



European Monitoring Centre  
for Drugs and Drug Addiction



**2007 NATIONAL REPORT (2006 data)  
TO THE EMCDDA**

by the Reitox National Focal Point

**“NORWAY”**

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

Norwegian Institute for Alcohol and Drug Research - SIRUS



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Oslo, November 2007

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## Summary – main trends and developments

### Epidemiology

#### Drug use among young people

Two surveys in 2006, both conducted in the same manner, one among the 15-20 age group, and one among young adults aged 21-30 showed major differences both in terms of both lifetime prevalence and use during the past six months of all types of drugs. The levels for 21-30 year-olds are more than twice as high as for 15-20 year-olds, both in Norway as a whole and in Oslo. And while lifetime prevalence has increased strongly among young adults during the period 1998-2006, the opposite has happened among young people under the age of 20.

For cannabis, it can be concluded that experimentation is most frequent from the late teenage years and into the twenties. Here, prevalence is still on the increase, while new recruitment among the very youngest appears to be declining. As regards recent use of cannabis, these surveys cannot substantiate that there has been a definite increase among young adults. The data display a high degree of stability. The decrease in “use during the past six months” among 15-20 year-olds is more striking, a decrease that has been fairly pronounced since the turn of the millennium.

For other drugs, it is more problematic to identify clear trends, since so few people report use and random factors can go in both directions. Among young people under the age of 20, lifetime prevalence for amphetamine, cocaine and ecstasy, the three most reported drugs, appears to have declined during the period 1998-2006. Among young adults, the opposite trend is even clearer. In an eight-year perspective, lifetime prevalence for all the three drugs has increased considerably; for amphetamine it has doubled and for cocaine it has increased even more. But the prevalence for use during the past six months has not increased, with the exception of cocaine, which has seen a doubling during the last four years. The biggest increase in the use of cocaine is among men in Oslo.

#### Drug-related infectious diseases

The number of HIV cases among injecting users remains low. In 2006, only 7 new cases (3 % of the total number of HIV cases) concerned injecting users. The proportion that has developed AIDS is somewhat higher (13 %), but the number remains low and stable.

The hepatitis B outbreak continued, and 74 of a total of 149 cases of acute hepatitis B in 2006 were among injecting drug users. During the period 1995-2006, the total number of reported cases of acute hepatitis B among injecting drug users was 1 812. Hepatitis C is not monitored to the same extent as hepatitis A and B, and the number of new cases of drug users being infected with the hepatitis C virus in Norway is therefore still not known.

#### Drug-related deaths

There are two bodies that register drug deaths, Statistics Norway and the National Crime Investigation Service - Kripos. Both series of figures peak in 2001 and decline thereafter. According to the statistics from Kripos, 195 persons died as a result of drug use in 2006, 11 more than in 2005. Oslo had most: 72 deaths (2005:78). The 2006 figures from Statistics Norway are not yet available.

The statistics from Kripos also show that 72 per cent of the deceased in 2006 were under the age of 40, while just over 20 per cent were under the age of 25. The percentage of drug-related deaths among the youngest group (15-25 years) has remained relatively stable, although disturbingly high, since the turn of the millennium.

## **Drug Markets**

In 2006, the highest number of cases and seizures for four years was registered. The number of seizures of cannabis and cocaine is the highest ever. A record amount of amphetamine was seized in 2006.

For methamphetamine, the trend is still moving steeply upwards. The number of seizures has almost tripled since 2001. Methamphetamine also accounts for the biggest change in terms of positive findings for illegal substances in road traffic cases, from slightly less than 10 per cent positive in 2003 of the total number of cases received to almost 20 per cent positive finds in 2006.

Norway is probably one of the biggest markets for methamphetamine in Europe, with respect to both the amounts seized and the number of seizures. Most of the methamphetamine comes from illegal laboratories in Russia, Poland and Lithuania. Lithuania has probably taken over the role of main supplier of synthetic drugs such as amphetamine, methamphetamine and Rohypnol to Norway. Poland and the Netherlands are still important countries, but the majority of those arrested are Lithuanians.

On the basis of the seizures, the availability of cannabis still appears to be great. Cannabis was seized in all the 27 police districts in 2006. Twenty-one police districts have made more seizures than in 2005, and many of them have experienced an increase of between 20 and 80 per cent in the number of seizures compared with 2005.

In 2006, cocaine was registered in all the police districts. There are many indications that cocaine is more widespread geographically than ever before, both in terms of absolute figures and in relation to other drugs. The amount of unreported cases/use may be particularly large since cocaine is often used in nightlife arenas where the police are seldom or never present.

The number of heroin seizures in 2006 was the lowest for 15 years, and the number has been more than halved since 2001. Although the reduction is an indication that the demand for heroin has fallen substantially, the reduction in recent years is nonetheless so marked that doubts can be raised about whether the seizure statistics reflect the situation on the street with respect to availability. Kripos also claims that it has no reason to believe that the availability of heroin has been reduced in relation to previous years. 25 of 27 police districts made seizures in 2006. Interviews among injecting drug users in Oslo conducted by SIRUS as part of the mapping of the illegal street market do not indicate that it has become more difficult to obtain heroin in the Oslo area. The estimated price level for heroin on the street also appears to remain quite unchanged.

## **Legal framework/policies/strategies**

The Temporary Act no. 64 of 2 July 2004 relating to a trial scheme for premises for the injection of drugs (the injection room scheme) has been prolonged. It has been decided to extend the period during which the temporary act will be in force by two years, until 16 December 2009. The reason for the extension is to ensure that there is sufficient time to assess the results of the evaluation of the scheme, for which SIRUS is responsible, and to assess and, if applicable, draft a proposal for the permanent regulation of this service before the Act ceases to apply.

In October 2007, as part of its budget proposal, the Government presented an escalation plan for the drugs and alcohol field. It consists of goals and measures in the whole drugs and alcohol field.



and ranges from prevention to treatment and rehabilitation. The plan, which will apply until 2010, deals with both alcohol and drugs policy and national and international measures. The aim of the plan is a policy with a clear public health perspective. The aim is to raise professional standards through research and strengthening competence and quality. The escalation plan will be formally adopted when the national budget for 2008 is considered by the Storting in December 2007.

# ***Part A: New developments and trends***

## **1. National policies and context**

### **1.1 Legal framework**

The temporary Act relating to injection rooms<sup>1</sup> has been prolonged (see NR.<sup>2</sup> 2004 chapter 1.1). It has been decided to extend the period during which the temporary act will be in force by two years. The Act will therefore be in force until 16 December 2009. The reason for the extension is to ensure that there is sufficient time to assess the results of the evaluation of the scheme, for which SIRUS is responsible, and to assess and, if applicable, draft a proposal for the permanent regulation of this service before the Act ceases to apply.

### **1.2 Institutional framework, strategies and policies**

The Minister of Health and Care Services has overall responsibility for drugs and alcohol policy in Norway and for coordinating efforts in the field. Drugs and alcohol policy involves several different sectors and requires coordination across ministry and agency boundaries. In Norway, moreover, there is also a tradition for viewing drugs policy and alcohol policy as one integrated field. There is therefore one combined drugs and alcohol policy and corresponding action plan, rather than one alcohol policy and a separate drugs policy.

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

#### **1.2.1 Escalation plan for the drugs and alcohol field in Norway**

In October 2007, as part of its budget proposal, the Government presented an escalation plan for the drugs and alcohol field<sup>3</sup>. It consists of goals and measures in the whole drugs and alcohol field and ranges from prevention to treatment and rehabilitation. The plan, which will apply until 2010, deals with both alcohol and drugs policy and national and international measures.

The aim of the plan is a policy with a clear public health perspective. The aim is to raise professional standards through research and strengthening competence and quality.

As regards services, the principle is that the ordinary services will also be available to people with drug or alcohol problems. In its nationwide review and assessment of the Administrative Alcohol and Drugs Treatment Reform in 2006 and 2007, the Norwegian Board of Health points to challenges and needs in the drugs and alcohol field – not least with respect to the need for cooperation between different bodies and administrative levels. The escalation plan addresses these challenges. The user perspective is also a central element in the plan. The overriding goals are:

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

2 NR = National report

3 The action plan discussed in NR 2006 chapter 1.2 has been withdrawn.

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

The plan must be seen in conjunction with the Government's special efforts in the fields of poverty, housing, work and mental health, which also have a bearing on the drugs and alcohol field. In order to achieve the goals of the escalation plan, the Government will, among other things:

- Strengthen the municipalities' follow-up work, create more treatment places for interdisciplinary specialist treatment and cut waiting times for treatment
- Ensure that everyone has an individual plan
- Carry out trial schemes with coordinating "representatives" for drug addicts and alcoholics
- Establish drugs and alcohol advisers under the auspices of the county governors
- Improve the quality of the services by introducing quality indicators, mapping tools, guides and professional guidelines
- Introduce a waiting time guarantee for children and young drug addicts and alcoholics under the age of 23
- Produce guides for the services about children of the mentally ill and drug addicts and alcoholics
- Improve knowledge about children who need help, draw up a strategy for early intervention and strengthen the regional child welfare service
- Quantify unsatisfied needs in the municipalities and in the specialist health service
- Award a youth prevention prize

The escalation plan will be presented to the Storting for consideration in autumn 2007 as part of Proposition no.1 to the Storting (2007–2008) for the Ministry of Health and Care Services.

### **Implementation of policies and strategies**

The Directorate for Health and Social Affairs is an executive and advisory body in the field of drugs and alcohol policy. The Directorate is responsible for implementing large areas of the drugs and alcohol policy and for maintaining an overview of the drugs and alcohol situation at the regional and local levels. It also allocates grants to voluntary organisations in the drugs and alcohol field. Responsibility for interdisciplinary specialist treatment has been assigned to the regional health authorities. Norwegian drugs and alcohol policy is decentralised to a great extent, and the municipalities have a considerable responsibility for prevention, rehabilitation and reintegration of drug addicts and alcoholics in the local community.

The Directorate for Health and Social Affairs will have a large part of the responsibility for implementation of the proposed escalation plan for the drugs and alcohol field and will have chief responsibility for many of the proposed measures. Continual follow-up during the plan period will be ensured through collaboration between the ministries involved. The plan assigns chief responsibility for each measure to a specific body. That body will be responsible for instigating measures and involving affected parties. The body with chief responsibility will also be responsible for reporting. In other respects, the general division of responsibility in the public administration will apply.

### **Evaluation of policies and strategies**

A number of the measures in the escalation plan will be specified in more detail during the plan period. In order to ensure systematic development and implementation, a scheme will be established for coordination meetings between affected ministries and relevant subordinate agencies. The Ministry of Health and Care Services will be in charge of coordination, and it will also be responsi-

ble for coordinating the escalation plan with other plans. The status and progress of the different measures will be reported annually to the Ministry of Health and Care Services, and this reporting will form the basis for an annual summary of the attainment of goals and the progress of the measures.

In connection with the Directorate for Health and Social Affairs' grant schemes, great emphasis is placed on evaluating the measures and earmarking funding for the evaluation of measures. The aim is that this will contribute to improving the quality of the measures. Within the limits of the grant schemes, it is seen as being important to support knowledge-based strategies and measures that have continuity and local roots.

### **1.2.2 New centre for research on drugs and alcohol and addiction**

In autumn 2006, the Research Council of Norway advertised funding for a university-affiliated research centre for drugs and alcohol research. The University of Oslo was awarded the centre on 20 June 2007, and it will build on the existing *Unit for Addiction Medicine*, which is affiliated to the Faculty of Medicine.

The main emphasis of the research centre will be on clinic-related drugs and alcohol research, and, in addition to research and network building, it will also offer teaching and supervision of Master's degree students and doctoral students in the field. The research at the centre will be organised into four research teams:

- 1) The development of drugs and alcohol use and addiction,
- 2) Problems and illnesses related to problem drugs and alcohol use,
- 3) Treatment and intervention research,
- 4) Health services related to the treatment of problem users of drugs and alcohol.

The centre will cooperate closely with SIRUS – the Norwegian Institute for Alcohol and Drug Research and with the National Institute of Public Health.

A grant has been allocated for an initial period of up to five years with the possibility of an extension for a corresponding period.

## **1.3 Budget and public expenditure**

### **Law enforcement.**

See selected issue Public expenditure.

### **Social and health care**

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

In 2006, the cost of interdisciplinary specialist treatment for problem drug and alcohol users is estimated to amount to EUR 262.5 million<sup>4</sup> (NOK 2.1 billion) of the regional health authorities' budgets. The figure includes the treatment of both alcoholics and drug addicts. However, the estimate only includes institutions specifically aimed at drug addicts and alcoholics. The costs of drugs and alcohol treatment at other institutions are included under other functions (for example mental health care). These costs cannot be quantified, but they come in addition.

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

## Research

State funding is allocated annually to SIRUS and other research milieus (Table 1).

Table 1. Funding for research and dissemination purposes in 2006. Figures in EUR and (NOK) millions.

SIRUS	4.125 (33)
The Behavioural Centre	0.375 ( 3)
National Institute of Public Health*	1.25 (10)
The research programme – Research Council of Norway/ University of Oslo	1.875 (15)
Unit for Addiction Medicine, University of Oslo	0.625 (5)
Drugs and alcohol research conducted by the regional health authorities*	1.125 (9)
<b>Total</b>	<b>9.375 (75)</b>

\*Approximate figure

The regional drugs and alcohol competence centres. Allocation for 2007: EUR 8.1 million (NOK 64.1 million).

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

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

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

## International actions

Grant for 2007 to UNODC<sup>5</sup>: EUR 3 million (NOK 24 million).

## Special grant schemes

In addition to the ordinary block grant funding allocated to municipalities and health authorities, funds are channelled to specially-prioritised purposes through grant schemes that are largely administered by the Directorate for Health and Social Affairs. The grant schemes are divided between two items on the national budget for 2007:

*Grants for municipal drug and alcohol measures* – EUR 21.591 million (NOK 172.73 million). Among other things, grants shall be used to strengthen personal guidance and individual follow-up, low-threshold health measures for alcoholics and drug addicts, a trial scheme for injection rooms, dental services for people with drug or alcohol problems and publications such as "Oslo" (Norwegian equivalent of "Big issue" in UK).

*Voluntary drug and alcohol prevention work etc.*: EUR 14.971 million (NOK 119.774 million). Grants are earmarked for follow-up, care and rehabilitation services run by voluntary organisations and private undertakings, self-help and interest groups and work among family members, measures aimed at prostitutes and grants to the street hospital in Oslo. In addition, EUR 444,425 (NOK 3.554 million) is channelled through the regional drug and alcohol competence centres to stimulate the municipalities and specialist health service.

5 United Nations Office for Drugs and Crime

The grant scheme *Measures among children and young people in large towns and cities* is administered by the Ministry of Children and Equality. Grants are given to 23 urban municipalities for youth measures and, in 2007, they amount to EUR 2.19 million (NOK 17.5 million). These measures should target youth groups and youth milieus that are deemed to be at risk. Young people from immigrant backgrounds face particular challenges, and measures that promote integration are given high priority. These measures will specifically target young people who make little use of existing cultural and leisure services and provide better opportunities for qualification, inclusion and coping.

## **1.4 Social and cultural context**

### **Public opinion on drug issues**

In recent years, no specific opinion surveys have been carried out on the population's views on drugs policy. There is nonetheless reason to believe that there is relatively extensive support for the current policy. Although certain groups advocate a more liberal drugs policy, this is seen as being a marginal view. Opinion is evolving, however, and an acceptance is gradually emerging for harm reduction measures, but without this changing the ideal goal of freedom from drugs. There is also broad political agreement about the main aspects of drug policy.

### **Attitudes to drugs and drug users**

Attitudes to the use of drugs among young people are still predominantly negative. Surveys among young people, particularly in relation to cannabis, confirm the tendency that the proportion expressing a positive attitude to drugs is no longer increasing. During the last two to three years, approximately 6 to 8 per cent of 15-20 year-olds nationwide have expressed the opinion that it should be permitted to sell cannabis freely here in Norway. In the 21-30 age group in 2006, this proportion was 10 per cent, the same proportion as eight years ago. However, there are more young adults who would have tried cannabis if there was no risk of being arrested. The proportion in this context has varied between 13 and 19 per cent from 1998 to 2006.

There is great acceptance and sympathy among the general population for the view that drug addicts and alcoholics need and should be given help. In large towns and cities where drug addicts congregate, this view often has two elements: that these people need and deserve help, and that they are to a certain extent an annoyance factor viewed with a certain amount of fear. Surveys carried out by the police (in Oslo), however, show that this fear is largely unfounded.

### **Initiatives in parliament and civil society**

No new information available.

### **Mass media campaigns**

No major media campaigns have been conducted in 2006 targeting illegal drugs in particular.

In order to increase awareness about the damage alcohol can result in and to increase knowledge about which methods work best, the Directorate for Health and Social Affairs has carried out separate campaigns during the past three years – [www.settegrenser.no](http://www.settegrenser.no). These campaigns are followed up at the local level, among other things through cooperation with the council of parents for primary and lower secondary schools. Young people and parents are particularly important target groups and there must be agreement between the information aimed at these groups. In addition, people from immigrant backgrounds and pregnant women are given priority. More emphasis will be placed on adapting information to suit the section of the population at which it is aimed. Moreover, the Directorate's information efforts should support and strengthen the understanding that a restrictive alcohol policy is necessary.

### **Action week to combat drugs**

During a week in October every year, a number of voluntary organisations, schools and youth clubs, the police, local help services, the business community and political youth organisations and many others join forces to give an extra boost to the opposition to drugs. The action week in 2007 will be the fourteenth in a row.

In 2007, its profile is one of creating dialogue between youth and adults about drugs. At the same time, it aims to help parents to talk with young people about drugs in a constructive manner. A section of the action week's website will be reserved for adults. In 2006, the action week held more than 400 events throughout the country ([www.actis.no](http://www.actis.no)).

## 2. Drug use in the population

### 2.1 Drug use in the general population

The most recent survey of the general population's drug use was carried out by SIRUS in autumn 2004. The main results were discussed in NR 2005, chapter 2.1. The next nationwide survey is scheduled for 2009.

### 2.2 Drug use among youth and young adults

Data from two new questionnaire surveys have been analysed in 2007:

*The use of drugs among young adults aged 21-30.* Data from the years 1998, 2002 and 2006.  
*The use of drugs among students at the University of Oslo.* The data are from 2006, and comparisons have been made with a corresponding survey in 1997.

In addition, data from 2006 are also presented from the annual questionnaire survey among young people aged between 15 and 20. Since the division into age groups and questions about recent drug use are not in harmony with the division used by the EMCDDA, the data cannot be included in standard tables.

#### 2.2.1 Youth aged 15 – 20

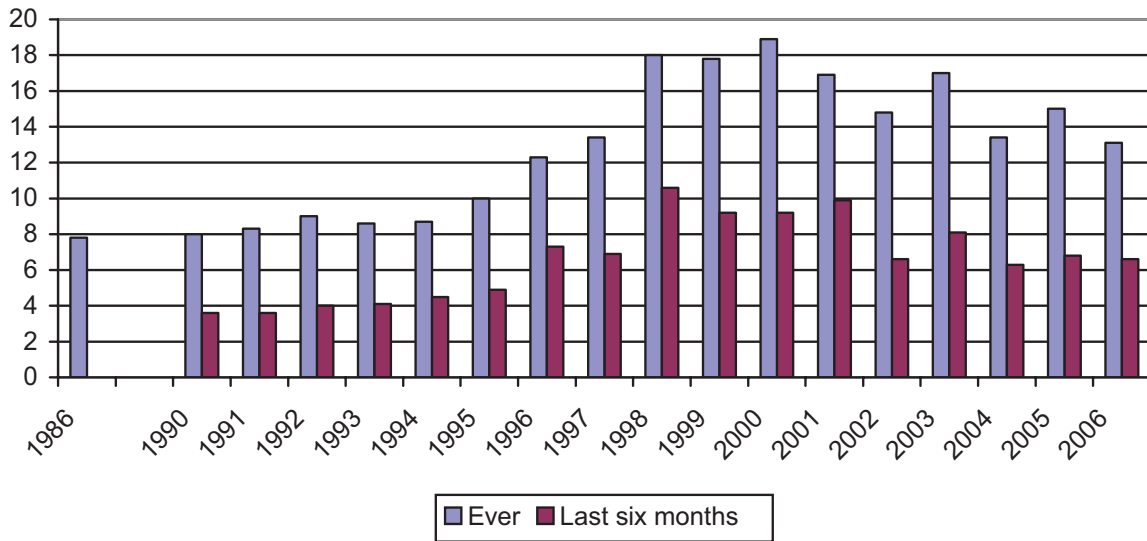
SIRUS conducts an annual questionnaire survey on the use of drugs among young people aged 15-20 (Skretting, 2006). When these surveys first started in 1968, they only included youth in Oslo. A corresponding survey was carried out in 1986 that covered the whole country, and since 1990 both the nationwide survey and the Oslo survey have been carried out annually. The two sets of surveys are conducted by sending the same questionnaire to two representative samples of youth aged between 15 and 20, one sample that only includes youth registered as living in Oslo and one that includes the whole country, including Oslo.

Cannabis, primarily in the form of hash, is the drug most young people report having used. After peaking at the turn of the millennium, a certain reduction has been registered in recent years. The percentage of 15-20 year-olds in Norway who state that they have ever used hash or marijuana has been between 13 and 15 per cent during the last three years, while the proportion reporting having used the drug during the last six months has been stable at around six per cent (Figure 1). The corresponding percentages around the turn of the millennium were around 18 and 9-10 per cent, respectively. Of course, the youngest age cohorts lower the average considerably. For 19-20 year-olds, lifetime prevalence has been stable at around 25 per cent during the last three to five years.

For Oslo, the percentage reporting ever having used cannabis has fallen steadily in recent years and in 2006 it was approx. 20 per cent, whereas approx. nine per cent reported that they had used cannabis during the last six months. At the turn of the millennium, the corresponding percentages were 28 and 16 per cent (Figure 2).

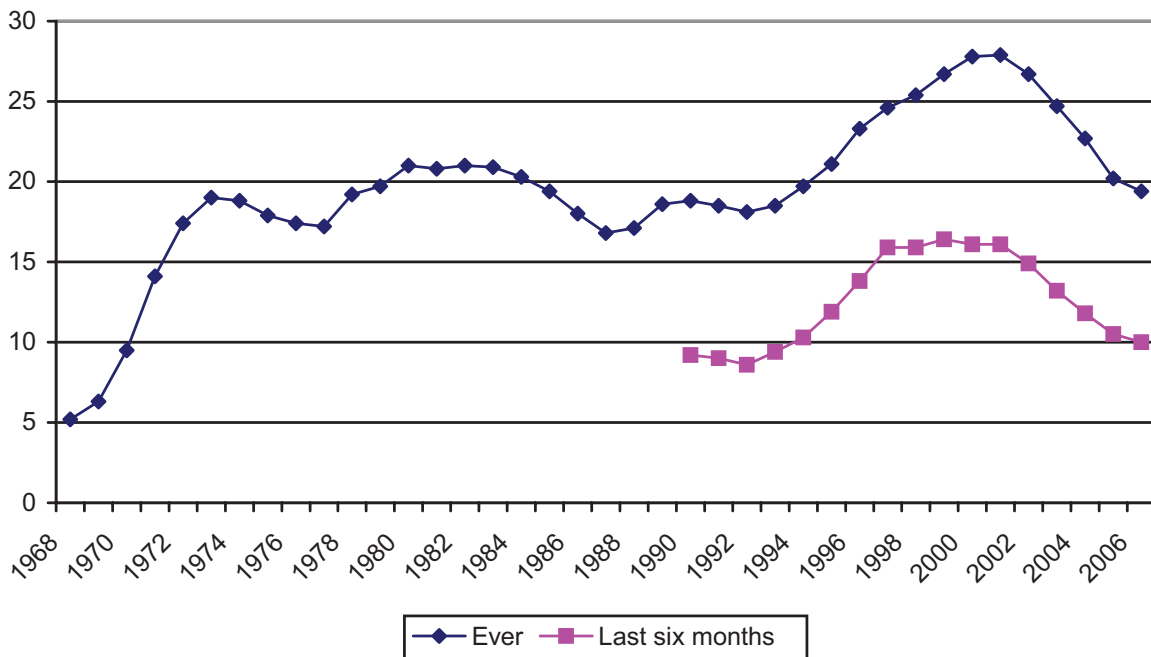


Figure 1. The percentage of youth between the ages of 15 and 20 in NORWAY who state that they have used cannabis: ever and during the last six months, respectively, 1986 - 2006.



Source: SIRUS

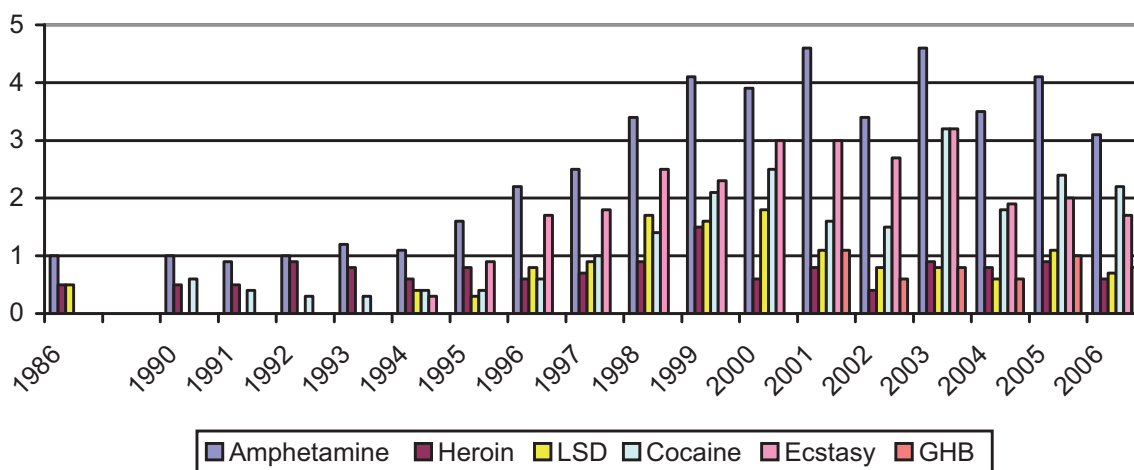
Figure 2. The percentage of youth between the ages of 15 and 20 in OSLO who state that they have taken cannabis: ever and during the last six months, respectively, 1968 -2006(three- year sliding average).



Source: SIRUS

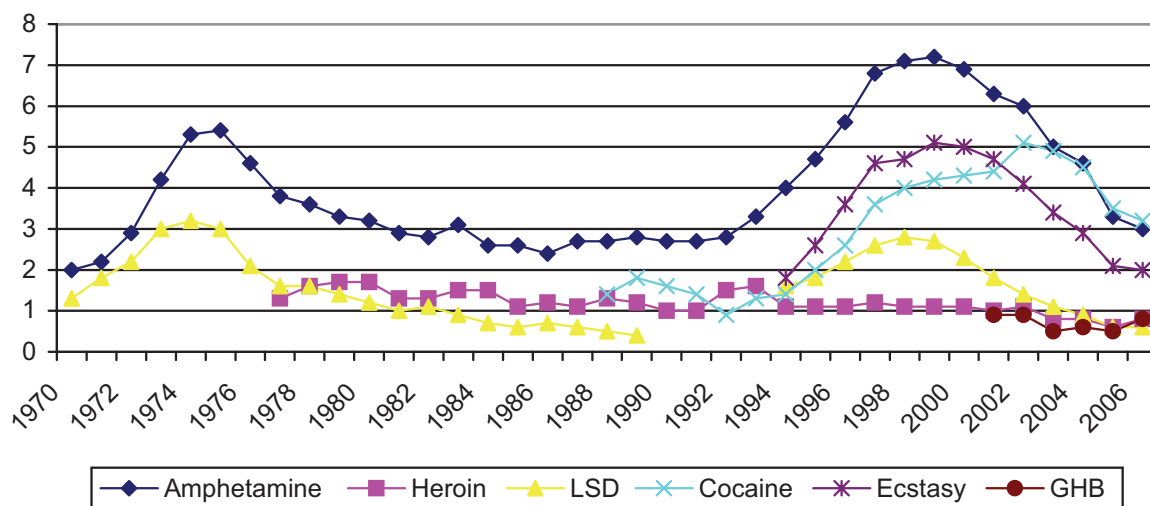
After increasing in the late 1990s, the proportion who state that they have used other drugs has also largely stagnated/ declined in recent years (Figures 3 and 4). For example, the proportion of 15-20 year-olds in the country as a whole who state that they have used amphetamine in the last two to three years has been around 3 per cent, while the proportion stating that they have ever used ecstasy has remained at around 2-3 per cent for several years. The corresponding figures for Oslo are 2 - 4 per cent for amphetamine and the same for ecstasy. The decline appears to be somewhat greater among young people in Oslo than in the country as a whole.

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



Source: SIRUS

Figure 4. Percentage of youth between the ages of 15 and 20 in OSLO who have ever used various drugs, 1970 – 2006 (three-year sliding average).



Source: SIRUS

### 2.2.2 Young adults aged 21 – 30

In the years 1998, 2002 and 2006, SIRUS conducted questionnaire surveys for the 21 – 30 age group on the use of drugs and other substances (Lund, Skretting 2007). The use of tobacco, alcohol, illegal drugs, medicinal drugs and anabolic steroids was included in the questions. The survey is a supplementary survey to the annual youth surveys among the 15 – 20 age group. The survey was conducted in the same manner, i.e. using a special sample which only includes those registered as living in Oslo and a nationwide sample that also includes Oslo.

#### Data and methods

The questionnaire was sent in the mail to a random sample. The nationwide sample consisted of 8 571 respondents for the three survey years (1998:3 455; 2002:2 731; 2006:2 385). The separate sample for Oslo consisted of a total of 10 084 respondents (1998:3 241; 2002:4 561; 2006:2 282).

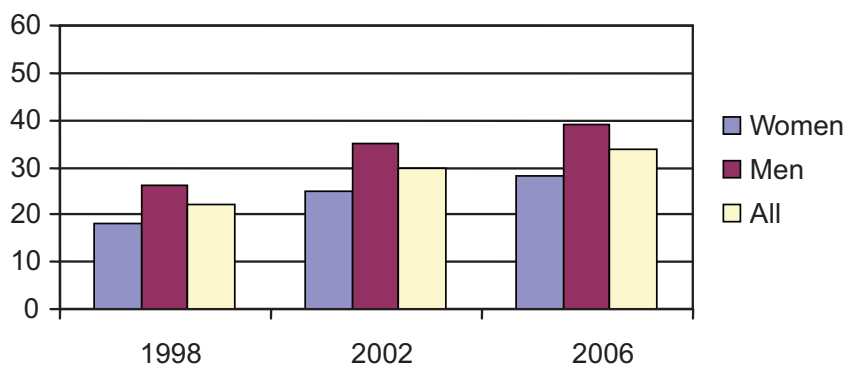
The response rate varied between 40 and 50 per cent. The questions have changed somewhat during the three survey years. However, most of the questions are the same and they thus provide a good basis for studying changes over time.

In both samples, there was a higher proportion of women than men, and a higher proportion of older than younger respondents have answered the questionnaire. In the analyses, the two samples are weighted for gender and age so that the distribution corresponds to the gender and age distribution in the population for the different survey years, for the country as a whole and for Oslo in particular.

### The use of cannabis

Figure 5 shows that the proportion that have ever used cannabis in the nationwide sample has increased from 22 per cent in 1998 to 30 per cent in 2002 and 34 per cent in 2006. A higher proportion of men than women report having used cannabis at least once. In all the survey years, the difference between the genders is approximately 10 percentage points (in 2006: 39 per cent men and 28 per cent women  $p < 0.01$ ).

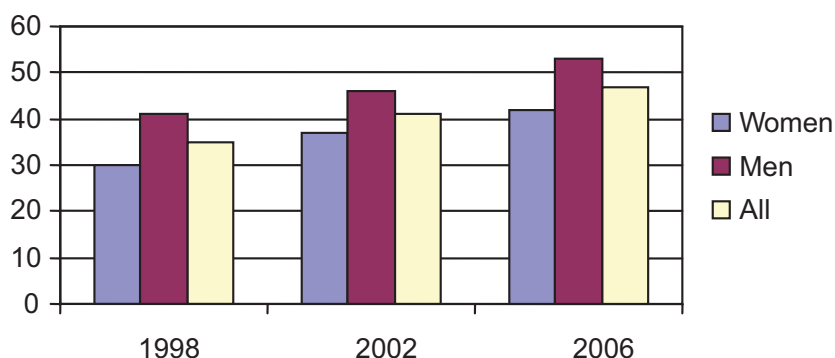
Figure 5. The proportion between the ages of 21 and 30 in NORWAY who state that they have ever used cannabis, by gender and survey year. Percentage.



Source: SIRUS

In the Oslo sample, the proportion that has ever used cannabis is higher than in Norway as a whole. Figure 6 shows that, for all respondents, the proportion was 35 per cent in 1998 and that it had increased to 47 per cent in 2006 ( $p < 0.001$ ). The proportion is also more than twice as high among 15-20 year-olds (20 per cent in 2006). The gender difference in the Oslo sample was approx. ten percentage points in all the survey years, the same as in the nationwide sample. In the 2006 survey, 53 per cent of men and 42 per cent of women stated that they had tried cannabis ( $p < 0.001$ ).

Figure 6. The proportion between the ages of 21 and 30 in OSLO who state that they have ever used cannabis, by gender and survey year. Percentage.



Source: SIRUS

Naturally, the intensity of cannabis use varies (Table 2). The highest proportions are those who have only used the drug a few times and those who have used it more than 26 times. There is a tendency that a larger proportion have used cannabis more than 26 times during the survey period. The proportions are consistently higher in the Oslo sample than in the nationwide sample.

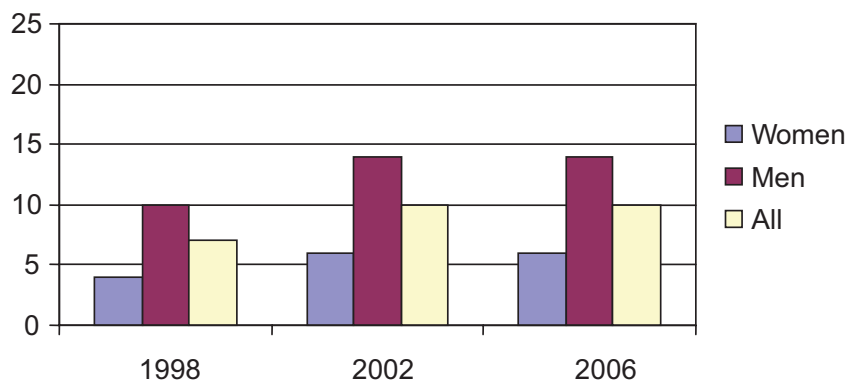
Table 2. Proportion of the 21 – 30 age group in NORWAY and OSLO that have used cannabis a various number of times during their lives, by survey year. Percentage.

	NORWAY			OSLO		
	1998	2002	2006	1998	2002	2006
1-4 times	10	13	13	13	16	17
5-10 times	4	4	6	7	6	7
11 - 25 times	2	3	4	4	5	6
26 times or more	6	10	11	11	14	16

Source: SIRUS

As expected, the proportions who state that they have used cannabis during the past six months are much lower than the proportions who state that they have ever used it (Figure 7). There has been an increase from seven per cent in 1998 to ten per cent in 2002 and 2006. In 2006, there were more than twice as many men (14 %) than women (6 %) who reported having used cannabis during the past six months ( $p < 0.05$ ).

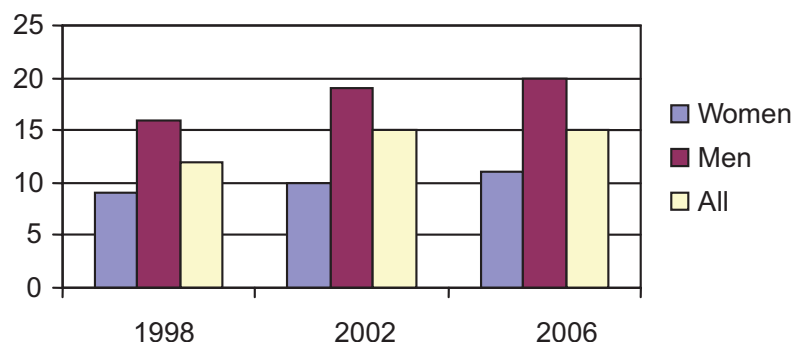
Figure 7. The percentage between the ages of 21 and 30 in NORWAY who state that they have used cannabis during the past six months, by gender and survey year.



Source: SIRUS

The proportion of the Oslo sample that have used cannabis during the past six months is also higher than the nationwide figure (Figure 8). In 2006, it was 15 per cent. The percentage has increased somewhat during the period 1998 – 2006, but the increase is not significant. In 2006, 20 per cent of the men in the Oslo sample and 11 per cent of the women reported having used cannabis during the past six months ( $p < 0.05$ ). In 2006, of those who reported ever having used cannabis, 31 per cent of the nationwide sample and 33 per cent of the Oslo sample also reported use during the past six months.

Figure 8. The percentage between the ages of 21 and 30 in OSLO who state that they have used cannabis during the past six months, by gender and survey year.



Source: SIRUS

## Debut age

The results from the nationwide sample and the Oslo sample are very similar with respect to the proportion that report having used cannabis at different ages. In 2006, approximately one in ten of those who reported ever having used cannabis reported that they had made their debut when they were 14 or younger. Roughly one in three had made their debut when they were 16 or younger. The proportion that report having made their debut after reaching the age of 21 is declining, from 24 per cent nationwide in 1998 to 14 per cent in 2006, and in Oslo from 26 per cent in 1998 to 19 per cent in 2006. In this survey, the average debut age has declined from 18.8 years to 17.8 years for the country as a whole and from 18.8 years to 18 years in the Oslo sample.

## What characterises cannabis users?

Even though very many young people have now tried cannabis, most of them have only used it once or just a few times. In the following, some characteristics are described of those who can be said to be regular users: those who have reported using cannabis during the past six months.

Table 3 shows that younger respondents reported having used cannabis during the past six months to a greater extent than older respondents. In 2006, the proportion was 12 per cent among 21 – 25 year-olds and nine per cent among 26 – 30 year-olds. The relative difference is greater for women than for men. In the separate Oslo sample, the differences between the age groups are greater than in the nationwide sample. Among the 21 – 25 year-olds, 10 per cent reported having used cannabis during the past six months, while the corresponding proportion was 13 per cent among 26 – 30 year-olds (not significant). In this sample, the differences were greater among women than among men, both in 2002 and 2006.

Table 3. The percentage between the ages of 21 and 30 in NORWAY and OSLO who state that they have used cannabis during the past six months, by gender and survey year.

		NORWAY			OSLO		
		Women	Men	All	Women	Men	All
1998	21 - 25 years	5	12	9	12	22	17
	26 - 30 years	4	9	6	8	12	10
2002	21 - 25 years	7	17	12	13	23	18
	26 - 30 years	5	11	8	8	17	13
2006	21 - 25 years	8	15	12	14	24	19
	26 - 30 years	4	13	9	9	18	13

Source: SIRUS

### Educational level

The proportion who have completed a university or university college education is somewhat lower among those who have used cannabis during the past six months than in the sample as a whole. The material thus points in the direction of a preponderance of people with lower secondary or upper secondary school as their highest completed education among those who have used cannabis during the past six months. In the nationwide sample, we find a clear difference with respect to main occupation. It is those who are unemployed at the time of the survey who stand out from the others and who have a particularly high proportion (23 per cent). We find corresponding significant differences in the Oslo sample, in which the proportion of unemployed was 32 per cent.

### Income level

There are relatively big differences in the proportions that have used cannabis during the last six months seen in relation to income. In the nationwide sample, there is a difference of six percentage points between those who earn least and those who earn most. Moreover, the nationwide sample and the Oslo sample follow each other to a great extent, but with higher proportions and greater impacts in the Oslo sample than in the country as a whole. The EUR 12,500 to 25,000 income group (annual income) come top in the Oslo sample with 21 per cent reporting having used cannabis during the past six months. There is a relatively big difference between this group and the eight per cent in the income group over EUR 50,000 ( $p < 0.01$ ).

### The use of other drugs

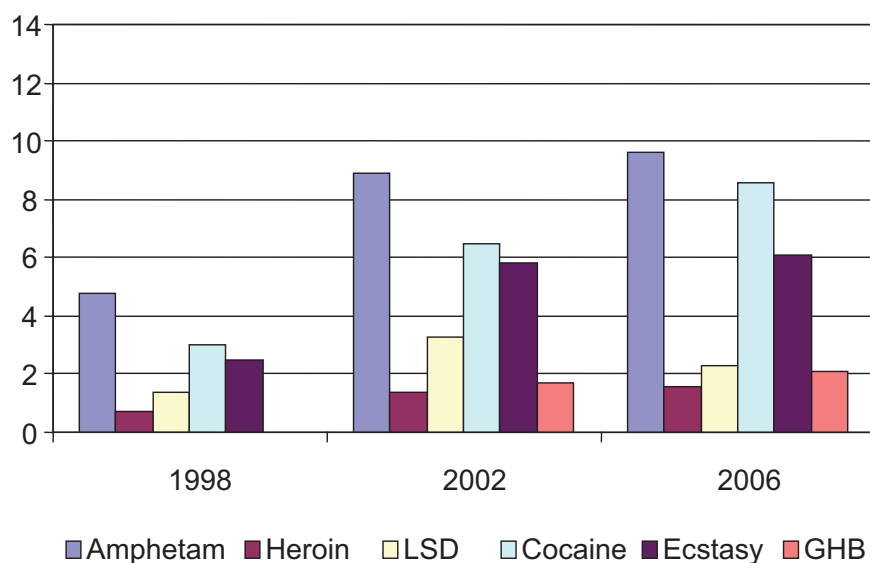
In addition to cannabis, questions were also asked about the use of amphetamine, ecstasy, cocaine/crack, LSD, heroin, GHB<sup>6</sup> and anabolic steroids.

#### Norway as a whole

Figure 9 shows the percentages that have ever used various drugs in the three survey years in the country as a whole.

<sup>6</sup> There were no questions about the use of GHB in 1998.

Figure 9. Proportion between the ages of 21 and 30 in NORWAY who have ever used various drugs, by survey year. Percentage.



Source: SIRUS

Cocaine is the drug for which the increase has been greatest, from 3 per cent in 1998 to just under 9 per cent in 2006 ( $p < 0.05$ ). In 2006, the proportion of men (11.6%) who reported ever having used cocaine in 2006 was roughly twice as big as the proportion of women (5.5%) (not significant).

Lifetime prevalence for amphetamine has also increased during the period. In 1998: 5 per cent, in 2006: 9 per cent (not significant). It was asked about both amphetamine that was injected and amphetamine taken in another form. The biggest proportion take amphetamine in another form than by injecting. As is the case for cocaine, the proportion of men who reported ever having used the drug is twice as large as the proportion of women.

The use of ecstasy appears to have stabilised. Lifetime prevalence increased from 2.5 per cent in 1998 to almost 6 per cent in 2002, but only showed a marginal increase in 2006. Again, the proportion of men is twice as high as the proportion of women. Moreover, the proportion reporting ever having used heroin also appears to have stabilised. In 1998, less than one per cent had ever used heroin, while in 2006 the proportion had increased to approx. 1.5 per cent. This percentage includes both injection and smoking as the method of taking the drug. Of those who had used heroin, 1.5 per cent had smoked heroin and 0.5 per cent had injected it. A few have reported experience of both injection and smoking. People who have smoked heroin are probably registered to a greater extent in this type of survey than injecting drug users.

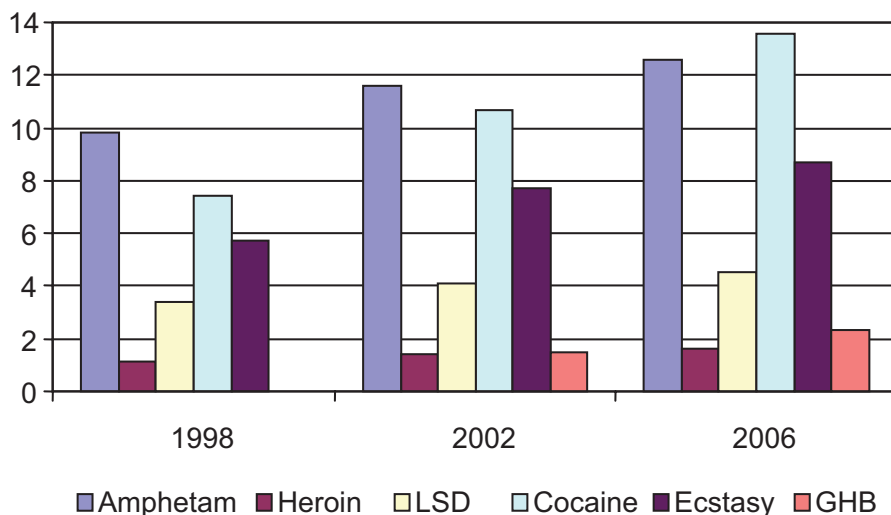
The proportion that report having used LSD has fallen somewhat, from just over 3 per cent in 2002 to just over 2 per cent in 2006. A question about the use of GHB was included in the survey from 2002. There has been a marginal increase in the proportion who report having used GHB, and this proportion was +/- 2 per cent in both 2002 and 2006.

### The Oslo sample

The reported use of amphetamine, LSD, cocaine and ecstasy is greater in Oslo than in the country as a whole (Figure 10). The greatest increase in Oslo was also in the proportion reporting ever having used cocaine. In 1998, just over 7 per cent reported ever having used cocaine, the proportion

increased to just under 10 per cent in 2002, and in 2006 it had increased further to just under 14 per cent ( $p < 0.05$  from 1998 to 2006). In 2006, the proportion of men (18 %) who reported ever having used cocaine was significantly greater than the proportion of women (10 %) ( $p < 0.05$ ).

Figure 10. Proportion between the ages of 21 and 30 in OSLO who have ever used various drugs, by survey year. Percentage.



Source: SIRUS

The proportion who have ever used amphetamine increased from 10 per cent in 1998 to 11.5 per cent in 2002 and to 12.5 per cent in 2006. The proportion who have ever used ecstasy continued to increase somewhat, from 5.5 per cent in 1998 to 8.5 per cent in 2006. The proportion that reported ever having used LSD is also greater in Oslo than in Norway as a whole. In 1998, it was 3.5 per cent, while the proportion in 2006 was almost 4.5 per cent. In Oslo, the proportion that reported ever having used heroin was 1.5 per cent in 2006, roughly the same proportion as in Norway as a whole. The proportion that reported having used GHB is the same in Oslo as in the country as a whole. The proportion in Oslo was relatively stable in the two survey years in which questions were asked about the use of GHB, approx. 2.5 per cent.

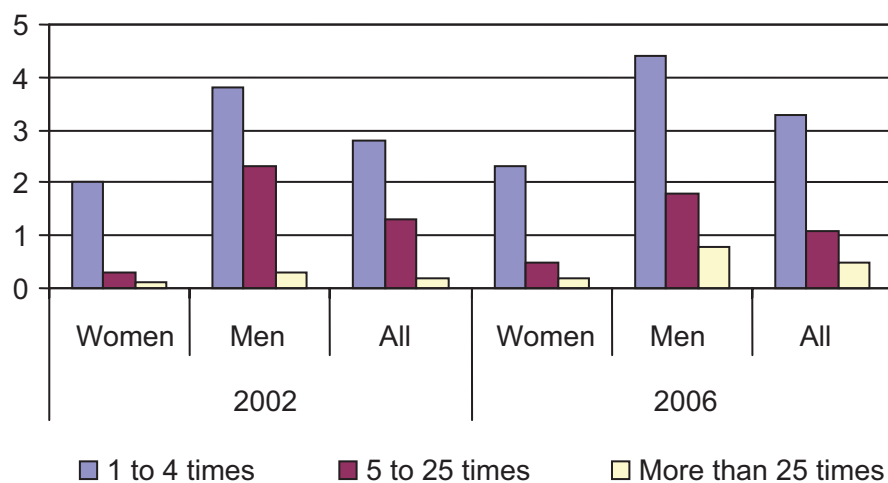
### Recent use (in both samples)

Only a very small proportion reported having used various drugs during the past six months.

With the exception of cocaine and amphetamine, the proportion was less than one per cent in both the country as a whole and the Oslo sample. In the nationwide sample, the proportion that had used amphetamine during the past six months fell from 2.5 per cent in 2002 to 2 per cent in 2006, and in Oslo from 3.5 per cent to 2.5 per cent in 2006. On the other hand, the survey shows that recent use of cocaine in the country as a whole increased from 2 per cent to approx. 4.5 per cent during the same period. Most of those concerned have only tried cocaine a few times. Figure 11 illustrates the frequency.



Figure 11. The number of times people between the ages of 21 and 30 in OSLO have used cocaine during the past six months as a percentage, by gender and survey year (2002 and 2006<sup>7</sup>).



Source: SIRUS

### Statistical margins of error and other possible sources of error

There are statistical margins of error attached to the figures in the two surveys (15-20 years and 21-30 years), and they must be interpreted with caution. Moreover, questionnaire surveys are always susceptible to certain sources of error (not everyone responds, some responses contain deliberate or inadvertent errors etc.). The surveys also targeted young people in general. There is reason to believe that young people who regularly use drugs, either cannabis or stronger substances, will be under-represented in the surveys. Surveys of this type are therefore primarily suitable for telling us something about experimentation and recreational use. Another source of uncertainty is the fact that the response rate for both surveys has been between 40 and 50 per cent in recent years. The purpose of the surveys is primarily to serve as a tool for examining trends over time (Lund, Skretting 2007).

### 2.2.3 Tendencies

The two surveys show major differences both in terms of lifetime prevalence (LTP) and use during the past six months of all types of drugs. Levels for 21-30 year-olds are more than twice as high as for 15-20 year-olds, both in Norway as a whole and in Oslo. And while LTP has increased strongly among young adults during the last eight years, the opposite has happened among young people under 20.

The differences are probably largely due to the cumulative effect ('if you have used once, then you will always have used'). Cannabis use among 15-20 year-olds, for example, reached its highest level so far around the turn of the millennium. This group is now part of the young adults group. Moreover, a considerable number of people make their cannabis debut after reaching the age of 21. Even though the proportion is falling, this factor helps to raise prevalence.

The young adults survey includes ten year cohorts, while the youth survey includes six year cohorts. By comparison, population surveys show that LTP is highest in the 25-34 age group and recent use is most frequent among those between the ages of 20 and 24 (NR 2005, chapter 2.1). The youngest members of the youth sample traditionally use drugs least and contribute to a lower average (cf. data from ESPAD). A more-detailed breakdown of the age groups under 20 shows that LTP for 19-20 year-olds has been relatively close to the level for the whole sample of young adults in recent years.

<sup>7</sup> The question was not asked in 1998.

For cannabis, we can conclude that experimentation is most frequent from the late teenage years and into the twenties. Here, prevalence is still on the increase, while new recruitment among the very youngest appears to be declining. As regards recent use of cannabis, these surveys cannot substantiate that there has been a definite increase among young adults. The data display a high degree of stability. The decrease in “use during the past six months” among 15-20 year-olds is more striking, a decrease that has been fairly pronounced since the turn of the millennium.

For other drugs, it is more problematic to identify clear trends, since so few people report use and random factors can go in both directions. Among young people under the age of 20, LTP for amphetamine, cocaine and ecstasy, the three most reported drugs, appears to have declined during the period 1998-2006. Among young adults, the opposite trend is even clearer. In an eight-year perspective, LTP for all the three drugs has increased considerably; for amphetamine it has doubled and for cocaine it has increased even more. But the prevalence for use during the past six months has not increased, with the exception of cocaine, which has seen a doubling during the last four years. The biggest increase in the use of cocaine is among men in Oslo.

## 2.3 Drug use among specific groups

### 2.3.1 The use of drugs among students at the University of Oslo.

In 2006, 1 655 students at the University of Oslo took part in the project *Studenter og Rusmidler (Students and alcohol and other drugs)*, a questionnaire survey on the use of alcohol and other drugs, smoking and gambling (Tefre, 2007). The results have been compared with findings from a corresponding student survey in 1997. The overriding purpose of the project was to gain insight into and knowledge about the extent of alcohol use, the use of other drugs, anabolic steroids and gambling among students in 2006. The results of the project were to be compared with a similar student survey in 1997.

#### Method and data basis

The criteria for belonging to the target group for the survey were to be the same as for the 1997 survey. Because of the language barrier, foreign students were excluded. The target group thus numbered 13 070 students. Of these, 3 000 students were selected at random, who would be representative in terms of gender, age and faculty.

A gross sample of 2 922 was arrived at and 1 679 of them responded. Twenty-eight responses had to be left out because of missing information about gender, age and alcohol consumption. The final number of questionnaires that form the basis for the statistical analysis was thus 1 655, or 57 per cent of the actual gross sample. That is two per cent lower than for the previous survey. The decline in the response rate was less than there was reason to fear given the general decline in response rates that has characterised survey-based research.

#### Illegal drugs – main findings

- The use of hash (ever) has increased from 1997 to 2006; use during the past six months has not increased
- The use of cocaine and ecstasy (ever) has also increased
- The use of other drugs does not appear to have increased
- Few respondents had used drugs during the past 12 months; hash is the most common drug
- Approx. one in twenty has used legal medicinal drugs for intoxication purposes (ever)

## Hash

As Table 4 shows, 35 per cent of the students had tried hash in 1997. Nine years later, 42 per cent had done so. This represents an increase of 20 per cent. Since the use of hash is more common in Oslo than in the rest of the country, it should be added that almost half of those who responded to the survey in 2006 stated that they came from Oslo. Nor is it surprising that some of the students who come from places other than Oslo adopt the urban youth culture in Oslo.

Table 4. The use of hash 1997 and 2006 Both genders<sup>8</sup>. Percentage.

Type of drug	Year	Used ever/ number of times used				Used during past 12 months
		Never	1 - 5 times	6 - 50 times	51+ times	
Hash	1997	65	19	11	5	14
	2006	58	23	12	7	15

Source: Tefre, E-SIRUS.

The difference between the number of times of use in 1997 and 2006 was significant,  $p < 0.01$ , while there was no significant difference in use during the past 12 months.

A large proportion try drugs once or just a few times. Almost half the students, 42 per cent, had ever used hash, but experimental use (defined in the survey as 1-5 times) accounted for more than half of this. Almost two in ten (19 per cent) had used hash more than five times and 15 per cent had used hash during the past year.

In 1997, 31 per cent of the women students had tried hash ever, while the figure in 2006 was 39 per cent, corresponding to an increase of 25 per cent. The proportion of male students who had tried hash was 40 per cent in 1997 and 47 per cent in 2006, an increase of 17 per cent.

In 2006, experimental use amounted to 23 per cent among women, while 16 per cent had used hash more than that. At 22 per cent, the level of experimental use among men was almost the same as among women, while 26 per cent of the men had used hash six times or more. Measured as a proportion of hash users, experimental use was lower among men (47 per cent) than among women (60 per cent), i.e. regular use was higher among men than among women. The extent of hash use among students agrees well with the figures from SIRUS for young adults aged 21-30 in Oslo (chapter 2.2.2).

## Other drugs

Naturally, the use of all drugs other than hash is reported more rarely. Cocaine use showed the greatest increase in this survey as well. In 2006, 8 per cent reported having used cocaine. More than one in ten male students have ever tried cocaine, while 6 per cent of female students have used the drug (Tables 5 and 6). In 1997, the proportion was 5 per cent for men and 2 per cent for women. Experimental use is most common, and it has doubled since 1997, among both women and men. Use during the past 12 months also doubled among both sexes between the two survey years, although it must be stressed that the samples are small.

<sup>8</sup> The total figures for Oslo students are not weighted in relation to gender. The figures will thus be lower due to the high percentage of women (64%) and higher due to fewer students in the highest age groups.

The use of amphetamine ever is close to the level for cocaine, 7 per cent in 2006. The proportion also increased somewhat, but the difference is not so large as to rule out this being the result of random effects in the measurements. It cannot, therefore, be claimed that there has been an increase in amphetamine use from 1997 to 2006. In 1997, 4 per cent of women reported that they had ever tried amphetamine, while 5 per cent reported the same in 2006. The figures for men were 7 per cent and 9 per cent, respectively.

The use of ecstasy has increased somewhat in this survey. From 1997 to 2006, the reported use increased (ever used) among students from two to four per cent.

For more regular use, defined in the survey as more than six times, the samples are so small for all drugs other than cannabis that it is impossible to prove any changes.

Table 5. The use of illegal drugs among female students 1997 and 2006. Percentage.

Have you used:	Year	Ever used				During the past 12 months
		Never	1 - 5 times	6 - 50 times	51+ times	
Hash	1997	69	17.6	9.4	3.6	10.0
	2006	62	22.9	10.6	5.1	10.9
Amphetam.	1997	96	2.8	0.8	0.3	1.6
	2006	95	3.6	1.5	0.2	0.7
Cocaine	1997	98	1.9	0.4	-	0.9
	2006	94	4.4	1.2	0.3	1.9
Heroin	1997	99	0.5	-	0.1	0.1
	2006	99.5	0.4	0.1	-	0.1
Ecstasy	1997	98	1.4	0.2	-	0.9
	2006	96	2.7	0.6	0.3	0.2
Other drugs	1997					
	2006	95	4.5	0.6	0.3	0.6

Source: Tefre E.-SIRUS

Table 6. The use of illegal drugs among male students. 1997 and 2006. Percentage.

Have you used:	Year	Ever used				During the past 12 months
		Never	1 - 5 times	6 - 50 times	51+	
Hash	1997	59.9	21.3	12.1	6.6	19.4
	2006	52.9	21.6	14.7	10.8	22.0
Amphetam.	1997	92.7	5.0	1.9	0.4	2.8
	2006	91.1	7.0	1.9	-	2.4
Cocaine	1997	95.2	3.9	1.0	2.1	-
	2006	88.4	8.2	3.2		5.1
Heroin	1997	99.2	0.6	-	0.3	0.3
	2006	99.5	0.5	-	-	-
Ecstasy	1997	96.7	2.6	0.6	0.1	1.1
	2006	95.4	3.8	0.9	-	0.9
Other drugs	1997					
	2006	89.2	8.8	1.9	0.2	2.8

Source: Tefre, E.- SIRUS

## Medicinal drugs

In the questionnaire, it was up to the students themselves to assess what they would define as medicinal drugs used for intoxication purposes. Medicinal drugs such as Valium, Rohypnol, Mogadon and similar are the most commonly used drugs for this purpose. All together, a good 5 per cent had ever used a medicinal drug for intoxication purposes and slightly more than one per cent had used such drugs during the past year, while four per cent had previously used such drugs. Very few had used medicinal drugs for intoxication purposes very frequently (Tefre, 2007).

## 3. Prevention

### 3.1 Universal prevention

See information in Structured Questionnaire 22/25<sup>9</sup>.

#### The Regional Project

The municipalities are one of the most important arenas in the prevention field. Municipal prevention efforts in the drugs and alcohol field include administering the Alcohol Act and in offering children and young people attractive drug and alcohol-free activities and places to meet. In order to encourage coordination and cooperation in the municipalities, the Regional Project was started in nine pilot municipalities in 2004 (discussed in NR 2005, chapter 3.3). The intention was to develop new measures and coordinate existing preventive efforts in the participating municipalities. The experience gained will be communicated to other municipalities and form the basis for future locally-based preventive work. The Regional Project is currently being evaluated by SIRUS.

#### Local action plans

Given its objective of “reducing the harmful effects of alcohol to individual and society”, the Alcohol Act and its pertaining regulations are, together with municipal licensing rules, a central policy instrument in the alcohol field. The Alcohol Act gives municipalities considerable freedom to reduce the harmful effects of alcohol, and responsibility for doing so. For instance, the Act obliges the municipalities to adopt action plans for alcohol policy. The Directorate for Health and Social Affairs has produced a guide that is intended to make it easier for municipalities to draw up such plans. The target group consists of municipal employees, planners and local politicians who are to consider such plans. The guide provides facts and information about what should be emphasised in the work and it contains references to other sources and aids.

As an aid for use in planning work, a new website was launched in 2007: “Kommunetorget.no”. This website is a practically-oriented guidance service, which aims to:

- Strengthen control methods so that drugs and alcohol-related issues are dealt with in a professional and expedient manner.
- Contribute to increasing the competence of municipal employees and local politicians about drugs and alcohol-related prevention and treatment-related issues.
- Contribute to a holistic approach being taken in the different drug and alcohol-related plans.

The work on drug and alcohol policy action plans and individual plans for problem drug and alcohol users have a central place on the website. The website is intended to provide a professional foundation for the planning and instigation of planning processes in the municipalities in addition to illustrating practical experiences from various plan work and user experiences.

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<sup>9</sup> All Structured questionnaires referred to have been submitted to the EMCDDA separately.

## Early intervention

Early intervention is on the borderline between prevention and treatment. Knowledge about what to look for in order to identify possible drug and/or alcohol problems and how to proceed in order to intervene varies from arena to arena and player to player. There is a good knowledge base in some of these areas today. This applies, for example, to children of kindergarten and primary/lower secondary school age and their families, and to adults with high-risk alcohol consumption. For these user groups, the challenge primarily consists of making use of available knowledge. In relation to other arenas/ target groups, knowledge is poorer and it is necessary to develop a better knowledge base. This applies, for example, to work with young people in the age group 15 and older (Nesvåg et al. 2007).

In order to meet the need for a national strategy for early intervention in the drugs and alcohol field, the Directorate for Health and Social Affairs has drawn up a proposal for a national strategy. The following three main strategies are proposed in the report:

1) *Broad-based, overriding securing of early intervention in the drugs and alcohol field in a forum in which the relevant ministries and directorates take part (coordination groups, for example).* Link early intervention efforts to the forthcoming escalation plan for the drugs and alcohol field.

2) Selected priority areas. The following are proposed as the eight most important areas:

- Children of parents with drugs and/or alcohol problems/ mental health problems
- Youth at risk
- Youth admitted for alcoholic intoxication (poisoning)
- Pregnant women
- General practitioners as an arena
- Hospitals as an arena
- The workplace as an arena
- Schools as an arena

3) *The instigation of long-term, purposeful efforts targeting selected groups and arenas and with the same timeframe as the forthcoming escalation plan for the drugs and alcohol field.* The working group proposes that overriding coordination groups be appointed for each of the priority areas, led by the authorities and with representatives of key bodies at different levels as active participants. It will be natural to draft action plans, goals and measures, for example through the production of guides (Directorate for Health and Social Affairs, 2007).

A more-detailed description of some of the target groups for early intervention is provided in chapter 12.

## 3.2 School programmes

Norwegian schools employ a number of different measures and programmes to reduce and prevent problem behaviour. The evaluation of some of the programmes was discussed in NR 2006, chapter 3.2.1. Preventive efforts in schools should be knowledge-based, but it turns out that some of the measures used are based more on good intentions than on a professional and empirical basis. A lot of the work that is done and many of the measures instigated are not evaluated in a satisfactory manner.

In 2005, the Directorate for Health and Social Affairs and the Directorate for Primary and Secondary Education therefore appointed four research teams who assessed 29 different programmes in the field of problem behaviour, social competence and drug and alcohol preventive work in schools, 16

of which concern drug and alcohol preventive work in schools (Nordahl et al., 2006). In the report, great variations are pointed out between the different programmes. The best programmes built on research-based knowledge, included evaluation of the programme, had a clear strategy for implementation and, as a rule, also had several theoretical approaches to the problem. The less satisfactory programmes failed on several of these criteria. The programmes were assessed in accordance with international standards and divided into three categories:

1. Programmes with a low probability of having an effect: These programmes are characterised, among other things, by good intentions, but have a poor basis in knowledge and they lack an evaluation. Eleven programmes ended up in this category.
2. Programmes with a good probability of having an effect: These programmes are based on theoretical and/or empirical knowledge and have good implementation strategies, but lack evaluation or have undergone an evaluation with significant deficiencies. Of the drugs and alcohol programmes, three programmes were placed in this category.
3. Programmes with documented effects: These programmes build on research-based knowledge, have been properly tested and thoroughly evaluated, have clearly defined strategies for implementation over time and, as a rule, comprise all members of staff. Of the drugs and alcohol programmes, it was the programmes: "Youth and Alcohol" and "BeSmokeFree" that were placed in this category.

The drugs and alcohol field stood out in relation to other prevention areas in that there were few programmes with documented results. Many programmes have unclear implementation strategies and are based on short-term efforts.

### 3.3 Selective prevention

See information in Structured Questionnaire 26.

#### A summary of existing knowledge

A summary of existing knowledge about early intervention in the drugs and alcohol field carried out by the International Research Institute of Stavanger (IRIS) on assignment for the Directorate for Health and Social Affairs, shows that instigating early measures in relation to children of kindergarten and primary/lower secondary school age and their families produces results in terms of preventing both drug and alcohol problems and mental health and social problems (Nesvåg et al. 2007). The same applies to early measures aimed at adults with high-risk alcohol consumption.

Early help for children and their families can prevent both drug and alcohol problems and mental health and social difficulties. Preventive measures in relation to groups at risk include measures that target groups with certain characteristics and individuals who show early signs of problems. It is important that such measures are instigated in relation to young people who are in danger of developing or reinforcing problem drug or alcohol use. The goal should be to halt the development of, or a relapse into, problem behaviour and difficult life situations. The social services, child welfare services and schools have a central role in this type of preventive work.

The effective interventions aimed at children and their families are those that are based on observation, dialogue and advice given in the families' home arena, and those that aim to stimulate children's intellectual development. Effective measures aimed at older children often combine the family and the school arenas, and, to a certain extent, the local community. Effective programmes are not just educationally oriented, but also emphasise training in the development of good cooperative skills between adults and children. Examples include the Strengthening Families Program (SFP)



and Multisystemic Therapy (MST) (NR 2006, chapter 3.5). The programmes are intended to strengthen the family's internal ties and ties to the local community, to teach parents to develop a dialogue that balances care, the setting of limits and young people's need to become independent, to improve communication and conflict-management skills and to impart knowledge about children and young people's development.

As regards intervention efforts in relation to young people over the age of 15, there is a need for methods in relation to both illegal drugs and the development of high-risk alcohol habits. IRIS recommends the development of measures that can communicate with youth in new ways, in new arenas and through new channels. It will be necessary to utilise a combination of professional health and social competence, competence about youth culture and competence in communication and the media in new and innovative ways (Nesvåg et al. 2007).

## 4. Problem drug use and the treatment demand indicator

### 4.1 Prevalence and incidence estimates of problem drug use

See the data in standard tables 07/08<sup>10</sup>.

In the EMCDDA context, problem use is defined as “Intravenous use of drugs or prolonged/regular use of opiates, cocaine and/or amphetamines.” In Norway, we only have estimates for injecting users. So far, data sources are lacking that can provide figures for prolonged/regular use of opiates, cocaine and/or amphetamines. People in medically-assisted treatment, but who nonetheless inject various drugs, are included in the injecting users group in the calculations.

In NR 2006 chapter 4.1, figures were shown for the number of injecting users based on three methods: the Mortality Multiplier, questionnaire surveys sent to the police and the social services in the municipalities and the Multiple Indicator Method for calculating intravenous use, i.e. persons who at least once in the relevant year have taken drugs by injecting them, regardless of the drug involved. Update for all three methods have not yet been carried out. However, insight into developments from 2004 to 2005 and 2006 can be based on those parts of the material that have been analysed and on the change in other indicators that have previously been proven to correspond to developments in injecting use over time.

The number of injecting drug users in Norway increased until 2001, after which time it declined until 2003 and then flattened out. Summarising estimates from three different methods, it was presumed that there were approximately 8 200-12 300 injecting users in Norway<sup>11</sup> in 2004. The main impression based on preliminary calculations and indicators is that there has been no marked change in the number of injecting users in 2005 or 2006.

The basis for this impression consists of overviews of drug deaths from the National Criminal Investigation Service (Kripas), the Municipal Surveys from SIRUS in 2005 and 2006, the police and customs authorities' figures for seizures of heroin, cocaine and amphetamine/methamphetamine (chapter 10.3) and the Institute of Public Health's statistics for positive findings of heroin in road traffic cases (chapter 8.2.3)

Development work is currently being done in SIRUS relating to the calculation of recruitment to injecting use over time.

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<sup>10</sup> All Standard tables referred to have been submitted to the EMCDDA separately

<sup>11</sup> The estimate has an upper limit higher than that which results from the Multiplier Method, but lower than that which resulted from the Multiple Indicator Method and the Municipal Survey. This is because the latter two methods probably produce figures that are too high.

Table 7. The number of injecting drug users in Norway 2002-2005. Three methods.

	<b>Municipal Survey*</b>	<b>Multiple Indicator Method*</b>	<b>Mortality Multiplier</b>
2002	15 394 (12 889-18 513)	15 456 (11 885-19 027)	10 238 - 14 030
2003	15 322 (12 911-18 306)	16 215 (14 801-17 629)	8 604 - 11 914
2004	16 335 (13 460-20 099)	15 690 (14 062-17 319)	7 857 - 11 000
2005	16 888 (13 135-21 701)	14 406 (13 232-15 580)	7 918 - 11 086

\* Figures for Oslo have been estimated using the Mortality Multiplier.  
Source: SIRUS

## 4.2 Treatment demand indicator

### 4.2.1 Client mapping data for 2006

Norway has a national documentation system for use by the help services for problem drug and alcohol users (see NR 2005 chapter 4.2). The system includes all treatment and care measures. Participation in and use of the mapping forms has not been defined as mandatory by the authorities in question, so that the individual measures have been permitted to not participate. Otherwise, there is reason to believe that there are variations between the measures as regards how large a proportion of the queries and admissions are covered by the client mapping system, and the extent to which the whole mapping form is used for all clients.

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

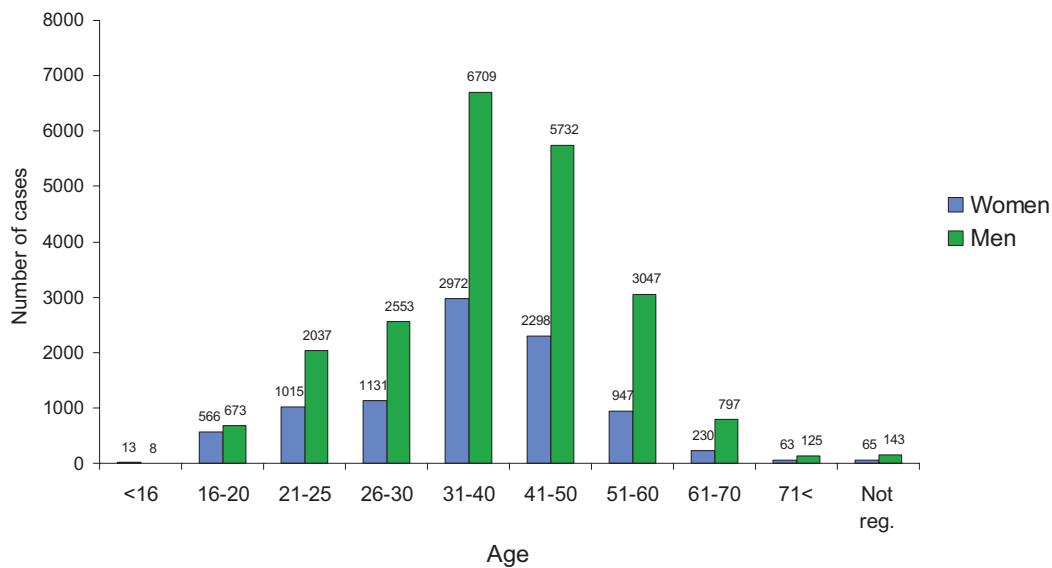
### Queries and admissions

In 2006, 31 495 queries were registered, and 34 740 queries in 2004. The reduction is partly due to a fall in participation; 107 measures submitted the client mapping form in 2004, compared with 98 in 2006. The gender distribution was 70 per cent men and 30 per cent women, roughly the same as during the years 1998 to 2005.

In 2006, a total of 21 987 admissions were registered in treatment/care measures, a reduction from 2004 (24 485). The reduction is due to the same factors as discussed in relation to queries. The gender distribution, which was also 70/30 per cent for admissions, has been very stable in all the survey years.

Figure 12 shows the number of registered queries for women and men in various age groups. By far the largest number of queries concerned the age groups 31 to 50 years.

Figure 12. Queries by age and gender 2006. Number of queries.



**N=31124 (Women: 9 300; Men: 21 824)**

Source: The Bergen Clinics Foundation

### Education, income, social factors

As regards highest completed educational level, there is little difference from year to year. The largest group, roughly 40 per cent, consists of those whose highest completed education is lower secondary school. The picture is the same for women and men, with a tendency for a slightly larger proportion of women than men to have lower secondary and upper secondary school as their highest education, while a slightly higher proportion of men than women have occupational training as their highest education.

The social background variables paint a picture of a group of problem drug and alcohol users who are not in employment and who are therefore dependent on public support. In 2006, as many as 77 per cent of the patients/ clients were neither in employment nor in education. The proportion who were in full-time jobs was as low as 15 per cent, the lowest proportion observed since the documentation started. The picture is otherwise fairly similar from year to year. There is a tendency for a somewhat larger proportion of men than women to be in full-time jobs, and for a higher proportion of women than men to be in part-time jobs or in education.

Social security (including single parent benefit) was the most important source of income for the largest group during the first years of the 1999 to 2006 period, while a switch from social security to temporary national insurance benefit means that temporary national insurance benefits are now the most important type of income in recent years. This general tendency appears to continue in 2006. Whether the changes are due to differences between client samples from one year to the next or whether they reflect actual trends is difficult to say on the basis of the available data. There are very small gender differences as regards the most important source of income. The information about income must also be seen in light of the fact that questions are not asked about any illegal income. It is most probable that such income will remain unregistered.

As many as 3 140 people were registered as not having a stable housing situation during the last four weeks prior to the start of treatment. However, there is reason to believe that many of them

have stayed in hostels or institutions, although more than 1 400 were registered as homeless when hostels, institutions and staying with others were included.

Almost two per cent of women admitted to the measures were registered as pregnant. These amounted to a total of 130 admissions in 2006. Questions about pregnancy were not registered in 460 admissions.

In 1 996 cases, the patients/clients stated that they lived together with children under the age of 18.

Table 8 shows the proportion of admissions in which the patient/client was a foreign national or of foreign descent. This applied to a greater proportion of the admissions in the Oslo region than in the rest of the country. The gender distribution in Oslo was the same as in the rest of the country.

*Table 8. The proportion of admissions in which the patient/ client was a foreign national/ of foreign descent, 2006, as a percentage.*

	Norway	Oslo
Foreign national	2 %	4 %
Born outside Norway	4 %	9 %
Mother born outside Norway	4 %	9 %
Father born outside Norway	6 %	11 %

*Source: The Bergen Clinics Foundation*

### Most used intoxicant

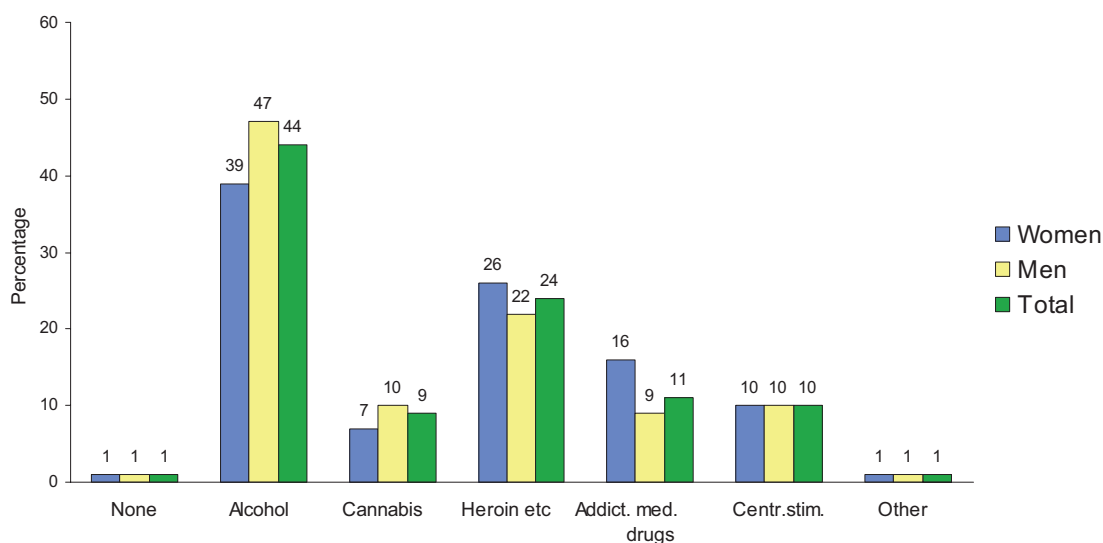
Among women, the proportion reporting alcohol as the most used intoxicant has previously been roughly as big as the proportion reporting heroin, while in the years 2004, 2005 and 2006, the proportion of women who reported alcohol as the most used intoxicant was greater (39, 42 and 39%, respectively) than the proportion who reported heroin (30, 26 and 26%, respectively). Among men, alcohol was reported as the most used intoxicant by 47 per cent in 2006, while 22 per cent reported heroin. The corresponding figures in 2004 were 46 and 28 per cent, while in 2005 they were 50 and 23 per cent.

A clearly larger proportion of women (13 % in 2005 and 16 % in 2006) than men (6 % in 2005 and 9 % in 2006) reported addictive prescription drugs as the most used intoxicant. This also includes patients/clients who have become addicted to prescription drugs which they have been given as part of normal medical treatment. Medication given in medically-assisted treatment (MAT) should also be registered under addictive medicinal drugs, but in practice they are probably registered as often under "Heroin and other opiates". The increase in registrations of addictive medicinal drugs may be due as much to a more correct registration practice as to an increase in MATpatients.

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

Figure 13 shows the most used intoxicant in 2006 and a percentage comparison between women and men.

Figure. 13 Most used intoxicant 2006. Percentage.



**N = 5370 / 12207 / 17577**

Source: The Bergen Clinics Foundation

Apart from alcohol, which clearly predominates (44 %), heroin is most often reported (24 %), followed by addictive medicinal drugs (11 %) and central stimulants (10 %). Only 9 per cent report cannabis as the most used substance. The gender difference is biggest as regards alcohol and addictive medicinal drugs. In the mapping form, cocaine is part of the central stimulants category, so that it is not possible to state a share for cocaine on its own. Together with, among other things, LSD, ecstasy is categorised under "other". Ecstasy was cited as the most used substance in 21 cases in 2006.

The use of one intoxicant alone was reported in around a third of the admissions. A check of the data basis from individual measures shows that this applies overwhelmingly to persons who cite alcohol and much less to those who cite addictive prescription drugs as the most used substance.

At more than 30 per cent, addictive medicinal drugs were "the second most used substance" in the biggest proportion of admissions in 2006 as well, followed by cannabis (21 %) and central stimulants (16 %). This is the same picture as in the years since 2001. Alcohol and heroin are less often reported as being the second most used substance, at 8 and 6 per cent respectively.

Daily (or almost daily) injecting was most common among the majority of the 32 per cent who stated that they were injecting users. Here, it is important to remember that the data basis includes problems users of both alcohol and drugs. There was a slight difference between those who attended treatment and care measures in the Oslo region and in the rest of the country. In the Oslo region, clients had injected in 36 per cent of admissions (38 % in 2004 and 29 % in 2005), while the corresponding percentage for the rest of the country was 24 per cent (26 % in 2004 and 2005). (Iversen et al., 2007).

#### **4.2.2 Clients in medically-assisted treatment - MAT**

The data from the regional centres (14) in the Norwegian programme for MAT are included in the client mapping survey discussed in chapter 4.2.1. The probability of duplicate registration is small in this context because MAT patients largely remain within one treatment system. It may nonetheless occur in exceptional cases that the same patient is registered at several regional centres in the same year.

At the end of 2006, there were 4 166 patients receiving MAT, an increase of 15 per cent since 2005 (3 614). Four hundred and ten patients had discontinued treatment for one or several reasons during the year. The total number who were or had been in treatment in 2006 was therefore 4 576. The average age was 39.9 years and the proportion of women was 30.5 per cent. Both the average age and the gender distribution have been fairly similar during the last three years. Since the use of and addiction to heroin is the central problem targeted by MAT, opiates naturally dominate the substance profile on admission (SKR report 1/2007).

## 5. Drug-related treatment

### 5.1 Treatment systems

Changes in the treatment systems were discussed in NR 2004 and 2005, chapter 5.1.

Summary: The regional health authorities took over responsibility for the treatment of problem drug and alcohol users from 1 January 2004. This includes measures for which the county authorities were previously responsible pursuant to the Social Services Act. The municipalities will still have responsibility for coordinating the services and for measures at municipal level. The goal of the Administrative Alcohol and Drugs Treatment Reform was to ensure good health treatment services for problem drug and alcohol users. It was particularly important to ensure better services for patients with compound needs for drug and/or alcohol treatment as regards psychiatric and somatic health services. In relation to the provision of services and treatment results, quality is a key concept and goal. The Norwegian parliament, the Storting, has stipulated certain criteria for good quality in these services: an interdisciplinary approach, a holistic approach and individually-adapted treatment.

#### 5.1.1 Evaluation of the Administrative Alcohol and Drugs Treatment Reform

In connection with its consideration of the reform, the Storting decided that the reform should be evaluated by the end of 2006. The purpose of the evaluation was to acquire knowledge about how the reform was working after having been in effect for three years. The International Research Institute of Stavanger was assigned the task of evaluating the reform. Its report was published in January 2007 (Report IRIS – 2006/227).

#### Summary of the evaluation

##### Increased resources

On implementation of the Administrative Alcohol and Drugs Treatment Reform, the regional health authorities were allocated EUR 175 million<sup>12</sup> (NOK 1.4 billion) to cover the costs they incurred as a result of taking over responsibility for interdisciplinary specialist services for problem drug and alcohol users. In addition, the health authorities have increased their budgets for the same services by approx. 40 per cent during the period 2004-2006 (nominal growth).

The increased use of resources has been aimed at increasing health staff levels and assessment and treatment capacity. The service in connection with enforced treatment has been improved somewhat. There has not been any move from long-term to short-term treatment or from in-patient to outpatient treatment, rather the opposite. Several of the regional health authorities devote a lot of resources to guest patient placements with the negative consequences this may have in terms of long distances between the treatment service and follow-up on the part of the home municipality.

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<sup>12</sup> Conversion rate: EUR 1 = NOK 8.00.



**Increase in the number of places and man-years in alcohol and drug treatment measures**

After the introduction of the reform in 2004 and up until 2006, the number of places in in-patient treatment increased by eight per cent, but the increase is unevenly distributed between the treatment facilities. There has been growth in the number of man-years in in-patient facilities and outpatient clinics. Calculations show a total increase of approximately 280 man-years in drug and alcohol psychiatric outpatient clinics and in drug and alcohol facilities, divided between 225 health professionals and 55 social work professionals and educational staff.

**Individual plans**

There has been a clear increase in the use of individual plans in the specialist health services (NR 2005 chapter 5.1). Information from the patient survey shows that it is not until the patient commences treatment in the specialist health service that an initiative is taken to establish an individual plan.

**Little change in municipal responsibility for problem drug and alcohol users**

The Administrative Alcohol and Drugs Treatment Reform has given the specialist health service considerable responsibility for problem drug and alcohol users, and the state finances the patients' stays in drug and alcohol treatment facilities. One conceivable development of this was that the municipalities would take less responsibility for drug and alcohol clients than previously. Information from social security offices does not indicate that this is the case. Slightly more than half of the social security offices reply that there has been no change in responsibility, while a third reply that responsibility has increased in certain areas.

**Poorer service in relation to demand**

In 2006, fewer patients had their needs met in terms of examination and treatment at a somatic hospital. This uncovered need for examinations increased by 14 per cent from 2003 to 2006. Uncovered needs for treatment at a somatic hospital have increased by 10 per cent.

Fewer clients have their needs met in terms of activation/ day centres. Uncovered needs increased from 55 per cent in 2003 to 63 per cent in 2006.

More clients have their needs met in terms of low-threshold services in municipalities. In 2003, 43 per cent had uncovered needs for such services, compared with 31 per cent in 2006.

Fewer clients have their needs met in terms of psychiatric youth teams. In 2003, 27 per cent had uncovered needs for such services, compared with 18 per cent in 2006.

Fewer clients have their needs met in terms of outpatient services. Uncovered needs increased from 10 per cent in 2003 to 18 per cent in 2006.

**Has the reform been a success?**

The answer to this question will depend on the expectations one had of the reform. If one's expectation was that the Administrative Alcohol and Drugs Treatment Reform would be an administrative reform whereby the treatment facilities for problem alcohol and drug users were to be adapted to and subjected to the same legislative requirements as the rest of the specialist health service, then it is reasonable to conclude that the reform has been a success.

If one's expectation was that the reform would lead to the same coverage of treatment needs and the same staffing factor in the interdisciplinary specialist health service for problem drug and alcohol users as in the rest of the specialist health service, then much remains to be done.

In the preparatory works to the reform, the emphasis was on the services being interdisciplinary, on their being based on a holistic approach and on individually adapted treatment. The greater number of health professionals means the services have become more interdisciplinary. It is more in doubt whether the reform has resulted in a more holistic (coherent) and individually adapted service.

So far, the implementation of the Administrative Alcohol and Drugs Treatment Reform appears to have led to a more fragmented and rigid service, with many interruptions to courses of treatment and less individually adapted treatment as a result. The biggest challenge facing the interdisciplinary specialised services for problem drug and alcohol users is thus to develop cooperation models and forms of practice that satisfy professional requirements for coherent and adopted treatment rather than focusing one-sidedly on formal referral procedures and compliance with deadlines (Report IRIS - 2006/227).

## 5.2 Drug-free treatment

The evaluation of the Administrative Alcohol and Drugs Treatment Reform is described in chapter 5.1.1. No major new evaluations or studies of treatment services were conducted in 2006.

## 5.3 Medically-assisted treatment (MAT)

See chapter 4.2.2 for data about the number of patients etc. in the MAT programme.

### **A study: Abstinence-orientated buprenorphine replacement therapy for young adults in outpatient counselling**

This study (Kornør et al, 2006) assessed treatment retention, compliance and completion of a 9-month buprenorphine replacement programme. In addition, changes in drug use and other relevant variables, as well as predictors of completion, were examined. Seventy-five opioid-dependent outpatients (mean age 26 years; 33% females) who aimed for opioid abstinence were enrolled into the study. Assessments were undertaken prior to buprenorphine induction and again after 3, 6 and 9 months.

40 (53%) completed the buprenorphine programme. At 9 months, 67 patients (87%) were still in counselling. Mean attendance rates for buprenorphine dosing and counselling sessions were 0.91 and 0.74, respectively. There were significant and persistent reductions in drug use during treatment with, however, a reversed tendency in the ninth month. Psychiatric problems escalated at 9 months, and three patients died during the detoxification phase. Completion was predicted by fewer previous treatment episodes. Detoxification from buprenorphine is associated with substantial psychological distress and an increased death risk. Buprenorphine replacement therapy should be continued until the patient chooses to leave, and close monitoring during the detoxification phase is essential (Kornør et al, 2006).

## 6. Health Correlates and Consequences

### 6.1 Drug-related deaths and mortality among drug users

See the data in Standard tables 05/06.

#### Methodological considerations

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

With effect from 1996, Statistics Norway's figures have been based on EMCDDA's definition of drug deaths. This widened the inclusion criterion which had been used until then. In the period after 1996, Statistics Norway's figures have been consistently higher than the figures from Kripos. However, if we exclude suicide (in which drugs were used) and drug deaths among the elderly from Statistics Norway's figures, the difference is almost non-existent. The trends are largely identical in both series of figures.

#### Situation and development

According to Kripos statistics for 2006, 195 persons died as a result of drug use, 152 men and 43 women (Table 9). The figure has remained relatively stable since the peak years of 2000 and 2001. The decline since the turn of the millennium is most probably due to the strong increase in the number of clients in medically-assisted treatment. Twenty-two of 27 police districts registered drug-related deaths in 2006, the same geographical distribution as in 2005. Oslo had most deaths, 72, which corresponds to 37 per cent. Very many of the deaths are believed to be due to extensive multiple use. The 2006 figures from Statistics Norway are not yet available.

Table 9. Drug-related deaths 1991-2006. Total number of deaths and deaths broken down by gender. Figures from Kripos and Statistics Norway (underlying cause of death).

1991-2006	Number of deaths according to Kripos			Number of deaths according to Statistics Norway		
	Men	Women	Total	Men	Women	Total
1991	74	22	96	66	22	88
1992	78	19	97	81	23	104
1993	77	18	95	76	17	93
1994	102	22	124	105	19	124
1995	108	24	132	114	29	143
1996*	159	26	185	173	31	204
1997	149	28	177	160	34	194
1998	226	44	270	228	54	282
1999	181	39	220	191	65	256
2000	264	63	327	302	72	374
2001	286	52	338	327	78	405
2002	166	44	210	240	67	307
2003	134	38	172	174	49	223
2004	168	55	223	171	60	231
2005	146	38	184	142	48	190
2006	152	43	195	**	**	**

Source: Kripos and Statistics Norway.

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

\*\* Figures for 2006 are not yet available.

The statistics from Kripos also show that 72 per cent of the deceased in 2006 were under the age of 40, while just over 20 per cent were under the age of 25. The percentage of drug-related deaths among the youngest group (15-25 years) has remained relatively stable, although disturbingly high, since the turn of the millennium. The percentage in 1999 was less than 14 per cent, in 1995 15 per cent. One possible explanation is that medically-assisted treatment does not include the youngest group since the lower formal age limit for admission to the programme is 25 years.

## 6.2 Drug-related infectious diseases

See the data in Standard table 09.

### 6.2.1 HIV and AIDS

In 2006, 276 cases of HIV infection were reported to the Norwegian Notification System for Infectious Diseases (MSIS) (Table 10). Only seven of these cases were among injecting drug users, all of them men and with an average age of 36 years (23-53). Five of the drug users had been infected in Oslo. The number of HIV-cases remains relatively low, and little new infection is detected in this group.

As of 31 December 2006, a total of 528 persons had been diagnosed as HIV positive with injecting use as a risk factor. This amounts to 15 per cent of all reported cases of HIV since 1984. Development into AIDS has been reported in 152 of the cases.

Table 10. Percentage of injecting drug users among persons infected by HIV and AIDS, with injecting risk behaviour, by year of diagnosis.

	HIV Total	HIV injecting drug use	Percentage HIV injecting drug	AIDS Total	AIDS Injecting drug use	Percentage AIDS injecting drug use
1984-89	894	315	35 %	144	8	6 %
1990	90	22	24 %	59	13	22 %
1991	142	16	11 %	59	16	27 %
1992	105	12	11 %	50	8	16 %
1993	113	13	12 %	64	13	20 %
1994	94	12	13 %	74	19	26 %
1995	105	11	10 %	67	8	12 %
1996	116	9	8 %	56	12	21 %
1997	113	11	10 %	34	8	24 %
1998	98	8	8 %	39	5	15 %
1999	147	12	7 %	29	7	24 %
2000	176	7	4 %	38	6	16 %
2001	158	8	5 %	27	5	18 %
2002	205	16	8 %	33	3	9 %
2003	238	13	5 %	43	7	16 %
2004	252	15	6 %	34	4	12 %
2005	219	20	9 %	32	4	13 %
2006	276	7	3 %	32	4	13 %
Total	3539	528	15 %	930	152	16 %

Source: Norwegian Institute of Public Health

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

## 6.2.2 Hepatitis

During the nationwide outbreak of hepatitis A from 1996 to 2000, 1 360 injecting drug users were identified as having acute hepatitis A. Since then, only sporadic, individual cases of hepatitis A have been reported among injecting drug users. Since 1996, there has also been a considerable increase in hepatitis B among injecting drug users. In 2006, 74 of a total of 149 reported cases of acute hepatitis B were among injecting drug users. During the period 1995-2006, the total number of reported cases of acute hepatitis B among injecting drug users was 1 812.

In recent years, in connection with needle distribution in Oslo, small-scale prevalence surveys have been carried out to register the incidence of, for example, hepatitis among injecting drug users. The 2006 survey showed that 71 per cent of the 231 persons included in the survey had experienced a hepatitis A infection or been vaccinated against the disease, 43 per cent had had a hepatitis B infection and 59 per cent had experienced a hepatitis C infection. 47 per cent had tags indicating that they had been vaccinated against hepatitis B. In Norway, hepatitis C is not monitored to the same

extent as hepatitis A and B, and the number of new cases of drug users being infected with the hepatitis C virus is therefore not known. These Oslo surveys are the only prevalence surveys that are carried out regularly among drug users in Norway.

## 6.3 Psychiatric co-morbidity (dual diagnosis)

### 6.3.1 Mapping of patients in the psychiatric health service with concurrent problem drug and alcohol use

A new report, which Sintef Health Research (Sintef report A1159, 2007) has produced on assignment for the Directorate for Health and Social Affairs, mapped this patient group on the basis of information about all in-patients in Norwegian adult psychiatric institutions on 20 November 2003, and all outpatients at Norwegian adult psychiatric outpatient clinics in two weeks in September 2004. The report is based on existing reports and data sources about the extent and characteristics of patients with mental health problems and concurrent drug and/or alcohol problems.

The report concludes that far more patients in the psychiatric health service than those who have been diagnosed as having drug and or alcohol problems report problem drug and/or alcohol use. It is difficult to find reliable methods to identify those patients who have a mental health problem in addition to problem drug and/or alcohol use.

Patients with a mental health problem and problem drug and/or alcohol use have compound difficulties and they are often treated in different systems. Since the Administrative Alcohol and Drugs Treatment Reform entered into force in 2004, there has been a pressing need to map the status of this patient group before the reform is fully implemented in the health authorities in order to obtain a basis for following developments and drawing up guidelines for the field. The report describes two approaches to identifying the patient group:

- Those who have been diagnosed with a drug and/or alcohol problem (Drug related problems F10 – F19 in ICD-10)
- Information about drug and alcohol use in the weeks prior to the start of treatment

The report shows that only 10 per cent of the in-patients examined and 13 per cent of the patients at outpatient clinics have a drug and/or alcohol diagnosis. When a drugs and/or alcohol diagnosis is combined with information about the patient's problem use of drugs and/or alcohol during the last weeks prior to the start of treatment, it is found that 25 per cent of the patients in outpatient treatment and 26 per cent in adult psychiatric institutions have concurrent problem use of drugs and/or alcohol and mental health problems. The report also states that the number of patients with problem drug and/or alcohol use is probably even greater than is registered in the mapping carried out in connection with this report.

The report also shows how patients with both mental health problems and problem drug and/or alcohol use differ from the other patients in the mental health service. Those with both drug and/or alcohol problems and a mental health problem are younger. They are more often treated in acute wards and have shorter admissions than those with mental health problems alone. The patient group with average/major problem use of drugs and/or alcohol who have not been diagnosed as having a drug and/or alcohol problem have a great deal in common with those who have been diagnosed as having a drug and/or alcohol problem.

The researchers behind the report propose measures to delimit and identify this patient group in as expedient a manner as possible, and these measures will be employed in the efforts to ensure uniform use of procedures and definitions in reporting from the drugs and alcohol and mental health fields.

## 7. Responses to health correlates and consequences

Low threshold health services, including the injection room in Oslo, were discussed in NR 2006 chapter 7.1.

### 7.1 Prevention of overdoses in Oslo

The number of overdoses in Oslo in 2006 increased in relation to the year before. 72 persons died in 2006, and 56 in 2005 (Kripos figures). It is presumed that the reason may be easy access to drugs and the fact that the overdoses with fatal outcomes take place indoors and not on the street, where help can be given more quickly. The municipal and private services are not very successful in motivating and passing on problem users to long-term treatment or rehabilitation. Users often go straight back to the drug milieu after contact with the ambulance service and outreach service after overdoses.

#### **Clinic Motivation** (*Klinikk Motivasjon*)

As part of the efforts to reduce the number of overdoses/overdose fatalities, the Alcohol and Drug Addiction Service in Oslo opened Clinic Motivation in August 2006, a service for those at risk of overdosing and users who use heroin extensively and have little stable contact with the help services.

Clinic motivation is organised with outpatient activity and has 10 bedrooms at its disposal in a dedicated section of a lodging house.

The clinic is a service for heroin addicts in Oslo who have little or highly irregular contact with the municipal help services and the social services in the city wards. They are in regular contact with the field health care stations and the needle distribution service, they live as vagabonds and use the acute places and the winter services offered by the institutions and are sought out in connection with overdose problems.

The goal of Clinic Motivation is to follow up these users and help and motivate them to enter the ordinary treatment system. Field health care services, outreach services, the ambulance service and in-patient institutions with acute in-patient places pass on users to Clinic Motivation. The users belong to Oslo and cannot be registered as participants in medically-assisted treatment in Oslo. They are given Subutex as outpatients and the medication is increased under supervision. If the user wishes a place in the institution and is allocated one during the course of the first three months, the increase in medication will continue until the normal dose is reached.

The institution provides care, and the stay there is intended to be an active one and not just a place to stay. Work on finding a place in the specialist health service starts soon as possible. After three months, a decision will be made on whether medication will continue. If the medication is to continue for a further three months, a responsible team will be appointed. The user's independent living skills and future housing situation will be assessed. It must be clarified whether the user is motivated for prolonged medication-free treatment in an institution or whether the user wishes to apply for medically-assisted treatment. In exceptional cases, medication can be given for a further three months to users who are clearly motivated and who are waiting for medication-free treatment in an institution or the start up of medically-assisted treatment.

The clinic project is funded by state funds, and it will be evaluated by an external body ([www.rme.oslo.kommune.no](http://www.rme.oslo.kommune.no)).

## 7.2 Interventions related to psychiatric co-morbidity

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

The Directorate for Health and Social Affairs has started work on drawing up national professional guidelines for studying, treating and following up patients with drug and alcohol problems and concurrent mental health problems.

The guidelines will deal with three main areas:

- Knowledge about concurrent serious mental health problems and drug addiction/alcoholism/problem use
- Recommended methods for examination and diagnosis
- Recommended treatment and other follow-up

A project group has been appointed, as has a broad-based reference group, which will help in this important work. The plan is that the guidelines will be distributed for consultation in autumn 2008 and will be completed in February 2009.

### New treatment service

In autumn 2007, Diakonhjemmet Hospital in Oslo opened an interdisciplinary treatment unit for patients with a dual diagnosis. The unit comprises an outpatient service and 12 in-patient places. The goal is to intervene in crises, stabilise the situation, and facilitate and motivate the patient for further treatment.

The service is meant for patients who it is currently difficult to provide with a satisfactory service within existing measures. The buildings which house the service are specifically designed for optimal adaptation to this group of patients. It contains two separate units, each with room for six patients. If more privacy is required, each unit can be divided into smaller units for two and four patients, respectively. In addition, there is a room that has been specially designed for optimal monitoring ([www.dobbeldiagnose.no](http://www.dobbeldiagnose.no)).

### Street hospital

The Street Hospital is a somatic low-threshold service for problem drug and alcohol users in Oslo that is run by the Salvation Army and fully funded by the state (see NR 2006 chapter 7.1). The patients often have major, compound health problems that are not dealt with by the rest of the health service, and they also have bad experiences from dealings with public services. Typical problems include: extensive chronic sores, serious infections, deep vein thrombosis and abscesses. Many of them are also undernourished, emaciated and completely physically exhausted. In addition to physical complaints, the vast majority of the patients suffer from mental health problems of various kinds.

On start-up in 2005, its capacity was 10 beds. Admission periods vary from one week to up to three months. The Street Hospital was originally a three-year project. The Ministry of Health and Care Services has now proposed making it permanent. In addition, it has been proposed to extend the service by adding a separate ward for women ([www.dobbeldiagnoser.no](http://www.dobbeldiagnoser.no)).



### 7.3. Prevention and treatment of drug-related infectious diseases

In Norway, preventive measures aimed at protecting injecting users against infection are based on the following strategies:

- Cooperation between the health services in the municipality, outreach services, treatment institutions, prisons etc.
- Spreading information in drug user milieus about outbreaks, symptoms, how infection is spread, personal protection and offering vaccination
- Harm-reduction measures such as good access to clean needles and other user equipment and medically-assisted treatment (e.g. methadone programmes)
- Vaccination of drug addicts against hepatitis B (and hepatitis A)

Antiviral treatment of the blood infection diseases HIV, hepatitis B and hepatitis C(HCV) is available and free for addicts throughout the country. No data are available for how many addicts receive or have received such treatment.

#### **A study: Hepatitis C treatment of opioid dependants receiving maintenance treatment: results of a Norwegian pilot study.**

The study (Krook et al., 2007) covers 17 HCV-infected heroin addicts. All of them were taking part in medically-assisted treatment (MAT) and were being given maintenance treatment with methadone or Subutex. The goal of the work was twofold. The primary goal was to examine the effect of combination therapy using the medicines peginterferon and ribavirin, and secondarily to examine whether such a treatment regime was feasible for the patient group. The 17 patients with HCV genotype 3a were treated for 24 weeks. To optimise compliance, the treatment was given from a department of infectious diseases in cooperation with a MAT centre. All injections were given in the MAT centre and the patients were given psychosocial support. The compliance was 100 per cent. All of them responded to the therapy and 16 (94%) were sustained responders.

This study indicates that compliance and treatment outcome of opioid dependants on methadone or buprenorphine maintenance after 24 weeks of HCV treatment corresponds to that for non-dependants if extra support is given. The treatment should be undertaken in collaboration with specialists in addiction medicine, hepatology and infectious diseases (Krook et al., 2007).

In recent years, new treatment methods have been introduced that completely eradicate the hepatitis virus in many patients. And the combination of the two medicines used in the study is now recommended as the first choice in the treatment of hepatitis C. The Norwegian Medicines Agency, Cochrane Library and, most recently, Clinical Evidence all make identical therapy recommendations in this area ([www.dobbeltdiagnose.no](http://www.dobbeltdiagnose.no)).

### 7.4 Prevention and reduction of driving accidents related to drug use

#### **Alcohol Treatment Programme**

The Alcohol Treatment Programme was established as a trial scheme in five counties in 1996 and, following a gradual expansion, it became a nationwide scheme in 2003. For a trial period, courts can sentence drivers convicted of violation of the Road Traffic Act and who have an alcohol problem to a fine and suspended prison sentence including compulsory participation in the programme instead of a fine and an unconditional prison sentence. The purpose of the programme is to combat drink driving, contribute to greater safety in traffic and reduce the number of accidents. It is the correctional service that is responsible for following up convicted persons who complete the pro-

gramme. The programme consists of 20-30 hours of teaching, individual conversations, control and mapping of treatment needs. Follow-up lasts for a year.

The number of such judgments has more than doubled since the programme became nationwide. The Ministry of Justice and the Police now wishes to expand the alcohol treatment programme to also include persons who drive under the influence of substances other than alcohol (Odelsting proposition no. 31 2006-2007).

## 8. Social correlates and consequences

### 8.1 Social exclusion

No new information available.

### 8.2 Drug-related crime

#### 8.2.1 Drug offences

See the data in Standard table 11.

In 2006, 13 245 penal sanctions were registered in which a drug crime was the main violation (Table 11). At 40 per cent, drug crimes accounted for the largest proportion of the total number of penal sanctions in 2006. The ratio has been approximately the same in recent years. Of the drug crimes, only 1 543 resulted in a penal sanction of unconditional imprisonment. The others were given milder sanctions such as a suspended sentence alone, community sentences, court-imposed fines and fixed penalties.

Table 11. Penal sanctions in criminal cases by type of crime, 2000-2006. Number.

Year	2000	2001	2002	2003	2004	2005	2006
Total	21 444	34 962	27 513	29 380	29 529	33 307	33 103
Drug crimes	8 374	14 861	11 894	12 265	11 815	12 524	13 245
Economic crime	1 215	1 816	1 299	1 382	1 606	1 846	1 635
Other crime against property	6 658	9 652	7 376	8 213	8 217	9 333	8 919
Crimes of violence	3 195	5 055	4 186	4 687	4 826	5 777	5 419
Sexual crimes	356	510	429	571	570	722	723
Vandalism, crimes	715	1 170	873	867	905	1 049	1 018
Other crimes*	931	1 898	1 456	1 395	1 590	2 056	2 144

\* Also includes environmental crimes.

Source: Statistics Norway.

There is reason to believe that a relatively large percentage of all crimes against property are committed by drug addicts as a means of financing their own habit. Since the crime statistics are organised on the basis of the individual offences, they do not provide information about how large a percentage of, for example, thefts and vandalism can be linked to drug addicts. The available crime indicators with respect to drugs are thus limited to those crimes that are related to violation of drug laws, i.e. the Penal Code and the Act relating to medicines. The Penal Code is applied in cases of serious drug crime, while the Act relating to medicines is applied in cases involving the use of drugs and possession of small quantities. Table 12 shows developments in the number of penal sanctions for violation of drug laws and how they break down in terms of the application of law.

Table 12. The number of penal sanctions for violation of drug laws 1996-2004.

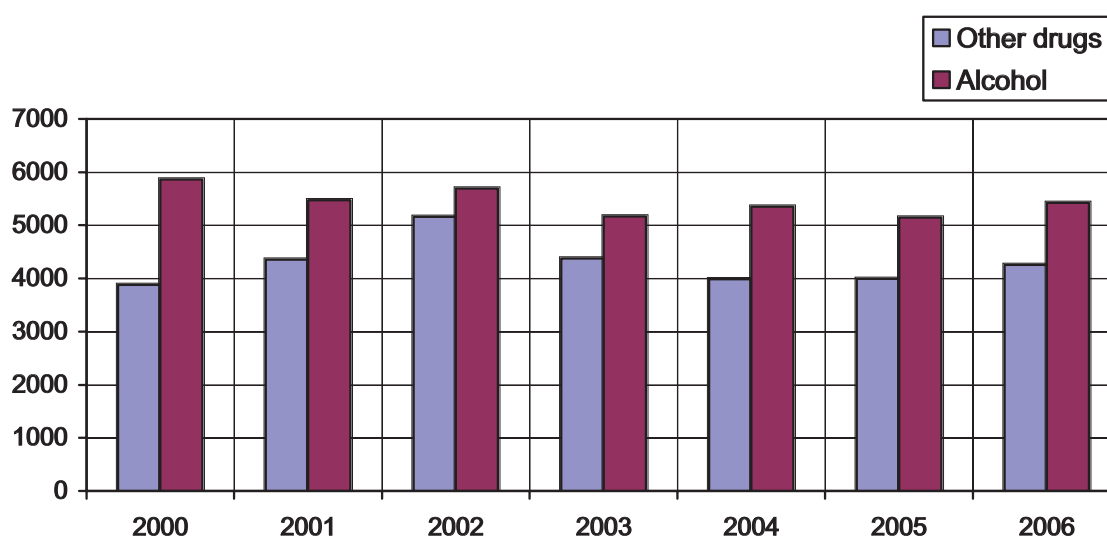
Year	Penal Code section 162	Medicines Act section 31-2	Total
1996	2 716	1 765	4 481
1997	2 858	1 472	4 330
1998	3 932	3 039	6 971
1999	4 648	3 525	8 173
2000	4 451	3 893	8 344
2001	7 456	7 314	14 770
2002	5 738	6 072	11 810
2003	6 310	5 874	12 184
2004	6 029	5 684	11 713
2005	6 830	5 540	12 370
2006	7 181	6 065	13 245

Source: Statistics Norway, Criminal justice statistics

### 8.2.3 Driving offences

The statistics relating to driving under the influence are monitored by the Division of Forensic Toxicology and Drug Abuse at the Norwegian Institute of Public Health. The number of arrests in 2006 on suspicion of driving under the influence of alcohol and other substances shows little change in relation to previous years. A small increase was registered in cases involving substances other than alcohol in relation to 2005 (approx. 6 per cent), while the number of cases involving alcohol has remained virtually constant since the mid-1990s at approx. 5 000 – 5 500 cases per year, based on the total number of breathalyser and blood tests (Figure 14).

Figure 14. The number of road traffic cases received involving suspicion of alcohol/ other substances.



Source: Norwegian Institute of Public Health

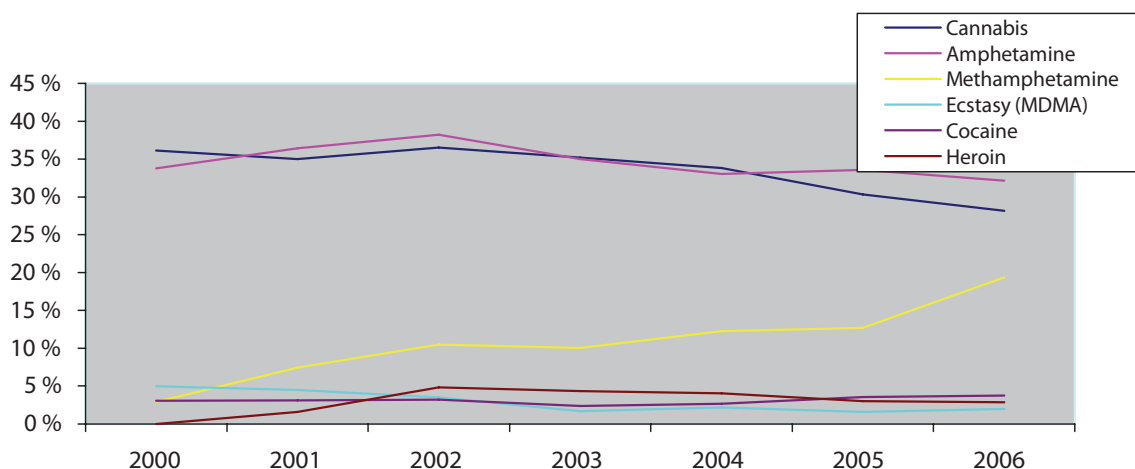
### Finds of individual substances in road traffic cases

Methamphetamine accounts for the biggest change in terms of positive findings for illegal substances, from slightly less than 10 per cent positive in 2003 of the total number of cases received to almost 20 per cent positive finds in 2006 (Figure 15). A corresponding increase was registered by Kripos in the number of seizures of methamphetamine (chapter 10.4). Amphetamine and cannabis

are still at the top with around 30 per cent positive findings. Here, it should be remarked that some positive findings for amphetamine may be due to taking methamphetamine, which is partly converted into amphetamine in the body. For other illegal substances (ecstasy, cocaine and heroin – registered as 6-monoacetylmorfin – 6-MAM), no significant changes were registered.

Diazepam accounts for the biggest increase in findings of medicinal drugs, from approx. 20 per cent positive findings in relation to the total number of cases received in 2004 to almost 35 per cent positive findings in 2006. The reduction in positive findings for flunitrazepam continued after the “peak year” of 2002 when the drug was found in more than 40 per cent of the cases (Norwegian Institute of Public Health).

Figure 15. Finds of illegal drugs as a percentage of the total number of road traffic cases received.



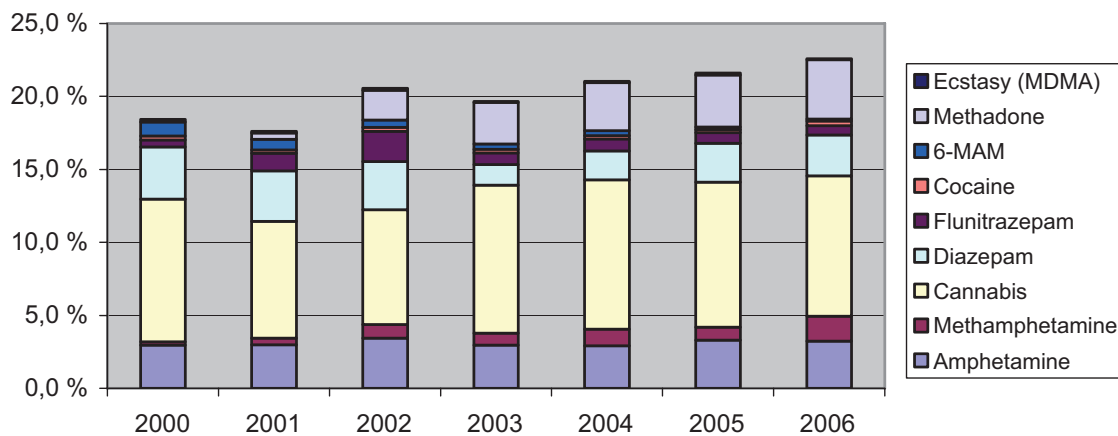
Source: Norwegian Institute of Public Health

### 8.3 Drug use in prison

The National Institute of Public Health is also responsible at the national level for securing evidence, analysis and interpretation of drugs, medicines and poisons in samples taken from persons for whom the analysis results may have consequences in criminal law or corresponding consequences. The clients are for the most part the police and prosecuting authorities, the armed forces, medical examiners, the correctional service, social services and child welfare services, and some private companies.

The number of cases from prisons in which illegal drugs or medicinal drugs are found amounts to approximately 24 000 per year. The number of such cases has increased somewhat in recent years. Methamphetamine is increasing most, as in road traffic cases and in seizures made by Kripos. Figure 16 provides an overview.

Figure 16. Drug finds in correctional service cases as a percentage of the total number of cases received. Percentage.



Source: Norwegian Institute of Public Health

## 9. Responses to social correlates and consequences

### 9.1 Social re-integration

#### 9.1.1 Employment

##### **National strategy plan for employment and mental health (2007-2012)**

The strategy plan was presented on 19 September 2007. The strategy continues and strengthens employment-related efforts in the escalation plan for mental health (1998-2008). The Government's goal is to:

- Prevent exclusion from the employment market
- Ease inclusion in the employment market for persons with mental health complaints/ problems

In order to achieve this, the Government will endeavour to:

- Achieve good cooperation between the employment market and welfare administration and the health service, other parts of public services, and with employers
- Ensure user participation and active participation by the individuals concerned
- Ensure good, relevant employment and health-oriented measures and services
- Ensure good competence about work and mental health in the workplace and in public services
- Ensure good knowledge, research and development

The work on strengthening possibilities for work and the accessibility of employment market measures for people with mental illnesses/ problems has shown that permanent and systematic efforts are required in this field. The policy instruments in the strategy supplement existing services and measures.

Some of those with mental illnesses/ problems also have drug and/or alcohol problems or other problems. The strategy and the measures in the action plan therefore also include persons who have drug and/or alcohol problems in addition to being mentally ill. The work on including/retaining persons with mental illnesses in employment will thus involve more than working on the mental illness or problem. The measures are designed on this basis, also those where this is not specified. The same applies to inhabitants from minority language groups who may face major challenges as regards both mental health problems and participation in employment.

People who also have drug and/or alcohol problems are already an important part of the target group. The Norwegian Labour and Welfare Organisation (NAV) already offers a service to persons undergoing methadone and Subutex treatment (MAT) and who require more extensive assistance than the local NAV office can provide. The MAT service has competence in occupational rehabilitation and is familiar with methadone and Subutex and drug and alcohol problems. The local NAV office assists applicants with referrals to the MAT service. The policy instruments in the strategy supplement existing services and measures aimed at this target group.

## 9.2 Prevention of drug-related crime

### 9.2.1 Assistance with rehabilitation

It is estimated that 60 per cent of all inmates have a drug or alcohol problem on imprisonment. The correctional service endeavours to ensure that inmates and convicted persons can be given help to live a life without drugs and alcohol abuse and without crime. Relevant measures include:

In August 2006, the justice and health sectors strengthened cooperation aimed at providing better follow-up during and after the serving of sentences. A circular from the Ministry of Justice and the Ministry of Health and Social Affairs sets out guidelines for cooperation between municipal health services, the specialist health service, the municipal social services and the correctional services in relation to inmates and convicted drug addicts and alcoholics. The circular clarifies the division of responsibility in relation to drug addicts and alcoholics. It will also strengthen the cooperation between the services and contribute to better cooperative solutions and joint plans or agreements at the regional or local level.

From 1 January 2006, problem drug users who would previously have been given unconditional prison sentences for criminal offences can be sentenced to take a rehabilitation programme. The trial scheme for a drug programme under court control (described in NR 2005 chapter 1.1.) means that problem drug users can be sentenced to complete a rehabilitation programme as a condition for being given a suspended sentence. If the scheme had not been initiated, the target group would have been given unconditional sentences. The participants receive services from the municipalities and the specialist health services as part of an active rehabilitation arrangement. Through the trial scheme, models are developed for inter-service cooperation between the correctional service and the participating health authorities and municipalities. Day centres have been established in Oslo and Bergen.

Some inmates need treatment, training in independent living skills or work training that cannot be given in a prison. Section 12 of the Execution of Sentences Act therefore provides that, in individual cases, convicted persons can serve their sentences in institutions that are not under the auspices of the correctional service (discussed in NR 2006 chapter 9.2). This applies in particular to persons with drug and/or alcohol problems. It is a clear goal that more inmates with problem drug and/or alcohol use be transferred to rehabilitation institutions. In 2006, the Ministry of Justice and the Police presented a proposal for consultation concerning rapid reaction, measures to reduce the queue for the serving of sentences and improved content during the serving of sentences. A proposal to increase the number of "section 12 days" was part of this consultation proposal.

### 9.2.2 Alternative penal sanctions in relation to young offenders

During consideration of the general part of the new Penal Code in 2004, the Justice Committee asked the Government to present a separate proposal to the Storting on conditions during serving of sentences for persons who are under the age of 18 when sentenced. *The goal is to facilitate a fundamental review of how we can reduce the use of prison sentences for young people between the ages of 15 and 18 and how the punishment can be better adapted to this group in cases where a prison sentence is unavoidable.*

White paper no. 20 (2005-2006), *Alternative straffereaksjoner overfor unge lovbrøyttere (Alternative penal sanctions for young offenders)* was discussed by the Storting on 18 December 2006. The White Paper will later be followed up in the form of a concrete bill.



The Storting supported the Government's proposal for:

- A delimitation in the Penal Code that means that a person who was under the age of 18 when an offence was committed may only be sentenced to imprisonment when this is absolutely necessary.
- A prohibition on prison sentences exceeding 8 years for these offenders.
- A prohibition on arresting and imprisoning persons under the age of 16 and a prohibition on imprisoning persons under the age of 18 for more than one week at a time.
- Introducing a statutory prohibition on persons under the age of 18 being subjected to full isolation while on remand.
- If imprisonment is necessary, the main rule shall be the use of a prison substitute rather than prison when the accused is under the age of 18. It is desirable that child welfare institutions can be used as prison substitutes to a great extent.
- The White Paper proposes appointing a committee that can present proposals for alternative penal sanctions for young offenders. In its considerations of proposals, the committee shall take into account the fact that many of the young offenders who are currently in prison are from foreign backgrounds and take account of the special needs of this group.

## 10. Drug Markets

### 10.1 Availability

#### Availability based on seizures

Several factors must be emphasised when describing any changes in availability. Seizures of illegal substances by the police and customs authorities are an important parameter in this context. However, the number of actual seizures and the quantities involved are affected by the internal priorities of and resources available to the police and customs authorities, and by surveillance methods and international cooperation. The statistics 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.

On the basis of the seizures, the availability of cannabis still appears to be great. Cannabis was seized in all the 27 police districts in 2006 as well. Twenty-one police districts have made more seizures than in 2005, and many of them have experienced an increase of between 20 and 80 per cent in the number of seizures compared with 2005.

In 2006, cocaine was registered in all the police districts. There are many indications that cocaine is more widespread geographically than ever before, both in terms of absolute figures and in relation to other drugs. The amount of unreported cases/use may be particularly large since cocaine is often used in nightlife arenas where the police are seldom or never present.

The number of seizures of amphetamine, and methamphetamine in particular, is clearly higher than the level in recent years. Measured in terms of the number of seizures, these two drugs are the second most widespread in Norway after cannabis. All the police districts made seizures of amphetamine and methamphetamine in 2006, and 19 districts made more seizures than the year before.

The number of heroin seizures in 2006 was the lowest for 15 years, and the number has been more than halved since 2001. Although the reduction is an indication that the demand for heroin has fallen substantially, among other things because of the number of people undergoing substitution treatment, the reduction in recent years is nonetheless so marked that doubts can be raised about whether the seizure statistics reflect the situation on the street with respect to availability. Kripos also claims that it has no reason to believe that the availability of heroin has been reduced in relation to previous years. 25 of 27 police districts made seizures in 2006. Interviews among injecting users in Oslo conducted by SIRUS as part of the mapping of the illegal street market do not indicate that it has become more difficult to obtain heroin in the Oslo area.

#### Availability based on questionnaire surveys

In order to measure availability, the respondents in the survey of young adults between the ages of 21 and 30 (chapter 2.2.2) were asked whether they had been offered drugs and whether they believed that they would be able to obtain the drugs during the space of one to three days if they so wished.

There has been a clear increase in the percentage who have been offered cannabis, from 48 per cent in 1998 to 66 per cent in 2006. The increase is greatest among women. The percentage in the nationwide sample who believe they could obtain cannabis has been stable. In the Oslo sample, more respondents reported having been offered cannabis and being able to obtain the drug than in the nationwide sample, but the trend was the same. There has been an increase in the proportion reporting having been offered cannabis in Oslo as well, while the proportion reporting that they could obtain the drug has remained stable.

For other drugs, it appears that the percentage who believe that they can obtain the drugs has stabilised or fallen slightly. There has been a clear decline in the percentage in Norway who report that they could obtain ecstasy, from 42 per cent in 2002 to 33 per cent in 2006. The percentage who reported having been offered ecstasy has more than doubled, however, from ten per cent in 1998 to 23 per cent in 2002 and 24 per cent in 2006. The percentage who reported that they had been offered amphetamine increased from 15 to 25 per cent during the same period. In the Oslo sample, the availability of the different drugs appears to be the same as in the country as a whole.

The availability of cocaine appears to be increasing. The percentage of the nationwide sample who have been offered cocaine has increased from seven per cent in 1998 to 15 per cent in 2002 and 21 per cent in 2006. The percentage who report that they are able to obtain cocaine also shows an increase. In the Oslo sample, for example, this percentage increased from 35 per cent in 2002 to 40 per cent in 2006. In 1998, 16 per cent reported having been offered cocaine in Oslo. The percentage increased to 32 per cent in 2006 (39 % of men and 24 % of women). The observed increase in the availability of cocaine is in line with the increase in lifetime prevalence (Lund, Skretting, 2007).

## 10.2 Production, sources of supply and trafficking patterns

Most of the amphetamine and methamphetamine on the Norwegian market comes from illegal laboratories in Russia, Poland and Lithuania. The customs service's section for border controls states that Lithuania has taken over the role of main supplier of synthetic drugs such as amphetamine, methamphetamine and Rohypnol to Norway. Poland and the Netherlands are still important countries, but the majority of those arrested are Lithuanians.

Until last year, the main routes from Lithuania/Poland were through Germany and Denmark to the Øresund Bridge and on through Sweden to Norway. In 2007, there has been a shift towards the Baltic ferries, where ordinary passenger cars more or less shuttle back and forth. It is not unusual for those who are caught to have made many trips during a fairly short space of time. Cars prepared with concealed cavities seems to be the most frequent method used.

New ferry routes across the Baltic Sea:

Klaipeda (Lithuania) – Karlshamn (Southern Sweden) and on by car to Norway  
 Paldiski (west of Tallinn) – Kappelska (north of Stockholm) and to Norway  
 Riga-Stockholm  
 Tallinn-Stockholm and then to Norway  
 Tallinn-Helsinki – and then to Norway

As before, *cannabis* mostly comes to Norway from Morocco via two main routes – Spain and Italy up to the Netherlands/Germany and on to Denmark and Norway.

*Heroin* comes from Pakistan and Afghanistan via two northerly routes via Bulgaria/Romania – the Ukraine/Russia, and then to Poland /Lithuania. Two southerly routes go through Greece/the Balkans to the Netherlands/Germany.

As before, *cocaine* comes from South America to Spain and from there to the Netherlands and Germany before continuing up through Denmark to Norway (The custom service, personal communication).

### 10.2.1 Players in the heroin trade

SIRUS has conducted a qualitative study with the chief goal of describing the players involved in the heroin trade and the tasks they perform (Snertingdal, 2007). The study is based on 26 qualitative interviews with heroin dealers and importers. Of the interviews, 24 are with convicted felons serving sentences for heroin offences and two with heroin dealers who were interviewed outside prison. The sample consists of five women and 21 men. Thirteen of the informants are Norwegian and 13 are of other ethnic origin. In addition, five police officers who have followed developments in the heroin trade over time were interviewed.

#### How are players recruited?

The heroin dealers, whether they act as couriers, recipients or store the heroin, say that they are either recruited by close friends and family (strong ties) or by more chance acquaintances (weak ties). The stories about recruitment via strong ties point in the direction of heroin being imported through established and long-term relations in which kinship and friendship are access criteria and constitute a recruitment potential. The police officers believe that heroin importation is often run by various ethnic groups with hierarchic family structures. The leader (often the father) is usually also located abroad. Recruitment to heroin importation therefore takes place via ties of marriage and kinship. The police informants state that, since the year 2000, collaboration across ethnic groups has become more common in the heroin trade, but they maintain that the hierarchic family structure is important in heroin importation.

In addition to recruitment through strong ties and weak ties, the convicted felons state that they have performed jobs in connection with the sale of other drugs before and at the same time as heroin. As these informants tell their stories, the path to dealing in heroin goes via other types of drugs. In this context, they point in particular to hash and amphetamine. This interweaves the heroin trade with sales on a larger drug market and points towards there being flexibility in terms of tasks within this larger drugs market.

#### How are contacts made in the milieu?

Several of the convicted felons state that the importation of heroin is controlled from abroad and that the people who are caught in Norway are not the ringleaders. Moreover, the convicted felons say that the power of the ringleaders over the family, both in the country of origin and in Norway, is very strong. The police informants also state that contacts in heroin importation are made via ties of kinship, and that these ties of kinship bind the Norwegian heroin trade to the international heroin trade.

None of the dealers in this material claim that they have been controlled by their suppliers. On the one hand, it is reasonable to assume that the dealers are relatively free in relation to their suppliers in that they can choose who they wish to deal with. Several of the dealers claim that there are many suppliers to choose from. Both the availability of heroin and the current low prices support this claim. On the other hand, the dealers may become subordinate to their suppliers if a situation arises where they owe them money. The police informants support the claim that the heroin dealers are free in their choice of suppliers, but they also say that some heroin dealers who are not ethnic Norwegians are subordinate to family members who are their regular suppliers.

Both the police and the convicted felons claim that dealers no longer travel abroad themselves in order to bring back heroin for sale. The main argument is that "sole proprietorships" have been beaten in terms of price by other players who can import larger consignments. If it is the case that

sole proprietorships are a historical phenomenon in the Norwegian heroin trade, this may indicate that things are more specialised and organised further up the ladder in heroin trade than is the case in other types of drug dealing, while sales levels are characterised by flexibility between the positions. The police confirm the convicted felons' stories and also emphasise that players move between different roles relating to heroin sales, but they focused less on the individuals' drug and dealing careers (Snertingdal, 2007).

## **10.3 Seizures**

### **10.3.1 Main features**

In 2006, a total of 26 264 drug seizures were registered. This is the highest number of cases and seizures for four years. However, there are big differences between the different drugs.

The number of seizures of cannabis and cocaine is the highest ever.

A record amount of amphetamine was seized in 2006. For methamphetamine, the trend is still moving steeply upwards. The number of seizures has almost tripled since 2001. Norway is probably one of the biggest markets for methamphetamine in Europe, with respect to both the amounts seized and the number of seizures.

In 2006, large amounts of heroin were seized, largely because of one single big seizure. In terms of the number of seizures, there were fewer than in previous years, and there has been a steady reduction since the year 2000.

For benzodiazepines (BZD), both the number of seizures and the amount seized show that this group of drugs is on the increase. More than a million BZD tablets were seized in 2006. The number of tablets seized was only higher in 2002. Most of the seizures stem from illegal importation into Norway. The abuse of prescription drugs is still at a marginal level (Kripos, 2007).

### **Tendencies during the first six months of 2007**

Large amounts of amphetamine and methamphetamine were seized during the first six months of 2007. The total amount of seizures is markedly greater than in any previous six-month period. Taken together, the amount of these two drugs seized is greater than for cannabis for the first time. The number of seizures, on the other hand, has declined somewhat.

For cocaine, both the number of seizures and the amount seized are record high.

On the other hand, very little heroin has been seized so far, and the number of seizures continues to fall. The figures for the first six months of 2007 are comparable with the seizure situation in the 1980s. The number of seizures of cannabis has fallen by 15 per cent. The most striking development is the relatively small amounts of hash seized. This not only applies in relation to last year, when the amount was four times greater, but also in relation to the amounts that have been usual in previous years (Kripos, 2007).

### **10.3.2 Seizures and purity of different types of drugs**

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

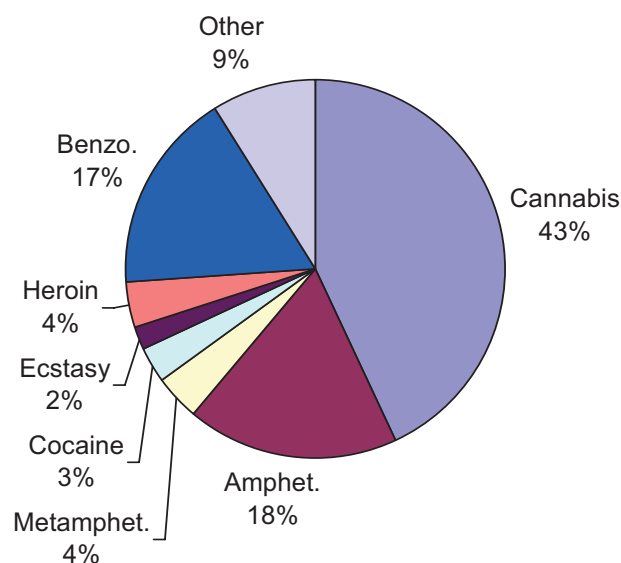
Table 13. The number of seizures during the period 2001-2006 by the most discussed types of drugs\*.

Drug type	2001	2002	2003	2004	2005	2006	% change 2005-2006	% change 2001-2006
Cannabis	10 838	10 921	10 397	10 066	10 128	11 221	+10,8 %	+ 3,5 %
Amphetamine	4 283	5 037	4 578	4 149	4 410	4 680	+6,1 %	+9,2 %
Methamphetamine	392	696	640	830	950	1 139	+19,9 %	+190,6 %
Heroin	2 501	1 906	1 709	1 390	1 151	1 087	-5,9 %	-130,1 %
Benzodiazepines	6 006	8 058	4 700	4 393	3 928	4 552	+15,9 %	-31,9 %
Painkillers/ opioids	1 109	1 237	1 216	1 179	1 319	1 161	-13,6 %	+4,7 %
Cocaine	496	577	504	489	685	726	+6 %	+46,4 %
Ecstasy	837	693	405	456	341	411	+20,5 %	-103,6 %
Khat	198	238	249	305	210	220	+4,8 %	+11,1 %
LSD	52	15	31	31	34	28	-21,4 %	-85,7 %
GHB	81	75	120	28	46	65	+41,3 %	-24,6 %
Opium	21	14	7	18	16	23	+43,8 %	+9,5 %
Psilocybe mushrooms	59	66	89	77	75	82	+9,3 %	+39 %

Source: Kripas

\*The figures have been adjusted as of September 2007.

Figure 17. Market share for the different drugs in 2006. Percentage.



Source: Kripas

### Cannabis

A total of 1 542 kg was seized in 2006. Considerably more has been seized in some years, for example in 2003 (2 292 kg). On the other hand, cannabis is seized more frequently than ever before. A total of 11 221 seizures of cannabis were made in 2006.

Table 14. Individual seizures of cannabis above 70 kg in 2006.

Police district	Amount
Oslo	224 kg
Oslo	195 kg
Østfold	94 kg
Oslo	70 kg
Romerike	94 kg

Source: Kripos

For hash – which dominates the Norwegian market – the average THC purity is roughly seven per cent, as it has been for many years.

### Heroin

Ninety-three kilos of heroin were seized in 2006. Larger amounts of heroin have only been seized in one previous year (129 kg in 2004). The number of seizures (1 087), however, continues to fall, and heroin now only accounts for just over four per cent of the total number of drug seizures in Norway. By comparison, heroin accounted for 20 per cent of the total number of drug seizures in 1998.

Twenty-five of 27 police districts made seizures. Almost half of the total amount seized was seized in Nord-Trøndelag police district (44.93 kg). The drugs were found in an uncollected suitcase at Værnes Airport. It is the biggest single seizure of heroin ever made in Norway. The drugs consisted of two main types: 10.84 kg heroin chloride (purity 63 %) and 34.1 kg heroin base (purity 26-31 %).

Table 15. Individual seizures of heroin above 1 kg in 2006.

Police district	Amount	Purity
Nord-Trøndelag	44.93 kg	26-63 %
Oslo	10.94 kg	31-36 %
Østfold	9.78 kg	41 %
Oslo	6.62 kg	21 %
Østfold	1.65 kg	45 %

Source: Kripos

The average purity of heroin is 29 per cent, and this is relatively low seen in a historical perspective. However, there is still great variation in purity from seizure to seizure.

In 2006, paracetamol and caffeine were also found in many seizures, and intoxicating substances such as Phenobarbital, Diazepam, Flunitrazepam and Alprazolam were found in several of the mixtures of drugs containing heroin.

### Amphetamine/methamphetamine

A total of 3 184 kg of amphetamine was found in 4 680 seizures and 68 kg of methamphetamine in 1 139 seizures. In addition, 4 005 tablets containing amphetamine were seized in 23 seizures, including 370 tablets (11 seizures) containing medicinal drugs. The proportion of amphetamine and methamphetamine in relation to other drugs has increased since 2005 and now amounts to 22 per cent.

Table 16. Individual seizures of amphetamine above 15 kg in 2006.

Police district	Weight	Purity
Oslo	58.8 kg	18 %
Romerike	40 kg	Not analysed
Oslo	26 kg	32-36 %
Oslo	18 kg	Not analysed
Østfold	17 kg	14 %

Source: Kripas

Table 17. Individual seizures of methamphetamine above 2 kg in 2006.

Police district	Weight	Purity
Østfold	14.6 kg	88 %
Oslo	9.32 kg	44 %
Telemark	4.95 kg	61-67 %
Søndre Buskerud	4.72 kg	67 %
Østfold	2.76 kg	73 %

Source: Kripas

As in previous years, the purity of these drugs varies in all types of cases. The average purity was estimated to be roughly 43 per cent for amphetamine and 55 per cent for methamphetamine.

### Ecstasy

In 2006, however, 28 636 tablets were seized in 411 seizures, which is a marked increase from 2005. In relation to other drugs, ecstasy still appears to have a much smaller market share than was the situation from 1999 to 2003. Unlike the period around the turn of the millennium, when ecstasy was registered in all police districts in the country, ecstasy was only seized in 17 police districts in 2006. On the other hand, all the 17 police districts made more seizures in 2006 than the year before.

Table 18. The largest individual seizures of ecstasy in 2006.

Police district	Number of tablets	Active agent	mg per tablet
Oslo	10 300	MDMA	128 mg
Oslo	3 260	MDMA	79 mg
Sør-Trøndelag	2 800	MDMA	27 mg
Oslo	989	MDMA	47 mg
Østfold	950	MDMA	77 mg

Source: Kripas

### Cocaine

Seven hundred and twenty-six seizures of cocaine were made in 2006, the highest number of seizures of cocaine ever made in Norway. The amount seized was slightly over 40 kg, and this is regarded as being at the normal level in relation to the preceding years. The proportion of cocaine in relation to all other drugs has increased from 0.5 to 3 per cent in 10 years.



Table 19. Individual seizures of cocaine above 1.5 kg in 2006.

Police district	Amount	Purity
Østfold	15.64 kg	33 %
Østfold	4.5 kg	33–56 %
Oslo	2.0 kg	36–38 %
Østfold	1.66 kg	44 %
Østfold	1.64 kg	52 %

Source: Kripas

The average purity of cocaine has fallen considerably in recent years. Ten to fifteen years ago, the purity was usually 70 per cent or more. In 2004 and 2005, it was estimated to be approx. 50 per cent, while it was estimated to be approx. 38 per cent in 2006. The explanation for this is that suppliers – probably in Europe – add substances with no intoxicating effect.

### GHB

The seizure figures for GHB and the chemically related industrial products GBL and butandiol are relatively small, and the data do not indicate that the market share of these drugs is increasing.

Table 20. Seizures of GHB, GBL and 1.4 butandiol in 2006

Drug	Number of seizures	Amount seized
GHB	65	18 litres
GBL	11	11 litres
1.4 butandiol	17	25 litres

Source: Kripas

### Benzodiazepines (BZD)

More than a million seized tablets in 4 552 seizures means more than a doubling of the amount and a 16 per cent increase in the number of seizures in one year. One individual seizure accounted for all of 498 500 Valium tablets, and that is by far the biggest seizure of BZD ever made in Norway. Twenty-one police districts made more seizures in 2006 than the year before.

Seizures of BZD are often made together with several other drugs, such as heroin, amphetamine and cannabis. There were major shifts in the seizure frequency between the different BZD drugs in 2006 as well. This is primarily due to a big decline in tablets containing Flunitrazepam. The seizure frequency for Diazepam exceeded that for Flunitrazepam in 2005, something that has not been registered for more than 10 years. This trend was reinforced in 2006, both in terms of the amount seized and the number of seizures. Moreover, other types of BZD are more frequently seized than before. This may be connected to an increase in the prescription of such alternative medicinal drugs, since Rohypnol is now de-registered in the medical context and is thus no longer prescribed.

### Painkillers, drug-classified medicinal drugs

A total of 15 685 tablets were seized in 1 161 seizures. No particularly large seizures were made in 2006. Both the number of seizures and the amounts seized were at roughly the same level as in previous years. Information received indicates that the cases increasingly concern illegal importation of such medicinal drugs via internet shopping, while the number of tablets in each seizure is relatively

small. It is primarily medicinal drugs containing buprenorphine, codeine, methadone and morphine that dominate the statistics, with approx. 97 per cent of all seizures (Kripos, 2007).

Table 21. Seizures of drug-classified medicinal drugs in 2006.

Drug	Percentage of seizures	Number of tablets
Buprenorphine	47 %	2 900
Codeine	25 %	8 500
Morphine	18 %	1 800
Methadone	7 %	275 tablets/units
Other	3 %	418

Source: Kripos

## 10.4 Prices

See the data in Standard table 16. The estimated prices for drugs bought on the street generally show little change in 2006.

## ***Part B: Selected Issues***

### **11. Public expenditure**

The topic is limited to drugs law enforcement costs only. Some data concerning health costs are given in chapter 1.3.

#### **11.1 Drugs law enforcement costs in Norway 2005.**

##### **Summary**

It is estimated that the direct costs of police investigation, prosecution and jail for drug offences in Norway is EUR 234 million (NOK 1.8 billion), which is 15 per cent of the total costs of the criminal justice system and about EUR 51 (NOK 400) per capita.

##### **11.1.1 Introduction**

Several large studies have tried to estimate the social cost of drug use. All of them include the cost of crime as a major component. In some it is second to “lost productivity” and “health costs”, in others it is the main cost category. For instance, according to Harwood (1999), the cost of drug abuse to the United States in 1992 was USD 97,6 billion, of which crime was responsible for 18.4 per cent. The main cost category was “lost earnings” which accounted for 71 per cent of the estimated costs. In another study (Henley et al, 1998), based on a sample of 1 075 drug users in the UK, the conclusion was that each user cost society about \$17,000 and that crime represented 78 per cent of these costs (the rest were mainly health care costs). One of the reasons why crimes turned out to be so costly in that study was the inclusion of the value of the goods stolen as a cost of the crime.

This paper gives a first approximation of how much illegal drugs cost the criminal justice system in Norway in 2005. It takes a direct approach, focusing only on direct expenses, not on indirect costs, victim costs, or the value of the stolen goods. This is not because these costs are believed to be unimportant, but because information about their magnitude is very unreliable.

##### **11.1.2 Calculating the costs: A first approximation**

The state has at least three direct costs as a result of criminal activities:

- 1 Police expenditure (investigation etc.)
- 2 Expenses relating to courts (defence lawyers, judges etc.)
- 3 Expenses relating to jail

Based on the national accounts, total outlays in these three areas in 2005 in Norway amounted to about EUR1.6 billion (NOK12 billion).The question then is how much of this we can “blame” on drugs?

A very simple approach would be to examine how many investigations, prosecutions and (inmates serving) prison sentences are traceable to drug offences. Statistics Norway has the following table:

Table 22. Percentages of cases directly related to drugs, 2005.

	Total number of cases	Cases directly related to drug use	Percentage drug cases
Police investigations	399 074	40 092	10.05%
Prosecutions	88 962	19 882	22.35%
Jail inmates	3 170	912	28.77%

Source: <http://www.ssb.no/vis/emner/03/05/lovbrudde/art-2007-08-13-01.html> (Table 7 and 53)

We already know the total cost of all cases and we use the results from Table 22 to estimate the costs directly related to drugs (Table 23).

Table 23. Drug law enforcement costs in Norway 2005. In EUR.

	Total expenses	Drugs %	'Cost of drugs to the state	Per capita
Police investigations	1,080,423,507	10.05%	108,542,123	24
Prosecutions	210,181,095	22.35%	46,973,096	10
Jail inmates	273,499,005	28.77%	78,684,887	17
ToTotal	1,564,103,607	14.97%	234,200,106	51

Source: National Budget 2007 (<http://www.regjeringen.no/nb/dep/jd/dok/regpubl/stprp/20062007/Stprp-nr-1-2006-2007-11.html?id=298317>)

Note: The table only includes the cost of illegal drugs, not alcohol, and it only includes direct costs.

If one is willing to accept the rough approximations made, the figures show that the Norwegian government spends a minimum of approx. EUR 234 million each year in connection with directly crime-related drug control expenses. This is about EUR 51 for each taxpayer in Norway. Compared with other countries, this is quite high. Single et al (1999), for instance, calculated that the total cost of illicit drugs in Canada in 1992 was about EUR 36 per capita.

### 11.1.3 Drugs and property crimes: A Brief overview

One might argue that drugs are also behind a great deal of property crime, and that the cost of property crime should therefore be included in the estimates above. This is true, but the problem is how to estimate this accurately enough to justify a particular amount.

It may be useful to have some factual knowledge about property crime and drug use in Norway. A total of 195 229 property crimes were reported to the police in Norway in 2005 (this includes theft, burglary etc. but not "white-collar crime"). They constituted almost 50 per cent of all crimes reported to the police. About 25 per cent of the convictions of current prison inmates involved property crimes as the most serious offence, and 30 per cent involved drug crimes as the most serious offence. It is commonly believed that drug users are responsible for a large number of the property crimes.

In the absence of hard evidence there is good reason to question the common belief. First of all, one could ask how many drug users really finance their habit by property crimes (and to what extent). Secondly, even if it turns out that almost all drug users engage in property crimes, the group itself is very small compared with the non-users. A high percentage of a small group may be a smaller number than a small percentage of a very large group. Hence, the common inference from "all drug addicts are thieves" to "all thieves are drug addicts" may be an example of a widespread cognitive

mechanism that produces logically invalid conclusions. To be more certain, however, we need hard evidence.

On the matter of the extent to which drug users finance their habit with income from property crimes, there is some evidence to suggest that it is smaller than assumed in the view that “most or all regular drug users are thieves.” For instance, Bretteville Jensen (1996, 2005) has conducted a large survey of drug users and, on average, they report that between 20 per cent and 25 per cent of their income is generated by property crimes. It should be noted, however, that the distribution was highly skewed. A small minority of drug users committed a lot of property crimes while many committed few or no such crimes. For instance, women were far less likely than males to engage in crimes (but much more likely to engage in prostitution).

Moreover, to cover “just” 20 per cent of their average expenses they would have to steal goods worth large sums of money, since stolen goods typically only command between 10 and 30 per cent of their market value in the legal market. Similar results can be found in other surveys. For instance, in an admittedly non-random and skewed sample of about 500 drug users in treatment, 63.5 per cent reported that they had been prosecuted for property crimes (unpublished survey results from the Cost-Benefit project, see NR 2003 chapter 11.2). However, “only” about 10 per cent reported that crime (excluding the sale of drugs) was their main source of income. In short, while there is evidence to suggest that many drug users engage at some point in some crime, it seems far from true that all drug users finance most of their expenses with income from property crimes.

It is very difficult to collect reliable data on the relative percentages of drug users and non-drug users among those who commit property crimes because of the illegal nature of both activities. It is possible, to some extent, to focus on the sub-group consisting of those who are caught, but this group may not be representative of the whole group. There may, for instance, be an overrepresentation of drug users among those who are caught because they may tend to leave more traces or because the police tend to focus on them as a group that is easy to catch (they are already well known to the police).

If we choose nevertheless to focus on those who are caught, we can use data from Statistics Norway on recidivism among different types of offenders to get some impression of the percentage of drug users in those convicted of property crimes. The data tell us that out of the 17 168 persons convicted of property crimes in 2000, 9 573 (56%) were convicted again within five years, and 1 719 (10%) were reconvicted for a drug offence as the most serious charge. This is an indication that far from all property crime convictions involve drug users. However, we should also remember that the police seldom prosecute simple possession of drugs for own use, and when they do so it may be as part of a larger package including a more serious offence. It is only when a drug offence is “serious” (dealing in large quantities, smuggling) that it is counted in the statistics as a drug offence.

Altogether, the evidence suggests that we should avoid making drug users the main culprits for property crimes. This is not to say that they do not commit property crimes, only that they do so less than is commonly believed. Moreover, the group is so small that property crimes committed by its members may easily drown in the sea of property crimes committed by the much larger group of “non-regular drug users.”

## 12. Vulnerable groups of young people

### 12.1 Vulnerability and risk factors. Definitions and delimitations

Vulnerability is the inability to cope with external pressures and deviations, which may result in severe harm or major loss of value. Vulnerability says something about how easily something can be harmed or ceased to function (definition, Research Council of Norway).

Nordahl et al. (2005) define a risk factor as “any factor in an individual or his or her childhood environment that can be associated with increased probability of future negative psychosocial development”. A protective factor is defined as “any factor in an individual or his or her childhood environment that can be associated with decreased probability of future negative psychosocial development” (ibid). Risk factors and protective factors are not necessarily opposites; it would be more correct to say “that a protective factor is a factor that interacts with risk factors and reduces their negative impact ...” (ibid.).

It is important, however, to underline that a risk factor does not imply a linear and necessary progression from a specific exposure to risk to, for example, a serious drug and/or alcohol problem. Young people who are not in vulnerable situations or in a defined risk group may also develop drug and/or alcohol problems. The use of vulnerability and protection models is relevant when outlining interventions in cases involving increased probability of developing problems, but they are not meant to be predictors of individual fates. In short, not all young people in risk groups develop problems (ibid) and we should therefore be very careful about how we use the terms “risk factor”, “vulnerability” and “risk group”. They are best used exclusively in connection with interventions.

In this chapter, the term youth is limited to persons under 25 years of age. However, most of the data and comparisons mainly refer to the under-twenties and apply to problem drug and alcohol use in general, often in combination with other risk factors. There is little information specifically distinguishing between the use of illegal and legal substances in a description of vulnerable groups of children and adolescents.

### 12.2 Profile of main vulnerable groups

#### Children and adolescents

There are no good estimates at the national level of the amount of people at risk of developing drug and/or alcohol problems. With respect to children and behavioural problems, it is estimated that one to two per cent have a high risk and five to ten per cent a moderate risk of developing severe behavioural problems (Nordahl et al. 2005).

#### Children/ adolescents with parents with drug, alcohol or mental health problems

We now have solid documentation that children of parents who misuse drugs and/or alcohol are at increased risk of developing mental health or psychosocial problems during childhood, including problem use of drugs and/or alcohol. Several studies of problem drug users document that more than one in two have had parents with drug and/or alcohol problems (Lauritzen et al. 1997, Melberg

et al. 2003). There are, however, no good estimates of how many children are affected by their parents' drug, alcohol and/or mental health problems. Uncertain estimates indicate around 200 000 children.

### **Children/ adolescents exposed to violence**

So far, a connection has not adequately documented in Norwegian research between having been subjected to or witnessed violence and the subsequent development of drug and/or alcohol problems. It can be observed in general that children and adolescents living in violent homes are at risk of many things, including alcohol and/or drugs and violence. Pedersen (2006) points out that boys are more exposed to violence than girls, and that there is strong correlation with their own alcohol consumption. "The typical victim of violence is a lonely boy. He has a problematic relationship with alcohol, perceives himself as masculine and uses violence himself" (ibid.).

Up to the age of twelve, approximately one school pupil in six is exposed to bullying. Between the ages of 13 and 17, the number is about one in ten, according to studies carried out in Norway in the late 1990s. Children with poor sight or hearing or with other health problems are bullied more often than healthy children. However, we have no documentation at present of any connection between being exposed or subjected to bullying and subsequent problem use drugs and/or alcohol (Schancke 2004 red.).

### **Children/ adolescents exposed to neglect**

Almost ten per cent of all children have received help from the child welfare service before the age of 18, with approximately one in ten of them spending a shorter or longer period in an institution (Kristofersen 2005). Children with links to the child welfare service, and their biological parents, suffer far more illness than other families and they experience major health problems. The suicide fatality rate is significantly higher in children in receipt of help from the child welfare service than in the rest of their age group: 16 per 10 000 as against 2 per 10 000. Drugs and/or alcohol are involved in a greater number of deaths and accidents in both the children and their parents (ibid). This is a clear indication that problem use of drugs and alcohol is a serious problem among children receiving help from the child welfare service.

There is no good documentation of the extent of the problem use of drugs and/or alcohol among these children. However, experience at the local level indicates a substantial misuse of drugs and/or alcohol among children in child welfare institutions. We note, for example, that a large proportion of problem drug users receiving treatment have previously been in the care of or received help from the child welfare service. The transition from child welfare institution to adult life is a particularly difficult phase for some. SIRUS is involved in a collaborative initiative with the Norwegian Directorate for Children, Youth and Family Affairs concerning awareness in child care institutions of early development of problem use of drugs and/or alcohol. So far, empirical data indicate that such problem use in child welfare institutions is poorly mapped, and that any existing mapping is unsystematic.

### **School dropouts**

Dropping out of school is only one of several indicators of a perturbing development, and it must be viewed along with other behavioural patterns. We have no good estimates of the numbers of school dropouts where the problem use of drugs and/or alcohol is a contributory factor. Approximately five per cent of problem users embarking on treatment/care measures in the period 1999-2004 stated that they had not completed their basic compulsory schooling, in other words they had dropped out of lower secondary school (Iversen et al. 2005). This estimate is too low, however, with respect to the total school number of dropouts as these data do not show how many pupils dropped out at the next level, i.e. upper secondary school.

## Children and adolescents with mental health problems

Between five and seven per cent of children and adolescents have mental health problems that require treatment (Agledal et al. 2006). Some studies show that children with mental health problems are at greater risk of developing drug and/or alcohol problems during their youth (Agledal et al. 2006). The incidence of drug and/or alcohol problems is significantly greater in persons with schizophrenia, affective disorders, personality disorders, posttraumatic stress disorders and gambling addiction (ibid). Some young people have an individual vulnerability related to ADHD, behavioural problems etc. An estimated nine per cent of all 15-year olds in Oslo have both mental health and drug and/or alcohol problems. As many as 39 per cent of the children and adolescents in Oslo who have mental health problems are also problem users of alcohol (Agledal et al. 2006).

Pedersen (2006), however, points out on the basis of his longitudinal study that anxiety and depression would seem to be weak predictors of the subsequent development of drug and/or alcohol problems. This is partly because the group that has suffered from occasional anxiety and depression is large and partly because such disorders are associated with introversion and caution, which both Pedersen (2006) and Pape (1996) associate with a reduced tendency to use drugs and/or alcohol.

## Children and adolescents who have developed severe behavioural problems

Some children have developed severe behavioural problems that meet the formal diagnostic criteria in ICD-10 and DSM-IV. These are children and adolescents with what is called "risk behaviour" such as violence, crime, conflicting relationships with their surroundings, aggressiveness, acting-out and the use of drugs and/or alcohol. What distinguishes this group from the previously mentioned groups with the same risk behaviour is the severity of the behavioural disorder. Behavioural disorders constitute the most common mental disorder in children and adolescents in Norway, affecting approximately five per cent of the total child and youth population. A great preponderance of those affected are boys, in a ratio of 3:1.

## Young people hospitalised for intoxication or other drug and/or alcohol harm

Data from the Norwegian Patient Register show that a total of 889 young people aged 15-24 were admitted to Norwegian somatic hospitals in 2005 with alcohol intoxication as either the main or a secondary diagnosis (Table 24). On the basis of these figures, the number of intoxications seems to have increased greatly in the last five to six years by as much as 75 per cent in the 20-24 age group. Nevertheless, the numbers fell from 2004 to 2005.

Table 24. Alcohol intoxication in children and young people aged 15-24. 1999-2005.

Age groups	1999	2000	2001	2002	2003	2004	2005	% change 04-05	% change 99-05
Females 15-19	210	232	231	272	270	269	251	-6.7	19.5
Males 15-19	188	211	224	232	236	278	244	-12.2	29.8
Females 20-24	106	118	138	150	162	196	185	-5.6	74.5
Males 20-24	119	154	184	255	201	236	209	-11.4	75.6

*Comment: development in number of hospital admissions with alcohol intoxication as either the main or a secondary diagnosis recorded in NPR patient data for somatic hospitals. By age group and gender. 1999-2005. Including ICD10 codes T510, T511 and F100.*

*Source: Norwegian Patient Register*

On the basis of the above table, there seems to be no significant gender difference. Admittedly, the number of intoxications in 1999-2005 increased more among males aged 15-19 than in females in



the corresponding age group, but the numbers are relatively similar. In the 20-24 age group, rather more males than females were registered as having been admitted with intoxication as the main or a secondary diagnosis.

At present, professionals in the field experience that there is a lack of system in terms of registration and intervention in relation to young people admitted to casualty/ hospital departments for alcohol intoxication or drug and/or alcohol-related injuries. Practice probably varies from hospital to hospital. Therefore, the figures in the table above probably do not give a full and accurate picture (Directorate for Health and Social Affairs, 2007).

## **12.3 Drug use and problematic drug use in vulnerable groups**

### **Vulnerable young people from ethnic minority backgrounds**

Young people from immigrant backgrounds are described on the one hand as being more abstemious in some situations than ethnic Norwegian youth (Puntervold Bø et al. 2004, Amundsen 2005, Schultz 2003). This applies in particular to young people from Muslim backgrounds. Pedersen (2006) finds few traces of ghetto development, marginalisation and use of drugs and/or alcohol among non-western immigrants in the Oslo East district. "On the contrary, what is striking is their law-abiding and tradition-bound way of life. Moreover, more recent data indicate that their cautious consumption is 'infectious' in relation to young people from Norwegian backgrounds." (Ibid.)

Nevertheless, a number of professional groups identify special problems relating to the various immigrant youth milieus, including gang formation and the use of drugs and/or alcohol. Persons from immigrant backgrounds who develop drug and/or alcohol problems seem to be excluded more frequently from their own environment than is the case for ethnic Norwegian youth who are starting to misuse drugs and/or alcohol. Moshuus (2005) demonstrates the existence of a small group of poorly integrated young immigrants, but, according to Pedersen (2006), this represents the exception rather than the rule.

Øia (2005) shows that immigrant youth are exposed to many of the same pressures/ risk factors as ethnic Norwegian youth. In addition, immigrant youth are at risk in connection with ethnic culture conflicts, adaptation strategies in relation to Norwegian society and identity management. It is, therefore, not just a matter of an individual's ability to adapt to Norwegian culture; the tolerance and integrative capacity of the local population are also a factor.

## **12.4 Vulnerable groups among the treated population**

See chapter 4.2.1. No further information is available.

## **12.5 Correlates and consequences of substance use among vulnerable groups**

### **Criminal behaviour**

Along with traffic offences, crime against property is the most common reason why 15-20-year olds end up in police registers. Although young people are overrepresented in the group charged with aggravated theft, the trend throughout the 1990s has been towards fewer aggravated theft charges and more simple theft charges among young people. The increase in recent years in the number of people arrested for drug offences applies to most age groups, but the most striking trend is among young people. In almost a third of the arrests of 15-20 year-olds for crimes in 2004, drugs were the main offence.

In May 2007, Oslo Police District and the City of Oslo launched the trend report *“Barne- og ungdomskriminaliteten i Oslo 2007 (Child and Youth Crime in Oslo 2007)”*. This report was prepared as part of a collaboration between the Oslo Police District and the City of Oslo and is the second in the series. Its aim is to increase knowledge about crime and drug/alcohol use among children and youth in Oslo and thereby obtain a broader picture of the current situation and trends. The report deals with children and young people up to and including the age of 23, with the greatest emphasis on those under 18. A new feature this year is the inclusion of crimes to which children and youth are exposed. In addition, there is special focus on recidivist crime and the recruitment of young people to criminal groups of troublemakers, networks and gangs.

In 2006, children and young people under 18 were responsible for 6.7 per cent of reported offences in the Oslo Police District. The majority of these young people were only reported for one offence during the year. It is important to note that only a small percentage are reported for multiple offences. The most common offence for girls under 18 is petty theft, while drug offences are prevalent among girls in the 18-23 age group. Petty theft is the most common offence among boys under 15, while for boys in the 15-17 age group, violence and threats are most common, closely followed by drugs. For boys in the 18-23 age group, the most common offence is drugs.

Statistics and informants confirm that there is cause for concern about several milieus that commit a lot of crimes together. An analysis of recidivists shows that it is the same young people who are registered with most criminal offences in the areas of robbery, physical violence and drugs ([www.rme.oslo.kommune.no/kompetansesenteret](http://www.rme.oslo.kommune.no/kompetansesenteret)).

## 12.6 Responses to drug problems among vulnerable groups

### 12.6.1 Policy and legal developments

#### **The action plan *Sammen mot barne- og ungdomskriminalitet (Together against child and youth crime) (2005-2008)***

This action plan (Ministry of Justice and the Police, 2006) has been drawn up in a collaboration between six ministries. It focuses on individual young offenders under 18 years of age – both above and below the age of criminal responsibility (Note: It is not specifically related to drug and alcohol problems) The plan contains 21 measures intended to ensure age-adapted, responsabilising and rapid follow-up of individual young offenders. It targets recidivists and perpetrators of serious crimes in particular. In the case of adolescents between the ages of 15 and 18, steps will be taken to facilitate a customised and coordinated use of remedies within the penal justice system and in society at large. In this age group, young people who are in prison (either on remand or serving a sentence) represent a particular challenge.

#### **Alternative penal sanctions for young offenders (under 18).**

The proposals in White Paper no. 20 (2005–2006) to the Storting *Alternative straffereaksjoner overfor unge lovbrysterer (under 18 år) (Alternative penal sanctions for young offenders (under 18))* are discussed in chapter 9.2.2.

### 12.6.2 Prevention and treatment

#### **Early intervention**

The Directorate for Health and Social Affairs has drawn up a proposal for a national strategy for early intervention in the area of drugs and alcohol. The report *“Tidlig intervensjon på rusområdet, sentrale perspektiver – aktuelle målgrupper og arenaer (Early intervention in the area of drugs and alco-*

*hol – relevant target groups and arenas)*” was submitted to the Ministry of Health and Care Services in December 2006. The report also deals with adults, but its main focus is on children and young people. The strategy proposals are discussed in chapter 3. 1.

### **Young people from immigrant backgrounds and early intervention in relation to drugs and alcohol**

The Directorate for Health and Social affairs has commissioned the Alcohol and Drug Addiction Service in Oslo (RKS) to lead a national project to clarify the need for early intervention in drugs and alcohol matters in various immigrant youth groups, and to submit proposals for how such work can be organised. The project’s main purpose is to determine the extent to which young people from immigrant backgrounds need special measures to prevent the development of drug and/or alcohol problems.

Various risk and protection factors relating to the development of drug and/or alcohol problems will be used to shed light on the matter. One of the project’s central questions is whether an ethnic identity represents a protective and/or risk factor in relation to the use of drugs and/or alcohol. RKS will present the results of the project in a report on conclusion of the project, which is scheduled for 31 December 2007.

### **The treatment methods: parent management training and multisystemic therapy**

The Ministry of Children and Equality has been working for a long time on the implementation of family and community-based methods for the treatment of serious behavioural disorders. The use of drugs and/or alcohol is often a part of the problem complex.

*Parent Management Training (PMTO)* is a treatment method targeting children aged four to twelve. The method is intended to change intractable negative patterns. Training using this method started in Norway in 1999. Parent management training is provided by the Directorate for Child, Youth and Family Affairs or the mental health service for children and youth. The method is being evaluated in Norway and the results so far are promising. Reducing behavioural problems may well have a preventive effect on the development of drug and/or alcohol problems later in life. Work is currently in progress to implement the method in municipal services.

*Multisystemic therapy (MST)* is a method targeting adolescents aged 12 to 18. It involves close follow-up of the adolescents concerned, their families and the local community. Treatment is provided by the five regional child welfare and family welfare services. Training started in Norway in 1998. So far, the evaluation results are positive. Research from the USA shows a substantial reduction in behavioural problems, including drug and/or alcohol problems, both at home and at school. In Norway, multisystemic teams attached to the child welfare service have been set up.

*MultifunC* is the name of a service currently under establishment in the child welfare service. Six open institutions will be established targeting young people with behavioural problems who cannot be helped through home-based measures. As of 31 July 2006, four institutions have been opened. The young people in the target group have problems in several areas, and drug and/or alcohol may be one of them. These young people need intensive and coordinated action on the part of the child welfare service. The institutions will offer a limited period of residential care followed by a period of aftercare once the young people have moved back home. Cooperation with the families and the young people themselves will be emphasised throughout. Motivation and involvement of the families in the decisions that are made is an important part of the treatment. Staff at the institutions will be given thorough training in the methods to be used. Systems to evaluate the measure will be integrated into the treatment through counselling and registration (Directorate for Health and Social Affairs, 2007).

### **Measures on the part of the police**

In collaboration with other public bodies and voluntary organisations, the police will carry out preventive work to limit the use of drugs. Particular weight will be attached to measures to reduce the availability of and demand for drugs, thereby reducing recruitment to the user milieu. The prevention of the problem use of drugs and/or alcohol is a central element in efforts to create good conditions for children and young people to grow up in. The police work with the home and with schools, among other things by means of their "Bry deg" (Show that you care) initiative. The police conduct cause-for-concern interviews with parents of children and adolescents under 18 who are suspected of using illegal drugs (Directorate for Health and Social Affairs 2007).

### **Outreach work**

Outreach workers (<http://www.utekontaktene.no/>) are particularly important in the early intervention context, identifying and intervening in relation to young people who are in need of support or help but who are not adequately picked up by other parts of the help services. Outreach teams work with youth clubs, schools, the child welfare service, social security offices, school health services and health stations for young people, preventive police services, young people's families and others. There are currently about 70 outreach units in Norway. "This means that outreach workers are in constant contact with approximately 14 000 young people who are experiencing moderate or severe problems in life" (president of the Norwegian national association of outreach workers - quote). Some focus on preventive work among children and young people, others on drug addicts and alcoholics of different ages. Outreach units have also been established to better identify emergency situations, inform about/bring in available help and follow-up if there is a risk of overdosing. These services also carry out home visits and offer transport home or to detoxification stations (Directorate for Health and Social Affairs, 2007).

### **Grant schemes**

There are several grant allocation schemes targeting children and young people. Chapter 1.3 deals with grants for specific focus areas in preventive work and measures aimed at problem drug and/or alcohol users.

The grant scheme "Measures among children and young people in large urban communities" targets children and young people with special needs and vulnerable groups of young people. The scheme, which is a measure to improve the conditions in which children and youth in urban communities live and grow up, includes 23 urban municipalities across the country. Young people from immigrant backgrounds face special challenges, and high priority is given to measures to promote their integration.

This grant scheme also has earmarked funds for measures to counteract poverty problems, in particular in the cities and areas with major living-condition problems. The grants are intended to finance holiday and leisure activities for children, young people and their families, and measures to improve contact with the employment market for young people with little or inadequate education. The four largest cities - Oslo, Bergen, Trondheim and Stavanger – will be given special priority ([www.bld.dep.no](http://www.bld.dep.no)).

## 13. Drug related research in Norway

### 13.1 Research structures

#### Drug-related research in national policy

Norway's policy in this field covers both drugs and alcohol. This is also reflected in research. Drug research is not, therefore, a separate area, but is included as part of drug and alcohol research, which to a certain extent also covers tobacco and gambling.

Formally, Norway does not have a functioning action plan in the drugs and alcohol field. On presentation of the national budget for 2008 in October 2007, however, the Government presented an escalation plan for the drugs and alcohol field. Research is mentioned in the escalation plan under the objective of improving quality and raising competence in the drugs and alcohol field. The escalation plan will be formally adopted when the national budget is considered by the Storting in December 2007. The plan is discussed in more detail in Part I, chapter 1.2.1.

Research into drugs and alcohol is one of the priority areas in the escalation plan. The Government will build on the central research milieus at the Norwegian Institute for Alcohol and Drug Research (SIRUS) and the Norwegian Institute of Public Health. Moreover, the plan emphasises that a separate drugs and alcohol research programme has been established under the auspices of the Research Council of Norway, and a new centre for drug and alcohol research has been established at the University of Oslo. The escalation plan also states that the regional health authorities (which are responsible for the treatment of drug and alcohol problems) should prioritise research on the treatment of drug and alcohol problems and that steps should be taken to facilitate research combined with clinical service and research leave for doctors and psychologists involved in interdisciplinary specialist treatment of drug and alcohol problems.

#### Relationship research – policy

In general, the central authorities emphasise data from research in policy documents. For instance, it is common in such contexts to refer to surveys on the use of drugs. Similarly, evaluation is emphasised when testing different measures.

#### Main national structures for drug-related research

Norway does not have a body dedicated to the coordination of drug and alcohol research. SIRUS is an independent research institute under the Ministry of Health and Care Services. In 2007, the Ministry has also allocated funding through the Research Council of Norway to a new drug and alcohol research programme and a centre for drug and alcohol research at the University of Oslo. Moreover, drug and alcohol research is also carried out by the Institute of Public Health (biomedicine). Drug and alcohol research is also carried out to a certain extent at the Universities of Bergen, Trondheim and Stavanger, at Norwegian Social Research (NOVA), at the International Research Institute of Stavanger (IRIS) and at the Bergen Clinics Foundation.

Drug and alcohol research is partly financed via the national budget (SIRUS, Institute of Public Health), partly through the Research Council of Norway and partly through the Directorate for Health and Social Affairs (various evaluation assignments) and the municipalities.

## 13.2 Main recent studies and publications

### Five main recent studies since 2000

#### (1) The drugs market

Research institute: SIRUS

Funding: SIRUS and the Ministry of Justice and the Police

*Abstract:* The objective of the project is to study the illegal drugs market in general and the heroin market in Oslo in particular. The initial goal was to increase knowledge about drug prices, financing, methods of payment and total drug use among injecting users, as well as to study these factors over time and in relation to changes in control policy measures. The aims of the project included finding out how addicts react to fluctuations in the price of drugs, how important crimes against property are in terms of financing drug use, how much an individual's total drug use costs per day, what amounts of money are involved in the illegal market etc. Another goal is to increase knowledge about the seller side of the heroin market: How is the heroin market in Norway organised? What can heroin dealers and importers tell us about the division of labour and networks in the market? How have conditions for sellers developed over time? How do heroin dealers and importers understand and present themselves and their activities?

The project started in 1993 with the collection of data through regular interviews of injecting users recruited at the needle distribution service in Oslo city centre. This data collection is still ongoing. The survey shows, among other things, that the nominal price of heroin and amphetamine has fallen dramatically during the period.

In 2006, moreover, a qualitative study was also conducted (Snertingdal, 2007). The study was based on 26 qualitative interviews with heroin dealers and importers. Of these, 24 were with offenders serving prison sentences for heroin-related offences, and two were with heroin dealers on 'the outside'. The main questions in the study were: How are the players recruited to the various positions in the heroin trade and what are the players' motives for being involved in illegal activity? The project's main purpose is to describe the players in the heroin trade and how they perform (See also Part I, chapter 10.2.1).

The project is ongoing.

Publications:

Bretteville-Jensen, A. L.: *Understanding the demand for illicit drugs. An empirical approach based on self-reported data*. Dissertation in Economics No. 25. Department of Economics, University of Bergen 2002.

Bretteville-Jensen, A. L.: *Understanding the demand for illicit drugs. En analyse av intervjuer foretatt 1993-2004*. SIRUS-report no. 4/2005 (EN summary)

Snertingdal, M. I.: *Kalkulerende kjeltringer eller offer for omstendighetene? En kvalitativ studie av heroinomsetningens utvikling og aktører*. SIRUS report no.1/2007 (EN summary)

#### (2) What benefit, for whom and at what cost? A prospective study of drug addicts undergoing treatment

Research institute: SIRUS

Funding: SIRUS and the Research Council of Norway

*Abstract:* Do some treatment measures produce better results than others for different groups of drug addicts? What is achieved through treatment seen in relation to the use of treatment resources/

socioeconomic costs that result from the clients moving between different forms of treatment and public institutions, such as prison? In light of the fact that many problem drug and alcohol users are in and out of several treatment facilities, it is assumed that the result of one type of treatment may build on what has been achieved in previous treatment(s).

The study is based on a sample of 482 clients from 20 treatment facilities who have been followed up and interviewed using EuropASI and two forms filled in by the clients themselves (MCMI-II, SCL-25) on admission to treatment in 1998/1999. An initial follow-up survey was conducted one year after admission to treatment, a second follow-up survey two years after admission and a third follow-up survey seven years after admission to treatment. Data from criminal records, social security records and the Cause of Death Registry were also collected.

The project is ongoing.

Publications:

Melberg, H.O., Lauritzen, G. & Ravndal, E.: *Hvilken nytte, for hvem og til hvilken kostnad? En prospektiv studie av stoffmisbrukere i behandling*. SIRUS report no. 4/2003. (EN summary)

Melberg, H.O.: *Costs and benefits of treating drug users: Essays on selection bias, contagious drug use, the gateway hypothesis and the concept of social cost*. Department of Economics, University of Oslo. 2005 (Dissertation)

### **(3) Evaluation of "The action plan for alternatives to drug and alcohol milieus in Oslo city centre" 2003-2006 and the trial scheme for injection rooms.**

Research institute: SIRUS

Funding: SIRUS

*Abstract:* In 2002, the City of Oslo presented a comprehensive action plan that aimed to disperse the highly visible injecting user milieus in Oslo city centre. The action plan was partly aimed at strengthening/establishing various low threshold services, partly at improving collaboration between the City of Oslo and Oslo Police District and between the City of Oslo and the home municipality of drug addicts from out of town in Oslo city centre. The evaluation attempted to establish whether the different goals of the action plan were achieved.

The evaluation showed that the planned measures were largely implemented. However, there is no basis for concluding that the plan contributed to the drug addicts staying away from the city centre area more than previously. The work on the plan resulted in increased collaboration between various players (see also NR 2006 chapter 7.1).

In December 2004, the Storting passed a temporary act relating to a trial scheme for premises for the injection of drugs, and, on 1 February 2005, an injection room was opened in Oslo. The target group consisted of hardcore heroin addicts over the age of 18. The trial scheme is intended to facilitate an evaluation of the effect of freedom from prosecution for the possession and use of drugs in a limited area (i.e. in the injection room). Otherwise, the objective of the trial scheme is to give injecting users a more dignified existence, increase their opportunities for contact with the help services, contribute to preventing infections and reduce the number of overdoses and overdose fatalities. The aim of the evaluation was to establish how and to what extent the various goals of the trial scheme can be said to have been achieved. The evaluation also examines the role of staff.

In the first two years of operation, slightly less than 400 people made use of the injection room. There was great variation in terms of how often the registered users of the trial scheme used the injection room. Given that the trial scheme has been limited, there is no basis on which to draw a conclusion as to whether the scheme has contributed to reducing infection, overdoses and overdose fatalities.

## Publications:

Olsen, H & Skretting, A. :*Ingen enkle løsninger. Evaluering av tiltaksplan for alternativer til rusmiljøene i Oslo sentrum*. SIRUS report no. 2/2006 (EN summary).

Olsen, H. & Skretting, A.: *Hva nå? Evaluering av prøveordning med sprøyterom*. SIRUS report no. 7/2007(EN summary).

**(4) Abstinence-oriented replacement therapy for opioid dependence.**

Research institute: University of Oslo and Norwegian Knowledge Centre for the Health Services.

Funding: Not known

*Abstract:* The aim of the study was to assess the feasibility of short-term buprenorphine replacement therapy programmes for dependent opioid users who were not eligible for the ordinary long-term substitution treatment programmes.

The research project comprised three studies. Firstly, a literature review was undertaken to assess post-treatment abstinence rates in former patients in methadone or buprenorphine replacement programmes. Secondly, 75 dependent opioid users in outpatient counselling were recruited to a nine-month buprenorphine replacement programme and followed up for two years. Thirdly, 65 study participants' personality profiles were compared with those of an age-matched norm sample.

In the literature review, 14 studies were identified. The pooled abstinence rate across the studies was 33 per cent. For individuals who had left treatment voluntarily or on the recommendation of staff, the pooled abstinence rate was 48 per cent, compared with 25 per cent for persons who had been discharged involuntary or against staff recommendations.

Forty study participants (53 %) completed the nine-month buprenorphine replacement programme. Three non-completers died during detoxification. At two-year follow-up, the number of deaths had increased to five. Nine participants were abstinent from all opioids (illicit and prescribed), and thirty-seven participants were still in or had returned to opioid replacement therapy. The opioid-dependent sample was less emotionally stable, less outgoing and less conscientious than the non-clinical sample.

## Publication:

Dissertation, Faculty of Medicine, University of Oslo, 2007.

**(5) The cannabis market in Oslo**

Research institute: University of Oslo, Faculty of Social Science

Funding: Not known

*Abstract:* The project deals with recruitment to problem drug use in central Oslo. What was the significance of the milieu around the "Plata" area? What is happening now in relation to socialisation into illicit drug milieus in central Oslo East? In what way are ethnic minority youth at risk?

## Publication:

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**Peer-reviewed scientific journals**

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## 13.3 Collection and dissemination of research results

### Information flows

The National Focal Point is an integrated part of SIRUS. Researchers at the institute provide data for the national report. Data is also provided by other institutions.

Information from the Focal Point is mainly disseminated on the website: [www.sirus.no](http://www.sirus.no)

### National scientific journals

Norway has no national scientific drug research journal.

Other national scientific journals:

- Tidsskrift for den norske legeforening, [www.tidsskriftet.no](http://www.tidsskriftet.no) (Medicine, national, peer-reviewed, EN abstract)
- Tidsskrift for ungdomsforskning (Adolescence, national, peer-reviewed, EN abstract)
- Norsk psykologisk tidsskrift (Psychology, national, peer-reviewed, EN abstract)
- Tidsskrift for samfunnsforskning (Social science, national, peer-reviewed, EN abstract)
- Sosiologi i dag (Sociology, national, peer-reviewed, EN abstract)

### Other means of dissemination

Non-scientific journals:

Rus & samfunn [www.rus.no](http://www.rus.no)

Websites dedicated to drug-related research:

[www.sirus.no](http://www.sirus.no) (SIRUS)

[www.fhi.no](http://www.fhi.no) (Norwegian Institute of Public Health)

[www.uio.no/psy/skr](http://www.uio.no/psy/skr) (University of Oslo, Unit for Addiction Medicine)

[www.rf.no](http://www.rf.no) (IRIS)

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