



**REPORT TO THE EMCDDA  
by the Reitox National Focal Point**

**NORWAY  
DRUG SITUATION 2003**

**REITOX**

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## Introduction

The report on the drug situation in Norway 2003 is based on collected data and written contributions from central public institutions and important players in the alcohol and drugs field in Norway. Part I was mainly written by the Ministry of Social Affairs. The external authors who contributed to parts II and III are mentioned under "co-authors". The authors of part IV are listed under each specific topic.

Most of the data in the report are from 2002. For seizures of narcotic substances and tendencies and trends, a summary has been included for the first six months of 2003.

Odd Hordvin, the Focal Point's senior advisor, has edited the report. An internal reference group in SIRUS, consisting of Director Knut Brofoss, Head of Research Sturla Nordlund, Advisor Hege C. Lauritzen, Researcher Astrid Skretting (scientific committee), Researcher Einar Ødegård and Advisor Marte K. Ødegård Lund, has commented on and approved the written contributions and the data.

I would like to thank everyone, both at SIRUS as well as external partners, for their contributions.

Oslo, November 2003

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## Summary

- The most marked change in relation to 2001 is the strong reduction in the number of drug fatalities in 2002. Figures from the National Criminal Investigation Service show that 210 persons died as a consequence of narcotic substance abuse in 2002. This is almost 40% fewer than in 2001, when 338 such deaths were reported. The reduction may have several causes, including reduced heroin availability, less pure heroin, the fact that an increasing number of opiate users are in substitution treatment and the considerable increase in low threshold health services.
- There was no demonstrable increase in the use of narcotic substances among young people between the ages of 15 and 20 from 2002 to 2003. SIRUS' survey of 15-20 year-olds for 2003 shows a marked increase in the use of alcohol, but no major changes from 2002 as regards the use of and attitudes to illicit drugs.
- Various data sources and surveys show that drugs are being increasingly used and sold outside Oslo. There are hardly grounds for claiming that the number of young people at risk has increased, but the rural – urban constellation is in a process of change. Moreover, the socio-cultural dimension with increased availability of new substances in new milieus is a relatively clear trend viewed in a longer-term perspective.
- An increasing number of drivers are caught driving under the influence of narcotic and medicinal drugs. The increase from 2001 to 2002 is much greater than any previously recorded – almost 20%. The samples taken reveal the presence of illicit drugs and a high proportion of medicinal drugs, particularly tranquillizers and sleeping pills. Figures showed a doubling in the incidence of Rohypnol.
- At the same time we have seen a clear increase in the number of seizures of several of the most common illegal substances in 2001 and 2002. Figures for 2002 show that the biggest absolute increases were for benzodiazepines and amphetamines. Seized quantities of benzodiazepines also increased markedly, particularly the quantities of Rohypnol.
- Figures for the first six months of 2003 show, however, a clear decrease in the number of drug cases and seizures. This applies to most substances, except LSD and GHB, and is particularly marked for ecstasy, benzodiazepines, cocaine and heroin. On the other hand, there have been many big seizures of most types of drugs.
- In 2003 efforts to expand low threshold health services for heavy problem users have been intensified. There has again been a steep rise in the number of clients in medically assisted rehabilitation.
- From 2002 ownership and operational responsibility for hospitals passed to the state. It is expected that also the counties' responsibility for institutions and associated specialist services for the treatment of drug users will be transferred to the state from 2004. A bill (Drugs and Alcohol Reform 2) is scheduled for consideration by the Storting in the autumn of 2003. The aim is to implement the reforms concurrently, with effect from 1 January 2004.
- The Government's new Action plan to combat alcohol and drug problems (2003-2005) outlines strategically important goals for a policy on drugs and alcohol. As part of the implementation two expert advisory committees were appointed in 2003 – one on alcohol and one on drugs. The committees are to provide the Government with ongoing advice about specific drug policy challenges, evaluate interventions, propose new ones and stimulate the development of more knowledge.

- On commission from the Minister of Social Affairs, a research commission has summarised existing knowledge on the effects of drug abuse prevention measures, identified a need for further research and pointed out political dilemmas and possibilities in this area in coming years. The commission submitted its report in February 2003. On the basis of this report, among other things, the Ministry of Social Affairs is now considering the future organisation of drug and alcohol-related research and the prioritisation of research topics.

# Part I NATIONAL STRATEGIES: INSTITUTIONAL & LEGAL FRAMEWORKS

## Chapter 1. Developments in Drug Policy and Responses

### 1.1 Political framework in the drug field

#### Objectives and priorities of national drug policy

Norwegian drug policy is based on a comprehensive, multidisciplinary approach, in which prevention and treatment measures are balanced by concurrent measures aimed at control and supply reduction. Norway has pursued a restrictive drug policy ever since the use of drugs became a social problem among young people in the mid-1960s, banning both possession, non-medical use and sale of the substances in question.

Important strategic objectives for the Government are to:

- Reduce the supply of illegal narcotic substances
- Reduce all illegal use of drugs
- Increase the number of successful treatment forms for drug problems
- Reduce morbidity and other social and health-related problems associated with drug abuse.

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

#### New action plan

On 3 October 2002 the Government proposed a new action plan to combat alcohol and drug problems, for the period 2003-2005. The challenges and strategic choices reflected in Norwegian drug policy are based on the following objectives:

- Pursue a policy that both reduces alcohol and drug problems and is supported by the general population
- Strengthen the municipalities' and local communities' preventive efforts, with particular emphasis on preventive and health-promoting initiatives aimed at children and adolescents in schools and in educational and leisure activities.
- Ensure that problem users and their close families receive quality treatment and rehabilitation/follow-up so that the individuals concerned can live a dignified life.

Through the action plan, the Government wishes to provide the basis for a broad-based strategy of effective measures that cover the entire alcohol and drugs field. The plan stresses the following specific target areas:

- Integrated, locally-based measures to combat alcohol and drug use among children and young people, and alcohol and drug problems in general
- Treatment and care for the most problematic users
- Increased international cooperation
- Improved coordination of efforts

- Knowledge production and quality assurance.

The use of illegal substances is in principle unacceptable both out of consideration for individuals and the society at large, and prevention work is based on this principle.

A separate system for follow-up is being developed, consisting of annual performance targets, specific measures to be implemented within certain deadlines, and a system for evaluating target attainment. The action plan takes into account that developments may require changes and adjustments, for example as a result of the emergence of new narcotic substances.

### **Treatment and rehabilitation of drug users**

The government is strengthening the treatment offered through redistribution of responsibility for measures to help drug users. Particular emphasis is placed on strengthening the competence and efforts of the health-care services vis-à-vis this group. It also aims to ensure more comprehensive, individually adapted treatment alternatives, so that the clients avoid being passed from one agency to another in the area.

Medically assisted rehabilitation for heavily dependent heroin users has been available nationally since 1998. National guidelines have been drawn up concerning responsibility for and the organisation of medically assisted rehabilitation at regional and local levels. The system is based on specialised regional centres, but the municipal health and social services are responsible for follow-up. Experiences in this area are being evaluated.

### **Reduction of Drug Related Harm**

A number of damage-reducing measures have been established for the most dependent problem users whereby continued use of drugs is accepted to a greater or lesser degree. Existing low-threshold health services for drug users have been strengthened through a significant increase in government grants. Low-threshold health services are important instruments in combating overdose fatalities. The services offered include health checks, vaccinations, the distribution of user equipment, protection against infectious diseases, guidance and follow-up after overdoses.

A majority in the Storting has requested the government to facilitate trials with drug injection rooms. The government is drafting the required legislative amendments which will be put forward as soon as possible.

### **Nordic and international cooperation**

Increased international cooperation is regarded as one of the most important factors if we are to succeed in reducing the availability of drugs in the years to come. International cooperation - both at regional and global level - is considered one of the main elements of Norwegian drug policy, and is an important element in a comprehensive approach to fighting drug abuse. Since 1970 Norway has been an active participant in joint Nordic efforts aimed at combating drug problems, since 1979 through the Nordic Council of Ministers. The joint Nordic effort includes cooperation between the police and customs authorities, research, continual exchange of information about the drug situation and related measures, coordination as far as possible of the countries' views in international forums, and measures aimed at developing cooperation with neighbouring regions. At the European level, Norway is a member of the EMCDDA and the Council of Europe's Pompidou Group. Norway has ratified the UN conventions on drugs, is a member of the UN Drugs Commission 2004-2007 and one of the main contributors to the UN's work against drugs.

### **Organisation and coordination at central and local levels**

The main responsibility for coordinating drug policy, including preventive measures, care and treatment, lies with the Ministry of Social Affairs (formerly the Ministry of Health and Social

Affairs). The Ministry of Health has now been given a clearer responsibility for developing health services for drug users.

Three central bodies work on drug prevention:

- Norway Net, consisting of seven regional competence centres on drug and alcohol issues
- The Directorate for Health and Social Affairs
- The Norwegian Institute for Alcohol and Drug Research (SIRUS).

They operate in the areas of education and competence development, quality and intervention development, grant administration and research and documentation.

Pursuant to the adopted guidelines, the municipalities are responsible for preventive measures, as well as procuring places on treatment programmes for drug users. The basic principle is that the services must be anchored in the local community. Drug and alcohol policy is regarded as an important part of Norwegian welfare policy, and cooperation with other local services and sectors is vital. It is not only necessary to coordinate social services for drug users, but also their dealings with the mental health services, child welfare services and primary health care services. Moreover, close cooperation is also necessary with respect to housing assistance, the labour market and educational system. Voluntary organisations make an important contribution, including ownership and operation of treatment centres and residential facilities, often with public funding.

The police work to prevent drug-related crime in two ways: firstly, by reducing the availability of drugs through police investigations and interventions and, secondly, by spreading information about the harmful effects of drug abuse. The police run an active information service aimed at different youth groups, parent groups and schools, in which the strategy is to prevent recruitment of new groups to the drug scene.

### **Research commission**

On commission from the Minister of Social Affairs, a research commission has summarised existing knowledge on the effects of drug abuse prevention measures, identified a need for further research and pointed out political dilemmas and possibilities in this area in coming years. The commission submitted its report in February 2003. On the basis of this report, among other things, the Ministry of Social Affairs is now considering the future organisation of drug and alcohol-related research and the prioritisation of research topics.

## **1.2 Legal framework**

Norway has no specific legislation that exclusively addresses drugs. Legislative responsibility is divided between the Ministry of Justice (the Penal Code), the Ministry of Social Affairs (the Social Services Act) and the Ministry of Health (the Act on Medicinal Products, the Act on municipal health services and the Act on specialist health services). The provisions of the Norwegian Penal Code were explained in the National Report for 2002.

### **Legislative and regulatory changes**

Section 21 of Act no. 21 of 18 May 2001 on the execution of sentences opens for treatment as an alternative to imprisonment. In contrast to earlier practice, admission to treatment can take place at the time deemed most expedient for the convicted person's rehabilitation, and not necessarily towards the end of the term in prison, which was the main rule under the now revoked Act no. 7 of 12 December 1958 on the execution of sentences, section 12. Decisions relating to the serving of sentences in an institution (cf. the Execution of Sentences Act section 12) are generally made by the Correctional Service at local level (cf. the Sentences Execution Act section 6). For persons sentenced to long prison terms (more than

10 years) or special sanctions, and high-security prisoners, the decision shall be taken at the regional level. The Correctional Service must not decide on alternative forms of serving sentences if security grounds dictate against doing so, or if there is reason to assume that the convicted person will evade completing the programme.

The Act on execution of sentences also authorises the use of various forms of compulsory measures, among other things with a view to preventing the use of drugs during the serving of a sentence. Section 29, for example, authorises the use of urine samples, breathalyser tests or blood tests to detect such use.

From 2002 ownership and operational responsibility for hospitals passed to the state. It is expected, that also the counties' responsibility for institutions and associated specialist services for the treatment of drug users will be transferred to the state from 2004.

In the autumn of 2002, the Ministry of Social Affairs introduced a bill proposing legislative amendments ("Drugs and Alcohol Reform 1" - Odelsting proposition no. 3 2002-2003). The proposed amendments were adopted by the Storting in January 2003. The Ministry of Social Affairs has furthermore introduced a bill (Odelsting proposition no. 54 2002-2003) containing proposals for the future organisation of interventions for which the counties will remain responsible under the Social Services Act (Drugs and Alcohol Reform 2). The bill is scheduled for consideration by the Storting in the autumn of 2003. The aim is to implement the reforms concurrently, with effect from 1 January 2004.

Responsibility for the further development of low threshold health services and medically assisted rehabilitation was transferred to the new Ministry of Health with effect from 1 January 2002.

In March 2002 the *Penal Code Commission* submitted its final report on amendments to the Norwegian Penal Code, in which a majority of the Commission's members proposed decriminalising the purchase, use and possession of small quantities of drugs for personal use, and reducing the maximum prison terms for drug offenders from 21 to 10 years. However, the Minister of Justice has rejected allowing any discussion of decriminalisation in the follow-up of the report, with reference to the Government's objective of opposing all forms of legalisation of narcotic substances.

### **1.3 Laws implementation – Case law priorities and goals relating to drug users and drug-related crime**

Practice shows that the penalty for drug-related crimes is largely dependent on 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 importation or purchasing of drugs intended for personal consumption than in cases where the act was motivated by profit.

In three recent court decisions (Norwegian Legal Gazette 1999, p. 33 and p. 1504 and the Supreme Court's decision of 6 September 2000), the Supreme Court very clearly emphasises the need to clearly distinguish between the purchase and possession of drugs intended for personal use and the purchase and possession of drugs intended for sale. In the Supreme Court's decision of September 2000, the first voting justice stated that this decision, in his opinion, "must be understood to entail a change of practice" compared to previous practice. It appears, therefore, that the Supreme Court wishes to make even more of a distinction than previously between involvement with drugs intended for personal use and involvement with drugs intended for resale.

## 1.4 Developments in public attitudes and debates

One issue of current interest is the ongoing debate relating to the open drug user scene around Oslo's central railway station and the recruitment of new young people to heavy drug abuse. It has been claimed that one should draw on experience of models that have been tested with positive results in other European cities – such as Frankfurt.

Critics point to what they argue is an imbalance between the severity of the crime and the guidelines pursuant to which different drug-related crimes are punished. The general level of punishment for crime in Norway is regarded as relatively low, while the level of punishment for drug-related crimes is tough. Individual citizens and lawyers have also raised doubts about how effective the current penal system is in preventing drug abuse, and asked whether the restrictive Norwegian control system perhaps creates more problems than it solves.

## 1.5 Budget and funding arrangements

In addition to the normal funding of operations, the Ministry of Social Affairs and the Ministry of Health have extraordinary budgetary funds at their disposal for the development of special high priority programmes in the areas of epidemiology, research, prevention and treatment. Such funds are channelled through SIRUS, the Directorate for Health and Social Affairs, the regional competence centres on drug and alcohol issues, specialised centres for substitution treatment and low-threshold measures. As funds are allocated to a large number of public bodies, institutions and organisations, either as operational funding or as allocations to projects, it is very difficult to present exact figures in relation to specific areas.

In the research area (including alcohol, drugs and tobacco), SIRUS was allocated a total of EUR 3.43 million in operational funding in 2003.

In 2002 the Ministry of Social Affairs allocated approx. EUR 21.6 million towards the development of social services and drug and alcohol measures<sup>i</sup>. Priority areas in 2002 included the following:

- Drug and alcohol prevention work at the local level
- Competence building
- Strengthening of the municipal social services' work to help drug users
- The work of voluntary organisations in the drugs area.

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<sup>i</sup> Government funds at the disposal of the Directorate of Health and Social Affairs are discussed in chapter 9 d) . Grants towards the reduction of drug-related harm are discussed in chapter 10.1

## PART II EPIDEMIOLOGICAL SITUATION

### Chapter 2. Prevalence, Patterns and Developments in Drug Use

#### 2.1 Main developments and emerging trends

There was no demonstrable increase in the use of narcotic substances among young people between the ages of 15 and 20 from 2002 to 2003. SIRUS' survey of 15-20 year-olds for 2003 shows a marked increase in the use of alcohol, but no major changes from 2002 as regards the use of and attitudes to illicit drugs. On the contrary, the surveys from the last two years appear to indicate that the trend may be towards reduced consumption and more restrictive attitudes to narcotic substances among young people in this age group.

No equivalent surveys have been made of the adult population in the last two years. But the fact that an increasing number of drivers are caught driving under the influence of narcotic and medicinal drugs is an indication of prevalence in the adult population. In 2002 the number of cases increased by 20%. The samples taken reveal the presence of illicit drugs and a high proportion of medicinal drugs, particularly tranquillizers and sleeping pills. Figures from the Norwegian Institute of Public Health (NIPH), for instance, show a doubling in the incidence of Rohypnol.

Various data sources and surveys show that drugs are being increasingly used and sold outside Oslo. There are hardly grounds for claiming that the number of young people at risk has increased, but the rural – urban constellation is in a process of change. Moreover, the socio-cultural dimension with increased availability of new substances in new milieus is a relatively clear trend viewed in a longer-term perspective.

The estimated number of active intravenous users, most of whom inject heroin, indicates that the number is still increasing slightly from one year to the next. We still lack reliable estimates of other forms of problem use, such as persisting use of amphetamines, ecstasy and cocaine.

The most marked change in relation to 2001 is the strong reduction in the number of drug fatalities in 2002. Figures from the National Criminal Investigation Service (NCIS) show that 210 persons died as a consequence of narcotic substance abuse in 2002. This is almost 40% fewer than in 2001, when 338 such deaths were reported. The reduction may have several causes, including reduced heroin availability, less pure heroin, the fact that an increasing number of opiate users are in substitution treatment and the considerable increase in low threshold health services.

At the same time we have seen a clear increase in the number of seizures of several of the most common illegal substances in 2001 and 2002. NCIS' seizure figures for 2002 show that the biggest absolute increases were for benzodiazepines and amphetamines. Seized quantities of benzodiazepines also increased markedly, particularly the quantities of Rohypnol. There was, on the other hand, a marked decrease in the number of heroin and ecstasy seizures, but in the case of ecstasy the quantities seized are large and have increased significantly. GHB, classified as a narcotic substance in 2000, still constitutes only a very small proportion of the total quantity seized.

NCIS claims that there is much evidence to indicate a relationship between developments relating to ecstasy and heroin and the police and customs authorities' investigations, and that there is reason to believe that the big seizures have limited the supply of these substances on the market, which in turn has led to fewer seizures among users. It is difficult to read changes in use directly from the seizure figures, but it will be interesting nevertheless, to

keep an eye on developments, especially in the use of heroin and on whether the considerable number of persons now in medically assisted rehabilitation, will result in a reduced demand for heroin.

## **2.2 Drug use in the population**

### **2.2.1 General population**

The most recent national interview survey on the Norwegian population's use of alcohol and other intoxicants was conducted in 1999. The main data from this survey were presented in the report for 2002. The next interview survey is scheduled to take place in 2004. The questions will be adapted to the EMCDDA's standards, so that the data can be compared with that of other EU countries (standard table 01).

### **Registration of the drug situation in some selected municipalities**

In 2002 SIRUS registered the drug situation in 60 selected municipalities by collecting information relating to the situation in 2001 from respondents in three public services in each municipality. Similar surveys have been conducted since 1992, but using different questionnaires so that the data are not comparable.

The 60 municipalities constitute a relatively representative selection of the country's municipalities in terms of both size and geographical distribution. All the counties were represented and the biggest municipality in each county was included. The selection was broken down into large municipalities (Oslo, Bergen, Trondheim, Stavanger and Bærum), 21 medium-sized municipalities (with populations of between 20,000 and 99,000) and 34 small municipalities (with populations of between 1,000 and 19,000).

The 60 selected municipalities included a total of 50% of Norway's population at 1 January 2002 (Statistics Norway: Population statistics).

Data for the 2002 survey was collected from the police, health and social services and outreach services. They were all asked to estimate the number of drug users in their municipality, whether they had observed any increase in the availability of drugs and the priority given by the service in question to drug-related work during the year. The response was high (83-91.5%) for the three services involved.

Since the survey concerned selected municipalities only, the data does not provide an overall picture of the situation for the country as a whole. Comparisons of the data are mostly on the basis of the three municipal size categories. Moreover, the data is largely based on information about persons known to the respondents. The data can therefore tell us something about tendencies and trends, but not about prevalence.

In most of the selected municipalities both the police and social services had the impression that there had been a general increase in the number of users of narcotic substances from 2000 to 2001. Very few respondents believed that there had been a decrease in number of users of any of these substances. Most respondents mentioned cannabis, amphetamines and tranquilizers as substances where the number of users had increased.

Tranquilizers stood out as a "substance category" believed by many of the informants to have attracted more users. Rohypnol was mentioned most frequently.

As regards amphetamines, more than half of the respondents reported that the number of users had increased in the last year. None of them thought that the number of amphetamine users had decreased or that this substance was not available in the municipality. In general, the police have the most "dramatic" assessment of changes in drug use.

In summary, the informants seem to think that young people under 18 mostly use cannabis and amphetamines. Most typical users of all narcotic substances are found in the 18-41 age group, while there are few in the over 41 age group who use amphetamines and ecstasy.

One third of the social service informants and almost half of the police informants reported that opiates are also taken by smoking.

More generally, the social services report that more drug abusers are injecting, regardless of the type of drug, and that they are experimenting with various combinations of drugs (www.sirus.no).

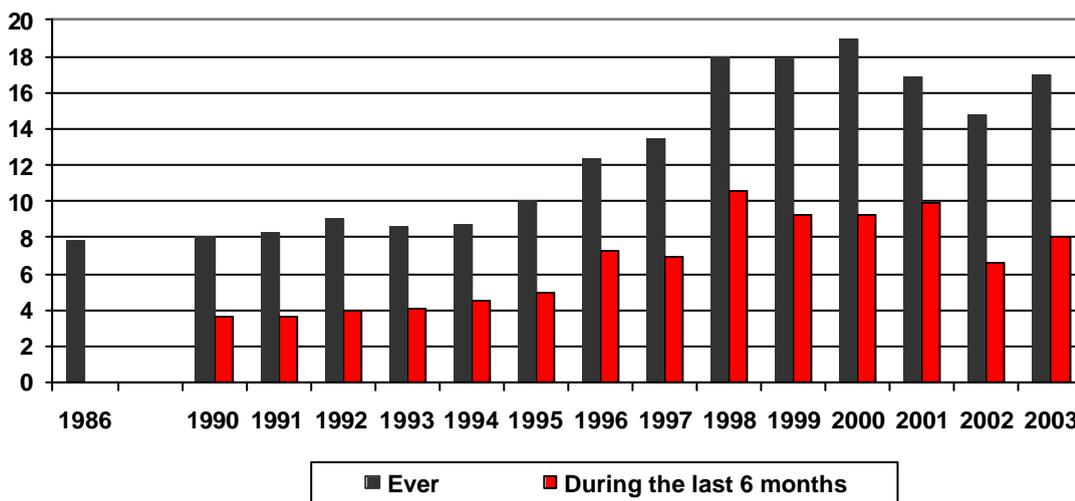
In 2003 the collection of data will be extended to include all of Norway's 434 municipalities, and the data will therefore give a more complete picture. The purpose of this annual reporting is primarily to provide information about how the situation is changing. Together with other methods, the registration will also enable us to provide more reliable estimates of problem drug use.

### 2.2.2 Young people

#### Annual youth survey 2003

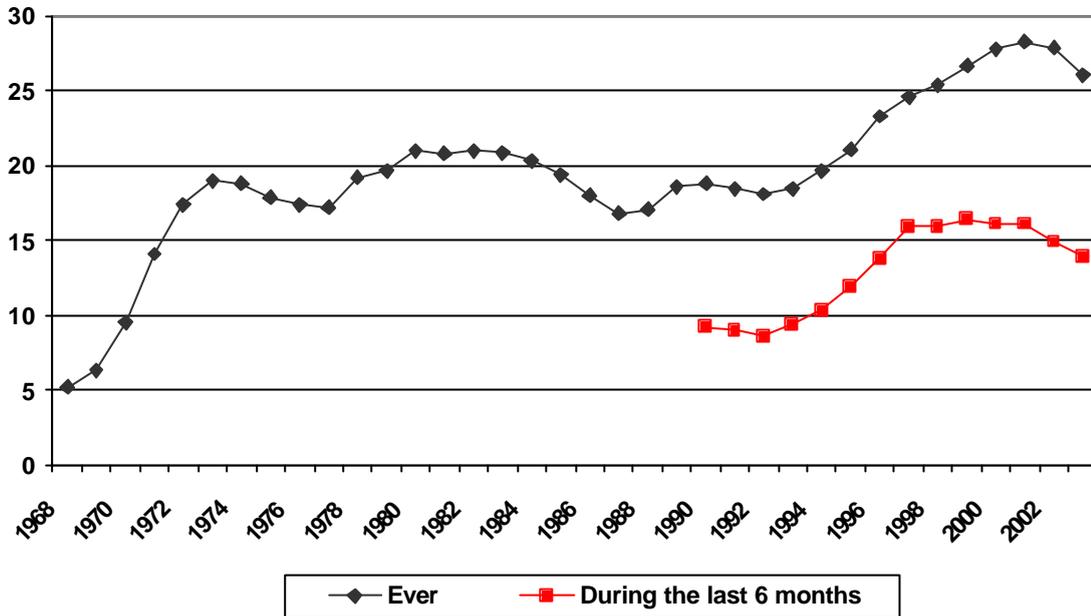
SIRUS conducts an annual questionnaire survey on the use of drugs among young people aged 15-20. The 2003 survey showed no major changes in the use of illegal substances. In recent years the difference between the proportion of young people at national level and the proportion of young people in Oslo who state that they have used various drugs has continued to decrease. While at the national level the proportion stating that they have used cannabis, ever and during the last six months, has been 15-17% and 8-10%, respectively, for the last three years, the corresponding figures for young people in Oslo are approx. 25-28% and 7-12% (figures 1 and 2).

Figure 1. Percentage of young people aged 15-20 in Norway who report having used cannabis, ever and during the last six months, 1986-2003.



Source: SIRUS

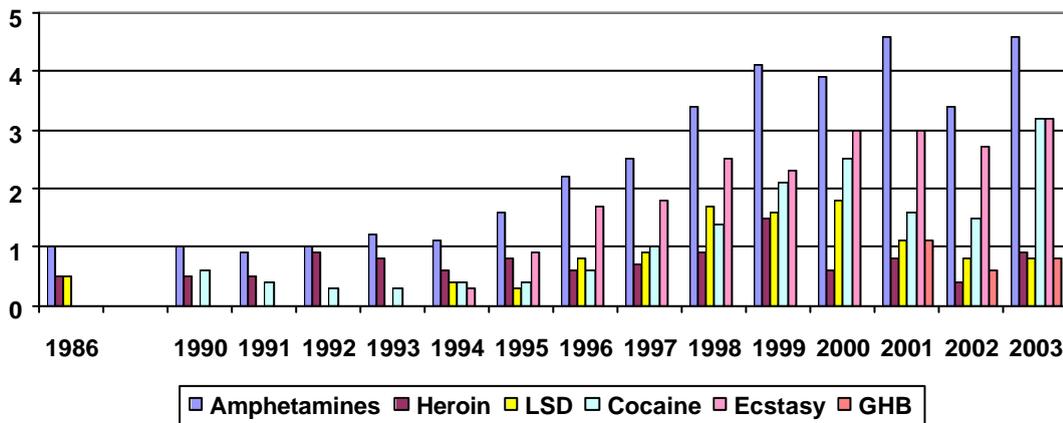
Figure 2. Percentage of young people aged 15-20 in Oslo who report that they have used cannabis, ever and during the last six months, 1968-2003 (three year sliding average).



Source: SIRUS

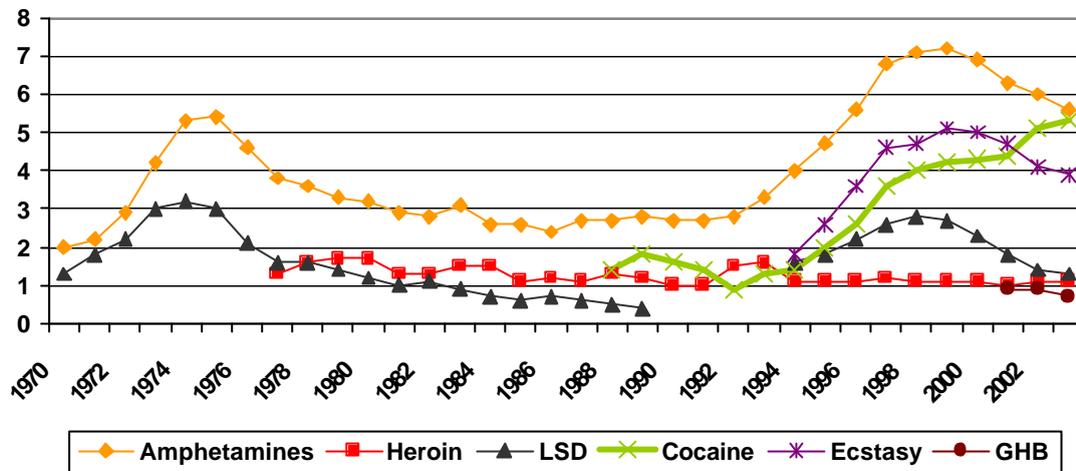
With respect to the percentage who report having used other substances, the trend has largely flattened out in the last few years (figures 3 and 4). For example, the proportion of 15-20 year olds who report ever having tried ecstasy has remained at approximately 3% for the nation as a whole and 4-5% in Oslo. However, there appears to have been an increase in the percentage who report ever having used cocaine.

Figure 3. Percentage of young people aged 15-20 in Norway who have ever tried different narcotic substances, 1986-2003.



Source: SIRUS

Figure 4. Percentage of young people aged 15-20 in Oslo who have ever used different narcotic substances, 1970-2003 (three-year sliding average).



Source: SIRUS

As regards the availability of illicit drugs, the situation seems to have been relatively stable in recent years, measured by the responses to the question of whether or not young people have been offered various substances. At the national level, the proportion of 15-20 year olds stating that they have been offered cannabis has been around 40% for the last five years, while the proportion stating that they think they would be able to get hold of cannabis in a matter of 2-3 days should they want to do so, has been around 65%. Similarly at the national level the proportion stating that they have been offered amphetamines and ecstasy has been approximately 14-17% and 13-14% respectively.

In Oslo the proportion of 15-20 year olds stating that they have been offered cannabis has been approx. 55%, the proportion stating that they would be able to get hold of cannabis in the course of 2-3 days has been approx. 70%, while the proportion stating that they have been offered amphetamines or ecstasy has been around 20-25% and 17-22%, respectively.

The 2003 survey confirms the tendency in recent years that the proportion expressing that they have a positive attitude to narcotic substances is no longer increasing. In the last two or three years approx. 10% of 15-20 year olds at national level and 13% in Oslo have stated that they think cannabis should be sold freely in Norway.

### Statistical error margins

The figures are subject to statistical error margins and must be interpreted with considerable care. Questionnaire surveys are always susceptible to certain sources of bias (not everyone responds, some responses contain deliberate or inadvertent errors, etc.) and the surveys referred to here targeted young people in general. There is reason to believe that young people who regularly use narcotic substances, whether it be cannabis or stronger substances, will be underrepresented in the surveys ([www.sirus.no](http://www.sirus.no)).

### The ESPAD survey 2003 (the Norwegian part)

The European School Survey Project on Alcohol and other Drugs (ESPAD) is a European questionnaire survey on the use of drugs among 15-16 year olds. The survey is conducted in 30 countries, including Norway. Three sets of data are now available – from 1995, 1999 and

2003. The international report in which Norway will be compared with other European countries will be available in 2004.

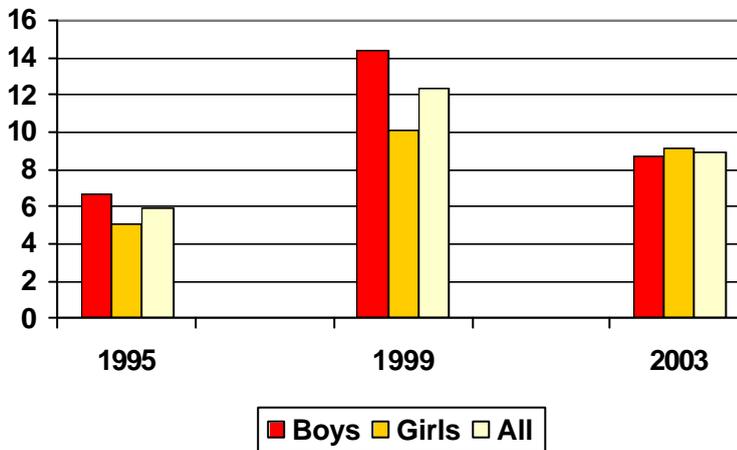
The Norwegian part of the survey includes just under 4,000 10<sup>th</sup> year students (9<sup>th</sup> year students in the 1995 survey).

The main results relating to the use of drugs in the three surveys are shown in tables and figures. A more comprehensive report including updated results from the Norwegian 2003 survey will be available in the autumn of 2003.

**Cannabis**

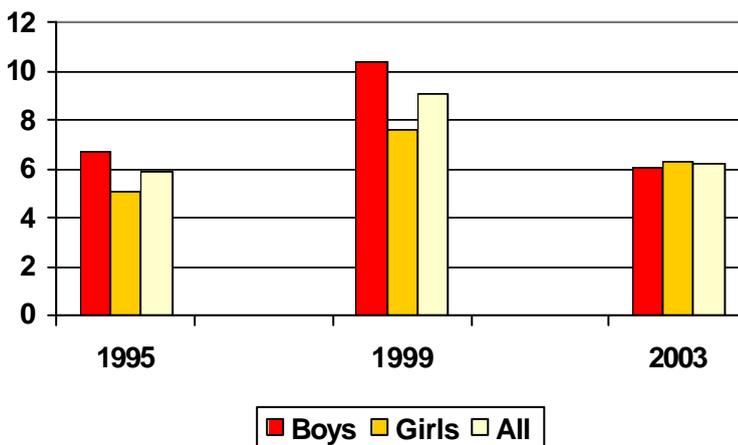
While there was quite a dramatic increase from 1995 to 1999 in the proportion stating that they had used cannabis, there was a clear decrease in 2003 in the proportion stating that they had used cannabis ever (figure 5), during the last 12 months (figure 6) and in the last 30 days (figure 7), respectively. As illustrated by the figures, the decrease from 1999 to 2003 is quite marked. The same tendency can be observed in the annual youth surveys for the group aged 15-20.

Figure 5. Percentage of boys and girls who state that they have ever used cannabis.



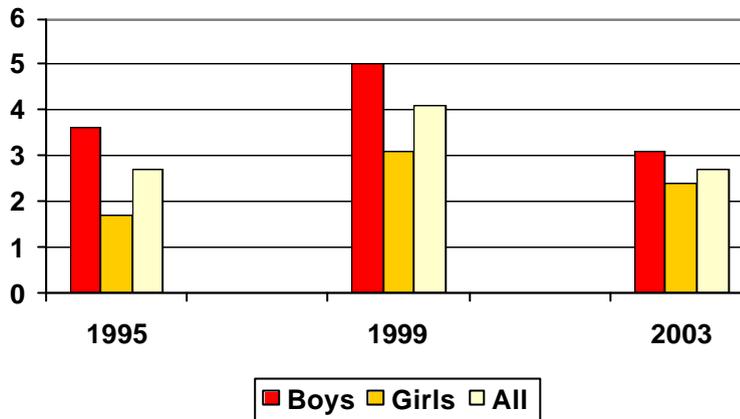
Source: SIRUS

Figure 6. Percentage of boys and girls who have used cannabis during the last 12 months.



Source: SIRUS

Figure 7. Percentage of boys and girls who state that they have used cannabis during the last 30 days.



Source: SIRUS

### **Other narcotic substances**

There was also a decrease for other narcotic substances from 1999 to 2003. The figures are small however and must be interpreted with care. One-two per cent state that they have ever used amphetamines, ecstasy, cocaine and heroin. The proportion stating that they had ever used medicinal drugs like Valium, Rohypnol and Mogadone without a doctor's prescription was 2.7% in 1995, 3.5% in 1999 and 2.5% in 2003.

### **Sniffing**

There was a gradual decrease from 1995 to 1999 which continued until 2003, except in the proportion stating that they had sniffed solvents during the last 30 days ([www.sirus.no](http://www.sirus.no)).

### **2.2.3 Drug use in prison**

The prison population reflects in concentrated form the problems that exist outside the prison walls. The percentage of inmates serving sentences for violation of drug laws has been increasing in line with the increasing problems experienced in the rest of Norway. In 2001 just under 30% of inmates in Norwegian prisons at any given time, had been convicted of various drug crimes. Additionally, some prisoners have been convicted of drug-related crimes that are directly related to drug use, but that are not reflected in the statistics. Typical examples of this are theft and robbery committed in order to finance drug use.

The prison authorities estimate that around 40-60% of inmates in Norwegian prisons use drugs once or more during their term in prison. This estimate is based on previous studies carried out in prisons, including anonymised questionnaire surveys among inmates, and reports submitted to the Prison Board by prisons and from inspection rounds.

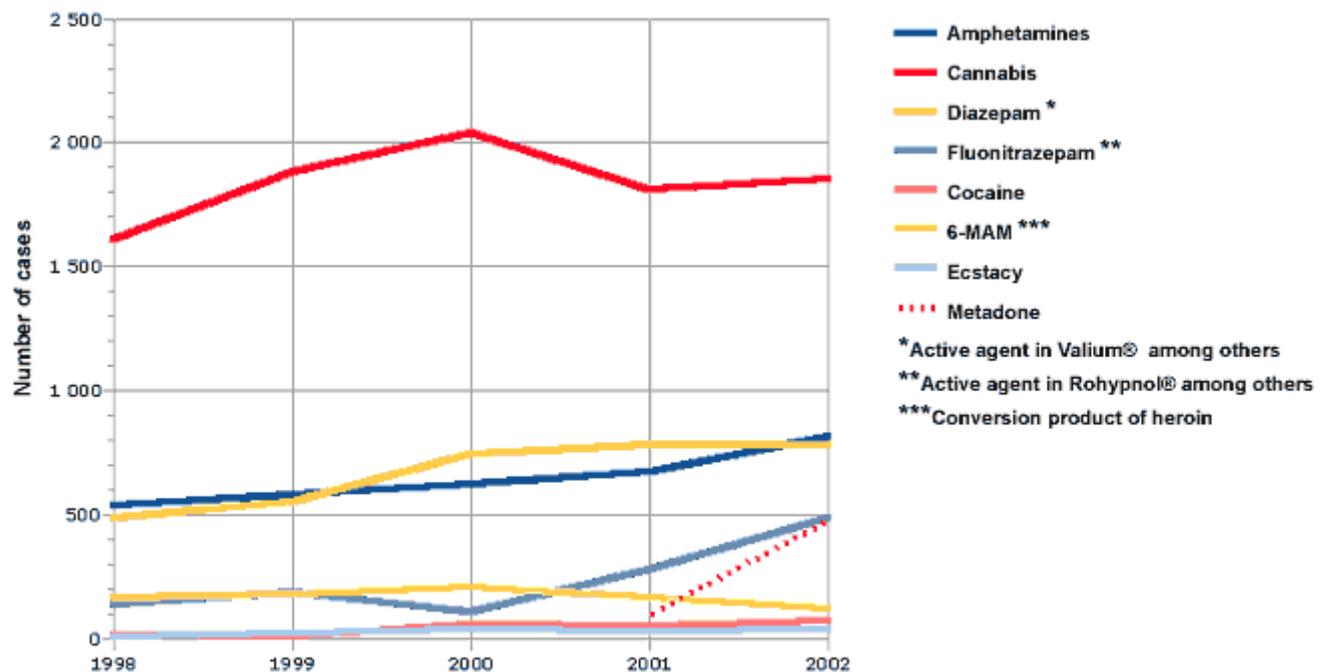
After the new Act of 18 May 2001 on sentence execution entered into force, the prisons have improved access to control measures to combat drug use. Among other things, they have been authorised to take urine and blood samples on a general basis. Another new feature is that sniffer dogs can be used for searches of the person. Additionally, the right to search visitors has been introduced, and the right to hold these individuals until the police arrive. Moreover, health care personnel, on the request of the prison, can conduct body searches (cavity searches) of inmates in the case of suspected use or possession of drugs. There are also a number of other control measures, including the use of blue lighting in toilets, sniffer dogs and communication checks.

The number of body searches (cavity searches) has remained stable from 1993 to 2002. The total number of finds of drugs and user equipment increased from 1988 to 2002. In 1988 there were 234 finds of drugs and 777 finds of user equipment, while in 2002 the number of finds was 651 for drugs and 1,008 for user equipment. The increase may be due to increased prevalence and use of drugs in prisons, but may also be related to improvements in the control procedures.

The number of urine samples testing positive for drugs increased from 1,019 in 1988 to 1,999 in 2002. But, given that the total number of samples taken increased from 6,706 to 21,663 in the same period, the percentage testing positive dropped substantially from 15.2% to 9.2%. Some of the decrease can be explained by the fact that the statistics have become more precise since 2002, when legal narcotic substances (medicinal drugs and legally prescribed methadone/ subutex) and drugs taken before arrival in the prison were no longer included in the figures for illegal intake in proven samples. This means, in other words, that approx. 90% of the urine samples show no traces of illicit drug intake in prisons. The majority of the positive tests are for cannabis substances and various narcotic tablets. This corresponds with the seizures that are made (Ministry of Justice ) (Standard table 12).

Cannabis is the clearly most frequently found substance in samples from inmates in prisons and open facilities (figure 8). Amphetamines and diazepam (active agent in e.g. Valium) are also frequently detected. This picture has not changed much in recent years, but an increase in flunitrazepam, the active agent in e.g. Rohypnol, has been registered (NIPH).

Figure 8. Drugs detected in correctional service cases



Source: NIPH

### 2.3 Problem drug use

Estimates relating to the extent of problem drug use in Norway are based on the number of overdose fatalities. The estimates indicate the scope of intravenous abuse. In 1989 the number of injecting users at the national level was estimated at 4-5,000, in 1999 at 9-12,000, in 2001 at 10,500-14,000 and in 2002 at 11-15,000. This corresponds to a doubling from 1990 to 1999 and probably a continued modest increase since then.

Heroin is the predominant injected drug. Amphetamines and cocaine may also be injected, but intravenous users of these drugs seldom die of an overdose. Hence, intravenous use of these substances will be underrepresented in the figures. Sustained or regular use of opiates, amphetamines or cocaine, when these substances are not injected, will not be included in the estimates of intravenous users. The actual extent of problem drug use is therefore greater than 11-15 000 persons. Approx. one third of the intravenous users are women, and this figure has remained stable over time.

The problem user population seems to be getting older. Studies of persons visiting the needle bus in Oslo show that their average age has increased somewhat. This may be because few people are able to stop problem use and that the population of intravenous users is therefore growing older. The increase in average age may also be due to recruitment taking place from older age groups than previously.

The growth indicated by the above estimated figures for intravenous drug use, does not necessarily mean that recruitment is continuing to increase. Even lower recruitment will contribute to an increase in numbers if few persons stop their problem use or die. The increase in the number being treated with methadone from 1999 to 2002 and stability in the numbers of places in other forms of treatment, indicate that the proportion who stop being active injecting drug users is higher than it used to be. This may be an indication that recruitment to intravenous drug use is not on the decrease.

The municipal survey from 2002 and indicators of problem use around the country provide a basis for alternative methods of estimating problem use at the national level. Work on such supplementary figures relating to problem use has not yet been completed (standard table 7).

### **Risk behaviour**

Risk behaviour associated with injecting relates to the risk of infectious diseases, injuries sustained from incorrect injection and the risk of overdosing. In addition, surveys show that this group has poor general health and nutrition, particularly for heavy problem users. They are therefore very receptive to infections and disease in general.

Experience of caring for drug and alcohol abusers and various low threshold responses show a large under-consumption of ordinary medical services among drug users. Low threshold responses include health services that do not require prior appointments and that target the problems of drug and alcohol abusers. Other services include accommodation and food, and other forms of care and activities. Needle distribution and free condoms are often an integrated part of these services. Such low threshold responses have been introduced in the big cities and some populous municipalities near cities (chapter 10).

HIV testing continues to be extensive among intravenous users, with almost 90% having tested themselves in the last three years. The prevalence of HIV among intravenous users in Norway remains stable and low compared with most other European countries, even if the number of new cases registered in 2002 was the highest for many years (chapter 3.3). In a survey among users of the needle bus in Oslo (Hepatitis C survey by the Alcohol and Drug Addiction Service in Oslo), more than 70% stated that they were aware of their hepatitis C status, 58% stated that they had tested positive and 14% that they had tested negative. Blood tests showed the presence of hepatitis C antibodies in 80% of the same group.

The extent of needle sharing has been measured using roughly comparable questions in surveys from 1992/2000 (User surveys of the needle bus) and 2002 (the Hepatitis C survey) among users of the needle bus. In 1992, 32% of all respondents stated that in the course of the last four weeks they had used a needle used by someone else (including their regular

partner) before them. The 2000 and 2002 surveys showed somewhat lower figures – around 16%. This may indicate that there was a reduction in needle sharing over the ten-year period (SIRUS) (standard table 10).

## Chapter 3. Health consequences

### 3.1 Drug treatment demand

Norway has established a registration system for the treatment of clients with drug and alcohol problems. The system is based on a client registration form, which is used to register the clients' situations on requesting treatment, the client's situation at the time treatment begins, and situation on the completion of treatment. The form is to be completed by the therapist based on an interview with the client, and should include variable sets that cover the "core items" in the EMCDDA's Treatment Demand Indicator. The system is designed to suit the needs of clients with both alcohol, prescription drug and illicit drug problems.

Because of official regulations protecting the right to privacy, data from the client registration system is collected at the facility/ institution level before it is collated at regional and national levels as aggregate figures for each facility/ institution. The fact that national data is only available in the aggregate form means that it is not possible to distinguish clients whose problems are purely or primarily alcohol-related from clients whose problems are primarily drug-related. The form in which data are available also makes it impossible to check for duplicate data, i.e. treatment in which the same client appears for several treatment sessions in the same or different facility/ institutions in the same year. The client cannot be "followed through the system" over time.

Work is now in progress to develop an individualised registration system that can be used in conjunction with the EMCDDA's Treatment Demand Indicator. Proposals have been drafted for an encryption system for data and personal identifiers for individual facility/ institutions, a system for secure data transfer from institutions to a central data administration, for choosing a central data administrator and storage system, and a provision concerning access to centrally stored data. These elements are, however, subject to approval by the Data Inspectorate. The Ministry of Health and the Ministry of Social Affairs are involved in this process.

*Table 1. Registered requests for and initiated treatment. Note: The same person may be registered more than once in the same year. Includes both individuals whose problems are primarily alcohol-related and those whose problems are primarily drug-related.*

Year	No of resp. institutions etc.	No. of requests	No. of initiated courses of treatment
1998	110	18,115	13,541
1999	110	20,426	15,700
2000	113	26,462	18,981
2001	106	23, 280	17,850

Source: *The Bergen Clinics Foundation*

Table 1 shows the development of registered requests and initiated courses of treatment from 1998 to 2001. The records for 2002 are being collected. The fall in the number of institutions responding in 2001 was caused by reorganisation in Oslo and computer problems in several facilities/ institutions. Altogether, in the four years from 1998 to 2001, 145 different facilities/ institutions have supplied data to the client registration programme. Eighty facilities/ institutions have provided data in all four years.

When broken down by gender and age, the requests show a clear tendency towards a more even gender distribution the younger the clients. In 2001 women represented 43% and men 57% of the requests in the 16-20 age group, while the figures were 21% for women and 79% for men in the 51-60 age group. Gender differences between different age groups followed the same trend in 1998, 1999 and 2000.

Alcohol is the most frequently used intoxicant among most men, used by approx. 36%, while 28% of the men use heroin/ other opiates most frequently. The most frequently used intoxicants among women are alcohol (28%) and heroin/other opiates (also 28%). Addictive prescription drugs are the most used drug among many more women (9%) than men (slightly over 3%). Ecstasy was the most frequently used drug in 14 cases in 1998, in 18 cases in 1999 and in 82 cases in 2000. The figures for 2001 show that ecstasy is the most frequently used drug in 49 cases (figures 11 and 12 in chapter 15)

Addictive medicinal drugs are the “second most used drug” by most clients, followed by cannabis. Alcohol and heroin/ other opiates are stated as being the “second most used drug” by approx. 4-5%, for both genders. In 153 cases ecstasy was the second most used drug, while in 27 cases it was LSD (the Bergen Clinics Foundation).

### 3.2 Drug-related mortality

There are two bodies in Norway that register drug fatalities: Statistics Norway (SSB) and NCIS. SSB's figures are based on the medical examiner's reports, autopsy reports and doctors' declarations of death. SSB codes cause of death by using a Norwegian version of the international classification of diseases, accidents and injuries (ICD-10). The deaths included in these statistics are registered according to their determined *underlying cause*, i.e. drug use is the direct cause of death. NCIS' registration system is based on reports received from police stations around the country.

The figures from NCIS include cases of acute poisoning (overdoses) as well as deaths that are clearly related to the deceased persons abuse. Experience indicates that the actual number of drug-related deaths will be somewhat lower once autopsy reports become available from the Institute of Forensic Medicine. NCIS uses unadjusted figures for previous years, however, in order to have a correct basis for comparison.

Table 2. Drug-related deaths. Total number of deaths and broken down by gender. Figures from NCIS and SSB (underlying cause of death).

1991-2001	Number of deaths according to NCIS			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	173	31	204
1997	149	28	177	160	34	194
1998	226	44	270	228	54	282
1999	181	39	220	191	65	256
2000	264	63	327	302	72	374
2001	286	52	338	327	78	405
2002	166	44	210			

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

Source: NCIS and SSB

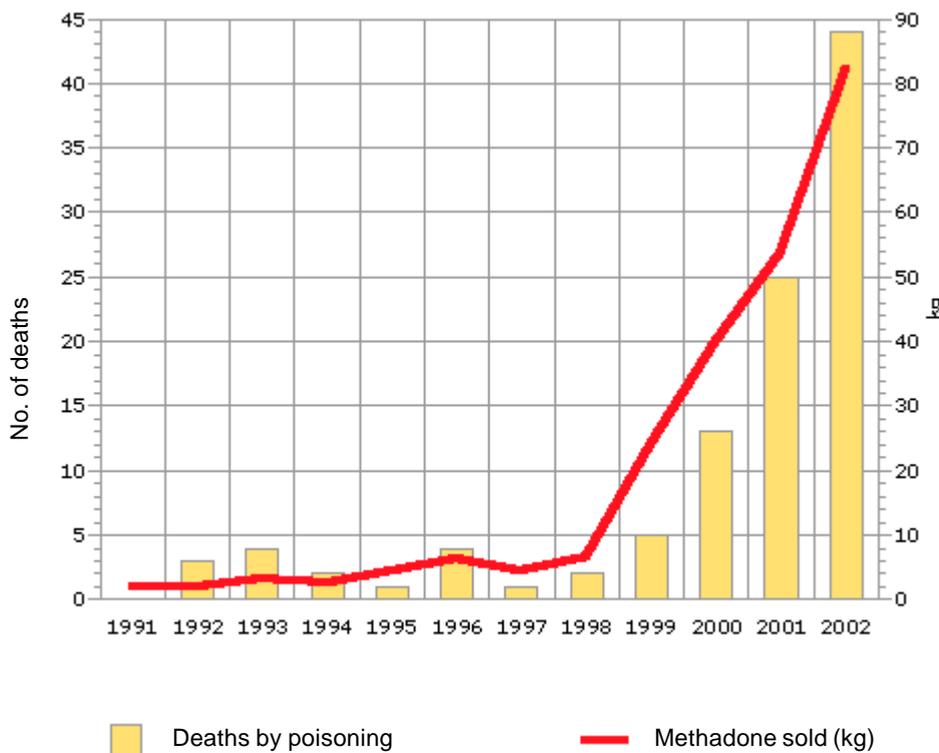
NCIS' records show that the number of drug-related deaths fell markedly in 2002. The police districts report a total of 210 deaths - 166 men and 44 women – as a result of drug use in 2002. This is 128 (almost 40%) fewer than in 2001 when 338 deaths were reported, and the lowest figure since 1997.

The average age of the deceased in 2002 was 33 years for men and 34 years for women. All together 23 of a total of 27 police districts reported drug-related deaths in 2002. As in previous years, the Oslo Police District reported the highest number of deaths (79). More than one in three drug-related deaths took place in the capital, although Oslo's share of the total has been decreasing in recent years (standard tables 05 and 06).

**Methadone-related deaths**

A comparison of the presence of methadone in forensic autopsies (i.e. test material analysed by NIPH) with the sale of methadone, shows a very strong correlation between the total quantity prescribed and the number of poisoning fatalities in which methadone was an important factor. A sharp rise has been seen in the number of such deaths over the last few years, paralleling the increase in the quantities prescribed. Poisoning by methadone alone accounts for 10% of the material on which figure 9 is based, while the rest being mainly combined poisonings.

Figure 9 Methadone-related deaths in Norway 1991-2001



Source: NIPH

### **THC-related deaths**

In a study in 2001 of autopsy cases in which tetrahydrocannabinol (THC - the active agent in cannabis) was found to be present, six cases of sudden death without a clear cause of death were reported. By comparing identified THC concentrations, clinical data and autopsy findings the study found indications of acute heart failure in these persons. THC intake and its timing in relation to the symptoms, or in some cases death, have not previously been documented by measuring THC levels in the blood. Cannabis is generally considered a fairly non-toxic substance, involving little danger of serious poisoning or death.

However, this study concluded that cannabis has a considerable acute effect on the cardiovascular system both in healthy individuals and those with heart conditions, and suggests that there may be a correlation between cannabis use and sudden heart failure. Such serious, but rare side effects can be detected after a substance has apparently been used safely over a long period of time (Bachs, L. and Mørland, H.).

### **Causal factors**

The major changes in the total number of drug fatalities have no simple explanation. Factors that may have contributed to this development are:

- The number of intravenous drug users has doubled over the last 10 years
- A more prevalent injecting culture in Norway than in other countries, including the other Nordic countries. In Norway heroin is taken almost exclusively by injecting.
- The heavy drug user group has grown older and is more debilitated both physically and mentally.
- Except in 2002, heroin has been readily available and therefore dropped in price, which in turn has led some users to use larger doses.
- Multiple use, whereby heroin is taken in combination with alcohol and/or prescription drugs such as Rohypnol, has become increasingly common.

The substantial decrease in the number of drug fatalities in 2002 may be partly due to the sharp increase in the number of persons undergoing medically assisted treatment, both in Oslo and in the rest of the country. There has also been an increase in the number of low threshold services in the cities and big towns.

Mortality among heavy drug users in Norway has been 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 attached to their estimate, which is based on a review of the available literature and stipulates an annual mortality rate of between 3 and 4% among intravenous drug users.

### **The establishment of a Norwegian register of drug fatalities**

In order to follow the development in deaths due to overdoses and be able to evaluate the treatment programmes and preventive measures, it is absolutely necessary to establish a register of drug fatalities based on a uniform registration method. The Ministry of Health has therefore given the Norwegian Institute of Public Health the task of establishing a national register based on uniform registration. In order to stay in step with international developments, it is also important to ensure that statistics are comparable with the statistics of other countries. A reference group has been established, consisting of representatives from forensic medicine, NCIS, SIRUS, the Directorate of Health and Social Affairs and SSB.

The project is in its first phase, which will consist of drawing up definitions of drug fatalities and criteria for subdivision into categories. Among other things, it is important to find criteria to distinguish overdose deaths from other causes of death, such as traffic accidents and suicides. In addition to the conclusions from forensic autopsies and forensic toxicology

findings, reports from the individual police districts to NCIS will be important sources of information.

The criteria for classifying drug fatalities adopted by the EMCDDA will be helpful in establishing the Norwegian register. In addition to harmonisation with other European countries, it is important that the new register covers specifically Norwegian conditions.

So far the project has been allocated funding for 2003 and the register is expected to be in place in 2004. So far, it has not been decided which body will be responsible for maintaining and operating the register (NIPH).

### 3.3 Drug-related infectious diseases

#### HIV and AIDS

In 2002, 205 cases of HIV infection were reported to the Reporting system for infectious diseases (MSIS). Only 16 of these cases concerned intravenous drug users. This represents a slight increase in newly diagnosed cases compared with recent years, but it is too early to say whether this represents an increase in the spread of disease among drug users. Half of these cases were reported from Oslo, eleven were men and five were women and the mean age was 36 years. Two of the cases concerned immigrants infected before arriving in Norway, both from Eastern Europe. At 31 December 2002, a total of 472 persons were registered as HIV positive with injecting use as the risk factor. This is 19% of all reported cases of HIV since 1984. 131 of the cases have been reported as having progressed to AIDS (table 3) (standard table 09).

Table 3. Proportion of intravenous drug users among persons infected by HIV or AIDS, showing risk behaviour in the form of injecting use, by year of diagnosis.

	HIV Total	HIV intravenous drug use	Percentage of HIV intravenous drug use	AIDS total	AIDS Intravenous drug use	Percentage of AIDS intravenous drug use
1984-89	894	315	35%	144	8	6%
1990	90	22	24%	59	13	22%
1991	142	16	11%	59	16	27%
1992	105	12	11%	50	8	16%
1993	113	13	12%	64	13	20%
1994	94	12	13%	74	19	26%
1995	105	11	10%	67	8	12%
1996	116	9	8%	56	12	21%
1997	113	11	10%	34	8	24%
1998	98	8	8%	39	5	15%
1999	147	12	7%	29	7	24%
2000	176	7	4%	38	6	16%
2001	158	8	5%	27	5	18%
2002	205	16	8%	33	3	9%
<b>total</b>	<b>2 555</b>	<b>472</b>	<b>18,5%</b>	<b>773</b>	<b>131</b>	<b>17%</b>

Source- NIPH

Intravenous users were the group for whom fears of an uncontrolled spread of infection were greatest. The incidence of HIV in this group has, however, remained stable over the last decade with about 10-15 cases of HIV infection a year. The reason for this is not fully clear, but a high level of testing and degree of openness concerning HIV status in the user milieu,

combined with a strong fear of being infected and self-imposed discipline, are assumed to be important factors. Additionally, many of the sources of infection in the drug-using milieus have disappeared through deaths from overdosing or rehabilitation through substitution or other treatment. However, the extensive outbreaks of hepatitis A and B in recent years, and the high incidence of hepatitis C, show that needle sharing is still prevalent. The situation as regards HIV is therefore regarded as very unpredictable.

When the virus was introduced to this group in the mid-eighties, around 250 drug users were probably infected in the course of a three-year period, which demonstrated how fast HIV can spread in user environments. The group's high HIV test activity ensures good monitoring, however, and an increase in the spread of HIV in this group would probably be discovered quickly.

### **Hepatitis**

Since 1995, we have observed an increase in the incidence of hepatitis A and B among drug users. This has coincided with a significant increase in the reported number of new intravenous users since 1995. During the nationwide outbreak of hepatitis A from 1995 to 2000, 1,360 drug users with acute hepatitis A infection were identified. Only two cases were reported in 2002. The hepatitis B outbreak continued into 2002, when 120 of a total of 183 cases of acute hepatitis B were among injecting drug users. In the period 1995-2002 the total number of reported cases of acute hepatitis B among injecting users was 1,417.

The high incidence of hepatitis B among drug users has resulted in increased sexual transmission, often to younger women in the drug user milieus. The outbreaks have illustrated the fact that intravenous use is no longer limited to cities and large towns, but has spread to smaller municipalities all over the country. The outbreaks have led to free hepatitis A vaccine being offered to all drug users in Norway since 2000. Hepatitis B vaccine has been offered free to drug users since 1984.

In Oslo small-scale prevalence surveys have been conducted in recent years, including one on hepatitis among drug users visiting the needle bus. In 2002 the survey showed that 60% of the 410 drug users examined had experienced a hepatitis A infection, 53% a hepatitis B-infection and 79% a hepatitis C infection. In Norway hepatitis C is not monitored to the same extent as hepatitis A and B, and hence the number of newly infected victims of the hepatitis C virus among drug users is unknown. These Oslo surveys are the only regular prevalence surveys conducted among drug users in Norway. In connection with these annual prevalence surveys, drug users are also offered x-ray examinations to detect tuberculosis and vaccination against hepatitis A and B (NIPH).

### **Other infections among drug users**

Syphilis, gonorrhoea and other sexually transmitted diseases are rarely reported among drug users in Norway. No outbreaks of tuberculosis have been registered among drug users in Norway. For several years, the City of Oslo has conducted regular x-ray examinations among drug users, and there are no signs that drug users in Norway are a risk group with respect to contracting tuberculosis. In the last five years, four sporadic cases of wound botulism have been diagnosed among drug users in Norway. The world's first known case of systemic anthrax transferred through intravenous drug use was diagnosed in Oslo in the spring of 2000. This was an isolated case, and it is assumed that the heroin had been contaminated by anthrax bacteria in the country where it was produced. Skin infections and abscesses are not uncommon among drug users. In some cases they may become seriously septic/ toxic. Bacterial endocarditis is a well-known consequence of injecting. Every year a small number of cases of such infections among drug users is reported, but it is clear that many such infections are under-reported in reports to the Reporting system for infectious diseases (NIPH).

### **3.4 Other drug-related morbidity**

Co-morbidity is dealt with in chapter 16.

#### **3.4.1 Drugs and driving**

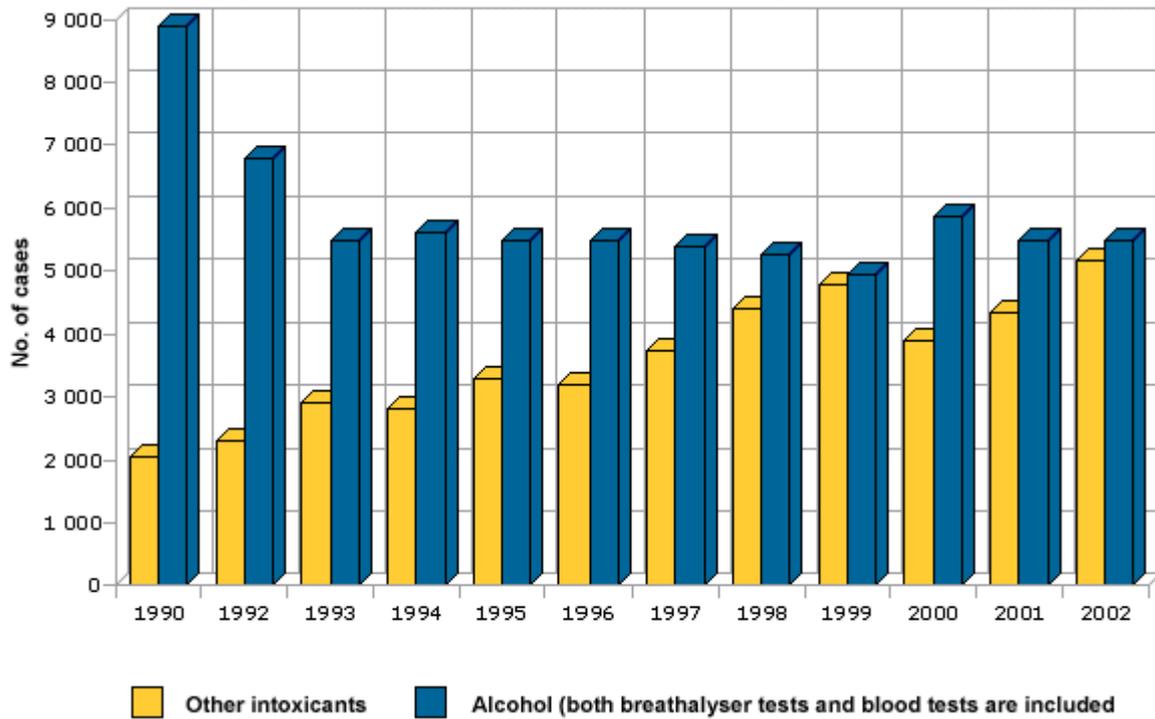
Statistics relating to driving under the influence of intoxicants have been monitored by the forensic toxicology and drugs and alcohol research division at NIPH (formerly the National Forensic Toxicology Institute - SRI) for many years.

In the period 1990-2002 the number of cases in which the police suspected drivers of being under the influence of alcohol had stabilised at around 5,500 cases per year. The biggest change was in the number of cases in which the driver was suspected of being under the influence of intoxicants other than alcohol and medicinal drugs. In 2002 the number of such cases (5,161) was almost as high as for alcohol (5,486). The trend from 1990 to 2002 shows:

- A gradual increase in the number of cases over the last 11 years.
- However, the increase from 2001 to 2002 is much greater than any previously recorded – almost 20%.
- Benzodiazepines (tranquilizers and sleeping pills) are the most frequently found substances in these cases. Flunitrazepam, the active agent in Rohypnol, has increased dramatically (a doubling in the last year). In 2002, flunitrazepam was the most frequently detected substance.
- There has also been a big increase in amphetamines – approx. 25%.
- Methadone shows a strong increase, even if the absolute figures are much lower.
- On average between two and three substances are found in each sample.
- Intoxicants or medicinal drugs are found in almost 80% of the cases in which the police require drivers to take blood tests.
- Norway is the leading country in Europe when it comes to catching drivers who are under the influence of intoxicants.

The distribution between cases in which the offender was suspected of being under the influence of alcohol and cases in which the offender was suspected of being under the influence of other intoxicants is shown in figure 10.

Figure 10. Number of traffic cases investigated by SRI/NIPH in 1990-2002, in which being under the influence of alcohol or other intoxicants was suspected.



Source: NIPH

The detection of various narcotic substances is shown in table 4.

Table 4. Detection of various narcotic substances in traffic cases investigated by SRI/NIPH in 1990-2002

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
<b>Cannabis</b>	564	627	842	741	660	995	708	1 027	1 502	1 504	1 686	1 732	1 886
<b>Diazepam*</b>	430	475	676	541	577	712	744	928	1 004	910	808	1 050	1 113
<b>Flunitrazepam**</b>	233	255	212	221	198	270	321	458	540	603	656	1 252	2 107
<b>Amphetamines</b>	233	216	391	475	533	937	898	1 081	1 327	1 290	1 312	1 587	1 972
<b>Morphine</b>	72	108	107	142	193	261	311	392	483	533	601	539	452
<b>6-MAM***</b>		6	29	64	92	172	195	263	317	320	307	295	213
<b>Ecstasy (MDMA)</b>					0	6	23	27	67	123	194	194	180
<b>Cocaine</b>					10	9	6	19	40	80	118	135	166
<b>Methadone</b>											22	64	102

\* Active agent in Valium, among others \*\* active agent in Rohypnol, among others \*\*\* chemical conversion product of heroin

Source: NIPH

## Chapter 4. Social and Legal Correlates and Consequences

### 4.1 Social problems

Studies of Norwegian drug users show a major over-representation of various social problems. Many live under very poor housing conditions, in environments with high crime, violence and prostitution. A study of users of the needle bus in Oslo, for example, shows that more than 4/5 received welfare or social security benefits, while only approximately 10% were in paid employment. Over half of the women had earnings from prostitution (Bretteville-Jensen 2000).

### 4.2 Drug offences and drug-related crime

#### Legislation

The Norwegian Penal Code section 162 and the Act on Medicinal Products section 31 (2), cf. section 24 (1), regulate drug offences. The Penal Code regulates serious offences, while the Act on Medicinal Products has provisions for what are considered less serious offences. In Norway, statistics are kept for crimes reported, investigated, prosecuted and for convictions relating to drug offences. However, information is not provided on the substances involved.

Table 5. No. of reported and investigated drug offences.

	Penal Code, section 162		Act on Medicinal Products		Total	
	Reported crimes	Investigated crimes	Reported crimes	Investigated crimes	Reported crimes	Investigated crimes
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	18 667	27 548	25 073	48 959	43 740
2002	20 600		26 410		47 010	

Source: Crime statistics, SSB

Crime statistics (table 5) reveal a clear rise in drug-related crime. During the period 1991 to 2002 the number of violations of the Medicinal Products Act increased almost fivefold. The number of arrests for violations of section 162 of the Penal Code, which regulates more serious drug crimes, nearly tripled during the same period. Compared with other types of crime, the statistics covering drug-related crime clearly show the sharpest increase. The high number of cases can, however, be attributed to the fact that the same case may be registered as several violations if the person is reported or investigated for both use, possession and purchase for his/ her own use.

The number of persons charged for violation of drug laws has almost tripled from 1990 to 2002 (table 6). Statistics on the number of reactions against drug offences show a similarly sharp increase (standard table 11).

Table 6. Number of persons charged with drug crimes

	Penal Code, s. 162	Act on Medicinal Products	Total
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
2001	6 287	4 459	10 746

Source: Crime statistics, Statistics Norway

### 4.3 Social and economic costs of drug consumption

a) In general it is always difficult to estimate the social costs of drug use. As regards the economic costs for municipalities, SIRUS carried out a study in 2003 on "Intoxication and psychiatry in the municipalities' income systems", commissioned by the Ministry of Local Government and Regional Development.

Among the most important direct costs for municipalities are the municipalities' own share of treatments costs and the cost of work directly among drug and alcohol users (outreach workers etc.). In total Norwegian municipalities spent approx. EUR 63 million on this work in 2001 (net)<sup>ii</sup>. There are no corresponding figures relating to how much money the municipalities spent on mental healthcare, but there is reason to believe that municipal expenditure is moderate – both because the municipalities do not pay an own share for psychiatric treatment and because the funds allocated by central government for stepping up psychiatric healthcare cover many of the municipalities' expenses.

In addition to direct costs relating to drugs and alcohol and psychiatry, there are indirect costs, of which social security and child welfare expenditure stand out as particularly important. On the basis of user surveys we can assume that roughly 23% of social security expenditure is spent on persons with alcohol and drug problems. Estimates based on these surveys show that the total municipal expenditure on drugs and alcohol abusers is at least EUR 275 million. This is a relatively small share of total municipal operating expenditure, but there are great variations between the different municipalities (SIRUS report no. 3, 2003).

b) Central government expenditure on preventive measures and treatment of drug and alcohol abusers was described in chapter 14 of the National Report for 2002. An overview of central government grants in 2003 is provided in chapters 1.4 , 9 d) and 10.1.

<sup>ii</sup> Includes users of all types of intoxicants, both alcohol and narcotic substances.

## Chapter 5. Drug Markets

### 5.1 Availability and supply

The seizures made by the police and customs authorities of different substances in recent years are a clear indication that use and abuse of the various narcotic substances increasingly takes place in all parts of the country. Seizures of cannabis, amphetamines/metamphetamines and benzodiazepines have been made in all 27 police districts, cocaine in 24 districts, heroin in 23 districts and ecstasy in 25 districts (NCIS' six-monthly report 2003).

Together with data from the survey of some selected municipalities (chapter 2.2 ), this is a reliable indication that drug use and drug dealing is increasingly spreading to small communities throughout the country, even if the problem is still most preponderant in the cities and large towns.

Surveys are another means of measuring changes in availability. The annual survey of young people aged 15-20 shows, for example, that there has been an increase in the proportion of those stating that they have been offered cannabis from approximately 25% during the first half of the 1990s, to about 40% in recent years. Similarly, the proportion who state that they would be able to obtain cannabis within 2-3 days has increased from about 55% to 65% during the same period.

The increasing mortality rate confirms that the use of heroin is increasing throughout the country. Even though the number of drug-related deaths dropped sharply in 2002, such deaths were registered in 23 of the 27 police districts.

The narcotics section at Oslo police district estimates that approximately 80% of all drugs that are smuggled into Norway are destined for Oslo and are spread to the rest of the country from there. The trend is that drugs are spreading to more and more police districts. Drugs are often smuggled through natural ports of entry such as the Swedish border crossings and ferry ports. New substances largely arrive in Oslo and the central eastern part of the country first. Once a market has been established for such drugs, they are then spread to other areas of Norway.

### 5.2 Seizures

NCIS registers drug seizures made by the police and customs authorities. 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 on the basis of the number of times a substance is detected and is quantified by different types of substances, the time of seizure and how it was carried out. In other words, multiple seizures are registered for one and the same case if different types of substances are confiscated. The same holds true if the seizures are made in different locations or at different points in time.

#### Main trends in 2002

The number of drug cases reported to NCIS in 2002 once again showed a marked increase. The number of drug seizures increased by approx. 10% compared with 2001, which was also a record year. The trend is not unambiguous however. Benzodiazepines - of which Rohypnol constitutes 3/4, and metamphetamines have increased most. The increase is also great for medicinal pain killers classified as illicit narcotic drugs.

It is also worth noting that the number of heroin seizures has dropped markedly, and we have to go all the way back to 1995 to find the same frequency of seizures. The amounts seized were, however, relatively large.

The number of cocaine seizures increased by 16%, and this can only be described as a marked increase, even though the rate of increase has decreased slightly compared with recent years.

For ecstasy, the number of big seizures increased considerably, while the total number of seizures decreased by 14%.

Cannabis remains the most frequently seized drug. In 2002 cannabis accounted for approx. 1/3 of all seizures, but the increase is smaller than in the last 5 years.

Seizures of GHB remain at a low level, on a par with what has been recorded during recent years. It seems that its prevalence is very marginal compared with other drugs.

Based on the number of seizures, it appears that LSD has almost disappeared from the market.

### **Trends in 2003**

NCIS' figures for the first six months show a clear decrease in the number of drug cases and seizures. The decrease in the number of seizures (17% compared with the same period in 2002) applies to most substances, except LSD and GHB, and is particularly marked for ecstasy, benzodiazepines, cocaine and heroin.

On the other hand, there have been many big seizures of most types of drugs. The quantities of cannabis, heroin, amphetamines, metamphetamines, khat, ecstasy, benzodiazepines and LSD are well above the average indicated in the six-monthly statistics in recent years. The number of seizures of GHB during the first six months has already exceeded the number of seizures made during the whole of 2002.

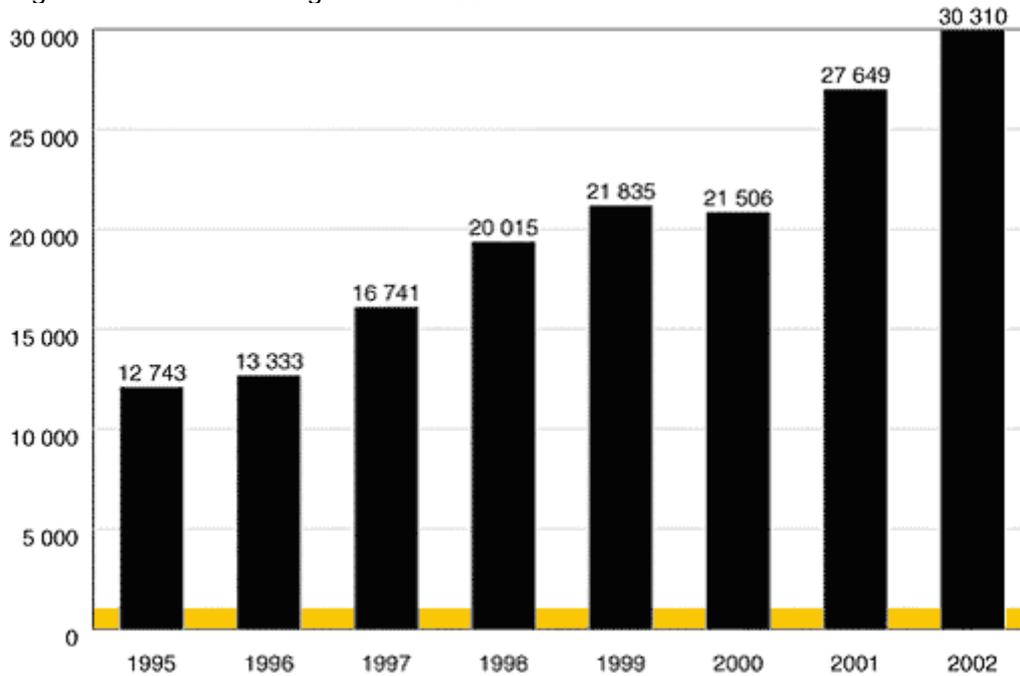
NCIS assume that the reduction in the number of seizures is related to the fact that the police have given priority to investigating major drug cases and directed their efforts less at users and the final link in the chain of distribution.

While the increase in seizures of flunitrazepam (Rohypnol) was quite dramatic in 2002, there has been a marked decrease in the first six months of 2003.

This trend is confirmed by substance analyses in road traffic cases. In 2002, flunitrazepam was the most frequently detected substance. The trend in 2003 shows a decrease during the first six months. The decrease may be due to the fact that illegal importation from Eastern Europe has been considerably reduced.

The tables, figures and text included in the following relate to 2002 (standard table 13).

Figure 11. Number of drug seizures 1995- 2002



Source: NCIS

Table 7. Number of seizures 2000 – 2002, broken down by the most common substances

Substance	2000	2001	2002	Change in% from 2001
Cannabis	9 224	10 844	10 921	+0.7%
Amphetamines	3 077	4 596	5 035	+9.6%
Methamphetamines	173	392	695	+77.3%
Heroin	2 314	2 501	1 906	-23.8%
Benzodiazepines	4 265	6 024	8 056	+33.7%
Pain killers	845	1 009	1 237	+22.6%
Doping	469	643	697	+8.4%
Cocaine	390	496	577	+16.3%
Ecstasy	827	837	716	-14.5%
Khat	255	198	238	+20.2%
LSD	87	52	15	-71.5%
GHB	83	82	75	-8.5%
Opium	19	24	14	-41.7%

Source: NCIS

## **Cannabis**

In 2002 seizures of cannabis totalled 1,221 kg. This is well above the average for the last ten years. Only three times previously has a greater quantity been seized in a single year. The number of seizures increase marginally compared with 2001. Hash accounts for more than 85% of the total number of cannabis seizures.

Most of the cannabis that reaches the Norwegian market is produced in North Africa. It is often transported via Spain, the Netherlands and Denmark to Norway. There are many players involved – both in the importation and at the receiving end, and the importation cannot be tied to any particular ethnic group. In most cases importation and reception is carried out by Norwegians.

## **Amphetamines/ metamphetamines**

The quantities of amphetamines and metamphetamines seized in 2002 were 209 kg and 23.6 kg, respectively, divided between 5,035 and 695 seizures. The quantities seized have almost trebled compared with the average for the last ten years, and the number of seizures has increased by 133% in five years.

Ten years ago there were far more seizures of heroin than amphetamines. In 1998 the number of seizures was the same for both these substances, while in 2002 the frequency of seizures was three times higher for amphetamines and metamphetamines than for heroin. The average purity of seizures of more than 15 grams is estimated to be approx. 34%. This is significantly less pure than in 2001, when the average purity was 42%.

Most of the amphetamines seized in Norway are produced in Europe and mainly originate in the Netherlands, Belgium, Poland and Estonia. Most of the metamphetamines that are seized are produced in the Baltic countries and imported by criminal groups of Baltic origin.

## **Heroin**

A total of approx. 59.1 kg heroin was seized in 2002. Only in two previous years have the quantities seized been greater. There has been a marked drop in the number of seizures for the country as a whole, however, including Oslo. This trend was particularly marked in the last six months of the year. The number of seizures fell by 13% in Oslo, and by as much as 24% at the national level.

The average amount of heroin in the substance mix has been estimated at approx. 30% weight, which represents the lowest purity registered in any one year. It is worth noting that the purity was the same for large seizures as for the smallest seizures for the second year running.

## **Ecstasy**

The number of "ecstasy" tablets seized in 2002 was 102,433. In addition, 75 g of powder containing ecstasy was seized. The quantity has never been this high before, and the increase on 2001 is marked. The number of seizures was only 716, however, and this is a decrease of approx. 14%. There is reason to believe that this has to do with the fact that there were many large individual seizures. MDMA dominates the market and was detected in 99.6% of the seizures. Only four seizures have been recorded for the substances MDA, PMA and MDEA.

Neither 2C-B, DOB, 2C-J, 2C-T-2 or other known hallucinogenic substances were detected in the seizures made in 2002.

New tablets are received nearly every week, and a total of 47 new logos were registered in 2002, of which three turned out not to contain ecstasy. Compared with 2001, the supply of new tablets/ logos fell by about 25%.

"Ecstasy" tablets are produced illegally and are therefore not subject to quality control like commercial medicinal products. Nor is there any declaration of contents in connection with the distribution of the tablets. Despite this, very few deviations from the "norm" have been registered during the last 15 years; the great majority of tablets contain between 70 and 120 mg of the active agent (MDMA). So far, opioids have not been detected in any of the tablet seizures.

### **Benzodiazepines**

Throughout the country, the benzodiazepine group of substances has increased more than any other, both in terms of quantities and number of seizures. In 2002 the quantity seized was 1,251,100 tablets (an increase of 50% on 2001) in a total of 8,000 seizures (an increase of 33% on 2001). At present, benzodiazepines account for approx. one quarter of the total number of seizures in Norway. The number of seizures and the quantities seized have increased manifold in the course of just a few years.

Rohypnol is the predominant substance, its share having risen from 60% to 76% in two years. Other frequently seized benzodiazepines are Valium, Rivotril and Sobril.

Benzodiazepines are very often registered together with other substances (heroin, amphetamines, cannabis and ecstasy) in one and the same drug case. The great majority of cases concern drugs that have been smuggled into the country.

### **Cocaine**

In 2002 a total of 35.8 kg cocaine was seized in a total of 577 seizures. This quantity was only exceeded in 1998 (due to one big seizure of drugs found in the sea) and 1999. In general, large quantities of cocaine are smuggled into Europe from South America, with Spain being regarded as the main route of entry. However, the number of seizures in Spain fell compared with the two preceding years.

In the last two years the amount of cocaine in the powder seized has also been much lower on average than that registered in several decades. The purity of cocaine used to be more than 80%, while the average for 2002 is estimated at 51%.

### **Other substances**

#### **Khat**

The amount of khat seized decreased for the third year running. The number of seizures in 2002 (238) was, however, much higher than in 2001 (198).

#### **LSD**

There was a marked decrease in both the quantity and number of seizures.

#### **GHB**

Seizures of GHB remain at a low level in line with what has been registered during recent years.

#### **Opium**

There was a marked decrease in both the quantity and number of seizures compared with recent years.

### **Other opioids (medicinal pain killers classified as narcotic drugs)**

Both the quantity and number of seizures of substances in this medicinal product category increased markedly in 2002. A total of 70,000 medicinal doses were seized in a total of 1200 seizures. One single seizure of Temgesic consisted of as much as 50,000 tablets. It is also worth noting that there was a relatively large increase in the number of seizures of drugs

containing methadone, which comprised 1,720 medicinal units divided between 65 seizures of methadone solution. In the course of three years the number of methadone seizures has trebled and the quantity seized has increased manifold. (NCIS)

### 5.3 Prices

The prices reported for different narcotic substances are based on information obtained from the narcotics section in the Oslo police district. The prices of the different narcotic substances vary according to the quantity being sold, so that the price per gram will be cheaper if one gram is bought than if individual doses are bought. Prices for small quantities of cannabis have remained stable over the last year, but the price for larger quantities (1 kg) has fallen significantly. The price of heroin remains stable following a marked price fall during the previous five-year period. There are minor changes as regards amphetamines, while ecstasy (MDMA) prices have been cut by almost half for large purchases (per 100 tablets).

Table 8. Prices for some drugs in Oslo (January 2003). In Euros. Exchange rate: EUR 1= NOK 8.00

Type of substance	Dealer doses	1 gram	10 grams	1 kilo
Heroin	0.1 g/19-25, 0.2 g/38-50	100-150	750-250	31,250-62,500
Hash	12.5 (0.5-0.7 g)	-	75-100	1,750-4,375
Amphetamine	19-25 (0.2 g)	25-50	250-625	7,500-11,250
Ecstasy	12.5-19 per tablet		6-7.5 per tablet (100)	3-4 per tablet (1000)
Cocaine	ca. 20 lines per gr.	ca. 31	750 – 1,250	37,500 – 75,000

Source: Oslo Police District

The “price list” is based on information from users and dealers at different levels, as well as information received from police officers working in the narcotics section. Prices can vary widely at times, depending on quality, contacts and quantity.

Price developments are also monitored 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 the result of an increase in the price of that product. Many people have claimed that those addicted to narcotics, particularly substances like heroin and amphetamines, will not be very sensitive to changes in price. It has been argued that addiction leads the addict to use approximately the same amount of the 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 users will adjust their consumption significantly if the price of the substance changes, and heroin abusers appear to be more price sensitive than amphetamine users (Bretteville-Jensen and Biørn 2002). The material also suggests that women are more price sensitive than men (Bretteville-Jensen 1999).

## Chapter 6. Trends per drug

### ***Cannabis***

There has been an increase in the use of cannabis in the course of the last decade. This is evident from, among other things, surveys and analyses of blood samples taken from drivers suspected of driving under the influence. The number of seizures has also increased, particularly in the last four years. The price of cannabis has remained relatively stable in the same period. The fact that cannabis has become more available on the Norwegian market is also illustrated by survey data in that an increasing proportion of the respondents state that they have been offered cannabis or would be able to get hold of cannabis should they want to use it.

### ***Synthetic substances***

Amphetamines are either injected or taken orally. Even though amphetamines have not been as predominant among intravenous drug users in Norway as, for instance, in our neighbouring country Sweden, amphetamines have been used extensively by established drug abusers, and particularly so outside the Oslo area. Together with ecstasy the use of amphetamines is part of the drug culture partly associated with the "house" scene in the cities and large towns, and these substances are also a part of the party culture in some youth subcultures. Various data sources, such as seizures, surveys and drivers testing positive for ecstasy and amphetamines, indicate that the use of synthetic substances has increased and become more prevalent.

### ***Heroin/opiates***

Estimates indicate that the number of intravenous drug users has doubled during the last decade. Most of them inject heroin. Even though the number of drug fatalities decreased considerably in 2002, it remains high. More heroin is being seized throughout the country. The number of heroin seizures has dropped significantly since 2002, however. Even though it is difficult to read changes in use directly from the seizure figures for one single year, they seem to indicate a positive trend as regards the use of heroin. It must also be assumed that the now considerable number of people undergoing substitution treatment has somewhat reduced the demand for heroin.

### ***Cocaine/ crack***

The survey data do not indicate that cocaine is widely used. There has been an increase in the number of seizures, however, and even if cocaine seems to be infrequent among drug abusers, it is reported that cocaine, like ecstasy and amphetamines, has increasingly become part of the party culture in certain milieus. We do not know of any crack use in Norway.

### ***Multiple use***

Data from research on treatment and clinical reports indicate that most drug abusers are multiple users. Alcohol is usually part of the picture, either in combination or alternating with other substances. The extensive use of other narcotic substances in addition to heroin is one of the big problems in connection with medically assisted rehabilitation.

## Chapter 7. Discussion

### 7.1 Consistency between indicators

There is consistency between the indicators, but some degree of uncertainty attached to the interpretation of the different indicators relating to the development of drug use in Norway. In the long-term perspective, there has been a consistent increase in the number of seizures, the number of drug offences, the proportion of the population that has tried different substances etc. Developments for ecstasy are a possible exception. In 2002 the number of seizures increased for all substances, with the exception of heroin and ecstasy. The quantities seized increased for these substances too, however. The price level, on the other hand, has remained relatively stable, which does not clearly point to an increase in availability. This is supported by the fact that the proportion of young people aged 15-20 who report having ever used narcotic substances has actually fallen in the last two or three years.

### 7.2 Methodological limitations and data quality

For Norway's part, several of the indicators provided by the EMCDDA are still inadequate. This applies in particular to data on clients undergoing treatment and estimates of heavy drug use. As far as drug-related fatalities are concerned, the data based on the ICD-10 classification have been updated for previous years. Norwegian reporting on those arrested for drug offences, intravenous drug users with hepatitis, HIV and AIDS deviates from the guidelines provided. This is due to specific national procedures for reporting this type of information.

The data on prevalence of drug use may also be somewhat unreliable. For example, a low response rate in the annual youth surveys means that they are not representative. The illegal nature of the different substances might also contribute to statistical underreporting. Moreover, young respondents might have fewer qualms about providing information about their drug use than older respondents, thereby contributing to a higher reporting rate for younger than older respondents.

Estimates of the number of intravenous drug users have been made using a multiplication method based on registers of the number of drug fatalities. This method is based on there being a relationship between the number of drug fatalities and the number of users. One source of bias here 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 based on drug fatalities registered by NCIS. There may, however, sometimes be reason to question the grounds on which the police register a death as a drug fatality. Some cases might have been mistakenly defined as drug fatalities because the person was a drug user even though the individual died of other causes. SIRUS is in the process of developing several methods to provide better estimates of problematic heavy drug use.

Drug offences are "victimless crimes" and are seldom reported by others. The number of crimes that are investigated and lead to convictions is 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, attributable to differences in the intensity of control activity, without there necessarily being any difference in the number of crimes committed.

Seizures of drugs, both the number and volume confiscated, vary according to the priorities and efforts of the police and customs authorities. Among other things, the seizure figures tell us very little about the actual volume of substances that reach the market and are illegally used. The figures for seizures can also be influenced by legislative changes.

## **PART III – DEMAND REDUCTION INTERVENTIONS**

### **Chapter 8. Strategies in Demand Reduction at National Level**

#### **8.1 Major strategies and activities**

In Norway, little distinction is made between alcohol, medicinal drugs and narcotic 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 preventive measures as well as treatment.

The Government's new Action plan to combat alcohol and drug problems (2003-2005) outlines three strategically important goals for a policy on drugs and alcohol:

1. Prevention of all forms of alcohol and drug abuse, with particular focus on preventive work among children and young people
2. Improved availability of efficient advisory services, help and treatment for persons with drug problems and their families
3. Significant reduction in the incidence of drug-related damage to health and the number of drug-related fatalities.

The Government aims at establishing a low threshold for receiving help, and a high threshold for discontinuing such help. The main objective is to considerably reduce the harmful health and social effects of drug abuse. The action plan points out that in the field of alcohol and drug prevention, parents, local neighbourhoods, voluntary organisations, municipal, county and state agencies must constitute a chain of measures that compliment one another. There must be particular emphasis on measures that address the greatest needs and most dire situations, and areas where measures have been documented to have the best effect.

The Government points out that the interventions used must knowledge-based and constitute cost-effective ways of attaining the goals. It will be important to ensure that all interventions carried out by the public sector, or with public funding and approval, comply with specific quality criteria. This requires, among other things, that the interventions are evaluated and that the evaluation is such that both the short and long-term effects of the interventions are made clear. The evaluation should be based on clear, universal criteria, including a shared understanding of what constitutes good prevention and successful treatment.

The Government will establish a system for follow-up whereby new and existing measures are structured on the basis of the new goal and instrument structure. There will be requirements for clearly defined targets, target groups and measurement criteria, and for a planned evaluation to be implemented concurrently with the intervention itself.

Two expert advisory committees were appointed in 2003 – one on alcohol and one on drugs. They focus on a user perspective because the Government considers it important that also families/ other care personnel and former drug users participate in the committees with their first-hand knowledge and experience. The committees are to provide the Government with ongoing advice about specific drug policy challenges, evaluate interventions, propose new ones and stimulate the development of more knowledge.

## 8.2 Approaches and new developments

### 8.2. a) *New, innovative approaches*

The Government's action plan outlines a pilot project to "develop targeted and coordinated preventive efforts at the municipal level". The project has three cornerstones: procurement of the relevant local data; broad, coordinated development and implementation of intervention measures; and evaluation. The project is innovative in that it is inter-sectorial. The work will cut across the boundaries between the different administrative and organisational levels, and public and voluntary efforts will be combined. The pilot project will be evaluated by SIRUS.

### 8.2. b) *Socio-cultural developments relevant to the reduction of demand*

The traditional view of how a drug career starts is that smoking hashish gradually evolves into experiments with other, harder drugs, of which amphetamines/ecstasy are currently the most likely. Qualitative data give some indication that this picture may be about to change. New drug career patterns may emerge, in which ecstasy or amphetamines are the door openers to illicit drug use, even if this tendency is not as yet confirmed by quantitative studies.

In several youth subcultures, there appears to be a tendency for drugs which have long been linked to a specific youth subculture to now also be adopted by other groups, and thereby become detached to some extent from their original cultural context.

It is a reasonable assumption that all these spectacular trans-national youth cultures are innovative at the outset (often inspired by movements in other countries), only to end up as a part of the big popular culture landscape to which the majority of young people belong (mainstream position). How this takes place and what happens to the drugs associated with these cultures is less certain. We do know that ecstasy, for example, like cannabis, does not seem to disappear along with the youth culture which introduced it (Mushuus G; Rossow I; Vestel V. 2002).

### 8.2. c) *Public opinion*

Public opinion on drugs can be said to be largely stable. Very generally speaking it can be said that the vast majority of the population condemn, and do not use, narcotic substances. The same majority has a correspondingly positive attitude to, and uses, alcohol.

The mass media play a pivotal role in maintaining this picture. The media's presentation of alcohol and narcotic substances is completely different in many respects: The choice of focus, degree of problematisation and use of value-loaded words etc. help to create a picture of narcotic substances as a major and grave problem, while alcohol is most often presented outside of a corresponding problematic context (Norwegian official reports – NOU 2003:4).

### 8.2. d) *New research*

In September 2001 the "Research commission on the knowledge base for drug and alcohol policy" was appointed by the former Ministry of Health and Social Affairs, its terms of reference being to provide knowledge that would serve to enhance the scientific basis for decision-making in the area of drugs and alcohol. The commission submitted its report to the Ministry of Social Affairs in February 2003.

The commission employed two strategies for collecting relevant knowledge on topics relating to the prevention and treatment of drug and alcohol problems.

1. Searching the literature for systematic outline articles of a certain quality published in the English language, and a Swedish and a Scottish summary dealing with the relevant topics.

2. In order to obtain more detailed material concerning national data, all the relevant Norwegian milieus were contacted, so that the commission could gain access to reports/publications from the period since 1980 that contained evaluations of measures. (Norwegian official reports - NOU 2003:4).

Its conclusions are discussed in chapter 9.1 d) Evaluation studies and results.

**8.2. e) *Specific events***

No specific events to report.

## Chapter 9. Prevention

### 9. a) National Strategy

The government's action plan (2003-2005) divides preventive measures into two types of complimentary measures:

1. *Supply reduction*, where efforts are aimed at influencing the production, distribution and sale of different drugs, and where prohibition, regulation and control will be the most important means employed.
2. *Demand reduction*, aimed at influencing the purchase and use of drugs. The means of achieving this will consist of different forms of educational and attitude-building measures and other preventive measures, as well as control measures such as taxes and regulation and control of use.

Central elements of preventive work in Norway are based on:

- Viewing prevention and health-promotion as two inter-related aspects
- Directing preventive measures at individuals and specific risk groups, as well as large population groups
- Taking a long-term view of prevention
- The municipalities have a central role in preventive work
- Broad mobilisation of various voluntary organisations.

### 9. b) Organisation and coordination of preventive efforts in Norway

The Ministry of Social Affairs has overall responsibility for drug issues, including preventive measures.

The Directorate of Health and Social Affairs has been assigned responsibility for coordinating the implementation of preventive strategies and interventions.

The drugs and alcohol competence centres have been given the task of assisting in the implementation of drugs and alcohol policy by the Directorate of Health and Social Affairs. Each competence centre has one or more speciality areas in which it is expert and about which it has a national responsibility for disseminating knowledge<sup>iii</sup>. The competence centres have an important role in cooperating with the municipalities in their regions to develop competence, methods and interventions in the prevention field.

<sup>iii</sup> The competence centres have the following speciality areas:

REGION NORD (NORTHERN NORWAY): Counties: Nordland, Troms and Finnmark

- *Nordland's Clinic* – [www.nordlandsklinikken.no](http://www.nordlandsklinikken.no) Speciality area: Group therapy approach to drugs and alcohol problems

REGION MIDT-NORGE (CENTRAL NORWAY) Counties: Nord- og Sør-Trøndelag, Møre og Romsdal

- *Central Norway competence centre for alcohol and drugs* – [www.mnk-rus.no](http://www.mnk-rus.no) Speciality area: Youth and drug use, young drug addicts

REGION VEST (WESTERN NORWAY) Counties: Sogn og fjordane, Hordaland and Rogaland

- *Rogaland A-centre* - [www.rogaland-asenter.no](http://www.rogaland-asenter.no) Speciality areas: Families and children of school age, alcohol and drugs in the workplace
- *The Bergen Clinics Foundation* – [www.bergenclinics.hl.no](http://www.bergenclinics.hl.no) Speciality area: Women and drugs and addiction, female drug addicts

REGION ØST (EASTERN NORWAY) Counties: Oppland, Hedemark, Akershus and Østfold

- *Sanderud Hospital, Drug addiction ward* – [www.sanderud-sykehus.no](http://www.sanderud-sykehus.no) Specialty area: Double diagnoses – psychiatry and drugs, gambling addiction

REGION OSLO.

- *Alcohol and drug addiction service* – City of Oslo - [www.rusmiddeletaten.oslo.kommune.no](http://www.rusmiddeletaten.oslo.kommune.no) Specialty areas: New trends of use among young people

REGION SØR (SOUTHERN NORWAY) Counties: Aust-Agder and Vest-Agder, Telemark, Buskerud and Vestfold

- *Borgestad Clinic* – [www.borgestadklinikken.no](http://www.borgestadklinikken.no) Specialty areas: Pregnant addicts and addicts with small children.

Prevention of drug and alcohol abuse is otherwise a municipal responsibility as set out in the Act on social services. Municipal social services shall work to prevent and combat the use of alcohol and other drugs through information and outreach services and spread information on the harmful effects of such use. Drug prevention work shall mainly focus on local measures, emphasising the interplay between home, school, the social and health sectors and the leisure and cultural sectors. The goal is to achieve coordinated and inter-disciplinary efforts.

How the work is organised is up to the individual municipality. In most municipalities responsibility lies with the social services, but some of the bigger municipalities have elected to establish dedicated positions for the coordination of crime and drug prevention efforts. The aim is to strengthen preventive work by making it easier to coordinate the efforts of the different services and sectors.

Building on the idea that coordination of efforts can be cost effective, and that youth milieus and drug milieus cut across municipal boundaries, inter-municipal cooperation on drugs has been initiated in some areas.

In addition to the public sector, voluntary organisations engaged in the drugs and alcohol field play an important role in preventive work. These organisations have their own rules and guidelines for the activities that they run. The Directorate of Health and Social Affairs has a grant scheme, under which voluntary organisations can apply for funding for their projects.

### **9. c) Overview of central government funding for preventive work**

*(Exchange rate used: 1 Euro=8 NOK)*

In 2003 the Directorate of Health and Social Affairs allocated a total of EUR 7,454,000 to the seven competence centres on drug-related issues. The allocations are meant to cover expenses relating to day-to-day operation and the development of interventions.

The Directorate of Health and Social Affairs administers four grant schemes for preventive work, from which funding can be applied for according to specific guidelines. Grant schemes and available funds for distribution in 2003:

1. *"Grants for alcohol-free establishments providing overnight accommodation etc.":* EUR 469,500
2. *"Grants to the Norwegian centre for the development of drug-free milieus":* EUR 685,000
3. *"Grants to voluntary organisations engaged in the drugs and alcohol field"* EUR 4,356,625
4. *"Other grants"* (deserving national/ regional measures aimed at the prevention of drugs and alcohol abuse) EUR 937,500.

In addition EUR 725,000 was allocated to prevention work through the Norwegian Tripartite Committee for the Prevention of Alcohol and Drug Problems in the Workplace (AKAN).

## **9.1 School programmes**

### **9.1 a) Central guidelines/ specific action plans**

Schools have long played a central role in preventive work. Education on alcohol and drugs is incorporated in the national curriculum plan, under which it should be integrated with other lessons (National Curriculum Plan of 1997). The goal is to carry out active preventive work in elementary and secondary schools in order to combat the use and abuse of alcohol and drugs. This is underlined in the government's action plan (2003-05). The government wants

"knowledge-based drugs and alcohol education in schools that focuses on the students' social skills and ability to master situations and with active parent participation" as one of several measures to prevent drug use.

There are currently a great number of so-called drug prevention programmes and measures aimed at schools, but the quality of such measures is very variable. This year, therefore, the Directorate of Health and Social Affairs initiated the development of a joint strategy for the coordination of drugs and alcohol prevention efforts in schools, with clear recommendations with respect to what, on the basis of scientific criteria, can be regarded as expedient and effective programmes. A committee has been appointed to prepare the recommendation scheme. The committee consists of representatives of the Directorate of Health and Social Affairs and the competence centres. The work is expected to be completed in 2004.

### **9.1. b) Models/ principles for school programmes**

The committee preparing the recommendation scheme will emphasise programmes and interventions that have a documented effect and/or are based on research-based principles. Central elements will include efforts over time, ensuring support from those in charge of schools, all-inclusive and coordinated efforts by those involved, cooperation between home and school, parent involvement, programmes which include or are designed to carry out process and results evaluations.

### **9.1. c) Examples of school programmes/ interventions in schools**

Most of the school programmes currently in use focus on primary prevention. Some focus mainly on tobacco and alcohol, others on social skills and mastering rather than on actual drug and alcohol use. Only a few target youth at risk and/or have drug prevention as their main focus. The programme concepts can provisionally be broken down as follows:

- ♦ *Dialogue/ communication programmes* in which issues and situations are described in a way that enables the participants to reflect and communicate with others about these topics ("Youth and drugs and alcohol", "Time breakers", "This year's first-time users", "the Rainbow programme" etc.)
- ♦ *Peer education*; Peers (in this case youths) teach/ pass on knowledge to each other ("Dialogue conferences", "Future" etc.)
- ♦ *Education programme/ guidance programmes* ("Freezing point", "Local guide" etc.)
- ♦ *Lifeskill training programme* ("Lions Quest", "Step by step"). (standard table 19: School programmes)

### **9.1. d) Evaluation studies and results**

The Research Commission's report on research in the area of drugs and alcohol, included an evaluation of school programmes targeting children and adolescents. The commission divided the measures into two main types: didactic and interactive. In this context, "*didactic measures*" means different forms of classroom teaching in which the main emphasis is on adult "experts" conveying factual information to the students. The aim is to develop negative attitudes to drugs and alcohol, prevent damage and postpone use. These programmes focus on the idea that sufficient knowledge will result in correct behaviour. By "*interactive measures*" they mean educational schemes with participant involvement and in which the focus is on strengthening the students' ability to make good choices in difficult situations (mastering).

The evaluation of drug-related measures is based on seven outline articles. Two of the articles are of reasonably high quality, the remainder are of medium or poor quality. The results must therefore be interpreted with some care. The number of primary studies is slightly less than 400, 90% of which are from the USA. The results of this summary of knowledge relating to drug-related measures show:

- that it is well-documented that school programmes increase the students' level of knowledge about drugs and the dangers of using them, while attitudes and behaviour are affected to a lesser extent;
- that it is well-documented that interactive programmes are more effective than didactic teaching methods;
- that only short-term effects have been demonstrated, measured in terms of differences between intervention and control groups, while good studies of high quality and with a long follow-up period are lacking;
- that the DARE (drug abuse resistance education) programme, whereby the police are brought in to teach in the schools, is probably not expedient.

Only two of the Norwegian studies have result indicators that included drugs (attitudes and use). They underpin the results of the international studies, particularly as regards the finding that interactive schemes can result in positive changes in behaviour in the short-term. But these studies have a short follow-up time, and it has not been documented that any of the interventions that were evaluated have an effect in the long term. There has been little investigation of undesirable side effects.

The Research Commission concluded, therefore, that the primary effect of the programmes is on the actual level of knowledge, while behaviour is less affected. Interactive programmes are more effective than didactic programmes, but these measures appears to have little effect in preventing drug use among those groups that are at risk with respect to abuse (NOU 2003:4).

In 2001 the former Directorate for the Prevention of Alcohol and Drug Problems (now the Directorate of Health and Social Affairs), ordered an external evaluation of the four grant schemes for preventive measures relating to drugs and alcohol. A report was submitted in 2002 (NOR Consulting AS). The evaluation started with an evaluation of objectives, regulations and awarding practice, and went on to examine some individual projects to assess the products and effects that the funding had resulted in. The main conclusion of the report was clear: The grant scheme as it had been practised until then could not be said to promote the intention of stimulating efforts to prevent drug and alcohol problems. The report made clear recommendations for changing practice. In 2003, as a result of this evaluation, the Directorate of Health and Social Affairs started work on changing the grant schemes.

### **9.1. e) Research projects**

No new information is available concerning research into specific drug and alcohol abuse prevention programmes/ interventions in schools in the current year. One expert group appointed by the Ministry of Education and Research and the Ministry of Children and Family Affairs produced a report in 2001: "Evaluation of programmes and measures to reduce problem behaviour and develop social skills". Fifty-six different programmes were evaluated but only 9 programmes were recommended for use in schools. None of these was specifically related to drugs. Only one programme – Dan Olweus's programme to combat bullying – was recommended without reservation. Eight other programmes were evaluated as promising, but they all required further evaluation and, in part, further development, before it could be ascertained whether they actually had the desired effect. The report can be read at <http://skolenettet.ls.no/sosial-kompetanse>.

## 9.2 Youth programmes outside schools

### 9.2. a) Definitions

The criteria for being designated a youth intervention/ youth programme outside schools is that the activity is not directed at students during school hours. Hence, measures linked to schools – such as various programmes for parent involvement, though organised through schools, where the meetings are held in school in the afternoons/ evenings, will belong in this group.

### 9.2. b) Types and descriptions of youth interventions outside schools

At the end of the 1960s a system of public *outreach* services was established in a number of municipalities, and today there are 63 such services, covering most of the cities and large towns. They are engaged in outreach work among children and young people. On average each unit has two-three employees. The outreach service in Oslo is the biggest with 25 employees, all with professional qualifications. Their activities encompass different preventive measures directed at older children and youths, including contact with young people and helping those who have developed drug and alcohol abuse problems to get treatment. The project, "Stop the dope not the dancing" was initiated in Oslo in 1995 as a collaboration between the outreach service in Oslo and young enthusiasts from the house scene on an information campaign on drugs in the house and party scenes. The project has changed its name to "*Future*" and is now found in four cities/ towns: Bergen, Trondheim, Tønsberg and Oslo, as part of the activities of the outreach services.

"Future" targets young people aged 13-22 who are interested in/ belong to the rave/ techno/ trance subcultures. The objective is: to create good norm transmitters in drug-free subcultures, prevent/ reduce the damaging effects of drugs, create alternatives that can compete with drugs and focus on new trends and developments in this subculture. The cornerstone principle of the project is "youth-to-youth" contact. Young people (called dozers) work voluntarily in the projects in the different towns (standard table 21).

Much of the municipal prevention work is based on various interventions/ programmes based around schools: various parent and local community-based activities. Examples are:

- "*Time breakers*" is a programme targeting adults with responsibility for children aged 6-12. It is a communication programme intended to provide parents/ guardians with issues and descriptions of situations that can be discussed, reflected on and raised with others.
- "*Parent cooperation on drug and alcohol prevention*" is an intervention programme targeting parents of 8<sup>th</sup> year students (lower secondary school). Parent meetings are organised around various topics, the aim being to strengthen the bonds between parents and boost their authority to set limits for their children's experimentation with drugs and alcohol.
- "*This year's first-time users*" is based on a parents' meeting of parents of 8<sup>th</sup> year students and includes the use of a handbook to get parents to reflect on their own views on the topic. It is a dialogue-based programme, intended to get parents to talk to each other by dividing them into groups. The focus is on communication – on using one's own resources in cooperation with others (standard table 19: School programmes).

A number of voluntary organisations engaged in the drugs and alcohol field run their own programmes and interventions/ measures aimed at young people outside schools with funding from the Directorate for Health and Social Affairs.

### **9.2. c) Statistics and evaluation results**

*Føre Var* (“Earlier warning system”) is a project, which was started in Bergen and Oslo in 2002, to further develop methods of collecting information on new trends and modes of use of narcotic substances among young people. The objective is to identify new and upcoming drug trends, provide in-depth information in order to inform practitioners and politicians, increase the accuracy of political interventions and increase the effectiveness and use of management by objectives in the practical field, update survey questionnaires and increase cooperation between different agencies.

A report on the “Earlier warning system” in Bergen was published in June 2003, based on a comparison of information from autumn 2002 and spring 2003. It showed little change in availability and use for the majority of the illicit drugs. It showed a flattening out and possible reduction in the availability of Rohypnol during the period in question. There has been an increase in the use of anabolic steroids in connection with body building.

### **9.2. d) Further education and training for professionals in the prevention field**

#### **Further education**

There are 12 different training programmes within the drugs and alcohol field in Norway. All are university college based, and most offer 20 credits (60 points). They aim to provide a general introduction to the drugs and alcohol field by covering the whole range of issues from early prevention to treatment and after-care.

#### **Training in outreach work**

The Alcohol and Drug Addiction Service’s competence centre in Oslo (RKS) is working to integrate outreach work/ field work/ visiting services with the Service’s other professional training with a view to developing national expertise in this area.

The work is based on the joint efforts of RKS, the National Association of Outreach Workers and the City of Oslo’s outreach service and aims to:

- Establish a two-semester course of training in outreach work in cooperation with a local university college. The aim is a 30-credit course.
- Intensify the work on a new textbook manuscript in this field.
- Market an English “introductory book” on field work, such as (drug) prevention work among young people. To be carried out in cooperation with the European Council’s Pompidou group
- Initiate structured evaluation projects by different outreach services to make the work being done more visible and identify success factors.

## **9.3 Family and childhood**

### **9.3. a) Definitions**

There is no shared, uniform and unequivocal definition of drug and alcohol prevention measures aimed at families and children. But the government’s action plan emphasises that the situation of children is a particularly important priority area, and the government wants to increase resources to make it possible to intervene as early as possible.

### **9.3. b) Types/ descriptions of interventions aimed at families and children**

We know a lot about the consequences for children of living in families where there is substance abuse. Studies have shown that the incidence of a number of problems is higher among the children of substance abusers, and there are proven correlations between substance abuse in the home and criminality during adolescence and adulthood (West & Pinz 1987, Miller & Jang 1977, Christensen 1994). When these children grow up, they are

also reported to suffer from psychosomatic problems, depression, eating disorders and borderline problems (Black et. al. 1986, Kashubeck 1994, Belliveau et. al. 1995).

The public duty to intervene on behalf of children living in families where there is substance abuse and/or other forms of serious neglect is also regulated by law. Each municipality has a child welfare service which, after an evaluation of what is *best for the child* (the Child Welfare Services Act section 1), can if necessary remove the child from the family by force. The child welfare service also has a preventive role, and shall provide help, support and guidance to families (long) before it becomes necessary to take over daily care and control.

All municipalities have health clinics for children. They employ doctors and nurses and sometimes also midwives. They carry out pregnancy checks and all newly-borns are invited to participate in a vaccination programme stretching over two years, followed by a health check at the age of five. Many health clinics follow a practice of visiting the home soon after children are born. The health clinics thus act as public bodies that reach most families with small children, and their personnel can have an important role to play in the area of substance-abuse prevention.

On this basis the Borgestad clinic competence centre, whose special competence is "Pregnant addicts and families with children", has initiated a training programme aimed at health clinic employees. The programme focuses on drugs and alcohol work in health clinics, with special emphasis on increasing the employees' ability to take action. This training programme will be continued next year.

Different voluntary organisations have also become involved in the issue of drugs and alcohol use during pregnancy and parents' attitudes 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 as a result of adult neglect. The programme provides various services for local health clinics, kindergartens, primary and lower secondary schools as well as inter-sectorial co-operation. The message is directed at adults, but is about children.

*Parents Against Drug Abuse* is an organisation for drug users' close family members. The objective is to offer the families of drug users help to help themselves and to help the problem user back into society. The organisation has around 60 local branches. They organise courses, seminars and meetings and engage in individual support work.

### **9.3. c) Research projects and evaluation results**

There are no recent results from major research projects in Norway in this area.

## **9.4 Other programmes**

### **9.4. a) Regional and local strategies relevant to the regulation of the leisure sector.**

Many municipalities have drugs and alcohol policy action plans. These provide guidelines for local drug-related work, in the areas of prevention, treatment and rehabilitation, and also outline local drugs and alcohol policy strategies/ instruments relating to licences for serving alcohol, opening hours for the sale and serving of alcohol etc.

### **9.4. b) Brief analysis of the framework for leisure-based activities**

There are many players who run leisure-based facilities, even though there are no statutory requirements in this area. A number of municipal facilities exist, such as after-school clubs or activity houses/ multi-use halls. The drug prevention effect of such facilities is at best indirect in that people who might otherwise be adrift are "caught" and offered meaningful activities.

Voluntary organisations are most active in this area, however. They include various ideological (religious, humanitarian, political) associations/ organisations, various youth organisations, sports clubs etc. Each organisation has its own objectives and rules. Some, such as "Youth against drugs" and the "Association against drugs" have specific focus on drug prevention, but the vast majority do not. Insofar as what they provide can be said to have a preventive intention (or effect), they also qualify for inclusion in the category health-promoting activities.

**9.4. c) Central framework for regulating licensed premises etc.**

The most important regulatory mechanism relating to licensed premises is the "Act on the sale of alcoholic beverages etc. The Alcohol Act provides a framework that regulates the sale and serving of alcohol, while the licensing authorities are the municipal councils. In cases of breach or non-fulfilment of requirements imposed on the licensee, their licence can be withdrawn. Note: A licence can also be withdrawn in the case of repeated drug dealing on the licensed premises.

**9.4.d) Applicable guidelines for the leisure sector and how they are enforced.**

There are no formal guidelines or regulations.

## Chapter 10. Reduction of drug-related harm

### 10.1 New initiatives in 2003

In 2003 efforts to expand low threshold health services for heavy problem users have been intensified. The central government allocates EUR 5,250,000 for such health measures in the municipalities. This is an increase of EUR 1,750,000 compared with 2002. This year 27 municipalities will receive funding for various measures, compared with 24 municipalities last year. Several of the municipalities that have previously received support, now have the opportunity to extend and strengthen the services offered.

Low threshold health services target heavy problem users who are incapable of availing themselves of the normal health services. Services include offering problem drug users health checks, vaccinations, user equipment, protection against infectious diseases, guidance and follow-up after overdoses. It has been demonstrated that such measures reach the most abject problem users. They are also an important contribution in fighting overdose fatalities. In several municipalities low threshold measures are integrated with other health services, such as the accident and emergency service and ambulance service. New measures, including dental health measures and "street psychiatry support measures", are being tried out.

In Oslo an action plan has been drawn up to provide alternatives to the drug milieu in the city centre. The action plan was launched at the end of 2002 as a result of the work of a working group consisting of representatives of the Ministry of Justice, the Ministry of Health, the Ministry of Social Affairs, the Ministry of Children and Family Affairs, the Ministry of Local Government and Regional Development, Oslo Police District and the Oslo's Municipal Department for Welfare and Social Services. The working group proposed measures intended to break up the drug abusing milieu in the centre of Oslo in order to prevent the extensive drug dealing and reduce recruitment.

These measures are aimed at achieving a more active rehabilitation of, and care for, the clients, so that they as far as possible can be offered meaningful welfare services where they live and can stay during the day. These measures also aim to provide alternative social milieus, so that the number of drug abusers in the centre of Oslo will be reduced. Further interventions by the police and municipal services will target new recruits to these milieus.

The Ministry of Social Affairs has given the City of Oslo a grant of EUR 625,000 for three projects under the action plan. The three projects are:

- return to/ resettlement in the home municipality
- an extension of the residential training programme and follow-up
- referral from low threshold measures.

These funds are additional to the previously mentioned grant schemes available to municipalities. Moreover, in the budget for 2003 the Storting allocated EUR 500,000 to Oslo Police District, earmarked for following up the action plan. These funds are mainly being used to increase the manning of the police unit at Oslo Central Station, in addition to following up the cooperation with the City of Oslo and the Emergency Child Protection Service.

The implementation of the action plan will be evaluated by SIRUS.

## 10.2 Description of interventions

### Needle distribution programmes

Since 1988 Oslo has had a bus doing the rounds of the streets, providing clean needles and condoms free of charge. The bus now distributes 2 million needles annually. Other large municipalities also distribute needles, often using a combination of self-service dispensers, outreach services and one or more 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. The incidence of hepatitis continues to be high, however (see chapter 3.3.). In 2003 the needle distribution programme in Oslo was moved into permanent premises alongside 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 ordinary health services have not managed to deal with these problems. This is true of primary health-service physicians as well as hospitals. In 1999, so-called field nursing stations were established in Oslo, in connection with low threshold day shelters and institutions at six locations in the city. These offer street level healthcare to out-patients. The intention is to provide healthcare and healthcare information, register health problems and any needs for medical assistance, provide rudimentary treatment for somatic problems and channel users into the established health and social services. The programme is non-bureaucratic and free of charge to the users. Those who wish to visit a field nursing station do so anonymously without an appointment, regardless of whether they are under the influence of drugs or not. The field nursing stations in Oslo now have about 2,000 clients. Similar programmes of varying scope have also emerged other places in Norway, for example the *Strax house* in Bergen and the *Social Medicine Centre* in Tromsø.

Over the last four years the field nursing stations in Oslo, in association with the needle bus, have run vaccination campaigns against hepatitis, and also completed a successful x-ray programme.

A separate nutrition project has also been carried out at a rehabilitation centre in Oslo for women with drug problems. It turned out that many of the women suffered from malnutrition or undernourishment. Greater emphasis on regular meals has proven to have a positive effect on their health.

Oslo has prepared an injection room, linked to the field nursing stations in the city centre. A political decision on whether or not to put this room to use is pending (see chapter 1.1.)

### Outreach work

Many of Norway's municipalities have a long tradition of outreach work targeting drug users. The objective is partly to offer assistance and guidance to new recruits to the drug scene at an early stage, and to help people get out of the drug milieu quickly. (See chapter 9.2. on outreach work).

Outreach services have also been established, more geared to addressing emergency situations, making referrals and following up those at risk of overdosing. These services also carry out home visits and drive people home or to a detoxification station. For example, in Oslo the Outreach and Coordination Service (OKT) has access to mobile funds that can be used to help clients in need of treatment or care to get assistance quickly, also in those cases where the municipality has no spare capacity, but where there are openings elsewhere. In most cases the OKT cooperates closely with the ambulance service when

someone has overdosed, and it operates its own follow-up service for clients who have survived an overdose.

*The PRO Centre* in Oslo is a competence centre that addresses the needs of street prostitutes, both through outreach work and by providing a warm-up shelter. Other municipalities also run similar services. One of the six field nursing stations in Oslo is at the PRO Centre and it offers low threshold health services to prostitutes. Similar measures are also found in other towns and cities.

The Alcohol and Drug Addiction Service in Oslo cooperates with the ambulance service to offer courses in first aid, not only to active drug users in downtown Oslo, but also to the police, shop workers, railway station security staff and persons manning the public toilets, café and restaurant personnel and others who work daily or move in areas frequented by drug users. It is not known how effective this is, but the number of overdose fatalities in the city centre has dropped significantly in recent years.

### **10.3 Standards and evaluation**

Most harm reduction programmes in Norway have been carried out without extensive scientific evaluation. As harm reduction programmes in Norway have become more goal-oriented, greater emphasis has also been put on proper evaluation, although few long-term results are available as yet. 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, and it has also formed the basis for several studies of the drug using community.

## Chapter 11. Treatment

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

Treatment is by and large voluntary, but pursuant to the Act on social services (section 6-2) drug users can be held in an institution for up to three months on the decision of the County Social Welfare Board. Individuals who are voluntarily admitted can enter into an agreement to be held for up to three weeks (section 6-3). The intention behind the use of compulsion is to motivate the client for further treatment.

Pursuant to the Act on social services (section 6-2 litera a), pregnant drug abusers can be admitted to an institution and held there for the duration of their pregnancy, if their abuse is such that the child, in all probability, would sustain congenital damage and voluntary measures are deemed insufficient.

Section 6-2 litera a) is used actively 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 pregnant drug users who are negative to all forms of intervention by the health services, but who will nevertheless agree to voluntary measures when they learn about the social services' access to compulsory detention.

### 11.1 Drug-free treatment and healthcare

Drug-free treatment aimed at achieving a future drug-free existence is still the main approach adopted in the majority of Norwegian treatment programmes.

A wide array of treatment and care programmes has been developed in Norway based on different professional and ideological approaches. Treatment alternatives vary from professional psychotherapeutic approaches to simpler approaches in which acceptance of the Christian message plays a central role. Psychiatric assistance to out-patients is offered by psychiatric clinics for children and adolescents, open social medicine clinics, and psychiatric youth teams. Psychiatric outpatient clinics for children and adolescents offer treatment to children and adolescents under the age of 18 for all types of mental disorders and problems. There are approximately 70 psychiatric outpatient clinics for children and adolescents and approximately 100 psychiatric outpatient clinics for adults across the country. Some adult clinics employ personnel dedicated to working with drug and alcohol abusers suffering from mental disorders. The psychiatric youth teams work especially with adolescents and young adults between 15 and 30 years of age who have both drug problems and mental health problems. Norway has 34 psychiatric youth teams. Instead of separate youth teams, four counties have employed dedicated alcohol and drug personnel in the psychiatric clinics for adults.

Institutions offering 24-hour services include everything from small institutions with few employees and few clients to large institutions with several departments. Ownership varies: They may be owned by the county, by public or private foundations, limited companies or be privately owned. Approximately two-thirds of the 24-hour facilities available to alcohol and drug abusers are in private hands. Hence organisations like the Church's City Mission, the Pentecostal Church's Evangelical Centre, the Blue Cross and the Salvation Army, among others, represent a considerable supplement to public institutional services.

Common to all these treatment alternatives is that they are generally open to problem users of alcohol, medicines and drugs alike and are mainly financed by public funds.

Emergency and detoxification institutions offer detoxification and motivation for admission to other rehabilitation programmes. Emergency institutions may be units forming a part of treatment institutions or other facilities that focus on saving lives in a crisis.

In addition to the facilities described above, there are a number of care programmes for abject abusers who have little potential for rehabilitation, offering them supervision and care in a drug-free environment. Other such facilities include halfway houses, which aim to improve the residents' ability to master a "normal life".

## 11.2 Research on treatment and evaluation

SIRUS is charged with the task of conducting and disseminating research and documentation on drugs and alcohol issues, with particular emphasis on social-scientific issues. The institute's research can be divided into five main areas: the drugs and alcohol market, drugs and alcohol use and drugs and alcohol culture, preventive measures, consequences, treatment and care.

SIRUS is responsible for the treatment study, *"What benefit, for whom and at what cost? A prospective multi-centre study of the treatment of drug abusers"*. Co-operating partners in the study include 20 treatment programmes in Oslo and surrounding municipalities. The project is intended to evaluate treatment approaches and different treatments for drug users to ascertain whether any of the responses lead to better results than the rest for the various groups of drug users. The project is organised as a prospective multi-centre study in which *482 clients from 4 different treatment categories* were followed up over two years. The clients were interviewed using a structured survey (ASI) to measure drug use and psychosocial status and they also completed three questionnaires (MCMI, SCL-25, CTQ) themselves. Moreover, information is being collected relating to what the clients think of their own drug abuse, and their evaluation of the treatment they have received and the follow-up by the first line services. The clients are also asked to describe different "life events" after leaving the recruitment programme. Information about resource consumption and accounts will be obtained from the programmes, and questions asked about treatment ideology and structure. The number of hours spent on the different treatment programmes for each client will also be registered. Information will also be collected from different databases, such as the Criminal Records Register, the National Insurance Administration, the Cause of Death Registry and Statistics Norway (various social security payments, welfare support measures).

The second and final follow-up of the 482 clients was concluded in July 2002. A very good response rate was achieved in both follow-ups; 92% in the first follow-up and 88% in the second. 2.9% of the sample (n=482) died before the first follow up, and 1.5% died before the second follow-up (n=468), i.e. in the course of a two-year observation period. The average age of the clients admitted for treatment was 31 years, and the proportion of women was 33%.

So far, the project has made several interesting findings. When it comes to the benefit of the treatment, the study shows that the average intake of drugs such as heroin and amphetamines was halved following treatment. There were also clear improvements in other areas: the number of days including criminal activity fell by 60%, and the number of days mental problems were experienced was reduced by 20%. However, these average figures conceal large variations between the different types of measures, in terms of both the extent of the change and the costs of the treatment. The Psychiatric Youth Teams (PUT) were by far the cheapest treatment, in which an average of EUR 3,750 was spent per client. However, this treatment was also the least effective in reducing the intake of heroin (7% reduction). On the other hand, the PUTs achieved the best mental health improvements (40% improvement measured by the number of days with mental problems).

The treatment that on average produced the best results in terms of reduced use of heroin was medically assisted rehabilitation (MAR) (reduction of 69%). But unlike the PUT clients, MAR clients reported a considerable *increase* in the number of days with mental problems (85%). The average spending on each MAR client was EUR 28,875 (slightly more than EUR 37.5 per client day).

The improvement in terms of heroin intake in clients who have undergone traditional medication-free treatment in residential facilities is almost as great as in MAR clients, and the results are better in terms of mental health. The cost of treatment in such facilities is higher, however, averaging around EUR 81,250 per client (approx. EUR 250 per treatment day).

As expected, the most costly treatment in residential facilities was that for very young clients (average age 16 years) attending so-called youth facilities. Average expenditure here was EUR 187,000 per client. The period of treatment was also the longest, which explains the high costs. These clients had almost no intake of heroin before admission, but there was a big reduction in their use of cannabis. These clients had the biggest percentage reduction in days with criminal activity (88%). All in all, the figures show that no type of treatment scores "best" on all counts. MAR was, for instance, best in terms of reducing the use of heroin, while the PUTs were best in terms of reducing mental problems (SIRUS ).

### **11.3 Substitution and maintenance programmes**

Medically assisted rehabilitation using methadone and other medication for heavy drug abusers has been available nationally since 1998. National guidelines have been adopted, describing 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. At present the system has been extended so that this type of assistance is offered in all municipalities and counties.

#### **Objectives**

The objective is to provide assistance and treatment for heroin abuse and social and health problems. Everyone who satisfies the criteria is to be offered assistance in their home municipality. The scheme aims to provide clients with adequate housing, an orderly life and orderly finances. It should offer clients a sense of belonging and leisure pursuits outside the drug milieus. The use of medicinal drugs for intoxication purposes and the use of illicit drugs must stop.

#### **Criteria**

The criteria for admission were revised in 2000 and made less restrictive: The applicants must be at least 25 years old, heavily addicted to an opiate despite reasonably extensive treatment and have several years of opiate addiction behind them. The criteria may be deviated from on the basis of an overall evaluation of health and social problems. When methadone or another adequate medicinal drug is necessary for treating serious illnesses, the criteria relating to age and previous treatment do not apply.

#### **Availability and organisation**

Clients apply for treatment themselves through their social services centre, possibly in cooperation with their doctors or therapists in other programmes. The application must include a description of their drug use and previous treatment. An action plan shall be prepared describing the existing problems and the cooperation planned to remedy them. It is also possible to apply for and start treatment while in prison. The treatment can be initiated without application in a psychiatric or mental institution after an evaluation by the responsible

head doctor, but cannot be continued after discharge without an application being made. Doctors can also use opiate medicines for crisis intervention and for clarification of assistance needs and an intervention plan.

The application shall be sent to and approved by the regional centre. The treatment starts under the auspices of or in the regional centre with weaning from other drugs, the necessary examinations and stepping up of medication. Medication is prescribed by the centre or by doctors cooperating with the centre.

Unless there are special requirements, the treatment will mainly be ambulant, the medication being supplied by chemists or in a regional facility. Admission may take place for weaning purposes, crisis intervention or treatment of specific conditions.

### **Medication and administration methods**

Methadone and buprenorphin are currently approved for this type of treatment. Methadone must be drunk as a solution, normally in dosages from 80 to 130 mg/day. Buprenorphin is taken in the form of high-dose resorbibles (Subutex) for putting under the tongue, normally in dosages of 8-16 mg/day. Considerably higher dosages are used when required.

In both cases the medication must be taken daily under supervision until the patient is deemed to be stable and to have sufficient mastery of his/her drug problem. Permission for take-home use can then be granted to an increasing degree. Medication can be collected for maximum one week at the time. The right to home-use is conditional on documented drug checks in the form of supervised urine samples.

Suboxone containing buprenorphin and the antagonist naloxon are available on a registration-exemption basis, but are so far not extensively used. It is expected that this drug will lead to less need for control, since it cannot be taken intravenously. This reduces the danger of overdosing and the tendency to resell will be less of a problem.

### **Psychosocial assistance interventions**

Such interventions are conditional on individual action plans being drawn up which describe targeted measures for dealing with the problems present. Every client must have a social consultant who maintains regular contact and acts as coordinator. Inter-disciplinary responsibility groups must be established for all patients with multiple problems, the social consultant and the regular GP sharing principal responsibility with the specialised centre. All clients' rehabilitation needs will be evaluated and they will be offered education and training on this basis. Consultations with a psychologist will be provided if required

In practice, there may not be sufficient local competence or interest for this work. The specialised facilities also have varying capacity in relation to the demand, which has generally been very high. There have been some complaints that the treatment programme has to a large extent consisted of handing out medication, control measures and conversations about the use of drugs.

### **Leakage**

The system aims at a high degree of control, and the main rule is therefore daily administration of medication under supervision. Close follow-up including regular supervised urine samples is a condition for being given medication. Generally this works well when the regional facilities are in charge of follow up and, if applicable, handing out medication. Nevertheless, methadone and Subutex have been registered on the illegal market and in samples taken in connection with suspicious driving and overdoses in persons who are not registered for treatment. Some of these finds can possibly be attributed to illegal importation, but a substantial proportion must come from MAR medication. The impression is that the problem is increased by decentralisation, with reduced regional control by specialists.

## Evaluation and statistics

All clients are registered as patients in a regional facility, even if their medication is prescribed by their GP. The centres submit four-monthly reports to the national centre in Oslo on the number on waiting lists, the number of admissions and the number of discharges. Figures are therefore available three times a year. There has been a steep rise in the number of clients. The latest figures from August 2003 show an aggregate figure of 2,285 for the country as a whole ( table 9 ). 2,995 persons have undergone treatment at some stage or another. The most recent records show that 585 persons were waiting for treatment or for their applications to be considered.

Table 9. Number of clients in medically assisted rehabilitation

No. of clients at 31.12.1998	No. of clients at 31.12.2001	No. of clients at 31.12.2002	No. of clients at 31.08.2003
173	1,501	1,984	2,285

Evaluation of the treatment has started, on the basis of ordinary reporting and research projects. Very little has been published, however. A more systematic evaluation has started in the form of individual reports on each patient from the patient's main therapist. This "status report" describes the client's social situation at the time of reporting and the treatment administered (medication and psychosocial). The report also includes clinically observed drug use and the results of urine samples for the last month, the number of months the client is adjudged to have been drug-free, criminality, and suicide and overdose figures for the last year. The preliminary reports from the autumn of 2002 indicate no proven or stated use of opiates among 60-90% of the clients during the last month.

It is too early to conclude on the effect of the treatment. So far, the information and studies indicate a significant reduction in overdose mortality. The patients are more able to cooperate on the treatment of other diseases. Most individuals experience a clear improvement in their social functioning and quality of life. Criminality is substantially reduced. Many still have problems with the continued use of drugs, especially benzodiazepines, and partly alcohol and cannabis. Trial projects have also been carried out with buprenorphin. A randomised study was carried out of 106 opiate addicts who were waiting to be admitted to the methadone programme in Oslo. Fifty-five received buprenorphin – 51 received a placebo over a 12-week period. The conclusion was that the waiting list patients benefited considerably 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 (Krook et al: *Addiction* 2001).

A research project with buprenorphin for young opiate addicts was initiated in March 2002, led by the Unit for Addiction Medicine at the University of Oslo in co-operation with psychiatric youth teams in five counties. Seventy-eight persons have been admitted to the project, which aims to evaluate whether or not the treatment can lead to freedom from opiates. The project will also evaluate the use of naltrexon to prevent relapses after completion of medically assisted treatment. Another project will examine the use of methadone in patients with psychoses and opioid dependence, while yet another project will examine the use of naltrexon implantates for those wishing a relapse prophylaxis following abstinence-oriented treatment.

## Training

All the centres conduct extensive training of personnel in cooperating municipal health and social services centres. The Unit for Addiction Medicine has initiated courses for doctors in addiction medicine and maintenance treatment. Courses have been held in all the regions.

This treatment has also been incorporated into the curriculum for further training of social workers at several university colleges (Helge Waal, UIO).

#### **11.4 After-care and re-integration**

After-care and re-integration is a municipal responsibility described in the Social Services Act. After-care is otherwise the weakest link in the treatment 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 renewed abuse and the drug milieu. Experience shows that life after completing treatment involves a unique set of problems requiring a different professional approach than that taken by other support services. Currently, there are too few support services using this as their starting point.

Several institutions run their own systematic after-care schemes and provide after-care housing. One example is *Stensløkka resource centre* in Oslo. The institution admits clients of both genders and couples, primarily those who have completed treatment for their drug problems. The overall goal is to enable the users to make use of their intact and potential resources so that they, on completion of their stay, are capable of coping independently – without drug abuse – finding housing, work/education and a social network.

*The Idea Workshop* is a unit of the Stensløkka Resource Centre. The facility is offered to former drug addicts. The idea workshop is based on a learning facilitation approach and is a social meeting place for people with a common background. It is an integration measure based on the participants' resources and leisure interests. The overriding goal of all the activities included in the measure is to contribute to the integration of the individual into "normal everyday life".

## Chapter 12. Interventions in the criminal justice system

Regulations, laws and the correctional services' legal practice were described in chapter 2.2.

### 12.1 Assistance to drug users in prison

The control measures described in chapter 2.2 also have an important preventive effect in addition to their control aspect. More specifically, for several years the Correctional Service has offered sentencing alternatives that target the inmates' drug problems and drug-related crime. During and after serving a prison sentence, inmates with a drug dependence problem are offered participation in a number of programmes. Such programmes include:

- Contract sentences, alternative to serving sentences in prison pursuant to the Penal Code section 12
- Drug-related influence programmes
- Life mastery programmes
- 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 Correctional Service's measures are concerned with issues that directly or indirectly address the convicted person's drug dependence. Over the last two years, Canadian drug mastery programmes, called "Drug Prevention Programmes in Prison" (RIF), have been organised in some prisons. After release from prison these programmes will be followed up by the "My Choice" programme, which aims to reduce the likelihood of relapsing.

Contract sentences aim to combat drug use among inmates. They are based on a contract between the inmate and the prison, whereby he/she agrees to refrain from drug use while serving his/her sentence. The contracts are entered into on an individual basis in ordinary prisons or in conjunction with being transferred to a contract wing or contract prison. Normally no other demands are made of the inmate with respect to participation in other rehabilitation measures apart from the requirement that he/she must abstain from using drugs. Contracts are also used in non-custodial schemes, which may include conditions and requirements concerning abstention from drug and alcohol use, drug checks, frequency of attendance, participation in educational programmes, training in everyday lifeskills, participation in discussion groups and efforts to plan for the future.

The HIV/AIDS issue involves major challenges for the prison system. An important aim is to protect inmates and staff from HIV infection. There are intravenous drug users in prisons, and despite control measures, needles are sometimes used. In order to prevent the spread of disease through needle sharing among inmates, the Correctional Service, together with the Norwegian Health Inspectorate, has reviewed the scheme whereby chlorine is available for cleaning needles. There are no needle distribution programmes in Norwegian prisons.

Substitution treatment is provided to inmates who have already begun such treatment, so that they can continue the treatment while serving their sentence. In principle, substitution treatment may also be commenced while a sentence is being served, provided that the inmate satisfies the admission criteria for the programme (Ministry of Justice). The registered number of inmates receiving substitution treatment has increased manifold and will continue to rise in the years to come.

## 12.2 Alternatives to prison

The Execution of Sentences Act section 12 offers inmates with drug problems the opportunity of being transferred to a halfway house or other treatment institution. Emphasis is on the institution being able to offer a programme that meets the individual's needs. The law specifically requires that there must be compelling grounds for a convicted person to serve his/her entire sentence in an institution, i.e. the convicted person's need for treatment must be so great that the entire sentence should be served in a treatment institution. In practice, this provision is used almost exclusively as an alternative to prison for drug users.

The prison system does not have specific lists or approval schemes for relevant section 12 institutions, but considers in each case whether an institution can offer a programme that suits the needs of the individual in question. An institution will only be able to admit a convicted person in need of treatment if his/her sentence can be served under secure conditions, so that the requirements for alternative service of sentence are met. Facilities that only offer care are generally not accepted as treatment institutions. Transfers can only be made to institutions in Norway. A total prohibition against the use of alcohol and other drugs will be imposed on the convicted person for the duration of his/her sentence. This prohibition is also applicable during periods of leave, recreational activities, etc. As a rule, the opportunity to serve a sentence in a treatment facility/ halfway house is not granted if the time remaining until expected release exceeds 12 months.

The *Pathfinder Project* is a rehabilitation programme run in co-operation between the Oslo prison authority and the Tyrili Foundation, a rehabilitation facility. This alternative targets heavy drug users and currently has capacity for 18 clients annually. Participants undergo an 8-month introductory and motivating phase in the "Pathfinder house" at Oslo Prison, after which they are transferred to serve their sentences under section 12 of the Execution of Sentences Act in the Tyrili Foundation's continuation treatment programme, which includes life and work training.

*Influence programmes* aim at crime prevention. They are based on dealing with social and personal problems assumed to contribute to crime. Violence and vice groups and release groups are examples of influence programmes.

The *Drunk Driver Programme* extends over one year and is an alternative to a custodial sentence.

The Correctional Service cooperates with a number of organisations with humanitarian, religious, sporting, cultural or drug prevention goals. These make a major contribution through home visits and activity programmes that promote skills, improve self-esteem and integrate former criminals into active recreational milieus. The intention is to strengthen such cooperation, among other things by involving voluntary organisations more directly in planning while inmates are serving their sentences. Special emphasis will be put on network building and on establishing inmates in positive, drug-free milieus, already before their release (Ministry of Justice).

## 12.3 Further training

The Correctional Service, through its training centre, the Correctional Service of Norway Staff Academy (KRUS) initiates and organises training for personnel who work with drug-related treatment and control measures.

In 2003, KRUS has implemented the web-based refresher course "Narko på nett" ("Drugs online").

It has also organised web-based training in Motivational Interviewing (MI) or change-focused advice, developed for persons with dependence problems. MI is one of the basic tools and

an important method for use by contact officers and those involved in various influence programmes.

For the last three years, training in drug programmes has been conducted by a Canadian instructor and twelve officers are trained annually for the implementation of programmes in non-custodial schemes or prisons. The Drunk Driver Programmes have gradually been extended to include the whole country, and are offered to persons convicted for very high blood alcohol content in connection with driving or for repeated drunken driving offences (Ministry of Justice).

## Chapter 13. Quality Assurance

At present there are no formal quality requirements for establishing programmes for drug users.

New initiatives to raise the quality of preventive measures were discussed in chapters 9 a) and 9 d).

The issue of quality and quality assurance of treatment programmes has been raised on several occasions. The Ministry of Social Affairs' circular 1-1/93 on the Social Services Act etc. mentions quality requirements in several places. The circular is not very concrete, however, and the amended Act from 1998 states that "The King may issue regulations to further provide for quality requirements in treatment and rehabilitation programmes", but no such quality regulations have been issued. Pursuant to the current regulations anyone is free, in principle, to establish such programmes, but their operation will depend on whether or not the public sector is willing to buy the services offered.

Pursuant to the Social Services Act the County Governors are responsible for supervising institutions providing care and treatment for drug users. The purpose of such supervision is to ensure compliance with laws and regulations and that clients are offered proper treatment and care. Supervision shall focus on all matters of importance to the clients' wellbeing, welfare and legal rights. The supervisory body must visit the institutions at least four times a year. At least two of these visits shall be without prior notice.

The client registration tool, Addiction Severity Index (ASI), is used in treatment planning and research. The adapted European version (EuropASI) is, for instance, used as the main instrument in SIRUS' cost benefit study. Various treatment groups in Norway now wish to use EuropASI and the youth version, European Adolescent Assessment (EuropADAD), for more extensive client registration, both in order to meet the requirement for more emphasis on individual treatment plans and in order to establish a basis for treatment evaluation.

## **PART IV SELECTED ISSUES**

### **Chapter 14 Evaluation of Drugs National Strategies**

**By Dag Rekve, Senior advisor, Ministry of Social Affairs**

#### **14.1 Existence of evaluation**

The previous Action plan for reducing the use of alcohol and drugs (1998-2000) focused primarily on preventive efforts, but included a strengthening of municipal intervention programmes for users. The implementation of the plan as such was not subject to any separate evaluation.

The Government's Action plan against alcohol and drug problems for 2003-2005 (see chapter 1.1) includes close monitoring of developments for both alcohol and drug problems. The plan aims at developing a system for measuring the extent to which the main goals and sub-goals of the action plan are realised. The purpose of the system is to determine whether the measures that are implemented are in line with and help to realise defined goals and strategies, and to uncover problem areas and any needs for improvement. This requires that the goals are made operational, that indicators for goal attainment are developed and that the various measures in the area can be linked to these indicators and goals. The Ministry of Social Affairs has chief responsibility for the development of the follow-up system, but is expected to work in close collaboration with other ministries, subordinate agencies and other players in the field.

The development of a system of this kind that is meaningful will be very demanding in terms of resources. It requires not only a good overview of available instruments and measures in the area and their effects, but also good development indicators at the overall level. Extensive data has been available in both these areas, some of which is adequately quality assured and systemised, while other data has been collected on a more random basis and remains unsystemised. Nevertheless, there are deficiencies in certain areas as regards indicators, particularly relating to registration of harm.

These deficiencies have delayed the efforts to establish a follow-up system, first and foremost, perhaps, because the development of a sufficiently stringent system has proved very demanding in terms of resources. Few countries or agencies have developed this type of system, and those that have, spend a lot of resources on it, for instance the USA's Performance Measure System which is managed by the ONCDP.

#### **14.2 Methodology of evaluation**

For the reasons mentioned in 14.1 the Government intends to start by drawing up a more intervention-oriented document, showing how the different measures included in the plan are to be followed up and by whom. It is a twofold system. New (project-like) interventions will be followed up through reporting pursuant to a fixed template, while current policy task will be followed up by means of the ordinary (existing) reporting tools.

A system is being prepared for continuing with the goal and intervention structure of the Action plan. The Action plan defines a total of 124 measures. All of them are reflected in the follow-up system. The initiation and implementation of the measures will depend on several different sectors and administrative levels. Some of the measures are partially overlapping. Some are permanent, while others are concrete and for a limited period only.

In order to improve the coordination of drugs and alcohol policy at ministerial level, an inter-departmental working group has been established. Each of the ministries is responsible for following up measures linked to its own sector. However, the system will be used by all the

ministries in their follow-up. The Ministry of Social Affairs is responsible for coordinating the follow-up.

Part I of the follow-up system will consist of collecting and systemising all the measures and clarifying the distribution of responsibility at ministerial level. Where responsibility is split between several ministries, or where several ministries have part responsibility, this will be made clear. Part I describes how the follow-up is planned, and what this means to those in charge of follow-up. The status of follow-up work is also included here. Part II is a template for following up new measures or limited projects.

The Ministry of Social Affairs has delegated a great deal of the responsibility for following up the Action plan to the Directorate of Health and Social Affairs. This includes coordination in relation to the regional competence centres for drugs and alcohol issues, the National Police Directorate, the Norwegian Customs and Excise and the Learning Centre. The Directorate of Health and Social Affairs will fulfil its share of the responsibility for follow-up by means of the ordinary reporting tools such as agency management meetings and annual reports. Additionally, the Directorate files reports using a fixed template for new measures and limited projects for which it is responsible.

As regards measures expected to be implemented at the municipal level, it is considered expedient for the Ministry of Social Affairs to request the County Governors to collect status information. Follow-up of the municipalities is intended to ensure that locally implemented measures help to realise the strategic goals of the Action plan. Here, it is necessary to develop a set of indicators that adequately measure municipal activities in light of the Action plan's objectives.

As part of the Action plan the Directorate of Health and Social Affairs has been assigned the task of coordinating a pilot project for locally based prevention over three years in selected municipalities. The model consists of a number of prevention strategies which are adapted to local needs and implemented concurrently. New measures that are implemented shall be based on research and have a documented effect. This pilot project will be evaluated by SIRUS.

In the long term the aim is to develop a system capable of measuring the effect of the measures that are implemented in relation to the goals of the Action plan. The results of the follow-up will be incorporated into the annual statement by the Minister of Social Affairs on the alcohol and drug situation in Norway, starting in the spring of 2004.

## **Chapter 15. Cannabis problems in context: understanding increased treatment demand.**

**By Martin Blindheim, editor of the journal 'rus & avhengighet' ("alcohol/drugs and dependency").**

### **15.1 Cannabis use in the general population**

Cannabis has been a part of all illegal use of drugs in Norway since the 1960s. Since then, after alcohol, cannabis has been the drug with most users. Police's statistics show that there have been cannabis seizures throughout the country in recent years.

Norway has several good data sets that show how the use of cannabis has evolved among young people. The most important is the annual questionnaire survey conducted by SIRUS. For a more detailed presentation and discussion of the data, see chapter 2.2.2. In recent years almost 30% of young people in the 15-20 age group in Oslo state that they have tried cannabis at some time. At the national level the figure is just over 15%. These figures are generally confirmed by several other surveys<sup>iv</sup>.

There is less reliable data on use by older age groups. A questionnaire survey on drugs and alcohol habits in a nationwide representative selection of people aged 15–64 was carried out in 1991 and 1999 (chapter 2.2.1). The percentage that had ever tried cannabis increased from 9.6 to 15.4%<sup>v</sup>. In an opinion poll conducted for one of the newspapers in Oslo in 2003<sup>vi</sup> around one third of the respondents in the 30–39 age group stated that they had tried hashish.

### **15.2 Demand for treatment for cannabis use**

#### **a) Client registration data**

A system for the registration of client data from out-patient and in-patient treatment institutions in Norway is being developed (see chapter 3.1). The data is so far incomplete. Data is not supplied by all institutions. Moreover, complete data sets are not collected for all clients. An important limitation in the data is that there is no registration of the type of drug problems for which the clients are admitted, only of the extent of their use of the different drugs.

Data collected in 2001 show that 6% of the women and 9% of the men admitted to drug treatment programmes in Norway stated that cannabis had been the most frequently used drug in the six months before starting treatment (figures 12 and 13). The share has increased slightly for men in the period from 1998 to 2001, while it has remained stable for women. A few large institutions offering both in-patient and out-patient treatment have registered roughly the same proportions. We emphasise that these are aggregate data. Several requests and registered courses of treatment may therefore be attributable to one and the same client.

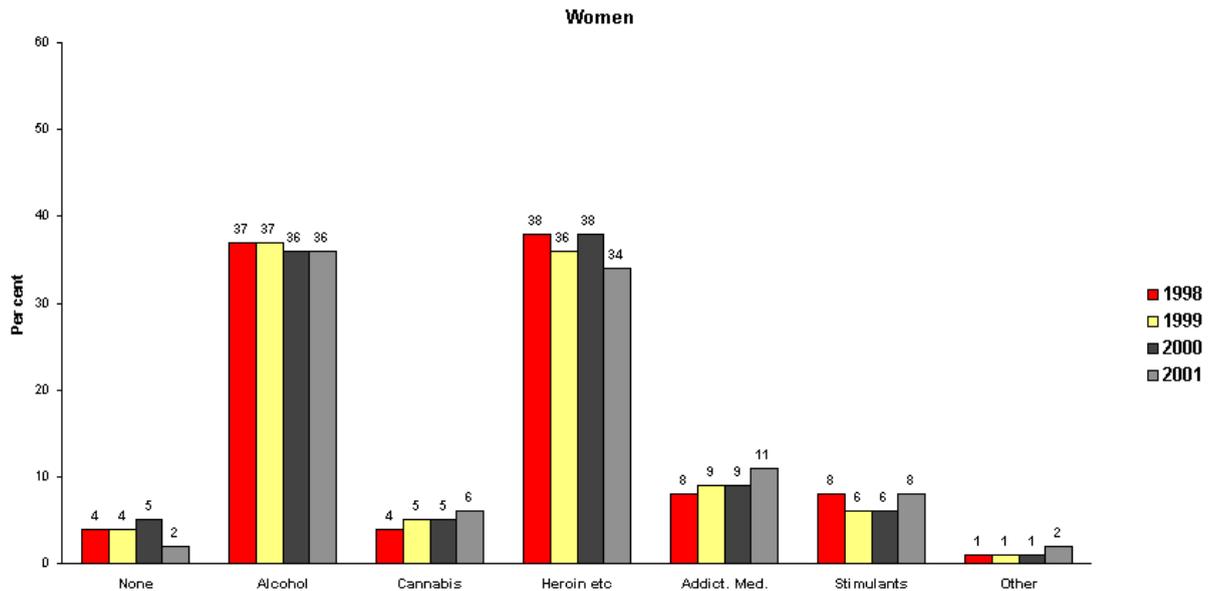
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<sup>iv</sup> The drug situation in Norway 2002. SIRUS 2003.

<sup>v</sup> The drug situation in Norway 2002. SIRUS 2003.

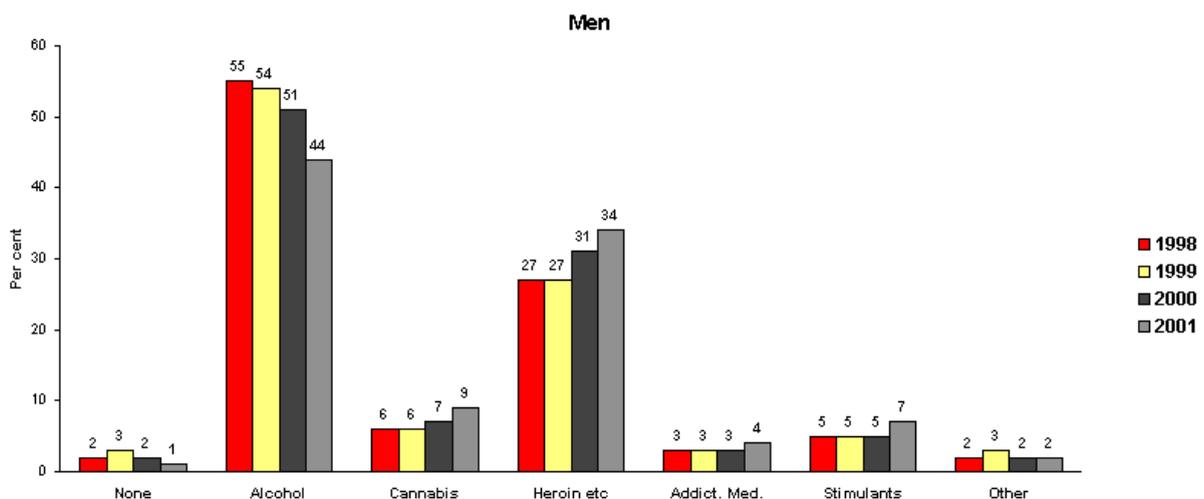
<sup>vi</sup> Dagsavisen 6 Oct. 2003

Figure 12. Most Frequently used drug 1998-2001



Source: The Bergen Clinics Foundation

Figure 13. Most Frequently used drug 1998-2001



Source: The Bergen Clinics Foundation

Despite the limitations in the data, it can be assumed that only a small minority of the clients admitted to Norwegian treatment programmes have drug problems that can be primarily ascribed to the use of cannabis.

**b) A questionnaire survey**

In 2003, in an attempt to register the scope of specific cannabis problems encountered by the treatment services I sent a short questionnaire to 27 facilities containing questions relating to their experience of persons who needed treatment for problems with the use of cannabis<sup>vii</sup>. The facilities registered in SIRUS' database ([www.rustiltak.no](http://www.rustiltak.no)) was used as the basis. It includes out-patient services, in-patient treatment and housing and care facilities. Seventeen facilities that can be regarded as more or less representative, responded. I also

<sup>vii</sup> Unpublished.

contacted the outreach services in the cities and large towns. This survey is an attempt to obtain a rough indication of how extensively treatment is requested by cannabis users and to register the views of employees in the treatment services on this matter.

Both the out-patient facilities and outreach activities, which work mainly with users under the age of 30, state that they have clients who need help relating to their cannabis use. This applies to both men and women. A minority of these clients only use cannabis substances, however; cannabis is used in addition to a number of other drugs. The most common are alcohol, amphetamines, ecstasy and tranquilizers. A typical comment from a psychiatric youth team: "The users present their other problems first; their use of "hash" is often disclosed after some time."

In-patient institutions have the impression that the use of cannabis by clients is stable or slightly on the increase. Employees feel that many people have problems relating to the use of cannabis, but that such use nearly always takes place in combination with other drugs. One big treatment foundations states, for example: "Nobody says that they have only used cannabis". Another states: "We have multiple drug abusers. They all start by using cannabis – then they extend their abuse."

### **c) Substitution treatment**

In medically assisted rehabilitation, cannabis together with tranquilizers is often part of "additional abuse" of other drugs. The policy for dealing with this varies, but such use of drugs is incompatible with participation in medically assisted rehabilitation. This has proved difficult to enforce, however. Many of the facilities state that they "therefore turn a blind eye to" (modest) use of other drugs and choose to focus on bettering the quality of life rather than on the client being drug-free.

### **d) Relapse**

A large proportion of those who have undergone treatment, will after a shorter or longer period relapse into a situation in which their lives are marked by the use of drugs. Many relate how the relapse has been a process in which the drug user started with a moderate intake of alcohol and/or hashish and gradually lost control. Many after-care measures, therefore, systematically target the use of alcohol and cannabis in an apparently normalised life style. The users are always recommended to stay completely away from cannabis substances.

### **e) Sources of referral**

The services come into contact with their clients by way of referrals from a broad range of agencies: the primary healthcare services, schools, social services, psychiatric services, the correctional service, parents and through user requests. We have no information as to whether those with specific cannabis problems are mostly referred by particular agencies.

### **f) Reasons for treatment demand**

We have insufficient information to properly answer this question.

**g) Profile of clients**

The limitations of the registered client data make it difficult to provide a more detailed description of the minority admitted to treatment primarily due to cannabis problems.

The questionnaire (15.1.b) included two questions relating to client characteristics. The respondents replied that the youngest among those who used cannabis extensively have problems associated with “dropping out” of family, school and social contexts, while the older users have mental problems such as anxiety/ depressions and general antisocial behaviour. One of the facilities replied that “being high becomes a way of life, with personal, family and social problems as a consequence.” The existing data do not allow for a more comprehensive description of clients who use cannabis frequently.

**h) Changes in legislation**

There have been no changes in the legislation affecting cannabis or other illegal narcotic substances. All use, possession, procurement, production and sale of cannabis is still a criminal offence under the Penal Code and/or the Medicinal Products Act. Law enforcement is less strict today, however, than it was only a few years ago. Today’s sanctions are milder for possession/ import for own use than if the intent is sale/ profit. In practice small quantities of cannabis for own use are no longer subject to criminal proceedings.

**15.3 Prevalence of problematic cannabis use and patterns of problems****a ) Prevalence of heavy use**

Norway has no existing generally accepted definition of “problematic cannabis use”. Vague definitions linked to behaviour and to the part the drug “plays in the life of the user” have been suggested, but are not commonly used. “Habitual use” is a term often used, but which has not been clearly defined. In connection with SIRUS’ questionnaire surveys, “regular use” was defined as more frequently than ten times in the course of the last six months. This type of definition says nothing about the extent of the problem, however.

As regards Norway there are only grounds for saying something about the frequency of use. In the SIRUS surveys (young people aged 15–20) 7–10% nationwide and approx. 15% in Oslo stated that they had used cannabis during the last 6 months<sup>viii</sup> while 3–4% stated that they had used it during the past month. Around 3% at the national level and around 7% in Oslo stated that they had used cannabis ten times or more in the last six months.

SIRUS points out that “there is reason to believe that young people who regularly use narcotic substances, be it cannabis or stronger substances, will be underrepresented in the surveys”<sup>ix</sup>. There are therefore grounds for suspecting that the actual percentages are higher.

We have no surveys that provide any data about habitual use of cannabis in the adult population. Nevertheless, researchers have agreed on several occasions that the use of cannabis in Norway is mainly a youth phenomena.

**b) Cannabis and driving accidents<sup>x</sup>**

Norway has no available statistics on the number of traffic accidents involving drivers who have used cannabis substances. The National Institute of Public Health’s department of forensic toxicology, which analyses blood samples for the police among others, has reported that in a 15-month period they registered a sixfold increase in the number of blood samples from drivers stopped by the police on suspicion of being under the influence of other drugs

<sup>viii</sup> Skretting, Astrid. Ungdom og rusmidler. The Directorate for the Prevention of Alcohol and Drug Problems, Oslo 2000.

<sup>ix</sup> The Drug Situation in Norway 2002. SIRUS 2003.

<sup>x</sup> Data from: Drug problems in Norway 2000. Ministry of Social Affairs 2000.

than alcohol. After alcohol, cannabis is the substance most frequently detected in such analyses. The number of samples testing positive for cannabis increased from 564 in 1990 to 1,886 in 2002 (chapter 3.4.1).

### **c) Social problems related to cannabis**

In Norway there has been no research that demonstrates a causal relationship between the use of cannabis and social problems. Several studies demonstrate that there is a relationship, however, and possible explanations are discussed.

The Young in Norway survey (Norwegian Social Research - NOVA), which analysed various aspects of young people's life situation, including drugs and alcohol use, showed that extensive use of cannabis is linked to a high consumption of other drugs, criminal behaviour and problems at school and in the workplace<sup>xi</sup>.

SIRUS' questionnaire survey<sup>xii</sup> shows more extensive use of cannabis among those living with only one or neither of their parents than among those living with both their parents. There is also a clear relationship between interrupted education and the use of cannabis at least once, and also between a feeling of satisfaction with one's own life and the use of cannabis.

### **d) Psychiatric problems related to cannabis use**

In Norway no figures are available as regards cannabis-triggered psychoses or other mental health problems. The discussion on whether or not there is a relationship between the use of cannabis and the development of mental illnesses crops up at irregular intervals. The term cannabis psychoses has been launched in this context. In Norway, as in other countries, the professionals seem to agree that there is a correlation between mental problems and the use of cannabis, but opinions differ about possible causal relationships.

### **e) Health problems related to cannabis**

No surveys are available in Norway that document specific health problems relating to the use of cannabis.

## **15.4 Specific interventions for problematic cannabis use**

Among those who replied to the questionnaire ( 15.1.b), only three stated that they had tried out interventions for cannabis users. Very few respondents answered that they knew of others who had implemented such specific interventions. The lack of specific interventions for cannabis users is confirmed by searches on the internet, where the hits almost exclusively concern medical use of cannabis.

Of particular interest, therefore, is a recently started cessation programme for cannabis users organised by the outreach service in Stavanger. This is described in more detail under a).

Of the two other facilities that replied that they had experience of own measures, one psychiatric youth team reported that it had organised discussion groups for "cannabis quitters" a few years ago. This measure was not described in detail, but reported to be "successful".

To the question of whether there is a need for treatment of cannabis problems, most facilities reply that they see an increasing need, but without stating any exact figures or supporting their statements in any way. Opinions differ as to whether the need should be met by

<sup>xi</sup> Pedersen, Willy: *BitterSøtt*, Universitetsforlaget, 1998.

<sup>xii</sup> Skretting, Astrid. Ungdom og rusmidler. The Directorate for the Prevention of Alcohol and Drug Problems, Oslo 2000.

specially developed measures or whether it can be met by existing measures. Those who believe that new measures are required have proposed individual treatment and discussion groups using cognitive therapy, and group therapy using the same model as courses to wear smokers off nicotine.

#### **a) Smoking cessation for cannabis users**

In spring 2003, the outreach service in Stavanger carried out a pilot project aimed at young people who wished to stop using cannabis. The project has been thoroughly described.<sup>xiii</sup> The starting point for the project "Stop smoking course for hash smokers" was the statistic showing that a quarter of this group uses so much that it "will influence their lives in a negative direction."

Those in charge of the project say that "it proved difficult to find anyone at all in Norway with experience of group therapy in relation to cannabis. They therefore chose to develop a course based on Swedish material that was translated into Norwegian<sup>xiv</sup>."

The target group for the course was "Young people who have expressed a desire to stop smoking hashish and who believed that they needed help to do so." The goal of the course was to become drug-free "with a view to freeing the young people's resources so that they would be able use their talents and abilities."

The methods employed consisted of discussion groups that focused on problems experienced by the participants themselves and the development of mastery strategies in relation to them. The discussions were combined with ear acupuncture using the NADA method, relaxation exercises and other means of fostering "wellbeing".

The course started with five participants and lasted for six weeks, with thrice-weekly meetings during the first weeks gradually decreasing to one meeting per week. Three of the participants completed the whole course, and all five participants have stated that they have reduced their cannabis use greatly or stopped completely. Those in charge of the project say that the participants themselves point out "that the success of the course is in large part due to them being part of a group" with discussions in which they could exchange experiences, receive support and backup with respect to how hard it was.

All the participants expressed great satisfaction with the wellbeing part of the course. All the participants will be contacted as part of a six-month evaluation "to register their general life situation and degree of freedom from drugs."

The outreach service's summing up is that the project has been so successful that it intends to start a new course in October 2003 following the same model. The most important change will be to extend the course to eight weeks. Several other outreach services, in Bergen and Oslo among others, wish to copy this course.

#### **b) Schools**

Traditionally, schools in Norway have been an important arena for prevention of drugs and alcohol abuse and associated problems. For years, cannabis has been seen as a "gateway drug" to heavier use of illicit substances and schools have focused strongly on cannabis. Endeavours have been made, however, through the school counselling services to offer help to students who are in the process of developing problem behaviour rather than expel them. This work has not been systematically summarised, but our impression is that endeavours are made to view the students' life situation as a whole rather than focusing exclusively on the use of specific drugs.

#### **c) Workplaces**

<sup>xiii</sup> Hege Sundby and Zoila Santiago: Røykeavvenningskurs for hæsjrøykere. Project report . Outreach service in Stavanger 2003. All quotes in this chapter are taken from a preliminary draft of the project report and are reproduced with the authors' consent.

<sup>xiv</sup> Thomas Lundqvist: En guide for deg som vil slutte med hasj. The Borgerstad Clinic competence centre, 1999.

Through the work of the Tripartite Committee for the Prevention of Alcohol and Drug Problems in the Workplace (AKAN), Norway has a unique and recognised system for prevention and for providing assistance to employees who are in the process of developing problems relating to alcohol and drugs. As in schools, attempts are made to help and integrate employees with alcohol and drug problems instead of firing them, and focus is placed on their total life situation rather than on their abuse of drugs or alcohol. There are no good data showing the prevalence of alcohol and drug problems in Norwegian workplaces. Nor is the work of the Tripartite Committee for the Prevention of Alcohol and Drug Problems in the Workplace (AKAN) linked to specific intoxicants.

## **15.5 Conclusions**

- Between a fifth and a quarter of young Norwegians aged 15-20 try cannabis substances at least once.
- A smaller proportion of this age group (15-20) uses cannabis frequently, while only a small group develop habitual use.
- For persons with an extensive consumption of illicit drugs, cannabis often constitutes an important element in their abuse.
- Very few of those who avail themselves of facilities in the drugs field, have problems exclusively linked to the use of cannabis substances.
- Experience of special interventions aimed at those with cannabis-related problems is highly limited.
- Several facilities have expressed the opinion that such measures are required.

Problem use of cannabis is overwhelmingly perceived as being part of a broader substance abuse problem which involves several substances. It is to some extent also perceived as being an expression of underlying mental problems. It is difficult to say whether this is an expression of the situation as it actually is or whether cannabis-related problems have been "overshadowed" by graver problems relating to harder drugs, and have therefore not been recognised and addressed through relevant interventions.

## Chapter 16. Comorbidity

By

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Comorbidity between intoxication and psychiatry has many different aspects. It may involve clients with serious mental problems such as schizophrenia or a bipolar disorder, where the concept of dual diagnosis is often used. Clients with very serious personality disorders also belong in this category. Comorbidity in this context may also include a number of alcohol/drug-abusing clients displaying a wide range of slightly less serious mental problems, anxiety and depression being their main symptoms. They may be marked by having grown up under difficult conditions, and some may also be marked by traumatic experiences in childhood and adolescence. Social abjectness and difficulties in utilising existing treatment facilities are often central characteristics. In the following description, we will take a relatively broad approach to various mental health problems in alcohol and drug abusers.

The treatment statistics (Skutle & Iversen 2002, Iversen 2002) show that 26,000 courses of treatments for abuse of legal and illicit substances were carried out in Norway in 2000. In the Norwegian medication-free treatment the same methods are often employed regardless of which intoxicants the patient/ client has used. There are various treatments available to young people and adults, and there are a few treatments available only to women or only to men. The treatment statistics say nothing about the clients' mental health problems or illnesses.

A cross-sectional survey is carried out every five years in the mental healthcare sector on patients admitted to psychiatric wards. In 1994 the survey included 3,060 patients<sup>xv</sup>. Approx.16% of these had a serious drug abuse problem (Norwegian Board of Health 2000). However, it is known from other surveys that registration of alcohol and drug abuse is often inadequate, so that it is reasonable to assume that a higher proportion of the psychiatric patients had substance abuse as an additional problem.

### 16.1 Main diagnoses, prevalence

In recent years a number of surveys have been carried on Norwegian abuser populations in order to study mental infirmity. These studies have involved alcohol or drug users who are undergoing some kind of treatment or other. The most thorough was the Alcohol/drug use and psychiatry survey (ROP) carried out by the Eastern Norway competence centre in 1997-98. Two hundred and sixty clients who were either in out-patient treatment or in institutions for alcohol and drug problems were studied. Of these

- 91% had lifetime experience of suffering from psychiatric complaints
- 83% had suffered from anxiety
- 44% had suffered from depression.

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<sup>xv</sup> In a corresponding cross-sectional survey from 1999, questions directly relating to alcohol and drug abuse were not asked.

Only one single patient in this population had symptoms commensurate with schizophrenia, while 14% had schizotypal personality disorders. In all, 72% had personality disorders, of which evasive and passive-aggressive were the most common. Thirty-one per cent had antisocial personality disorders, while 44% met the criteria for more than two personality disorders (Landheim et al 2000). The study also showed that a high proportion of the women (38%) satisfied the criteria for post-traumatic stress disorder (PTSD). The same applied to 17% of the men. For most of the clients the psychiatric symptoms appeared to predate the alcohol or drug abuse (Bakken et al 2002). The survey shows a lower degree of social integration in family and working life than several other European and North American surveys of corresponding populations, which indicates that this is a very abject group of substance abusers.

Both the ROP survey and other surveys in Norway show that a high proportion of drug users have had pretty massive family problems, during their upbringing and in school. A survey of 2,359 drug users undergoing treatment in 1992-93 showed that 70% had experienced learning and behavioural problems in schools, 38% had experienced bullying and 21% had received psychiatric treatment during childhood or adolescence (Lauritzen et al 1997). The survey was based on questions put to therapists, who stated that 57% of the clients currently had problems with depression and 56% with anxiety. Forty-three per cent had experienced life-threatening overdoses, and 33% had attempted suicide. The survey did not provide good information concerning personality disorders and psychoses.

A survey carried out at a therapeutic community for alcohol and drug abusers in Oslo also found a high proportion (69%) with depression, measured using self-reporting methods (SCL 90 and MCMI). Those who were still depressed on discharge had a considerably higher drop-out rate during the after-care phase than the other clients. These were assumed to be individuals with more pronounced depression who would probably benefit from a more specific antidepressant psychotherapeutic and medicinal treatment. The survey also demonstrated that clients with antisocial character traits coped better during the 12-month stay in the institution than more withdrawn, cautious and anxious clients. However, clients with pronounced antisocial traits often dropped out during the after-care phase. (Ravndal & Vaglum 1994).

In 1999, the Norwegian Board of Health carried out a registration of the prevalence of patients with dual diagnoses in Norway and their treatment needs. The registration was based on clients known to have such problems, in the psychiatric sector, the alcohol and drugs sector and in the municipalities. The Norwegian Board of Health concluded that there were approx. 4,000 individuals in Norway at that time (9 per 10,000 of the population) who had both a serious psychiatric complaint and an extensive alcohol or drug abuse problem, and who needed treatment facilities over and above the existing ones. Roughly half of them primarily had alcohol problems. Of the 4,000 individuals, approx. 1,200 were thought to have schizophrenia-like psychoses or bipolar disorder, 800 had serious depression or anxiety or similar complaints with a very serious dysfunction, and approx. 1,700 had a serious personality disorder, most of which were of the emotional instability or dissocial type. A group of more than 300 persons with serious cognitive dysfunction, either in the form of mental disability or impairment of more selective cognitive skills, was also included.

The above-mentioned surveys concern alcohol or drug users undergoing some form of treatment. Some reports are also available on clients not undergoing treatment. Naturally, these are less exact and consist of evaluations of problem loads in clients in various types of low-threshold facilities. Some were carried out at acute accommodation facilities for the homeless, others at low-threshold health facilities for drug users. What they have in common is that they show a significant load of combined problems involving alcohol/drug abuse and psychiatric symptoms in these populations. These problems include schizophrenia, personality disorders, mental effects of traumas such as rape or other types of violence.

They also include mental health complaints that are closely related to the substance abuse itself (SINTEF Unimed 2003, Feltpleien 2001).

## **16.2 The impact of comorbidity on services and staff**

With the exception of a few ambulant measures, housing facilities and specialised treatment units (chapter 16.4), there are few examples of measures tailored to the needs of this type of comorbidity. These are patients in mental healthcare, particularly in acute facilities, out-patient alcohol/drug or psychiatric services, in facilities provided by humanitarian charitable organisations (warm-up centres), low-threshold accommodation facilities (hostels) or in institutions run by the correctional services. Because of the compound nature of the problems involved, they are also in receipt of services from many different agencies, both welfare and care facilities and specialised treatment facilities in the areas of alcohol/drug abuse and psychiatry. There is reason to assume that in Norway this patient group experiences that it meets with a somewhat inconsistent response.

It has been decided that services that address the needs of those with dual diagnoses will be integrated in a comprehensive patient and intervention-based national plan that was instigated in 1999 and will run for eight years. Its goal is to expand both specialist and care services (Escalation plan for mental health (1999-2006) in 2003, proposed extended until 2008). On the basis of the registration of the situation of dual diagnosis patients, the Ministry of Health has issued a guideline that "this group needs special services with special expertise, both in the form of separate in-patient facilities and out-patient follow-up." Rather than establishing special projects, it will be most expedient in Norway to integrate new services with already existing facilities. Three or four integrated teams based on experience of ACT (Assertive Community Treatment), inspired by the New Hampshire model among others, are now being tested in the mental healthcare sector in Norway.

In general, treatment evaluation shows that it is important that those who work with persons with dual diagnoses simultaneously address both the alcohol/drug abuse problems and the mental illness. More training is required in special attitudes and techniques adapted to clients with combined problems. Such programmes are in the process of being introduced in some places.

Increased competence can be achieved in many ways, for instance by establishing a common training programme that will be able to ensure mutual exchange of experience between different professions. Systematic training of staff can also take place through practice periods in workplaces which have the competence required. There are currently a number of short courses available on mental health problems and alcohol/drug abuse. However, there is no distinct speciality in the treatment of dual diagnoses in Norway at present. Nor is the treatment of alcohol/drug abuse a medical speciality. It is possible for those with university college qualifications to supplement their education by taking a two-year course of further training in substance abuse treatment or mental healthcare work. Both these educational courses include the treatment of mental health problems in combination with drug/alcohol dependency. Studies leading to a masters degree in mental health work are also planned and comorbidity will be part of the course of study. Courses in medicine relating to alcohol/drug abuse have also been initiated for doctors.

Six of the seven regional competence centres are attached to clinical milieus and each centre has specialised in one area relating to drugs and alcohol. The Eastern Norway competence centre has "dual diagnosis" as its speciality field and it has carried out extensive registration of the mental health of clients seeking treatment for alcohol or drug abuse in two counties (chapter 16.1). Various forms of knowledge and competence building around alcohol/drug abuse and psychiatry is being carried out in all five Norwegian health regions.

### 16.3. Service provision for persons with drug abuse and psychiatric complaints

There are several reasons why persons with alcohol/drug abuse and psychiatric problems are difficult to reach with treatment. It is normal to attribute this to the patient's situation, but the difficulties may also be due to poor interaction between the support services and the patient. The fact that the local community, the treatment services and society as a whole lack understanding of the client's assistance needs, for instance, may lead to such people being described as "lacking motivation". Persons with dual diagnoses may have many reasons for feeling despondent and without any hope for the future. They have often had many negative encounters with the support services and may therefore resist new treatment. This may lead to them being blamed for a poor treatment result, which might equally well be the result of the helplessness of the support systems.

The ordinary health services, both somatic and psychiatric, have generally proved unable to reach heavy substance abusers to a sufficient extent. This has led to the development during the last two years of low-threshold health services in the cities and large towns. The aim is partly to provide health services and partly to establish contact with the regular health services. Among other problems these patients have – and this is hardly peculiar to Norway – is the fact that they have poor networks of family and friends as well as poor education and work experience. Their contact with psychiatry is often characterised by brief admissions, often on a compulsory basis, but seldom for systematic long-term treatment. There are frequent interruptions in therapeutic relationships instead of continuity.

A select committee appointed four years ago by the Ministry of Health and Social Affairs (Ministry of Health and Social Affairs 1999) concluded that persons with dual diagnosis problems often become clients of the alcohol and drugs services, even though the mental healthcare services would in many cases have been able to provide more adequate treatment. This may have to do with the fact that capacity considerations are often decisive with respect to where clients are offered treatment, rather than which treatment options would best suit the client.

Employees in three low-threshold facilities and two rehabilitation centres in Oslo were interviewed about how persons with dual diagnoses for whom applications are submitted, are treated by the institutions (Bjønntegaard 2000). With one exception all the five facilities accepted dual diagnosis clients. They regarded themselves as the system's "losers" because there were great difficulties attached to getting others in the support services to assume further responsibility for this group. Funnelling the client from a low-threshold facility to treatment/rehabilitation was experienced as being very difficult. They felt that they could not provide adequate help themselves because they lacked competence, manning, time and other resources, because storing medicines and administering medication was outside the institution's responsibility and because they had to take other persons in the facility's target group into consideration.

It was clearly the case previously that persons with dual diagnosis were often excluded from alcohol/drug abuse treatment because of their mental problems and from psychiatry because of their alcohol/drug problems. This still happens but there may be grounds for believing that the efforts described here mean that it happens less often than before. Evaluations of individual patients, particularly of their mental health problems, are difficult to perform while the patient is intoxicated and also during the first period after they stop their substance abuse. It is important to be able to repeat the psychiatric evaluation during the course of treatment.

Several regions have initiated specific measures aimed at reaching individuals who are in the process of developing schizophrenia as early as possible – since research indicates that early treatment can improve the prognosis. These projects show that many of the patients in question also have serious substance abuse problems. The projects have therefore emphasised integrating the treatment of these two problem areas (chapter 16.4).

Another problem which is more pronounced in patients with comorbidity than in others, is the difficulty of obtaining and holding on to a place to live. There is a substantial need for supported housing for this group. How such houses can best be designed and manned is a matter still under discussion. There are plans to allocate funds for this purpose in the escalation plan for psychiatry, but whether the allocated funds will be adequate is uncertain. It is also uncertain whether the municipalities will place sufficient emphasis on the needs of the target group when distributing funds.

At least half of those serving prison sentences are assumed to have a drug-related history; they are serving short or long sentences for violation of drug laws (30%) or for crimes closely related to their drug abuse (20%). The treatment of psychiatric complaints during prison sentences has often proven difficult. Nor do most inmates receive meaningful treatment for their drug abuse. No good Norwegian study is available on mental health problems and drug use among inmates in Norwegian prisons, but many of the clients in prisons are clearly not unlike those in treatment institutions for drug abusers. The relapse rate is high among drug users who have served prison sentences, and there is increasing recognition of the fact that prison terms can contribute to a worsening of mental health problems and unfortunate patterns of behaviour.

### ***Norwegian legislative provisions relating to the treatment of those with alcohol and drug dependency problems***

The Mental Healthcare Act (section 3) authorises the use of compulsion in mental healthcare, in or outside institutions. This possibility can also be used for seriously mentally ill alcohol or drug abusers. This authority is most often used in very acute psychotic episodes, but it is possible to use it without special time limitation in the most serious cases. In general, compulsion is more often used for acute admissions to psychiatric institutions in Norway than in many other Western countries. Compulsion is more often used for committing mentally ill alcohol and drug abusers than other psychiatric patients (Norwegian Board of Health 2000a, annex 2).

The Social Services Act (section 6.2) authorises the admission without consent of alcohol and drug abusers for stays of up to three months in institutions. It is a precondition that the client's abuse seriously threatens his/her life or health. This section is relatively little used. The Mental Health Act is most frequently used in connection with alcohol and drug abusers with mental illnesses (normally psychosis).

The Execution of Sentences Act (section 12) allows for treatment in an institution during the serving of a prison sentence (section 12.1). This possibility is used, but only in a very small proportion of cases where alcohol and drug abusers are serving sentences. There is no reliable information as to whether it is more often used for mentally ill drug users than other users. All inmates in Norwegian prisons are offered medical examinations but it is uncertain whether this is sufficient to detect all cases of serious mental illnesses. Reports are available from some prisons concerning the extent of mental illness and drug abuse, but no systematic registration of this has been carried out.

In Norway, there is a widespread understanding that drug users should serve their sentences in such a way as to facilitate treatment and follow-up, but treatment is not instigated by the correctional services. Only recently was a working committee appointed to evaluate the Penal Code's authorisation of the use of compulsion in the treatment context, through the postponement or cancellation of sentences if a person becomes drug-free.

### ***Voluntary treatment***

In the international context, Norway has one of the highest numbers of treatment places for alcohol and substance abusers and, traditionally, it has concentrated a lot of its resources on treating addicts in institutions, compared with the resources used by the municipalities on long-term help in clients' local communities.

Evaluating patients in Norwegian alcohol and drugs facilities for further help in mental healthcare necessitates cutting across administrative boundaries. Very many alcohol and drugs facilities report difficulties in getting specialists in mental healthcare to take responsibility for meeting the treatment needs of a patient group that requires specialist services from both sectors. The reform which entails including both alcohol/drug treatment and mental healthcare under the same regional health trusts, aims to improve cooperation between the specialist health services. Including these services under the same administrative level will give the alcohol/drug treatment services the same status as specialist health services on a par with the specialist psychiatric service. This will facilitate coordination. The specialist health services' responsibility for the treatment of alcohol and drug abusers will be strengthened, thus improving the services provided for this group.

It is emphasised that an interdisciplinary approach is a precondition for achieving the goals in the escalation plan for mental health. Competence in the social work field and a knowledge of network building are seen as necessary requirements for helping clients to manage on their own in supported housing and helping with supported employment. The municipalities are responsible for care services, while specialist responsibility rests with the state. Because many of these persons need both treatment and care, i.e. simultaneous help from both specialist services and the municipality, it is very probable that clients will simply be passed from one service to the other. In order for the cooperation to work on the user's terms, it is important that professional care work is given the same status as other approaches. The number of out-patient, and in a few cases in-patient, facilities treating patients with comorbidity is increasing. Developments have also taken place in alcohol/drug treatment measures through the addition of psychiatric competence.

### ***Specialised teams***

There are 34 specialised teams for adolescents and young adults with drug dependency problems, the Psychiatric Youth Teams (PUT). The teams include professionals such as doctors, psychiatrists, social workers and child care workers and offer consultations on an out-patient basis.

In a survey the teams themselves estimated that 30% of their clients suffer from serious mental problems in addition to substance abuse. Nearly one in three clients break off treatment and one in three fail to attend treatment appointments. A publication about the needs of persons with dual diagnosis today states that "Therapeutic services are of little value if you do not know where you are going to sleep at night or how you are going to get your next meal" (Bratteteig, 2001). The Ministry of Health and Social Affairs wants to give priority to persons with dual diagnosis and to redirect resources from PUT to special measures for drug users with serious mental illnesses, (Storting Report 25, 1996-97), and proposed the setting up of "special services for young people with alcohol and drug problems and mental illnesses in each county. These could take the form of one or more "Psychiatric youth teams" attached to the central hospitals' departments for alcohol and substance abuse-related psychiatry or to one or more district psychiatric centre in each county. The teams should work externally and take an outreach approach. Any reorganisation of the services should be carried out in such a way that existing competence is preserved."

Three to four teams have been established to test models for ambulant/ outreach services aimed at persons over the age of 18 with a dual diagnosis. They consist of inter-disciplinary units that together have high competence in the comorbidity field and where one and the

same group of therapists will be able to deal with both alcohol and drug abuse and mental illness.

The department of alcohol/drugs-related psychiatry at the Psychiatric Clinic at Rogaland central hospital has set up two ambulant groups<sup>xvi</sup> each attached to a psychiatric youth team intended to reach patients with abuse problems and mental illness and who do not avail themselves of, or drop out of, existing services. The team in Sandnes has had 44 patients up to October 2003, most of them between the ages of 25 and 35. Twenty-four of the patients have psychosis problems. Thirty-one of them do not have satisfactory housing arrangements. An evaluation of the project is planned.

In Oslo the project Alcohol/drug use and psychiatry (ROP) is attached to a district psychiatric centre. The project, which started in January 2001, will run for five years and is staffed by psychologists, psychiatric nurses, social workers and psychiatrists. The target group consists of patients from Oslo who have difficulty, or are completely incapable of, availing themselves of the general health and social services. They must have serious drug dependency problems of at least two years' duration, and there must be grounds for assuming that they also suffer from serious mental health symptoms such as schizophrenia, schizotypal disorders, bipolar disorder or serious personality disorders. The project will offer follow-up for up to two years. The team will be very accessible. It will be possible to contact/visit the patients at home, in hostels, on the street or in prison. The focus will be on basic needs such as housing, work, social benefits and social relations. The project will be evaluated through interviews with a selection of patients and collaborating partners, by systematising diagnostic material.

Up to summer 2003, 64 patients had been helped by the project and 25 had completed treatment and been discharged. Sixty per cent have no fixed abode. Their average age is 34. Twenty-five of them are opiate users, while most (50%) are multiple users. Twenty-one of the patients are receiving treatment using methadone or Subutex, and these patients appear to be benefiting more from the project than those not receiving substitution treatment. It is estimated that 49% have psychotic illnesses, 14% affective disorders and 25% personality disorders or other mental problems. Among those with psychoses, many have more than one additional diagnoses. (Øverås 2003). The goal is to establish a parallel service to the existing one, but that contact with the regular help agencies will be established and maintained during the period the patient is part of the project. The project has generated cooperation on depot medication pursuant to decisions to use compulsion, where the medical responsibility lies outside the team.

### ***In-patient treatment***

There are 6-7 in-patient treatment facilities in the alcohol/drugs and psychiatry field that include persons with dual diagnosis problems in their target group (Evjen 2003). The treatment facilities either have expertise on dual diagnoses themselves or they bring in expertise for guidance purposes. So far, there has been no research into or evaluation of these facilities.

One survey of a hierarchic therapeutic community in Norway (Ravndal & Vaglum 1994) showed that patients with antisocial personality traits coped fairly well during the actual stay in the institution, but that they had a high drop-out rate in the after-care phase. It was concluded that the situation following discharge should probably include structural elements and limits similar to those applying during the stay in the institution.

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<sup>xvi</sup> Cf. The Ministry and Health and Social Affairs' circular 1 – 36/2001.

**Medically assisted treatment**

Treatment of opiate addicts using methadone was initiated in Norway in 1998. A three-year trial project, the Methadone Project in Oslo (MIO), tried out in advance a model that included close follow-up, control and active rehabilitation in addition to medical treatment. The evaluation showed that anxiety and depression were widespread among the patients. These problems improved only slightly during the project period. The evaluation concluded that treatment specifically aimed at the mental health problems is essential. It was also the case that those with antisocial personality disorders completed the programme as successfully as those without such problems. This reinforces the supposition that for clients with such personality disorders, stringent rules, control and predictability - as found in the Norwegian model - have a positive effect.

A research project on the use of substitution treatment for patients with schizophrenia and opiate abuse is in the start-up phase. The project will be carried out by the Section for clinical drug problems at the University of Oslo and will initially include 40 patients with medium to serious opiate abuse and schizophrenia. The aim is to test the use of substitution treatment, which will be administered by a hospital department in the initial phase and subsequently by the district psychiatric centres. Among other things, the study will evaluate how well psychiatric treatment works for these patients. Extensive diagnostic examinations will be performed prior to inclusion and after two to three years. A questionnaire survey will also be carried out into the incidence of psychosis and opiate dependency in Oslo.

**16.4 Examples of best practice and recommendations for future policy**

Persons with dual diagnosis often have negative experiences of treatment. Establishing good relations with helpers in the social and health services takes a long time in itself. Many in the target group have good relations with street-level facilities and low-threshold institutions that see it as their duty to cover their most basic needs, such as accommodation, food and keeping warm.

It may be necessary to link these services to specialist services in order to create the required alliances.

***New organisation of services***

The examples in chapter 16.3 provide experience of the effect of different programmes or individual interventions. Since the Norwegian policy aims to prevent persons with co-morbidity from being excluded from the general services, we will include an example where a local community has organised its services in such a way that user influence and an integrated approach are central elements. The example is from a small municipality in Northern Norway.

***“The Øksnes project”***

Øksnes municipality set up a Council for local psychiatry with users in the majority in 1997. The Council evaluates existing services and proposes measures relating to the services provided in the fields of alcohol and drug care and mental healthcare.

A survey showed that 16 persons with compound psychiatric and alcohol/drug problems fell outside the services offered. They were constantly passed between the municipal help services, the psychiatric hospital, the clinic for drug and alcohol problems and other mental healthcare services. The doctors in the municipality had a heavy workload relating to the fact that drug use in this group was out of control. Contact with the patients was characterised by acute emergency solutions involving short compulsory admissions to institutions requiring transport by plane or taxi/ambulance. The consultant for drug and alcohol problems, the psychiatric health worker, doctor and milieu therapist in the users' arena have been formed into a professional team, without barriers and appointments, with responsibility for social

work and health measures. The team is physically accessible between 8:00 and 22:00, and by phone at night and at weekends.

The premises used by the professional team, the "Meeting place", is rented by the users. Up to 30 users come here daily. Various self-help groups have been set up and they help each other with practical tasks. For many of them this "haven" is a first step out of an isolated existence. It will be developed in cooperation with users, and with genuine user participation. The users will be able to influence what happens to both individuals and the group, but families and other involved persons will also be taken into consideration.

Through cooperation with the local press, among others, a lot of effort was put into changing attitudes in the community, and the media monitored how user participation was put into practice. There was some resistance among staff to introducing a more accessible and flexible system in which those providing the services had to work more irregular hours than before.

Today, the team also includes a representative of local labour market enterprises. Staff in non-municipal positions (the Team for adult psychiatry and the Team for child and youth psychiatry) now have regular working hours in the municipality. Integrated into the municipal services, they are thus part of preventive efforts instead of being brought in on an emergency basis as they were previously. Municipal employees receive continuous guidance and updating. The evaluation of the users is done while they are in their home environment.

The "Meeting place" triggered a need for help, day and night. During the Meeting place's first year the project staff were very much in demand, but this fell off as time passed. The users stated that housing was problem number one. Good housing solutions have been the key to reaching this user group with other forms of help. Efforts have also been put into adapting workplaces, in cooperation with a local labour market enterprise among others.

This is an important part of the project that provides relief for the specialists and that can be used "constructively" instead of just meeting a need for acute treatment. The number of acute and compulsory psychiatric admissions has fallen sharply. Control of the use of medication has improved for the group with compound problems. The evaluation of the project showed that the target group's situation had improved and that the public sector has "saved" the cost of hospital admissions, social security and welfare benefits (Foss 2000).

### ***Case management***

There is a need in Norway to coordinate services provided under different Acts and to adapt different local services and treatment measures. Various case-management models are being developed in work with psychiatric patients, including "Coordination of Psychosocial Work" (CPS) for the follow-up of patients with persistent and serious mental illnesses. The method consists of drawing up and implementing an action plan in cooperation with the user, which the coordinator uses to follow him/her up over time. Providing guidance for all those involved and ensuring organisational support in the existing services are central elements. CPS is not intended to replace traditional treatment. However, coordination often uncovers unrecognised treatment needs that are unknown to the specialist services.

CPS will alternate between user-oriented rehabilitation and care work and work on adapting the network of interventions. A few of the users in the trial project had dual diagnoses. The CPS model works on the assumption that users will manage to attend appointments. This was a limitation in work with this group. The group that developed the CPS model in Norway has drawn attention to some experiences (Evjen 2003) involving users with particularly compound problems, as is often the case with dual diagnoses:

- The personal coordinator must take an outreach approach and be accessible to a high degree. Systems should be developed whereby it is possible to alternate between counselling, treatment, care and rehabilitation according to the user's needs. Treatment –

with cure as its goal – should only be included as one of several strategic options, that can be used for limited periods if expedient.

- Emphasis on building good alliances. One should, for instance, drop the demand for urine sample controls if this creates mistrust and prevents the development of good relations.
- Needs-based, not crisis-based follow-up.
- Individual adaptation, matching different treatment methods to the user's different needs.
- Broaden the understanding of what constitutes the goal of the work – be it improvement of symptoms, reducing the experience of stress or easing the situation for the user's family.
- Register the benefits of one's efforts. Increase understanding for "measuring" the results of interventions.
- Pay great attention to the risk of a relapse of symptoms – which for this target group will often have major consequences.
- Work systematically on preventing crises in individual users, be alert with respect to a deterioration of symptoms and initiate solution-oriented discussions. "What have I done previously in corresponding situations?"
- Planned interventions must appeal to the user's real needs. When "getting high" is an important part of the user's life, interventions cannot be based on full freedom from intoxicants.

The possibilities of evaluating interventions aimed at the co-morbidity group are limited. In order to measure the effect of interventions, it is necessary to carry out initial evaluations or diagnoses of persons who are the subject of interventions and then repeat them after the intervention. Only after stabilisation has taken place will it be possible to tell whether the person has an enduring mental health problem or whether it is drug-triggered, i.e. is a consequence of the abuse. One major challenge is to base the intervention firmly on the user's needs and not on the existing services that established facilities can offer. Changes must also be made at the societal and system level where attitudes, theories and methods need to be changed so that the services do not exclude "difficult" groups of this type and so that they feel that they have sufficient "dual competence" or "cross competence".

### ***Treatment adapted to different patient groups***

A study has been carried out summarising the treatment of clients with both alcohol/drug abuse problems and psychopathology based on the findings from six different Norwegian treatment studies carried out during the period 1967-1990 that showed a high incidence of mental illnesses, mostly personality disorders, anxiety and depression among patients (Vaglum 1996). One conclusion of this treatment study was that aggressive, impulsive behaviour was best treated by confrontational, structured group therapy combined with family therapy. Patients who were depressed or anxious benefited more from individual psychotherapy and supportive group therapy.

### ***Early intervention***

The project, *Early Intervention in Psychotic Disorders* in Rogaland aims to reach young people from as early as the age of 15, in order to start the treatment of psychotic conditions early on, based on recognition of the fact that the longer the psychosis remains untreated, the easier it will manifest itself. One method is the establishment of a discovery team. The team will provide follow-up lasting at least five years. The project started in 1997 and has had 600 patients. Thirty per cent of those reached by the project, abuse alcohol/drugs as well having psychosis problems. The proportion with dual diagnosis is greater than in previous Norwegian surveys. One reason may be that the project searches so thoroughly for patients and registers both symptoms in detail.

The project's experience is that many of the alcohol/drug abusers show significant improvement when they receive treatment for their psychoses. It appears that the need to "get high" thereby decreases. So far, too little is known to be able to decide whether psychosis or near psychosis in this group is triggered by substance abuse or whether these conditions could have been prevented if the patient had not used drugs.

### **Recommendations for future policy for the area**

- Integrated rather than isolated help. The treatment must be directed simultaneously at the alcohol/drug abuse and the mental illness.
- The capacity to intervene early should be increased.
- The therapeutic teams should develop special treatment methods designed for dual diagnosis patients.
- The therapists must reach out to the clients, understand them on their own terms and find an approach that suits the patient.
- Concrete help must be available in the client's local community. A secure framework must be created so that the client can be helped to achieve better control of his/her alcohol/drug use and psychiatric symptoms.
- The services must comprise comprehensive rehabilitation that includes the establishment of a secure housing situation, stabilisation of the client's finances, family support, vocational training, crisis measures and stress management.
- The possibilities for admission to a psychiatric in-patient department must be improved.
- Medical treatment must be part of the programme.
- Follow-up responsibility must be expected to last for several years.
- The treatment programmes/therapists must build good alliances with the clients and focus on the successful formation of attachments to private and public networks.

In light of the Norwegian Board of Health's studies of the need for specialised treatment facilities for those alcohol/drug abusers with the most serious mental illnesses, the Ministry of Health (the Ministry of Health and Social Affairs 2001) recommends the establishment of an ambulant team that can reach out to and follow up patients at home as required, and "psychiatric youth teams" that work externally and on an outreach basis. It is possible to find, both in the trial projects with ambulant teams and in the alcohol/drugs sector, good Norwegian examples that give grounds for believing that therapists who are able to spend enough time on cases often succeed with treatment on a voluntary basis.

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## Abbreviations

Abbreviations for Norwegian institutions used in this report.:

AKAN	The Norwegian Tripartite Committee for the Prevention of Alcohol and Drug Problems in the Workplace
NCIS	The National Criminal Investigation Service
NIPH	Norwegian Institute of Public Health
SIRUS	Norwegian Institute for Alcohol and Drug Research
SSB	National Bureau of Statistics