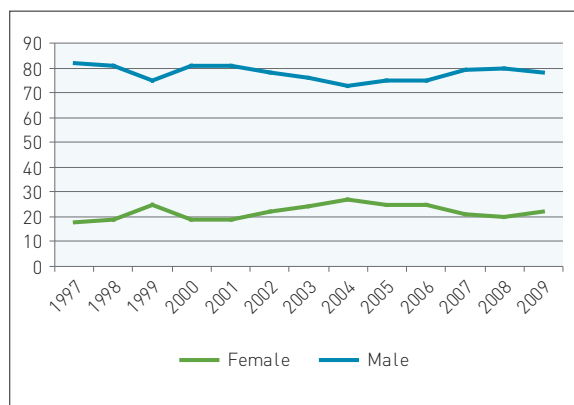


Source: SIRUS and Statistics Norway

### Gender distribution -stable

In 2009, 222 of the deaths were males and 63 females. The proportion of females was 22 per cent, which, seen in a longer-term perspective, seems to be within the ‘normal range’. During the period 1997 to 2009, the proportion of women has varied between 18 and 27 per cent, with an average close to 22 per cent (Figure 9). During the period 1980 to 1990, the average proportion of women was also close to 22 per cent.

**Figure 9: Drug-related deaths broken down by gender, 1997–2009. Per cent**



Source: SIRUS and Statistics Norway

### Data from Oslo

Oslo is the region with most deaths, and 68 Oslo residents died of drug-related causes in 2009. However, a detailed study of drug-related deaths (Gjersing et al., 2011) from 2006 to 2008 revealed that one-third of all drug-related deaths in Oslo involved non-residents. The non-residents who died from drug-related causes in Oslo differed from the Oslo residents by being younger and more often intoxicated by heroin, as well as often being found dead outdoors or in public spaces.

A total of 232 persons under 70 years of age died from a fatal overdose in Oslo between 2006 and 2008. Approximately one-fifth were women and the average age of those who died was 36 years. Among those who died from a fatal overdose, 67 per cent were found at a residential address, whereas 18 per cent died outdoors. Heroin was judged to be the main intoxicant in 66 per cent of the fatal overdoses. Among those between 46 and 70 years of age, strong pain medication was the main intoxicant in one out of every three fatal overdoses. Methadone was the main intoxicant in 10 per cent of the deaths. The number of different substances per case was between three and four on average. The most common combinations of substances were heroin and benzodiazepines, and central stimulants in combination with benzodiazepines or heroin. See also Chapter 7.1.1.

## 7. Responses to health correlates and consequences

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

See also information in Structured Questionnaire 23.

#### 7.1.1 Fatal overdoses in Oslo, Norway between 2006 and 2008. A new study

Both historically and at present, Oslo has a high number of fatal overdoses. In March 2009, the city council therefore decided to investigate possible causes for these high numbers. The Norwegian Centre for Addiction Research (SERAF) at the University of Oslo conducted the investigation. The report was published in March 2011 (Gjersing et al., 2011). It also proposes a number of measures to prevent overdose fatalities. The report has so far not been the subject of political consideration.

#### Methods

Three different methods of investigation were employed:

- An assessment of different registers and patient records, including data from the National Register of Deaths for patients who died in Oslo from a fatal overdose between 2006 and 2008.
- Interviews and focus groups with persons who used or had used illegal and legal substances, next-of-kin of persons who had died from a fatal overdose and professionals from the health, social welfare and criminal justice fields.
- An investigation into how five European cities (Vienna, Frankfurt, Amsterdam, Lisbon, Zurich) had handled the issue of open drug scenes and overdoses.

#### Main features

As mentioned in Chapter 6.3, a total of 232 persons under 70 years of age died from a fatal overdose in Oslo between 2006 and 2008. The majority of those that died (186) had contact with health and/ or social welfare services in the year prior to the fatal overdose. On average, the persons had contact with three to four different services. Many (57 %) had contact with health services and social welfare services within three weeks of the death. Oslo residents had used social welfare services most compared to other services. Non-residents had mostly been in contact with ambulance services.

According to the study, there was an accumulation of deaths within the first weeks after release from prisons, and after completed abstinence-oriented in-patient drug treatment. There was no similar accumulation of deaths in the first weeks after concluding OST for various reasons.

Drug users, next of kin and professionals in the health, social welfare and criminal justice fields described different types of fatal overdoses, such as 'accidental' and 'exhaustion'. The drug users believed the 'exhaustion' overdoses were related to their general living conditions. The experience of social isolation, recent breakdown(s) of relationship(s) and many subsequent overdoses were described as risk factors for new overdoses. At the same time, it appeared as though professionals in the social welfare services and public (municipal) drug services did not generally ask about experiences with overdoses and/or suicidal intentions. This investigation has shown that there are many different factors related to fatal overdoses and that these are complex matters.

Health and social welfare services in Oslo were described as fragmented and lacking in written

procedures for overdoses, and with minimal interaction and flow of information between services. Interviewed next-of-kin had to a varying degree been informed and participated in the treatment and follow-up of the person they were related to. They had not experienced being seen, followed-up or been supported by health or social welfare services.

Professionals in the health and social welfare services had experienced the principle of confidentiality as an obstacle to collaboration and information exchange between services. In addition, they stated that there were various interpretations of drug problems and how issues related to them should be dealt with. Many felt powerless in their work with persons who were at risk of overdoses, and high turnover of staff was also a challenge. However, they all wanted to further develop work on the prevention and treatment of overdoses.

All those who were interviewed (drug users, next-of-kin, professionals) had different views on coercive measures in the treatment of persons with problem drug use, but most agreed that it could be used in situations with frequent overdoses. Professionals did not refer to political objectives when they spoke of their experience of fatal overdoses. Political documents from Oslo City Council of were assessed, and specific objectives for the prevention of fatal overdoses were not found.

According to the study, it was not possible to assess the risk of fatal overdoses in this study due to the study design. A cohort study over a longer period could have estimated the risk of fatal overdoses and their relationship to different factors.

### **Recommendations for prevention**

The study contains several recommendations, such as:

The high prevalence of fatal overdoses in Oslo can be explained by the high number of persons who inject heroin in combination with other

substances. Thus, a reduction in the number of fatal overdoses will be possible if the number of persons who inject is reduced. This can be achieved by facilitating smoking instead of injecting through the distribution of smoking equipment and allocated areas ('user rooms') where the substances can be smoked. In addition, it is necessary to make sufficient health and social welfare services available to persons with problem drug use.

The majority of those who died from fatal overdoses in Oslo had been in contact with several services. However, the services appeared to be fragmented and no single individual or service appeared to be capable of taking charge when there was a crisis situation. There appears to be a lack of critical assessment of each fatal overdose aimed at improving health and social welfare services. One of the proposed measures to improve the lack of critical assessment is for the municipality to employ an '*overdose physician*' with responsibility for reviewing each fatal overdose. This would make improved coordination and collaboration possible between services and help to develop services related to prevention, follow-up and treatment of overdoses (Gjersing et al,2011).

### **7.1.2 Overdoses in Bergen. A survey report**

A recent survey report from Bergen on the risk of overdoses and protective factors (Gerdtts and Grung, 2011) also points to inadequacies in the help services and calls for better coordination and more cooperation between services across agency boundaries. The report is based on standardised telephone interviews with 24 agencies in Bergen, seven interviews with key informants, i.e. persons who are considered to possess 'expert knowledge' in the drugs and alcohol field, and five interviews with users with long-term drug dependency dominated by opioid use. Existing data from different local and national sources have also been used.

The report states that oral and/or written information seems to be the only strategy for the

prevention of overdose fatalities. In many cases, the implementation of the information measures was reported to be sporadic and unsystematic in relation to who received information and the contents of the information.

Moreover, the help services seem to focus most of their attention on risk associated with the interruption of treatment due to drug use and discharge from institutions. Both treatment personnel and people from the drug scene refer to the fact that the purpose of leaving treatment is a desire to use drugs, which undoubtedly entails great risk. In this connection, next-of-kin, among others, call for treatment institutions to maintain contact with the person in question to motivate him or her to return to treatment.

When asked whether the services have plans for new measures to prevent overdose fatalities, the treatment institutions in the survey material stand out in that they have concrete plans. They are largely measures that involve different forms of contact with the patients when they are not at the institution, such as the use of ambulant services, contact via text messages etc. Several of the services point out that it should be possible to involve next-of-kin as a resource, but none of the services seems to have plans for how this can be done or for establishing/maintaining contact with patients in connection with interrupted treatment.

Both the agencies and the drug users identify the period before planned detoxification as a risk period. This is explained by the users' wish for one final maximal drug experience before they enter treatment, often referred to as a 'last party' before admission to the treatment institution/prison. This phase nonetheless seems to receive less attention in the form of preventive information measures.

As for measures targeting overdoses and overdose fatalities in particular, the conclusion is that the chain of measures seems to lack the concluding/follow-up link. While emergency assistance is reported to work, follow-up after an overdose has

not been ensured in the same way, regardless of other factors such as age, mental/physical condition, how many overdoses the patient has experienced etc. Both next-of-kin and representatives of treatment institutions emphasise the need for methodical follow-up in the period after an overdose.

The report proposes some specific measures:

- Establishing a local notification system to get relevant information out to the users.
- Considering/further developing a procedure for following up overdose episodes, including the use of interdisciplinary ambulant teams.
- Establishing a team to map the health, care and living situation of the above-30 age group.
- Offering guidance to next-of-kin who experience overdose episodes in their close family, and offering crisis counselling to next-of-kin who experience a fatal overdose.

In addition, in line with Oslo: Initiating a common strategy and targeted efforts to promote smoking as an alternative to injecting heroin.

In August 2011, the Commissioner for Health in Bergen City Government stated that she would immediately appoint a working group that would be tasked with preparing and initiating measures on the basis of the report.

### **7.1.3 The health and overdose team in Trondheim**

The team was established by the City of Trondheim in September 2001 after the city had experienced many overdose fatalities that summer. The purpose was to prevent overdoses and overdose fatalities, and to follow-up next-of-kin and drug users after an overdose/death.

The team reports having had contact with as many as around 950 named injecting drug users (of around 1,500) in Trondheim. The team consists solely of health personnel. Seven nurses will be employed by the team in 2011. They engage

with the drug user scene on a daily basis, assess trends, take the pulse of the milieu and observe whether any new drugs are introduced to the scene.

Overdose prevention is an important task dealt with by providing information to the drug users: about the purity of the drug; that several people should be together when taking the drug; about reduced tolerance after a period of abstinence from opioid/medication use; about the importance of splitting the dose into several small ones; focus on multiple use issues; calling the emergency telephone number-113 on suspicion of an overdose; providing first-aid by keeping the patient moving and awake, and applying pain stimuli until help arrives.

Two members of the team are always called out in the event of an overdose after being notified by the emergency medical communication centre that an ambulance has been dispatched to perform life-saving first aid. They follow up the person who has overdosed and others who are present. The overdose team always have nalcantol (an antidote) with them. Note: The police are not contacted.

The team refers the overdose victim for follow-up by the specialist health service and/or a GP, as required. In the event of a fatal overdose, they follow up the next-of-kin for as long as they want them to. They always arrange a meeting, although next-of-kin often say that they are being looked after and do not wish to be followed up. The team has not yet encountered next-of-kin who do not want further follow-up from the team. The follow-up conversation with the patient following an overdose involves several steps:

- What has the patient taken, and how much?  
If a new substance or pure heroin is involved, the milieu/employees in Trondheim municipality are warned directly and through the media.
- Parasuicides are referred to the accident and emergency service and psychiatric follow-up,

if relevant. The team ensures that this one of the team members accompanies the person.

- They consciously use the fear of death that the patients experience in further conversations. The purpose is to make them understand how close they came to dying and that they would have been dead if the antidote had not been administered.
- Examining the options and what the patient is willing to do him/herself. Contacting next-of-kin, social workers / contact persons and offering an emergency bed, if necessary.
- They also attend to the others who witnessed the overdose – addressing their experiences, thoughts and feelings, and they refer them to other agencies in the system, if necessary.

The health and overdose team has three round-the-clock supervised emergency beds at its disposal in a dedicated building that can be used to help persons who have experienced an overdose or to help down-at-heel drug users who need time to get back on their feet. The team is responsible for admissions. There is no waiting time, as it is for those who need it most there and then. Overdoses are always the number one priority. Stays are voluntary and the maximum duration is 14 days.

In 2002, the year after the team was established, the number of overdoses fell by more than fifty per cent, from 78 to 36 cases. In the three following years, the figure was down to just over 20 cases. The number has since varied, with an average of around 45 overdoses per year. As regards fatal overdoses, the number of deaths has varied between zero and eight a year, compared with ten in 2001. The team identifies the success criteria as an absolute duty of confidentiality, being present in the milieu and, not least, excellent cooperation with the specialist health services, ambulance personnel and the municipal administration/ follow-up personnel in Trondheim municipality (personal information from the manager).

### 7.1.4 The LASSO project, Oslo

In autumn 2010, the Oslo Drug and Alcohol Addiction Service and the Norwegian Centre for Addiction Research established a new project involving the distribution of buprenorphine (Suboxone) to patients, aimed at harm reduction and giving them a better life. Experience from a similar project, Clinic Motivation, which was run by the City of Oslo from 2006 to 2009, formed the basis for the start-up of the LASSO project (harm-reduction substitution treatment in Oslo).

The background to the start-up of the project was that experience had shown that many patients drop out of substitution treatment. For different reasons, some of them are never referred to and assessed for substitution treatment, while others fail to meet the admission criteria. Many of them are visible in public places, they are difficult for the ordinary health services to reach and they are excluded from or drop out of residential/low-threshold services. For large parts of the day, they are busy obtaining drugs through crime and prostitution. Many of them have extensive mental and physical health problems. The initiators of the project identified a need for a type of substitution treatment that is more adapted to opioid addicts in this group, in the form of greater availability and less bureaucracy.

The project covers the whole city and is offered to everyone in the target group who lives in the municipality over time. The substitution treatment is based on the specialist health service.

The participants can refer themselves to LASSO or be referred by other services such as the field nursing service, the injection room or the ambulance service.

The goal of the use of substitution medication is:

- To reduce the risk of harm to health caused by injecting opioids.
- To reduce the risk of excessive drug use and overdose fatalities.

- To enable illnesses to be diagnosed and treated, thus improving the physical and mental health situation of this group.
- To reduce the number of 'crisis situations' in the participants' day-to-day lives and contribute to improving/maintaining their independent living skills.
- To help those who so wish to use the ordinary support services.
- To contribute to participants not having to obtain and inject illegal drugs through criminal activity /prostitution.

Organisation:

- The project is located in one of the Alcohol and Drug Addiction Service's 24-hour residential facilities.
- The project personnel are employed by the Alcohol and Drug Addiction Service.
- The project manager is a health professional, a registered nurse.
- The project also comprises two other nurses and a social worker.
- The substitution medication is prescribed by a doctor.
- Medication is handed out during the day/afternoon, and also at weekends and on holidays.

Since 1 January 2011, when the project became fully operational, the project staff has consisted of three nurses. The project is still in the start-up phase, but so far (end of August 2011), 87 people have been referred to the project. Most have come at their own initiative. The doses of Suboxone have been stepped up for fifty-four of them, 20 women and 34 men. Several of them have had their medication stepped up several times, and many have periods during which they do not pick up their medication. Eight persons have chosen not to continue their participation in the project.

Seven persons have started ordinary substitution treatment since starting treatment in LASSO. Three persons have applied for substitution treatment and wish to start ordinary substitution

treatment in the longer term. Three persons who were affiliated to the project have died; two due to illness and one as a result of an overdose. One of the three had not yet started taking medication, while the two others died during a period in which they did not collect their medication (the Oslo Drug and Alcohol Addiction Service, personal correspondence).

## 7.2 Responses to health correlates among drug users

### 7.2.1 Psychiatric and somatic co-morbidity

#### Development of the services

As mentioned in chapters 5.3 and 6.2, treatment for concurrent drug/alcohol problems and mental health problems is provided by two different sectors in Norway, but they are often located in the same place. It is a goal for the renewal of the health and welfare systems that these patients should receive as integrated treatment as possible for both problems. Documentation from research and reports suggests, however, that there is still some way to go before these challenges are resolved. It is a well known fact that many patients with a co-morbidity diagnosis and other 'difficult' patients can end up being passed back and forth in the system or not receive adequate help for one of their problems.

Organisational, legal and financial measures have been implemented in both mental health care and interdisciplinary specialised drug/alcohol treatment with a view to boosting and strengthening these fields in relation to somatic health. In order to prevent patients being passed back and forth and to ensure concurrent treatment of mental health problems and drug or alcohol problems, several government and municipal agencies have been organised together in recent years. The goal of providing integrated treatment, by the same team, by the same group of treatment providers or in the same treatment programme, is gaining increasing support both professionally and politically.

As part of the escalation plan for mental health 1999–2008, management signals were issued stating that *ambulant teams* should be set up at all Psychiatric District Centres. The aim was to ensure follow-up of patients with long-term needs for complex services, including many people with concurrent drug/alcohol problems and mental health problems.

A government grant scheme was established in 2009 for the establishment of ACT teams (Assertive Community Treatment teams) for patients with psychoses, reduced functional level and extensive additional problems such as problem drug or alcohol use. Grant schemes have also been established for the development of other types of coordinated teams between the municipal and specialist health service levels, targeting patients with co-morbidity diagnoses.

Reports from the mental health care service indicate that more outreach-based methods are employed at 62 of 75 Psychiatric District Centres and that more people with a dual diagnosis are receiving treatment in the mental health care sector than before. Some municipalities have established residential and follow-up projects based on the principle of 'housing first'.

#### Professional guidelines

The Directorate of Health plans to issue national professional guidelines for concurrent drug/alcohol problems and mental health problems in the course of 2011, in which responsibility for treatment of this group of patients will be more clearly defined. In brief, the recommendation is that, if the drug or alcohol problems are dominant, chief responsibility should rest with specialised treatment for drug or alcohol use, and with the mental health care service if the mental illness is serious. Schizophrenia, affective mental disorders or serious personality disorders are deemed to be serious mental illnesses. In the draft guidelines, the Directorate of Health underlines that disagreement about who is responsible must not result in patients not receiving a good offer of diagnostics and treatment. It is proposed that assessments and admissions be

coordinated between mental health care and specialised treatment services in order to provide patients with a dual diagnosis with coordinated, integrated treatment.

### **7.2.2 Needle exchange programmes**

See the data in Standard table 10.

The primary objective of needle exchange programmes is to reduce the risk of infectious diseases associated with the sharing of injection equipment. Approximately 3.3 million syringes

were handed out in Norway in 2007, largely through low-threshold services. In a follow-up survey carried out by SIRUS, 14 towns/municipalities reported that almost 3.1 million syringes were handed out in 2009. Of these, 85 per cent – 2,635 million were distributed in the three biggest cities, Oslo, Bergen and Trondheim. In 2010, these cities reported about the same number, 2,612 million, 1.9 million of them in Oslo alone. Sales through pharmacies come in addition, but we lack an overview of sales to drug users in this context.



## 8. Social correlates and social reintegration

### 8.1 Social reintegration

See also information in Structured Questionnaire 28.<sup>11</sup>

#### 8.1.1 Housing

A survey from 2008 estimates that the number of persons with no fixed abode in Norway is 6,100, which is an increase from a corresponding survey in 2005. It is reported that approximately 60 per cent of homeless people have drug or alcohol problems and that 32 per cent have mental health problems. The survey also showed that homelessness is mainly a problem in cities. In recent years, a range of 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 further developed and that experience from them will be spread to more municipalities.

The following four measures in the Action Plan 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 so that they can be offered permanent housing.
- Introduce a new investment grant for nursing homes and sheltered housing.

All four measures were initiated in 2009.

In 2009, the State Housing Bank established a social housing development programme, the purpose of which is to enter into binding collaboration with the municipalities with the greatest social housing problems. The programme aims to encourage the municipalities to develop coherent social housing services that enjoy local support. This will contribute to a better service for people at a disadvantage in the housing market by raising competence in the municipalities, improving the utilisation of state funding and developing methods in the field of social housing.

In the period 2007 to 2009, in a collaboration between the Directorate of Labour and Welfare and the State Housing Bank, a project aimed at developing methods and models was carried out in the four biggest cities in Norway and five neighbouring municipalities that had problems relating to the use of temporary housing arrangements. The purpose of the project was to develop methods and measures for following up people in temporary housing so that they can be offered permanent housing. Ethics, relations building and the testing of forms of collaboration have been important elements in the development of methods. Participating municipalities are reported to have made good progress in testing different mapping systems and user participation. Some municipalities have identified efficient methods for obtaining housing in the private rental market.

#### Housing on release from prison

Efforts to obtain housing for inmates on their release are dependent on whether the municipality has suitable accommodation to offer. At the end of 2008, more than half of all inmates had no accommodation upon their release. It was also reported in 2009 that many municipalities had no housing to offer these groups.

<sup>11</sup> All structured questionnaires referred to have been submitted to the EMCDDA separately.

The correctional services have been allocated funding by 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 establish agreements with the individual municipalities. The number of agreements increased from 44 in 2007 to 62 in 2008, and there were approximately 80 housing agreements between the correctional services and municipalities in 2009. In addition, the State Housing Bank has funded the appointment of seven housing advisers, who will work on obtaining accommodation for more inmates upon their release.

### 8.1.2 Employment

A qualification programme aims to strengthen the efforts for persons with significantly impaired work capacity and earning ability who have limited or no National Insurance rights.

The qualification programme was described in NR 2009 Chapter 8.1.3. The programme, and the pertaining benefits, targets persons with significantly impaired work capacity and earning ability, who have limited or no rights to National Insurance benefits. The purpose is to help more people in the target group to find employment. The programme must be individually-adapted and work-related, so that it supports and paves the way for the transition to employment. Persons with drug or alcohol problems are part of the target group provided that they meet the conditions for participation. There are no figures available to indicate how many of the participants have drug or alcohol problems, but feedback from the local NAV<sup>12</sup> offices shows that they are included among the participants.

#### Convicted persons' connection to the employment market

It is an express goal of the Action Plan that more convicted persons who are serving prison sen-

tences succeed in finding employment or join a qualification programme on their release.

There are eight NAV advisers in Norwegian prisons. They cooperate with the NAV offices in connection with prisoner releases. All the regions have entered into agreements with NAV at the regional level. A number of local agreements between prisons and NAV offices are also in place.

In a collaboration between the Directorate of Labour and Welfare and the central administration of the correctional services, a three-year national trial was initiated in 2009, with the aim of identifying good models that ensure continuity, integrated services and closer individual follow-up of inmates in connection with the transition from prison to freedom. Methods will be tested to motivate inmates in the target group to make use of the qualification programme on their release. In 2009, seven projects were initiated in a collaboration between local NAV offices and prisons. The municipality in which the prison is located will cooperate with inmates' home municipality to ensure that more inmates find employment.

#### Work training etc.

As part of the Government's efforts to combat poverty, the Ministry of Labour awards grants to voluntary organisations with the aim of strengthening and developing activation and work training models. The target group consists of people who are highly marginalised in relation to the employment market and in many ways excluded from the social arena. Persons with drug or alcohol problems are a prioritised target group. The scheme received EUR 1.25 million (NOK 10 million) in additional funding in 2009, increasing its budget to EUR 2.7 million (NOK 21.5 million). A total of 34 projects received grants in 2009.

The Directorate of Health also allocates grants to a number of voluntary and charitable organisations involved in activation and work training for persons with drug or alcohol problems.

<sup>12</sup> The Norwegian Labour and Welfare Service

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

### 9.1 Drug law offences

#### 9.1.1 Legal basis and type of statistics

Norway does not have separate legislation relating to drugs. Two acts apply in connection with the reporting, charging and prosecution of drug crimes: the Act related to medicines and the General Civil Penal Code.<sup>13</sup> Statistics Norway is the Norwegian institution responsible for keeping statistics on drugs in the judicial system. Four types of crime statistics are published annually (<http://www.ssb.no/kriminalitet/>):

- Offences reported to the police
- Offences investigated – clear-up rate – persons charged – relapse figures
- Penal sanctions – persons convicted – previous criminal offences
- Prison sentences – inmates

<sup>13</sup> Minor drug offences that involve the use or possession of drugs are punished pursuant to the Act relating to medicines (Act No 132 of 4 December 1992) section 24, for which the maximum sentence is up to two years' imprisonment. Other drug crimes are punishable pursuant to section 162 of the General Civil Penal Code (Act No 10 of 22 May 1902 with subsequent amendments). The General Civil Penal Code section 162 distinguishes between four degrees of gravity, depending on the drug and amount involved and the nature of the offence in other respects. If a small quantity is involved, the offence is punishable by fines or imprisonment for up to two years. Aggravated drug crimes include the three other degrees of gravity. If a somewhat larger quantity is involved, the offence is punishable by imprisonment for up to ten years; if a substantial quantity is involved, the offence is punishable by imprisonment for between three and 15 years, and under particularly aggravating circumstances the punishment can be up to 21 years' imprisonment, which is the maximum punishment under Norwegian criminal law.

Statistics Norway's regular crime statistics provide information about the criminal prosecution of:

- Drug offences

These are partly differentiated on the basis of the law's classification of different types of offences – including the provisions of the Act relating to medicines on use and possession (of user doses).

- Offenders with drug offences as their primary offence<sup>14</sup>

As a *minimum*, these statistics show the number of persons who are prosecuted for the different types of drug crime.

The statistics do not contain information about the types and quantities of narcotic substances involved in prosecutions. Nor does Statistics Norway have statistics containing a full count of *persons who are punished* for the use and possession of narcotic substances (irrespective of more serious drug offences, other drug offences or other crimes). However, Statistics Norway has published individual surveys based on the data that form the basis for the statistics. They include full counts of all persons charged with drug offences (irrespective of the primary offence), the progress of the drug offence through the criminal justice system and descriptions of criminal careers and imprisonment.

#### 9.1.2 Statistics

##### Reported crimes

See data in Standard table 11.

<sup>14</sup> Only the primary offence, the most serious crime, is registered in the statistics.

In 2010, nearly 45,000 drug crimes were registered, which is on a par with the record levels in 2001/2002 (Table 7). The number of reported aggravated drug crimes pursuant to the General Civil Penal Code section 162, second and third paragraphs, was 1,312, which is 250 more than in 2008 and 2009. The number of reported drug crimes pursuant to the General Civil Penal Code is higher than ever, but that the number of violations of the provisions of the Act relating to Medicines concerning the possession of small amounts of drugs is still lower than in 2001–2002.

### Investigated crimes

Statistics Norway has updated the statistics for investigated offences up to and including 2009. The number of investigated drug crimes pursuant to the General Civil Penal Code section 162 was just over 18,000 in 2009, which is roughly the same as the average for the years 2005–2008. However, the number of investigated offences relating to use and possession pursuant to the Act relating to Medicines is down by eight per cent since 2008 and 14 per cent since 2007. The decline is probably partly related to an internal police conflict in autumn 2009.

In 2009, 16,385 investigations were completed pursuant to the General Civil Penal Code section 162 first and fourth paragraphs, which concern less serious offences. Charges were brought in 8,243 (50 %) cases, while 4,532 (28 %) such cases were settled by a fine. The number of investigated cases for violations of the Act relating to

Medicines was 18,854. Charges were brought in 6,597 (35 %) cases, while fines were issued in 8,535 (45 %) cases.

The proportion of those charged with drug offences who are foreign citizens has increased steadily in the last few years – from around 11 per cent in 2002 to 18 per cent in 2009.

### Penal sanctions

Statistics for penal sanctions are not yet available for 2010. As regards penal sanctions in 2009 drug crime was the primary offence in 43 per cent of all types of criminal cases, a slight reduction from 2008 (Figure 10). However, this percentage can result in a skewed picture of the prevalence of this type of crime. The clear-up rate for drug crimes is higher than for all other types of crime, which means that drug crimes account for a far bigger proportion of crimes among convicted persons. On the other hand, many judgments may serve to conceal drug crimes, also relatively serious ones, because only the primary offence, i.e. the most serious offence, is identified in the statistics.

In 2009, 12,862 penal sanctions were imposed with drug crime as the primary offence. Of these, 7,279 were penal sanctions imposed pursuant to the General Civil Penal Code while 5,583 were imposed pursuant to the Act relating to medicines. The latter mainly relate to the use and possession of small quantities of drugs. It is worth noting that only 1,191 were convictions by a court resulting in unconditional prison

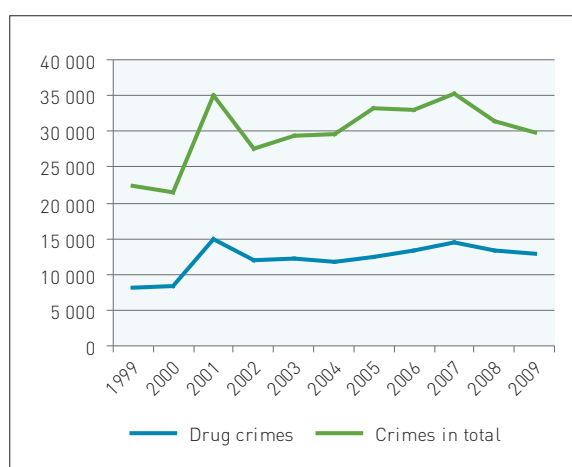
**Table 7: Number of reported drug crimes 2001–2010.**

Year	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Total number of drug crimes reported	45,904	44,616	36,133	36,818	37,178	41,165	40,113	36,738	38,515	44,741
Total pursuant to the General Civil Penal Code section 162	19,945	19,294	16,152	16,814	17,118	19,156	19,086	17,547	18,616	21,954
Total pursuant to the Act related to medicines	25,959	25,322	19,981	20,004	20,060	22,009	21,027	19,191	19,899	22,787
- Drugs, use	14,520	13,377	10,547	10,925	11,259	12,635	12,806	11,585	12,040	13,819
- Drugs, possession	10,410	10,930	8,533	8,364	8,070	8,627	7,562	7,005	7,100	8,242
- Drugs, miscellaneous	1,029	1,015	901	715	731	747	659	601	759	726

Source: Statistics Norway.

sentences, while 335 convictions resulted in partly unconditional and partly suspended sentences. The total number of fines was 9,212, while community sentences were imposed in 463 cases, almost all of them pursuant to the General Civil Penal Code. Other sanctions included conditional waivers of prosecution (293), court-imposed fines (173), suspended prison sentences (381) and suspended prison sentences and a fine (813) (Statistics Norway).

**Figure 10: Number of penal sanctions for drug crime as the primary offence 1999–2009.**



Source: Statistics Norway.

### Drugs as the main reason for prison sentences and remand

As of 1 January 2009, a drug crime was the primary offence for 29 per cent of prisoners in Norwegian prisons. By comparison, crimes against property and crimes of violence each accounted for 21 per cent. If we only look at those who were held on remand, drug crime was the primary offence for 31 per cent, while it was theft or other crimes against property for 28 per cent.

The crimes committed by those who are imprisoned in the course of a year differ considerably from the distribution of crimes among the prison population at any given time. One of the reasons for this is that short sentences and minor offences account for a larger proportion of new imprisonments. For example, 20 per cent of new imprisonments in 2009 were primarily due to traffic offences, while the proportion of such crimes

among inmates at the start of the year was less than seven per cent. Drug crimes, on the other hand, were the primary offence among far fewer of the new imprisonments (16 %) than among those who were in prison at the start of the year.

Although the figure must be treated with caution due to the large number of persons serving sentences in lieu of payment of a fine, for whom no information about the primary offence is available, we see an increase of three and four per cent, respectively, in new imprisonments from 2008 to 2009 for both crimes against property and drug crimes.

## 9.2 Driving offences

Alcohol is still the most commonly detected drug in blood samples from motorists and motorcyclists who are suspected of driving while intoxicated. The second most common is amphetamine, followed by THC (the active ingredient in cannabis) and methamphetamine. In the benzodiazepine group of sedative drugs there was also an increase in the detection of clonazepam last year, which indicates increasing illegal sales of the drug.

In 2010, drug analysis was carried out by the Norwegian Institute of Public Health (NIPH) in 9,537 cases where drivers were suspected of driving while intoxicated. Of these, 1,637 breath tests were taken by the police locally, about 3,178 blood samples were analysed by the NIPH for alcohol only, and about 4,722 blood samples were analysed for alcohol, intoxicating drugs and narcotic substances. The NIPH routinely looks for over 30 different intoxicating drugs and narcotic substances, and detects an average of two or three drugs in the same blood sample.

Table 8 shows the most frequently detected narcotic substances / intoxicating drugs. Both the illegal drugs (e.g. methamphetamine and cocaine) and prescription medicines (e.g. codeine and diazepam) are included. The analysis findings do not necessarily indicate whether the substance taken is illegal or not. As a rule, several

**Table 8: Some finds of substances other than alcohol in blood samples from drivers suspected of driving under the influence in 2010. The number and percentage of blood samples on which a broad analysis was carried out.**

Name of substance	Example of name of medicine Explanation	Number	Percentage (of N=4,722)
Amphetamine		1,513	32 %
THC	Active agent in cannabis	1,454	31 %
Methamphetamine		1,433	30 %
Diazepam	Valium ® Vival ® Stesolid ®	1,148	24 %
Clonazepam	Rivotril ®	1,077	23 %
Morphine	Heroin Dolcontin®	276	6 %
Codeine	Paralgin forte® Pinex forte®	158	3 %
GHB		133	3 %
Methadone	Methadone®	127	3 %
Zopiclone	Imovane Zopiclone®	121	3 %
Buprenorphine	Subutex® Temgesic® Subuxone®	95	2 %

Source: Norwegian Institute of Public Health

substances are usually detected in blood samples.

Amphetamine is detected in blood samples after use of both amphetamine and methamphetamine. Two-thirds of amphetamine findings are probably due to the taking of methamphetamine. Some of the methamphetamine taken is converted into amphetamine in the body. Many of the blood samples that contain methamphetamine will therefore also contain amphetamine, even though the person in question has not actually used both drugs. The number of cases where amphetamine was found will therefore include both amphetamine used alone and amphetamine as a bi-product of methamphetamine. If we wish to say something about the use of amphetamine and methamphetamine combined, it is therefore misleading to simply add up the figures for amphetamine and methamphetamine.

The number of cases in which THC is found has been relatively stable in recent years, at just around 30 per cent. The fact that THC is found in a blood sample means that cannabis has been taken (usually smoked) shortly before the sample was taken, usually during the last few hours before driving (Norwegian Institute of Public Health).

## 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.<sup>15</sup>

In 2010, 511 persons were serving sentences under this system, 13 per cent of whom were women (Table 9). A total of 287 persons started serving their sentence in prison and were later transferred to an institution. The other 224 started serving their sentence in a treatment institution.

In 2010, 40,777 days were served in an institution pursuant to section 12, which is a reduction in relation to the previous three years (Table 10).

<sup>15</sup> Section 12 states that 'A sentence may in special cases be wholly or partly executed by 24-hour detention in an institution if such detention is necessary for improving the convicted person's capacity to function socially and law-abidingly, or there are other weighty reasons for doing so. The convicted person may be restrained against his or her will and brought back in case of escape, if necessary by force and with the aid of public authorities. The Correctional Services shall not decide on such execution if it is opposed to security reasons or there is reason to assume that the convicted person will evade the execution.'

**Table 9: Number of sentences started pursuant to section 12, 2004–2010.**

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

Source: The central administration of the correctional services

**Table 10: Number of days served pursuant to section 12, 2004–2010.**

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

Source: The central administration of the correctional services

### Suspended sentence with a programme for driving under the influence

This sanction replaces the previous alcohol treatment programme. In the course of 2010, a total of 531 suspended sentences were imposed on condition of a programme for driving under the influence. Eighty-five per cent of the sentences were completed and 82 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 started in 2006 in the cities of Oslo and Bergen. The project has been prolonged until end of 2014 and will be evaluated by SIRUS. In 2010, 21 new sentences were implemented; seven in Oslo and 14 in Bergen. Twenty-two suspended sentences were completed during 2010. Seven sentences were completed without the conditions being breached, while the rest, 15 sentences, were interrupted, mostly because of new crimes being committed.

### Community sentences

Community sentences are often imposed for less serious offences. In 2009, community sentences were imposed for 463 drug crimes. It is worth noting that 86 of the sentences concerned aggravated drug crimes pursuant to the General Civil Penal Code section 162 second and third paragraph.

## 9.4 Drug use and problem drug use in prison

Drug-related health policies and services in prison are discussed in Chapter 11.

### Finds of drugs/user equipment

Reports received by the central administration of the correctional services for 2010 from regions/prisons show that the number of seizures of drugs has decreased somewhat compared with 2009. There was a decline in seizures of narcotic substances, from 1,095 in 2009 to 773 in 2010. At the same time, the proportion of cases involving illegal drug use uncovered by urine samples has declined from 10.1 per cent in 2009 to 9.4 per cent in 2010. The correctional service took 2,703 fewer urine samples in prisons in 2010 than in 2009.

Cannabis is still the drug most often found in urine samples, followed by illegal tablets, and then by amphetamine and methamphetamine. The use of heroin does not appear to be widespread in Norwegian prisons. There has been a decline in the number of positive samples, from 144 in 2009 to 68 in 2010. There are also few seizures of syringes and needles.

The number of seizures of user equipment has declined from 1,042 seizures in 2009 to 933 in 2010. Based on reports received, there are great variations between the regions as regards uncovering illegal drug use through urine tests and seizures of drugs/user equipment. The number of seizures also varies greatly between the regions (the central administration of the correctional service, 2011).

## 10. Drug markets

### 10.1 Availability

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

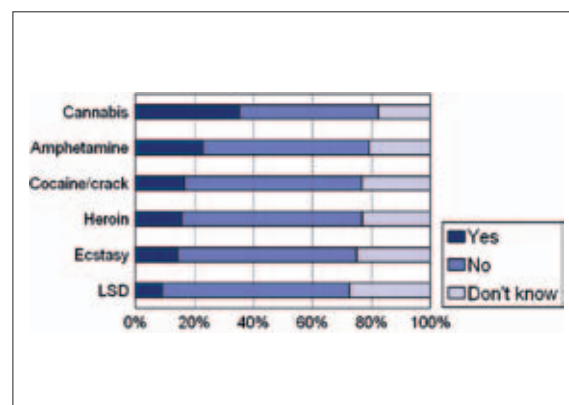
The police comments that, for drugs that are widespread in Norway, the changes in the number of seizures correspond well with changes in use as reported by social science research. The situation is probably more complex than that, however. Cannabis can be used to illustrate this. Different surveys among the population show that there has been a decline in the use of cannabis in recent years (see Chapter 2). On the other hand, however, the number of seizures of cannabis has increased. For the period 2006–2010, the average increase was nine per cent compared with the previous five-year period, and the increase from 2009 to 2010 was as much as 13 per cent (Chapter 10.3).

Measured by seizures, the most common illegal substances are geographically widespread. In 2010, all the 27 police districts made seizures of cannabis, BZD and amphetamines, whereas cocaine and heroin were seized in 25 districts. It must be emphasised, however, that the quantities vary greatly between the different police districts.

For cocaine and heroin, the seizures are often small. For example, the amount of heroin seized varied between 0.5 and 10 grams in six of the police districts, while seven districts made seizures of between 10 and 80 grams. The biggest markets are still the Oslo area and the regions that include the biggest towns and cities. Moreover, the customs authorities in Østfold county make many large seizures, which can largely be explained by the proximity to the most important border crossings to Sweden, where large parts of the drug trafficking to Norway take place by road and by train.

It nonetheless appears to be relatively easy to obtain drugs also outside the big towns and cities. In the latest population study from 2009, respondents were asked whether they could obtain various substances within the space of 24 hours. Figure 11 shows the results for the illegal substances concerned. The proportion of 'yes' answers seems high considering that the survey also includes small places with, presumably, poorer access to narcotic substances.

**Figure 11: Percentage 'yes' answers in 2009 to the question: Do you believe that you could obtain any of the following substances in the space of 24 hours?**



Source: SIRUS



## 10.2 Supply

### 10.2.1 Smuggling routes to Norway

According to the customs service, most of the *amphetamine/methamphetamine* on the Norwegian market comes from illegal laboratories in the Netherlands, Poland and Lithuania. Lithuanian criminals still have a dominant role as suppliers of synthetic drugs to Norway. Although a decrease was registered in the quantity seized during the first six months, the proportion of seized methamphetamine from Lithuania is considerable. The travel route varies. At the national border, most seizures are made from means of transport from the Netherlands and Belgium, but seizures are also made from passenger cars that travel by ferry from the continent. Passenger cars with concealed cavities and regular bus services seem to be the most frequent methods used.

*Hash* seized in Norway mainly comes from Morocco via Spain and the Netherlands. So far this year, the customs service has registered a significant increase in seizures of *hash*. From the Netherlands, the drug is transported via Denmark to Norway by car, bus, train or plane. During the first six months of 2011, the customs service uncovered large quantities of *hash* smuggled in goods transport across the border and by ferry. At the same time, there has also been an increase in the smuggling of smaller quantities by plane, bus and passenger car. The number of couriers who have attempted to smuggle *hash* inside their bodies has increased so far in 2011.

There are also many indications that the smuggling of *marijuana* to Norway has increased significantly. The customs service has registered many seizures on trains, buses and in passenger cars. Substantial seizures have also been made in connection with goods transport. There are many indications that much of the *marijuana* seized by the customs service comes from Poland and the Czech Republic.

*GHB* and *GBL* are smuggled to Norway from the Netherlands, Poland, Germany and China. So

far in 2011, the customs service has registered a sharp decline in seizures of drugs dispatched by post and sent by courier. It is assumed that considerable quantities are smuggled in other ways, as there is nothing to indicate that sales have been reduced.

*Heroin* sold in Norway mainly comes from Afghanistan via Turkey along the so-called Balkan route to Western Europe. It is smuggled to Norway by plane, bus, train and car. So far in 2011, the customs service has registered a marked decline in the amount of *heroin* seized. This is due to the fact that no major seizures have been made so far. Part of the reason could be changes in smuggling routes and major seizures in other countries of *heroin* destined for Norway. The number of couriers who smuggle *heroin* inside their bodies and in their hand luggage remains at a stable, high level.

*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. Cargo planes carrying large amounts of *khat* arrive in the Netherlands daily. The *khat* destined for the Nordic market is distributed from there. Large quantities are also transported by road in cars from the Netherlands via Germany, Denmark and Sweden.

*Cocaine* sold in Norway comes from production areas in South America. It is then transported via West Africa or directly to ports and airports in Europe. *Cocaine* is smuggled to Norway using various means of transport and couriers. So far in 2011, the customs service has registered a decline in the amount of *cocaine* seized. This is due to the fact that no large seizures have been made so far. Part of the reason could be that large seizures were made in other countries of *cocaine* destined for Norway. The proportion of couriers who smuggle *cocaine* inside their bodies and in their hand luggage remains at a stable, high level. So far this year, the customs service has registered an increasing amount of *cocaine* being smuggled via Poland. A challenge seen in other countries is an increase in the smuggling

of liquid cocaine from South America. Liquid cocaine is difficult to uncover, whether smuggled inside the body or in luggage.

The customs service is uncovering an increasing amount of drugs sent in the post and by courier. This applies in particular to narcotic tablets ordered online. As regards *tranquillising narcotic tablets*, the smuggling of Rivotril and Subutex appears to have increased in particular. Towards the end of 2010 and in spring 2011, the customs service registered a significant increase in the smuggling of Rivotril tablets from Hungary.

The customs service has also registered an increase in the smuggling of *new drugs (legal highs)*. New versions of synthetic cannabinoids and other synthetic substances are being uncovered all the time. The challenge is that many of these substances are difficult to stop as they are not yet on the list of narcotic substances (personal communication, Directorate of Customs and Excise Enforcement Department, Anti Smuggling Section).

### 10.3 Seizure statistics

See also the data in Standard table 13.

#### Main features

The number of cases and seizures has increased to record levels in 2010. However, with the exception of GHB and GBL, the big increase in cases has not led to seizures of record amounts of drugs. For heroin, however, it is only in 2004 and 2009 that greater quantities have been seized, for cocaine only in 2005 and 2007, for benzodiazepines (BZD) in 2002 and 2006, and for amphetamine/methamphetamine the three preceding years.

There has been a decline in the number of cases involving the most aggravated drug crimes that fall under the General Civil Penal Code section 162 third paragraph, from 64 cases in 2009 to 46 in 2010. The number of cases pursuant to the third paragraph involving heroin has remained

high, while there has been a decrease in cases of this type involving amphetamine and cannabis.

GHB/ GBL, benzodiazepines, amphetamine/methamphetamine and, not least, other stimulants seem to have become more prevalent in the user market, with increases in the number of seizures of 36 per cent, 30 per cent, 24 per cent and 58 per cent, respectively, from 2009 to 2010. The number of seizures of heroin is the highest since 2003. The number is far lower, however, than in the period 1995–2003. Moreover, the purity of heroin base has sunk to a historically low level, 21 per cent in 2010 on average, declining further to 17 per cent in first half of 2011. The total seized amount of all cannabis products is not particularly high, which can be explained by the relatively small amount of hash seized. On the other hand, the number of cultivation cases and the number of seizures of marijuana have yet again increased strongly. Both the quantities and the number of seizures substantially exceed those in the years 2007 and 2008, which were registered as record years until 2010.

Although far bigger quantities of both amphetamine and methamphetamine have been seized in previous years, 290 kg is nonetheless regarded as a considerable quantity. In total, the number of seizures of these two drugs has increased relatively strongly in 2010 compared with the period 2006–2009.

If we look at the total amount of seizures of stimulants, including drugs that were classified as narcotic substances in 2010 (see NR 2010 Chapter 1.1), the statistics show a greater increase for this class of drugs than for depressants seen as a whole.

Of the new stimulants that were introduced to the user market in 2010, it is mainly parame-thoxymethamphetamine (PMMA) that stands out, 24 kg of which was seized in the second half-year 2010 in 81 seizures. According to the National Institute of Public Health, PMMA has so far (end of September 2011) been linked to 20 overdose cases with fatal outcomes. Although

2007 is the only year in which more seizures of cocaine were made than in 2010, cocaine nonetheless appears to have a somewhat smaller market share during the last three years compared with seizures of other drugs.

The seizure figures are very low for ecstasy, both in terms of the amount seized and the number of seizures. We have to go back to 1994 to find a lower figure. Among tablets with logos, MDMA has largely been replaced by other drugs, primarily mCPP (1,3-chlorphenylpiperazine).

Both the number of seizures and the number of tablets of benzodiazepines (BZD) have increased since 2008, a trend that was reinforced in 2010. Only in two previous years have greater quantities been found and more seizures made than in 2010. It is clonazepam (Rivotril) and diazepam (e.g. Valium) in particular that dominate the user market.

### Data basis and sources of error

The annual report from the National Criminal Investigation Service (Kripas) 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 Kripas laboratory. In these cases, relevant information is usually given about what the seizures probably contain. The sources of error are not deemed to have a significant bearing on the main trends, but experience indicates that some of the minor seizures may include other types of drugs than those stated in statements to the authorities. This may apply in particular to the ratio between am-

**Table 11: Amounts seized for the most relevant drugs 2006–2010\***

Year	2006	2007	2008	2009	2010
Cannabis (kg)	1,544	853	1,732	2,588	1,184
Amp/methamphetamine (kg)	386	559	362	431	290
Other stimulants(units)	1,603	1,979	2,796	3,469	6,149+24 kg
Heroin (kg)	93.0	8.0	55.2	130.1	102.3
BZB (units)	1,006,400	729,082	308,582	668,995	881,800
Opioids (units)	15,685	11,906	11,193	15,186	18,800
Cocaine (kg)	40.5	95.0	76.8	61.1	94.2
Ecstasy (units)	28,636	78,725	30,678	22,700	6,250
Psilocybe mushrooms (kg)	0.84	1.36	0.5	1.66	2.0
LSD (units)	226	26	245	510	174
GHB (ltr)	31.3	58.6	36.5	83.6	83.4
GBL (ltr)	14.2	42.3	220.8	129.8	397.0

\*The figures from 2009 and previous years have been revised for some drugs

Source: Kripas

**Table 12: Large drug seizures pursuant to General Civil Penal Code section 162, third paragraph in 2008–2010.**

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

Source: Kripas

phetamine and methamphetamine or to so-called 'ecstasy tablets' that no longer always contain MDMA or analogues.

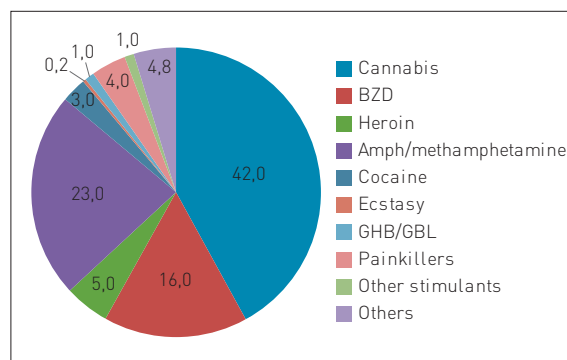
### 10.3.1 Statistics for 2010

In 2010, 26,087 drug cases were registered. Of the total number of drug cases, 10,749 were analysed, while 15,338 were fixed-penalty cases. The increase in the number of cases since 2009 is 19 per cent – an increase of 21 per cent for the analysis cases and 18 per cent for fixed-penalty cases.

Table 11 shows that the quantities seized (naturally) vary considerably from one year to the next. As an indicator of the size of individual seizures, based on quantitative criteria for prosecution that meet the definition of aggravated drug crime in the General Civil Penal Code section 162, third paragraph, 46 such large drug seizures were made in 2010 (Table 12).

Table 13 shows the changes in the number of seizures during the period 2006 to 2010, while Figure 12 shows the market share in 2010 for the most common substances.

**Figure 12: Market share for different drugs in 2010. Number of seizures. Percentage.**



Source: Kripas

### Comments on the individual drugs

#### Cannabis

Following a marked decline in 2007 both with regard to the quantity and the number of seizures of cannabis, both these parameters increased significantly in 2008 and 2009, mainly because hash increased strongly. In 2010, the situation was roughly the same as in 2007, relatively small amounts of hash and considerably more marijuana and cannabis plants. The most striking development in 2010, however, is that the number of 'cannabis plantations' has increased strongly, and it is now far higher than in 2007 and 2008.

**Table 13: Number of seizures in the period 2006–2010 broken down by some types of drugs\*.**

Drug type	2006	2007	2008	2009	2010	% changes 2009–2010
Cannabis	11,221	9,952	10,599	11,754	13,326	+13
Amph./methamph.	5,819	5,507	5,153	5,775	7,167	+25
Heroin	1,087	1,204	1,145	1,430	1,582	+11
Benzodiazepines	4,500	4,058	3,451	3,796	4,945	+30
Painkillers/ opioids	1,161	959	936	1,078	1,184	+10
Cocaine	726	909	854	804	868	+8
Ecstasy	411	421	309	110	71	-35
LSD	28	13	15	26	30	+15
GHB	111	163	133	218	308	+41
GBL	11	25	40	103	132	+28
Psilocybe mushrooms	82	77	54	75	92	+23

\*The figures from 2009 and previous years have been revised for some drugs

Source: Kripas

The amount of cannabis seized, 1,186 kg, breaks down as follows: approximately 822 kg of hash (69 %), 209 kg of marijuana (18 %), 156 kg of cannabis plants (13 %) and 0.016 kg of cannabis extract. This distribution is very different from 2009, when the proportion of hash was as high as 93 per cent.

The number of cannabis seizures breaks down as follows: 76 per cent hash, 22 per cent marijuana and two per cent cannabis plants. Seen in relation to the number of seizures, the proportion of hash is also lower than in 2009 (82 %). As regards cannabis plants, 400 seizures were made in 2010. By comparison, 243 seizures were made during the period 1 July 2007 – 30 June 2008, when the police uncovered particularly many ‘cannabis plantations’. The growing cultivation activity also coincides with a significant increase in marijuana seizures, both in terms of absolute figures and in relation to other cannabis products. It is reasonable to assume that domestic production is a significant cause of the spread of marijuana.

#### *Amphetamine and methamphetamine*

Approximately 150 kg of amphetamine was seized in 2010, divided between 3,490 seizures, and 140 kg of methamphetamine, divided between 3,677 seizures. For both drugs, the seized amount is lower than in 2009, while the number of seizures of amphetamine has increased by more than 50 per cent. The proportion of methamphetamine compared with amphetamine culminated in 2009, and it was estimated to be 45 per cent in the second half-year 2010 (Table 14). The whole increase in the total number of seizures, 25 per cent from 2009, can be ascribed to amphetamine, while the number of seizures of methamphetamine is about the same as the year before.

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

Year	2006	2007	2008	2009	2010
% Meth.	26.0	35.3	43.5	64.3	56

Source: Kripas

#### *Heroin*

Although the number of seizures of heroin is far lower than at the turn of the millennium, there has been an increase since 2006. The proportion of heroin seizures in relation to seizures of other drugs has also increased somewhat, from 4.2 to 5 per cent in the same period. By comparison, heroin seizures accounted for 20 per cent of the total number of drug seizures in 1998. As before, most heroin seizures are made in the biggest towns and cities in Norway. Together, Oslo Police District and Hordaland Police District (Bergen) made 64 per cent of all the seizures of heroin in 2010.

#### *Other opioids*

Both the quantity and the number of seizures of painkillers classified as narcotics are higher than in recent years. No particularly large seizures of these medicinal drugs were made in 2010, however. Several of the cases concerned illegal importation via internet shopping, but the number of tablets in each seizure is relatively small. It is once again buprenorphine (Temgesic, Subutex and Subuxone) and codeine (e.g. Paralgin forte) that dominate the statistics. Together with methadone, buprenorphine accounted for almost 60 per cent of all seizures in this class of medicines in 2010.

#### *Cocaine*

Following a strong increase in the number of cocaine seizures after the turn of the millennium, especially from 2005, the number of seizures culminated in 2007. Although the number of seizures and the quantities seized were almost as high in 2010 as in 2007, the number of cocaine seizures has increased less than the overall increase in cases. From accounting for approximately 1.5–2 per cent of drug seizures at the start of the 2000s, the proportion of cocaine seizures increased to four per cent in 2007. The proportion has fallen somewhat again since then, but it was back at three per cent in 2010, the same as in 2006.

*Ecstasy*

The market is primarily characterised by a sharp decline in both the quantity and number of seizures of ecstasy tablets. Moreover, the active agent MDMA has largely been replaced by other drugs, mainly mCPP (1,3-chlorphenylpiperazine), a drug with a mild hallucinogenic affect (Chapter 10.5). mCPP was included on the list of narcotic substances in March 2010. The decline can be explained by more stringent regulation and thereby increasing scarcity of the raw materials used to manufacture traditional ecstasy tablets containing MDMA.

LSD has probably never been very widespread in Norway. Since LSD is easy to conceal, however, we cannot exclude the possibility that the seizure statistics fail to give an accurate picture of the actual situation.

*GHB, GBL and 1,4-butandiol*

In 2010, the total number of seizures of these three drugs exceeded 400 for the first time. Compared with 2009, the increase was particularly great for GHB. Overall, these drugs nonetheless only account for just over one per cent of all seizures of substances classified as narcotics. However, we cannot exclude the possibility that the chances of GHB/GBL being detected is lower than for other drugs, since the appearance and effect of GHB/GBL and alcoholic beverages are very similar. This could mean that the seizure statistics fail to reflect the actual prevalence.

*Benzodiazepines-BZD*

From 2009, both the quantities seized and the number of seizures have increased significantly. Based on the seizures, the illegal trafficking appears to mainly involve diazepam (Valium, Stesolid) and clonazepam, mainly Rivotril. Rohypnol (flunitrazepam) and Flunipam (flunitrazepam), which dominated this tablet market at the start of the 2000s, have declined strongly. This is probably related to both a strong reduction in illegal imports and more stringent prescription rules. From 1 January 2003, both these medicinal drugs were reclassified as class A drugs, and Rohypnol was de-registered as a

medicinal drug on 1 August 2004. All seizures of Rohypnol must therefore come from illegal imports.

Phenazepam is a Russian benzodiazepine that is not in medicinal use in Norway. Even though this drug has never been very common on the illegal market in Norway, it nonetheless attracted a lot of attention in both 2008 and 2009. Phenazepam was formally classified as a narcotic substance on 24 March 2010. This drug has had a limited spread, but in 2008, relatively large quantities were seized in Nord-Trøndelag Police District, both illegally manufactured tablets and technically pure active agents. A similar case was uncovered in Agder Police District in 2010, where approx. 9.9 kg of tablets and about 600 grams of technically pure phenazepam were seized.

## 10.4 Price of illicit drugs at retail level

The latest overview of estimated drug prices from Oslo police district of May 2010 was presented in the National report for 2010. Compared with the previous overview from October 2008, the nominal price of a typical user dose in the Oslo area has remained relatively stable: EUR 25 (NOK 200) for 0.2g of heroin, EUR 12.5 (NOK 100) for 0.2g of amphetamine, EUR 37.5–50 (NOK 300–400) for 0.5g of cocaine, and EUR 12.5 (NOK 100) for 0.7g of hash.<sup>16</sup>

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

<sup>16</sup> Conversion rate: 1 EUR=8 NOK

313. For hash and amphetamine, the changes are only marginal.

The price also seems to have dropped for purchases of 10 grams. The estimated price of 10 grams of heroin is between EUR 450 and EUR 688 in 2010 (NOK 3,600 and NOK 5,500). In 2008, the price level was EUR 625–750. The price of 10 grams of cocaine and amphetamine is also markedly lower, approximately 18 per cent lower for cocaine and as much as 25 per cent for amphetamine. There are no such changes in relation to hash.

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

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

## 10.5 Purity/potency/composition of illegal drugs and tablets

See data in Standard tables 14 and 15.

Table 15 shows that the average purity of heroin base continues to fall. An average purity of 21 per cent is the lowest ever measured, and none of the seizures made in 2010 had a heroin content of more than 48 per cent. As in previous years, paracetamol and caffeine were found in a number of seizures, in addition to depressants such as benzodiazepines, primarily alprazolam. A typical mixture can contain 8–10 per cent heroin and a large proportion of alprazolam, which causes stronger and more untraditional intoxication symptoms. Such mixtures are registered both in heroin seized at the border and in seizures made in the user milieu.

**Table 15: Average purity of heroin 2005–2010.**

Year	2005	2006	2007	2008	2009	2010
Purity percentage	26	30	36	31	25	21

Source: Kripos

The average purity of amphetamine was about 25 per cent, and 44 per cent for methamphetamine. For amphetamine, this is lower than in 2009 (29 %). As in previous years, the purity varied greatly in 2010, from less than one per cent to as much as 97 per cent.

As reported for several years now, the purity of seized cocaine has been declining steadily, from more than 70 per cent more than 20 years ago to 25 per cent in 2009. In 2010, however, the purity increased again to 28 per cent. There are still great variations in the individual seizures. Fenacetine, xylocain and caffeine are often found as additives.

Experience shows that the THC content of cannabis products can vary a great deal. Whole plants usually contain three to seven per cent THC, and isolated top shoots usually contain 11 to 22 per cent. For hash, which dominates the Norwegian market, the average THC content has remained at around seven per cent for several years, but analyses for 2010 show that this average has increased to nine per cent.

For more than 20 years, MDMA has completely dominated in seizures of ecstasy tablets. Until 2008, no other substance accounted for a significant part of this tablet market. In 2010, however, the proportion of seizures of MDMA only accounted for 19 per cent, while it accounted for between 87 and 98 per cent in the period 2004–2007. The proportion of mCPP was as much as 69 per cent of tablet seizures in 2010. 2C-B accounted for eleven per cent, while the proportion of methamphetamine was less than one per cent.





# PART B

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Selected issues

# 11. Drug-related health policies and services in prison

*Tore Rokkan, Senior Advisor, Correctional Services of Norway, Staff Academy*

## 11.1 Prison systems and prison population: contextual information

### 11.1.1 Characteristics of the population, health and social status

The average number of inmates in Norwegian prisons was just over 3,700 in 2010.<sup>1</sup> This is an increase of almost 400 from the year before. The total number of inmates during the year was 14,606, which is slightly fewer than the year before. The number of new inmates in 2010 was 11,700, 3,900 of whom were held on remand.

Of the sentences imposed in 2009, sentences for crimes of violence accounted for 25 per cent, followed by driving under the influence (22 %) and drug crimes (15 %). Three per cent were sentenced for sexual offences. Around ten per cent were between the ages of 16 and 20, while 17 prisoners were below the age of 16 in 2010. Most stays in prison are relatively short: In 2010, four out of ten were released within 30 days, while 75 per cent were released within three months.

The proportion of foreign inmates (both on remand and serving sentences) has increased strongly in recent years, from 18 to 32 per cent of the average number of inmates in Norwegian prison from 2006 to 2011. Foreign inmates also

serve longer sentences than Norwegian inmates, most often for drug crimes (about 40 %). Foreign inmates are a complex group. Most of them are from countries in Eastern Europe and North Africa. Inmates in this group are entitled to necessary medical help in prison, but they will normally not be returned to Norwegian society after serving their sentences.

Several surveys show that the level of morbidity among inmates is generally higher than among the population at large.<sup>2</sup> This applies to drug and alcohol addiction, mental health problems and somatic illnesses. A survey conducted by the research foundation Fafo on the basis of interviews with 260 inmates shows that four out of ten have chronic illnesses that affect their everyday lives (Friestad & Skog Hansen, 2004). The corresponding figure in the general population is 25 per cent. Two out of ten inmates have financial problems. Outside prison, this was the case for around six per cent of the general population. Four out of ten inmates have no education after lower secondary school, while the same applies to fewer than one in ten of the general population. This may say something about an accumulation of several living-condition problems, and it shows that there is a connection between a high number of previous prison sentences and several problem areas (Ibid).

### 11.1.2 The extent of drug and alcohol use in Norwegian prisons

The three biggest surveys available on drug and alcohol use and prisons are all based on figures from the early 2000s:

<sup>1</sup> Annual statistics 2010. The central administration of the correctional services. <http://img3.custom-publish.com/getfile.php/1640752.823.befyrrfee/årsstatistikk+2010+bruk.pdf?return=www.kriminalomsorgen.no>

<sup>2</sup> Bjørngaard et al. 2009. The prisoner as patient – a health services satisfaction survey. *BMC Health Services Research* 2009, 9:176. <http://www.biomedcentral.com/1472-6963/9/176#B3>

- Skardhamar (2002)<sup>3</sup> has interviewed 247 inmates from a cluster sample of some prisons in a region (the Eastern Norway prison district) since the year 2000.
- Friestad and Skog Hansen (2004)<sup>4</sup> have data from 260 interviews of convicted persons from all prisons in 2003.
- Ødegård (2008)<sup>5</sup> uses data from a questionnaire survey of all convicted persons in 2002.

All the surveys ask about drug and alcohol use during a period of two to three months prior to imprisonment. The results vary from almost 60 per cent to 76 per cent reporting that they had used drugs in the period prior to imprisonment. The first two surveys focus on living conditions in general, while Ødegård focuses more specifically on the difference between alcohol and drugs. Ødegård also differentiates the results by type of use, i.e. the type of drug used, the frequency and the method of taking the drug (e.g. by injection). Here, the proportion of inmates displaying *serious problem drug use*<sup>6</sup> prior to imprisonment was estimated to be 45 per cent, while 23 per cent had *less serious drug use*.<sup>7</sup> Another finding in this survey concerns the consumption of alcohol prior to imprisonment. The findings stand out from the rest of the population, both in that a greater proportion report high-frequency alcohol consumption and in that more people abstain from alcohol than in the general population.

Several things can be said about whether the results of the surveys are representative of the situation in prisons today. This applies in particular to the proportion of inmates serving short sentences. On an average day in 2003, 20 per cent<sup>8</sup> of all inmates were serving a sentence shorter than three months. In Friestad and Skog Hansen's survey, this group was eleven per cent.<sup>9</sup> Over the whole year, 75 per cent of those who were released had served less than three months. The proportion of inmates who serve short sentences in the course of a year is therefore higher as a proportion of all inmates than figures based on measurements taken on a single day. This is a weakness of sample surveys, which are often based on the proportion of inmates on a given day. Moreover, Friestad and Skog Hansen only include inmates serving sentences, not those held on remand. The number of persons held on remand has increased in recent years and it now accounts for almost 30 per cent of the number of days served in prison. There are no good studies of drug use among persons held on remand, but this group of inmates is challenging in relation to systematic follow-up of possible drug or alcohol problems. Skardhamar found no differences in drug/alcohol use between inmates serving sentences and inmates held on remand.<sup>10</sup>

## 11.2 Organisation of prison health policies and service delivery

### 11.2.1 Drug-related health policies targeting prisoners

The white paper on the correctional service, *Punishment that works – less crime – a safer society* (Report no 37 (2007–2008) to the Storting),

<sup>3</sup> Skardhamar, T. 2002. Levekår og livssituasjon blant innsatte i norske fengsler ('Living conditions and life situation among inmates in Norwegian prisons' – in Norwegian only). Master's degree thesis in criminology. The Department of Criminology and Sociology of Law, the University of Oslo.

<sup>4</sup> Friestad, C. and Skog Hansen, I.L. 2004. Levekår blant innsatte ('Living conditions among inmates' – in Norwegian only) in Fafo report 429. Oslo <http://www.fafo.no/pub/rapp/429/429.pdf>

<sup>5</sup> Ødegård, E. 2008. Narkotika- og alkoholproblemer blant innsatte i norske fengsler ('Drug and alcohol problems among inmates in Norwegian prisons' – in Norwegian only). Published in the Nordic Alcohol and Drugs Journal (NAT) no 3 2008: p. 169-185.

<sup>6</sup> By serious problem drug use is meant the reporting of frequent use of heavy drugs.

<sup>7</sup> By less serious drug use is meant the reporting of sporadic use of heavy drugs or frequent or sporadic use of cannabis.

<sup>8</sup> Length of sentences for inmates serving sentences of less than three months as of 16 May 2003. Taken from Kompis KIA report v-02-10a as of 19 September 2011.

<sup>9</sup> Length of sentences for inmates taken from Table 2.2, Friestad and Skog Hansen 2004 p. 17.

<sup>10</sup> Skardhamar, T. 2002. Op. cit. p. 86

sets the direction for work on drug and alcohol problems in prison. The correctional service shall execute sentences while at the same time facilitating changes in the individual inmates and preparing their return to society in collaboration with ‘imported services’<sup>11</sup> and external partners. The correctional service has developed a drug and alcohol strategy (2008–2011) that contains three sub-goals for this work: 1) Motivate and facilitate, 2) Reduce the use of drugs and alcohol during prison sentences and 3) Strengthen the cooperation between drug and alcohol measures and collaborative partners.

Inmates have the same rights as the general population. This is particularly the case in relation to health, and drug and alcohol users in prison are entitled to treatment and follow-up by the health service. The municipal health service is present in all prisons. It is the municipality in which a prison is located that is responsible for health services in the prison. GPs are the most important resource for those serving sentences under the supervision of the probation service. *The Administrative Alcohol and Drugs Treatment Reform* in 2004 (see more details in Chapter 5.3)<sup>12</sup> and *the Norwegian Action Plan on Alcohol and Drugs* (2008–2012)<sup>13</sup> emphasised in particular the health service’s responsibility for collaborating with the correctional service during the serving of sentences and for following up inmates upon release.

When the Administrative Alcohol and Drugs Treatment Reform transferred responsibility for detoxification, assessment and specialised treatment for drug and alcohol use to the public health service, drug and alcohol dependency became a more limited category. The health service’s assessment of drug and alcohol dependency and of treatment needs became a medical assessment (the ICD-10 and DSM IV classification systems). It is an important point that it is this assessment of the patient’s condition/situation that constitutes the treatment order, which in turn triggers a right to treatment.

One of the sub-goals of the Action Plan is to *improve accessibility of services for prisoners and convicts*. It lists six measures that are also followed up in the correctional service’s strategies:

- Improve collaboration between the municipal health service, the specialist health services, the municipal social services and the Norwegian Correctional Services.
- Increase the number of prison days served in an institution pursuant to section 12 of the Norwegian Execution of Sentences Act.
- Establish units for people with problem drug/alcohol use in prisons.
- Improve the services for prisoners about to be released.
- Evaluate the trial scheme Drug Rehab Programme under Court Supervision and assess continuation and expansion.
- Develop a coordinated strategy to combat substance use in the Norwegian Correctional Services.

<sup>11</sup> Imported services are services provided in prison by persons/agencies not employed by the prison. Teaching, health services, library and other services are examples of such services. The health service has been an imported service in prisons since 1988, and the municipalities took over this responsibility in 1994.

<sup>12</sup> Information about the Administrative Alcohol and Drugs Treatment Reform is available on the Directorate of Health’s website: <http://www.helsedirektoratet.no/rusmidler/behandling/rusreformen/>

<sup>13</sup> Information about the Government’s escalation plan for the drugs and alcohol field is available on the Directorate of Health’s website: <http://www.helsedirektoratet.no/rusmidler/opptrappingsplanen/>

## 11.3 Provision of drug-related health services in prison

### 11.3.1 Treatment in the health service

From a social service and health perspective, prison is a good arena for starting change processes, since inmates are available and motivated for change. All inmates are entitled to the same medical treatment in prison as other users. This also applies to the right to an individual plan, a

right to participation and a right to information, the informed consent requirement and the right to referral to the specialist health service, if relevant.

The correctional service carries out basic assessment of inmates on arrival in prison. This assessment is intended to provide information about matters with a bearing on the prison term and to form the basis for referral to collaborative partners for a more detailed assessment. In spring 2012, the correctional service will start testing an electronic assessment form. Participation in this assessment will be voluntary for the individual inmate.

Inmates who are in opioid substitution treatment and/or have been prescribed other addictive medicinal drugs (class A and B drugs) will be able to continue this treatment in prison. For persons held on remand, it is their GP who has medical responsibility, if relevant in collaboration with the prison health service. The prison health service and the prison doctor take over responsibility for convicted persons and consider continuation of the treatment during the stay in prison.

Although the prison health service is part of the municipal health service, the extent to which it is integrated with the municipality's other health care varies. The prison health service staff are mainly nurses and doctors, while some units also have a physiotherapist and a psychologist. The average time health services are available per inmate in all prisons in Norway is one hour and ten minutes per week, but there are great variations between prisons. There has been an increase in the number of nurses and doctors from 2007 to 2010, but not as great as the increase in the number of inmates during the same period.<sup>14</sup>

<sup>14</sup> Kartlegging av fengselshelsetjenesten i Norge 2010 ('Survey of the prison health service in Norway 2010' – in Norwegian only). Synovate Norge. 21 March 2011.

In the health service's report for 2007, 15 out of a total of 45 prison units express concern about capacity. Several units are also concerned about inadequate provision of specialist health services. The Directorate of Health's assessment points out that *the need for health services in prison is probably much greater than in the rest of the population...* and that *the provision varies so much that a survey of the coverage of health personnel in prisons should be considered.*<sup>15</sup> In a survey conducted by Synovate Norge on assignment for the Directorate of Health in 2010, eight of out ten health departments report that the prison health service provides adequate health services, while one out of ten disagree. The health departments were also asked whether the prison health service had sufficient resources to provide the necessary health services. More than half agreed that they did.

Collaboration with the prison health service is one of the most important measures in the correctional service's drug and alcohol strategy. It is regulated in a separate circular,<sup>16</sup> which is intended to contribute to improving coordination and strengthening local and regional cooperation. The circular has also been important in collaboration on the Action Plan, which also focuses on measures aimed at drug and alcohol users during and after the serving of sentences. Among other things, it emphasises follow-up of individual plans, which are the users' own plans, in order to coordinate treatment and rehabilitation, and collaboration between the prison health service and the specialist health service in order to offer treatment during the serving of sentences.

<sup>15</sup> The Directorate of Health 2009. Helsetjenester til innsatte i fengsel ('Health services for inmates in prison' – in Norwegian only). Report 2007.

<sup>16</sup> Rundskriv G-8 2006 om Samarbeid mellom kommunehelsetjenesten, spesialisthelsetjenesten, kommunenes sosialtjeneste og kriminalomsorgen overfor innsatte og domfelte rusmiddelavhengige ('Circular G-8 2006 concerning collaboration between the municipal health service, the specialist health service, the municipal social service and the correctional service in relation to inmates and convicted problem drug or alcohol users' – in Norwegian only).

The units for mastering drug and alcohol problems, which are also part of the correctional service's drug and alcohol strategy, are one such collaboration measure (see Chapter 11.3.2).

A proposed new health and care act (expected in 2012) will transfer responsibility for more health tasks from the specialist health service to the municipalities. The consultative paper discusses in particular services relating to people with mental illnesses and people with drug/alcohol dependency.<sup>17</sup> The municipalities will also be assigned clearer responsibility for following up individual plans and for coordinating the measures before, during and after treatment. This also applies to the prison health service's responsibility for providing health care for convicted persons.

### 11.3.2 Measures and treatment provision for inmates

A description of the most important measures for drug prevention, information and educational activities follows below. They are part of the correctional service's overall drug and alcohol strategy and aim to motivate and facilitate abstinence from drugs and alcohol by convicted persons/persons on remand during imprisonment and better control of drug and alcohol use after release.

#### Units for mastering drug and alcohol problems

The units for mastering drug and alcohol problems are a rehabilitation service for inmates who are being assessed for entitlement to interdisciplinary specialised drug or alcohol treatment. Entitlement to such treatment may confer a right to treatment beyond the duration of the sentence. In the course of 2011, 13 units for mastering drug and alcohol problems will be established in Norway, in addition to two corresponding units that have already been established. Eight units

have been established in high-security prisons, and five in prisons with lower levels of security. The precursor to the units for mastering drug and alcohol problems was the collaboration on the Pathfinder Programme between Oslo prison and the Tyrili foundation. In the units for mastering drug and alcohol problems, prison staff work together with health professionals from the specialist health service on a treatment-enhancing measure aimed at further treatment in prison, either pursuant to the Execution of Sentences Act section 12 or by the specialist health service after release.

A separate circular is being prepared on the organisation of the collaboration in the units for mastering drug and alcohol problems. It will contain guidelines and procedures for reporting on the collaboration and the development of the units.

#### Suspended sentence with drug courts

Suspended sentence with drug courts is a separate penal sanction based on the model of Drug Courts in Ireland and Scotland. The programme was established as a three-year trial scheme from 2006 with two units in Oslo and Bergen. It has since been extended until the end of 2014 (see Chapter 9.3.3). The correctional service's education centre has completed a follow-up evaluation of the start-up of the project.<sup>18</sup> SIRUS is now collecting data from two years' follow-up of 115 persons who have been included in the project. Admission to the programme has taken more time than expected, which will delay the evaluation by up to two years.<sup>19</sup>

#### Serving of sentences pursuant to section 12

The Execution of Sentences Act section 12 gives inmates who have drug or alcohol problems and/or mental health problems the possibility of serving their sentence in a treatment or care institution (see

<sup>17</sup> Consultative paper; draft new municipal health and care act. <http://www.regjeringen.no/nb/dep/hod/dok/hoeringer/hoeringsdok/2010/horing2/horingsbrev.html?id=621193>

<sup>18</sup> Johnsen, B. and Svendsen, M. Narkotikaprogram med domstolskontroll ('Suspended sentence with drug courts' – in Norwegian only). Start-up of the teams and centres 2006. <http://img3.custompublish.com/getfile.php/502689.823.wcquuyytdf/dok22007.pdf>

<sup>19</sup> Personal correspondence, Astrid Skretting, SIRUS 19 September 2011.

Chapter 9.3.1). Many of those who are transferred pursuant to section 12 are under assessment for entitlement to interdisciplinary specialised drug and alcohol treatment in the specialist health service. The number of convicted persons who are transferred has remained stable at around 500 per year, following an increase since the early 2000s.<sup>20</sup> More measures are now being initiated to increase the number of convicted persons serving their sentence this way. In order to achieve this, collaboration with the health service must start as early as possible. In April 2010, the correctional service took over responsibility for summoning convicted persons to serve their sentences. One of the advantages of this is the opportunity it offers to include information about measures such as serving sentences pursuant to section 12. It is also important that the health service and the municipalities make use of this opportunity to continue or start treatment in prison.

#### **The return-to-society guarantee**

The Government's return-to-society guarantee was launched in Report no 37 (2007–2008) to the Storting. It entails that all inmates who lack housing, employment or training, who need social services, treatment for drug or alcohol dependency or other health services, shall be offered this when they are released from prison. It is a goal that all agencies with which the correctional service cooperates shall offer their services in all large prisons. Today, schools and health services are established in all prisons, while social services, labour and other welfare services that are organised under the Norwegian Labour and Welfare Service (NAV), and the specialist health service, are only present in a few prisons.

The qualification programme is a measure organised by NAV that aims to help more people to find employment and engage in activity through closer and more binding collaboration. Seven

prisons are included in this programme to test the collaboration between NAV and the correctional service. It is the NAV office in the municipality in which a prison is located that takes part in the collaboration instead of the office in the inmate's home municipality. This is modelled on the collaboration with the health service. Of the seven prisons taking part in the qualification programme, five are establishing units for mastering drug and alcohol problems.

#### **11.3.3 The correctional service's overall drug and alcohol strategy**

The correctional service is implementing several measures as part of its drug and alcohol strategy. The prison officer, acting as contact officer, is the most important resource in this context. All permanently employed prison officers in Norway act as contact officers. The contact officer has day-to-day contact with the inmate and is responsible for motivating and facilitating contact and follow-up of plans with the inmate. Interviewing methods such as motivational interviewing, assessment and sentence planning are tools used in this process. The contact officer usually participates in the inmate's individual plan or other plans for the period in which the convicted person is serving his/her sentence.

The drug and alcohol coordinator or the prison's social counsellor shall contribute to coordinating collaboration between the inmate, the contact officer and collaborative partners that work in or outside the prison. In connection with the implementation of the return-to-society guarantee, dedicated reintegration coordinators have been appointed who will assist in planning reintegration after sentences are served.

A substance abuse interview is an alternative to sanctions for violation of the prohibition on drug and alcohol use in prison. It can also be used as a rehabilitation measure to create motivation to change drug and alcohol habits. The interview consists of three structured conversations based on motivational interviewing and cognitive methodology. All prisons shall offer such interviews as an alternative to sanctions for violating the

<sup>20</sup> An evaluation of the section 12 scheme by Ploeg, G. 2006. *Straff i institusjon* ('Punishment in institutions'). (English <http://img3.custompublish.com/getfile.php/327910.823.aqavswtdyu/rapport32006.pdf>)

prohibition on drug and alcohol use. This entails closely linking control and rehabilitation measures.

### **Measures and cognitive programmes in prison**

The purpose of measures and cognitive programmes carried out under the auspices of the correctional service is to motivate or prepare the inmate for treatment or follow-up. Some programmes are offered as a result of criminal offences, such as the most comprehensive programme *Trafikk og rus* ('Driving under the influence'), which is a cognitive programme targeting persons convicted of driving under the influence who are serving their sentences in prisons with a lower level of security. In 2010, 350 inmates completed this programme. More specific programmes are offered to inmates with an acknowledged drug or alcohol problem, such as the Canadian National Substance Abuse Programme (NSAP).<sup>21</sup> To ensure quality, programmes that are organised under the auspices of the Norwegian correctional service must be approved following an assessment by a dedicated accreditation committee. Following a trial period of three years, NSAP is now being implemented in several prisons on a permanent basis. In several prisons, NSAP is part of the service offered by the units for mastering drug and alcohol problems. Up to 100 inmates took part in such programmes in 2010.

A special penal sanction is being implemented under the auspices of the probation service as an alternative to prison for persons convicted of driving under the influence. The penal sanction includes participation in a cognitive programme over a period of ten months and it entails the convicted person being referred to an assessment for drug and/or alcohol treatment in the specialist health service. The number of participants per year is approximately 500.

### **11.3.4 Quality and scope of the services**

There are two important questions relating to the collaboration between the correctional service and the health services: How extensive services must be offered in order to ensure equal right to treatment in and outside prison, and how shall the services be adapted to ensure that the individual inmates can make use of this service?

Most prisons have procedures for basic assessment on arrival, and several of them involve the health and school departments. There is no uniform system for such assessments today, but a trial project aimed at identifying inmates and convicted persons' needs is scheduled to start-up in Halden prison and at Østfold probation office in 2012. The assessment is intended to identify needs relating to the person's housing situation, education, work, finances, health and other factors that are important in the rehabilitation context. Participation in the assessment is voluntary, and it will not replace the collaborating agencies' own mapping or evaluations.

Subject to the patient's consent, the prison health service will obtain information from the patient's GP and from any treatment facilities by which the inmate was being treated prior to imprisonment. Subject to the client's consent, the municipal social services will contact the correctional service to establish contact with the prison and maintain contact with the inmate during his/her stay in prison. A right to specialised interdisciplinary drug or alcohol treatment is conferred following a medical assessment.

### **11.3.5 Adaptation of the services**

It is the inmate/convicted person who, together with the health service, decides how much and to what extent the prison shall be informed about his/her health situation and treatment. Persons held on remand can continue to use their GP outside the prison. For convicted persons, this responsibility is transferred to the prison doctor during the serving of the sentence. The health service shall continue work on individual plans or start such work for those who wish and are entitled to such a plan.

<sup>21</sup> Correctional Service Canada, SubstanceAbuseProgrammes, NSAP. <http://www.csc-scc.gc.ca/text/prgrm/sub-eng.shtml>



A survey of the prison health service from 2011 shows that procedures have been established for collaboration with the specialist health service in all prisons. This applies in particular to collaboration on psychiatric treatment and treatment for drug or alcohol problems, but also to somatic treatment to some extent. There is also extensive collaboration with the correctional service during the serving of sentences, but to a lesser extent after the transfer of inmates to another prison or upon their release. Procedures for collaboration with the home municipality (GP) upon imprisonment and release have only been established to a small extent. The prison health service has to some extent established collaboration with NAV during imprisonment, but to a lesser extent upon release.<sup>22</sup>

In some prisons, the specialist health service also offers outpatient treatment for inmates with mental illnesses. The goal is that convicted persons who are included in the units for mastering drug and alcohol problems will be transferred to treatment in an institution during serving of their sentence pursuant to section 12, or to treatment in an institution or outpatient clinic upon their release.

As mentioned above, both NAV and the correctional service contribute to the qualification programme in the form of staff and facilitating collaboration in prison. The health service and, if relevant, the unit for mastering drug and alcohol problems, are also part of this collaboration.

### 11.3.6 Coordination of planwork

Individual plans are the most important tool for coordinating planwork in the health and social services. The legal basis for them is set out in both health and social services legislation. Problem drug and alcohol users in prison will usually be entitled to have an individual plan prepared if they do not already have one. It is expedient that the prison (the contact officer) participates in the

work on the plan and at meetings about the plan, so that it can facilitate meetings and implementation of the plans during the serving of sentences.

An evaluation was carried out in the period 2006–2008 following a trial involving the coordination of planwork at eleven correctional service units.<sup>23</sup> The units that succeeded in finding solutions were the ones that started by holding a meeting with the inmate at which all the relevant parties were present and involved in the information that was given.<sup>24</sup>

## 11.4 Control in prisons

The fundamental principle underlying the correctional service's overall drug and alcohol strategy is to see control measures in conjunction with motivational/rehabilitation measures. It shall always be possible to follow up control measures with motivational and rehabilitation measures. The substance abuse interview (cf. Chapter 11.3.3) is an alternative to a sanction following violation of the prohibition on drug and alcohol use for inmates with drug or alcohol problems. Other sanctions can include loss of privileges such as watching TV or participation in social activities.

Control measures such as urine tests, breathalyzer tests (alcohol) and searches are carried out on a regular basis with a view to discovering drugs and user equipment. There has been a slight downward tendency in the use of drugs and illegal medicinal drugs uncovered by urine tests in recent years. There are great difference between the units and regions, however, in the proportion of positive tests.

<sup>22</sup> Synovate 2011. Survey of the prison health service in Norway 2010.

<sup>23</sup> Rokkan, T. 2006. Samordning av planarbeid: Fra kaos til orden ('Coordination of plan work: From chaos to order' – in Norwegian only). Final report with comments and recommendations. KRUS. [http://www.krus.no/upload/Samordning%20av%20planarbeid\\_evaluering.pdf](http://www.krus.no/upload/Samordning%20av%20planarbeid_evaluering.pdf)

<sup>24</sup> Often called a 'responsibility group meeting', but is has no legal basis in legislation or regulations.

Over the last three years, 75,588 urine tests have been carried out, and illegal drug use was found in 8,857 samples, including those who refused to give samples (11.7 %).<sup>25</sup> The ten prisons with the most finds of illegal use are mainly large prisons (more than 50 inmates), and high-security prisons. Prisons with few finds of illegal use are often small prisons and prisons with lower security levels.

## 11.5 Training of prison staff

Competence-raising is an important tool in the correctional service's drug and alcohol strategy. This applies in particular to the sub-goal of *motivating and facilitating abstinence from drugs/alcohol by convicted persons during imprisonment and better control of drug/alcohol use after release*. It includes the development and use of new mapping tools that combine mapping on a broad basis with knowledge about finds from controls and observations to form a complete picture of convicted persons/prisoners on remand. Training in planwork is also crucial for all correctional service staff if they are to be able to cooperate with the health service and other partners on the convicted person's own plan during and after the stay in prison.

The correctional service's education centre (KRUS) provides staff training. All correctional service staff must be conscious of their own use of drugs/alcohol, they must be knowledgeable about drug and alcohol dependency, have the ability to identify drug and alcohol problems, and be able to assess motivation, motivate for change using motivational interviewing (MI), carry out controls and recognise signs and symptoms of drug and alcohol use, be aware of the connection between drug and alcohol dependency and mental illness, and be familiar with

the support system and treatment available to drug addicts and alcoholics.

This comprehensive goal is linked to a two-year basic education and/or further education for all correctional service staff. The goal is that all staff shall be able to evaluate and implement measures as a reaction to finds or suspicion of drug or alcohol use during the serving of prison sentences. This also includes specialised control functions, such as the drug service dog handlers, who also need skills in motivation, assessment and change work.

KRUS also offers training to partners in the prisons: the health service, the social services and the municipalities. This training is currently focused in particular on training in substance abuse interviews, the training and certification of programme leaders in the National Substance Abuse Programme (NSAP), the training of staff at the units for mastering drug and alcohol problems and professional conferences aimed at strengthening the collaboration on reintegration, collaboration at the units for mastering drug and alcohol problems, with the focus on inmates with mental illnesses.

## 11.6 Further issues

There are several challenges relating to the coordination of plan work between collaborative partners and the correctional service. Many prisons are small and have limited capacity. In the smallest prisons (15–25 inmates), there are only one or two permanent staff members at work during daytime due to work rotas. Work rotas may also be an obstacle to continuity of collaboration in larger prison units.

The difference of approach between the correctional service's vision of fully drug-free prisons and the health service's treatment and harm-reduction measures is a challenge in relation to collaboration. This applies to substitution treatment, the distribution and use of other addictive medicinal drugs and to the use of needles. As

<sup>25</sup> Calculated on the basis of statistics from controls carried out using urine tests (drugs and medication) or breathalyser tests (alcohol) in all prisons in Norway for the years 2008, 2009 and 2010.

regards treatment with methadone, Subuxone and Subutex, which is permitted, the distribution and administering of the medicines could be a challenge, especially in prisons with few prison health service staff.

This conflict of interest is most apparent in the discussion about the use of needles in prison. In a report from 2009, the Directorate of Health recommended giving inmates access to clean needles.<sup>26</sup> Previous practice has been to grant access to chorine for sterilisation purposes. The Norwegian Board of Health and the Norwegian Medical Association endorsed the recommendation, while the prison officers' unions, the prison health service and the police were against it. In 2010, the Ministry of Health and Care Services decided to reject the proposal, stating that there was little need to change the current practice, that the safety of prison staff was important and that the distribution of needles in prisons could undermine work on motivating inmates for change and treatment.<sup>27</sup>

Another critical factor in connection with collaboration is the fact that many inmates serve relatively short sentences. Three out of four convicted persons released in 2010 had served up to 90 days. The average duration of sentences was 123 days. Almost half were released after 30 days on remand and one of three after 60 days. The average time spent on remand was 79 days. This means a high turnover and a short time frame in which to implement measures during the serving of sentences.

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<sup>26</sup> Ekeid, S.E. 2009. Tilgjengelighet i norske fengsler til sterile sprøyter og spisser for injiserende rusmiddelavhengige. Forslag til en ny tilnærming. ('Access to sterile needles and syringes for injecting drug addicts in Norwegian prisons. Proposal for a new approach' – in Norwegian only). The Directorate of Health

<sup>27</sup> The Ministry of Health and Care Services. Press release 28 July 2010: Nei til utdeling av sprøyter i fengslene ('No to the distribution of needles in prison' – in Norwegian only). <http://www.regjeringen.no/nb/dep/hod/aktuelt/nyheter/2010/nei-til-utdeling-av-sproyter-i-fengslene.html?id=611770>

In several prisons, the prison health service describes the increasing number of foreign inmates as a major challenge, both in relation to access to interpreting services and in relation to the provision of necessary help. This emerges from a qualitative survey of the prison health service in four selected prisons (Synovate, 2011).<sup>28</sup>

Some prisons have better health resources than others, and they also seem to be allocated new resources through the focus on units for mastering drug and alcohol problems, collaboration with NAV and the correctional service's own drug and alcohol strategy. However, if we compare the location of the units for mastering drug and alcohol problems with the overview of finds of illegal drug use in connection with control measures, there is little correlation between units with a high proportion of finds of illegal use and the establishment of units for mastering drug and alcohol problems. There does not seem to be a connection between prison health services and the prevalence of illegal use detected through controls. There are as many units with extensive resources as units with few resources that have a high proportion of finds of illegal use.

Equal right to treatment is an important principle in the Norwegian health service. The basis for such equal treatment is an individual assessment of needs. It is therefore important that the health departments in all prisons have the resources they require to be able to refer inmates for assessment, and that the prison is capable of facilitating any necessary treatment in collaboration with the specialist health service and NAV. In order to plan such collaboration, a common knowledge base is required of the scope of drug and alcohol dependency among inmates and convicted persons. In a consultative paper on new national professional guidelines for the assessment, treatment and follow-up of persons with concurrent drug and/or alcohol problems

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<sup>28</sup> Synovate 2011. Op. cit.

and mental health problems,<sup>29</sup> it is proposed that the prison health departments be given responsibility for screening all inmates on admission to

prison. Such screening, both in prisons and in the probation service, would be a good starting point for designing appropriate measures.

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<sup>29</sup> The national professional guidelines for assessment, treatment and follow-up of persons with concurrent drug or alcohol problems and mental health problems are available online: [http://www.helsedirektoratet.no/vp/multimedia/archive/00316/H\\_ringsversjon\\_av\\_r\\_316179a.pdf](http://www.helsedirektoratet.no/vp/multimedia/archive/00316/H_ringsversjon_av_r_316179a.pdf)

## 12. Drug users with children (addicted parents, parenting, child care and related issues)

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### 12.1 Size of the problem

#### 12.1.1 Epidemiological characteristics

Norway lacks the data sources needed to estimate the number of pregnant women or parents of young children who use narcotics. However, some relevant data is available from studies of patients under treatment for drug problems.

Among 2,325 patients in a national cross-section study of substance abusers in treatment in 1992–1993, 35 per cent reported having children (Lauritzen et al., 1997). In the age group 20 years or younger, 6 per cent reported having one or more children. In the age bracket 21–30 the share was 34 per cent, whereas 58 per cent of those who were aged 31 and upwards had children. Upon admittance for treatment, 11 per cent informed that they had daily custody of children. The share of women confirming to have children in their care was significantly higher than the share of men reporting these responsibilities. In an earlier study from Oslo in the years 1990–1991, which comprised 697 persons admitted to treatment, 39 per cent answered that they had children and 14 per cent said they had daily responsibility and custody of children under the age of 15 (Arner et al., 1995).

Also available is a prospective cohort study of 481 drug users who were admitted to treatment in 1998/1999 and who were followed up for 10 years. The material here was analyzed in relation to the type of treatment patients were admitted to. This reveals that 50 per cent of the patients at residential units for adults had children and 11

per cent had custody of children. At the outpatient clinics 21 per cent had children and 5 per cent had daily custody, whereas 70 per cent of the patients receiving opioid substitution treatment (OST) had one or more children and 4 per cent had daily custody (Lauritzen, 2010).

As regards OST patients, in the period 1996–2009 some 250 children were registered as born by mothers who had used methadone or buprenorphine during their pregnancy. Only an estimated 10–15 per cent of these children were living with their mothers. About 60 per cent of the mothers reported having prior children (Welle Strand, 2011).

In 2010, 8,750 new patients with drug diagnoses were accounted for at the Norwegian Patient Register (NPR). The share they represent of the total number of patients being treated with a drug diagnosis cannot be estimated yet, as the individual-based registry is new and reporting is still deficient. The uncertainty here applies particularly to patients undergoing outpatient treatment. In future registrations the NPR will routinely receive information on the number of children for each patient, their ages, and their custody and care situation at the time when parents are admitted to treatment.

### 12.2 Health-related risks among children living with alcohol and drug abusing parents.

In the past decade Norwegian health authorities have become more alerted to the issue of pregnancy combined with substance use. The report *Pregnancy, children and substance use* (The Directorate of Health, 2000) addressed the

primary health care service, social services and child care services. It provides information about the harm of substance use on the foetus and includes birth parameters assessed by types of substances. As a vital preventive strategy, clear warnings were given to abstain from alcohol and other substances during pregnancies. However, for pregnant patients undergoing OST it is recommended to continue their use of substitute medication. A few Norwegian studies have been conducted on pregnant patients in OST and their children. Not many patients were involved in the studies, however, so the findings have to be interpreted prudently.

Research on OST patients and their children has been carried out in Oslo since 2002. (Bakstad et al., 2009; Welle Strand, 2011). A diminishing number of patients have partaken in substitution treatment during pregnancy in recent years, and most of them had been in OST for some time before pregnancy. These women have often left their drug use behind and are undergoing rehabilitation. Pregnant women in OST in Norway use relatively high doses of OST medication compared to what is given in other countries, despite some of them decreasing dosages during pregnancy. In the studies by Bakstad and Welle-Strand the methadone dosages averaged 90mg or more, both during initiation and at the time of birth. About half of the newborns exposed to OST medications required medication for neonatal withdrawal syndrome (NAS) with an average treatment period of just over 40 days, whereas the duration for infants exposed to buprenorphine was a little shorter. No statistically significant connection was found between the mothers' dosages of methadone/ buprenorphine during pregnancy and the frequency or duration of NAS. Nearly all the women smoked tobacco during their pregnancy.

We have insufficient knowledge in Norway about the development of children exposed prenatally to methadone or buprenorphine, but studies are underway. A prospective study (Sarfi et al., 2009) found that infants aged three months in the OST group displayed no difference from peer infants

in a control group with regard to certain measurements used as indicators of regulation difficulties. However, a study at ages six months and one year does show differences in parent-child interplay variables between the OST group and the control group, particularly regarding sensitivity and distraction. It could appear that children whose mothers are in OST have a higher degree of reported behavioural problems at ages two and three than children in the control group. But very few had problems requiring clinical intervention. As many as 95 per cent of the children live with their mothers at ages two as well as age five. These families have been intensively followed up.

A study from Bergen (Sandtorv et al., 2009) of pregnant patients in OST showed that more than half the children (N= 13) were exposed prenatally to substances other than substitution medications. During the follow-up period five of the 13 children displayed a sub-average psychomotoric development and two had symptoms of hyperkinetic behaviour disorder.

There are also prospective studies of children born by drug using women who have not been in OST. Sundfær (1992, 1999, 2001, 2004, 2009) has followed children of 40 such women from their birth to age 25. In a long-term follow-up of Norwegian children exposed to drugs *in utero* Moe (Moe, 2002; Slinning et al., 2007; Walhovd et al., 2009; Moe et al., 2010) and Slinning (Slinning, 2003; Slinning, 2004; Slinning & Moe, 2007; Walhovd et al., 2007, Walhovd et al., 2009) have contributed valuable information about attention and self-regulation and the effects of prenatal opiate exposure on brain development.

The consequences of growing up with parents with harmful use of substances will pivot on a wide range of factors. However, some common denominators for substance use and parenting are apparent which span all types of substances. Alcohol or drug use can undermine alertness to the daily needs of children, it can destabilize life rhythms, lead to wide swings in humour and behaviour that are bewildering for children. To

various degrees it can pan out in a deficit of parental care.

Children of substance abusers are not a homogenous group. Substance use problems in families express themselves in a variety of ways, in intensity and duration, and children will exhibit different degrees of vulnerability and capabilities for tackling the stresses they are exposed to. The problematic use of substances in families will nevertheless often lead to economic difficulties, transience and a lack of security for affected children.

Knowledge about these conditions has been accrued in many ways. Children's own accounts are rich sources for understanding the conditions in which they grew up and their developmental problems. The offspring of substance abusers have written biographies after coming of age. Therapeutic work with adult offspring represents a source that has provided essential phenomenological knowledge about how daily life is impacted and can continue to affect lives into adulthood (Hansen, 1990, 1994). A state of alert is often high among children in families where drugs or alcohol play a dominant role – a preparedness against both unfamiliar and familiar scares. Their efforts to gain control can have large consequences on a child. It can lead to introversion, difficulties in concentrating, physical ailments, anxiety and depression. Help toward validation of feelings and understanding of incidents and experiences can be important in various phases of the child's life.

Follow-up studies in Norway show that over 50 per cent of drug users in treatment report having had parents with a serious alcohol problem (Arner et al., 1995, Lauritzen et al., 1997). The share who relate serious mental disorders among their parents is also considerable and we see that alcohol abuse and mental problems are largely concurrent. Also a very high share of the youngest patients are the offspring of drug using parents. These studies concur with international research and show how important it is to evaluate

harmful substance use in a generational perspective.

## 12.3 Policy and legal framework

### 12.3.1 Policy

In 2003, the then Ministry of Children and Family Affairs took the initiative for a study charting provisions for children whose parents had substance use problems. Special attention was to be given to children who accompanied their parents in the residential treatment. Additional focus was given to obtaining a nationwide overview of specific provisions that had been established for the children. Documentation from the study was published in two reports (Solbakken et al., 2005, Solbakken & Lauritzen, 2006). In parallel, equivalent studies were made regarding children whose parents suffered from mental disorders (Åmodt & Åmodt, 2005).

The recommendations of these reports coalesced on a call to view the needs of both groups of children in a similar context. In keeping with this advice, the Government passed an inter-ministerial initiative in 2007 to follow up children from these two parental groups.

A national network of competence «Barns Beste» [In the interests of children] was established for prevention and treatment of problems encountered by the children. The objective is to facilitate the spread of expertise by gathering, systemizing and disseminating knowledge and experience to a widespread and often decentralized professional field. The scope of responsibility has later been extended to include children whose parents suffer serious somatic illnesses and children with incarcerated parents. A reference group for the network has been established as well as a group of researchers on a national level focusing on children at risk.

In the 1990s seven regional centres of competence regarding substance use were established in Norway. One of them, Borgestadklinikken, specializes in pregnant substance users and their

children. Another, Rogaland A-senter, has a special focus on children at school age. Annual national conferences are held with the theme «Barnet og rusen» [The child and substance use] and these make bountiful use of international expertise.

Mental health care for children and adolescents is required by national guidelines to give priority to bolstering competence about alcohol and drug use and addiction. This is vastly important for improving identification of parents' substance use problems where the child is the primary patient and to reach out with early interventions to children and youngsters. A national network of competence for infants' and young children's mental health care has been formed with the aim of offering education and conducting pertinent research about infants. Infants and young children who have been exposed to harmful substance use are included as an important target group.

Comparably, expertise about substance use is a priority area for the child care services. One of the ways this is being attended to is by implementing screening tools, among them Adolescent Assessment Dialogue (Friedman et al. 2001), which monitors the use of substances in a broader behavioural perspective. The instrument also includes questions about parents' use of drugs and alcohol.

### 12.3.2 Legal framework

Amendments have been made in the Health Personnel Act and the Specialist Health Services Act to ensure that personnel in health care services identify and attend to the underage child's needs of information and follow-ups as next of kin. The goal is to ensure that these children are getting early help and that processes are established to make children and their parents more suited to tackle the situation in cases of severe illness and substance use problems.

To enable health personnel to assist children as involved parties in their parents' problems, a new provision was made in the Health Personnel

Act (§25 third paragraph). The provision allows confidential information to be given to partners in cooperation as required in attending to the needs of a patient's children, as long as the patient does not object. To bolster the position of children when their parents are seriously ill, a provision has been made in the Specialist Health Services Act (§3–7a) that health institutions covered by the specialist health services are to have personnel responsible for children ([www.lovdata.no](http://www.lovdata.no)). The regulation channels responsibility to these persons so they can promote and coordinate health personnel's supervision and attendance to minors whose parents suffer from mental disorders, somatic illnesses, are seriously injured or have substance use problems.

Treatment of substance abuse in Norway is to be an interdisciplinary, specialised health service. Municipalities that have a coordinating and follow-up responsibility for these patients are not encompassed by this legal provision. However, they are free to adopt such a system.

### 12.3.3 Plans related to substance users and their children

#### Plans of action against substance use problems:

Three plans of action for 2003–2005, 2006–2008 and 2008–2012, have all aimed at placing prevention work in focus for children and youth and sought to be goal-oriented with regard to children and youth in risk relationships.

#### Relationship between mental health and substance use:

##### *Escalation plan for mental health*

The escalation plan (1998–2006) presupposes an overall approach and a broad spectrum of initiatives across sector lines. It also counts on considerable expansion, competence boosting and increases in efficiency in the specialist health services. As regards earmarked funding for municipal mental health care, the Directorate of Health has issued a circular that at least 20 per cent of the funds should be targeted for children and youth.



### Other public documents that have an impact on children whose parents have substance use problems:

#### *UN Convention on the Rights of the Child*

The UN Convention on the Rights of the Child was incorporated into Norwegian law in 2003. In accordance with article 12 regarding respect for the views of children, children are to be given the right to express their views on judicial and administrative proceedings that concern them.

#### *White Paper No. 40 (2001–2002) About Child and Youth Care*

This Government white paper concerns preventive help to children and families. Child Welfare should be a central player in efforts to help particularly vulnerable children and adolescents. Measures taken must be considered in an overall context in accordance with the needs of children and youth.

#### *White Paper no. 39 (2001–2002) About growing up and living conditions for children and youth in Norway.*

The main perspective is on children and youth as a resource. Another key issue is the bolstering of parental responsibility. Efforts to counteract marginalization and contribute to levelling dif-

ferences in living conditions among children and youth are the main concern.

#### *White Paper no. 6 (2002–2003) Plan of action against poverty.*

This maintains that parents' employment is the major prerequisite for counteracting poverty and for improving the conditions in which children are raised. Goal-oriented improvements are stressed in the welfare services and in initiatives aimed at promoting social inclusion of children and youth.

#### *The Child Care Act of 1994.*

The purpose of this act is to ensure that children and youth who live under conditions that could be detrimental to their health and development are given timely and necessary help and care and to contribute to secure conditions for children and youth to grow up in. Several of the provisions in the act impose the child care services to offer services and carry out necessary measures when conditions call for such action.

Policy documents and legal regulations, along with rather large budget allocations have sharpened the demand for vigilance and action with regard to children of substance abusers in Norway.

	Parents' substance use problem IS known	Parents' substance use problem IS NOT known
The child HAS signs of maladjustment	A: These children are easiest to identify. They display clear signs of maladjustment/developmental difficulties and their parents' drug/alcohol problem is known. The children often have comprehensive needs for help and child welfare is involved with many of the families.	B: These children display clear signs of maladjustment/developmental difficulties. Because the parents' substance use problem is unknown, the children's symptoms and difficulties are treated without being related to the drug or alcohol problem as a cause or burden.
The child DOES NOT have signs of maladjustment	C: The parents' substance use problem is known but the children appear to be resourceful, capable and well functioning. Compensational strategies that that can overburden the child and create developmental difficulties later are not dealt with.	D: These children are hardest to identify and provide interventions for. They often go unnoticed and catching on to a difficult childhood requires a professional eye and a sensitive approach. In such cases, schools and kindergartens are important arenas for observation and prevention and vital bases for care.

## 12.4 Specific responses for drug users with children

### 12.4.1 Availability of specific responses

The background material for the Government's initiatives for 2007–2014 indicated that the help offered to especially vulnerable children has been incidental and not comprehensive enough. Impressive individual efforts have been made but no general strategy has been implemented for detecting and reaching children who suffer from their parents' use of drugs and alcohol.

In the report «Tilbud til barn av rusmiddelmissbrukere» [Responses to children of substance users] (Solbakken & Lauritzen, 2006), the table below was used to illustrate the need to identify various groups of children needing help, depending on whether their parents' substance use problem is known or not, and whether the children themselves display maladjustment or developmental difficulties.

The division shows that diverse categories of children and parents will pose different challenges on the public and private facilities that provide assistance and treatment. Such challenges will link to awareness of parental substance abuse and the children's behavioural development and display of problems.

### Early intervention for pregnant patients and for young children and their parents

Family wards or mother/child units have been established at several of the Norwegian residential institutions. These are meant to receive mothers (or both parents) with children in situations where parents require treatment and well-founded, professionally assessed reasons are present for bringing their children along. In a study from these units we learned that 93 per cent of the children were under the age of three and 64 per cent under the age of one (Solbakken et al., 2005). Twenty-five per cent of these infants were born during their mother's stay at the institutions and priority was given to the youngest

children and to pregnant patients as early in their pregnancy as possible.

Therapeutic work in these facilities is particularly demanding. The parents' treatment and rehabilitation process has to be ensured while an ongoing evaluation needs to be made regarding optimal care of the children. This requires a high degree of competence in observation and intervention with regard to the interplay between parents and children, attachment issues, parental duties and possible development disturbances among the children. It calls for systematic and professional assessments and access to external specialists in child psychiatry and neurology, and sufficient monitoring and diagnostic tools. The Directorate of Health has put a lot of effort into gathering and evaluating instruments for various purposes and age groups in this context and these have been integrated in the Norwegian Electronic Health Library. Very few of the residential institutions have been evaluated so far.

As a link in the Government's initiatives (2007–2014), a systematic training programme lasting two years has been given to employees at this type of treatment centres (Killen, 2010). Its evaluations have been uplifting (Klette, 2011). A network for all of the country's treatment units that admit patients who are pregnant or parents with young children meets twice a year to share experiences and strengthen mutual competence.

Following a Danish model, so-called *family ambulatories* are being tried out (Olofsson, 2006). These are linked to somatic hospitals and are intended to provide preventive health assistance to pregnant substance abusers and follow-ups of their children until they reach school age. Preventive health assistance is safeguarded through contact with the pregnant woman and her family as early in pregnancy as possible. Focus is on prevention of drug and alcohol related developmental harm to the child. The provision has a family prospective with focus on psychosocial conditions and socioeconomic matters. The family ambulatory is a low-threshold measure requiring interdisciplinary collaboration among post-natal wards, mental health

care services and various municipal agencies and programmes which offer help. An ongoing coordination and adjustment of efforts is required to help these patients and their family's situation. Family ambulatories call for long-term monitoring and coordinated efforts.

Another of these initiatives is the so-called model municipality experiment. The intention here has been to evolve functional models for early interventions and systematic follow-ups of children. Twenty-six municipalities participate and they annually receive extra state funding. These municipalities must establish and develop inter-departmental cooperation among various municipal services and their services and special initiatives for children, youth and adults. Regional coordinators have been employed and the model municipalities are regularly given opportunities to improve their expertise and share their experiences in regional and national network gatherings. Emphasis is given to use of monitoring tools to detect and prevent early developments of problems among children. The activities of the model municipalities have been documented and the report for 2010 states that they have come a long way towards identifying the target group. Municipalities have started to use monitoring tools and are working systematically toward their implementation. The reports also show that they have initiated their development of tangible assistance measures.

A project affiliated with the model municipality experiment is the *Instruction programme for screening tools and clinical advice approaches in encounters with pregnant women and parents of young children*. The programme spreads knowledge to professionals working on a daily basis with pregnant women and parents with youngsters, such as GPs, midwives and public health nurses. The programme is also directed at relevant professionals in municipal child welfare, employees who work specially with substance abuse problems, deal with violence and mental health, family welfare offices, etc. Representatives from kindergartens and others who work with

preschool children can also participate. Central elements in this programme are:

- Alcohol and pregnancy, how alcohol harms the foetus. Use of the monitoring tool TWEAK (Tolerance, Worried, Eye opener, Amnesia, K(c)ut down)
- Mental problems during pregnancy and when children are young. Use of Edinburgh Postnatal Depression Score (EPDS). (Holden et al., 1989, Wickborg & Hwang, 1996)
- Violence during pregnancy and when children are young. Use of Abuse Assessment Screen (AAS) ([www.Nkvtvs.no](http://www.Nkvtvs.no))
- Teaching the Motivational Interviewing (MI), (Barth et al., 2001, Prescott et al., 2004, Rollnick et al., 2007).

The instructional programme is under evaluation to be presented in 2012.

### **Children at school age**

School age is often a critical period for children of substance users. New expectations and extensive socialization with peers and spare time activities make it harder to hide alcohol and drug use in the family. Schools can be important arenas for identifying children's care situation and applying appropriate help. Teachers are often in need of assistance and cooperation from other professionals. It was revealed (Solbakken & Lauritzen, 2005) that many of the provisions made for school-aged children of substance abusers are group-based and under the supervision of local public health centres for primary schools or public mental health care agencies for children and adolescents. Little has been done so far to evaluate these measures. In general, a high degree of expertise is required to deal with a child's role as participant in a therapeutic group. The study pointed out the importance of viewing group interventions within a systemic and cultural psychological/sociological perspective. The need for individual provisions for support and treatment of children and youth was also stressed.

### **Treatment measures for substance abusers**

When parents with harmful use of substances are admitted to treatment it should be obvious that attention also must be given to their children's situation. This applies to the specialised treatment centres for the patient group and for somatic and psychiatric health services. Since 2010 these specialised treatment centres are obliged to ask patients about their children, how old they are and what their care situation is. The data is reported to the Norwegian Patient Registry. Treatment units should also be responsible for ensuring that the child's situation is both looked into and attended to. Some treatment centres work according to family therapy principles and have plenty of experience with analyzing a family system and focusing on the children. Others have a long way to go. Another major challenge involves creating continuity in treatment and follow-up measures for the family members when their basis is rooted in different governmental levels and an array of services.

### **Knowledge development**

In connection with the Government's plan of action an overall strategy is being sought for developing expertise about drug and alcohol problems in families. This is directed toward the child welfare services, mental health care, kindergartens, schools, public health centres, and GPs. Efforts are underway to integrate expertise about substance abuse in relevant curriculums at colleges and universities.

## **12.4 Availability of specific guidelines and guides**

*The national guidelines for pregnant patients in OST rehabilitation and follow-ups of families with young children until the kids reach school were completed in 2011. See also Chapter 5.2. The goal for the guidelines is the provision of clear, knowledge-based recommendations for treatment and follow-ups of OST patients during pregnancy and at post-natal hospital wards. Children of OST patients are to receive systematic attention until school age. The project group*

that worked out these guidelines concurred on all recommendations with the exception of how methadone and buprenorphine should be used during pregnancies. This is a difficult and controversial issue. The Directorate of Health's primary recommendation is that female patients should not scale down their use of substitute medications during pregnancies, unless they choose to do so. A guide on early intervention in substance abuse cases, *Fra bekymring til handling (2009)*, [From concern to action] spells out responsibilities and alternative reaction and treatment forms. This guide was discussed in the national report for 2009, Chapter 3.3.1.

## **12.5 Concluding comments**

As shown in recent years some rather intensive and comprehensive initiatives have been made for children whose parents have severe health problems, the children of drug users inclusive. The strategy that has been followed involves the creation of all-embracing structures that are capable of spotting children who are burdened by special family conditions and developing specific measures for sub-groups that are adapted to the children's age and needs as well as the parents' problems. The child's own voice, as part of a user perspective is included as a key principle.

It has been pointed out that such an initiative requires an overall plan to maximise the utilisation of resources and ensure their direct benefit to children. No conclusive summaries of the Government's initiatives have been carried out, but a number of measures have been launched and a willingness to act is clearly evident.

# References

## Chapter 2

Bretteville-Jensen, A.L. (2011): *Rusmiddel- og tobakksbruk blant unge voksne i Norge. Hovedfunn fra en spørreundersøkelse foretatt i 2010 blant 18–30 åringer*. Nettrapport [www.sirus.no](http://www.sirus.no)

Hibell B., Guttormsson U., Ahlström S., Balakireva O., Bjarnasom T., Kokkevi A., Kraus L. (2009): *Substance abuse among students in 35 European countries. The 2007 ESPAD report*. The Swedish Council for Information on Alcohol and Other Drugs (CAN), Stockholm.

Vedøy, T.F., Skretting A. (2009): *Ungdom og rusmidler. Resultater fra spørreskjemaundersøkelser 1968–2008*. Statens institutt for rusmiddelforskning, SIRUS rapport nr 5/2009, Oslo (EN summary).

## Chapter 3

Baklien B. & Krogh U.(2011): *Prosessene ,planen og politikken –Rusmiddelpolitiske handlingsplaner* SIRUS rapport 2/2011 (EN summary)

## Chapter 4

Bretteville-Jensen, A.L. (2005): *Økonomiske aspekter ved sprøytemisbrukeres forbruk av rusmidler*. Sirus rapport 4/2005 (EN summary).

Bretteville-Jensen, A.L., Amundsen, E.J. (2009): *Heroinforbruk og heroinbeslag i Norge*. Sirus rapport 8/2009 (EN summary).

Hordvin, O. (Eds)(2009): *The Drug Situation in Norway 2009. Annual report to the EMCDDA*

Reid, M.J. Langford, K.H., Grung, M., Gjerde, H., Amundsen, E.J., Thomas, K.V., Mørland, J.: *Estimation of Community Cocaine Consumption:*

*A Critical Comparison of Three Complimentary Techniques* (unpublished manuscript 2011)

Waal, H., Clausen, T., Håseth, A., Lillevold, P.H. (2011): *Statusrapport 2010*. Senter for rus og avhengighetsforskning, Rapport 4/2011.

## Chapter 5

Helsedirektoratet (2011): *Behandlingstilbud til pasienter i TSB*. Samdata analyse.Rapport IS-1863

Helsedirektoratet (2011): *Aktivitetsdata fra psykisk helsevern for voksne og tverrfaglig spesialisert behandling av rusmiddelmisbruk 2010*. Norsk pasientregister. Rapport IS-1911

## Chapter 6

Gjersing L.,Biong S., Ravndal E.,Waal H.,Bramness J.,Clausen T.(2011): *Dødlige overdoser i Oslo 2006 til 2008. (Fatal overdoses in Oslo between 2006 and 2008)* Seraf rapport 2/2011 [www.seraf.uio.no](http://www.seraf.uio.no). (EN summary)

Dyb, E. og Johannessen K.:(2008): *Bostedsløse i Norge 2008 – en kartlegging*. NIBR-rapport 18, 2008

Gråwe, R. W. og Ruud T.(2006): *Rus og psykiske lidelser i psykisk helsevern for voksne* SINTEF Helse

Skog Hansen, I. L. og Øverås S.(2007): *Bolig for personer med psykisk lidelse og rusproblematikk i: Brodtkorb, Elisabeth: Under tak – mellom vegger. Perspektiver på boligens betydning i velferdsstaten* Gyldendal akademisk

Helsedirektoratet (2011): *Aktivitetsdata for psykisk helsevern for voksne og tverrfaglig spesialisert behandling av rusmiddelmissbruk 2010*. IS-1911

Lundeberg, Mjaland, Søvig, Nilssen og Ravneberg (2010): *Tvang overfor rusmiddelavhengige. Evaluering av Lov om sosiale tjenester, §§ 6-2, 6-2a og 6-3*, Rokkansenteret rapport nr 2, 2010

Melberg, H.O., Lauritzen G., Ravndal E. (2003): *Til hvilken nytte, for hvem og til hvilken kostnad? En prospektiv studie av stoffmisbrukere i behandling*. SIRUS rapport nr. 4/2003 (EN summary).

Mordal J. (2010): *Recent substance intake and drug influence among patients admitted to acute psychiatric wards. A cross – sectional study of toxicological findings, physician assessment and patient self-report in two Norwegian hospitals*. Journal of Clinical Psychopharmacology: August 2010 – Volume 30 – Issue 4 – pp 455–459

Vaaler A. E., Morken G., Flovig J. C., Iversen V. C., Linaker O. M. (2006): *Substance abuse and recovery in a Psychiatric Intensive Care Unit*. Gen Hosp Psychiatry 2006; (28): 65–70.

## Chapter 7

Gjersing L., Biong S., Ravndal E., Waal H., Bramness J., Clausen T. (2011): *Dødlige overdoser i Oslo 2006 til 2008. (Fatal overdoses in Oslo between 2006 and 2008)* Seraf rapport 2/2011 www.seraf.uio.no. (EN summary)

Gerdts A., Grung M. (2011): *Overdoser i Bergen. En kartleggingsrapport om risiko og beskyttende faktorer . Utekontakten i Bergen*

Helsedirektoratet (2011): *ROP-lidelser, sammensatte lidelser – Samtidig behandling. Forslag til retningslinje*

Eide, G.V. (2011): *Dobbelt så vanskelig? Doble diagnoser i doble systemer. Spesialisthelsetjenestens behandling av pasienter med samtidige psykiske lidelser og ruslidelser. En sammenligning av tre organisasjonsmodeller*. KORFOR-rapport 2011/01

## Chapter 9

Norwegian Institute of Public Health (2011): *Rusmiddelbruk i trafikken* www.fhi.no

Kriminalomsorgens sentrale forvaltning (2011): *Årsstatistikk 2010*

Statistics Norway (2011): *Kriminalstatistikk, anmeldte saker 2010* www.ssb.no

Statistics Norway (2011): *Kriminalstatistikk ,etterforskede saker 2009*

Statistics Norway (2010): *Kriminalstatistikk ,straffereaksjoner 2009*

## Chapter 10

Kriminalpolitisenralen-Kripos (2011): *Narkotikastatistikk 2010* www.kripos.no

Kriminalpolitisenralen-Kripos (2011): *Narkotikastatistikk. Første halvår 2011* www.kripos.no

## Chapter 12

Arner, O., Lauritzen, G., Waal, H., Amundsen, A. (1995): *Forprosjekt til en nasjonal studie av stoffmisbrukere i behandling*. SIFA-rapport nr. 3/95.

Bakstad, B., Sarfi, M., Welle-Strand, G.K., Ravndal, E. (2009): *Opioid maintenance treatment during pregnancy: occurrence and severity of neonatal abstinence syndrome. A national prospective study*. European Addiction Research; 15(3):128–34.

- Barne-, ungdoms- og familiedirektoratet (2010): *Modellkommuneforsøket*
- Barth, T., Børtveit, T., Prescott, P. (2001): *Endringsfokusert rådgivning*. Gyldendal akademiske (2001)
- Friedman, A.S., Utada, A. (1989): *A method for diagnosing and planning the treatment of adolescent drug abusers*. Journal for drug education, 19 (4):285–312.
- Hansen, F. (1990): *Rusmiddelbruk i et familieperspektiv – hvilke utviklingsmessige konsekvenser kan dette få for barn*. Tidsskrift for Norsk Psykologforening; (27):737–746.
- Hansen, F. (1994): *Barn som lever med foreldres rusmisbruk*. Oslo: Ad Notam Gyldendal.
- Holden, J. M., Sagovsky, R., Cox J.L. (1989): *Counselling in a general-practice setting- controlled study of health visitor intervention in treatment of postnatal depression*. British Medical Journal (1989)
- Killen, K. (2009): *Risiko-omsorgssvikt-samspill-tilknytning*. Borgestadklinikken, Blå Kors Forlag. ISBN 978-82-90-35465-2.
- Klette, T. (2011): *Rapport fra evaluering. Risiko-omsorgssvikt-samspill-tilknytning*. Borgestadklinikken, Blå Kors Forlag. ISBN 978-82-90-35467-6.
- Helsedirektoratet (2009): *Fra bekymring til handling. En veileder om tidlig intervensjon på rusområdet*.
- Helsedirektoratet (2010): *Far er syk, mor er syk. Barn som pårørende*. Rundskriv IS-5
- Helsedirektoratet (2011): *Nasjonal retningslinje for gravid i Legemiddellassistert rehabilitering (LAR) og oppfølging av familiene frem til barnet når skolealder*.
- Lauritzen, G., Waal, H., Amundsen, A., Arner, O. (1997): *A Nationwide Study of Norwegian Drug Abusers in Treatment: Methods and Findings*. Nordisk alkohol&narkotikatidsskrift. Vol. 14. 43–63. English Supplement.
- Lauritzen, G. (2010): *European Addiction Severity Index (EuropASI) i en oppfølgingsstudie av narkotikabrukere i behandling. Refleksjoner om kvaliteter ved instrumentet for forskning og praksisformål*. SIRUS rapport 6/2010. (EN summary)
- Moe, V. (2002): *A prospective, longitudinal study of children exposed to drugs. Predictions and developmental outcome at 4 1/2 years*. Department of Psychology: University of Oslo.
- NKVTS Rapport 1. 2009 (www.Nkvtv.no)
- Olofsson, M. (2003): *København-modellen. Det sårbare barnet. Barn, foreldre og rusmiddelproblemer* (red Killen, K. & Olofsson, M.) Kommuneforlaget.
- Prescott, P. & Børtveit, T. (2004): *Helse og atferdsendring*. Gyldendal akademiske 2004.
- Arbeids- og sosialdepartementet (2005): *Regjeringens handlingsplan mot rusmiddelproblemer 2006–2008*.
- Rollnick, S., Miller E.R & Butler, C.C. (2007): *Motivational interviewing in health care. Helping patients change behavior*. Guilford Press (2007).
- Sandtorv, L., reigstad, H., Bruarøy, S., Elgen, I., Lægreid, L.M. (2009): *Har legemiddellassistert rehabilitering i svangerskapet konsekvenser for barna?* Tidsskrift for den norske legeforening, 129:287–290.
- Sarfi, M., Martinsen, H., Bakstad, B., Røislien, J., Waal, H. (2009): *Patterns in sleep-wakefulness in three-month old infants exposed to methadone or buprenorphine*. Early Human development; 85 (12):773–8.

- Sarfi, M., Smith, L., Sundet, L.M., Waal, H. (2011): *Risks and realities: Dyadic interaction between 6-months old babies and their mothers in opioid maintenance treatment*. *Infant behavior and Development* 34:578–589.
- Slinning, K. (2004): *Foster placed children prenatally exposed to poly-substances. Attention related problems at ages 2 and 4 ½*. *European Child and Adolescent Psychiatry*; 13 (1): 19–27.
- Slinning, K. (2003): *A prospective, longitudinal study of children prenatally exposed to substances: With special emphasis on attention and self-regulation*. Psykologisk institutt, Universitetet i Oslo.
- Slinning, K., Moe, V. (2007): *Forskning i klinikk; langtidsoppfølging av spedbarn som har vært eksponert for rusmidler i fosterlivet*. Norges barnevern (Spesialnummer).
- Sosial- og helsedirektoratet (2007): *Veileder for psykisk helsearbeid for barn og unge i kommunene*. IS-1405.
- Solbakken, B.H., Lauritzen, G., Ødegård Lund, M.K. (2005): *Barn innlagt sammen med foreldre som er i behandling for rusmiddelproblemer*. SIRUS rapport nr. 5/2005. (EN summary).
- Solbakken, B.H., Lauritzen, G. (2006): *Tilbud til barn av foreldre med rusmiddelproblemer*. SIRUS rapport nr. 1/2006. (EN summary).
- Sosialdepartementet (2003a): *Forskning på rusmiddelfeltet: en oppsummering av kunnskap om effekt og tiltak*: Sosialdepartementet, NOU 2003:4
- Sosialdepartementet (2003b): *Ot.prp. nr 54 (2002–2003): om lov om endringer i lov 13. desember 1991 nr. 81 om sosiale tjenester m.v.(Rusreform II og rett til individuell plan)*.
- Sosial- og helsedepartementet – Rusmiddel-direktoratet – Borgestadklinikken kompetanse-senter (2000): *Graviditet, barn og rusmidler*. ISBN nr. 82–90345–50–9
- Walhovd, K.B., Moe, V., Slinning, K., Due-Tønnesen, P., Bjørnerud, A., Dale, A.M., Kouwee, A.D., Quinn, B.T., Kosofsky, B., Greve, D., Fisher, B. (2007): *Volumetric cerebral characteristics of children exposed to opiates and other substances in utero*. *Neuroimage* (36):1331–1344.
- Walhovd, K.B., Moe, V., Slinning, K., Sigveland, T., Fjell, A., Bjørnebekk, A., Smith, L. (2009): *Effects of prenatal opiate exposure on brain development - a call for attention*. *Nature Reviews Neuroscience*; (10):390–390.
- Welle Strand, G.K. (2011). Personal information
- Welle Strand (2011). *Norwegian national cohort of pregnancies in Medication Assisted Rehabilitation*.
- Helsedirektoratet (2010): *Nasjonal retningslinje for gravide i Legemiddelassistert rehabilitering (LAR) og oppfølging av familiene frem til barnet når skolealder*. Helsedirektoratet. IS-1876.
- Wickberg, B., Hwang P. (1996): *Counseling of postnatal depression: a controlled study on a population based Swedish sample*. *Journal of Affective Disorders*, 39.
- [www.lovdato.no](http://www.lovdato.no)
- Aamodt, L.G., Aamodt, I. (2005): *Tiltak for barn med psykisk syke foreldre*. Regionsenter for barn og unges psykiske helse. Helseregion Øst og Sør.



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SQ 32	Policy and institutional framework

## List of relevant websites in English:

Ministry of Health and Care Services:

<http://www.regjeringen.no/en/dep/hod.html?id=421>

Norwegian Directorate of Health:

[http://www.shdir.no/portal/page?\\_pageid=134,112387&\\_dad=portal&\\_schema=PORTAL&language=english](http://www.shdir.no/portal/page?_pageid=134,112387&_dad=portal&_schema=PORTAL&language=english)

Norwegian Institute of Public Health:

<http://www.fhi.no/eway/?pid=238>

Norwegian Centre for Addiction Research:

<http://www.seraf.uio.no/eng/>

Statistics Norway:

<http://www.ssb.no/english/>

Norwegian Institute for Alcohol and Drug Research:

<http://www.sirus.no/internett/OmSirus?language=en>