



**REPORT TO THE EMCDDA
BY THE NORWEGIAN NATIONAL FOCAL POINT**

THE DRUG SITUATION IN NORWAY 2002

REITOX

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Introduction

This second annual report by the Norwegian Institute for Alcohol and Drug Research (SIRUS) on the drug situation in Norway has been prepared for the European Monitoring Centre for Drugs and Drug Addiction - EMCDDA.

The report largely follows the guidelines provided for national reporting to the EMCDDA. However, some themes have been given greater attention where we have felt that the information provided can be of special interest internationally. We have also chosen to present more epidemiological data. Most of the data are from 2001. To give the report a more current face, the descriptions of trends are based on information and individual data from the first half of 2002. The Government's Action Plan Against Drugs (2003-2005) was presented 3 October of this year. Due to time limitations only a cursory review of this has been provided here.

To a greater degree than in 2001, the report is based on textual contributions and data from key public institutions and actors in the Norwegian drug field. Contributions have also been made by the staff of SIRUS. Part I: National Strategies: Institutional & Legal Frameworks was written by the Ministry of Social Affairs.

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I would like to thank everyone for their contributions such that the report can be presented in its present form.

Oslo 25 October 2002

Knut Brofoss
Director

Summary

Main trends and developments

- The tendencies that were described in the national report for 2001 appear to hold for the most part. Although the prevalence and incidence of use of illicit drugs remains relatively low when compared with other European countries, the latter half of the 1990s saw a marked rise in the proportion of youth who report that they have used cannabis and amphetamines. Over the last 2-3 years (2000-2002), however, the rise in use of illicit substances among youth 15-20 years appears to have flattened out.
- Different data sources indicate that there has been an increase in availability during 2001. This is true for the entire country and is reflected in the seizures made by the police and customs authorities, the drop in prices for different substances, and surveys that seek to describe the public's views on availability.
- There has been a clear increase in the number of seizures of the most common illicit substances. The same is also true for the number of cases and individuals who have been considered by the court system.
- Statistics for the first half of 2002 show that the greatest increase of seizures is for benzodiazepines, amphetamines and cannabis. Moreover the amount of benzodiazepines, largely flunitrazepam (Rohypnol) and diazepam, confiscated has also risen sharply, while there has been a clear drop in the seizures of ecstasy, heroin, opium and LSD. Only small changes or none have taken place for other substances. Developments for the first half of 2002 are similar to the trends from 2001, especially with respect to the second half of the year.
- The number of drivers arrested under suspicion of driving under the influence of drugs other than alcohol has more than doubled during the last decade. Narcotics and/or other medications have been identified in 80% of the cases where the primary suspicion is related to such substances, indicating a high hit rate on the part of the police with respect to motorists who are subjected to tests.
- The number of fatalities resulting from overdoses has increased during 2001, to 338 people. This is the largest number of such deaths ever recorded in Norway. However, for Oslo, which registers approximately 1/3 of overdose fatalities, there are indications of a possible downward trend. The number of deaths due to overdose in Oslo has dropped by nearly half for the first half of 2002 when compared with the same period in 2001.
- The number of new cases of HIV infection among intravenous drug users in Norway is low. This is also the case for the number of new intravenous drug users who develop AIDS.
- The outbreak of hepatitis A and B among intravenous drug users appears now to be in retreat.
- In October this year the Government proposed a new action plan against alcohol and drug problems, which is to be effective during 2003-2005. The challenges and choices reflected in Norwegian drug policy are based on the need to:
 - Conduct a policy that both reduces alcohol and drug problems and is supported by the general population.
 - Strengthen the municipalities' prevention efforts within local communities, by emphasising prevention and health promotion efforts directed towards children and youth in schools and in educational and extra curricular activities.

- Ensure that abusers and their close family receive quality care and rehabilitation/follow-up such that the individual is able to live her/his life with dignity.

With the action plan, the Government wishes to provide the basis for a broad-based strategy for effective measures that cover the entire alcohol and drug field. The action plan gives particular attention to these specific areas as central to efforts:

- Integrated, locally-based measures against alcohol and drug use among children and youth, and alcohol and drug problems generally
- Treatment and control
- Increased international work
- Better co-ordination of efforts
- Production of knowledge and quality assurance.

A specific system for follow-up will be developed, consisting of an annual quantification of results, concrete measures that are to be introduced according to specified deadlines, and a system for evaluating the achievement of goals.

- The existing low threshold health measures for drug abusers are strengthened through a substantial increase in funding in 2002.
- The number of applicants to medically assisted treatment is steadily climbing. The coverage is now approximately 13-19 percent of the estimated 10 500 – 14 000 intravenous drug users.
- The question of whether to establish an injection room was considered by Parliament on 21 June 2002, and the Government was called upon to pave the way for a limited trial to be made with injection rooms.
- The central social and health administration was reorganised and became effective as of 1 January 2002. In addition to the fact that the Ministry of Health and Social Affairs was dissolved and replaced by a Ministry of Social Affairs and a Ministry of Health, other effects included the establishment of a Directorate of Health and Social Affairs, with the incorporation of the work earlier conducted by the Directorate for the Prevention of Alcohol and Drug Problems.
- As of 2002 the State assumed ownership and operational responsibility for hospitals. Following this, it is also expected that much of the county responsibility for institutions for specialist services for treatment of drug users will be transferred to the state as of 2004.

PART I - NATIONAL STRATEGIES: INSTITUTIONAL & LEGAL FRAMEWORKS

Chapter 1. Developments in drug policy and measures

1.1 Political Framework in the drug field

Goals and priorities for the national drug policy

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

The continued objective of a society free from drug abuse is backed by a broad political consensus. Important strategic goals for the Government will be to:

- Reduce the availability of illegal narcotic substances
- Reduce all illegal use of drugs
- Increase the number of successful treatment forms for drug problems
- Reduce the incidence of death and other social and health-related damages that can be related to drug use.

Drug policy requires new modes of thinking in order to meet the dramatic increase in the availability and use of drugs that took place over the last decade. Greater experimentation, new narcotic substances and more abusers with extensive health-related and social problems require new solutions and an expansion of those measures that have proven effective. Long-term, goal-oriented work is needed in order to reduce drug problems.

New action plan

In October 2002 the Government proposed a new action plan against alcohol and drug problems, which is to be effective during 2003-2005. The challenges and choices reflected in Norwegian drug policy are based on the need to:

- Conduct a policy that both reduces alcohol and drug problems and is supported by the general population.
- Strengthen the municipalities' prevention efforts within local communities, by emphasising prevention and health promotion efforts directed towards children and youth in schools and in educational and extra curricular activities.
- Ensure that abusers and their close family receive quality care and rehabilitation/follow-up such that the individual is able to live her/his life with dignity.

With the action plan, the Government wishes to provide the basis for a broad-based strategy for effective measures that cover the entire alcohol and drug field. The action plan gives particular attention to these specific areas as central to efforts:

- Integrated, locally-based measures against alcohol and drug use among children and youth, and alcohol and drug problems generally
- Treatment and care for the heaviest drug abusers

- Increased international work
- Better co-ordination of efforts
- Production of knowledge and quality assurance.

As a point of departure, the use of illegal substances is deemed unacceptable for both the individual and society, and prevention work is based on this principle.

A specific system for follow-up will be developed, consisting of an annual quantification of results, concrete measures that are to be introduced according to specified deadlines, and a system for evaluating the achievement of goals. The action plan will take into account the fact that developments can make changes and adjustments necessary, for example as a result of the emergence of new narcotic substances.

Measures to reduce adverse consequences of drug abuse

A number of solutions have been established for the most addicted drug users whereby continued use of drugs to a greater or lesser degree is accepted. Medically assisted rehabilitation for heavily addicted heroin users has been available nationally since 1998. National guidelines have been created for delineating responsibility and for organising medically assisted rehabilitation at regional and local levels. The system is anchored in specialised regional centres, but the municipal health and social services have an overarching responsibility for follow-up. Practical problems have been encountered with respect to the necessary participation of general practitioners and the municipal social services. This has made it difficult to free up resources in order to admit new applicants to treatment, particularly in Oslo. Substantial efforts have been made to clarify issues surrounding organisation, responsibility and financing in order to make the system more effective. The Storting (Parliament) adopted a revised model 1 July 2001, which more clearly integrates medically assisted treatment into the regular municipal health and social services in order to increase the capacity of the system.

The existing low threshold health measures for drug abusers are strengthened through a substantial increase in funding in 2002. Low threshold health care measures are an important instrument in the fight against overdose fatalities. Services offered in this area include health check-ups, vaccinations, the distribution of user equipment, protection against infectious diseases, guidance and follow-up after an overdose.

Recently a debate has ensued on the establishment of a public injecting room, initially in a limited number of municipalities under strictly controlled trial conditions. The argument has been that no measure should go untested in the fight to reduce fatalities resulting from overdoses. On the other hand, it has been posited that this can be viewed as a step towards legalisation of drug abuse. The question of whether to establish an injection room was considered by the Storting on 21 June 2002, and the Government was called upon to pave the way for a trial to be made with an injection room. This trial is to take place within a limited timeframe with injection rooms in two municipalities. It is to be integrated with the low threshold alternatives that are already offered and directed towards the most addicted heroin abusers. The trial is to be evaluated. Important issues relating to the establishment of such a trial still need to be carefully addressed.

Both increased international cooperation and increased mobilisation in local environs are considered crucial factors for how successfully one can reduce the availability of narcotics in the years to come. International cooperation - both at local, regional and global levels - is considered one of the major focuses in Norwegian drug policy, and is an important element in an extensive approach to fighting drug abuse.

At European level, Norway is a member of and participates in the work of the EMCDDA and the Council of Europe's Pompidou Group. Norway has also ratified the three relevant UN conventions, and in addition to participation in and support of the UNDCP, Norway chairs the regional section of the Dublin Group covering the three Baltic States. Norway has been a member of this group since 1993. For many years the Nordic countries have closely cooperated on drug issues, both through formal and informal channels.

Organisation and coordination at central and local levels

The main responsibility for drug policy issues, hereafter prevention measures, care and treatment, lies with the Ministry of Social Affairs (earlier Department of Health and Social Affairs). The central social and health administration was reorganised and became effective as of 1 January 2002. In addition to the fact that the Department of Health and Social Affairs was replaced by a Ministry of Social Affairs and a Ministry of Health, other effects included the establishment of a Directorate for Health and Social Affairs, with the incorporation of the work earlier conducted by the Directorate for the Prevention of Alcohol and Drug Problems.

The primary objective behind the reorganisation is that one should be better equipped to achieve social and health-related goals and to meet the professional challenges of the future. Other important goals for this reorganisation were to reduce internal administration and overlapping, to strengthen prevention work, supervision and qualitative developments in the health and social services, as well as strengthen research and the use of information technology.

Through the reorganisation, the Ministry has sought to assure a broad and current access to knowledge and experience as a basis for strategic planning and development of drug policy. Three central milieus work with drug prevention; they are:

- The Norwegian Institute for Alcohol and Drug Research (SIRUS)
- Norway Net, which consists of seven regional professional competency centres
- The Directorate for Health and Social Welfare

These operate within the areas of research and documentation, education and competency, as well as administrative tasks.

According to the given guidelines, the municipalities are responsible for prevention work, as well as for ensuring treatment alternatives for drug abusers. A basic principle is that services shall be anchored in the local society where the problems exist. Drug policy is regarded as an important part of Norwegian welfare policy, and cooperation with other local services and sectors are essential. It is not only necessary to coordinate social services for drug abusers, but also their relationship to the mental health services, child welfare services and to primary health care services. Moreover, close cooperation between housing assistance, the labour market and educational system is also necessary. Voluntary organisations make an important contribution by owning and operating fortified housing alternatives, often with support from public funding.

Responsibility for treatment and rehabilitation of drug abusers currently rests with the county, but from 2002 some services, i.e. those tied to the specialised health services, will be organised as state-owned health measures. Currently work is being done to move towards complete state responsibility for these services (see 1.2).

The police work to prevent drug-related crime using two approaches. First, by means of an effective police force that investigates cases and impedes and therewith reduces the supply

of drugs. Second, the police spread information about the adverse consequences of drug abuse. An active information service for different youth groups, parent groups and schools is operated, as a strategy for preventing the recruitment of new youth groups to the drug scene.

Research commission

The Minister of Social Affairs has appointed a research commission to summarise existing knowledge on the effects of drug prevention measures, evaluate the need for further research and identify political dilemmas and opportunities in the years to come. The commission is expected to present its report during 2002.

1.2 Legal framework

There is no individual law treating drugs in Norway. Judicial responsibility is divided between the Ministry of Justice (the Civil Penal Code), the Ministry of Social Affairs (the Social Services Law) and the Ministry of Health (the Act on Medicinal Products).

All illicit dealings with drugs are covered by the Norwegian Civil Penal Code of 22 May 1902, with the exception of the use and possession of minor quantities of drugs, which is covered by the Act on Medicinal Products etc., of 4 December 1992. The maximum penalty applied for serious drug-related crimes is 21 years.

Regulations concerning care and treatment of drug users are proscribed in the Social Services Act of 13 December 1991, No. 81.

The General Civil Penal Code and the Act on Medicinal Products do not define the term "drugs". In accordance with Section 22 in the Act on Medicinal Products the Minister of Health (as of 2001 the Norwegian Medicines Agency) has created a detailed overview of narcotic substances (Drug list of 20 June, No. 8) on behalf of the King. This national narcotic substances list includes all psychotropic substances (cf. UN Single Convention on Narcotic Drugs) under international control and a few additional substances/plants, which are only under national control. Salts and derivatives of the substances listed in the national narcotic drug list, and any isomers, esters and ethers of the substances of their salts are also considered narcotic drugs.

Regulations issued on 19 December 1997 concerning Certain Substances that can be used in the Illicit Manufacture of Narcotic Drugs and Psychotropic Substances, precursors, implements Rdir. 92/109/EU, revised with Kdir. 93/46/EU.

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

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

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

In 1988, section 162a relating to profit derived from a drug felony was introduced. The objective of this provision was to impede the economic interests invested in drug trafficking. In 1993, the provision was repealed and replaced by the amended section 317 of the General Civil Penal Code, which was formulated in such general

terms that profiting from drug trafficking (e.g. acts involving the laundering of drug money) also fall under this provision. The fourth paragraph of section 317, however, still prescribes a special penalty scale for the intentional involvement with proceeds from a drug offence. Under very aggravating circumstances a term of imprisonment with a term not exceeding three years shall be imposed when a crime relating to the proceeds of a criminal act is of a more general nature.

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

Legislative and regulatory changes

The Act on Sentencing of 18 May 2001, no.21 paragraph 12 provides for treatment as an alternative to jail sentence. In contrast to earlier praxis, the treatment stay can take place at that point in time at which it is most appropriate given the convicted person's rehabilitation needs, and not necessarily towards the end of the sentence term, such as was the main rule according to the now revoked Act on Sentencing from 12 December 1958, no. 7, paragraph 12. The ruling that punishment should be served in an institution(jf. The Act on Sentencing, paragraph 12), is generally made at a local level by the criminal care system, jf. paragraph 6. For those serving a longer sentence (persons sentenced to more than 10 years), and persons sentenced to special criminal sanctions the decision is made at regional level. The criminal care system is not to make such a decision if security concerns indicate otherwise, or if there are reasons to assume that the convicted person will fail to complete the program. The sentencing act authorises the combination of different forms of compulsory measures, among other reasons, in order to prevent the use of drugs during the serving of a sentence. For example, according to paragraph 29 urine samples can be taken, breathalyser tests or blood tests to detect such use.

As of 2002 the State assumed ownership and operational responsibility for hospitals. Following this, it is also expected that much of the county responsibility for institutions for specialist services for treatment of drug users will be transferred to the state as of 2004. According to plan, a bill containing proposed legislative changes (drug reform 1) should be presented to the Ministry of Social Affairs in the fall of 2002.

Responsibility for the further development of low threshold health services and medically assisted rehabilitation of drug abusers resides with the Ministry of Health since 1 January 2002.

Alternatives for drug abusers shall be reorganised with an aim to provide the users with better access to effective treatment and rehabilitation programs. Services shall be tailored to a large degree to the individual, and user participation thereby strengthened. The aim is to reduce drug problems and make it possible for the individual to conduct as normal a life as possible with dignity in his/her own neighbourhood. Measures shall be tailored to the different needs of different groups, such as abusers with children or expectant mothers.

1.3 Laws implementation

Practice shows that the penalty for drug felonies is largely dependent upon the substance and quantity involved. Involvement with cannabis is subject to more lenient sentencing than involvement with more dangerous substances. The nature of the involvement is also a very important issue with respect to sentencing. Greater leniency is shown in cases involving the import and purchase of drugs intended for personal consumption than in cases where the act was motivated by profit.

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

1.4 Developments in public attitudes and debates

During the greater part of 2002 an ongoing media debate has taken place on the use and spread of ecstasy and other synthetic substances. A rather new element in this is the attention given to Rohypnol, which is also used as a party drug in some youth scenes. An issue that is both of current interest and which has particularly polarised the debate, is the question of open drug user milieus in Oslo and the recruitment of new youth to extensive abuse. Suggestions have partly pointed to breaking up the environment, but greater focus has been given to being able to offer this group better alternatives. Compulsory treatment, low threshold methadone distribution, injection rooms, moving the environment to other less visible areas in the downtown area and establishing "hang outs" with a certain degree of follow-up outside the city area are some of the suggestions. Better coordination between the police, health and social services authorities with respect to measures that can be effective in time and which are not regarded simply as "removing the refuse" have been sought after. It has been posited that one should draw upon models that have been tested with positive results in other European cities – such as in Frankfurt.

Media focus is still strongly directed toward the fact that the number of overdoses resulting in death has not been reduced on a nation-wide basis, and the lack of better life saving measures for the individual. With respect to the debate concerning injection rooms, we refer to the discussion under section 1.1.

Critics also point to what they argue is an uneven balance between the severity of the crime and the framework according to which different drug-related crimes are punished. The general level of sentencing for criminality in Norway is regarded as rather soft, while the level of punishment for drug-related crimes is tough. Individual citizens and barristers have also raised doubts about how effective the current penal system is with respect to preventing drug abuse. Questions have been posed as to whether the restrictive Norwegian control system creates more problems than it solves.

In March of 2002, the *Penal Code Commission* presented an extensive report on the revision of the Norwegian Civil Penal Code, whereby a majority of the commission agreed to the decriminalisation of purchasing, use and possession of small quantities of drugs for personal use (Norwegian official reports - NOU 2002:4). However, the Minister of Justice has rejected the idea of opening up for discussing the decriminalisation issue as a consequence of the report, by referring to the Government's objective of counteracting any form for legalising narcotics.

1.5 Budget and funding arrangements

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

In addition to block grants, the Ministry of Social Affairs and the Ministry of Health have extraordinary budgetary funds at their disposal for the development of special high priority efforts in the areas of epidemiology, research, prevention and treatment. Such funds are channelled through SIRUS, the Directorate for Health and Social Affairs (in 2001 the Directorate for the Prevention of Alcohol and Drug Problems), regional competency centres, specialised centres for substitution treatment and low-threshold measures. As funds are granted both via and to a large number of authorities, institutions and organisations, and often either as operational funding or on a contributory basis, it is very difficult to present the exact figures in relation to specific areas of interest.

In the area of research (alcohol and drugs), SIRUS was awarded a total of EURO 2.8 million in operating costs for 2001 (Conversion rate 1 EURO= NOK 7.50).

In the area of prevention, the Directorate for the Prevention of Alcohol and Drug Problems was awarded EURO 7.2 million in 2001 for voluntary drug prevention work centrally.

In 2001 the Department of Health and Social Affairs was awarded EURO 21.8 million for the development of social services and drug measures. Among other things, this funding prioritised the following in 2001:

- Local drug prevention work
- Medically assisted rehabilitation
- Low threshold health measures
- Funds for local prevention work, largely channelled through the regional competency centres.

PART II EPIDEMIOLOGY

Chapter 2. Prevalence, Patterns and Developments in Drug use

2.1 Main developments and emerging trends

The tendencies that were described in the national report for 2001 appear to hold for the most part. Although the prevalence and incidence of use of illegal drugs remains relatively low when compared with other European countries, the latter half of the 1990s saw a marked rise in the proportion of youth who report that they have used cannabis and amphetamines. Over the last 2-3 years (2000-2002), however, the rise in use of illegal substances among youth 15-20 years appears to have flattened out.

Surveys of the adult population show a rise in the proportion of people over 20 years old who report that they have at some time tried cannabis, which is likely due to a cohort effect. This relationship is supported by the fact that the number of motorists who are arrested under suspicion of driving under the influence of substances other than alcohol has more than doubled during the 1990s. The most common substances detected are cannabis and amphetamines.

While extensive drug use and addiction to amphetamines and heroin have traditionally been related to social and personal problems, there are strong indications that a more experimental use of cannabis, amphetamines and newer substances such as ecstasy, cannot be so readily linked to such underlying factors.

Over time the use of drugs has become a part of different youth milieus that traditionally did not use such substances. Benzodiazepines – especially Rohypnol – have become increasingly popular as a means of softening the effect of stimulants, and are to some extent also used as party drugs. Rohypnol is traditionally most used as a means of increasing the effect of heroin among problem users .

Nonetheless alcohol is by far the most common drug used within youth culture. The use of alcohol among young people under the age of 21 has increased significantly over the last 4-5 years. Wherever one finds illegal substances, alcohol is also likely to be found.

Estimates for the extent of active drug injectors indicate that a doubling has taken place during the 1990s. The number of applicants to medically-assisted rehabilitation has been far greater than initial prognoses indicated.

The number of fatalities resulting from overdoses has also increased during 2001, to 338 people. This is the largest number of such deaths ever recorded in Norway. However, for Oslo, which registers approximately 1/3 of overdose fatalities, there are indications of a possible downward trend. The number of deaths due to overdose in Oslo has dropped by nearly half for the first half of 2002 when compared with the same period in 2001.

At the same time there has been a clear increase in the number of seizures of the most common illegal substances. The same is also true for the number of cases and individuals who have been considered by the court system.

Statistics maintained by the National Bureau of Crime Investigations(Kripos) for the first half of 2002 show that the greatest increase is for benzodiazepines, amphetamines and cannabis. Moreover the amount of benzodiazepines, largely flunitrazepam (Rohypnol) and diazepam, confiscated has also risen sharply, while there has been a clear drop in the confiscation of ecstasy, heroin, opium and LSD. Only small changes or none have taken place for other substances. Developments for the first half of 2002 are similar to the trends from 2001, especially with respect to the second half of the year.

Also noteworthy is the frequency of confiscation of amphetamine and methamphetamine in relation to heroin. Such substances were confiscated nearly 2.7 times as often as heroin.

GHB, which was classified as a narcotic substance in 2000, was little known as a potential drug until 1997, and there were relatively few seizures of this. The relatively large increase that was registered for GHB in 2000 has culminated such that GHB remains a very small part of the total volume of substances confiscated.

Increased availability of drugs in Norway, and especially with respect to amphetamines and heroin, appears to be linked to global developments that have led to increased production and smuggling. The same is true for illegal production and sales of medication – particularly Rohypnol.

It is relatively easy to get access to most illegal drugs, at least within the larger townships. In downtown Oslo a noticeably heavy open market for drugs has existed. The "market place" has been moved several times following pressure by the police, in part also by the commercial community, and since the end of the 1990s it has been localised in the area surrounding the central train station. Although the area is under continuous video surveillance by the police, trade and use take place quite openly. These circumstances are similar to the open drug trade areas found in other large European cities. As of today, there are no signs that this traffic is slackening to any greater extent. It is particularly worrisome that the area also appears to be attracting a large number of new young people who have short drug careers behind them but many problems.

2.2 Drug use in the population

General population

In 1999 interviews were conducted with a representative country-wide sample of the Norwegian population in which respondents were asked to provide written anonymous responses to questions regarding their personal use of drugs. A similar study was also conducted in 1991, but with a more limited battery of questions concerning drug use. Among persons aged 15-64 years old the percentage of those who had at one time tried cannabis rose from 9.6% in 1991 to 15.4% in 1999. In the same population 3.8% in 1999 indicated lifetime use of amphetamines, 1.3% ecstasy, 2.1% of cocaine and 1.4% of heroin (Standard table 01).

The next interview survey is planned for 2004. The questions are adapted to EMCDDA's standards, such that the data will be comparable with that from other EU countries.

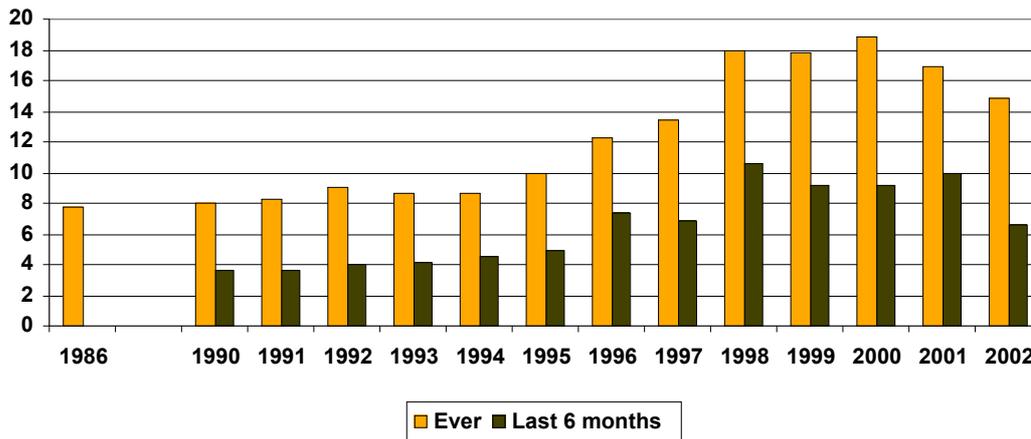
Among young people

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

Among the proportion of young people aged 15-20 years who report having tried different narcotic substances, it appears that the increase seen in recent years has flattened out. While the national figure for the proportion who reported that they had tried cannabis at some

time was about 18-19 per cent during the years 1998-2000, during the last couple of years the comparable figure has been 17 and 15 per cent (figure 1). With respect to the proportion who report they have used cannabis at some time during the last six months, an increase has taken place from approximately 7 per cent in 1997 to approximately 10 per cent for the years 1998-2001. In 2002, however, the proportion of 15-20 year olds across the country who report having used cannabis over the last six months has dropped to just less than 7 per cent.

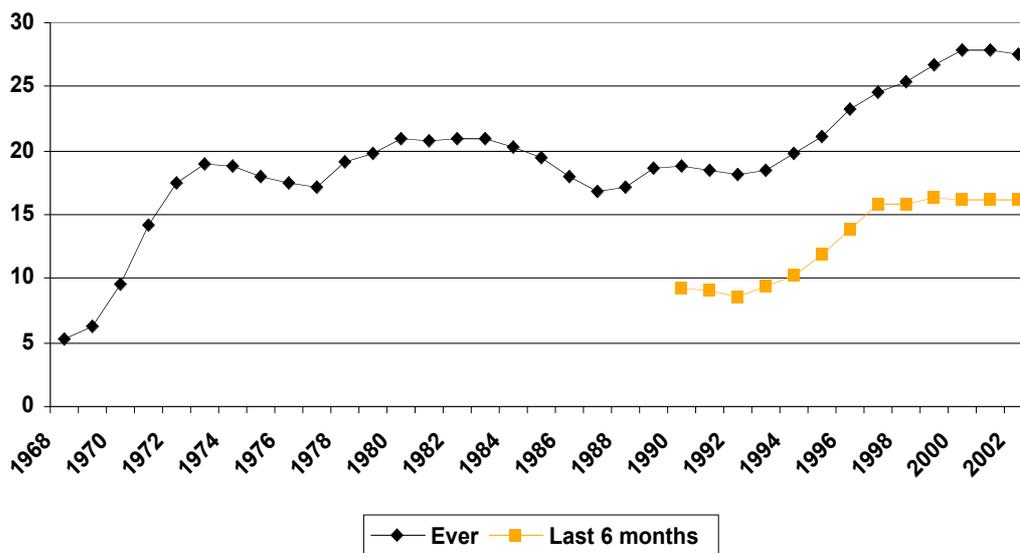
Figure 1. Percentage of youth aged 15-20 years in Norway who report having used cannabis at some time during the last six months 1986-2002.



Source: SIRUS

The percentage of those who have used cannabis is higher for Oslo than the national average. This is true for both use at some time as well as use over the last six months (figure 2). However, for Oslo one also finds something of a flattening out of the figures, both with respect to the percentage who report having used cannabis at some time (approximately 28 per cent the last few years) and during the last six months (approximately 16 per cent the last few years).

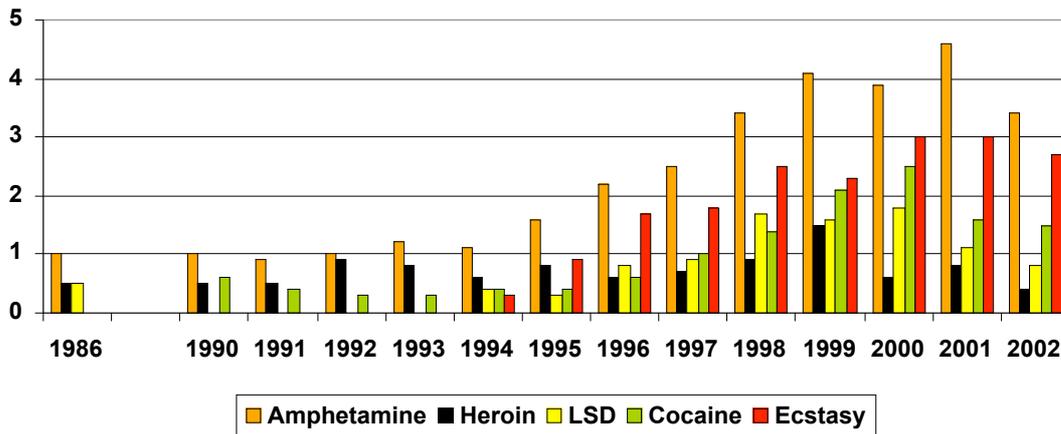
Figure 2. Percentage of youth aged 15-20 years in Oslo who report that they have used cannabis at some time during the last six months, 1968-2002 (three year sliding average).



Source: SIRUS

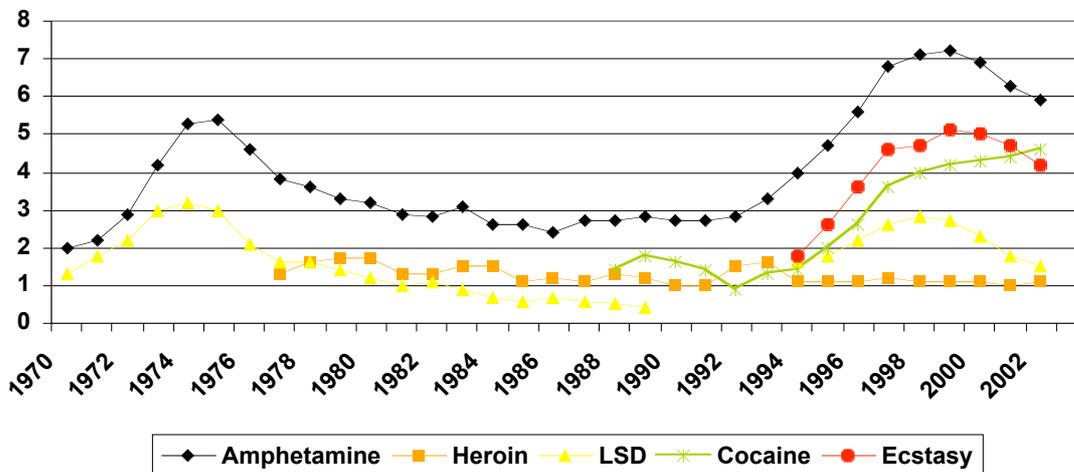
With respect to the percentage who report having used other substances, there has largely been a flattening out or drop in the figures for the last couple of years (Figures 3 and 4). For example, the proportion of 15-20 year olds who report having tried ecstasy has remained at approximately 3 per cent for the nation and 4-5 per cent in Oslo. Moreover, there appears to have been a small drop in the percentage who report having used amphetamines at some time.

Figure 3. Percentage of youth aged 15-20 years in Norway who have tried different narcotic substances at some time, 1986-2002.



Source: SIRUS

Figure 4. Percentage of youth aged 15-20 years in Oslo who have used different narcotic substances at some time, 1970-2002 (three year sliding average).



Source: SIRUS

One should be aware, however, that the figures are subject to statistical errors and should be interpreted with caution. Surveys are always susceptible to different sources of bias (not everyone replies, some responses can be consciously or unconsciously incorrect, etc.) and the surveys referred to here were directed to young people generally. There is therefore reason to believe that young people who regularly use narcotic drugs, whether it be cannabis or stronger substances, will be underrepresented in the surveys (SIRUS website).

ESPAD

Norway has participated in The European School Survey Project on Alcohol and Other Drugs – ESPAD among 15-16 year olds in 1995 and 1999 on the use of substances (standard table 2).

The Norwegian ESPAD survey among 15-16 year olds shows that while in 1995 six per cent report that they at some time had used cannabis, this proportion had risen to approximately 12 per cent in 1999 (table 1). Moreover, the survey shows that an increase has also taken place in the proportion who report use of cannabis over the last 12 months and the last 30 days. Both the yearly youth survey and ESPAD survey show that a consistently larger percentage of boys than girls report use of cannabis.

Table 1. Percentage of 15-16 year olds (ESPAD) who report having used cannabis at some time, during the last 12 months and last 30 days.

| | Any time | Last 12 months | Last 30 days |
|------|----------|----------------|--------------|
| 1995 | 5.9 | 4.7 | 2.7 |
| 1999 | 12.3 | 9.1 | 4.1 |

Source: SIRUS

With respect to other substances, the results of the ESPAD survey for 1999 show that 3 per cent reported having used substances such as amphetamines, ecstasy and heroin at some time. Likewise 2 per cent reported having used LSD/hallucinogenic substances and 1 per cent had used cocaine at least once during their lifetime. 6 per cent of school aged youth had tried or used solvents at some time, while 2 per cent had used solvents during the last 12 months (Hibell et al. 2000).

Drug use in prison

The prison population reflects the problems that exist outside prison walls in a concentrated form. The percentage of inmates serving sentences for drug-related crimes has been increasing and confirms the increase in problems seen in Norway more generally. For the year 2001, 899, or just under 30% of a total of 3 057 inmates per day in Norwegian prisons are serving sentences for different types of drug-related infringements. Additionally, some prisoners are convicted of drug-related crimes that are directly related to drug use, but which is not reflected in the statistics. Typical examples of this are theft and robbery committed in order to finance their drug use.

The prison authorities report that 40-60% of inmates in Norwegian prisons use drugs once or several times while serving their sentences (Stortingsmelding no. 16 (1996-1997) Narkotikapolitikken). This estimate builds on previous studies conducted in prisons, with anonymous surveys among inmates, reports submitted by prison and visitation officials to the prison board.

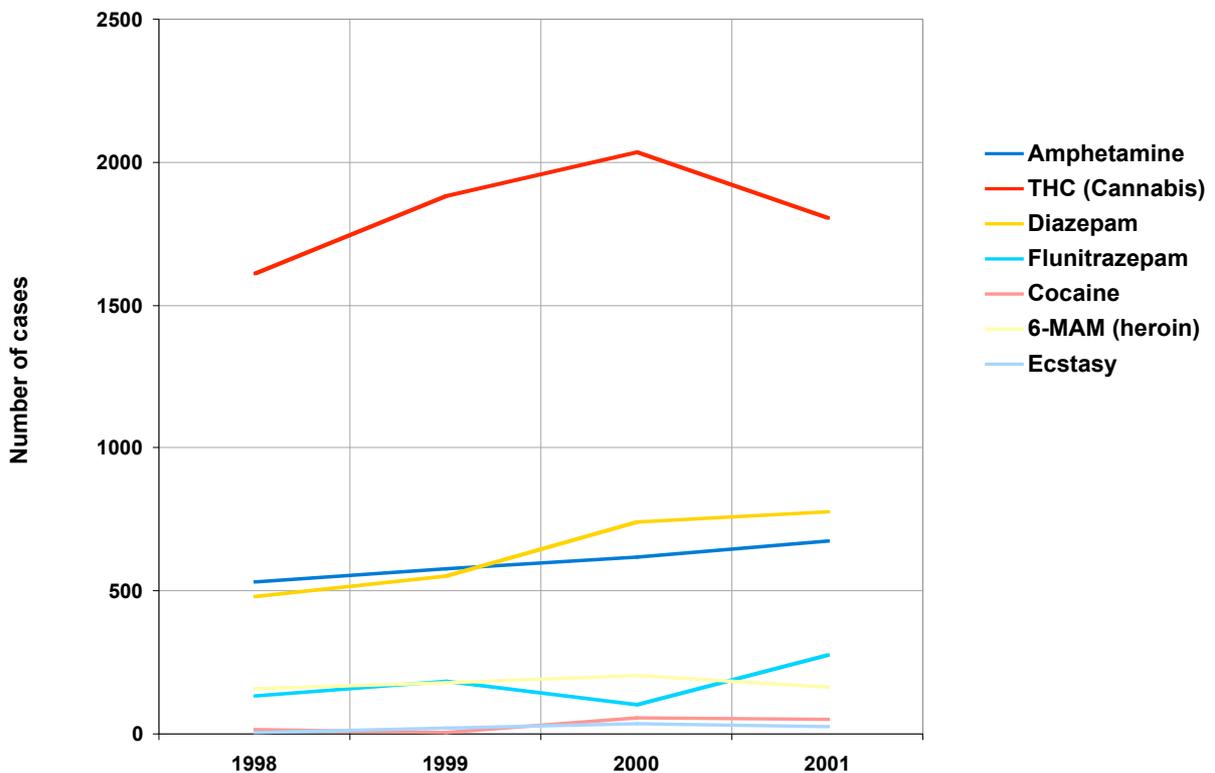
With the enactment of the Prison sentence law of 18 May 2001, prison officials now have better opportunities to introduce control measures to fight drugs. Among other things, they are now entitled to search individuals. Additionally, the right to inspect visitors has been introduced, and the right to hold these individuals until police arrive. Moreover, health care personnel, upon the request of the prison, can conduct a body cavity search upon suspicion of use or housing of narcotics on behalf of an inmate. In addition to these a number of other control measures, such as use of narcotics toilets, drug hounds and communication controls are also in use.

The number of body cavity searches has been relatively stable for the period 1993-2000. Overall the number of detection of drugs and user paraphernalia has increased from 1998 to 2001. In 1988 234 searches resulted in finds of drugs and 777 of paraphernalia. In 2001 only 523 drug finds were made and 882 of user paraphernalia. The increase can be due to the spread of use of drugs in prisons, but might also be related to improvements in control routines.

The number of urine sample tests showing positive for drugs has increased from 1 019 in 1988 to 2 538 in 2000. But, given that the total number of tests conducted for the same years increased from 6 706 to 20 995, the percentage of positive tests has dropped from 15.2% to 12.0%. The majority of positives are for cannabis substances and different narcotic tablets. This corresponds with the seizures that are made (Ministry of Justice).

Cannabis is clearly the most frequent substance shown in tests among prison inmates and open facilities (figure 5). Additionally, amphetamine and diazepam (active agent in e.g. Valium) are also frequently detected. There have not been any large changes in this picture in recent years, but an increase in flunitrazepam, the active agent in e.g. Rohypnol has been registered (SRI).

Figure 5. Drugs detected in criminal care cases



Source: SRI

2.3 Problem drug use

Calculations are available for intravenous drug users only (standard table 7). Such calculations have been made on three occasions, in 1989, 1999 and 2001. While the number in 1989 was estimated to be between 4 000 and 5 000, it had risen to 9 000- 12 000 in 1999. In 2001 estimates indicate that this figure is between 10 500 and 14 000 people, in other words a double over the last 10 years (Bretteville-Jensen and Ødegård 1999). Heroin is clearly the predominant drug that is injected.

There appears to have been an increase in the level of consumption of heroin that is not only related to the greater number of abusers, but also to the fact that the dosage per injection has increased. A survey of intravenous drug users by 'the needle bus' in Oslo shows that the average heroin use per occasion has grown since 1993 (standard table 10).

One surprising finding is that women intravenous drug users reported that they used 22 per cent more heroin than men. On average they report to have a significantly greater number of injection days per month, give themselves more injections per user day and inject larger doses per "shot". In line with other studies, one also finds that women use more benzodiazepines, but less alcohol and cannabis than male intravenous drug users (Bretteville-Jensen 1999).

Calculations made in 1999 also gave estimates by age group. It is estimated that 10% of drug injectors are under 21 years of age, 45% between 21 and 30 and 45% are 31 or older. Most drug injectors are men. Women are thought to account for one-third of users. The user population has grown older over time. There is good reason to believe that this development will continue. From at one time being a youth problem, it is currently on the verge of becoming a social problem that is increasingly related to middle-aged abusers. Moreover, it appears that more recruiting is taking place among the older age groups, particularly among men. One possible explanation for this is that those who have traditionally abused alcohol have now become heroin addicts.

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

Risk behaviours

Risk behaviour related to intravenous drug use is first and foremost related to the risk of contracting a contagious disease, harm resulting from an incorrect injection (abscesses, etc.) and the risk of an overdose. Risks related to the lifestyle itself include the fact that drug addicts are over-represented as victims of some illnesses and generally poor health statuses than persons of the same age in the population more generally. The annual report for 2001 by the Field Nursing Service, a low threshold programme in Oslo, confirms that risk behaviour related directly to injection as well as to health problems that can reflect the poor living conditions generally.

A user survey among 201 clients of the Field Nursing Stations (Strømsmo, Siri 2000, unpublished) reports that 36% are in poor health. In contrast, in the national health survey of the normal population only about 7% self-report the same. This picture is confirmed and strengthened by an ongoing nutrition study among drug addicts (College in Akershus and the Alcohol and Drug Addiction Service in Oslo). This suggests an expansion of the concept of prevention, such that it concerns not only the need to minimise the risks associated with injecting, but must also address more basic needs such as nutrition, more stable housing, etc. This would contribute both to increasing the likelihood of seeking treatment for different health conditions as well as to reducing the risk of illnesses as a result of lifestyle.

The "needle bus" in Oslo has a broad network of contacts among intravenous drug users, and has conducted four user surveys of this programme (1992, 1994, 1997 and 2000). Ongoing comparisons of the figures from the four surveys indicate an increase in the proportion of users who have experienced overdoses, and there has been a noticeable increase from 1992 in the proportion who report having given themselves an overdose on purpose. Moreover, nearly 30% report having shared needles during the last year, which is a

rather high proportion given the availability of clean needles. However, sharing has not taken place uncritically, but has been amongst partners and friends. The frequency of HIV tests among the bus users is still high and the number of new cases of HIV among intravenous drug users is low (see 3.3).

In 2001, for the third year in a row, the users of the "needle bus" were offered a vaccination for hepatitis A and B, an x-ray examination and immune system examination, in co-operation with the health authorities and the Alcohol and Drug Addiction Service of Oslo. During the fall of 2002, these agencies will once again offer the users vaccinations against hepatitis A and B, blood tests and x-rays as well as participation in hepatitis C examinations, which aim to identify risk behaviour in order to be able to develop better risk reduction strategies. In particular it will be important to identify those who still are hepatitis C negative and give generally more intensive attention to reducing behaviour that spreads diseases (the Alcohol and Drug Addiction Service of Oslo).

Chapter 3. Health consequences of drug use

3.1. Drug treatment demand

Norway has established a registration system for the treatment of clients with drug problems. The system is based on a client form, which is used to register the conditions associated with the request for treatment, the client's situation at the time treatment begins, and conditions pertaining to the completion of treatment. The form is to be completed by the care worker conducting treatment based on an interview with the client, and should include variable sets that cover the "core items" in EMCDDA's The Treatment Demand Indicator. The system is compatible with the needs of clients with both alcohol, prescription drug and other drug problems. In Norway it is common for the same institution to treat all of these types of problems.

Based on the official regulatory system concerning personal integrity and privacy, data from the client tracing system is calculated at an institutional level before it is collated at regional and national levels as aggregate figures. The fact that national data is only available in aggregate form means that it is not possible to identify clients whose problem is purely or primarily alcohol-related from clients whose problem is primarily drug-related. The form for data collection also makes it impossible to control for double recording of data; that is, treatment for which the same client appears for several treatment sessions in the same or different institutions within the same year. The client cannot be "followed through the system" over time.

Work has been initiated in order to develop an individualised tracing system that could be used in conjunction with EMCDDA's Treatment Demand Indicator. Such efforts aim to develop an encryption system for data and personal indicator that can be used in individual institutions, secure data transfer from institutions to central data administration, choose a central data administration and storage system, and decide on the availability of centrally stored data. These elements must be authorised by the authority on personal integrity and data warehousing, and must be accepted by treatment measures. It is hoped that the application to the authorities on a concession to allow such an individual-based client tracing system should be in place during the fall of 2002. Table 2 shows some aggregate data.

Table 2. Registered referrals, initiated and completed treatment

| Year | Nr of incidences (of approx.190) | Nr of referrals | Nr of Initiated treatment programmes | Nr treatment programmes concluded |
|------|--------------------------------------|-----------------|---|--------------------------------------|
| 1998 | 110 | 18.115 | 13.541 | 10.956 |
| 1999 | 110 | 20.426 | 15.700 | 12.634 |
| 2000 | 113 | 26.462 | 18.981 | 15.738* |

*Figures for completion for 2000 include 2271 treatment programmes that are registered as "incomplete" at the close of the year.

Note: The same person can be registered more than once for the same year. Includes both individuals whose problems are primarily alcohol-related and those whose problems are primarily drug-related.

Table 2 shows the development of registered referrals and treatment programmes and registrations that were completed from 1998 to 2000. Data for 2001 is currently being collected. The reason for the rising number of registered referrals is two-fold. First the large treatment programmes have received greater support. Second, it is likely that many programmes achieve better routines for registration over time such that these are now more complete. In the years 1998, 1999 and 2000 a total of 142 different programmes presented figures for national client mapping. Among these, some are permanently or temporarily

suspended, others have had problems with calculating figures due to computer problems and others due to turnover among personnel. 88 programmes have provided data for all three years.

When referrals for 2000 are broken down according to gender and age, it becomes clear that gender differences even out as one looks at younger groups. In the age group 16 to 20 years only 42 percent women and 58 per cent men, while for the age group 51 to 60 years we find four-fifths of referrals are from men. Age and gender are variables that are clearly identifiable and easily registered and therefore there is good reason to believe that these figures reflect real distributions for registered referrals. The same trend among gender and age groups is seen in the data for 1998 and 1999 and in the figures for different regions for all three years.

It is clear that alcohol is the drug used most by most men – approximately 46 per cent, while 28 per cent of men have heroin as their most used means of intoxication. Heroin is the most used drug for women – 33 per cent, while 31 per cent of women list alcohol as their most common intoxicant. Clearly a greater percentage of women (8 per cent) than men (about 2 per cent) list addictive medication as their most used intoxicant. This also includes people who have become addicted to medicines they have received by way of a regular medical treatment, and who do not use medicines in order to become intoxicated. Ecstasy was the most used intoxicant in 14 cases in 1998, and in 18 cases in 1999. Data for 2000 shows that ecstasy was the most used intoxicant in 82 cases (the Bergen Clinics Foundation).

3.2. Drug-related mortality

There are two authorities in Norway who register drug-related mortality, the National Bureau of Statistics (SSB) and Kriplos. SSB's figures are based on the medical examiner's reports, autopsy reports and doctors' declarations of death. SSB codes cause of death according to a Norwegian copy of the international classification of diseases, accidents and injuries (ICD-10). Deaths registered in these statistics are related to the determination of underlying cause, in other words, that drug use has directly led to death (standard tables 5 and 6). Kriplos' registration system is based on reports received from police stations around the country. Generally, the inclusion criteria appear to be less restrictive as the data is not based strictly on a medical diagnosis. Despite the different means of attaining data, the two sources are similar for the period 1991-2000 (SSB has not yet published figures for the period after 2000). Both series show a sharp rise in mortality.

Table 3.

Drug-related mortality by gender

According to Kriplos and SSB (underlying cause of death)

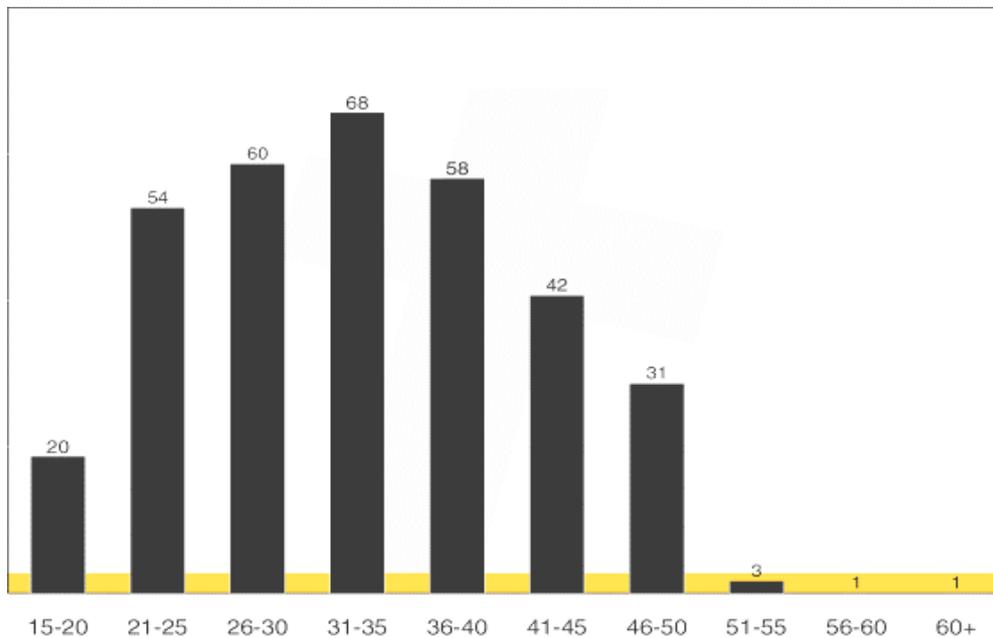
| 1991-2001 | Number of deaths according to KRIPOS | | | Number of deaths according to SSB | | |
|-----------|--------------------------------------|-------|-------|-----------------------------------|-------|-------|
| | Men | Women | Total | Men | Women | Total |
| 1991 | 74 | 22 | 96 | 66 | 22 | 88 |
| 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 | 171 | 26 | 197 |
| 1997 | 149 | 28 | 177 | 155 | 30 | 185 |
| 1998 | 226 | 44 | 270 | 224 | 50 | 274 |
| 1999 | 181 | 39 | 220 | 179 | 57 | 236 |
| 2000 | 264 | 63 | 327 | 302.. | 72.. | .374. |
| 2001 | 286 | 52 | 338 | .. | .. | .. |

Sources: Kriplos and SSB The National Bureau of Crime Investigation and Statistics Norway

Kripos' figures are based on continuous reports received from local police districts, as these were organised until the new organisation was introduced in 2002. The statistics cover all mortality among drug abusers for which the cause of death is poisoning, and drug-related mortality for which a relationship between the death and the deceased's abuse can be detected. Kripos emphasises that, in their experience, the actual number of drug-related deaths will be somewhat lower once autopsy reports become available from the The National Institute of Forensic Toxicology (SRI).

Altogether 41 (of 54) police districts reported drug-related deaths in 2001. In total, 338 individuals died as a result of drug use, with an average age of 33.6 years for men and 32.7 years for women. This is the highest number of such deaths to be registered in Norway ever. The gender distribution was 286 men and 52 women. The number of women has increased by 20% while the number of men has increased by 80% over the last five years. 109 of the deaths (90 men, 19 women) were registered by the Oslo police district.

Figure 6. Drug related mortality 2001 by age

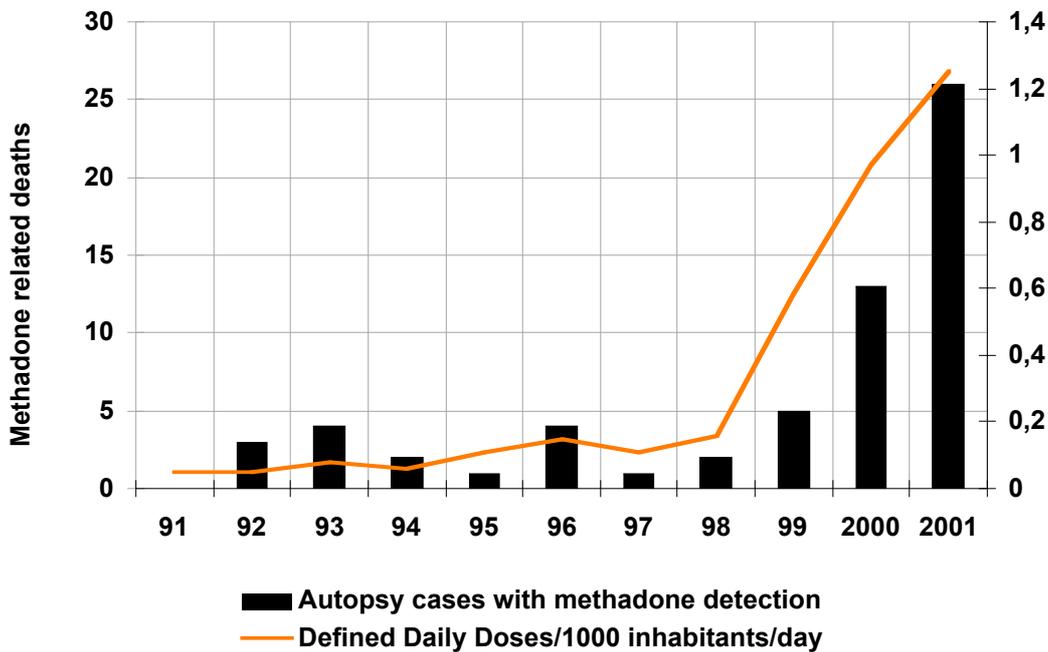


Source: Kripos

Methadone-related mortality

An comparison of the presence of methadone detected under legal autopsies (test material analysed at SRI) with the sale of methadone, shows a very strong correlation between the total quantity proscribed and the number of poisoning fatalities for which methadone was an important factor. A sharp rise in the number of deaths over the last couple of years is seen to parallel and increase in the quantity proscribed. Poisonings by methadone alone account for 10% of the material figure 7 is based on, the rest is primarily combination poisonings (SRI).

Figure 7 Methadone-related mortality in Norway 1991-2001



Source :SRI

THC-related mortality

In a study that was conducted by SRI in 2001, autopsy cases were examined for which there was evidence of tetrahydrocannabinol (THC), the active agent in cannabis. Six cases of sudden death without a clear cause of death were among these cases. By comparing identifiable THC concentrate, clinical data and autopsy findings the study provided factual evidence that acute heart failure had occurred in these victims. THC ingestion and the timing of its symptoms or eventual death had not been documented earlier by measuring THC levels in the blood. Cannabis is generally considered a less toxic substance; that is, there is little danger of a serious poisoning or death. However, this study concludes that cannabis has a considerable acute effect on the heart and circulatory system both in healthy individuals and those with heart conditions, and suggests that there is a correlation between cannabis use and sudden heart failure. Such serious, but infrequent side effects can be detected after a substance has been used seemingly safely over a longer period of time (Bachs L, Mørland: H).

Causal factors

The increase in the total number of deaths has no simple explanation, and information continues to be lacking in this area. Factors that might have contributed to the increase are:

- The number of intravenous drug users has doubled over the last 10 years
- The group of heavy drug addicts has grown older and they are deteriorating both physically and mentally
- Heroin has become more widely available and the price is falling, which in turn has led to larger doses among some addicts

- Multiple use, whereby heroin is taken along with alcohol and/or other prescription drugs such as Rohypnol, has become increasingly common
- Additionally it is thought that many addicts are more resigned to their problem and self-destructive after repeated rounds of treatment in different facilities.

The large number of deaths can also be related to a more expansive injection culture in Norway in contrast to other countries, including her Nordic neighbours. In Norway heroin is taken almost exclusively via injection (SIRUS).

Mortality among heavy drug addicts in Norway is calculated in several follow-up studies. However, it is problematic to generalise from group-specific mortality rates to the entire population. Bretteville -Jensen and Ødegård (1999) emphasise the uncertainty associated with the estimate they make on the basis of a literature review, stipulating that the yearly mortality rate among intravenous drug users is between 3 and 4%. The estimate indicates an increase in mortality. It is still not possible to calculate mortality based on client tracing data (see 3.1).

The situation in Oslo

Oslo is still over-represented in the mortality figures, 109 compared to 338 for the entire country (2001). In the municipality of Oslo a working group has analysed the basis for this sharp increase in drug-related deaths. Among other things they discovered:

It is first and foremost heroin that leads to overdose mortality. Tolerance to opiates drops quickly, a condition that increases the danger of an overdose after a dry period (e.g. after treatment or prison). Alcohol and benzodiazepines (e.g. Rohypnol) play an important role. Proscriptions for habit inducing medications by physicians (without close follow-up) increase mortality. Addicts with poor somatic and/or mental health are more susceptible. Men are more susceptible than women. With age the chance of an overdose increase. Age is often correlated with length of abuse career.

Most of the deaths occurred in private surroundings, while 32 percent in 1998 and 25 percent in 1999 occurred in what we could call "public surroundings". In the year 2000 this figure had declined to 21 percent.

The police provide the following evaluation: "There appears to be a correlation between the number of deaths and availability of narcotics. An active attempt to limit availability is therefore of great importance. More overdose fatalities are now registered than at any time previously in "non-tradition" areas, such as among the upper middle class neighbourhoods of Oslo's west side. 24-30% of fatalities in Oslo involved persons with a foreign background. More accurate and thorough registration routines of such fatalities can provide clearer information on the problem. Multiple abuse registered for alcohol/benzodiazepines is increasing.

The municipality of Oslo has been responsible for an EU Commission financed project (1999-2001) on strategies for reducing overdose fatalities, a co-operative effort between Oslo, Frankfurt, Copenhagen and Amsterdam. The objective was to accumulate better knowledge about why drug addicts die of overdoses, analyse how this knowledge can be of practical help and develop better health prevention measures. The final report is published (Strategic Choices for Reducing Overdose Deaths in Four European Cities, municipality of Oslo 2002).

Some correlating factors identified in the project report on the situation in Oslo:

"One type of problem stems from different registration practices. In Copenhagen the overdose cases are numbered by the registered address. The case will not be counted in the

Copenhagen figures if the deceased is registered or lived outside the city, even if it takes place in Copenhagen. The numbers given for Oslo concern all cases found in Oslo. If registered in the same way as in Copenhagen, the figures for Oslo would for the years 1998-2000 been 29-32 percent lower, and the figures for Amsterdam for 1999 would have been more than 50 percent lower. In Amsterdam the registration distinguishes between Dutch citizens and foreigners, giving figures for both groups. The total number is used in the tables. In Frankfurt the figures comprise all overdose deaths found in the city.

Overdose mortality seems to be the most important cause of death among drug users in Oslo.

The problem of increasing deaths came somewhat later in Oslo than in any of the other cities, and was met with increasing emphasis on drug free, abstinence-oriented treatment that should be available on demand. In 1992 the "immediate measures" were launched. These measures consisted first and foremost of a concerted effort from police and outreach workers to get drug users into drug free treatment immediately, as soon as they wanted to, with money to buy treatment over the whole country, wherever available. Part of these measures was also an outreach health team, providing follow-up for surviving overdose victims as well as preventive work among drug users, their relatives and friends.

Specific for Oslo is also the late introduction of methadone. The first methadone projects were primarily motivated by the treatment needs of the AIDS patients, and then to meet the particularly treatment resistant addicts. First in 1998 a new and broadened methadone programme was launched.

Of the four cities, Oslo seems to have prioritised drug free treatment highest, and to have used combined social- and treatment systems more intensively than the other cities. The rise of overdose numbers have been met with "more of the same" – increasing emphasis on abstinence oriented treatment, out-reach and different support systems. The policing have gradually changed priorities towards more interest for use among young drug users and less to control heroin use and sales on a growing "open drug scene" in central Oslo.

Cities, such as Oslo today, that have methadone programmes with restrictive inclusion criteria and strict demands on users, will have to change or supplement these programmes. It does also mean that the arenas where the destructive drug use patterns dominate, and where problematic users tend to dominate, the open drug scenes and the desolated slums of drug using subcultures, should be discouraged and dispersed. This again presupposes that the users have acceptable alternatives.

The strong injecting culture in Oslo is indisputably a major reason behind the high overdose death level in the city." (The Alcohol and Drug Addiction Service, Oslo)

3.3 Drug-related infectious diseases

HIV and AIDS

As of 31 December 2001, 456 persons were diagnosed as HIV positive, with a risk factor of intravenous drug use, including those with both a risk factor of intravenous drug use and homo/bisexual activity (table 4). Among those who had developed AIDS as of 31.12.2001, 126 were intravenous drug users or 17 % of the total number of AIDS cases. The number of new cases of HIV infection among intravenous drug users in Norway is low. This is also the case for the number of new intravenous drug users who develop AIDS. A large proportion of the drug injectors who have developed AIDS are already dead. Moreover, a relatively large number of HIV positive drug addicts died of other causes. Studies show that more than 90

per cent of intravenous drug addicts report that they have been tested, most of them several times. Therefore, the unrecorded population is likely to be relatively small (standard tab.6, part 2).

Table 4. Proportion of intravenous drug users who are registered as persons with HIV infection and AIDS with risk behaviour of drug injection, according to year of diagnosis.

| | HIV Total | HIV-intravenous drug user | Percentage of HIV intravenous drug user | AIDS total | AIDS Intravenous drug user | Percentage of AIDS-intravenous drug user |
|--------------|--------------|---------------------------|---|------------|----------------------------|--|
| 1984-89 | 894 | 315 | 35 % | 144 | 8 | 6 % |
| 1990 | 90 | 22 | 24 % | 59 | 13 | 22 % |
| 1991 | 142 | 16 | 11 % | 59 | 16 | 27 % |
| 1992 | 105 | 12 | 11 % | 50 | 8 | 16 % |
| 1993 | 113 | 13 | 12 % | 64 | 13 | 20 % |
| 1994 | 94 | 12 | 13 % | 74 | 19 | 26 % |
| 1995 | 105 | 11 | 10 % | 67 | 8 | 12 % |
| 1996 | 116 | 9 | 8 % | 56 | 12 | 21 % |
| 1997 | 113 | 11 | 10 % | 34 | 8 | 24 % |
| 1998 | 98 | 8 | 8 % | 39 | 5 | 15 % |
| 1999 | 147 | 12 | 7 % | 28 | 6 | 21 % |
| 2000 | 176 | 7 | 4 % | 38 | 6 | 16 % |
| 2001 | 158 | 8 | 5 % | 26 | 4 | 15 % |
| total | 2 351 | 456 | 19 % | 738 | 126 | 17 % |

Source: National Institute for Public Health

Hepatitis

An outbreak of hepatitis A and B among intravenous drug users was registered in 1995. During the period 1995-2000 a total of 1 162 intravenous drug users with hepatitis B were identified. However, the outbreak appears now to be in retreat, even if 134 new cases were reported in 2001 (in 2000:176; in 1999:375; in 1998:385).

Hepatitis C still need not be reported except in the case of acute infection. Therefore the number of cases reported does not represent the real incidence rate. However, 3, 17, 15 and 11 acute cases of hepatitis C infection were reported among intravenous drug addicts for the years 1997, 98, 99 and 2000, respectively. There are a number of factors that make these a rather unreliable picture of the real incidence of the disease. Among other things, the majority of newly infected persons do not experience symptoms and therefore do not seek medical treatment such that the condition can be diagnosed and reported. Additionally, when one does diagnose hepatitis C, it is seldom possible to identify when infection took place. The prevalence of hepatitis C in Norway can neither be defined with certainty. However, it is known that a large number of drug addicts have been infected with hepatitis C. Several prevalence studies have shown that 50-80% of drug addicts in Norway have tested positive to anti-HCV.

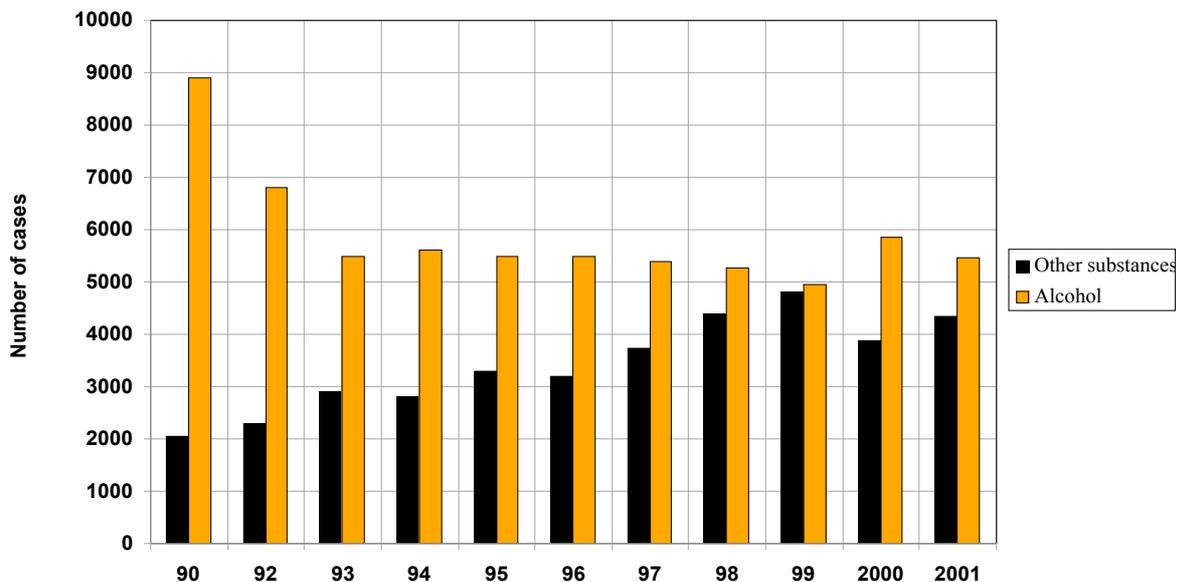
3.4 Other drug-related morbidity

During the period 1998-1999 persons who suffered from both a serious mental illness and heavy use of intoxicating substances were studied. The study concluded that approximately 4 000 people who abuse alcohol and/or drugs also suffer from a mental disorder of such calibre that they are in need of special treatment for their mental problems, above and beyond what is available to them today. 2/3 of these individuals were men and the average age was 31 years old. Approximately half, or 2 000, were drug addicts. The study identified a clear pattern: patients with mental disorders tended to abuse cannabis and amphetamines, while patients with personality disorders were over-represented among opiate abusers (The Norwegian Board of health 2000).

Drugs and driving

The number of drivers arrested under suspicion of driving under the influence of drugs other than alcohol has more than doubled during the 1990s, and in 2001 there were approximately 4 300 cases. This development over time is shown in figure 8, where cases related to suspicion of drinking and driving are also included. Narcotics and/or other medications have been identified in 80% of the cases where the primary suspicion is related to such substances, indicating a high hit rate on the part of the police with respect to motorists who are subjected to tests.

Figure 8. Number of motorists arrested for the period 1990-2001 for under suspicion of driving under the influence of alcohol or other drugs.



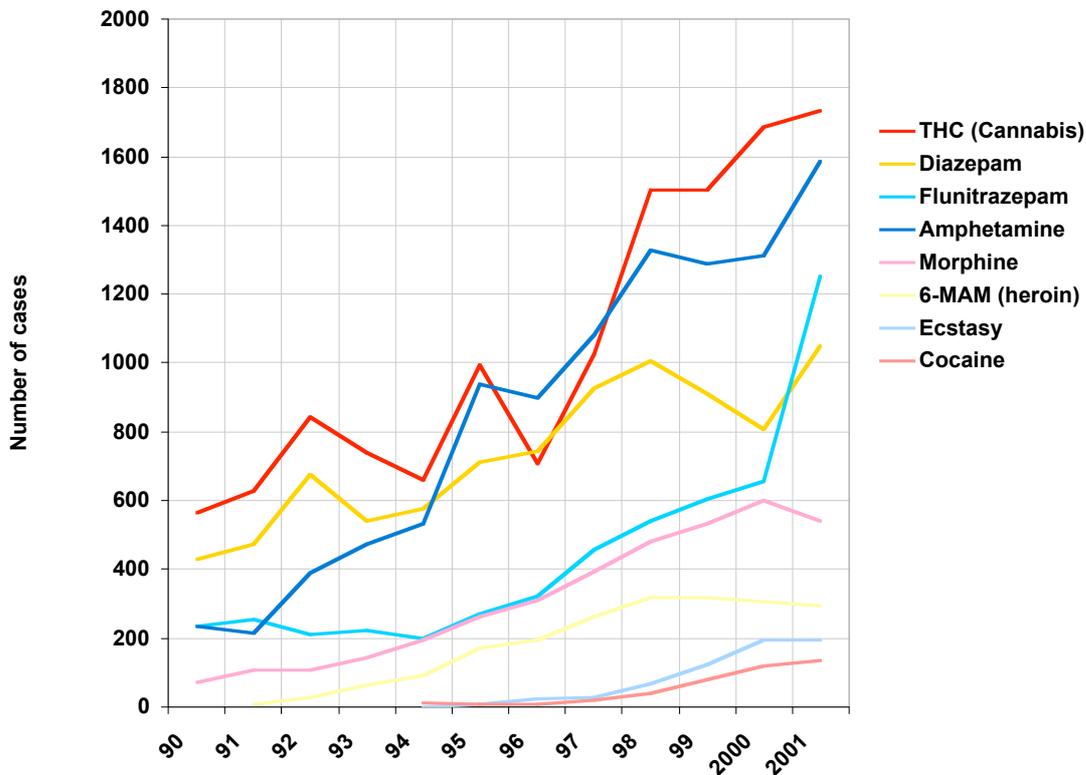
From 1996: *Both breath analysers and bloods tests for alcohol are included.
Source: SRI

For each positive test an average of approximately 2.6 substances was detected, which indicates a substantial level of mixed abuse among this group. The most common substances are cannabis and amphetamines. In the event that proscriptioin medicines are detected (e.g. flunitrazepam, diazepam, etc.), these are usually (80-90%) detected in combination with other substances (illegal substances, other medicines that affect the central nervous system, or alcohol) and in blood concentration that indicate consumption far beyond what is normally a recommended therapeutic dosage. During the 1990s a substantial

increase in amphetamines and heroin (indicated by identifying the enzyme 6-MAM). The presence of such substances was relatively stable over the last few years, but once again there has been an increase in amphetamine positive tests for 2001, approximately 20% (figure 9). At the same time, statistics show a tendency towards an increase in the presence of cocaine and ecstasy for the last 2-3 years, as well as a substantial rise in the detection of flunitrazepam. From 2000 and 2001, there was a rise in the number of tests indicating flunitrazepam by nearly twofold (from 656 positive individual finds to 1 252 individual finds).

However, it is difficult to draw any definitive conclusions about the level and trends based on these data. The police initiate the tests, meaning that the number of positive tests can be related to the resources and priorities of the police.

Figure 9 . Substance detection in traffic-related cases



Source: SRI

The typical motorist driving under the influence of drugs other than alcohol is a man between 20-39 years of age, who often combines several substances; illegal substances/medicines, sometimes in addition to alcohol. This driver has often been arrested for similar behaviour previously and will likely be detained again.

Currently statistics covering drug-related traffic accidents are not maintained in Norway. However, the Ministry of Transport and Communications has now taken initiative to provide the necessary clarifications for establishing and operating such a traffic accident registry (SRI).

Chapter 4. Social and Legal Correlates and Consequences

4.1 Social problems

Studies of Norwegian drug users show an extensive over-representation of different social problems. Many live under poor housing conditions, in environments with extensive crime, violence and prostitution. A study of users of 'the needle bus' in Oslo, for example, shows that more than 4/5 received economic assistance or social security, while only approximately 10% were in paid work. Over half of the women earned their income through prostitution (Bretteville-Jensen 2000). See also Chapter 16.

4.2. Drug offences and drug-related crime

Legislation

The Norwegian Civil Penal Code, paragraph 162 and the Act on Medicinal Products, paragraph 31, section 2 jf paragraph 24, section 1, regulate drug-related crimes. The penal code regulates the more serious crimes, while the latter act provides guidelines for punishing what are regarded as misdemeanours (see 1.2).

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

Table 5. Number of drug crimes reported and investigated

| | Civil Penal Code § 162 | | Act on Medicinal Products | | Total | |
|------|-------------------------------|---------------------|----------------------------------|---------------------|-----------------|---------------------|
| | Reported crimes* | Investigated crimes | Reported crimes | Investigated crimes | Reported crimes | Investigated crimes |
| 1985 | | 1 137 | | 3 666 | | 4 803 |
| 1986 | | 1 794 | | 2 789 | | 4 583 |
| 1987 | | 2 364 | | 2 244 | | 4 608 |
| 1988 | | 3 624 | | 2 605 | | 6 229 |
| 1989 | | 4 266 | | 3 837 | | 8 103 |
| 1990 | | 4 697 | | 4 394 | | 9 091 |
| 1991 | 7 377 | 5 328 | 5 711 | 4 621 | 13 088 | 9 949 |
| 1992 | 7 692 | 6 250 | 6 328 | 5 059 | 14 020 | 11 309 |
| 1993 | 7 640 | 6 458 | 6 432 | 5 281 | 14 072 | 11 739 |
| 1994 | 8 005 | 6 458 | 6 759 | 5 384 | 14 764 | 11 842 |
| 1995 | 11 911 | 8 044 | 11 420 | 7 629 | 23 331 | 15 673 |
| 1996 | 13 669 | 10 310 | 13 786 | 10 442 | 27 455 | 20 752 |
| 1997 | 16 169 | 11 639 | 18 376 | 12 360 | 34 545 | 23 999 |
| 1998 | 17 276 | 13 809 | 21 498 | 16 489 | 38 774 | 30 298 |
| 1999 | 17 820 | 16 041 | 23 167 | 20 135 | 40 987 | 36 176 |
| 2000 | 19 302 | 16 718 | 24 726 | 21 574 | 44 028 | 38 292 |
| 2001 | 21 411 | | 27 548 | | 48 959 | |

Source: Crime Statistics, Statistics Norway (SSB)

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

Crime statistics reveal a clear rise in drug-related criminality. During the period 1991 to 2001 the number of crimes against the medicinal act has increased by nearly five times. The number of arrests for breaches of paragraph 162 of the penal code, which regulates more serious drug crimes, has nearly tripled for the same period. Compared with other types of crime forms, the statistics covering drug-related crime clearly reveal the sharpest increase.

During the 1990s the number of investigated cases and number of convictions doubled. In 1996, 20 752 cases were investigated compared with 38 292 in 2000 (table 5). The number of persons involved in drug-related crimes has quadrupled, from 4 455 to 9 190 for the same period (table 6). Statistics on the number of convictions show a similarly sharp increase (standard table 11).

Table 6. Number of persons charged with drug crimes

| | Civil Penal Code, par. 162 | Act on Medicinal Products | Total |
|------|---------------------------------------|--|--------------|
| 1985 | 609 | 1 332 | 1 941 |
| 1986 | 825 | 1 150 | 1 975 |
| 1987 | 915 | 1 021 | 1 936 |
| 1988 | 1 260 | 1 064 | 2 324 |
| 1989 | 1 367 | 1 690 | 3 057 |
| 1990 | 1 511 | 1 821 | 3 332 |
| 1991 | 1 584 | 1 993 | 3 577 |
| 1992 | 1 974 | 1 929 | 3 903 |
| 1993 | 2 282 | 1 508 | 3 790 |
| 1994 | 2 143 | 1 303 | 3 446 |
| 1995 | 2 496 | 1 442 | 3 938 |
| 1996 | 2 878 | 1 577 | 4 455 |
| 1997 | 3 424 | 1 764 | 5 188 |
| 1998 | 4 056 | 2 430 | 6 486 |
| 1999 | 4 891 | 3 111 | 8 002 |
| 2000 | 5 539 | 3 651 | 9 190 |

Source: Crime statistics, Statistics Norway

4.3 Social and economic costs of drug consumption

The issue is partly covered in chapter 14.

Chapter 5. Drug Market

5.1 Availability and Supply

Different data sources indicate that there has been an increase in availability during 2001. This is true for the entire country and is reflected in the seizures made by the police and customs authorities, the drop in prices for different substances, and surveys that seek to describe the public's views on availability.

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

Both the frequency of seizures and the increasing mortality rate indicate that use and abuse of most illegal drugs have become more common throughout the country. Although cannabis has been confiscated for a number of years in all of the 54 police districts around the country, other substances are now found in an increasing number of districts.

The growing mortality rate confirms, for example, that heroin is becoming increasingly abused throughout the country. While drug-related deaths were reported in 16 of the country's 54 police districts in 1989, this number had risen to 41 in 2001.

The increase in availability of different substances is also evident from surveys. The yearly survey of young people aged 15-20 shows, for example, that there has been an increase in the proportion of those who report that they have been offered cannabis on occasion from approximately 25 per cent during the first half of the 1990s, to about 40 per cent in recent years. Similarly, the proportion who report that they would be able to obtain cannabis within 2-3 days has increased from about 55 per cent to 70 per cent. The ESPAD survey similarly indicates an increase from about 25 per cent in 1995 who reported that it was rather easy or very easy to obtain cannabis to 38 per cent in 1999.

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

5.2 Seizures

Kripos registers drug seizures made by the police and customs authorities (standardtab.13). In this way double-registration is avoided in cases in which both the customs authority and the police are involved. The number of seizures is defined based on the number of times a substance is identified and is quantified according to the type of substance, the time of seizure and how it was carried out. In other words, multiple seizures are registered for the same case if different types of substances are confiscated. The same holds true if the seizure is conducted at different locations or at different points in time. The data for the statistics is based on information provided by both the police districts upon requisition of analysis or upon destruction (exhibits) and verification of analysis results.

Major findings

The quantity of incoming cases in 2001 shows once again a rather sharp increase in the number of seizures (table 7). In 2001 it was as many as 21 577 seizures covering 11 255 analyses and 10 322 destruction cases (exhibits). Together this accounts for an increase of 20.7%. Only once before has such a relative increase in incoming cases been greater (1994-1995).

Table 7. Number of seizures 1999-2001 by most common substance

| Substance | 1999 | 2000 | 2001 |
|-----------------|-------|-------|--------|
| Cannabis | 8 485 | 9 224 | 10 254 |
| Amphetamine | 3 089 | 3 077 | 4 214 |
| Methamphetamine | 47 | 152 | 337 |
| Heroin | 2 378 | 2 314 | 2 499 |
| Benzodiazepines | 3 469 | 4 265 | 6 005 |
| Pain killers | 930 | 845 | 1009 |
| Doping | 398 | 469 | 559 |
| Cocaine | 309 | 390 | 477 |
| Ecstasy | 502 | 783 | 829 |
| Khat | 296 | 255 | 198 |
| LSD | 59 | 87 | 52 |
| GHB | 48 | 83 | 82 |
| Opium | 10 | 19 | 24 |

Source: Kripas

The Oslo police district dominates the seizure statistics, but depending upon which control point one considers, Oslo's share of seizures shows a downward trend for most substances. Such relative figures can be interpreted in several ways, but in any case show that most substances are more often seized outside of Oslo police district than earlier.

Table 8. Number of police districts that have seized different drugs (of 54 districts until 2001 and then number reduced to 27).

| | 1989 | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001* |
|--------------|------|------|------|------|------|------|------|------|-------|
| Heroin | 19 | 39 | 41 | 43 | 48 | 46 | 52 | 50 | 27 |
| Amphetamines | 39 | 45 | 52 | 49 | 53 | 52 | 54 | 54 | 27 |
| Cannabis | 53 | 54 | 54 | 54 | 54 | 54 | 54 | 54 | 27 |
| Ecstasy | - | 7 | 27 | 26 | 26 | 26 | 38 | 47 | 27 |
| LSD | 3 | 4 | 12 | 15 | 22 | 17 | 21 | 24 | 13 |
| Cocaine | 9 | 11 | 14 | 16 | 17 | 33 | 33 | 35 | 26 |

Source: Kripas

*new division of 27 police districts

Important trends for 2001

One sees an increasing tendency for heroin in both Oslo police district and across the country more generally. The total volume of heroin seized amounted to 67.8 kg. Only one

year earlier a greater quantity (in 1996 with 74.1 kg) was seized. The large quantity is primarily due to the fact that a seizure was made in Oslo of 34.9 kg, which is the largest individual seizure ever made.

The quantity of cocaine seized was 20.7 kg, accumulated from 477 individual seizures. The number of seizures continues to rise, but not as sharply as was registered over the previous years.

Seizures of amphetamine and methamphetamine amounted respectively to 92.8 and 14.5 kg confiscated in 4 214 and 337 individual seizures. For amphetamine this is the same quantity as last year, but for meta-amphetamine the quantity is substantially greater than the year before. The accumulated volume for these very similar substances (107.3 kg) is the next largest of all time.

Both the number of seizures and the quantity confiscated continue to rise for ecstasy, but the rise is not as sharp as for the period 1998-2000. Altogether 61 575 tablets from 829 individual seizures have been confiscated. MDMA dominates the total quantity confiscated, but other, more rare, hallucinogenic substances such as PMA and PMMA, which are regarded as more toxic than ecstasy, have also been detected.

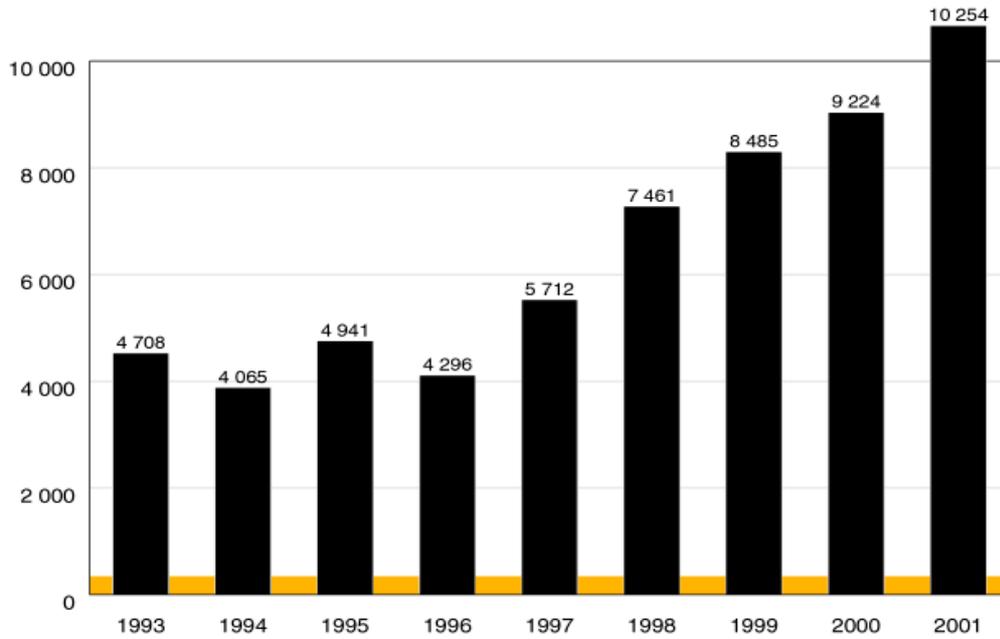
In 2001 there has also been a record high level of benzodiazepines (anxiety suppressants and sleeping medication such as Valium and Rohypnol). Benzodiazepines are the category of substances that have most increased with respect to volume and number of seizures. The number of seizures has increased by nearly 41% in one year.

Cannabis

The quantity of cannabis confiscated – 861 kg – was at about the same level as the last half of the 1990s. This amounts to about 0.8-1.6 million doses. The largest seizure took place during the latter half of 2001 and involved about 600 kg. The number of seizures has likely increased considerably, to 10 254, and it is worth noting that a quadrupling has taken place over five years. Cannabis seizures included 808 kg of hash, 35 kg marihuana, 17 kg cannabis plants and 9.3 g cannabis extract. Hash accounted for over 87% of the quantity confiscated.

Figure 10

Cannabis. Number of seizures 1993 - 2001



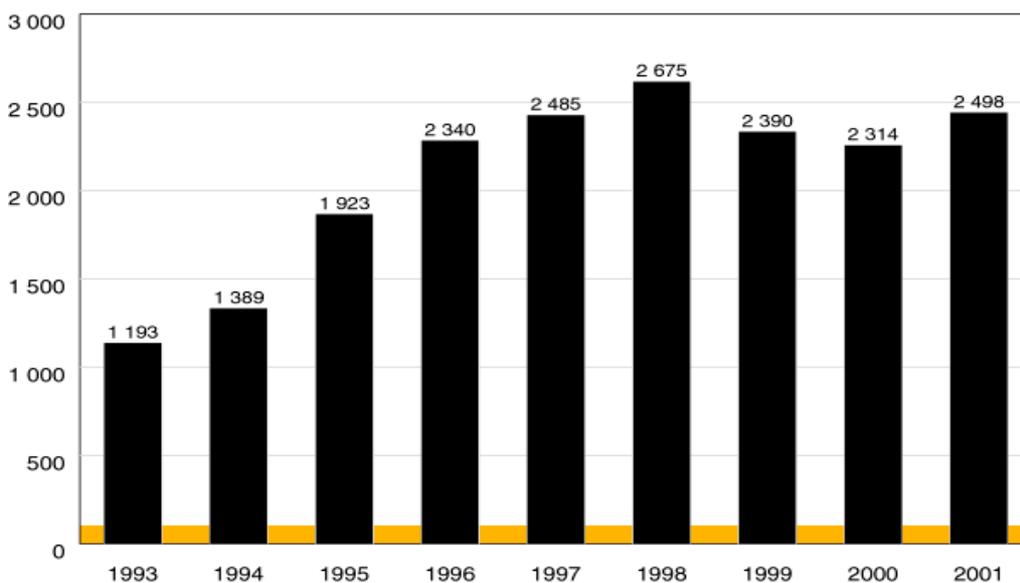
Source:Kripos

Heroin

In 2001, 67.8 kg of substances containing heroin were confiscated. This amounts to about 1-2 million injection doses. Only one time earlier has such a large volume of heroin been confiscated. The large volume is due primarily to a seizure of 34.9 kg that was made in Oslo. This is undeniably the largest heroin seizure that has ever been made in Norway. Four cases are registered where the substance was more than 1 kg.

The number of heroin seizures in Oslo is estimated to be 40% in relation to the rest of the country, and this is somewhat lower than in 2000. It is worth noting that since 1994 this relative figure has dropped from 75%. Of the 67.8 kg of heroin-based mixture that was confiscated, heroin chloride-based mixture (white heroin) amounted to 8.7 kg, obtained through 16 seizures.

Figure 11. Heroin. Number of seizures 1993 - 2001



Source:Kripos

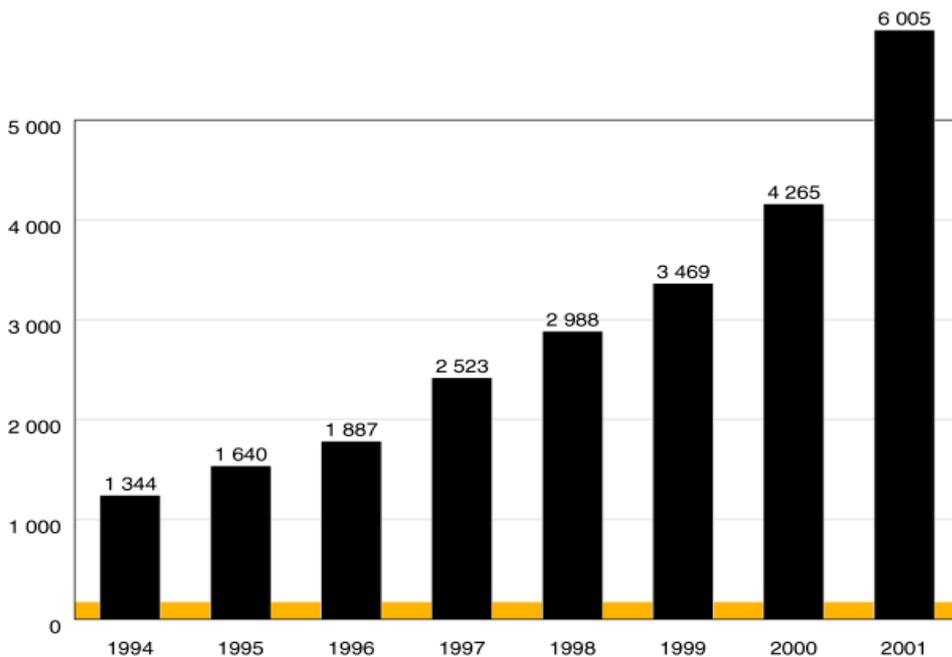
Other opiates

Both the volume and amount confiscated has risen in 2001. Altogether 18 800 different tablets were seized through 1 009 seizures. As before, buprenorphin (Temgesic) and kode-based preparations (e.g. Paralgin) were dominant.

Benzodiazepines

In 2001 large quantities of benzodiazepines were confiscated. Altogether over 847 000 tablets via 6 000 seizures were confiscated. This amounts to about 150 000-250 000 doses. This quantity includes seizures of 320 g pure diazepam, which equals about 64 000 valium 5 mg. Both the number of seizures and the quantity confiscated have doubled many times over in only a few years. Benzodiazepines are quite often registered together with heroin in one and the same case. The quantity confiscated is from 259 000 diazepam-based tablets and 538 000 flunitrazepam-based tablets. Something new last year was the very large, illegal import of Rohypnol (2 mg), a medicine that is being phased out of the legal, European market. The 2 mg variety has been removed from registries in Norway for the last 20 years. New for 2001 was the pure diazepam, which is sent and cut as either a crystalline powder or packed in gelatine capsules.

Figure 12. Benzodiazepines. Number of seizures 1994- 2001

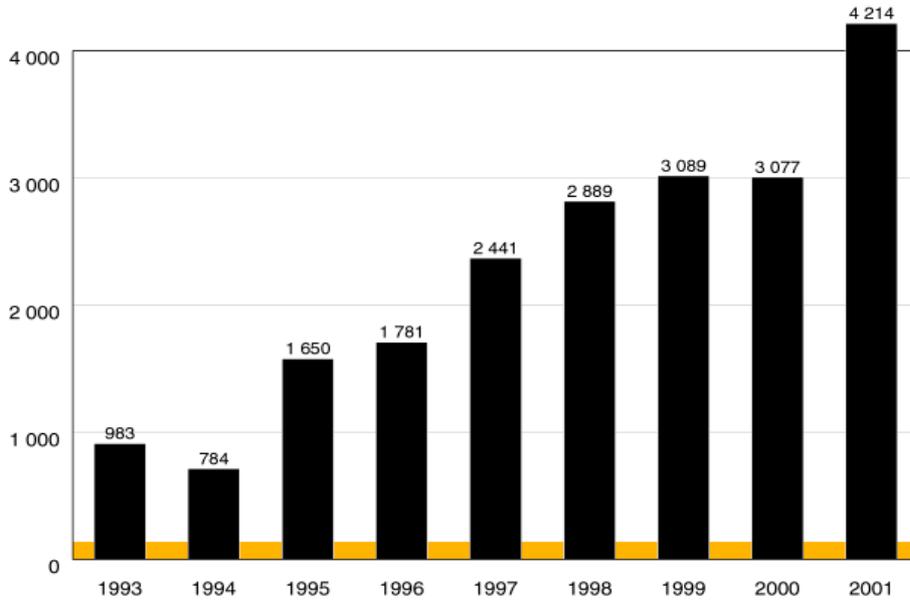


Source:Kripos

Amphetamines

During 2001 Kripos has registered 92.8 kg of amphetamine containing mixtures in 4 214 seizures. This marks an increase in the number of seizures over 1 200 since 2000. Together the quantity of amphetamine/methamphetamine confiscated is approximately 350 000 – 1 million doses. The quantity of substance confiscated is the second highest of all time. In contrast to previous years, the biggest seizures have not taken place, but rather a number of medium-sized seizures has taken place. Altogether 11 cases involving more than 1 kg each were registered.

Figure 13 Amphetamines. Number of seizures 1994- 2001



Source:Kripos

Methamphetamine

Methamphetamine have been detected every year for more than 30 years now, and in some years during the 1970s they accounted for a considerable portion of amphetamines that were confiscated. From the mid- 1990s methamphetamine have once again been on the rise, and currently amount to 8% of the seizures for amphetamines.

Cocaine

In 477 seizures, 20.7 kg of cocaine was confiscated, indicating a noticeable increase. Especially large seizures have not been made if one compares with those that took place in 1998 and 1999.

LSD

Based on the available data, LSD traffic appears to be dropping off and is entirely marginal in comparison with ecstasy. Altogether 417 doses from 52 seizures were attained. It is difficult to provide a good explanation for why LSD has such a small market share in relation to ecstasy. However, it is possible that this is related to the availability of the necessary chemicals for its production, but one cannot discount the users' preferences either.

Ecstasy

Altogether 61 205 tablets and 111 g of ecstasy-based powder from 829 seizures was confiscated. This is a clear increase over previous years, especially with respect to the volume seized. Compared with the seizures made in many districts, there is reason to suggest that ecstasy is still on the rise. This year more districts have witnessed a more than doubling in the number of seizures, and individual seizures are quite large.

Generally Kripos receives new types of tablets each week, for a total of 62 new ones in 2001. This is approximately the same situation as was registered earlier. Although they vary in appearance, the dominant active agent in the cases is MDMA with a share of about 98%. The remaining 2% involves other ecstasy substances, MDA and MDEA, as well as other

hallucinogenic substances like 2-CB, PMA, PMMA, ketamin and 2-C-T-7, or substances like amphetamine or methamphetamine.

Of course ecstasy tablets are not subject to quality control as would be commercial medication, and a declaration of contents is non-existent with the distribution of such tablets. Nonetheless, over the last 14 years the market has been characterised by few deviations from tablets containing 70-120 mg of active agent, with 100 mg MDMA as a type of norm. The laboratory at Kripos has not been able to detect opiates in any of the tablets seized.

Other hallucinogenic substances

Ketamin

Although ketamin is not classified as a narcotic substance, it often receives attention. Altogether 6.3 g of powder and 82 tablets from 17 seizures were confiscated. The figures are modest but show an increase over previous years.

Other substances

GHB

GHB was classified as a narcotic drug in Norway in July 2000. One of the raw materials used in the production of GHB, gammahydroksilakton (GHL) was classified as medication in January 2001. In 2001 82 seizures were made of GHB (2000: 83; 1999: 35; 1998: 2). The number is small in relation to other established drugs (0.3%), and the size of individual seizures varies from a few ml to several litres. The substance is easily produced, and the raw materials, which are not heavily controlled, can also be used as an intoxicant.

Price, purity

The prices of different narcotic substances are attained from information from the drug section of the Oslo Police Force (standard table16). The price per gram is calculated in relation to the user dosage. Prices for the different substances vary in accordance with the size of the quantity purchased, such that the price per gram will be cheaper for one gram than for one dosage. The price of cannabis has been stable over a five year period, while there has been a noticeable price drop for amphetamines, heroin, LSD, cocaine and ecstasy. The price fall for heroin had begun already during the 1990s and has continued to show a steady decline. While the price per gram for purchasing a user dose was approximately EURO 800 in 1996, this costs approximately EURO 250 today (Oslo police department) (standard table 15).

Table 9. Some drug prices in Oslo (January 2002). In EURO. Conversion rate 1 EURO= NOK 7.50

| Substance | User dosage | 1 gram | 10 grams | 1 kilo |
|--------------|------------------|------------------|--------------------|----------------|
| Heroin | 47-53 | 197-200 | 800 -1 333 . | 33 333 -53 333 |
| Hash | 13 | - | 87-107 | 4 000-6 667 |
| Amphetamines | 27 | 27-53 | 267-400 | +/-13 333 |
| Ecstasy | 13-27 per tablet | 13-20 per tablet | 10,5-13 per tablet | |

Source: Oslo Police District

The price list is based on information from users and sellers at different levels, as well as information received from civil servants working in the narcotics section. Prices can vary widely in some cases, due to quality, contacts and quantity.

Price developments are also followed in a study in Oslo on the price elasticity of narcotic substances. A price elasticity indicates how much the consumption of a product will vary as a result of a price increase for that product. Many people have claimed that those addicted to narcotics, particularly substances like heroin and amphetamines, will not be sensitive to changes in price. It has been argued that addiction leads the addict to use approximately the same amount of drug almost regardless of the price of the drug he or she uses. The results of the data gathered from intravenous drug users in Oslo indicate, however, that this is not correct. According to the study, both heroin and amphetamine addicts will adjust their use significantly in the event that the price of the substance changes, and heroin addicts appear to be more price sensitive than amphetamine addicts (Bretteville-Jensen and Biørn 2002). The material also suggests that women are more price sensitive than men (Bretteville-Jensen 1999). The data confirms that the large price reduction for heroin and amphetamines has led to an increase in consumption among intravenous drug users.

Information on the purity of different substances is derived from Kripos, which conducts a limited number of chemical analyses of confiscated narcotics. For example, it is not common to analyse the THC content in cannabis. With respect to brown heroin, the purity level in 2001 is estimated to be 48%, while the average purity level for cocaine was approximately 40%. The content of cocaine that was confiscated in powder form in 2001 was on average far lower than has traditionally been registered over several decades. Earlier the strength of cocaine was often over 80%, while today this appears to have dropped to only half this.

The average purity level of amphetamines (seizures over 15 g) has been estimated to be approximately 52%. There is no information available from Kripos on the purity of other narcotic substances.

Chapter 6. Trends per Drug

Cannabis

There has been an increase in the use of cannabis during the 1990s. This is apparent, among other means, through surveys and analyses of blood tests from drivers suspected of driving under the influence. Similarly, the number of seizures has increased, particularly over the last four years. At the same time, the price of cannabis has remained relatively stable. That cannabis has become more available in Norway is also illustrated through data from surveys showing that a larger proportion of the population reports that they are offered cannabis or that they are able to obtain it should they wish to. Surveys also show that opinions on cannabis have become more liberal.

Synthetic drugs

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

Heroin/opiates

Estimates of the number of intravenous drug users indicate a doubling during the 1990s, from 4-5 000 to 10500 - 14 000. A majority of these users injects heroin. Similarly, a dramatic increase in the number of drug-related deaths has also taken place and an increase in the number of seizures. In other words, all available data sources indicate that Norway is facing a serious expansion of heroin abuse.

Cocaine/crack

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

Multiple use

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

Chapter 7. Discussion

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

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

7.1 Consistency between indicators

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

7.2 Methodological limitations and data quality

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

The data on prevalence of drug use may also be somewhat unreliable. For example, a low response rate for the annual youth surveys makes them non-representative. The illegal nature of the different substances might also contribute to a statistical underreporting. Moreover, young respondents might have fewer qualms about providing information about their drug use than older respondents, thereby contributing to a greater coverage rate for younger than older respondents.

Estimates on the number of intravenous drug users have been calculated using a multiplication method based on a registry of the number of drug-related deaths. This method takes its point of departure from the relationship between the number of drug-related deaths and the number of abusers. Here a source of bias could be that the figures for drug-related fatalities are not as reliable as they are assumed to be. Among other methods, the estimates

are calculated using the deaths registered by Kripos. However, a scientific evaluation of these showed that they are relatively reliable (Bretteville-Jensen and Ødegård 1999). Nonetheless one can sometimes question on what grounds the police register a death as drug-related. Some of the cases might have been mistakenly defined as drug-related since the person was a drug user even though the individual died of other causes. In the future, additional methods should be developed in order to better estimate the number of problem drug users.

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

Seizures of drugs, both their number and volume confiscated vary according to the priorities and efforts of the police and customs authorities. Among other things, the amount seized says very little about the actual volume of substances that are on the market and illegally used. The number of seizures can also be influenced by legislative changes.

The Oslo police force reports information on the price of illegal drugs. The data is therefore limited to the situation in Oslo. The police register the average price based on information attained from a relatively random sample of drug dealers, users and others in Oslo. That is, the prices are not based on a representative sample.

PART III – DEMAND REDUCTION INTERVENTIONS

Chapter 8. Strategies in Demand Reduction at National Level

8.1 Major strategies and activities

In Norway few distinctions are made between alcohol, medications and drugs within the prevention and treatment field. This is reflected in the action plans and strategies over the last 15-20 years and in the implementation of prevention measures as well as treatment. In chapter 1.1 the main principles behind drug policy, its organisation and strategies at national level are described.

8.2 Approaches and new developments

The Government's Action plan against alcohol and drug problems (2003-2005)

The new action plan was launched in October this year. To reduce the demand for alcohol and drugs and the damages resulting from these the Government through its action plan will:

- Emphasise in particular measures that address the greatest needs and most dire situations, and areas where measures are documented to have the best effect.
- Prioritise solutions that address youth, especially children and youth at risk, including children of drug abusers, and the most problematic abusers. The Government will ensure a low threshold for receiving assistance, while the threshold for losing assistance will be high.
- Ensure that in the field of alcohol and drug prevention, parents, local neighbourhoods, voluntary organisations, municipalities, counties and state entities constitute a chain of measures that compliment one another. This chain of measures shall be dynamic; that is, in the event that a problem cannot be resolved by one link, it should be possible to receive assistance from the next link. It will be important to raise consciousness and strengthen competency among those who directly or indirectly work with alcohol and drug-related problems, particularly at local and regional levels.
- Emphasise that alcohol and drug-related work is to be well organised at all levels, and that the instruments used are to be knowledge-based and contribute to achieving goals in a cost effective way. It will be important to ensure that all measures that are carried out in the field by the public sector or with public funding and approval, meet qualitative criteria.
- Ensure that measures are evaluated. Such an evaluation must discern the effects both in the short term and over the long run. Evaluation should be based on clear, universal criteria, including a common understanding of what constitutes good prevention and successful treatment.
- Establish a system for follow-up whereby new and existing measures are structured in relationship to the new goals and infrastructure of instruments.
- Appoint two expert advisory committees for prevention and treatment (including harm reduction) respectively. It is important that close family /other caregivers and former drug abusers participate with their experience-based knowledge in these committees. The committees are to provide the Government with ongoing advice about concrete drug policy challenges, evaluation measures, as well as propose new ones and stimulate the development of more knowledge.

Chapter 9. Prevention

The Ministry of Social Affairs has overriding responsibility for drug policy issues, including prevention measures, while the Directorate for Health and Social Affairs is responsible for co-ordinating the implementation of national prevention strategies and programmes. Prevention of drug abuse is otherwise the responsibility of the municipalities as described in the social services law. Municipal social services are to work to prevent and deter abuse of alcohol and other drugs through information and outreach programmes and spread information on the harm related to use. Drug prevention work emphasises local measures, focusing on the interplay between home life, school, the social and health sectors and extra curricular and cultural sectors. Voluntary organisations operating in the alcohol and drug field play an essential role in prevention work.

The seven regional competency centres perform the important task of co-operating with municipalities to develop competency, methods and programmes for prevention. Each competency centre is charged with one or several speciality areas. An overview of the competency centres and their speciality areas is as follows:

Region Nord (Northern Norway)

Counties: Nordland, Troms og Finnmark

Nordland's Clinic – www.nordlandsklinikken.no

Speciality area: Group therapy

Region Midt-Norge (Central Norway)

Counties: Nord- og Sør-Trøndelag, Møre og Romsdal

Midt-Norsk competency centre for alcohol and drugs – www.mnk-rus.no

Speciality area: Youth and drug use, young drug addicts

Region Vest (Western Norway)

Counties: Sogn og fjordane, Hordaland og Rogaland

Region vest has two competency departments

Rogaland A-centre - no independent web.side

Specialty areas: Families and school-aged children, alcohol and drugs in the workplace

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

Speciality area: Women and addiction, female drug addicts

Region Øst (Eastern Norway)

Counties: Oppland, Hedemark, Akershus og Østfold

Sanderud Hospital, Drug addiction ward – www.sanderud-sykehus.no

Speciality area: double diagnoses – psychiatry and drugs, gambling addiction

Region Oslo. Alcohol and drug addiction service- Municipality of Oslo

www.rusmiddeletaten.oslo.kommune.no

Speciality area: new use trends among youth

Region Sør (Southern Norway)

Counties: Aust- og Vest-Agder, Telemark, Buskerud og Vestfold

Borgestad Clinic – www.borgestadklinikken.no

Speciality area: pregnant addicts and addicts with small children

Documentation

An Internet site <http://www.forebygging.no> was established in 2000, and was developed through broad-based co-operation among professionals in Norway. The competency centre at Nordland's Clinic has operational and editorial responsibility, while SIRUS acts as the sponsor and provides financing.

The overarching objective for [forebygging.no](http://www.forebygging.no) ([prevention.no](http://www.prevention.no)) is to be a *central interactive arena and portal* for all prevention and health promotion work in Norway by acting as a "glue" between research and practice, among other means by:

- establishing, developing and assuring the quality of a national reference area for alcohol and drug prevention work;
- providing users with theoretical and research-based knowledge and practical skills;
- inspiring and improving prevention workers by offering them an alternative network and exchange of experience;
- making visible good examples and effective strategies.

The main target groups are practitioners within local prevention work, for example health care/social workers and educators.

The net service contains both a knowledge bank and interactive services. The knowledge bank contains more than 4 000 topics, and more than 100 professionals have contributed texts and information. In addition to published documents users also have access to approximately 70 hours of video. The videos contain everything from interview sequences with youth who use ecstasy and cannabis to lectures and introductions to concrete action programmes. The videos are suitable for Internet (Nordlandsklinikken).

SIRUS established a working group in 2002 whose objective is to establish a *national documentation system for the prevention field*. The working group includes representatives from the net site www.forebygging.no, the regional competency centres, the Directorate for Health and Social Affairs and SIRUS. Primarily work is concentrated on registering drug prevention projects and measures that make use of professional and/or economic support from the public sector in "forebygging.no's" projects and projects database. The database will be an important means of making visible and spreading knowledge about projects and programmes with a documented effect, and motivating co-operation and co-ordination of information. Eventually it will also be used to promote evaluative activity. Moreover, the database will be able to contribute to identifying Norwegian projects for the EMCDDA database for prevention and treatment programmes – EDDRA.

A Norwegian version of EMCDDA's "Guidelines for the evaluation of drug prevention: A manual for programme-planners and evaluators" is currently being prepared by SIRUS. An adapted version of "Guidelines" will be helpful for planning and preparing for prevention projects and programmes in Norway, such that these can be evaluated and compared with other projects nationally and internationally to the greatest extent possible.

9.1. School programmes

Schools play a central role in prevention work. Alcohol and drug prevention education is founded on a curriculum and is to be integrated with regular education. The goal is to conduct active prevention work in elementary and secondary education in order to counteract use and abuse of alcohol and drugs. A school's chances of succeeding with this are dependent upon the interplay between students and parents, and co-operation with the local community and municipal services.

There are no established public authorisation processes for prevention programmes that are used in schools.

Schools have long been a popular arena for different private actors wishing to market their own models and approaches. Several programmes are imported, especially from the USA, and have been tailored to Norwegian conditions with varying degrees of success. Only a small number of such programmes are scientifically evaluated and the results are not always convincing when a programme is selected for use in schools. Rather frightening lectures by former abusers and short campaigns against drugs exist together with thematically balanced approaches with a long-term perspective. Peer programmes appear to be increasingly popular.

An example of a more recent programme is the parent programme, "Youth and hash". The primary aim is to give young people the strength to say no to hash and equip parents with the tools necessary to raise the topic with their children. The programme consists of a parent folder, teacher guidelines with transparencies and student workbooks. The teacher's programme for the eighth grade "Youth and alcohol", emphasising work with cohort groups, is presented on the Internet (www.rusdir.no) (Directorate for Health and Social Affairs).

The police and local authorities organise prevention work in schools among other means by offering a two-hour educational programme for different grades in elementary schools. To these means, the Ministry of Justice has developed course material, titled "The police binder"), consisting of three educational packets for the different grade levels with information and materials on work by the police in this area. The educational packet functions as a guide for the local authorities on how to conduct prevention work in schools.

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

The Alcohol and Drug Addiction Service (competency centre) in Oslo has created a video-based parent/class programme about hash and teenagers, and parenting. The programme is now in use in Oslo schools, but has also received attention outside of Oslo.

Work has been initiated that is aimed at secondary schools in Oslo. Its goal is that all schools will create constructive action plans for drug prevention work, thereby preparing them to handle worrisome use of drugs by students. The plans will be followed up to assure quality.

Three examples from the programmes developed by foundations and voluntary organisations are (Note: none of these are specifically directed at illicit drugs):

Lions Quest has supported schools for many years with the educational programme, "It's my choice" for grades 1-9. A programme for secondary level was also made available Fall 2000. The programme is based on a humanistic pedagogic approach and focuses on developing social competence. Teacher training is an important element. More than 18 000 educators in Norway are schooled in the curriculum. Materials have also been developed for teacher meetings and a separate book for parents: "The critical years". Currently a 3-year evaluative study is being conducted with intervention and control schools in order to more closely examine the results.

For many years now the youth organisation *Juvente* has run a programme called "Free style", "Action against drugs", whereby nearly 1 000 students in the ninth grade receive

education for four days and thereafter create activities for their classmates. The programme is evaluated. *Juvente's* musical theatre group "Kolon", which is aimed at high school level students, reaches a yearly audience of nearly 40 000 students.

MOT (in English: *courage, have guts*) is a foundation established by professional athletes. Their work involves opinion- building work in schools. MOT-ambassadors visit schools to reduce harassment, violence and use of drugs and create a more inclusive environment. Some school-related programmes are presented in Chapter 9.4.

Evaluation of school programmes

There are few evaluative studies of prevention-oriented school programmes on drugs. One professional group assembled by the Ministry of Education and Research and the Ministry of Children and Family Affairs created a report in 2001: "Evaluation of a programme and measures to reduce problematic behaviour and different social competencies". 56 different programmes were evaluated but only 9 programmes were recommended for use in the school system. None of these was specifically related to drugs. Only one programme – Dan Olweus's programme against harassment – was recommended in its entirety. The other 8 programmes that were recommended but were in need of evaluation and/or further development are: *Alternative schools, It's my choice (Lions Quest), You and I and We make Two, Creative Problem Solving in Schools, Harassment (Center for Behavioural Research), Problematic behaviour – is it a problem?, School negotiating* and *Step by Step*. The report can be read at <http://skolenettet.is.no/sosial-kompetanse>.

9.2 Youth programmes outside school

Outreach work among children and youth by the public sector was established in Norway during the late 1960s. Outreach entities are established in a number of municipalities, and as of today there are 63 such entities. On average, each entity has 2-3 employees, although the outreach centre in Oslo is the largest with 25 employees, all with professional backgrounds. Activities cover different prevention measures directed at older children, youth, including contact with and providing assistance with treatment for young people who have developed drug abuse problems (standard table 21).

The project, "Stop the dope not the dancing" was initiated in Oslo in 1995 in cooperation with the Outreach in Oslo and young people from the house environment to run an information campaign on drugs in house and party milieus. The project has changed its name to "*Future*" and is found in four larger townships, Bergen, Trondheim, Tønsberg and Oslo, and is linked to the outreach services (standard table 21).

Clubs with extra curricular activities for children and youth are found in many municipalities. Most are municipally financed, but in some cases they are run in co-operation with voluntary organisations.

A number of political organisations operating in the drug field run their own programmes and organise campaigns for youth with support from the Directorate for Health and Social Affairs.

9.3 Family and childhood

The competency centre for drug-related issues in the Health region South, Borgestad Clinic, has national responsibility for the special competence area, "Pregnant drug abusers and families with children". The centre works to develop and implement educational programmes.

The Borgestad Clinic, together with external resources, has created an educational campaign whose target group consists of employees from the municipal health clinics. The programme focuses on drug work in the health clinic with special emphasis on increasing the employee's competence in handling issues.

Different voluntary organisations have also become engaged in the problems surrounding use of drugs during pregnancy and parents' relationship to drugs. Among others, the Blue Cross has developed a programme called "*Children in the danger zone*", which aims to educate the network surrounding children to recognise, understand and act when children suffer due to their parents' neglect. The programme provides different services for local health clinics, childcare centres, elementary and middle schools as well as co-operation across services. The message is directed to adults, but is about children.

Parents Against Drug Abuse is an organisation for close family. The objective is to provide the families of drug users help and self-help and to assist the abuser in transitioning back into society. The organisation has 50 local county branches. Courses, seminars, evening meetings and support networks and a hotline are arranged.

9.4 Other programmes

Society-based measures/programmes

There are various locally based programmes and projects in Norway. Three more recent examples of projects developed by the Bergen Clinics Foundation are:

- 'Alcohol and drug related work in the municipalities' – a model for developing competency and common efforts in the prevention field.

As a competency centre, the Bergen Clinics Foundation is responsible for contributing to the development of competency in the public and private sectors and has prioritised developing co-operation between professional entities and different professionals in the local community. Efforts include both prevention work as well as work aimed at drug abusers. Mobilisation and an exchange of experience between different professions is used as a tool for developing competency, as well as for fostering alternative solutions for handling problems and initiating different types of drug prevention work. The model includes mapping out, organising, and identifying goals and priorities as well as raising levels of competency.

- "Time breaker" – a basic education for parents.

The idea behind "Time breaker" is to educate parents so that they are able to play an active role in communicating a prevention message. The programme uses the folder 'Right around the corner' – a debate folder on intoxication and sobriety for adults responsible for children between the ages of 6-12 years old. Parents communicate the information to other parents/adults. By encouraging parents to become so-called "Time breakers" in their own neighbourhoods, the programme ensures a local anchoring and contributes to a greater degree of similarity between parents and representatives from various educational entities who co-operate to develop the themes in the folder. The objective of this elementary course is that "Time breakers" will become an independent prevention force in each municipality/district over time.

- "Local guide" - a handbook for school staff who encounter students with drug problems.

When drug problems arise, schools and their staff encounter an enormous array of potential solutions. The handbook is an attempt to provide an overview of reasonable actions that can be taken. The goal is that the school will have one person who is familiar with its contents – a local "guide" - who will develop their own competency in the area while also educating others on drug prevention. Additionally, the school should have in place a structure that increases the likelihood that students contact this person themselves; that the school should be safe, certain and goal driven in its work with a student who abuses drugs.

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

Alcohol and drug prevention programmes in the workplace

The Norwegian Tripartite Committee for the Prevention of Alcohol and Drug Problems in the Workplace (AKAN) is a cooperative effort between employees, employers and the state. The goal is to prevent alcohol and drug problems in Norwegian workplaces as well as helping employees with drug abuse problems to find help. AKAN's work is conducted according to an independent charter based on the specific conditions the tripartite cooperation creates. AKAN provides consultative services to Norwegian companies to help them develop a preventive alcohol and drug policy with clear rules and guidelines. Emphasis is given to the important role the company culture plays as well as the involvement of management as prerequisites for successful prevention. Additionally the company's AKAN-agreement provides guidelines for how to proceed in individual cases, for example by offering an individually tailored support programme for an employee with an alcohol and drug problem. The programme is to have a clear structure and can include both internal efforts by the company as well as external measures; for example, co-operation with a treatment institution.

AKAN has largely focused on alcohol abuse, but in recent years illicit drugs in the workplace have also entered into the picture, and in the fall of 2000, co-operation between the Norwegian Industrial Security Council, The Centre for Working Environment and AKAN was established. The course curriculum addresses: factual knowledge about narcotic substances, working environment issues, current statistics, AKAN's experiences with drug cases and projects directed at young employees, e.g. methods for preventing the development of a drug problem. The course has proven itself useful. There have been many participants, and a growing number of companies are making contact, requesting AKAN to hold a course within their company.

In 1998 AKAN initiated its own project to address workplaces with many young employees, aiming to develop and implement strategies for drug prevention work for this type of environment. The programme has proven to be very popular and in 2001 it went from a project offered for a limited time to a permanent service by the AKAN secretariat, with a dedicated consultant responsible for it. New for 2002 is a course on medicines and prescription drug dependencies. This is still being tried and will be under process evaluation. (<http://www.akan.no>).

Telephone help lines

For a number of years Parents Against Drug Abuse have run help lines for close family. These help lines are intended to lend support to those with children or other family members with drug problems.

There are no public help lines that are dedicated specifically to drug-related problems. The directorate for Health and Social Affairs has nonetheless begun working with developing a "concern line" on drug issues for youth and their close family. The experiences of other similar European help lines will be reviewed.

Campaigns

Responsibility for conducting national information and opinion-building campaigns lies with the Directorate for Health and Social Welfare. The directorate has not initiated any new campaigns for 2002.

Action week against drugs was arranged in October 2002 for the ninth year in a row, in cooperation with voluntary organisations, schools, after-school clubs, the police and media and companies. The motto for this year's campaign was: "Use your power". Conferences, meetings and local events were held across large parts of the country (<http://www.narkotikauka.org>).

Internet

There are a number of web sites that in different ways treat the theme of drugs. In recent years the Internet has become a medium for communicating drug prevention campaigns. One example is the latest campaign from the Norwegian Directorate for the Prevention of Alcohol and Drug Problems, "Only you can take care of your brain" (2001).

The Directorate for Health and Social Affairs, the drug prevention unit's homepage – <http://www.rusdir.no> - contains factual information about the different narcotic substances and information on previous national campaigns.

On the website of the Alcohol and Drug Addiction Service (Oslo municipality) <http://www.rusmiddeletaten.oslo.kommune.no> one can find information on, for example, publications and earlier campaigns.

On SIRUS' website (www.sirus.no) provides information on the institute's activities, research reports, alcohol and drug statistics, as well as information on research activity. The site also contains public statistics on alcohol and drugs and different surveys.

<http://www.bks.no> is an extensive net service for professionals and others who are interested in alcohol and drug related issues, with a news service and links to relevant libraries, organisations and professional entities both in Norway and internationally.

The net service <http://www.forebygging.no> is covered in chapter 9 *Documentation*.

Further education and training for professionals

There are 12 different training programmes within the drug field in Norway. All are college based, and most offer 20 credits (60 points). They aim to provide a general introduction to the drug field and therewith cover everything from early prevention to treatment and after care.

Three of the programmes should be regarded as specialised programmes. These are at the College in Narvik, which emphasises prevention. The target group is mainly teachers and employees who work with early prevention. The higher education centre Diakonhjemmet, in Oslo, offers a purely treatment-oriented programme where the target group is those who

work with second-line assistance. In addition, the College in Agder offers courses that deal directly with children's problems.

The remaining educational facilities are found at Colleges in Østfold, Stavanger, Bergen, Vestfold, Volda, Hedmark and Tromsø. The Diakonhjemmet Higher Education Centres also provides coursework in general studies, designed for employees within the health/social services, education and political professions. The programmes aim to provide a holistic understanding that considers background and upbringing, early prevention and intervention, which are considered in the context of any potential treatment and necessary follow-up.

All higher education facilities offer courses in after care work in their region. They also accept cases for evaluation, investigation and study. This makes them not only an important element in the provision of competency among professionals, but also an active participant in driving developments in the field. Education centres maintain close ties to the competency centres. The clinical experiences these centres provide are a necessary supplement to the more theory-and research-based approach of the education centres.

Chapter 10. Reduction of drug related harm

In Norway there has been a long tradition of initiating actions to improve the social situation and health condition of those who are sick, overcome by and dependent upon drugs. This tradition was earlier developed in the alcohol field, with the distribution of food, shelter and temporary housing. Detoxification stations for alcohol dependent persons were also developed in the same spirit during the early 1970s. As drug abusers grew older and put many unsuccessful treatment attempts behind them, it became obvious that similar measures should also be adopted in the drug field, or that there should be an attempt to integrate problems for alcohol- and drug addiction.

From the 1980s the situation deteriorated in the large cities, as the drug abuse population grew older and more forlorn. Some of this negative development is related to the spread of HIV and Hepatitis C, but also the general health condition of these individuals deteriorated. During the 1990s a sharp increase in overdose mortality was added to the picture. The help services increasingly observed sores, abscesses, poor dental hygiene and mental problems among drug abusers. At the same time it became obvious that the regular health care system was limited in its ability to take care of these problems. New recruitment to intravenous drug use increased during the 1990s, a condition that contributed to an increase in the demand for both treatment as well as care programmes and general health care. In order to improve the situation, emphasis has been given to developing a low threshold health assistance in recent years. The government has contributed funds to 14 municipalities, with the largest funding going to Oslo, the largest municipality.

10.1 Description of interventions

Low threshold housing services and day shelters

Most municipalities have institutes that emphasise independence training and care, and most also offer warming huts and limited services for the homeless during the daytime. Many of these operate quite well, but their capacity has not increased in step with demand. The result has been that municipalities increasingly 'quarantine' the homeless with drug problems in hospices and other large housing institutions where follow-up in relation to finding a permanent residence, work or education and network are overlooked.

Substitution Treatment

In contrast to other countries, Norway still provides a rather low coverage of methadone assisted treatment or rehabilitation. Oslo has had a limited trial programme since the beginning of the 1990s, but a national methadone programme was established in 1998 (see chapter 11.2). Methadone programmes, to some extent also including buprenorphin, have had a clear rehabilitation profile, but relatively strict follow-up and controls, together with an extensive rehabilitation effort. For many users this has led to a clear improvement in their ability to function and their quality of life. However, it has also been shown that many users do not manage to follow the programme as intended. A change in the methadone programme for this group has been a topic of discussion. This would take the form of fewer demands and less control, but this has not yet been decided.

Needle distribution programmes

Since 1988 Oslo has had a bus circulating the streets, providing clean needles and condoms at no charge. The bus now distributes 2 million needles annually. Other large municipalities also distribute needles, often as a combination of dispensers, outreach services, or from one or several low threshold points of contact, often in co-operation with the health services. This

service is first and foremost a disease prevention effort and has hopefully contributed to the low incidence of HIV among drug users in Norway. For Oslo's part, it has now been decided that the needle distribution programme will be moved to permanent facilities tied to a low threshold health service (standard table 10)

Low threshold health measures

Those who are heavily addicted to drugs often have extensive health problems of both a mental and somatic nature, but the regular health services has not managed to handle these problems. This is true of both general physicians and hospitals. In 1999 field nursing stations were established in the municipality of Oslo, which are tied to low threshold day shelters and institutions at 6 locations in the city. These are a street level polyclinic health service. The intention is to provide a health service for somatic problems and channel users into the established health and social services. The programme is non-bureaucratic and free to the user. Those who wish to visit these health clinics can do so anonymously without an appointment, regardless of whether one is on drugs at the time or not. The Nursing stations in Oslo now have about 2000 clients. Similar programmes in different forms have also emerged other places in Norway, for example the Strax-house in Bergen and the Social medical centre in Tromsø.

In Oslo the Field Nursing Stations have also had ties to the needle buses the last four years, run vaccination campaigns against hepatitis, and also introduced a successful x-ray programme.

A separate nutrition project is also being run at a rehabilitation centre in Oslo for women with drug problems. It became known that the women suffered poor nutrition or were malnourished. Greater emphasis upon routine meals has proven to have a positive effect on their health status.

Outreach work

Many of Norway's municipalities have a long tradition of running outreach work for hard alcohol and drug users. The goal has partly been to offer assistance and guidance early on in new environments, and to allow people to leave the drug scene quickly .

Eventually outreach facilities were also established, which are to address emergency situations, link persons up with proper assistance and follow-up those who have nearly overdosed. These facilities also perform home visits and transport people home or to a detoxification station. For example, in Oslo the Outreach Work and Co-ordinated Services (OKT) have access to mobile funds that can be used to help clients in need of treatment or care to be quickly admitted to an appropriate service. This might also be when the municipality itself does not have capacity, but where such opportunities exist other places. In most cases the OKT co-operates closely with the ambulance services when an overdose has taken place, and operates its own follow-up services for clients who have survived an overdose.

The PRO Centre (PRO-senteret) in Oslo is a competency centre that addresses the needs of street prostitutes, both by way of outreach work as well as by offering a warm-up shelter. Other municipalities offer similar services. One of the six field nursing stations in Oslo is also placed together with the PRO Centre and performs low threshold health services for the prostitute scene. Similar measures are also found in other cities.

The Alcohol and Drug Addiction Service, Oslo Municipality), in co-operation with the ambulance service, arranges first aid courses for active drug users in the downtown area of

Oslo, as well as for police, shop keepers, railway and public WC workers, café and restaurant personnel and others who daily work or find themselves in areas frequented by drug users. It is not known how effective this is, but the number of overdose fatalities taking place in the city centre has dropped significantly in recent years.

Other possible harm reduction measures have not been established in Norway, even if they are being discussed. This includes a public injection room, prescribing heroin and onsite testing for possible narcotic substances in party milieus, etc. In Oslo, facilities are now in place for establishing a trial with two injection rooms in the event that the Government gives its approval. A four-month, unauthorised trial with an injection room at the PRO centre in Oslo for the centre's users was completed at year end in 2000, and the experiences gained have provided some of the basis for the debate on establishing an injection room.

10.2 Standards and evaluation

Most harm reduction programmes in Norway are conducted without extensive scientific evaluation. As harm reduction programmes in Norway have become goal-oriented, greater emphasis has also been placed upon proper evaluation, although few long-term results are available. However, trial projects with methadone have been evaluated both in terms of the process and client status. The field nursing stations in Oslo were evaluated after six months. The needle bus was evaluated in 1997, while it has also provided a point from which the drug user community has been mapped out on several occasions.

Chapter 11. Treatment

Overarching responsibility for co-ordinating care and treatment rests with the Ministry of Social Affairs. A closer examination of how this is organised is provided in chapter 1.1.

Treatment is by and large voluntary, but the social services law (chapter 6-2) does provide for withholding an abuser in an institution for up to 3 months upon the recommendation of the County Council for social cases. Individuals who are voluntarily admitted can enter into an agreement to be withheld for up to three weeks (paragraph 6-3). The intention behind compulsory treatment is to motivate the client for further treatment.

According to the social services law (paragraph 6-2a), pregnant drug addicts can be admitted to an institution and withheld there for the course of their pregnancy, if the abuse is of such a nature that it in all likelihood would lead to birth defects and whereby voluntary measures have been insufficient.

Paragraph 6-2a is actively used by the social services when voluntary approaches are not possible. This authority can also be used 'passively' in the sense that it has a 'disciplinary' effect on the pregnant drug addict who does not want health service intervention, but who nonetheless will agree to voluntary measures when she becomes aware of the social services' compulsory programme.

11.1 "Drug-free" treatment and health care at national level

Drug free treatment and the objective of a drug free existence is still the main objective behind the majority of Norwegian treatment programmes.

A vast array of treatment and rehabilitation services has been developed in Norway with different professional and ideological approaches. Treatment alternatives vary from professional psychotherapeutic approaches to a more simplistic approach based a lifestyle built around a central Christian message.

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

The youth psychiatric teams works especially with youths and young adults between 15 and 30 years of age who have both drug problems and mental disorders. There are 29 psychiatric youth teams in the country, distributed across 15 counties. Rather than specific youth teams, four counties have specially reserved "abuse spaces" at adult psychiatric clinics.

Institutions with 24-hour services span everything from minimal intervention with only a few employees to treatment places within large institutions with many different wards. Ownership varies; they can be owned by the county, by public or private foundations, corporations or privately. Approximately two-thirds of the 24 hour services available to alcohol and drug abusers are in private hands. However, organisations such as the Church's City Mission, the Pentecostal Church's Evangelical Centre, the Blue Cross and Salvation Army contribute more than a supplement to that offered by public institutions. Common to all these treatment alternatives is that they are generally open to those with problems involving alcohol, medications and drug use and are primarily financed by public funds.

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

In addition to the measures described above, there are also a number of purely care-related measures; that is, alternatives that accept downtrodden abusers, who show little potential for rehabilitation and offer them general help/care and a drug-free environment. Other measures include halfway houses, which aim to improve their residents' situation.

Research on treatment and evaluation

Research is being conducted in the drug field in a number of areas. Research takes place in research institutes, at universities, colleges and to some degree at the regional competency centres.

SIRUS is charged with conducting and spreading research and documentation related to drug issues, with an emphasis on social scientific aspects of the problem. The institute's research can be divided into five main areas: the drug market, drug use and drug culture, prevention measures, consequences, treatment and care.

The Unit for Addiction Medicine is a professional unit within the *Department Group for Psychiatry* (Faculty of Medicine, University of Oslo). The unit is to conduct research on the use of methadone and other medical and psychosocial means in the treatment of drug problems.

SIRUS is responsible for the treatment study, *"What benefit, for whom to what cost? A prospective multi-centre study of drug abusers"*. Co-operative partners in the study include 20 treatment programmes in Oslo and outlying municipalities.

The project will evaluate treatment approaches and the combination of treatment forms for drug abusers in order to determine whether some approaches lead to better results than others for different groups of drug addicts. The project is organised as a prospective multi-centre study whereby *482 clients from 6 different groups of treatment programmes* will be followed over two years. The clients will be interviewed using a structured survey (ASI) to measure drug abuse and psychosocial status and will, in addition, complete 3 surveys themselves (MCMI, SCL-25, CTQ). Moreover, information on the clients' evaluation of the treatment they have received and the follow-up by first line services. The clients will also be asked to describe different personal experiences after they left the recruitment programme. Information on how resources were used for the different programmes will be collected via accounting records. The survey also includes questions on treatment ideology and structure. Additionally the number of hours required for different treatment interventions clients receive will be recorded. Information from different databases, such as criminal records, the national welfare services, death registry and SSB (different social assistance, welfare support) will also be collected.

The second and final follow-up of the 482 clients was completed in July 2002. A very good response rate was achieved in both follow-ups; 92% with the first follow-up and 88% with the second. 3.9% of the main sample (n=407) were dead before the second follow-up; that is, within a two year period. The mortality rate among methadone clients was 6.7% (after 1 year) upon the first follow-up. In the main sample the average age was 29, and women accounted for 33% of the subjects.

Some comments can be made about the stability of changes for example in the use of drugs, by comparing the results from the first and second follow-up studies, among the group of clients that were out of treatment at both points in time. The data show that for heroin, average use dropped from 10.5 days per month before treatment, to 5.9 days at the first

follow-up and 6.0 days at the second follow-up, one and two years after initiation of treatment respectively. In other words, the change appears to be stable over time. For the other drugs, changes varied. With respect to alcohol to achieve intoxication, the drop was actually greater at the second follow-up than at the first (11% contra 32%), while the reduction in use of downers is less stable. Taken together, the figures indicate that there are greater variations between types of drugs with respect to the extent to which a short-term reduction also holds over time.

With respect to health, work and criminality, it is interesting to see that changes in all areas were stable in that it more or less does not matter whether one uses the results from the first or the second follow-up. The greatest change is the reduction in the number of days in illegal activity (from 8 to 2 days per month) and the number of days with mental problems (from 12 to 8 days per month).

An article covering a sub-population of 100 clients is published in International Journal of Social Welfare, 2001, no.2, vol.10, pp.142-147. Four newsletters have been published with the results of the project to date. These can be found on: www.sirus.no.

The cost evaluation from the study is reported upon in chapter 14.

11.2 Substitution and maintenance programmes

Medically assisted rehabilitation with use of methadone and other medication for hard-core drug abusers has been nationally available since 1998. National guidelines have been developed to describe responsibilities and the organisation of medically assisted rehabilitation at regional and national level. The system is based on specialised regional centres, although the municipal health and social services are responsible for follow-up.

The criteria for admission were revised in 2000 and made less restrictive:

The applicant shall be at least 25 years old, heavily addicted to an opiate despite reasonable treatment and have several years of abuse behind him/her. When methadone or other adequate medicine is necessary for the treatment of life-threatening illnesses, special criteria apply.

Practical problems have been encountered with respect to the necessary participation of general practitioners and the municipal social services. Particularly in Oslo this has made it difficult to free up resources in order to admit new applicants to treatment. A substantial effort has been made to clarify issues related to organisation, responsibility and financing in order to make the system more effective. The Storting adopted a revised model 1 July 2001 that more clearly integrates medically assisted rehabilitation into the regular municipal health and social services to increase capacity.

Nation-wide, 1 853 clients admitted to the treatment system as of 31.08.2002, while the figure for the first quarter of 2002 was 1 649. The number of applicants has steadily climbed, and the coverage is now approximately 13-19 per cent of the estimated 10500 – 14 000 intravenous drug users.

Evaluation

It is too early to provide a status of the overall effect of substitution treatment. Experience to date indicates that one has achieved a substantial reduction in overdose mortality and patients are better empowered to cooperate so that their other illnesses can be treated. Most individuals clearly experience an improvement in their social functioning and quality of life. Criminality has definitively been reduced. Problems related to continued abuse of drugs, especially benzodiazepines, and partly alcohol and cannabis, remain. Somewhere between

20 and 40 per cent achieve full mastery of their drug problem, and an equal number experience a clearly improved situation.

Trial projects have been conducted with buprenorphin. A randomised study has been concluded with 106 opiate addicts who were waiting to be admitted to the methadone programme in Oslo. 55 received buprenorphin – 51 received a placebo over a 12-week period. The conclusion was that the waiting list patients benefited greatly from buprenorphin as a temporary treatment with respect to relapse, self-reported use of narcotics and well-being. Nonetheless, the patients found it difficult to remain in treatment over time without some form of psychological support.

A research project with buprenorphin for young opiate addicts was initiated in March 2002, led by the Unit for Clinical Drug Problems at the University of Oslo in co-operation with psychiatric youth teams in five counties. 34 people are currently taking part in the project, while approximately 100 patients will be included until December 2002. The project is to last two years, and will also evaluate the use of naltrexon to counteract relapses after the medical treatment is completed.

11.3 After care and re-integration

After-care and re-integration is a municipal responsibility described in the social services law. After-care is otherwise the weakest link in the rehabilitation chain. Follow-up of and the building of a network around individual clients is often poorly organised and can have a time horizon that is far too short to be able to counteract a relapse into new abuse and the addict environment. Experience shows that life after a 'career' as drug abuser has its own problems that demand another type of professional attention than that which is provided by the help services otherwise. Currently there are too few services with this basis.

Several institutions run their own systematic after-care regime and have their own after-care residences. One example is *Stensløykka resource centre* in Oslo. The institution admits clients of both genders and couples who primarily have completed treatment for their drug problems. The overarching goal is to make it possible to make use of measures and potential resources such that they are able to live independently upon the completion of their stay – without drug abuse – with housing, work/education and a social network.

The Idea Workshop is a unit with the Stensløykka Resource Centre. The programme is directed to former drug addicts. The idea workshop has a pedagogical approach and is a social meeting place for people with a common background. It is a programme for integrating people that is based on the participants' leisure time resources and interests. The overarching goal for all activities related to the programme are to contribute to the integration of the individual into "normal everyday life".

Chapter 12. Interventions and the Criminal Justice System

Regulations, laws and legal practice within the criminal care system have been described in chapters 1.3 and 2.2.

12.1 Assistance to drug users in prison

The control measures described in chapter 2.2 also have an important prevention affect alongside their control aspect. More specifically, the Criminal Care System has offered sentencing alternatives that are tailored to the inmates drug problems and drug-related crime. During and after a sentence term in prison, the inmate with a drug addiction problem is offered opportunities to take part in a number of programmes. Such programmes include:

- Contract sentences, alternative sentence according to the Civil Penal Code, paragraph 12 programmes
- Life mastery programmes
- The establishment of networks
- Probation groups
- Work experience within the prison
- Education
- Leisure activities
- Participation in the prison system's work-furlough programme and support programme after release.

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

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

The HIV/AIDS issue involves major challenges for the prison system. An important aim is to protect inmates and staff from exposure to HIV. There is a relatively large number of intravenous drug users in prisons, and despite the frequency of strict controls, needles are used. In order to prevent the spread of disease by needle sharing among inmates, the State Health Authority has required that prisons make chlorine available in prisons, such that inmates are able to clean used needles. There are, however, no needle distribution programmes in Norwegian prisons.

Access to substitution treatment is provided to inmates that have already begun such treatment, such that they can continue while serving their sentence. In principle, substitution

treatment could also begin while carrying out a sentence if the inmate fulfils the admission criteria for the programme (Ministry of Justice).

12.2 Alternatives to prison for drug dependent offenders

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

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

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

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

Influence programmes, such as violence and crime watch groups as well as probation groups are also important. These are based on crime prevention motives. They take their point of departure from the social and personal problems that are assumed to contribute to criminal acts.

A *Drunk Driver Programme* lasts one year and is an alternative to jail sentence.

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

12.3 Evaluation of training

Criminal care, by way of the Criminal care education centre, KRUS, initiates and conducts education of personnel who work with drug-related treatment and control measures.

Canadian instructors have conducted training in drug prevention programmes the last 2 years. Training for the programme "My choice" and "Drug programme in jail" have involved 12 individuals per year. The blood alcohol programme is conducted now in 2/3 of the counties. The programme is under evaluation and a final report will be provided in 2003. Other evaluative measures that are being investigated are related to control routines and intoxication programmes and will be provided as they become available (Ministry of Justice).

Chapter 13. Quality Assurance

Still no formal quality criteria exist, nor is there a formal process for authorising programmes within the treatment and prevention field in Norway.

PART IV – KEY ISSUES

Chapter 14 Demand Reduction Expenditures on Drugs in 1999

14.1 Concepts and definitions.

It is very difficult to calculate the total cost to society of the use and abuse of drugs. Reference can be made in this connection to NOU (Norwegian Official Reports) 1995:24 "Alkoholpolitikken i endring"¹, which contains a discussion on the socio-economic costs associated with alcohol. We can, however, track some of the costs involved by examining the operation of specialist support services and by reading public financial accounts detailing specific chapters and items.

It is important to be aware that the concept of costs has both a positive and a negative meaning. Hence, the costs relating to a measure also depend on the use of resources generated by a client/patient under different conditions.

A large part of the treatment services in Norway has been built up by non-profit organisations, funded in whole or in part by the public purse, and subsequently increasingly under the control of groups of health care professionals. In the mid-1980s, intervention services for drug users were organised on a county basis within the limits of a framework allocation. The Norwegian parliament, Stortinget, has decided that there should be a joint intervention service for illegal and legal substances abuse, structured as chains of measures, whereby the municipalities are responsible for treatment outside institutions, and the county authorities are responsible for providing an appropriate level of specialist institution-based treatment. Treatment will be based more on which type of problem the individual has than on the type of drug he or she uses. With a joint intervention service it is virtually impossible to separate out costs specifically relating to drug users. Chapter 1.5 outlines the financial framework for the government's direct efforts in the field of prevention, for low threshold services and medically assisted treatment.

14.2 Financial mechanisms, responsibilities and accountability

The costs of drug abuse are related to both acute and more long-term harmful effects, and can be direct or indirect. The costs are partly related to the drug users themselves, partly to close family which is affected, to third parties (as a result of accidents/violence/murders occasioned by intoxicated persons), and partly to physical damage. The costs of drug abuse will be borne by different sectors (public and private) of society, and by private persons.

Some indicators for use in the calculation of relevant costs which can partly be related to drug users and drug abuse are:

- Direct and indirect expenses for the medical treatment of drug-related injuries and diseases
- Operating expenses of institutions treating drug users
- Indirect expenses as a result of additional expenditure on child welfare, educational psychology services, health centres, school health services and schools in general
- Expenses relating to social services
- Expenses relating to nursing and care services

¹ NOU 1995:24 "Alkoholpolitikken i endring (Alcohol policy undergoing change"; see also: Sundhedsanalyser 1999:10 "De samfundsokonomiske konsekvenser af alkoholmisbrug (The socio-economic consequences of alcohol abuse)", Sundhedsministeriet (DK)

- Social security benefits
- Direct and indirect costs relating to the implementation of specific measures, such as refuges, measures aimed at prostitutes
- Operating expenses of organisations engaged in the field of drugs and alcohol
- Control costs (police, judicial system, prisons service, customs authorities)
- Physical damage as a result of traffic accidents, fire, vandalism connected to drug abuse etc.
- Loss of contributions to value-creation in society (and losses of individual employers) because the use and abuse of drugs often entails a reduction in work capacity (absence from work due to illness, reduced efficiency)
- Possible loss of job or difficulty in obtaining employment.

There are also cost savings in connection with drug abuse, since drug abuse may affect *life expectancy*. For each year of life lost, each person who dies before or just after retirement age, represents a relatively substantial saving for society in terms of pension costs, health costs and nursing and care costs. *Early* death also represents a reduction in potential value creation in society.

14.3 Expenditures at national level

The considerable expansion of support services for drug users has resulted in many different kinds of treatment. This is now a substantial sector, also in financial terms. While the government, county councils and municipalities spent a total of approximately EURO 111.7 million on the drugs and alcohol sector in 1990, the amount increased to just over EURO 160 million in 1993, and in 1999 it amounted to EURO 224.9 million (all figures in 2000 kroner). In 2000, expenditure was EURO 230.6 million, an increase of more than 100 %² over the last ten years.

If we look at the costs/funds spent ratio in the *primary municipal sector* and the *county sector*, the *primary municipal sector's* share has increased most. Expressed in 2000 kroner, it increased from just over EURO 42.8 million in 1990 to EURO 127.6 million in 1999, which means that costs have trebled. During the same period the corresponding expenditure on drug abuse-related measures at county level increased from EURO 69.6 million to EURO 85.3 million (in 2000 kroner).

Table 10. Expenditure on measures for drug abusers 1980 - 2000. In million Conversion rate: 1 EURO= NOK 7.50

| 1980 | 1985 | 1990 | 1995 | 1997 | 1998 | 1999 | 2000 | Increase in % 1980- 2000 | Increase in % 1990- 2000 | Increase in % 1999- 2000 |
|------|------|-------|-------|-------|-------|-------|-------|-----------------------------------|-----------------------------------|-----------------------------------|
| 26.9 | 112 | 111.7 | 172.4 | 202.5 | 216.3 | 224.9 | 230.6 | 756.40% | 106.40% | 2.50% |

14.4 Expenditures of specialised drug centres

² This report has been prepared on the basis of a database supplied by Statistics Norway to the Norwegian Directorate for Health and Social Affairs and based on accounting statistics from municipal and national accounts. The report only covers public expenditure on social security benefits in Norway. Private expenditure is included where it is recognised in the public accounts on which the database is based. The database differentiates between the *application* and the *financing* of the expenditure. The amounts reported here are concentrated on the application of the funds.

Many drug users have developed their abuse over a period of many years, and consequently may need many years to extricate themselves again. Not everyone who succeeds in this, succeeds simultaneously in all fields. And even if specialised treatment results in particularly good results, most institutions have relatively little control over their clients' lives after they have been discharged. If this link in the chain is broken, resources spent on stays in institutions will have less effect. However, this is not the case with forms of treatment where clients stay for longer periods and the institution itself is responsible for follow-up and after-care. Systematic follow-up of clients after discharge is a precondition for benefiting in the widest sense from positive results.

Stays in institutions clearly contribute to reducing the clients' drug abuse. This applies both to those who complete the treatment as planned and to those who "drop out". The challenge is to find an effective follow-up, or possibly alternative measures, for the different groups of clients so that positive results become permanent and clients have a better and more realistic chance of readjusting to society on the basis of their individual abilities and the resources at their disposal.

In its newsletter no. 4 2002³ the comprehensive *Cost-benefit study* carried out by SIRUS has arrived at a preliminary evaluation of what treatment costs. Some other costs associated with drug use and the treatment of drug problems, such as criminality and social security benefits, have also been examined. It is difficult to draw clear conclusions from the data examined. In order to map the different costs of drug use and the treatment of drug abuse, the "Cost-benefit project" has collected data from several different registers. Information on treatment costs has mainly been gathered from the accounts of the treatment measures included in the project. Not all accounts are directly comparable and adjustments have therefore been made for this in the report (see also chapter 11.2).

The figures presented below do **not** represent annual costs. They are the total amount of money spent on clients in the various types of treatment during the time they spent in treatment – which for some was less than one year and for others more than one year. The figures referred to should also be regarded as preliminary, as the different treatment facilities do not keep accounts in the same way. The accounts of public sector measures do not include the cost of premises. Nor do they include central administration expenses. The project has allowed for this to a certain extent by adjusting expenditure upwards in those cases where rent and administration costs have been omitted. Another problem concerning the calculation of costs is that not all costs are included in the accounts of the treatment facilities. One example is the fact that while in-patient treatment includes food and accommodation expenses, these are not included in out-patient treatment. Hence, a comparison of the expenditure on treatment alone could be misleading if it turns out that there are high subsistence expenses (social security benefits, rent allowance) for clients not staying in in-patient institutions. This has been examined and is discussed in more detail in connection with the cost of social security benefits.

According to the Cost-Benefit project there is no doubt that, viewed in isolation, out-patient measures, in this case the psychiatric youth teams (PUT), represent an inexpensive form of treatment of drug abuse. This treatment cost EURO 17 per day on average, while admission to a children's or youth institution cost EURO 343 – nearly 20 times as much. Since the clients here spent shorter periods in treatment, the effect on the price per completed treatment was even greater. The PUT clients are in many ways those who have the least serious problems and are therefore more likely to receive sickness benefit, because they are in employment. This group of clients contains the largest proportion of individuals receiving sickness benefits (10 %). A client in a children's or youth institution cost almost EURO 240

³Lauritzen G, Melberg HO, Ravndal E: "What benefit, for whom, to what cost? A prospective multi-centre study of drug abusers", SIRUS, Newsletter no. 4 June 2002

000, while a client completing treatment in PUT cost slightly over EURO 4 670. However, the figures as such do not tell us anything about the effect of the treatment, nor about who received what kind of treatment or whether out-patient treatment is suitable for everybody. It cannot necessarily be assumed that those who were admitted to institutions could just as well have been treated in PUT at one fiftieth of the cost.

Methadone-based treatment, at EURO 33 per day and, was also shown to be relatively inexpensive in comparison with other measures. In 1998, methadone-based treatment, or medically-assisted treatment, was established as a permanent nationwide treatment. The treatment is organised through the five health regions, based around specialist centres with regional functions. The scheme is dependent on local follow-up of individual clients, i.e. the clients' regular GPs are responsible for the medical follow-up, and the municipal social services are responsible for coordinating the rehabilitation plan for each individual.

The average cost of all types of treatment in institutions was EURO 77 300.

The study shows that the differences between in-patient and out-patient treatment are to a certain extent compensated for by the fact that those who are not admitted to an in-patient, residential institution receive social security benefits and other subsistence benefits to a greater extent. On average, the 500 clients participating in the study received approx. EURO 5 470 annually in social security benefits. Three out of four clients received social security benefits – methadone clients received most at EURO 6 670, and PUT clients least at EURO 4 000 on average. The preliminary analysis shows a decrease in payments of social security benefits in the period following a stay in treatment. However, there is great uncertainty concerning the duration and size of this reduction, as the observation period following completion of treatment was too short. However, the data indicate a group of individuals who to a large extent are in receipt of social security benefits. In 1999 four out of five of these individuals received social security benefits, which amounts to total payments of EURO 2.52 million in social security benefits to this sample alone.

Almost four out of ten clients received *medical or vocational rehabilitation benefits* amounting on average to EURO 3 330 each. Clients in in-patient, residential institutions received most, while clients attending out-patient clinics and methadone programmes received significantly less – approximately half. The significant differences in the costs of the different types of measures are probably due to the fact that among PUT clients there are more individuals who are either studying or are in employment compared with other types of measures. The fact that the methadone clients also receive less than the others may be due to the fact that this group has, to a greater extent than others, either given up or been given up in terms of obtaining normal employment.

Disability pensions and sickness benefits

Every fifth client/patient in the sample received disability benefits (in 2001). At 37 % methadone clients had the largest proportion on disability pensions, compared with for instance 11 % in the PUT group and an average of 15 % of in-patients in institutions. This partly explains why methadone clients received less in rehabilitation benefits than the other clients. Since so many of the clients are either unemployed, in medical or occupational rehabilitation or on disability pensions, there are relatively few left who would qualify for sickness benefit. Clients in out-patient treatment are also the largest group among those in receipt of sickness benefits (a proportion of 10 %).

The total amount paid in sickness benefits is nonetheless small in relation to other costs, and it is assumed that any gain as a result of the treatment will not be in the form of a reduction in sickness benefits.

Criminality

One important cost category which fell markedly following treatment was the number of days spent in prison. Information regarding periods of imprisonment and arrests are taken from the Register of Convictions. This means that there is a high degree of certainty that the figures are correct and that there is no uncertainty related to self-reporting, for instance of periods of imprisonment. There are, nevertheless, some reservations as regards the figures since the follow-up period is relatively short so far, and it probably takes some time before people are sentenced and imprisoned again for criminal offences. The average period of imprisonment for the whole group of clients has been reduced from 20 to 7 days in prison or, in financial terms, from EURO 4 000 to EURO 1 400 per person. The total number of days in prison for this group fell from 9,200 days in 1997 to 3,200 in 2000. Given that the costs of imprisonment are estimated to be EURO 200 per day (a conservative estimate), this corresponds to a reduction in costs of almost EURO 2 470 per client per year, a total of EURO 1.2 million for the clients in this survey. Researchers point out that there is a problem in basing oneself on average periods of imprisonment in that the actual distribution is very uneven, also among the group of clients, the vast majority of whom have very few or no days in prison while a minority accounts for most of the days in prison. Even if the figures for days in prison must be interpreted with a certain care, there are also other findings which indicate a reduction in criminality. The amount of money spent on purchasing/consuming narcotics, for instance, had been reduced from EURO 1 600 per month to EURO 600 per month at the time of the first follow-up and, at EURO 735, had again increased somewhat at the time of the second follow-up (one year and two years respectively after admission to treatment). In so far as drug abusers finance their own consumption through crime, a reduction in consumption may also correlate with a reduction in criminality. One can see from the figures that money spent on drugs and the number of days in prison were more than halved following treatment, which indicates that the reduction in the number of days in prison is not due to the shortness of the observation period alone.

14.5 Conclusion

It is very difficult if not impossible to arrive at entirely satisfactory figures for the costs involved in prevention and treatment. In addition to the difficulties of selecting a result indicator, there are also problems in defining and describing what distinguishes the different treatments from each other. Consequently, it is also difficult to calculate costs. In further work on a financial evaluation of drugs-related treatment, efforts should be invested in arriving at good definitions of different types of treatments and emphasis should be placed on describing the differences in resource use. In line with this, it is important to develop cost-relevant indicators on which the Member States can agree. If it is important to be able to compare and evaluate different treatments, then the same instrument/indicator must be used. Initially, it is more important to use the same indicator than to arrive at a perfect indicator.

In comparisons with other countries and over time, differences in the statistical material for the social care and health sector may occur. This may be due to differences in definitions on which the figures are based, different classifications and/or the fact that the sources are different. Figures from other databases such as OECD's and Eurostat's, do not concur with the figures presented here. This leads to difficulties in making reliable comparisons with international figures. Even within the Nordic countries, where the organisation of the social care and health sectors is very similar, the differences are so great that it is difficult to make satisfactory comparisons.

In Norway, the Directorate for Health and Social Welfare will continue its efforts to further develop analyses of public expenditure on drug-related undertakings. As long as this concerns public expenditure then this is to a large extent possible to achieve in Norway. Nevertheless, there are many challenges in that it is hard to decide which costs are to be included and not least how they are to be identified or found in the accounts.

14.6 Methodological information

The following criterion has been used to determine whether to include a given cost in the analysis: *Costs are an expression of the benefits/gains lost through resources being used for the project rather than for other good purposes.* Or, to put it another way: expenses are included in those cases where the costs could have been avoided if drugs had not been used.

A socio-economic analysis should include costs that take account of any investment costs for the building of institutions and operating and salary expenses, but also any savings (negative costs) in other parts of the social and health care sector, and the loss of production from drug users who are not in employment or who work less efficiently. We only have a limited amount of reliable data for costs relating to the establishment and running of a specialist support services aimed at drug users. These have been mentioned and commented on. It is considerably more difficult to calculate the actual size of the production loss due to absence from work. Whether the production loss as a result of early death should be included as a cost is at least debatable. Many cost consequences are difficult to quantify.

An attempt has also been made to (offset) calculate how drug-related treatment affects the use of other social and health care⁴. Offset calculations from the treatment of alcoholics can serve as an illustration. They show that alcoholics and their families avail themselves of health services several times more often than non-alcoholic families. They also show that the treatment of alcoholics leads to a reduction in the use of other health services and that this use converges with the use by comparable non-alcoholic families after 4-5 years. Moreover, studies show that the reduction was independent of the type of treatment given. Offset calculations therefore provide important information about the effects of increasing or reducing resource use in the treatment of drug abuse.

⁴ Holder HD, Hallan JB: *Impact of Alcoholism Treatment on Total Health Care Costs: A Six-Year Study.* *Advances in Alcohol & Substances Abuse Treatment* 1986; 6 (1)

Chapter 15. The use of alcohol and drugs among young people aged 12-18

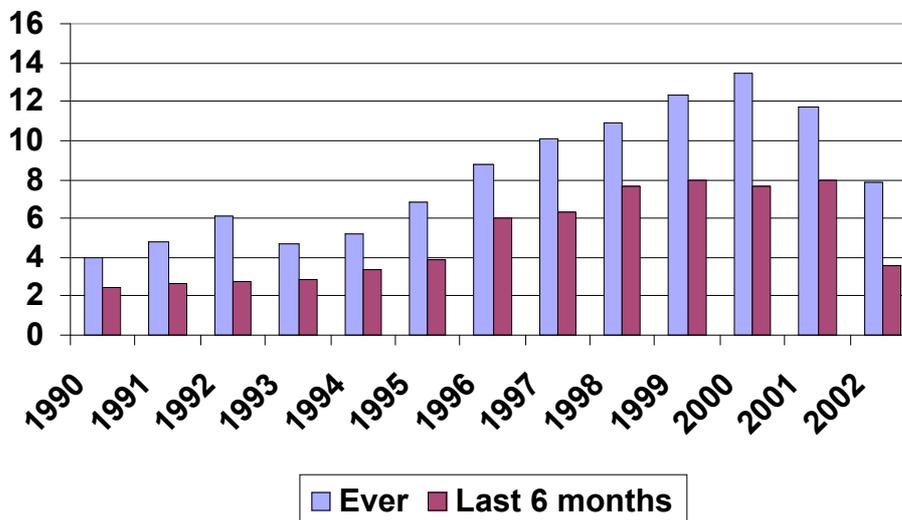
15.1 Prevalence, trends and patterns of use

Norway has relatively good survey data as regards drugs and alcohol use among young people. SIRUS carries out annual nationwide postal questionnaire surveys of drugs and alcohol use among a representative sample in the age group 15-20. Norway participates in the ESPAD surveys of 15-16-year-olds for which data is currently available for the years 1995 and 1999.

Drugs and alcohol use also formed part of a nationwide schools survey (12,000 students from 13 to 19 years old) on the lifestyle and living conditions of young people, which was carried out in 2002 (www.nova.no). However, the results will not be available before 2003/2004. A corresponding survey was carried out in 1992. In addition, there are several local schools surveys, some of which specifically map drugs and alcohol use and others which are more wide-ranging surveys aimed at casting light on different aspects of young people's life situation, including drugs and alcohol use. A survey has, for instance, been carried out on drugs and alcohol use among young people aged 15-20 in Oslo every year from 1968 until the present (www.sirus.no).

The data presented here comprise those 15, 16 and 17-year-olds who were included in the nationwide questionnaire surveys conducted by SIRUS during the period 1990-2002 and the ESPAD surveys carried out in 1995 and 1999. No nationwide Norwegian surveys are available on drugs and alcohol use among young people under the age of 15.

Figure 14. Proportion of 15-17-year-olds in Norway who report that they have used cannabis, ever and during the last six months respectively.

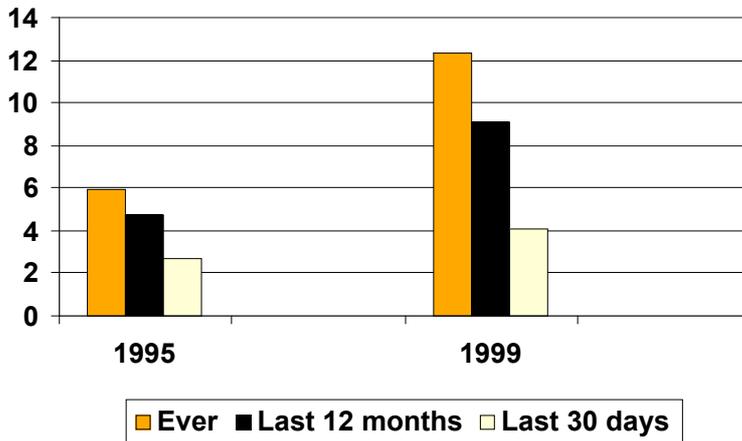


Source: SIRUS

Figure 14 shows a marked increase in the latter half of the 1990s in the proportion of young people aged 15-17 who reported that they had used cannabis, ever and during the last six months respectively. While in the first half of the 1990s 4-6 per cent reported that they had ever used cannabis, this proportion had increased to 12-13 per cent by the turn of the millennium. During the last few years, however, there has been a certain decrease. The coming years' surveys will give an indication of whether the decrease entails a lasting change or is the result of more random fluctuations.

In the same way as the annual questionnaire surveys, the ESPAD survey shows a clear increase from 1995 to 1999 in the proportion reporting that they had used cannabis, both ever, during the last 12 months and during the last 30 days (fig. 15). The next ESPAD survey, which is scheduled for 2003, will show whether this picture is going to "turn around", as has been seen in the annual postal questionnaire surveys.

Figure 15. Percentage of 15-16-year-olds who report that they have used cannabis, ever,



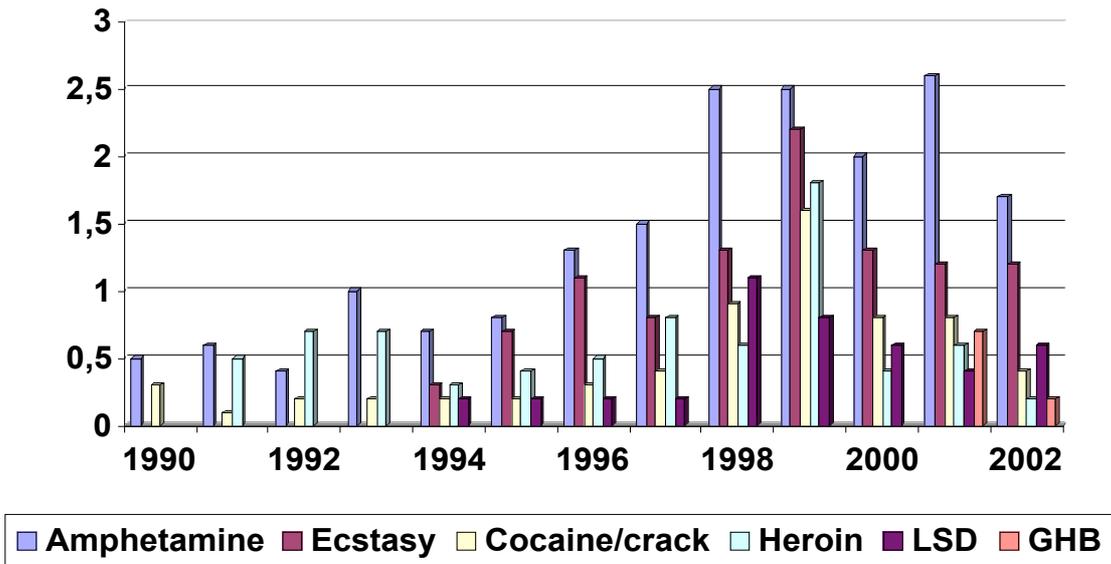
during the last 12 months and during the last 30 days respectively.

Source: SIRUS, ESPAD survey

Throughout, the proportion that reports having used cannabis is somewhat greater among boys than among girls. This applies both to the annual questionnaire surveys and to the ESPAD surveys.

Figure 15 provides a picture of developments as regards the proportion of 15-16-year-olds who report that they have used other drugs than cannabis. As is apparent, a relatively small proportion has used these substances but an increase has occurred in the latter half of the 1990s. Amphetamine accounts for the largest share, followed by ecstasy. The results of the ESPAD surveys also showed that only a small proportion of 15-16-year-olds reported that they had used other drugs than cannabis.

Figure 16. Proportion of 15-17-year-olds in Norway who report that they have ever used various drugs



Source: SIRUS' annual youth surveys

There is much speculation that young people who use drugs do so as a substitute for drinking alcohol. However, the annual surveys show that young people in the 15-17 age group who state that they have ever used cannabis drink far more alcohol than those who have not used cannabis. While the estimated annual consumption of alcohol among those who have not used cannabis in recent years has been around 2-3 litres of pure alcohol, the corresponding amount among those who have used cannabis is 8-10 litres, i.e. **3 to 4 times higher**. Even though there is statistical uncertainty attached to these estimates, the difference can only be described as dramatic.

Surveys primarily provide a picture of what must be called experimental use of various drugs. They are not very suitable for ascertaining how large a proportion of the age groups in question are what we can call problem drug users. This is primarily due to the fact that those who use drugs extensively are only included in such surveys to a limited extent, either because they do not respond to postal questionnaires or because they are not present in school during schools surveys. Thus, no more than about half of those who report that they have ever used cannabis have done so more than 5 times.

In addition to such surveys, qualitative anthropological studies have been carried out on various youth subcultures and their attitudes to drugs. However, these are not limited to young people under 18, but deal with young people who are involved in different youth culture activities regardless of age. A comparison of both quantitative and qualitative data concludes that *"...in several youth subcultures there appears to be a tendency whereby drugs which have long been linked to a specific youth subculture are now also being adopted by other groups, and thereby becoming to some extent detached from their original cultural context. At the same time as the big house parties are full of young people from relatively young age groups who are attracted by the more popular and commercial versions of house music – and where ecstasy is still regarded as normal – the more exclusive elites who previously spearheaded this subculture no longer participate. Young people who spend a lot of time in town centres or are oriented towards specific youth subcultures and music forms have more experience of drugs than others. Young people who belong to the house/techno and hip hop scenes have more experience of party drugs, while it is more uncertain what the link is between the snowboard and basketball subcultures and the use of drugs..... Traditionally, drug use among young people has often been perceived as a*

response to a disadvantaged background, psychosocial problems or similar. The use of party drugs is, however, probably also a response to a subcultural orientation in which drug use forms part of a "style package". This assumption fits well with the recorded tendency towards normalisation of illicit drug use and the spreading of use to groups of 'normal', resourceful young people studies of recreational use of drugs that form part of "cultural style packages" are important in uncovering motivational patterns and "stages" in the development of drug use" (Moshuus et al 2002).

As regards the extent to which young people under 18 consider the risks involved in drug use, the available data is limited to the ESPAD surveys. Here, the young people were asked to stipulate the risks of harmful effects people subject themselves to through different patterns of cannabis use.

Table 11. Presumed risk of subjecting oneself to harmful effects by smoking cannabis in the following ways. Proportion as a percentage.

| | Try cannabis once or twice | | | Smoke cannabis occasionally | | | Smoke cannabis regularly | | |
|------|----------------------------|----------------|-----------|-----------------------------|----------------|-----------|--------------------------|----------------|-----------|
| | No/ little risk | Mod-erate risk | High risk | No/ little risk | Mod-erate risk | High risk | No/ little risk | Mod-erate risk | High risk |
| 1995 | 32 | 27 | 36 | 11 | 34 | 49 | 2 | 8 | 87 |
| 1999 | 37 | 29 | 28 | 16 | 37 | 42 | 4 | 13 | 78 |

Table 11 shows that the changes from 1995 to 1999 are not very clear-cut, and that the data must be interpreted with care. Two matters are worth drawing attention to however:

Naturally, most people believed that the risk of harmful effects increases the more frequently one uses cannabis, but the proportion who believed that it entails a 'high risk' had fallen significantly in 1999 compared with 1995. On the other hand, the perception of 'no/little' and 'moderate' risk of harmful effects increased for all three levels of drug use even though these changes are less marked.

As regards perceptions of risk relating to other drugs, slightly more than 40 per cent assumed that trying different drugs carried a high risk, even if they were only tried a few times, while slightly more than 80 per cent assumed that there was a high risk associated with using the drugs on a more regular basis.

15.2 Health and social consequences

There are few Norwegian data available on the health and social consequences of drug use among young people under 18. This is due on the one hand to the general scarcity of systematic data on the various harmful social and health effects which can be directly linked to the use of drugs, regardless of age. On the other hand, there are also relatively few people who at such a young age (<18 years) suffer drug-related harmful effects of such a serious nature as, for instance, overdoses. As regards young people under 18 who undergo treatment for drug abuse problems, treatment will mainly take place in institutions under the auspices of the child welfare authorities, but the available data do not tell us anything about whether the background for admission to treatment is abuse, behavioural problems or other reasons. Section 24 of the Norwegian Act on child welfare services allows for the use of coercion to bring young people under the age of 18 with behavioural problems (including the abuse of drugs) under treatment in an institution.

15.3 Demand and harm reduction responses

Nationwide campaigns

As a contribution to the European Drug Prevention Week 1998 the then Norwegian Directorate for the Prevention of Alcohol and Drug Problems carried out a nationwide campaign "*You can write some fairytales yourself*", aimed at the 16-19 age group. The campaign included three 40-second films based on the stories of Hans Christian Andersen, which were shown on television and in cinemas. A tuition package was also produced for use in schools.

The Directorate was also responsible for the campaign "*Narko – what a T.R.I.P*" in cooperation with UNDCP, which was launched in 1999. It centred on the idea of solidarity and was aimed at socially aware young people who flirt with illicit substances. The campaign included a tuition package comprising a collection of articles from newspaper, a video containing reports from the Norwegian public broadcaster, NRK, and a teaching guide.

In 2001 the campaign "*You're the only one who can look after your brain*" was organised. The target group comprised young people perceived as being at risk of using drugs. The channels utilised were the internet, cinema, postcards, wall newspapers and youth magazines.

Local campaigns

One example is the City of Oslo which in recent years has organised the campaigns "*Don't mess with my brain*" aimed at ecstasy, and "*Stoned for four hours, apathetic for four weeks*" aimed at the increasing acceptance of cannabis use.

"Outreach workers"

Most large municipalities have outreach services with "Outreach workers". Their duties range from various preventive interventions aimed at older children and young people, and counselling and passing on to the support and treatment services of young people who have developed drug abuse problems.

Parties/techno

"*Future*" is an activity in which an outreach worker in collaboration with young volunteers who are active on the house/techno scene operates an information service about "party drugs" during events and at clubs. Many of the young people who take part in this work have personal experience of ecstasy use and similar. At big house parties, outreach workers also cooperate with the police. Interventions such as on-site pill testing do not form part of this activity.

Schools

Schools are an important arena for preventing drug abuse among children and young people. Drugs and alcohol measures/tuition in schools can be subdivided into two main groups – didactic programmes or classroom tuition, and various forms of interactive programmes. Classroom tuition is either done by the class' ordinary teacher or various "experts" such as the police and social workers, or former drug users are brought in. The aim here is both to provide students with knowledge about different types of intoxicating substances and the negative aspects associated with their use. The interactive programmes are primarily aimed at strengthening young people's social competence so that it is easier for

them to say no to the use of drugs. It varies whether and to what extent these programmes deal specifically with drugs.

15.4 Methodological aspects

As mentioned, there are no national Norwegian survey data about drugs and alcohol use among children/adolescents under the age of 15. That the annual nationwide questionnaire surveys start at age 15 is the result of a conscious choice made on the grounds that one does not wish to contribute to a normative "normalisation" of the use of intoxicating substances among the very young, regardless of whether it is drugs or alcohol that are involved.

For various reasons there is a shortage of general data on the harmful health and social effects of drug use among young people under 18.

Chapter 16. Social exclusion and reintegration

16.1 Definitions and concepts

The conceptual pairing exclusion/integration can both refer to specific social positions and to processes that generate such positions. Social positions can be defined on the basis of one's position in relation to the housing and employment markets, the voluntary organisation sector, informal social networks and prevalent social perceptions about what constitutes acceptable and unacceptable affiliation to the community and expressions of identity. To be excluded means standing on the sidelines of or outside such economic, social and cultural communities. To be integrated means attaining a position inside such communities either for the first time in life (habilitation) or through regaining previously integrated positions (rehabilitation).

Marginalisation is a concept which is often used in Norway to describe and understand the process that leads to exclusion. Marginality is a fluid intermediate position occupied by those who find themselves in the grey area between integrated and excluded positions. The concept of reintegration or inclusion could have been used to describe all those factors and processes that lead to a reduction in marginality, but usually the concept refers to specific interventions instigated in order to achieve the habilitation or rehabilitation of socially excluded persons and groups.

The problem with these concepts lies in defining exclusion or integration as fixed, given quantities. People's images of or own experience of being integrated or excluded will vary – both culturally, individually and historically. Similar problems of definition will also be encountered in the current service and support network. There are, also in the present system, local and regional differences with respect to for instance what triggers help or treatment for various types of drug problems.

In Norway, moreover, we see that the concepts of rehabilitation (and habilitation) are used to describe very many different approaches and goals for reintegration. Different and previously very common concepts such as early or brief intervention, treatment, and more recent concepts such as maintenance treatment and harm reduction are all often referred to as rehabilitation in the current debate. This use of terminology has also served to dampen previous debates on what should be counted as treatment, what measures could be called treatment measures and which groups of professionals that could call themselves therapists. This debate drew a lot of attention away from the fact that most drug users require efforts from many different types of intervention and groups of professionals if reintegration is to be possible.

16.2 Prevalence and patterns of use

Surveys

The question of the use of drugs by the socially excluded requires special surveys. Little information is available in Norway about such matters.

SIFA/SIRUS has carried out periodic surveys of people's use of different drugs. The most recent population survey from 1999 showed that the proportion in the 15-64 age group who had used cannabis during the last 12 months was 4.5 %, for amphetamine 1.2 %, for heroin 0.4 %, for cocaine 0.6 % and for ecstasy 0.7 % (SIRUS 2002).

It has been estimated that there are between 10,000 and 14,000 injecting drug users in Norway. Few characteristics have been published for this group. The age distribution shows that 10 % are under 21, 45 % between 21 and 30 and 45 % over 30. Over time, the drug-user population has become older, and the country will in future experience social problems which are increasingly related to middle-aged drug users (Ødegård et al 2002).

Since 1968, SIFA/SIRUS has carried out annual surveys of drugs and alcohol use among young people in Oslo and, in recent years, also in the rest of the country. (See 2.2)The

proportion of young people between 15 and 20 in Oslo that has used cannabis during the last six months increased from slightly below 10 % in 1990 to approx. 16 % in 2000. The proportion for the country as a whole was 10 %. The proportion that has used other illicit drugs varies from 1 % to 4 % for different types of drugs. However, the statistics do not contain defining characteristics which can identify groups who are particularly at risk (SIRUS 2001).

The report "Youth culture and drug abuse" (NOVA 1997) provides information about the social background of cannabis users. Young people from the social group 'higher academic professions' had a somewhat higher proportion of users than other social groups. Normally, we would not expect to find an overrepresentation of socially excluded persons from this group. Cannabis use is, therefore, probably not a good indicator of problem use of drugs. The report defines the term 'drug users' as users who report drinking alcohol relatively often and who have tried drugs during the last year. In a sample of foundation course students in upper secondary school, almost one third of the students were drug users as defined above. Forty six per cent were what are called low-frequency alcohol users (not drugs), while 22 % did not use drugs or alcohol. The report shows that the proportion of drug users is highest among students from upper managerial social backgrounds and lowest among students from working class backgrounds. Students with poor grades had a greater tendency than others to be drug users.

However, there are differences between drug users and risk users. By risk user is meant a person who reports using alcohol several times per week and/or having tried cannabis six or more times, and/or has tried hard drugs twice or more. Risk users occur most frequently among the middle classes (14-15 %) and least frequently among students from working class backgrounds (12 %). Young people with poor grades had the highest incidence of risk use. Boys had a greater tendency to be risk users than girls (16 % and 11 % respectively).

These figures cannot be taken as estimates of use among specific socially excluded groups. The report provides no information about for instance criminality or other information that might have provided an indicator of marginalisation. The fact that the survey concerns students in upper secondary schools indicates that there is no strong form of social exclusion in operation.

Information about prison inmates shows that 40-60 % of prison inmates use drugs one or more times while serving their sentences (see chapter 2.2).

The report "Pills gone astray" (Rogalandsforskning 1999) provides information about patterns of drugs use among drug users. Informants were recruited through GPs, through advertisements in newspapers and in other ways. The criterion for selection was that the informants used Class B drugs. The data was collected in the form of diaries kept by the informants and through personal interviews. Many of the informants must be described as established drug users. Socially, the informants represented a mixed group. A majority were outside the ordinary labour market and many lived on social security benefits, though some of them were in ordinary employment. Some had criminal backgrounds. Several of the informants can be described as socially excluded from 'normal' society.

Another report contains information about persons who have stayed in different treatment institutions for drug users, 122 clients in all (Rogalandsforskning 1998, report 1988/136). Nearly three quarters of the clients were men. All of them were poly-drug users mixing alcohol and drugs, amphetamine and heroin, heroin and pills, or pills and alcohol. The clients were to a large extent in a marginal situation in relation to the labour market; a majority lived on different types of social security benefits and more than half had no fixed abode before treatment started. A large proportion was involved in crime.

The abuse careers of a sample of drug users is described in a degree thesis (E. Brorson 2002). A small proportion of the informants were problem users. A typical pattern of use consisted of the use of cannabis, amphetamine/cocaine, heroin and alcohol. All in all, this

gives us a very mixed picture of patterns of use among users of illicit substances. We get a clear idea that the more extensive the abuse and the stronger the social exclusion, the more complex are the patterns of use.

A survey carried out by Rogalandsforskning (2001) shows the extent of drugs use among employees in the private sector. The results show that 2.5 % of the respondents had used drugs during the last year, mostly cannabis. This would be equivalent to 70,000 persons among the total working population. Only a small proportion of them could be defined as socially excluded.

16.3 The relationship between social exclusion and drug use

One of our goals is to define the extent to which people are both socially excluded and drug users. We have a lot of information about the prevalence of groups in the population who have a high consumption of drugs and alcohol or who abuse such substances, but it is difficult to document how many are both drug users and socially excluded.

It is natural to think of socially excluded groups as comprising people who score poorly with respect to different indicators of living conditions and life quality. Examples of such indicators are persons of working age outside the labour market, persons who subsist on various kinds of social security benefits, persons who receive municipal social assistance or who have no income, immigrants, persons who have served sentences for crimes, persons in poor housing conditions or of no fixed abode, persons with poor educational qualifications, poor health, long-term serious mental disorders or a poor social network. None of these indicators is in itself sufficient as an explanation of social exclusion, but persons who are socially excluded will often exhibit one or more of the characteristics mentioned.

We know of no statistical estimates of the number of people in the population who score poorly on such indicators simultaneously. There are, however, data regarding the number of persons who fall under the different categories mentioned above. Such data can give us an idea of the prevalence of 'socially excluded' groups.

Table 12. Overview of selected indicators of social exclusion*.

| | Number of persons |
|--|-------------------|
| Immigrant population 2002 | 164,441 |
| Long-term unemployed in all | 14,500 |
| Of whom: Men | 9,200 |
| Women | 5,300 |
| Number who are neither married or cohabitants, nor have a close friend | 285,000 |
| Persons on disability benefit 16-66 years old | 340,000 |
| Financial social assistance, support cases | 140,000 |
| Persons with high alcohol consumption (16 years and above) | 357,000 |
| Inmates in prison | 2,466 |
| Charged with drug-related crimes | 9,552 |
| Charged with crimes against property, except for financial gain | 20,287 |
| Charged with crimes of violence | 5,920 |
| All persons charged both in 1996 and 2000 | 65,000 |
| Of whom: Charged with drug-related crimes | 2,000 |
| Charged with crimes against property (except for financial gain) | 10,000 |
| Charged with crimes of violence | 2,370 |
| Injecting drug users 2000 | 10,000 – 14,000 |

*) Sources: Statistics Norway (SSB). Information about injecting drug users is taken from SIRUS. The information was published between 2000 and 2002. The immigrant population comprises persons with their national origins in Asia, Africa, South and Central America and Turkey.

Drug users may constitute a certain proportion of the population groups presented in table 12, but they may also be found in other sections of the population. We regard it as probable,

however, that drug users are more strongly represented in these population groups than in the remainder of the population.

We shall take a closer look at the individual indicators in table 12. We can with a high degree of certainty assert that not all persons with a high consumption of alcohol (357,000 persons) are socially excluded. There is probably a much higher probability that injecting drug users belong to the socially excluded group (10,000 – 14,000 persons).

The number of persons on disability pensions in the 16-66 age group is 340,000. Nowadays, disability is hardly a valid indicator of social exclusion, but in combination with other characteristics it may be a relevant figure to take into account. Persons combining the characteristics 'drug user' and 'socially excluded' are probably overrepresented among persons on disability benefit, but the majority of persons on disability benefit almost certainly do not belong to this group. Financial social assistance is temporary benefit paid in a difficult life situation, and is an indicator of a marginal position, particularly in relation to one's ability to support oneself/others. Social assistance comprises 140,000 assistance cases⁵.

Criminality is perhaps one of the most stigmatising criteria for social exclusion. The number of prison inmates is a strong indicator of social exclusion, but nevertheless too limited for our purposes to arrive at the prevalence of the combination of drug abuse and social exclusion. Statistics are available for recidivism among persons charged with crimes both in 1996 and 2000. In the drugs-related crime category, slightly more than 2,000 persons were charged in 1996 and charged again for a crime in 2000. The corresponding figures for the category crimes against property (excluding financial gain) were slightly less than 10,000 persons and for crimes of violence 2,370 persons. Repeated charges during this period indicate that we are dealing with persons who are habitual criminals.

The number of persons who are neither married or are cohabitants, nor have a close friend is almost 285,000. This is a relevant indicator of social marginality and is probably a form of social exclusion that comes in addition to other indicators.

In a historical perspective, unemployment has been socially stigmatising and an indicator of marginalisation. The long-term unemployed are still a socially vulnerable group, but we know too little about the extent to which drug abuse is part of the problem associated with unemployment. The number of long-term unemployed persons is around 14,500.

The number of persons with an immigrant background will depend on which countries are included in the definition. Immigrants with backgrounds in Asia, Africa, South and Central America and Turkey number slightly less than 165,000 persons. Here, we will probably find a certain overrepresentation of economic marginality and marginality in relation to the labour market (high unemployment). Even though social integration is poorer compared with ethnic Norwegians, social belonging relating to own ethnic background may be strong (see Skjortnes and Lie 1993, among others). We have no grounds for believing that the proportion of drugs and alcohol users is higher than in the rest of the population.

The information we have does not provide an adequate basis for determining the number of persons who are both drug users and socially excluded. As a lower limit it would not be unreasonable to suppose that the number of injecting drug users is somewhere near the extent of such a group. It would be speculative to attempt to estimate an upper limit. The total number of socially excluded persons is difficult to calculate because many individuals may belong to several of the groups mentioned, the groups not being mutually exclusive.

The number of persons in Norway 16 years old and above is approx. 3.5 million (2002). If we estimate that 5 % of these are socially excluded we arrive at a figure of 178,000 persons. According to this method of calculation the number of persons who are both socially excluded and drug users will be well below this figure.

16.4 Political topics and reintegration programmes

Central topics of discussion

⁵ The number of persons receiving social assistance will be somewhat smaller since individuals can be registered several times.

The public debate in Norway on drugs and alcohol abuse and social exclusion/inclusion has changed character radically three times during the past few decades:

(i)

Before 1960 the abuse of drugs only occurred among very limited and special groups of the population, and primarily in the form of abuse of narcotic substances (morphine and others). However, this abuse mostly took place in socially integrated groups, e.g. among health care professionals and was not a topic in the public debate on drugs and alcohol use. In this context, alcohol was still the dominant topic. As the 1960s and 1970s progressed, new narcotic substances began to be used by special but relatively limited groups of young people. The phenomenon was first understood as a cultural and moral challenge and was incorporated into a broader public debate. Drugs took over as "the good enemy" in the public debate, while the use of other intoxicants such as alcohol and addictive prescription drugs remained in the background. As the first "moral panic" died down and individual users developed major health problems associated with their abuse, the focus of the debate shifted to how to develop and organise satisfactory treatment for "drug users".

(ii)

In the 1980s, recruitment to drug abuse flattened out and the increase in the total consumption of alcohol turned the public debate towards the consequences to public health of higher alcohol consumption in the population as a whole. The debate came to be about possible preventive and health-promoting measures directed towards the population as a whole and measures for early and brief interventions aimed at extensive users and persons with an incipient abuse problem. For a period at the end of the 1980s and beginning of the 1990s, there was also interest in the extensive consumption/abuse of addictive prescription drugs and how changes in doctors' prescribing of such drugs could reduce abuse.

(iii)

As the 1990s progressed the public debate again changed character, and drug abuse has again come into focus. However, the ongoing debate concerns two very disparate phenomena although it is often difficult to keep them apart. The first phenomenon is the consequences of long-term, extensive abuse of narcotic substances and all the other intoxicants that almost invariably form part of such patterns of abuse. This applies not least to the combined abuse of drugs and legally and illegally available prescription drugs.

While the debate has long been about social and moral "deviation" with great emphasis being placed on criminal behaviour (the sale and use of illicit drugs in itself, crimes against property to obtain money for drugs, and crimes of violence in the excluded milieus), the debate in relation to these groups has more and more come to focus on the health aspects of abuse. The abuse of drugs is understood to be a physical and mental ailment and interest has steadily increased in the consequences to health of the abuse itself and in the life situation in which drug users find themselves. The consequences to health should be subdivided into acute health problems such as overdose deaths and more long-term health problems resulting from poor nutrition, hygiene and housing conditions.

The role of the health service

In the present political and professional debate this has led to a lot of attention being focused on the role of the health service in intervention services aimed at drug users. Nobody would disagree that the general health service, both at the primary and specialist levels, has neglected its duties in relation to the health needs of drug users. It is, however, more difficult to decide whether this is primarily due to a lack of competence and capacity to meet these needs, a lack of ability, willingness or opportunity to organise the health service in such a way that they will be more accessible for a group of citizens in a very difficult life situation, or whether it is primarily due to unwillingness to provide necessary health assistance to a socially and morally deviant and excluded group of citizens.

At the specialist level, the treatment services provided for drug users has been organised and authorised partly under health legislation (the Mental Health Act) and partly under social sector legislation (the Social Services Act) at county level. A proposal has now been put

forward by central authorities that the specialised treatment services for drug users, which until now have been organised separately under social legislation, should be brought under the overall legislation governing specialist health services and organised together with these in the new state-owned health enterprises. This is described in more detail in chapter 1.

So-called low-threshold health services have been established in most big towns with the help of government part-financing. This health service does not require referral from another body, patient payments or appointments and, for the most excluded and abject drug users in particular, has improved the chances of receiving necessary health care.

Concern about the miserable physical and mental state of health of many drug users and their deadlocked, excluded and degrading life situation is also the reason why the use of methadone and buprenorphin has gained increasing legitimacy and become more widespread in the Norwegian support services. But there is still extensive debate about what role such measures should have and how large a share they should have of the total resources spent on helping drug users.

Abroad, the use of such drugs is called harm reduction, damage reduction or maintenance treatment. Professionals directly involved in this work prefer the term maintenance treatment, but the programmes are otherwise referred to as medically-assisted treatment. This shows that there is a wish to uphold the goal that such measures be used actively as part of a programme of social integration. To a much greater extent than in most other European countries, therefore, stringent requirements have been stipulated that the abuse shall have lasted for a certain time, that other measures shall have been tried before admission to such a programme and that so-called additional abuse of other substances is brought under control.

There is also concern that measures aimed at increasing users' abilities and chances of achieving social integration (housing, education, work and social network) must form an integral part of medically-assisted treatment. However, many believe that both these types of requirements are under pressure; programmes have been opened for broader groups through a more discretionary evaluation of criteria such as age, length of career as user and acceptance of a certain amount of additional abuse of other substances. The criteria for admission to such programmes are currently being reconsidered and it is uncertain how far one will go in extending admission to new groups.

The municipal health and social care services and the government bodies, the National Insurance Service and the Labour Market Administration, will have a great responsibility for drug users admitted to such programmes, both in relation to providing housing, educational opportunities or occupational training programmes and lasting social security benefits or temporary benefits in the form of financial social assistance or rehabilitation benefit. In general, extensive support and rehabilitation measures are instigated in relation to most of those admitted, but many people are concerned that the scope and quality of the measures will be impossible to maintain or that efforts aimed at other groups will be given lower priority. The total investment in resources in municipal social services has for instance increased much less than the increase in capacity in medically-assisted treatment. While the municipalities' total expenditure on social services has increased by approx. 6 % annually in recent years, the number of patients admitted to programmes for medically-assisted treatment has increased from 204 at year end 1998 to 1,072 at year end 2000, and further to 1,503 at year end 2001 – and there were still 649 people on the waiting list or waiting to be evaluated for such programmes.

About new groups of users

The other major topic in the public and professional debate on drug abuse and the intervention services' ability to deal with the problem, is the use of established and more recent stimulants among groups and in milieus not previously associated with drug use. It started with attention being focused on such use in special music, dance and party settings and the substances in question are often referred to as "party drugs". However, this term has

become less appropriate as their use has spread to several other settings, including the private sphere.

What is new about this situation is the fact that we are dealing with groups of young people in an apparently integrated and well-functioning life situation, which has traditionally been believed to act as a barrier against the development of abuse problems. It has become increasingly important to distinguish between a relatively short period of experimentation with drugs, which fortunately appears to be the case for most people, and the rapid and destructive development of abuse, which seems to affect more and more people in this group. There is also concern about the serious mental disorders and the rapid social marginalisation, which seems to be associated with abuse of these substances.

A few years ago this kind of abuse was known to be evolving, but the traditional support services had great difficulty establishing contact with these groups. This was due to the fact that the harmful health effects of the abuse were not so pronounced to start with, with the exception of some overdose cases and acute physical and mental harmful effects encountered by the emergency medical services. It was first with the onset of more long-term mental health effects and the social marginalisation due to extensive long-term abuse that both the municipal health and social care services and the specialised drugs treatment services were contacted by these drugs users. The first people to come into contact with these groups were the outreach workers. Today, it is the psychiatric youth teams in particular and the rest of the psychiatric support services which, together with the municipal health services, comprise the support service for this group. There is also debate as to whether a separate institutional service should be established for this group.

In municipal social services, it is still the far-advanced "traditional" drugs and alcohol users who predominate. As already mentioned, the programmes of medically-assisted treatment have had a major impact on the municipal resources invested, although no surveys have been carried out to establish what distorting effects this may have had. A large proportion of middle-aged and elderly drugs and alcohol users now receive social security benefits on a permanent basis and have thereby achieved a kind of social inclusion. The municipalities have as a rule also managed to provide acceptable housing for this group so that the number of homeless is relatively small. But in relation to social networks and their life situation otherwise, these are often the most excluded and socially isolated of the drugs and alcohol users.

Results of the evaluation

Many forms of user surveys and self-evaluations are carried out in the Norwegian support services for drug users, while few systematic result evaluations are carried out, both with respect to treatment and measures aimed at social reintegration. Here, we shall focus on three evaluations dealing with different parts of the support services, with different designs and very different in scope. These may tell us something about how successful social reintegration appears to be.

SIRUS is currently carrying out a major evaluation of treatment and rehabilitation in which the focus is on costs and the benefit resulting from support measures. (See 11.1. Research on treatment and evaluation). A recruitment survey and two follow-up surveys of a sample of a total of 482 clients (including a sample of 75 "methadone clients" admitted to the project at a later date) have been carried out. The follow-up surveys show that a marked, rapid and lasting reduction in drugs and alcohol use and crime is achieved, as well as an improvement in mental health, while little seems to be achieved in relation to social reintegration. For instance, the number of days in legitimate employment did not increase during the period from recruitment to the first and second follow-up.

An evaluation by Rogalandsforskning (Tungland 1998) of clients at four treatment institutions appears to arrive at the same conclusions. Almost 70 % of the 122 clients in the survey were drugs-free or had achieved a marked reduction in their consumption, but the clients had not achieved any significant improvement in their housing situation or improvement of other criteria for increased quality of life. The survey points to the lack of an overall rehabilitation

perspective as one main reason for the poor results in terms of social reintegration, and reference is made to the fact that for some a drugs-free life leads to further social isolation both in relation to integrated and excluded social communities.

During the period after the survey by Rogalandsforskning, increased competence and interest in drugs and alcohol related work, coupled with the introduction of medically-assisted treatment, have led to a strengthening of comprehensive rehabilitation work. A survey on user satisfaction in the social services in Sola municipality (in progress) shows that between one fifth and one third of users who have been in treatment in an institution in recent years (a total of 33 clients) report that they are highly or very highly satisfied with the social services efforts aimed at improving their situation in relation to housing, finances, education and work. Furthermore, approx. one third report that they master their lives better or much better in terms of education, work and finances. Approx. half experience better or much better mastery in relation to leisure time, family, own children and friends. This feedback provides hope for the development of more comprehensive and efficient programmes and methods aimed at social reintegration and increased quality of life.

16.5 Conclusions and data basis

The use and abuse of drugs in Norway today is associated with varying degrees of stigmatisation and social exclusion. The spectrum ranges from the groups of abject extensive users to more fashion-conscious, thrill-seeking and seductive use. The first group appears to be totally excluded, the latter to be socially well-functioning and integrated.

In between these positions we find the marginalised or those who find themselves on the borderline between the abject (excluded) and the well-functioning (integrated). Marginality is about being allowed in or being rejected in a kind of musical chairs in which it is possible to switch between being included and excluded. If we examine this further in a life-course perspective, we see that different people can be more or less marginalized, integrated or excluded at different stages in their lives. However, a major problem of definition arises when an attempt is made to stipulate what one is marginalized or excluded in relation to. What does it mean to be integrated?

Our conception of "drug addicts", therefore, is not so much linked to the use or abuse of narcotic substances, but more to the lifestyle and wretchedness associated with the most visible and abject among them. The reverse side of this image consists of the issues relating to the physical dependency created by the substances, the crime that follows in the wake of drug abuse and the support services network established by society to alleviate these problems. How we explain or understand abuse and the users' dependency will therefore determine in different ways how we think about reintegration and rehabilitation. The same applies to the way we organise the support and treatment services we believe that drug users need, and/or are entitled to, in order to progress towards a more normalised everyday life – in which they are integrated.

This review shows that the major methodological problem has been to find statistics and research on the relationships between social exclusion/inclusion and the use/abuse of drugs among the socially excluded section of society. There are lots of statistics and research which can tell us something about the extent of, and the processes underlying, social exclusion or marginalisation. There are also lots of statistics about the use of different intoxicants in the population. There are far fewer statistics and research providing reliable information about the actual extent of what is defined as serious drug abuse. And hardly any statistics are available that could tell us something about the extent and patterns of social exclusion and inclusion among different groups of drug users, and provide reliable information about the degree of social exclusion which results from drug abuse. We need different types of user surveys and evaluations which provide background information and data about social reintegration in order to improve our knowledge about the life situations of different groups of drug users and thereby also be capable of strengthening comprehensive and differentiated rehabilitation services.

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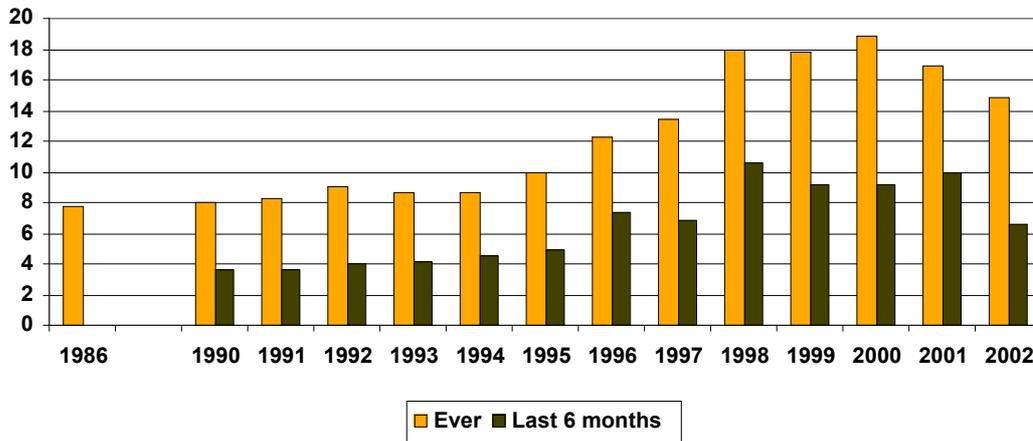
Norwegian abbreviations used in this report:

| | |
|----------|---|
| SIRUS - | Norwegian Institute for Alcohol and Drug Research |
| AKAN - | The Norwegian Tripartite Committee for the Prevention of Alcohol and Drug Problems in the Workplace |
| SRI - | The National Institute of Forensic Toxicology |
| Kripos - | National Bureau of Crime Investigations |
| SSB - | National Bureau of Statistics |

Annexes

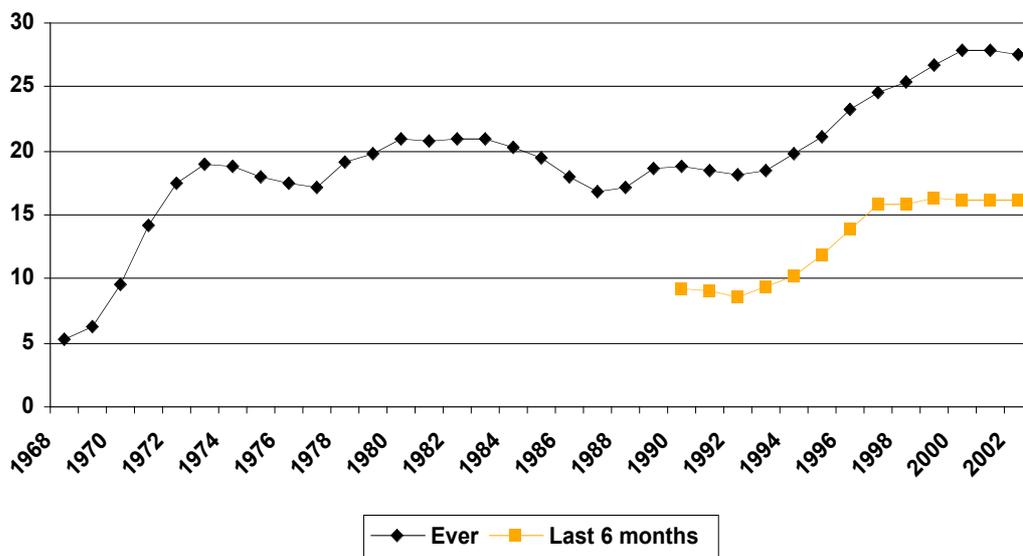
Figures 1-16

Figure 1. Percentage of youth aged 15-20 years in Norway who report having used cannabis at some time during the last six months 1986-2002.



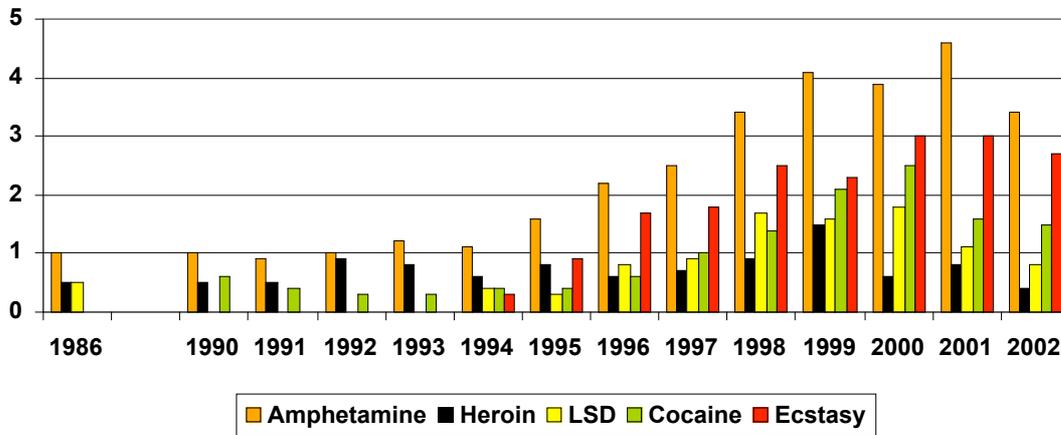
Source: SIRUS

Figure 2. Percentage of youth aged 15-20 years in Oslo who report that they have used cannabis at some time during the last six months, 1968-2002 (three year sliding average).



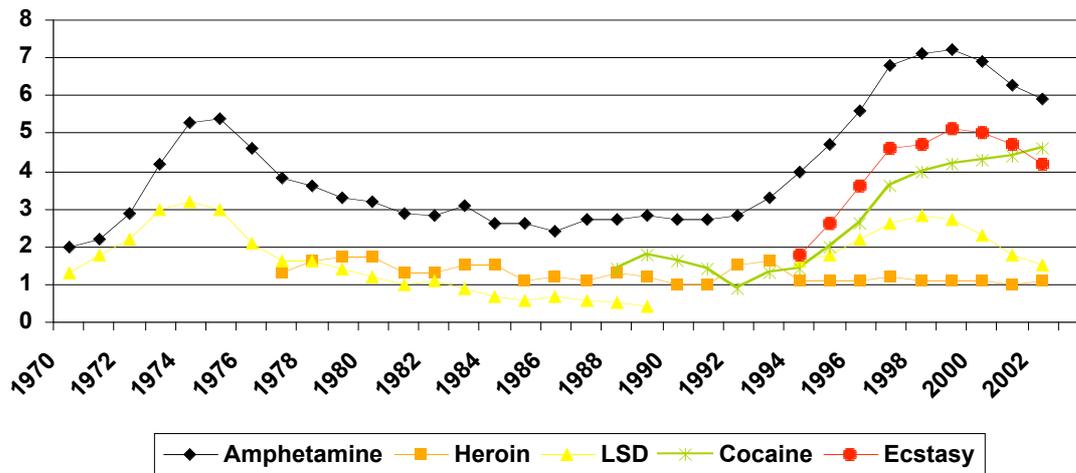
Source: SIRUS

Figure 3. Percentage of youth aged 15-20 years in Norway who have tried different narcotic substances at some time, 1986-2002.



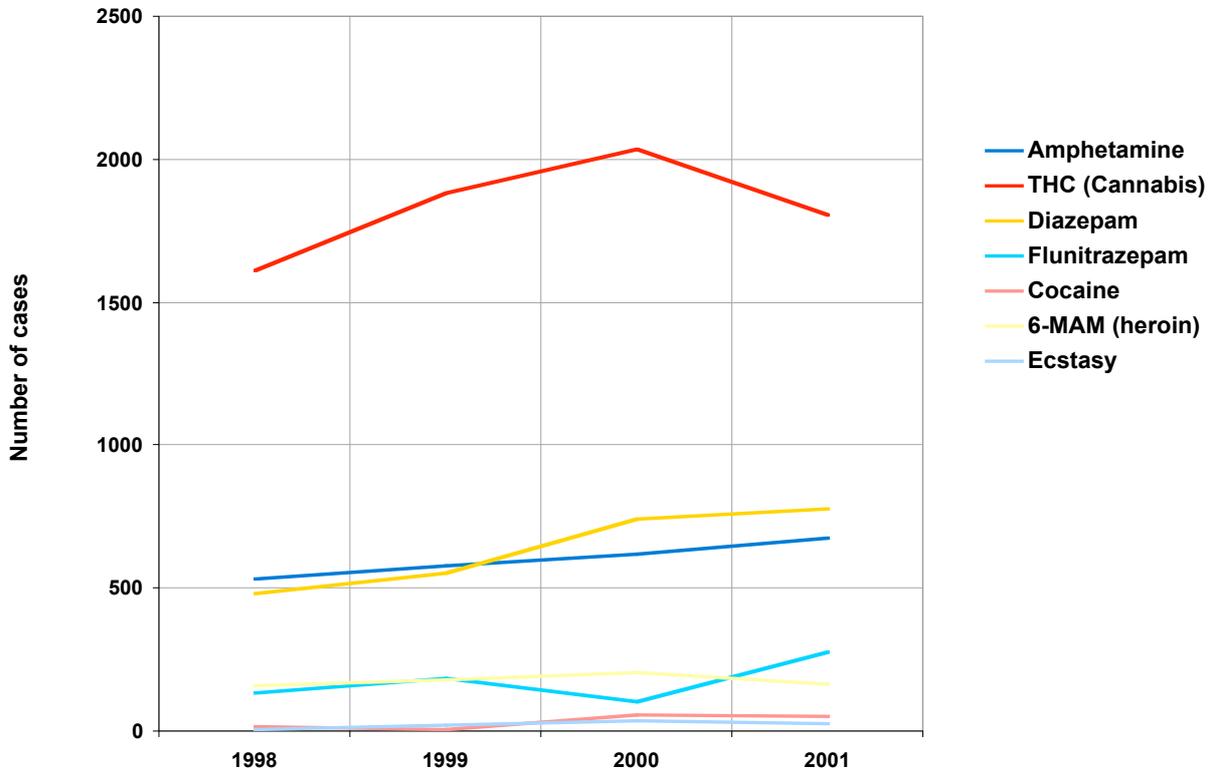
Source: SIRUS

Figure 4. Percentage of youth aged 15-20 years in Oslo who have used different narcotic substances at some time, 1970-2002 (three year sliding average).



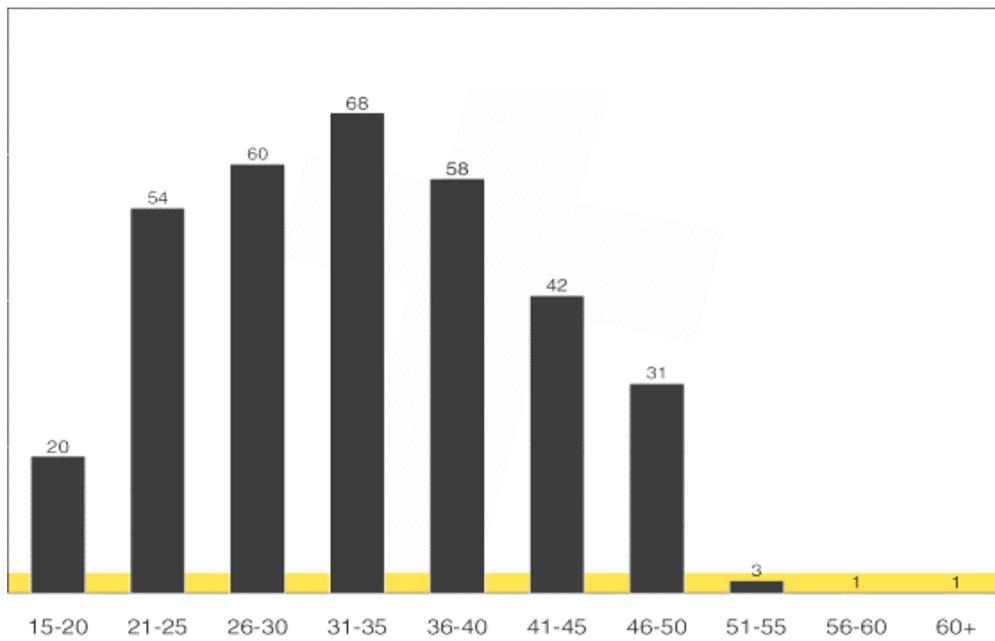
Source: SIRUS

Figure 5. Drugs detected in criminal care cases



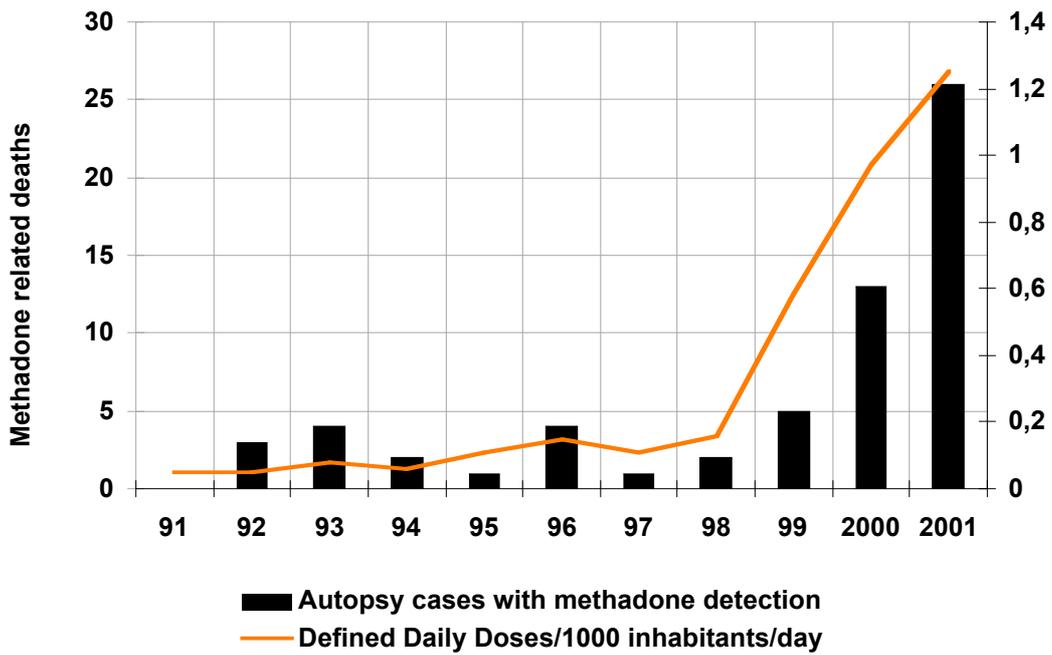
Source: SRI

Figure 6 Drug related mortality 2001 by Age



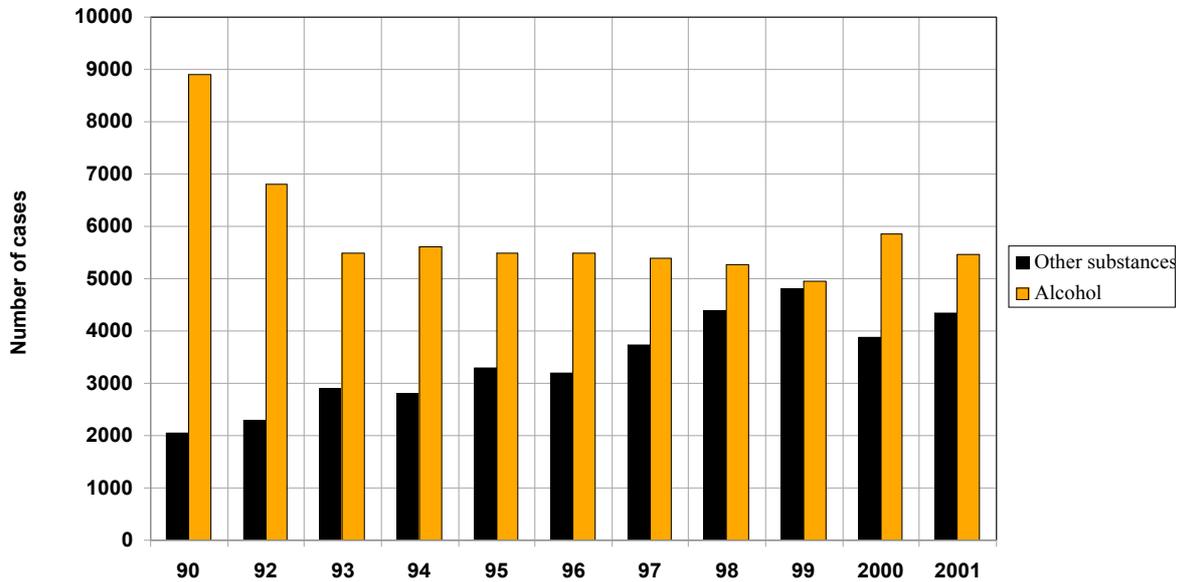
Source: Kripas

Figure 7 Methadone-related mortality in Norway 1991-2001



Source :SRI

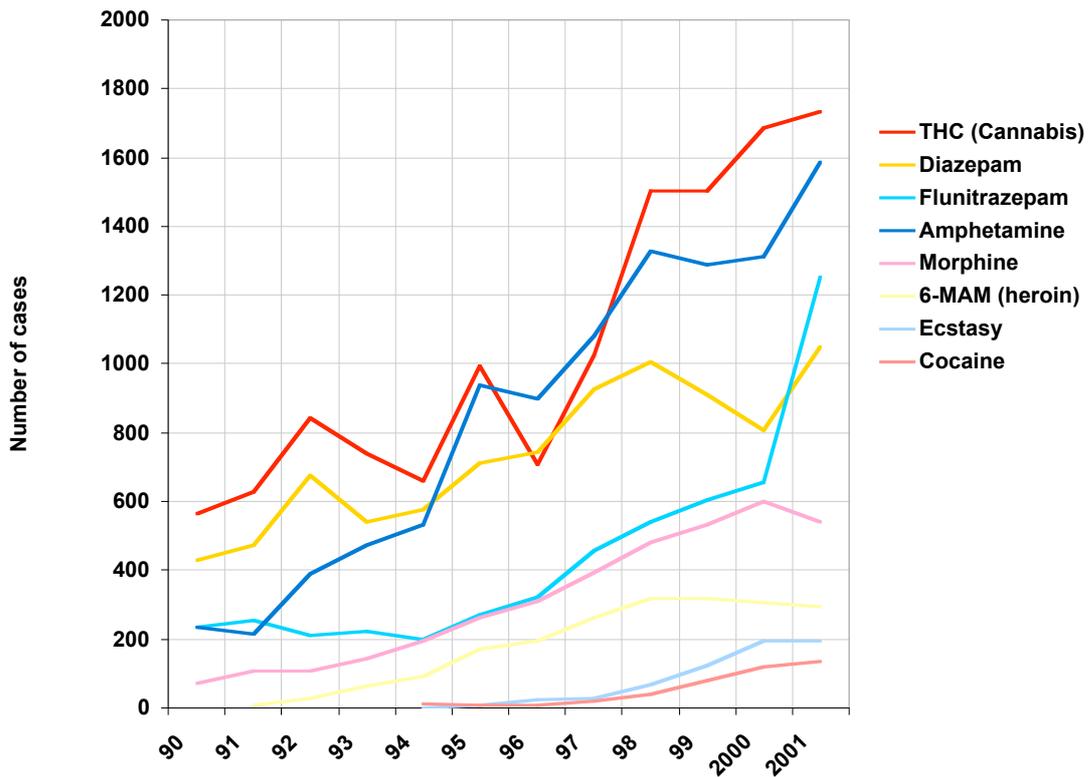
Figure 8. Number of motorists arrested for the period 1990-2001 for under suspicion of driving under the influence of alcohol or other drugs.



From 1996: *Both breath analysers and bloods tests for alcohol are included.

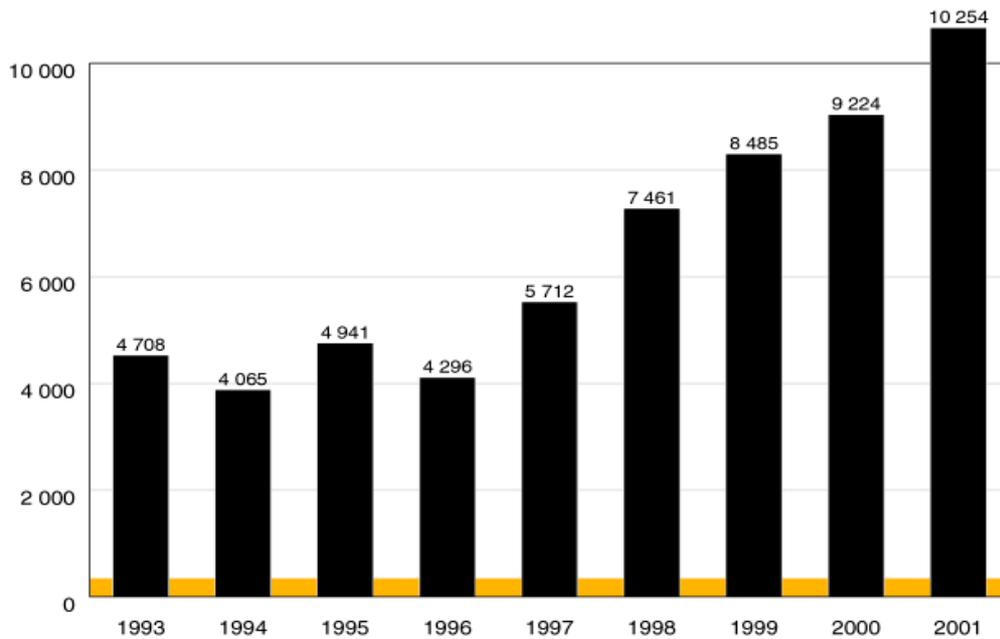
Source: SRI

Figure 9 Substance detection in traffic-related cases



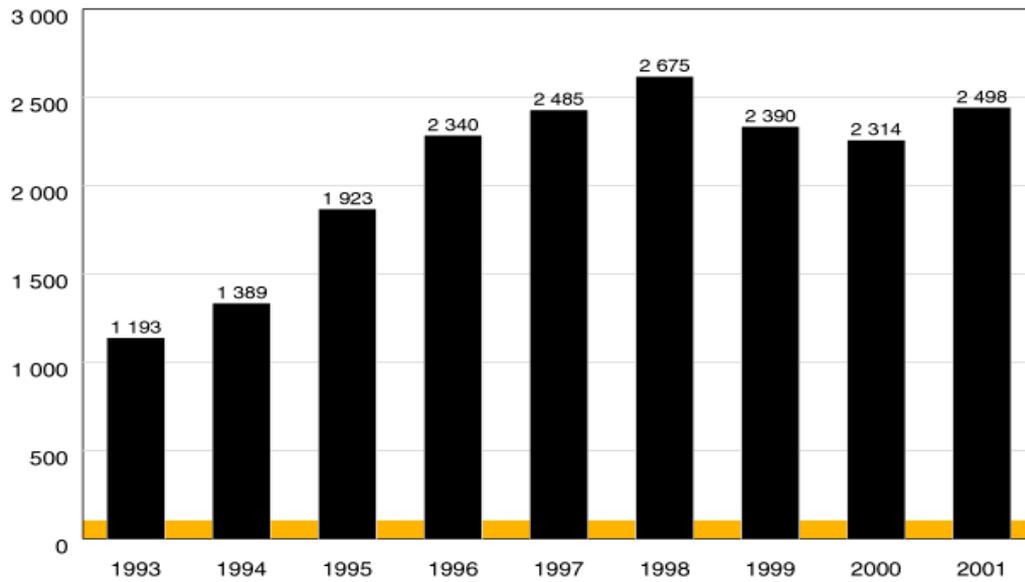
Source: SRI

Figure 10 Cannabis. Number of seizures 1993- 2001



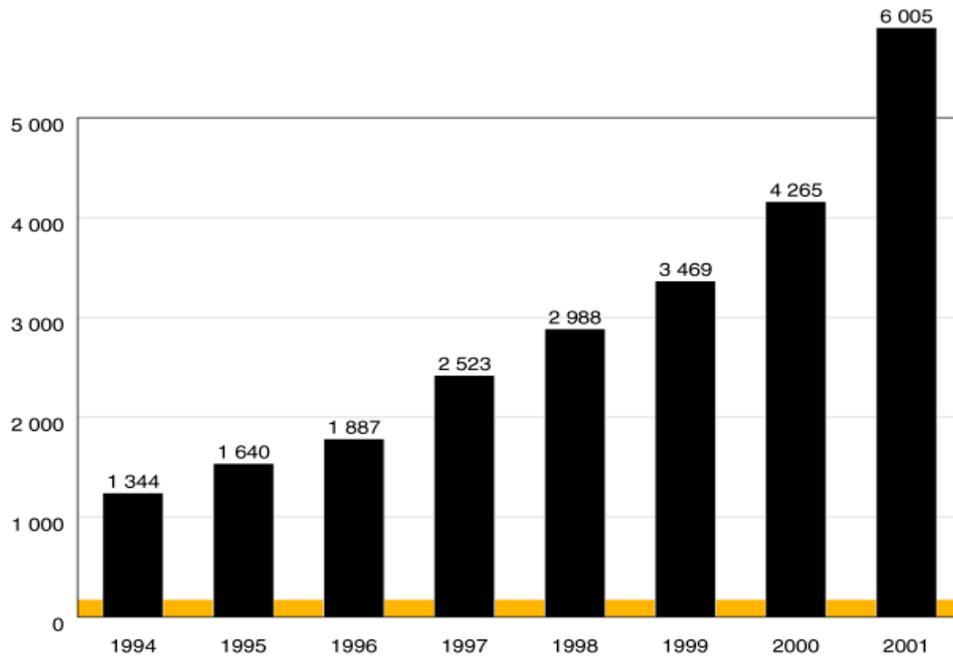
Source:Kripos

Figure 11. Heroin. Number of seizures 1993- 2001



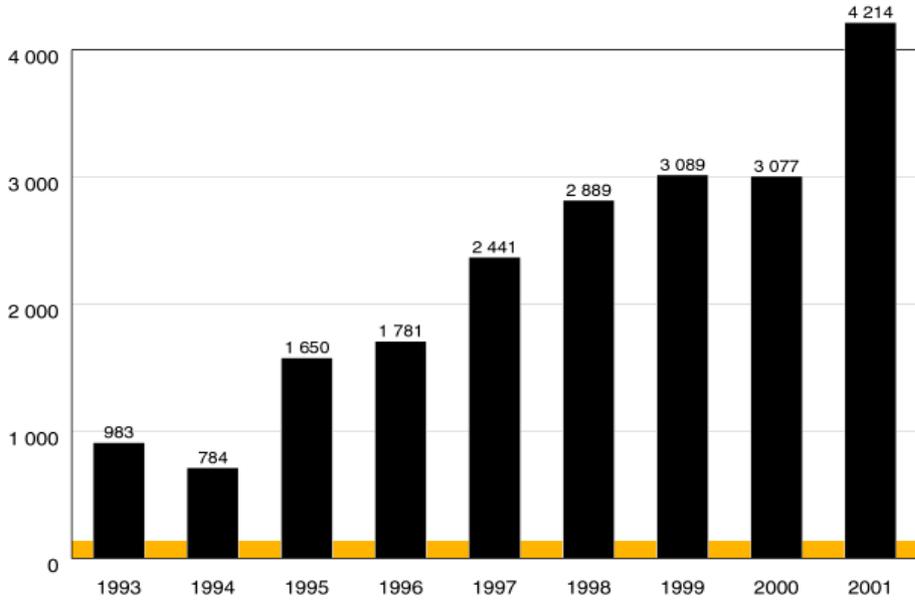
Source:Kripos

Figure 12. Benzodiazepines. Number of seizures 1994 - 2001



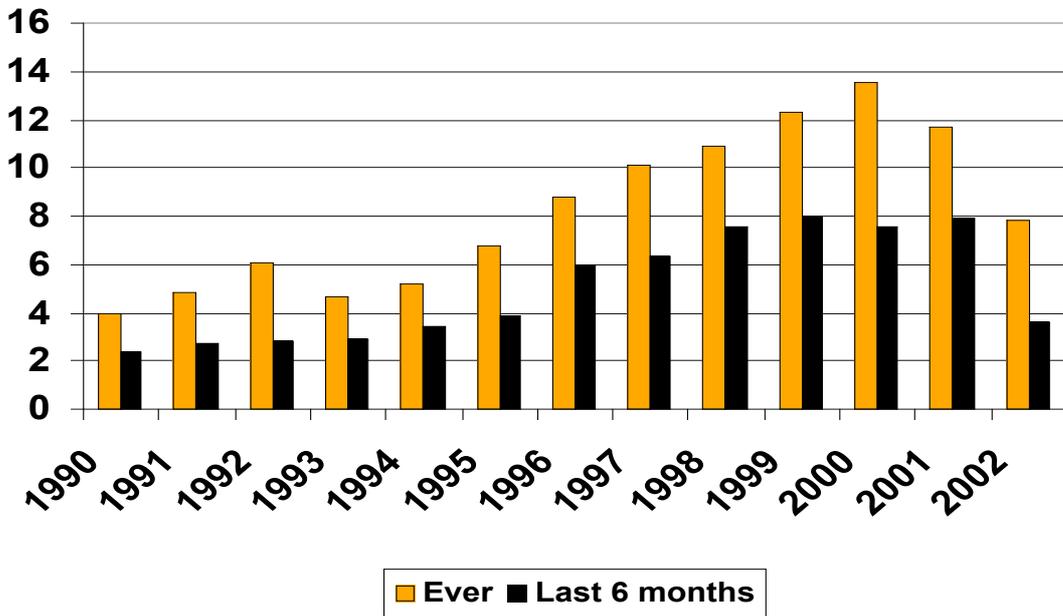
Source:Kripos

Figure 13 Amphetamines. Number of seizures 1993 - 2001



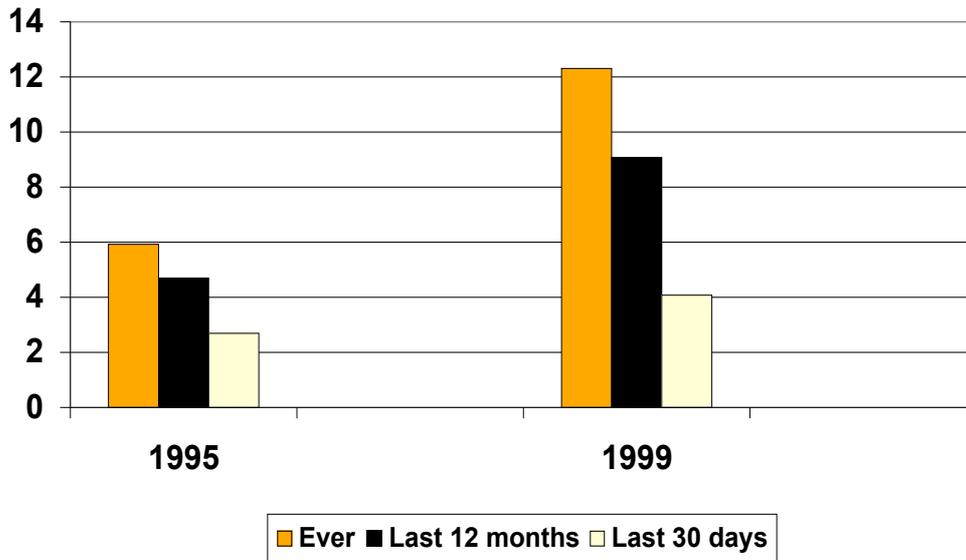
Source: Kripos

Figure 14. Proportion of 15-17-year-olds in Norway who report that they have used cannabis, ever and during the last six months respectively.



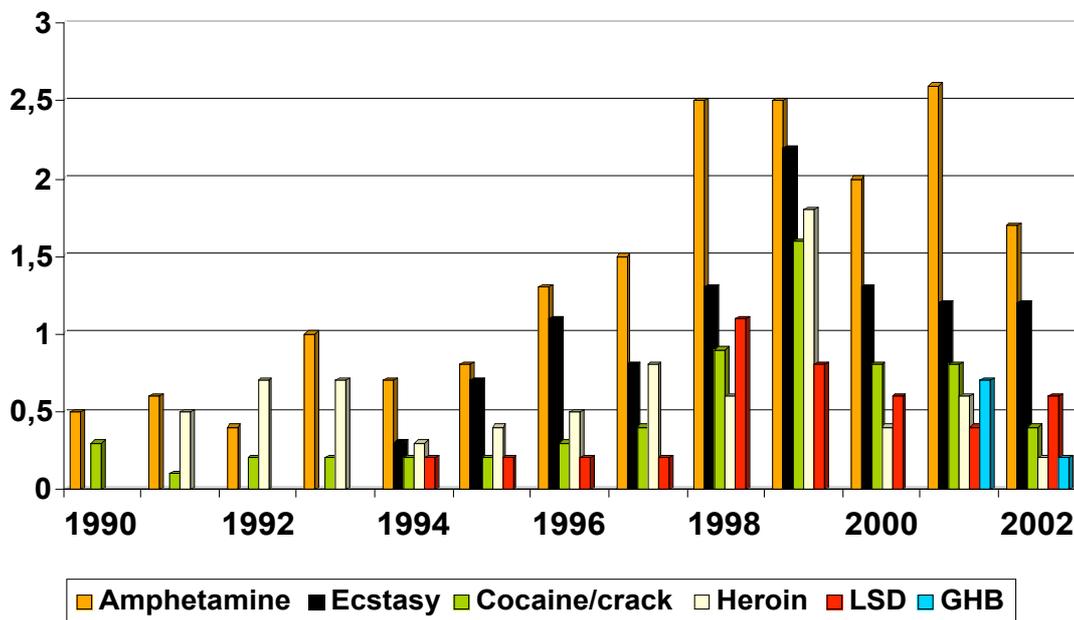
Source: SIRUS

Figure 15. Percentage of 15-16-year-olds who report that they have used cannabis, ever, during the last 12 months and during the last 30 days respectively.



Source: SIRUS, ESPAD survey

Figure 16. Proportion of 15-17-year-olds in Norway who report that they have ever used various drugs



Source: SIRUS' annual youth surveys

Tables 1-12

Table 1. Percentage of 15-16 year olds (ESPAD) who report having used cannabis at some time, during the last 12 months and last 30 days.

| | Any time | Last 12 months | Last 30 days |
|------|----------|----------------|--------------|
| 1995 | 5.9 | 4.7 | 2.7 |
| 1999 | 12.3 | 9.1 | 4.1 |

Source: SIRUS

Table 2. Registered referrals, initiated and completed treatment

| Year | Nr of incidences (of approx.190) | Nr of referrals | Nr of Initiated treatment programmes | Nr treatment programmes concluded |
|------|-----------------------------------|-----------------|--------------------------------------|-----------------------------------|
| 1998 | 110 | 18.115 | 13.541 | 10.956 |
| 1999 | 110 | 20.426 | 15.700 | 12.634 |
| 2000 | 113 | 26.462 | 18.981 | 15.738* |

*Figures for completion for 2000 include 2271 treatment programmes that are registered as "incomplete" at the close of the year.

Table 3.

Drug-related mortality by gender

According to Kripos and SSB (underlying cause of death)

| 1991-2001 | Number of deaths according to Kripos | | | Number of deaths according to SSB | | |
|-----------|--------------------------------------|-------|-------|-----------------------------------|-------|-------|
| | 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 | 171 | 26 | 197 |
| 1997 | 149 | 28 | 177 | 155 | 30 | 185 |
| 1998 | 226 | 44 | 270 | 224 | 50 | 274 |
| 1999 | 181 | 39 | 220 | 179 | 57 | 236 |
| 2000 | 264 | 63 | 327 | 302 | 72 | 374 |
| 2001 | 286 | 52 | 338 | .. | .. | .. |

Sources: Kripos and SSB

Table 4. Proportion of intravenous drug users who are registered as persons with HIV infection and AIDS with risk behaviour of drug injection, according to year of diagnosis.

| | HIV Total | HIV-intravenous drug user | Percentage of HIV intravenous drug user | AIDS total | AIDS Intravenous drug user | Percentage of AIDS-intravenous drug user |
|--------------|--------------|---------------------------|---|------------|----------------------------|--|
| 1984-89 | 894 | 315 | 35 % | 144 | 8 | 6 % |
| 1990 | 90 | 22 | 24 % | 59 | 13 | 22 % |
| 1991 | 142 | 16 | 11 % | 59 | 16 | 27 % |
| 1992 | 105 | 12 | 11 % | 50 | 8 | 16 % |
| 1993 | 113 | 13 | 12 % | 64 | 13 | 20 % |
| 1994 | 94 | 12 | 13 % | 74 | 19 | 26 % |
| 1995 | 105 | 11 | 10 % | 67 | 8 | 12 % |
| 1996 | 116 | 9 | 8 % | 56 | 12 | 21 % |
| 1997 | 113 | 11 | 10 % | 34 | 8 | 24 % |
| 1998 | 98 | 8 | 8 % | 39 | 5 | 15 % |
| 1999 | 147 | 12 | 7 % | 28 | 6 | 21 % |
| 2000 | 176 | 7 | 4 % | 38 | 6 | 16 % |
| 2001 | 158 | 8 | 5 % | 26 | 4 | 15 % |
| total | 2 351 | 456 | 19 % | 738 | 126 | 17 % |

Source: National Institute for Public Health

Table 5. Number of drug crimes reported and investigated

| | Civil Penal Code § 162 | | Act on Medicinal Products | | Total | |
|------|------------------------|---------------------|---------------------------|---------------------|-----------------|---------------------|
| | Reported crimes* | Investigated crimes | Reported crimes | Investigated crimes | Reported crimes | Investigated crimes |
| 1985 | | 1 137 | | 3 666 | | 4 803 |
| 1986 | | 1 794 | | 2 789 | | 4 583 |
| 1987 | | 2 364 | | 2 244 | | 4 608 |
| 1988 | | 3 624 | | 2 605 | | 6 229 |
| 1989 | | 4 266 | | 3 837 | | 8 103 |
| 1990 | | 4 697 | | 4 394 | | 9 091 |
| 1991 | 7 377 | 5 328 | 5 711 | 4 621 | 13 088 | 9 949 |
| 1992 | 7 692 | 6 250 | 6 328 | 5 059 | 14 020 | 11 309 |
| 1993 | 7 640 | 6 458 | 6 432 | 5 281 | 14 072 | 11 739 |
| 1994 | 8 005 | 6 458 | 6 759 | 5 384 | 14 764 | 11 842 |
| 1995 | 11 911 | 8 044 | 11 420 | 7 629 | 23 331 | 15 673 |
| 1996 | 13 669 | 10 310 | 13 786 | 10 442 | 27 455 | 20 752 |
| 1997 | 16 169 | 11 639 | 18 376 | 12 360 | 34 545 | 23 999 |
| 1998 | 17 276 | 13 809 | 21 498 | 16 489 | 38 774 | 30 298 |
| 1999 | 17 820 | 16 041 | 23 167 | 20 135 | 40 987 | 36 176 |
| 2000 | 19 302 | 16 718 | 24 726 | 21 574 | 44 028 | 38 292 |
| 2001 | 21 411 | | 27 548 | | 48 959 | |

Source: Crime Statistics, Statistics Norway (SSB)

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

Table 6. Number of persons charged with drug crimes

| | Civil Penal Code, § 162 | Act on Medicinal Products | Total |
|------|------------------------------------|--|--------------|
| 1985 | 609 | 1 332 | 1 941 |
| 1986 | 825 | 1 150 | 1 975 |
| 1987 | 915 | 1 021 | 1 936 |
| 1988 | 1 260 | 1 064 | 2 324 |
| 1989 | 1 367 | 1 690 | 3 057 |
| 1990 | 1 511 | 1 821 | 3 332 |
| 1991 | 1 584 | 1 993 | 3 577 |
| 1992 | 1 974 | 1 929 | 3 903 |
| 1993 | 2 282 | 1 508 | 3 790 |
| 1994 | 2 143 | 1 303 | 3 446 |
| 1995 | 2 496 | 1 442 | 3 938 |
| 1996 | 2 878 | 1 577 | 4 455 |
| 1997 | 3 424 | 1 764 | 5 188 |
| 1998 | 4 056 | 2 430 | 6 486 |
| 1999 | 4 891 | 3 111 | 8 002 |
| 2000 | 5 539 | 3 651 | 9 190 |

Source: Crime statistics, Statistics Norway

Table 7. Number of seizures 1999-2001 by most common substance:

| Substance | 1999 | 2000 | 2001 |
|------------------|-------------|-------------|-------------|
| Cannabis | 8 485 | 9 224 | 10 254 |
| Amphetamine | 3 089 | 3 077 | 4 214 |
| Methamphetamine | 47 | 152 | 337 |
| Heroin | 2 378 | 2 314 | 2 499 |
| Benzodiazepines | 3 469 | 4 265 | 6 005 |
| Pain killers | 930 | 845 | 1009 |
| Doping | 398 | 469 | 559 |
| Cocaine | 309 | 390 | 477 |
| Ecstasy | 502 | 783 | 829 |
| Khat | 296 | 255 | 198 |
| LSD | 59 | 87 | 52 |
| GHB | 48 | 83 | 82 |
| Opium | 10 | 19 | 24 |

Source: Kripas

Table 8. Number of police districts that have seized different drugs (of 54 districts until 2001 and then number reduced to 27).

| | 1989 | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001* |
|--------------|------|------|------|------|------|------|------|------|-------|
| Heroin | 19 | 39 | 41 | 43 | 48 | 46 | 52 | 50 | 27 |
| Amphetamines | 39 | 45 | 52 | 49 | 53 | 52 | 54 | 54 | 27 |
| Cannabis | 53 | 54 | 54 | 54 | 54 | 54 | 54 | 54 | 27 |
| Ecstasy | - | 7 | 27 | 26 | 26 | 26 | 38 | 47 | 27 |
| LSD | 3 | 4 | 12 | 15 | 22 | 17 | 21 | 24 | 13 |
| Cocaine | 9 | 11 | 14 | 16 | 17 | 33 | 33 | 35 | 26 |

Source: Krijpos

*new division of 27 police districts

Table 9. Some drug prices in Oslo (January 2002). In EURO. Conversion rate: 1 EUR= NOK 7.50

| Substance | User dosage | 1 gram | 10 grams | 1 kilo |
|--------------|------------------|------------------|--------------------|----------------|
| Heroin | 47-53 | 197-200 | 800 -1 333 | 33 333 -53 333 |
| Hash | 13 | - | 87-107 | 4 000-6 667 |
| Amphetamines | 27 | 27-53 | 267-400 | +/-13 333 |
| Ecstasy | 13-27 per tablet | 13-20 per tablet | 10,5-13 per tablet | |

Source: Oslo Police District

Table 10. Expenditure on measures for drug abusers 1980 - 2000. In million Conversion rate: 1 EURO= NOK 7.50

| 1980 | 1985 | 1990 | 1995 | 1997 | 1998 | 1999 | 2000 | Increase in % 1980-2000 | Increase in % 1990-2000 | Increase in % 1999-2000 |
|------|------|-------|-------|-------|-------|-------|-------|-------------------------|-------------------------|-------------------------|
| 26.9 | 112 | 111.7 | 172.4 | 202.5 | 216.3 | 224.9 | 230.6 | 756.40% | 106.40% | 2.50% |

Table 11. Presumed risk of subjecting oneself to harmful effects by smoking cannabis in the following ways. Proportion as a percentage.

| | Try cannabis once or twice | | | Smoke cannabis occasionally | | | Smoke cannabis regularly | | |
|------|----------------------------|----------------|-----------|-----------------------------|----------------|-----------|--------------------------|----------------|-----------|
| | No/ little risk | Mod-erate risk | High risk | No/ little risk | Mod-erate risk | High risk | No/ little risk | Mod-erate risk | High risk |
| 1995 | 32 | 27 | 36 | 11 | 34 | 49 | 2 | 8 | 87 |
| 1999 | 37 | 29 | 28 | 16 | 37 | 42 | 4 | 13 | 78 |

Table 12. Overview of selected indicators of social exclusion*.

| | Number of persons |
|--|--------------------------|
| Immigrant population 2002 | 164,441 |
| Long-term unemployed in all | 14,500 |
| Of whom: Men | 9,200 |
| Women | 5,300 |
| Number who are neither married or cohabitants, nor have a close friend | 285,000 |
| Persons on disability benefit 16-66 years old | 340,000 |
| Financial social assistance, support cases | 140,000 |
| Persons with high alcohol consumption (16 years and above) | 357,000 |
| Inmates in prison | 2,466 |
| Charged with drug-related crimes | 9,552 |
| Charged with crimes against property, except for financial gain | 20,287 |
| Charged with crimes of violence | 5,920 |
| All persons charged both in 1996 and 2000 | 65,000 |
| Of whom: Charged with drug-related crimes | 2,000 |
| Charged with crimes against property (except for financial gain) | 10,000 |
| Charged with crimes of violence | 2,370 |
| Injecting drug users 2000 | 10,000 – 14,000 |

*) Sources: Statistics Norway (SSB). Information about injecting drug users is taken from SIRUS. The information was published between 2000 and 2002. The immigrant population comprises persons with their national origins in Asia, Africa, South and Central America and Turkey.