

# *The Drug Situation in Norway* **2004**

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



Norwegian Institute  
for Alcohol and  
Drug Research



## **2004 NATIONAL REPORT TO THE EMCDDA**

by the Reitox National Focal Point

### **NORWAY**

New developments, trends and in-depth information  
on selected issues

REITOX

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## Table of contents

Table of contents.....	3
Introduction .....	6
External co-authors .....	7
Authors - selected issues .....	7
Summary - Main trends and developments .....	8

### PART A: NEW DEVELOPMENTS AND TRENDS

<b>Chapter 1. National policies and context</b> .....	10
1.1 Legal framework .....	10
1.2 Institutional framework, strategies and policies .....	11
1.3 Budget and public expenditures .....	13
1.4 Social and cultural context .....	15
<b>Chapter 2. Drug use in the population</b> .....	16
2.1 Drug use in the general population.....	16
2.2 Drug use in schools and the youth population .....	16
2.3 Drugs and driving. ....	17
2.4 Mapping surveys in Oslo and Bergen - Early warning system .....	18
2.5 Drug use among specific groups.....	19
<b>Chapter 3. Prevention</b> .....	21
3.1 Universal prevention.....	21
3.1.1 Local community-based prevention .....	21
3.1.2 The school sector/measures in schools .....	22
3.1.3 Drug and alcohol prevention measures aimed at families .....	22
3.2 Selective/indicated prevention .....	22
3.2.1 The leisure arena.....	22
3.2.2 Risk groups .....	23
3.2.3 Families at risk .....	24
3.2.4 Further education .....	25
3.2.5 New prevention database .....	25
<b>Chapter 4. Problem Drug Use</b> .....	26
4.1 Prevalence and incidence estimates.....	26
4.2 Profiles of clients in treatment.....	26
4.3 Main characteristics and patterns of use from non-treatment sources .....	27
<b>Chapter 5. Drug-related treatment</b> .....	28
5.1 Treatment systems .....	28
5.2 Drug-free treatment.....	28
5.3 Medically-assisted treatment .....	29
5.4 Quality assurance standards .....	31

<b>Chapter 6. Health correlates and consequences</b> .....	33
6.1 Drug-related deaths and mortality of drug users .....	33
6.2 Drug-related infectious diseases .....	34
6.3 Psychiatric co-morbidity (dual diagnosis).....	36
6.4 Other drug-related health correlates and consequences .....	36
<b>Chapter 7. Responses to Health Correlates and Consequences</b> .....	37
7.1 Action plan for alternatives to drugs and alcohol in Oslo city centre .....	37
7.2 Low-threshold health measures.....	37
<b>Chapter 8. Social correlates and consequences</b> .....	39
8.1 Social exclusion .....	39
8.2 Drug-related crime .....	39
8.3 Drug use in prison .....	40
8.4 Social costs .....	40
<b>Chapter 9. Responses to Social correlates and consequences</b> .....	41
9.1 Social Re-integration .....	41
9.2 Prevention of drug-related crime.....	41
<b>Chapter 10. Drug markets</b> .....	42
10.1 Availability/supply.....	42
10.2 Seizures .....	42
10.3 Purity .....	46
10.4 Prices .....	46
 <b>PART B: SELECTED ISSUES</b>	
<b>Chapter 11. Buprenorphine, treatment, abuse and prescription practices</b> .....	47
11.1 Treatment with buprenorphine.....	47
11.2 Abuse of buprenorphine .....	48
<b>Chapter 12. Alternatives to prison targeting drug using offenders</b> .....	50
12.1 Introduction .....	50
12.2 Political, organisational and structural information .....	50
12.2.1 National policy and strategy .....	50
12.2.2 Legislation.....	51
12.2.3 Public debate .....	52
12.2.4 Implementation structure .....	53
12.2.5 Funding .....	53
12.3 Interventions .....	53
12.3.1 Pre-trial .....	53
12.3.2 Trial stage .....	54
12.3.3 Post-trial .....	56
12.3.4 Scope of schemes providing alternatives to prison. Some trends .....	58
12.4 Quality control .....	60
12.4.1 Guidelines.....	60
12.4.2 Studies and research .....	60
12.4.3 Training.....	60

<b>Chapter 13. Public nuisance: definitions, trends in policies, legal issues and intervention strategies</b> .....	61
13.1 Introduction .....	61
13.2 From drink problems to drug problems .....	61
13.3 Cannabis use among young people .....	62
13.4 Adult problem drug users .....	63
13.5 The HIV epidemic among intravenous drug users.....	64
13.6 The 'house scene' and ecstasy use among young people .....	65
13.7 Drug addicts as a pollution problem.....	65
References .....	67
Lists .....	70
List of Standard Tables and Structured Questionnaires referred to in the text .....	70
List of Graphs used in the text .....	70
List of Tables used in the text .....	70
Most common abbreviations used.....	71

## Introduction

This is the fourth annual report to the EMCDDA from the Norwegian Institute for Alcohol and Drug Research (SIRUS) on the drugs situation in Norway. The report has been drawn up in accordance with the new reporting guidelines introduced by the EMCDDA this year. We have endeavoured to follow these as consistently as possible, with the main focus on “new developments” and substantial changes in epidemiology, legislation and organisation. To allow readers to obtain more background information the report contains a number of references to the national report for 2003, and occasional references to the report for 2002. In addition, it refers to standard tables and structured questionnaires for special areas or topics, without always repeating their contents. These were submitted separately in September 2004. The new reporting structure and the editorial changes mean that the report is shorter, but also less comprehensive than the 2003 report. This year’s report has first and foremost been drawn up for EMCDDA’s use, but we hope it may also be of value to other interested readers who wish to keep abreast of the drugs situation in Norway.

As in previous years, this report is based on textual contributions and data from central public institutions in Norway and other players in the drugs and alcohol field. These are named in the reference list or listed as co-authors. The preparation of the report has been a team effort, involving several members of the SIRUS staff. I would like to thank everyone who has contributed.

The whole report can be downloaded from [www.sirus.no](http://www.sirus.no).

*Oslo, October 2004*

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## Summary – Main trends and developments

**The significant decrease in the number of drug-related deaths, which started in 2002, continued in 2003.** The police districts report a total of 172 deaths in 2003. This is 38 fewer than in 2002, and nearly 50 per cent less than the record year of 2001, when a total of 338 drug-related deaths were reported. Not since 1995 have mortality figures been as low as in 2003. Factors which alone and in combination have most probably influenced the significant decrease, which began in 2002, include:

- a very low average purity percentage for heroin, 29 per cent in 2002 and a record low of 23 per cent in 2003;
- the number of persons in medically-assisted rehabilitation has increased strongly, especially in Oslo, but also in other areas of the country;
- there has been an increase in the number of low-threshold health services in the larger towns and cities.

Developments in drug mortality statistics confirm, however, that heroin is available in large areas of the country. In 2003, such drug deaths were registered in 20 out of 27 police districts, with roughly 70 per cent of them occurring outside Oslo.

**For the first time in over ten years there was a clear decline in the number of drug cases received by the National Criminal Investigation Service (NCIS).** In 2003 there were 5,000 fewer seizures than in 2002. Seizures of Rohypnol alone accounted for 54 per cent of the total reduction. On the other hand, the figures for quantities seized are very high for many types of substance. This is due to record figures for total quantities, not necessarily record individual seizures.

**The trafficking of Rohypnol was strongly reduced in 2003.** The most probable reason is that the police and customs authorities were able, through international cooperation, to stop the illegal importation of the drug to Norway and Sweden from Russia via Lithuania.

**The decline in the number of drug seizures continued during the first six months of 2004.** Seizures of heroin have fallen by 23 per cent compared with the same period in 2003, ecstasy by 24 per cent, and cannabis by nine per cent. While seizures of GHB increased in 2003, there has been a very marked decline in the first half of 2004. In the same period there has been a substantial increase in the quantities of heroin, amphetamines and methamphetamines seized.

**The prevalence of HIV among intravenous drug users is still very low.**

In 2003, 238 cases of HIV infection were reported to the Norwegian Notification System for Infectious Diseases (MSIS). Only 13 of these cases concerned intravenous users.

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 deemed to be very unpredictable.

**The Administrative alcohol and drug treatment reform,** which was implemented on 1 January 2004, transferred responsibility for the treatment of problem alcohol and drug users from the county councils to the regional health authorities on behalf of the state. The regional health authorities' new responsibility is defined as "interdisciplinary, specialised treatment of drug and alcohol abuse".

It forms part of the specialist health services on a par with the somatic and psychiatric health services. As a result of this transfer of responsibility, the regional health enterprises took over ownership of or signed operating agreements/ purchase agreements with a total of 74 treatment institutions, including the regional centres for medically-assisted rehabilitation.

**The Government's action plan to combat drug and alcohol-related problems (2003-2005)** outlines a three-year pilot project for future preventive work in the municipalities. It is called the **Regional project**, and its main objective is to develop more targeted and coordinated prevention efforts at the municipal level. The project is under the central management of the Directorate of Health and Social Affairs in close cooperation with the relevant regional drug and alcohol competence centres. The Regional project is the largest individual effort in Norway in 2004.

**Two expert groups have been established for drug and alcohol issues.** The groups shall advise the Government on specific drugs and alcohol policy challenges. The composition of the groups reflects the desire for broad, expert representation from different drugs and alcohol fields. They therefore include former drug abusers, family members, representatives of the local authorities, treatment institutions, competence centres, research groups, voluntary organisations and the police.

**The Storting (parliament) adopted Odelsting proposition no. 56 (2003-2004) on 14 June 2004, the Temporary Act relating to a Trial Scheme of Drug Injection Rooms.** This will, among other things, exempt users of an injection room from the provisions relating to punishment for the possession and use of a single user dose of drugs. The parliament also requested the Government to ensure that the required amendments and provisions are in place so that such injection rooms can be opened from 1 January 2005. The Act will be in force for three years from the date of its commencement.

**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.

# Part A: New Developments and Trends

## Chapter 1. National policies and context

### 1.1 Legal framework

Norway has no specific legislation that addresses drugs exclusively. Legal responsibility is divided between the Ministry of Justice and the Police (the Penal Code), the Ministry of Health<sup>1</sup> (the Act relating to medicines etc., parts of the Act relating to social services, the Act relating to municipal health services and the Act relating to specialist health services). The Ministry of Social Affairs<sup>2</sup> is responsible for parts of the Act relating to social services and has particular responsibility for coordination of the Government's work to combat drug and alcohol problems.

The National Report (NR) 2002, chapter 1.2 gives a detailed review of the legal provisions and the penalty framework.

#### Proposal for new Penal Code

The Government put forward a proposal on 2 July 2004 regarding the general part of the new Penal Code (Odelsting proposition no. 90 (2003-2004)). A separate proposition dealing with the special part of the new Penal Code will be submitted later.

In this connection, the Government also stated its views regarding which activities should be criminalised in the special part of the Penal Code, and on the severity of penalties. The Government proposes to retain a *minimum penalty for especially serious drug crimes*. A proposal has been made to change the application area for *community sentences* allowing this type of penalty to be used for serious drug crimes in rehabilitation situations.

#### Establishment of injection rooms

The Storting (Norwegian parliament) adopted Odelsting proposition no. 56 (2003-2004) on 14 June 2004, the *Temporary Act relating to a Trial Scheme of Drug Injection Rooms*. This will, among other things, exempt users of an injection room from the provisions of the Act relating to Medicines relating to punishment for the possession and use of a single user dose of drugs. The Storting also requested the Government to ensure that the required amendments and provisions are in place so that the injection rooms can be opened from 1 January 2005. The Act will be in force for three years from the date of its commencement <http://odin.dep.no/repub/03-04/otprp/56/>.

#### Judge-led drug programme (Drug Courts)

In line with the Government's action plan to combat drug and alcohol-related problems for 2003-2004 a scheme involving a "judge-led drugs programme" (drug courts) is being studied. An inter-departmental committee is studying the need for and possibility of operating such a scheme and the conditions under which such an arrangement could be established in Norway.

The aim of drug courts is to strengthen the collective efforts for providing treatment and assistance for problem drug users looking for a way out of their problems. The detailed report may conclude with a proposal to implement a trial drug courts project with the aim of providing better practical assistance and treatment options for convicted persons and problem drug users and preventing new

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1 New structure from 1 October 2004: the Ministry of Health and Care Services.

2 New structure from 1 October 2004: the Ministry of Labour and Social Affairs. In the following the old structure is maintained.

crime. The task force will use current knowledge, research and experience, in order to describe the purpose, organisation of and basis for such a project. The starting point will be drug-driven crime, and special emphasis will be placed on defining which criteria will allow heavy drug users to have their cases heard in drug courts.

The committee will also evaluate a clear delineation in relation to types of crimes that should not be allowed to be heard in the drug courts, with particular focus on serious violent crime. It must be clarified whether the implementation of a trial project with drug courts will require legislative amendments, or whether it will suffice to add supplementary provisions to the existing legislation, regulations and guidelines.

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

### **Organisation and coordination**

The main responsibility for the coordination of drugs and alcohol policy lies with the Ministry of Social Affairs. The Ministry of Health has been given overall responsibility for measures aimed at problem alcohol and drug users. The Ministry of Justice and the Police and the Ministry of Finance (Directorate of Customs and Excise) are responsible for the control aspects.

The National Police Directorate and the Directorate of Customs and Excise have the key roles in the prevention of the illegal importation and sale of alcohol and drugs. The police play a key informative role in prevention work, for example by giving talks in schools, and also by intervening in cases of drug use among young people.

The Directorate of Health and Social Affairs is responsible for coordinating the national strategy for prevention, and the Directorate for Primary and Secondary Education, the National Police Directorate, the regional drugs and alcohol competence centres and voluntary organisations are all important partners. The Directorate of Health and Social Affairs is also responsible for maintaining contact with the competence centres, the municipalities and the voluntary organisations. For more information regarding the directorate's work on drug and alcohol issues see [www.shdir.no](http://www.shdir.no) or [www.rusdir.no](http://www.rusdir.no).

The seven competency centres in the alcohol and drug field play an important role in implementing drugs and alcohol policy at the regional and local levels. The centres work together with the municipalities in their region, providing education, advice and guidance for frontline personnel and promoting the development of preventive measures. Each of the centres has its own national area of expertise (NR 2003, chapter 9b). The centres work together through Norway Net, which helps to ensure the sharing of expertise between the centres.

### **The Administrative alcohol and drug treatment reform**

The Reform, which was implemented on 1 January 2004 (NR 2003, chapter 1.2), transferred responsibility for the treatment of problem alcohol and drug users from the county councils to the regional health authorities on behalf of the state. The regional health authorities' new responsibility is defined as "interdisciplinary, specialised treatment of drug and alcohol abuse". It forms part of the specialist health services on a par with the somatic and psychiatric health services. As a result of this transfer of responsibility, the regional health enterprises took over ownership of or signed operating agreements/ purchase agreements with a total of 74 treatment institutions, including the regional centres for medically-assisted rehabilitation.

The overriding objective of the Reform is to improve the treatment options for problem drug and alcohol users. This means strengthening the health services for this patient group and improving cooperation between the specialist health services for problem drug and alcohol users who require

services from different parts of the specialist health services, for example persons with a dual diagnosis. Treatment of problem drugs and alcohol use is to be developed as an interdisciplinary specialist health service focusing on holistic and individual-based approaches, emphasising both the social and the health perspectives. The Reform will give problem drugs and alcohol users patient rights, including the right to choose a treatment centre. (Ministry of Health's circular regarding "The Administrative alcohol and drugs treatment reform – Patient rights and amendments to the Act relating to Specialist Health Services" Rundskriv I-8/2004).

The Reform has not entailed any changes in the responsibilities and tasks of the municipal authorities. The social services retain overall responsibility for the provision and coordination of measures to help problem drug and alcohol users. The social services will be able to make referrals to the specialist health service for treatment of alcohol and drug dependency, and will cooperate with the health service in the follow-up of drug and alcohol users after treatment is completed.

In collaboration with the Ministry of Social Affairs, the Ministry of Health has developed a policy document outlining national perspectives and strategies in the drugs and alcohol field. The main addressees for the document are the regional health authorities. The document points out the objectives and main challenges that must be addressed by the Reform if it is to succeed in improving treatment options.

The Reform will be evaluated after three years. The evaluation shall consider in particular whether and to what extent the Reform has led to problem alcohol and drug users receiving treatment for their abuse problems as well as their psychiatric and somatic complaints.

The Government has also set up two committees with the aim of improving cooperation between the health services and the social services and between the different levels of the services. The committees will submit their recommendations in the course of 2004.

### **Action plan to combat drug and alcohol-related problems (2003-2005)<sup>3</sup>**

The action plan (discussed in NR 2003 chapter 1.1) formulates the Government's policy for long-term and goal-oriented work to reduce drug and alcohol-related problems. The main objective is to achieve a significant reduction in the social and health problems caused by problem alcohol and drug use, in terms of the harmful effects on individuals as well as society in general. The action plan incorporates the prevention of drug and alcohol-related problems as well as treatment, care and harm reduction. In addition the plan details the measures the Government believes are particularly important if the different objectives are to be achieved. The plan thus lays the foundation for a comprehensive drugs and alcohol policy (see also chapter 3, prevention and chapter 5, treatment).

The municipalities, the Directorate of Health and Social Affairs, the health enterprises, the National Police Directorate, the Directorate for Primary and Secondary Education and the competence centres have a shared responsibility for establishing and implementing the measures and projects described in the plan. Voluntary organisations also play an important role in implementing the measures.

The action plan emphasises the importance of ensuring good analyses of the effects of the policies. The Government's policies shall be knowledge-based, and new knowledge will be acquired through research. When choosing between different health and social policy measures, those that prove efficacious and produce results shall be prioritised.

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3 English version: <http://odin.dep.no/sos/engelsk/news/publ/044051-990067/dok-bn.html>

In 2003, two expert groups were established for drug and alcohol issues. The composition of the groups reflects the desire for broad, expert representation in different drugs and alcohol fields. They therefore include former drug abusers, family members, representatives of the local authorities, treatment institutions, competence centres, research groups, voluntary organisations and the police. The groups shall advise the Government on specific drugs and alcohol policy challenges.

### **National strategy for quality improvement in the drug and alcohol field**

In 2003, the Directorate of Health and Social Affairs, on assignment from the Ministry of Social Affairs, began work on a project related to quality development of measures for problem drug and alcohol users. The strategy encompasses the social and the health services at all levels, and is based on the assumption that, pursuant to applicable legislation, all residents of Norway are entitled to public social and health services of a high standard. Problem drug and alcohol users will be offered better treatment, care and harm reduction measures. Quality development will ensure adequate quality of treatment, primarily for the user as an individual, but also for the public sector as a purchaser of health and social treatment.

Quality development requires the directorate to describe the status of and the main challenges facing services for problem drug and alcohol users. Areas requiring quality improvement should be detailed and means proposed to improve quality, including considering the use of quality indicators. It should also be considered whether the indicators could serve as a basis for drawing up professional guidelines, in line with the professional guidelines adopted for the nursing and care services. The final report will be completed by the end of 2004.

### **National strategy for drugs and alcohol-related education in schools**

Based on the action plan to combat drug and alcohol-related problems 2003-2005, the Directorate of Health and Social Affairs has begun work on developing a national strategy which will specify measures in the action plan which apply to drugs and alcohol-related education in schools. The strategy will be developed in collaboration with the Directorate for Primary and Secondary Education, the competence centres and other affected entities. Educational programmes should be developed in line with the current national curriculum, grounded in research-based knowledge on effective prevention. The material will be offered to owners and operators of schools. The work was started in 2003, and the strategy implementation is expected to commence in 2005. Evaluation will be considered within the context of other follow-up measures relating to the action plan.

## **1.3 Budget and public expenditures**

**In law enforcement:** No comprehensive overview is available.

**In social and health care:** No new overview is available. See NR 2002 chapter 14.3

**Research (alcohol, drugs and tobacco):** SIRUS (2003). EUR 3.3<sup>4</sup> million in operating funds.

### **National strategies:**

Action plan to combat drug and alcohol-related problems (2003-2005)

*Pilot project for improved prevention in nine municipalities.* Amount: EUR 964,000 per year over a three-year period.

### **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-

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4 Conversion rate: 1 euro= NOK 8.30

priority measures in the areas of epidemiology, research, prevention and treatment. These 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 therapy and low-threshold measures. As funds are allocated to both a large number of public bodies and institutions, and to organisations, either as operational funding or as project allocations, it is very difficult to give exact figures in relation to specific areas.

In 2003, EUR 20.3 million was allocated over the Ministry of Social Affairs' budget as extraordinary funding for drug and alcohol-related measures and EUR 12.8 million as extraordinary funding for voluntary drug and alcohol prevention work. Among other things, the allocations are intended to cover:

- measures to prevent and reduce the use of drugs and alcohol;
- treatment and rehabilitation of problem drug and alcohol users and prostitutes;
- trial and developmental efforts attached to social services, voluntary organisations and private foundations which work with disadvantaged groups, and voluntary drug and alcohol prevention efforts to promote drug and alcohol-free life styles and drug and alcohol-free environments.

Funds for trial and development work are not earmarked for drug and alcohol-related measures exclusively, but a large proportion of the funding is used for measures targeting problem drug and alcohol users. Moreover, a significant amount is spent on other measures that indirectly benefit the targeted group, for example measures targeting prostitutes or other measures addressing the development of social services in general.

### **Allocations in 2003**

In 2003, the Directorate of Health and Social Affairs allocated a total of EUR 7.3 million to the seven competence centres in the drug and alcohol field. The allocations are intended to cover normal running expenses and the development of measures.

The Directorate of Health and Social Affairs administers the allocations to voluntary organisations whose goal is to prevent drug and alcohol-related problems. EUR 12.4 million was allocated for this purpose in 2003.

For 2004, EUR 15.2 million has been budgeted for the same purpose. A change in the itemisation of the state budget makes it difficult to make a precise comparison with previous years, but there has been a marked increase in funding in this area in recent years.

The guidelines for grants for projects and measures have been changed with effect from 2004. Grants to cover operating expenses and for organisations working with drug and alcohol prevention remain unchanged. The change has been made following an evaluation of allocation arrangements and its purpose is to strengthen voluntary drug and alcohol prevention efforts at the national level. When allocating grants, preference will be given to those projects and measures that have a demonstrably probable preventive effect, and which have goals that allow evaluation to be carried out.

In addition to the new regulations, the Directorate of Health and Social Affairs, in cooperation with SIRUS, has produced the guide "Planning and evaluation of preventive work" which will be of assistance in planning of new measures (see also chapter 2.3.4).

## 1.4 Social and cultural context

### Debates and initiatives (parliament, media, public opinion)

The reporting period has seen a general shift in focus, both in the media and among politicians, with more attention being paid to harm reduction and measures targeting the most abject drug users.

Two issues in particular have been debated:

#### Injection rooms

The Storting's decision to enact temporary legislation to establish injection rooms (chapter 1.1) was made after a lengthy debate both in parliament and in the media. The debate was vehement and polarised, with strong disagreement between the parliament and the Government. A slim parliamentary majority (Labour, Socialist Left and the Progress Party) which supports injection rooms, has therefore instructed the Government (Conservatives, Christian Democrat and Liberal), which has always been against injection rooms. Opinion is very divided in professional circles and in the various organisations. It is worth noting that the drug users' own interest group is among the critics. For supporters of injection rooms, the objectives include the formation of closer ties between addicts and the health system and the promotion of respect and dignity among addicts. The critics view injection rooms as a step towards legalising the use of drugs, and consider their establishment to be in breach of UN conventions ratified by Norway. Some critics perceive the injection rooms primarily as the result of a wish to remove drug addicts from the streets.

The debate has also focused on more pragmatic concerns, such as minimum age limits, the possible introduction of admission cards, the type of substances that it will be permitted to use, whether to exclude persons receiving medically-assisted treatment, staffing, what rights the police will have to enter injection rooms etc.

The debate will most likely continue in connection with the upcoming discussion of the proposed circular for the regulation and administration of the trial scheme.

#### About the illicit drug market in Oslo

During the reporting period there has been continuous debate about the open illicit drug market in Oslo in the media, among professional groups, politicians, sections of the business community and the tourism industry. The area – called "Plata" – next to the Oslo Central Station has been a hang-out for drug users since 1998 (see also chapter 13). The size of the drug scene in this area has grown dramatically in recent years. Despite the area being under video surveillance, there was widespread buying and selling and undisguised injection of substances and the area became increasingly violent. Many people in Oslo, including politicians, argued against breaking up the milieu without having adequate alternatives. In June 2004 the "Plata" was cleared after the police, with the support of Oslo City Council, began expelling any drug users openly injecting, buying or selling drugs. Their main rationale was to reduce availability, especially for young and new users.

In September 2004, the drug scene moved a few blocks closer to the city centre. It is smaller and more dispersed than it was in "Plata". However, the move has resulted in a tougher drug scene in these city centre streets, which have also recently become a favourite haunt of prostitutes, and drug users have become a major nuisance to the legitimate businesses in the area. Debate on these issues has flared up again with differing opinions as to the expediency of breaking up the more easily monitored old scene. The police's expulsion of persons suspected of selling/using drugs in these streets has also sparked debate. Many people have pointed out the paradoxical situation that the injection room is planned for location in the same area.



## Chapter 2. Drug use in the population

### 2.1 Drug use in the general population

No new data is available. The most recent interview survey was presented in NR 2002 and the data are available in *standard table 01*<sup>5</sup>. The next national interview survey will be conducted in autumn 2004. The data from it will probably be presented in NR 2005.

### 2.2 Drug use in schools and the youth population

#### Schools

The data from the last ESPAD survey were presented in NR 2003, chapter 2.2.2.

#### Youth aged 15 – 20

SIRUS conducts an annual questionnaire survey on the use of drugs among young people aged 15-20. The data from the 2004 survey is being analysed, but the report is not yet available. The data from the 2003 survey were presented in NR 2003 chapter 2.2.2. The 2003 survey showed no major changes in the use of illegal drugs ([www.sirus.no](http://www.sirus.no)).

#### Young adults aged 21 – 30

In addition to its annual youth survey (15-20 years of age), SIRUS also conducted a national questionnaire survey of those aged 21-30 in **1998 and 2002** (table 1). The surveys show that the proportion who have ever tried cannabis increased from 22 per cent in 1998 to 28 per cent in 2002, while the proportion who have ever tried amphetamines increased from five per cent in 1998 to eight per cent in 2002. Similarly, the proportion in this age group who report ever having tried ecstasy increased from two per cent in 1998 to five per cent in 2002, and the proportion who have ever used cocaine increased from three per cent in 1998 to six per cent in 2002. As shown in table 1, the proportion of those reporting use of the same substances during the last six months is substantially lower.

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5 All standard tables referred to in this report have been submitted to the EMCDDA separately

Table 1. Percentage in age group 21-30 who have used different illegal drugs, ever or during the last six months, Norway

	1998	2002
Cannabis – ever	22	28
Cannabis – last six months	7	9
Amphetamines – ever	5	8
Amphetamines – last six months	2	2
Ecstasy – ever	2	5
Ecstasy – last six months	1	1
Cocaine – ever	3	6
Cocaine – last six months	-	2
LSD – ever	1	3
LSD – last six months	-	0
GHB – ever	1	1
GHB – last six months	-	0
Heroin – ever	1	1
Heroin – last six months	-	0

Source: SIRUS

### Statistical margins of error

The figures are subject to statistical margins of error and must be interpreted with care. Questionnaire surveys are always susceptible to certain sources of error (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 drugs, either cannabis or stronger substances, will be underrepresented in the surveys.

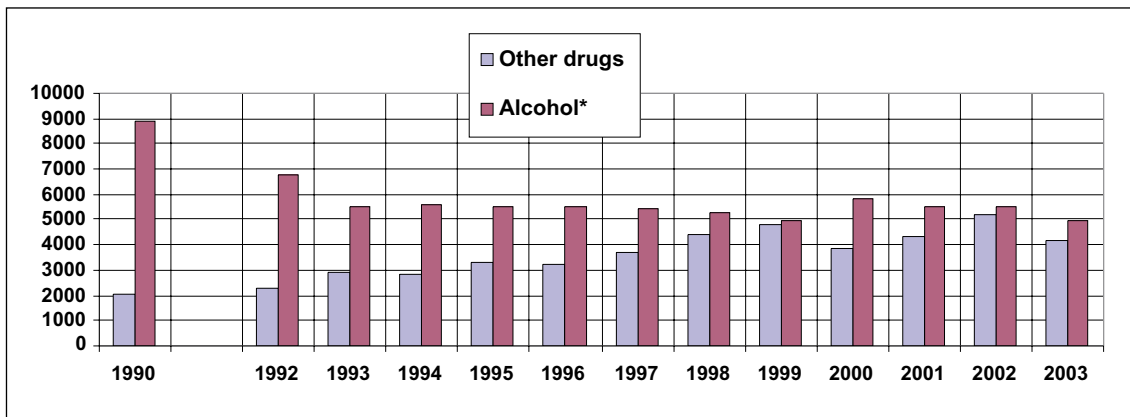
## 2.3 Drugs and driving.

The statistics relating to driving under the influence are monitored by the Division of Forensic Toxicology and Drug Abuse at the National Institute of Public Health (NIPH). Until 2002 by the National Forensic Institute – SRI. Sample statistics for the last two to three years show that the level of detected driving under the influence of alcohol or other drugs is more or less unchanged.

In 2003, there was a certain decrease in the number of road traffic cases involving suspicion of driving under the influence of substances other than alcohol (figure 1). It is uncertain whether this is actually due to fewer people driving under the influence of drugs. The decrease may also have a financial explanation. The police, who have to cover the costs of drug analyses, may in some cases have refrained from testing for drugs.

For medicinal products (figure 2) the trend in analysis results for individual substances correlates well with the statistics from seizures registered by the Norwegian National Criminal Investigation Service (NCIS). One example is flunitrazepam (Rohypnol), where the level of detections in traffic cases increased significantly during the period 1999-2002 (nearly doubling each year), whereas a significant decrease was registered in 2003. A corresponding fall in seizures of Rohypnol was registered by NCIS during the same period (chapter 10.2).

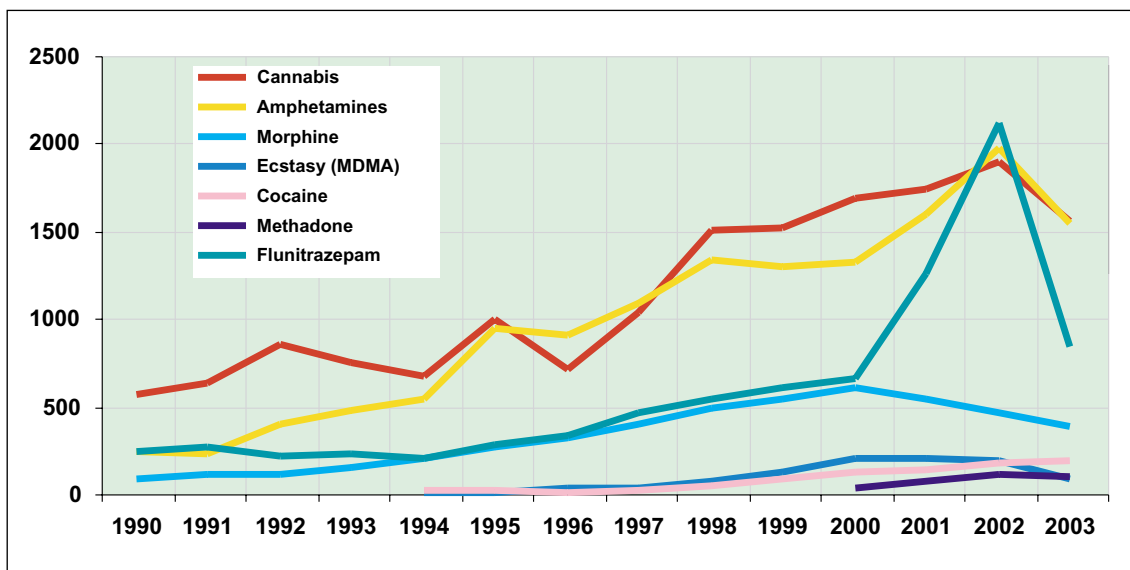
Figure 1. Number of traffic cases received by the NIPH/SRI 1990-2003, where there was suspicion of being under the influence of alcohol or other drugs.



\* Approved breath tests conducted by the police using Intoxilyzer 5000N are included (from 1995).

Source: NIPH

Figure 2. Drug finds (mainly illegal) in road traffic cases received 1990-2003.



Source: NIPH

## 2.4 Mapping surveys in Oslo and Bergen - Early warning system

"Føre var" ( EN: earlier warning system) is a mapping system aimed at detecting new abuse patterns. It is desirable to reduce the time lag between the development of new trends/ changes in drugs and alcohol use among young people and the point at which this information reaches the professional support services. Earlier warning of negative changes means that preventive measures can be implemented before new patterns of use become entrenched in the youth culture. So far, earlier warning systems have been initiated in the cities of Bergen and Oslo.

The system involves the compilation of factual data, statistics and more anecdotal information from formal sources: professionals from the various service/agencies working with young people, and

from informal sources: young people who are presumed to be knowledgeable about general drug and alcohol use and/or other new trends in youth circles.

The earlier warning system involves collecting data twice a year. Data from informants is collected using standardised questionnaires, telephone interviews and interviews of informants. The information reported by the informants is compared with the most recent statistics and research in the field and on this basis, a half-yearly report, "Youth and new abuse patterns" is prepared, giving an overview of the main findings in the field.

The data produced must be treated with certain reservations. The advantage of the earlier warning model is its ability to serve as a barometer, which can give an indication of positive or negative trends. The accuracy of the observations is probably good. A city is a limited action area and personal contact with and between regular informants makes the information more reliable. Moreover, the short interval between each publication means that the information is topical.

*The Bergen Clinics Foundation* in Bergen published two half-yearly reports (in May and November) in 2003. The most recent report was published in May 2004 ([www.bergenclinics.no](http://www.bergenclinics.no)).

*The Oslo Alcohol and Drug Addiction Service's Competence centre* published its first half-yearly report in December 2003 and the latest in May 2004 ([www.rusmiddeletaten.oslo.kommune.no/](http://www.rusmiddeletaten.oslo.kommune.no/)).

The report from Bergen from autumn 2003/spring 2004 indicates:

- no change in total sales of alcohol;
- no great change in respect of the majority of illegal drugs;
- a continuing increase in the use and availability of cannabis;
- a small increase in the availability of amphetamines;
- an increase in both the use and availability of anabolic steroids;
- a continuing increase in the use and availability of Temgesic.

The main findings of the report from Oslo for the same period:

- increased use of alcohol – girls in particular drink more than previously;
- young girls account for a significant proportion of the young people with serious drug or alcohol problems;
- cocaine is used in more arenas and by more user groups;
- ecstasy is not widespread in youth circles;
- anabolic steroids are used in more youth circles;
- professionals are concerned about boys from ethnic minority backgrounds.

## 2.5 Drug use among specific groups

### Among prostitutes:

*The Pro Centre*, a national competence centre addressing prostitution, estimates that on a national basis a total of 3,000 persons sold sexual services during the course of 2003. The majority of them are women, and nearly 50 per cent are persons with foreign backgrounds.

In 2003/2004, approximately 30 per cent of the women known to Pro Centre in the Oslo area were drug addicts. This proportion has decreased dramatically, as only two to three years ago nearly 80 per cent of those involved in prostitution were also active drug users. The decrease can be explained to a large extent by the large proportion of foreign, non-drug-dependent women. The presence of

more women on the streets, particularly young, drug-free women, makes for increased competition, in which the Norwegian, drug-dependent women experience that they are the losers.

In 2003, there was easier access to methadone treatment. This means that women who used to spend long hours on the streets in order to finance their drug habit, no longer need to do so as they receive medically-assisted treatment. Even though some of them still sell sexual services to finance their additional abuse of other substances or to supplement a tight budget, the frequency has been drastically reduced.

The majority of the women who visit the drop-in centre (shelter) in Oslo are drug or alcohol-dependent. Most have been addicted to heroin for many years and inject the drug daily, often in combination with benzodiazepines. Most of the women using the drop-in centre sell sexual services to earn money to cover the expenses associated with their own drug abuse ([www.prosenteret.no](http://www.prosenteret.no)).

**Among young people from minority backgrounds:**

Some more anecdotal observations from the last earlier warning report about the situation in Oslo:

More groups of young people from ethnic minorities are experimenting with various substances and they appear to be approaching the patterns of their Norwegian counterparts, also with regard to alcohol use. This applies primarily to boys from ethnic minorities from first and second-generation immigrant families. An increasing proportion of boys from Muslim backgrounds drink alcohol. The use of cannabis and pills among young people from ethnic minorities is also reported. Some point out that they use these substances in preference to or as a replacement for alcohol. The proportion of girls from ethnic minorities using drugs or alcohol is small.

Formal informants report a perceived increase in the proportion of problem users from ethnic minority backgrounds in the hardest drug milieus, despite the fact that they already comprise a large group. The problem users are mainly first-generation immigrants between 30 and 40 years of age. They have a poor command of Norwegian and come from a variety of ethnic backgrounds. Those who are under 25 are largely second-generation immigrants, but some are also first generation.

In addition, both formal and informal sources say that the exclusion process is far more rapid in immigrant communities than in most Norwegian communities. This means that young people from ethnic minorities who experiment with drugs and alcohol will often have a smaller network, and their drug careers may develop faster. Different forms of marginalisation and vulnerability can also be important factors in the recruitment of ethnic minority youth to the hardest drug milieus. We already know that many first-generation immigrants are susceptible to developing drug and/or alcohol problems. This may be due to factors such as traumas, deaths, lack of family, poor language skills, communication skills, unemployment, poverty, dependence on social security and belonging to destructive milieus.

## Chapter 3. Prevention

### Strategies at the national level

One of the strategically important objectives for drugs and alcohol policy in the Government's Action plan to combat drug and alcohol-related problems (2003-2005) is the prevention of all forms of drug and alcohol abuse, with particular focus on preventive work among children and young people.

Key components of preventive work in Norway are based on:

- seeing the connection between the prevention and health promotion perspectives;
- directing preventive measures at individuals and specific risk groups as well as large population groups;
- taking a long-term perspective on prevention;
- assigning a key role to the municipalities in prevention efforts;
- a broad mobilisation of different voluntary organisations.

The Government's action plan outlines a three-year pilot project for future preventive work in the municipalities. It is called the *Regional project*, and its main objective is to develop more targeted and coordinated prevention efforts at the municipal level.

The project is under the central management of the Directorate of Health and Social Affairs in close cooperation with the relevant regional drug and alcohol competence centres. The Regional project is the largest individual effort in Norway in 2004. The various sub-projects are described in chapters 3.1 and 3.2.

### Evaluation

SIRUS will evaluate the Regional project. The evaluation will focus on whether, and to what extent, the extra financial allocations (EUR 2.9 million<sup>6</sup> over a three-year period) for drug and alcohol prevention work in the selected municipalities/ regions leads to a reduction in drug and alcohol use and a reduction in drug and alcohol-related harm. In addition, it will study how the allocation is translated into municipal priorities, and how drugs and alcohol prevention measures/programmes are used and "maintained" over time. The evaluation, which will be concluded in 2007, will consist of several elements: school surveys, changes in alcohol consumption and in drug and alcohol-related harm, and a process evaluation ([www.sirus.no](http://www.sirus.no)).

## 3.1 Universal prevention

### 3.1.1 Local community-based prevention

As part of the Regional project, nine municipalities have been selected to participate in local community-based prevention efforts. Local steering and working committees have been set up in the municipalities, with responsibility for the day-to-day running and implementation of the projects. At least one of the selected municipalities is located in each of the seven competence centre regions, thus making the project nationwide. The nine selected municipalities have a total population of 143,035.

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6 Conversion rate: 1 euro= NOK 8.30

The municipalities can choose from a list of research-based and demonstrably efficacious projects/measures. The municipalities choose on the basis of the specific challenges they are facing, which other measures they already have in place and which of the projects they are interested in. The projects can relate to schools, families, the health sector and licensed premises.

Experience from the pilot municipalities will form the basis for community-based prevention in other places.

### **3.1.2 The school sector/measures in schools**

Central programmes in use in Norwegian schools are listed in *standard table 19*. The strategies, interventions and the emphases placed on them are discussed in *structured questionnaire 22*<sup>7</sup>.

The Directorate of Health and Social Affairs is developing a common strategy to bring together and coordinate drug and alcohol preventive work in schools, with clear recommendations in relation to what programmes are considered to be most expedient and effective on the basis of scientific criteria (chapter 1.2).

### **3.1.3 Drug and alcohol prevention measures aimed at families**

There is no common, uniform and unequivocal definition of drug and alcohol prevention measures targeting families and children. The Government's action plan emphasises the situation of children as an important target area, and the Government wants to increase efforts to enable intervention to take place as early as possible.

Given what we know about the harmful effects of a family life marred by drugs or alcohol, measures targeting families have been selected one of the priority areas for the Regional project.

## **3.2 Selective/indicated prevention**

*Standard table 21 Prevention in recreational settings* (submitted in 2002) provides a summary overview of various secondary prevention measures targeting young people. It includes outreach work.

### **3.2.1 The leisure arena**

The Regional project recommends one measure that is connected to the social/nightlife arena. This measure is called "Responsible host" and it will be implemented in all of the nine municipalities.

*Responsible host* is mainly alcohol-related, with the objective of improving the drinking scene by promoting responsibility in the serving of alcohol. The measures involve ensuring that employees in licensed premises have access to information and are given training in relevant intoxication and violence issues, as well as cooperating more closely with the authorities. Measures of this type take the form of collaborative projects between restaurants, bars and clubs, the local authority (licensed premises control committee) and the police. Key elements include instruction regarding the Alcohol Act, the effects of alcohol and drugs, the connection between intoxication and violence/accidents, and conflict management.

Responsible host has been tested in two cities, Kristiansand and Bergen. The project in Bergen was evaluated by SIRUS in 2004 (SIRUS report no. 1/2004).

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7 All structured questionnaires referred to in this report have been submitted to the EMCDDA separately

### 3.2.2 Risk groups

An overriding objective, and one of the main tasks in work with problem drug and alcohol users, is early intervention and in particular better work with children and young people at risk. For this reason, early intervention has been chosen as a focus area in the Regional project.

#### Arenas and target groups for early intervention

By early intervention in this context is meant measures targeting risk groups that are in danger of, or in the process of, developing a drug or alcohol problem.

Relevant risk groups include:

- pregnant drug or alcohol users;
- problem drug or alcohol users with babies and small children;
- children with foetal alcohol syndrome;
- children in exposed environments - dysfunctional families, family conflicts etc.;
- families with drug or alcohol problems;
- children and young people with problems at school;
- certain youth groups from immigrant backgrounds;
- persons with mental problems;
- unemployed persons;
- problem users/multiple drug users, men and women with risky alcohol consumption and/or concurrent use of prescription drugs.

Important arenas for early identification and mobilisation for early intervention at the municipal level will be: the primary health services; schools (training of teachers at all levels and mobilisation of counselling services); the youth arena (targeted work and leisure-time measures for young people at risk, outreach work among young people in the risk zone, binding cooperation and strengthened interdisciplinary efforts between school, child protection services and social services); the workplace (establishing systematic cooperation between company health services for early intervention, support and assistance functions in workplaces).

Measures will be implemented to increase the competence of all the professional groups and players involved. Competence-building measures will be aimed at improving knowledge of alcohol and drug-related issues, improving skills in working with drug and alcohol users, improving early intervention and ensuring better interdisciplinary and inter-service cooperation.

In the Regional project, four municipalities will implement early intervention.

*Rapid Assessment & Response (RAR)*<sup>8</sup> is a recommended information-gathering method in the Regional Project.

The objective of RAR is to obtain:

- a quick overview of selected problem areas;
- an overview of measures, and areas where efforts are inadequate;
- an action plan;
- different perspectives on the problems being mapped;
- a reliable picture;
- local ownership;
- increased cooperation.

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<sup>8</sup> World Health Organization: The Rapid Assessment and Response guide on psychoactive substance use and especially vulnerable young people ( <http://www.who.int/docstore/hiv/Core/acknowledgements.html> ).



A survey team consisting of municipal employees will be trained to use different methodological approaches to investigate problems. Methods to choose from include: collecting of existing information (statistical material), interviews with various persons (questionnaires, focus groups) and/or observations of the problem area.

RAR will be implemented in five municipalities.

### **3.2.3 Families at risk**

In the Regional project, the following two measures are recommended for families at risk:

#### **A. Parent Management Training – PMTO**

PMTO (the Oregon model) was originally a training and treatment method directed at families with children with serious behavioural disorders.

The method is based on a social learning and interaction theory concerning how aggression between family members develops and is maintained through compulsive patterns of interaction that become set and automatic. If such set patterns of interaction are allowed to develop over time and in different situations, the likelihood of increased levels of aggression between parents and children escalates. In the long term this may lead to the child developing behavioural problems of different levels of severity.

#### **Research:**

Two research projects are currently studying the implementation. These are intended to measure the efficacy of PMTO compared with another treatment (the Efficacy study) and the methodological integrity of PMTO specialists and therapists (the Implementation study). The latter is fully-financed by the American National Institute of Drug Abuse (NIDA). The Efficacy study is run by the Behavioural Centre at the University of Oslo.

The Efficacy study began in 2001 and involves approximately 20 therapists from among the first qualified Norwegian PMTO therapists, and the families they treat, as well as a control group of therapists and the families they treat. The objective is to evaluate the treatment of approximately 100 families as they complete either PMTO treatment (60 families) or undergo other treatment (40 families).

The evaluation takes the form of a pre-post evaluation in a randomised study design. Measuring instruments cover variables which describe the child's behaviour and interaction with others, both at home and in kindergarten/school. Data is collected through the use of questionnaires, structured interviews and observations. Both parents and teachers participate as informants.

PMTO has been selected by three municipalities.

#### **B. Iowa Strengthening Families Program (ISFP)<sup>9</sup>**

ISFP is a family intervention programme which seeks to combine activating ANT teaching methods for students with an educational programme for their parents. The target group consists of parents of adolescents in their fifth to seventh years at school (10-14 years of age).

ISFP is a knowledge-building programme which is designed to:

- Prevent tobacco, alcohol and drug use among teenagers
- Strengthen family competence
- Strengthen family ties

9 The Iowa Strengthening Families Program was developed by Karol Kumpfer at the University of Utah, together with Virginia K. Molgaard and Elizabeth Fleming at Iowa State University.

Only certified leaders can run the programme. The leader team consists of a class teacher and at least one leader recruited from outside.

The parents and adolescents meet in separate groups. The adolescents attend the programme during school hours. The parents meet in the evenings, generally on the school premises. The parent programme is based on twelve meetings - each meeting lasting two hours. The central element at most parent meetings is video films which provide discussion material for the meetings. The adolescent and parent parts of the programme are linked through homework exercises, and the seventh and twelfth meeting are family nights which the parents and adolescents attend together.

ISFP has been chosen by two municipalities.

### **3.2.4 Further education**

#### **Further education options in drugs and alcohol prevention work**

Narvik University College and the Oslo Alcohol and Drug Addiction Service Competence Centre are working together for the third year on this further education option, where the main focus is primary and secondary prevention work. One class has graduated, one is halfway through the course of studies and a new class will start in autumn 2004.

#### **Further education in outreach work**

This further education course is a collaboration between Oslo University College, the National Association of Outreach Workers and the Oslo Alcohol and Drug Addiction Service Competence Centre. The main goal is to boost knowledge and skills in outreach work through comprehensive and systematic training. The course of study has been developed and approved, and the first class will begin in autumn 2004.

### **3.2.5 New prevention database**

In 2004 a new prevention database ([www.forebyggingstiltak.no](http://www.forebyggingstiltak.no)) has been launched. This is in order to establish a national documentation system for the prevention field. The development has been carried out by a working group consisting of representatives from all seven regional competence centres, the Directorate for Health and Social Affairs, the website Prevention.no ([www.forebygging.no](http://www.forebygging.no)) and SIRUS.

The aim of the database is to spread information about drug preventive interventions, especially those with documented effects, and to promote evaluative activity. Furthermore, the database will hopefully help identify potential projects for the EMCDDA database for prevention and treatment programmes – EDDRA.

Interventions are entered in the database by means of a questionnaire concerning characteristics such as type of drug, background, setting, and status of evaluation. The questionnaire also includes a number of questions that are considered useful in the planning phase of process and outcome evaluation, with a link to a new set of evaluation guidelines: a Norwegian version of EMCDDA's "Guidelines for the evaluation of drug prevention: A manual for programme planners and evaluators" ([www.rusdir.no/tilskudd/tilskudd/rusforebyggende/index.htm](http://www.rusdir.no/tilskudd/tilskudd/rusforebyggende/index.htm)).

The database also allows the user to search for interventions using criteria such as name, type of drug, geographical location, setting and evaluation status. In future, it will also be possible to search for interventions by evaluation results and documented effects.

## Chapter 4. Problem Drug Use

### 4.1 Prevalence and incidence estimates

The level of intravenous drug abuse in Norway, based on statistics for overdose deaths, was estimated in 2002 to be between 11,000 and 15,000 persons (NR 2003 chapter 2.3). No new estimate is given this year as SIRUS has decided to switch from NCIS figures to Statistics Norway's (SSB) figures as the basis for estimating overdose deaths. SSB will not publish its figures for 2003 until spring 2005. By utilising the figures from SSB the data basis will be completely consistent with the definitions adopted by the EMCDDA.

SIRUS continues to work on developing alternative ways of calculating the prevalence of serious problem drug use. Reports on intravenous drug use from the municipal surveys in 2002 and 2003 are relevant sources of data, as well as other types of information from the police, the courts, the NIPH and SSB.

### 4.2 Profiles of clients in treatment

National data on clients receiving in-patient treatment and out-patient treatment is still only available in aggregate form (see NR 2003 chapter 3.1). This makes it impossible to extract unique data about the number of persons requesting treatment or to separate clients with exclusively or primarily alcohol-related problems from clients with exclusively or primarily drug-related problems.

In connection with the introduction of the new Administrative alcohol and drug treatment reform, the Ministry of Health requested the Directorate of Health and Social Affairs to draft a proposal for a national documentation system for the drugs and alcohol field. A working group has studied the existing registration of clients and measures. Its recommendation to the Ministry of Health is that client registration should be patient-unique and that the whole treatment field should be considered, i.e. not be limited to the regional health authorities' treatment units. It is also recommended that as from 2006 client information should be recorded in the Norwegian patient register in the same manner as information from the somatic and psychiatric health services. The work on coordinating the variables, the legal basis for unique patient registration etc. shall be clarified by August 2005.

#### **A study:**

SIRUS has conducted a study of persons admitted to 20 different treatments facilities during the period January 1998 to June 2000 (Ravndal, Lauritzen and Melberg (2002, 2003)). For more detailed information see NR 2003 chapter 11.2. The forms of treatments included were among the most frequently used and the study was geographically located in Oslo and surrounding counties. It included 482 persons with an average age of 41 (14 – 54), one third of whom were women. One third were receiving out-patient treatment (of this group approximately half were on methadone treatment) and two thirds were receiving medication-free in-patient treatment. The majority had been born in Norway (94 per cent), three per cent in Europe or other western countries and the remainder in Asia, Africa and South America.

Over 80 per cent of those interviewed injected regularly and had been doing so for ten years on average, of which six years on heroin and five years on amphetamines. Three out of four used hero-

in and amphetamines regularly. Of those who used heroin, only three per cent smoked it. More than 60 per cent of the amphetamine users injected. More than 60 per cent used prescription drugs (benzodiazepines) regularly and one third of these injected such substances.

Persons in treatment are a marginalised group in the community. Four out of five had never been married and only four per cent were married. Nearly 60 per cent have had an unstable housing situation during the six months prior to beginning treatment. Their educational level was much lower than in the general population and their most important sources of income were social security benefits, the sale of illegal drugs and crime. During the three years immediately prior to treatment, over half had been unemployed and nine per cent had spent most of the time in prison.

### 4.3 Main characteristics and patterns of use from non-treatment sources

#### Two studies from Oslo:

One study in 2002 included 327 persons who visited the needle bus in Oslo to obtain hypodermic needles (Egeland 2003). The overwhelming majority of these were intravenous drug users receiving no treatment. The majority of those interviewed had been born in Norway (92 per cent) or in another European country (five per cent). Only three per cent had been born outside Europe.

A study from autumn 2001 comprised 202 interviews of persons attending the field health care centres, a health care option for problem drug and alcohol users in Oslo. This group included a significant number of male alcoholics over the age of 50. In both studies just over one third were women. The majority were between 30 and 39 years of age (47 per cent) in Egeland's study, while the average age of persons in Strømmsmo's study was 39. Very few were under 20 years of age. Among the women, a large proportion were young.

Heroin was the most common drug used in both studies, 72 per cent and 66 per cent respectively. In Egeland's study, 33 per cent answered that amphetamines were the main drug (possibly together with heroin) while the proportion giving the same answer in Strømmsmo's study was much lower, less than ten per cent. The most common method of taking illegal drugs (heroin use) was injecting; nearly nine out of ten used this method. Among those who injected drugs during the last month, 74 per cent did so daily (Egeland 2003). It is common to use more than one type of illegal drug and some use prescription drugs in addition. Here, the incidence varies with the type of drug involved and between the two studies.

The persons in these studies also represented a marginalised group in the community. In both studies just over ten per cent were married or cohabitating, while two thirds had never been married. The housing situation varied somewhat between the two studies. Those who visited the needle bus had a more stable housing situation than those attending the field health care centres. In Egeland's study, one out of five lived in a hostel or similar, and two out of five in their own apartment, while the opposite was the case in Strømmsmo's study. In both studies, nearly 15 per cent were homeless. The educational level was very low in relation to the general population. The most common source of income in both studies was social security and different types of welfare benefits.

## Chapter 5. Drug-related treatment

### 5.1 Treatment systems

The organisation of treatment systems in Norway has been changed significantly. This is described in more detail in chapter 1.1.

When the Administrative alcohol and drug treatment reform came into effect in 2004, responsibility for treatment services regulated by the Social Services Act was transferred from the county councils to the state represented by the regional health authorities. The Reform also transferred responsibility for the organisation of medically-assisted rehabilitation to the regional health authorities. The Reform confers the same patient rights on problem users of drugs or alcohol referred for interdisciplinary, specialised treatment – including the right to choose the treatment facility – as patients referred for somatic and psychiatric treatment.

Drug-free treatment aimed at a future drug-free existence is still the main approach taken in the majority of Norwegian in-patient treatments. Medically-assisted rehabilitation generally takes place through out-patient/ambulant treatment. Over time, an increasing number of institutions have organised programmes for methadone clients in need of in-patient care.

*Standard table 21* provides some statistical information regarding in-patient institutions and out-patient treatment options.

SIRUS' database [www.rustiltak.no](http://www.rustiltak.no) contains a comprehensive searchable register of the different treatment options.

### 5.2 Drug-free treatment

The different drug-free treatment options are described in NR 2003, chapter 11.

The treatment options transferred by the Administrative alcohol and drug treatment reform to the regional health authorities can be roughly divided into acute/ detoxification measures, out-patient treatment facilities, and in-patient treatment facilities (psychiatric institutions, communal residential centres, therapeutic communities etc.).

#### **Acute/detoxification treatment**

There are three main categories:

- Drying-out or so-called "social" detoxification after a prolonged period of heavy use of alcohol and/or other substances
- Medical detoxification in situations where the person's condition is judged to be critical/life threatening
- Detoxification as part of rehabilitation/ treatment in an in-patient institution or out-patient treatment

"Social" detoxification, where there is no danger of medical complications, is generally carried out under the auspices of the municipalities.

Detoxification deemed to require qualified medical supervision and detoxification as part of a rehabilitation process are generally carried out in a hospital or treatment institution. After the state took over responsibility for the running of hospitals on 1 January 2002, both emergency units that were part of ordinary hospital operations and emergency units for drug and alcohol users regulated by the Act relating to Specialist Health Services were transferred to the state and run by the regional health authorities.

### **Out-patient treatment**

In recent years there has been great emphasis on the development of out-patient treatment for problem drug and alcohol users. Some measures primarily target the treatment of alcoholics, others the treatment of drug users. There are, for example, interdisciplinary youth psychiatry teams attached to adult psychiatric services in all the health regions. Many of the psychiatric out-patient clinics now have their own "drugs and alcohol team". In addition, more in-patient facilities also offer out-patient treatment.

### **In-patient treatment**

Today, there are great differences between treatment options as regards both the duration of the planned treatment and the nature of the treatment programme. Generally, in-patient institutions offering treatment primarily to alcoholics offer a far shorter treatment programme than in-patient institutions offering treatment primarily to drug users. An important challenge in the years ahead will be to carry out systematic evaluations of the types of treatment available in order to enable an assessment to be made of the benefits to different client groups of different treatment options. A requirement for treatment plans for clients with extensive and multiple treatment needs is a central aspect of the new drugs and alcohol reform. We need to ensure greater coordination of the different services for the individual client. Today, we endeavour to achieve greater flexibility than previously between specialist health care treatment and the municipal housing and care facilities, with follow-up by both the specialist health services and the municipal health and social services (Ministry of Health).

### **Evaluation - research**

The results from SIRUS's treatment survey "*What benefit, for whom and at what cost? A prospective survey of treatment options for substance abusers*", was presented in NR 2003 chapter 11.2. See also chapter 4.2.

Three communal residential treatment centres – *Samtun, Sollia* and *Frankmotunet* were recently evaluated. The evaluation, which is a follow-up study to investigate what has happened to the clients, was published in 2004. A summary has been sent to the EMCDDA for inclusion in the EDDRA database.

## **5.3 Medically-assisted treatment**

Medically-assisted rehabilitation using methadone and other medication for hard-core problem drug users has been available nationally since 1998. National guidelines have been developed to describe responsibilities and the organisation of medically-assisted rehabilitation at the regional and national levels. The system is based on specialised regional centres, although the municipal health and social services are responsible for follow-up. The system has now been expanded, and this type of assistance is now available in all municipalities and counties.

More detailed information regarding objectives, criteria, organisation, methods of administration and assistance is available in NR 2003 chapter 9.3. Methadone and buprenorphine are currently approved for this type of treatment.

## Statistics

All clients are registered as patients in a regional measure, even if their medication is prescribed by their regular GP. The centres submit reports to the national centre in Oslo every four months regarding the number of applicants, admissions and discharges. Figures are therefore available three times a year. There has been a steep increase in the number of clients. The most recent registration on 31 August 2004 showed 2,746 persons under treatment on a national basis, of whom approx. 80 per cent were treated with methadone, 20 per cent with buprenorphine (*standard table 21 gives figures for 2003*).

## Evaluation

Treatment evaluation has begun, based on both ordinary reporting and on research projects. Each treatment facility submits a status report for each patient, prepared by the patient's main therapist in November each year. The report records the social situation at the time of reporting and the type of treatment being given (medication and psychosocial treatment), drugs and/or alcohol use as assessed clinically and on the basis of the urine test results for the past month. It also provides information about the number of drug and alcohol-free months, crime, suicides and overdoses during the year.

In 2003, reports were submitted for 2,168 patients. This corresponds to 89 per cent of the patients who were undergoing treatment at the end of the year. Of these, approximately 15 per cent were reported to have injected drugs at least once. Twelve percent were thought by their main therapist to have used opioids, and twelve percent had at least one urine test that was positive for opioids. The percentage without certain information ranged from 11 per cent to 15 per cent, with the highest uncertainty relating to the question of injecting. Urine samples also showed that 28 per cent tested positive for cannabis, 30 per cent for benzodiazepines and 17 per cent for amphetamines or cocaine. Responses varied somewhat between the different regions in Norway, but the general assessment was that eight to nine out of ten had not used illegal morphine substances, seven to eight out of ten had not used cannabis and six to eight out of ten had not used central stimulants in the month preceding status evaluation. Eighty-three per cent had submitted urine samples, 77 per cent regularly and most twice a week.

The survey showed better results outside Oslo, and it also indicates that decentralised treatment combined with rehabilitation based on social centres and prescriptions from GPs can achieve good results.

The survey also indicates satisfactory results in other areas. Nine per cent had been arrested, two per cent had been charged and eight per cent fined and/or received a custodial sentence during the last year. Three per cent had taken a quantity of a drug sufficient to be deemed an overdose and two per cent had attempted suicide. While this is significantly higher than in the general population, the figures show a significant improvement on the pre-treatment situation.

Seventy-five per cent owned or rented their own housing and an additional nine percent lived in stable conditions with their parents or with others. Only one per cent had no fixed abode and six per cent lived in a hostel. Forty-four per cent spent most of their time with family or friends without drug or alcohol problems. Occupational rehabilitation showed slower progress. Only eight per cent were in full-time employment, while seven per cent had part-time work and seven per cent were studying. Only six per cent cited a salary as their most important source of income. Rehabilitation benefit and disability benefit dominate the picture.

Viewed together, these results point to several positive aspects. The overdose mortality rate has been significantly reduced. The patients acquire improved cooperation skills in the treatment of other diseases. Most of them function better socially and achieve a better quality of life, but very few manage to gain permanent employment. Crime was significantly reduced. The use of heroin has

dropped significantly, but many continue to have problems with other drugs, in particular benzodiazepines and cannabis.

Some trial projects have also been carried out with buprenorphine. A random study was conducted on 106 opiate addicts who were waiting to be admitted to the methadone programme in Oslo. Fifty-five received buprenorphine and 51 a placebo over a twelve-week period. The conclusion was that the waiting list patients benefited greatly from buprenorphine as a temporary treatment in terms of relapse, self-reported drug use and well-being. Nonetheless, the patients found it difficult to remain in treatment over time without some form of psychological support (Krook et al. 2001).

The treatment is also being evaluated in other studies. SIRUS has conducted a prospective, multi-centre study where maintenance treatment was one of the treatment options (Ravndal, Lauritzen and Melberg). A separate analysis has been published of developments among those treated with methadone (Ravndal and Lauritzen). The study shows that treatment is effective in reducing the use of heroin but that there is a tendency to increased mental problems in the form of depression. An analysis of the variations in treatment results indicates a lower success rate among patients in Oslo than patients in other places (Kornør and Waal).

There are also projects that focus specifically on buprenorphine. See chapter 11. A study of a time-limited treatment targeting young opiate addicts was initiated in March 2002, led by the Unit for Addiction Medicine at the University of Oslo in collaboration with youth psychiatry teams in five regions. Seventy-eight persons were included in the project, which will be concluded this year. Another project is studying the use of methadone for patients with psychosis and opioid addiction. A third project is studying the use of naltrexone implants for those who want a relapse prophylaxis following abstinence-oriented treatment.

### **Training**

All the centres conduct extensive training of personnel in cooperating municipal health and social centres. The Unit for Addiction Medicine holds a basis course in drug and alcohol medicine and maintenance treatment for doctors. Courses have been held in all regions. The course is currently held twice a year. An in-depth course on drug and alcohol-related topics is under development. The treatment has also been incorporated into the curriculum of several university colleges training social workers.

## **5.4 Quality assurance standards**

With the exception of the regional centres for medically-assisted rehabilitation, there is currently no special scheme for the official approval of facilities for assisting and treating drug and alcohol users. Nor have any criteria been drawn up for the content of such assistance and treatment. This means that organisations or private individuals are free to initiate such measures. Most of these will, however, be dependent on public sector purchases of their services, either through fixed operating agreements or the purchase of individual places, but there are also some private treatment facilities whose operation is funded by payments from clients/patients. Quality requirements must in such cases be set out when ordering/purchasing places/services.

The County Governors have had supervisory responsibility for treatment facilities. However, such supervision has hitherto not included quality control of either the treatment facility or the treatment methods used. Supervision has consisted of checking that clients have adequate protection of the law through inspections of in-patient facilities and follow-up of individual complaints.

The Directorate of Health and Social Affairs has been tasked with drawing up general criteria for evaluating the quality of health services. Such criteria may also be useful in evaluating the quality of



the individual treatment measures. The Directorate of Health and Social Affairs has also been charged with developing a national strategy for improving the quality of treatment, rehabilitation and care options for problem drug and alcohol users (chapter 1.2).

## Chapter 6. Health correlates and consequences

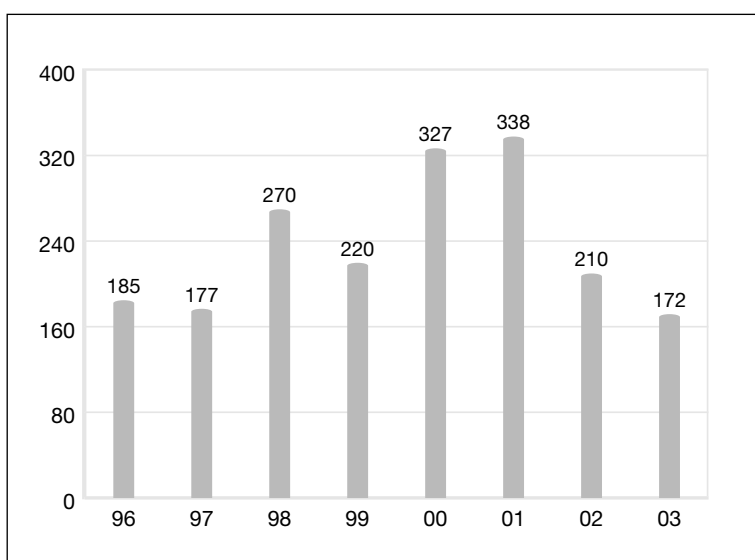
### 6.1 Drug-related deaths and mortality of drug users

There are two bodies in Norway that register drug fatalities: 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 person's 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.

The overview from the NCIS for 2003 shows that the significant decrease in the number of drug-related deaths which started in 2002, continued in 2003. The police districts report a total of 172 deaths – 134 men and 38 women – as a result of drug use in 2003. This is 38 fewer deaths than in 2002, and nearly 50 per cent less than the record year of 2001, when a total of 338 drug-related deaths were reported. Not since 1995 have mortality figures been as low as in 2003 (*standard tables 05 and 06*).

Figure 3. Drug-related deaths 1996 – 2003



Source: NCIS

According to the NCIS figures, the average age for drug-related mortalities was 35 years for men and 34 years for women. A total of 20 of 27 police districts reported drug-related deaths in 2003. This is three fewer than in 2002. There is a tendency for mortalities to be more evenly distributed

between the districts. While Oslo police district continues to report the greatest number of mortalities, Oslo's share has shrunk substantially in the last few years, from approximately 50 per cent in 1998 to approximately 30 per cent in 2003. On the other hand, there has been a marked increase in some police districts despite the low total mortality rate.

### **Causal factors**

The great variation in the total number of drug-related deaths for each of the last five years has no clear explanation, and there continues to be a lack of information in this area. Factors which alone and in combination have most probably influenced the significant decrease which began in 2002 include:

- a very low average purity percentage for heroin, 29 percent in 2002 and a record low of 23 per cent in 2003;
- the number of persons in medically-assisted treatment has increased strongly, especially in Oslo, but also in other areas of the country;
- there has been an increase in the number of low-threshold health services in the larger towns and cities;
- the greatly reduced availability of illegal Rohypnol (flunitrazepam) in 2003 may also have had an impact.

## **6.2 Drug-related infectious diseases**

See data in *standard table 09*.

### **HIV and AIDS**

In 2003, 238 cases of HIV infection were reported to the Norwegian Notification System for Infectious Diseases (MSIS). Only 13 of these cases concerned intravenous users. Of the cases ten were men and three were women and the average age was 36 (31- 48). Seven of the cases were immigrants infected before arrival in Norway, three of them from Russia. The cases were distributed over eight counties. Three were in Oslo. The number of HIV-cases remains relatively low, and little new infection is detected in this group.

As of 31 December 2003, a total of 486 persons had been diagnosed as HIV positive with injecting use as a risk factor. This constitutes 18 per cent of all reported cases of HIV since 1984. Development into AIDS has been reported in 138 of the cases (table 2).

Table 2. Percentage of intravenous drug users of persons infected by HIV or AIDS, with injecting risk behaviour, 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%
2003	238	13	5%	43	7	16%
Total	2 793	486	18.5%	816	138	17%

Source: NIPH

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 quite clear, but a high level of testing, great candour regarding HIV-status within the user milieu, combined with a strong fear of being infected and self-imposed rules, are assumed to be important factors. Additionally, many of the sources of infection in the drug-using milieu have disappeared due to overdose deaths and substitution therapy or other forms of rehabilitation. However, the extensive outbreaks of hepatitis A and B in recent years, and the high incidence of hepatitis C, show that needle sharing is still prevalent. The situation as regards HIV is therefore deemed to be very unpredictable.

### Hepatitis

During the national outbreak of hepatitis from 1995 to 2000, 1,360 intravenous drug users were identified as having acute hepatitis A infection. Only one case was reported in 2003. The hepatitis B outbreak continued into 2003, when 130 of a total of 204 cases of acute hepatitis B were identified as being intravenous drug users. In the period 1995-2003 there were 1,541 reported cases of acute hepatitis B among intravenous drug users.

The high incidence of hepatitis B among intravenous drug users has resulted in increased sexual transmission, often to younger women in the user milieu. The outbreaks have shown that intravenous use is no longer limited to the big urban centres, but has spread to smaller municipalities all over the country. The outbreaks have led to free hepatitis A vaccines being offered to all drug users in Norway since 2000. The hepatitis B vaccine has been free for drug users since 1984. In 2003 roughly 800 drug users in Norway were vaccinated against hepatitis A and 900 against hepatitis B.

In recent years, in connection with needle distribution in Oslo, small-scale surveys have been carried out to register the incidence of, for example, hepatitis among intravenous drug users. In 2003, the survey showed that 61 per cent of the 410 persons included in the survey had had a hepatitis A infection, 49 per cent a hepatitis B infection and 74 per cent 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 drug

users newly infected with the hepatitis C virus is not known. These Oslo surveys are the only prevalence surveys to be conducted regularly among drug users in Norway.

In connection with the annual prevalence surveys, drug users are also offered x-ray examinations to detect any cases of tuberculosis and are offered vaccinations against hepatitis A and B. Interview surveys conducted in connection with the prevalence surveys in Oslo show that approximately half of the intravenous drug users are not infected with hepatitis C three to four years after starting to inject. Similar surveys in other Western European countries have shown the same tendency. This is fresh information as it was previously assumed that most intravenous drug users became infected by hepatitis C shortly after starting to inject. This means that hepatitis C prevention work in drug user milieus is helpful, although it is still important to reach users with preventive measures as soon as possible after they have begun injecting drugs. The Alcohol and Drug Addiction Service in Oslo started a major campaign in 2003 called "Stop Hepatitis C" in user milieus using newly developed information material.

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

See NR 2003 chapter 3.3.

Syphilis, gonorrhoea and other sexually transmitted diseases are seldom reported among drug users in Norway. No outbreaks of tuberculosis have been registered among drug users in the country. Skin infections and abscesses are not uncommon. In individual cases these can develop into serious septic/toxic infections. Infectious endocarditis is a well-known consequence of injections. Every year a small number of cases of such infections is reported among drug users, but it is clear that such infections are under-reported to the Norwegian Notification System for Reporting system for Infectious Diseases (NIPH).

## **6.3 Psychiatric co-morbidity (dual diagnosis)**

Co-morbidity was thoroughly dealt with in NR 2003, chapter 16.

## **6.4 Other drug-related health correlates and consequences**

In 2003, two reports written on assignment from the Directorate of Health and Social Affairs were published on the health condition of and health services for problem drug users. (SINTEF Unimed 2003 *Helsetilstand hos tunge rusmiddelbrukere* - The state of health of problem drug users) (SINTEF Unimed 2003 *Helsetjenester for tunge rusmiddelmisbrukere* -Health services for problem drug users).

The reports concluded that persons with serious drug use problems were in a generally poor state of health, physically as well as mentally.

- personality disorders appear to be as prevalent in heavy substance abusers as in psychiatric patients;
- personality disorders occur more often in problem drug users than in alcoholics;
- antisocial/dissocial personality disorders, where aggressive behaviour is typical, occur most frequently in drug users;
- there is no simple causal correlation between problem use of drugs and alcohol and mental illnesses.

The regular health services do not seem able to offer this group the necessary health assistance. It is recommended that the level of in-patient treatment be maintained and that the capacity of medically-assisted rehabilitation be increased. The need for increased capacity and new treatment options in the mental health care sector should also be assessed.

## Chapter 7. Responses to Health Correlates and Consequences

See also *standard table 10 and structured questionnaire 23*.

New initiatives in 2003 to reduce drug-related harm were discussed in NR 2003 chapter 10. Chapter 7.1 and 7.2 primarily describe the progress of measures implemented in Oslo.

### 7.1 Action plan for alternatives to drugs and alcohol in Oslo city centre

The Action plan (see NR 2003 chapter 10.1) is the result of a collaboration between Oslo municipality and five ministries. The plan is an expression of the increased efforts being made and demonstrates that drug and alcohol problems in Oslo city centre are considered to be of national importance. The Alcohol and Drug Addiction Service in Oslo is responsible for the practical implementation of the plan and the follow-up of results.

In accordance with the Action plan, welfare measures have been implemented in the Service's own institutions to help users to have their needs satisfied where they live. Day shelters have been opened for problem drug and alcohol users, and voluntary organisations and neighbouring municipalities collaborate with the Service to achieve improved coordination of the support services.

Work with the most serious problem users is focused on fields such as nutrition, follow-up at home or in an institution, low-threshold health measures, disease prevention and mental health. New field stations and permanent premises for needle distribution have opened in Oslo city centre. There have been active efforts to send home users who come to Oslo city centre from other areas. This also includes registration and keeping statistics with a view to obtaining an overview of the number of users in Oslo who come from areas outside the city, and the characteristics of this group. In addition, throughout 2003 there was close cooperation between the Oslo police and the Alcohol and Drug Addiction Service with the goal of combating drugs and alcohol use in Oslo city centre (Annual report 2003, Alcohol and Drug Addiction Service).

### 7.2 Low-threshold health measures

Field health care is a street-level out-patient health service for drug addicts and alcoholics. There are six field nursing stations in Oslo linked to various care institutions and low-threshold contact centres. Field health care activities include consultation with nurses and doctors and conversations. Consultations/ conversations can lead to further follow-up, such as referral to a dentist, a GP or admission to hospital. Table 3 below gives an overview of the amount and type of services provided by the field health care service. Extensive supervision and guidance activity is provided by the field health care service in Oslo to the other centres in Norway. A method manual is currently being prepared for the field health care service.

Table 3. Field health care activities in Oslo

2003	Number of consultations	Visits to doctors	Wound-dressing	Anti-infection measures	Antibiotics	GP	Dental treatment	Hospital admission	Conversations
TOTAL	13 834	1 470	15 726	2 703	557	282	292	192	7 190

Source: The Alcohol and Drug Addiction Service, Oslo

In the last five years, the Health authorities, the Alcohol and Drug Addiction Service and the National Institute of Public Health have carried out various vaccination campaigns, checked immune system status and offered x-ray examinations in connection with needle distribution in Oslo. Needle users were offered vaccination against hepatitis A and B, x-ray examination and examinations for hepatitis A, B, C and HIV (chapter 6.2).

In 2003, a total of 239 persons were vaccinated and 333 took x-ray examinations. This is a lower level of participation than in 2002 when extra resources were set in. The survey shows that there were no great changes from 2002 to 2003 as regards the incidence of the hepatitis virus and HIV, and none of those examined in the last two years had active tuberculosis.

In 2003, moreover, the Alcohol and Drug Addiction Service in cooperation with others started and completed projects in the areas of psychiatry, dental health and gynaecology.

### Needle programmes and distribution

See data in *standard table 10*.

In 2003, 18 municipalities in Norway (including Oslo) reported that they had needle distribution schemes. In these municipalities, roughly 3.3 million needles were distributed through low-threshold programmes such as field health stations, outreach workers, and other "hand to hand" programmes (Information from the SIRUS municipality survey 2003 – unpublished).

Until 2002 only the needle bus distributed clean needles in Oslo. The needle bus was discontinued in 2003 and replaced by the field health care stations in the centre of Oslo. During 2003, five other field health care stations in Oslo implemented a distribution and return system for needles.

In 2002, 2,004,980 needles were distributed through the needle bus. The estimate for 2003 is approximately two million. The figures for 2003 are not completely certain, partly because 2003 was the first year with decentralised needle distribution and the registration and reporting routines did not work well enough.

The Competence Centre and the harm reduction department have worked together to develop a system of health cards (J-Kie Cards), which are handed out with the clean needles. The health cards are patterned on a model from Copenhagen, with a list of questions frequently asked of the help services and answers to them in clear and simple language. This information programme is intended to help to increase drug users' knowledge of how to avoid diseases and harm to health (Alcohol and Drug Addiction Service, Oslo).

## Chapter 8. Social correlates and consequences

### 8.1 Social exclusion

See NR 2002, chapter 16. No new surveys or data are available for the reporting period.

### 8.2 Drug-related crime

#### Reported and investigated crimes

SSB has statistics for reported drug crimes (pursuant to the Penal Code, section 162 and the Act relating to medicines etc.) for the first half of 2003 only. Statistics for the number of investigated drug crimes are unavailable after 2001. Updated statistics will be published later in 2004 (*standard table 11*).

In the first half of 2003 there was a significant decrease in the number of reported drug crimes. The numbers are provisional but indicate a decrease of 24 per cent compared with the same period in 2002. The greatest decrease is found in drug use and possession (violations of the Act relating to medicines etc.), which have fallen by 31 and 20 per cent respectively in comparison with the first half of 2002. There has also been a drop in drug-related crimes pursuant to the Penal Code, with drug-related crimes registering a 25 per cent decrease and aggravated drug-related crimes registering a 13 per cent decrease. The decline in drug-related crime is so great that we have to go back to 1997 to find a lower number of reported crimes. The exception is aggravated drug-related crimes, for which the figures continue to be higher than in 2001.

The statistics for this type of crime are greatly influenced by police activity. It is therefore difficult to ascertain whether the decline is due to an actual reduction in the number of drug-related crimes or whether it has other causes (Crime Statistics, SSB).

#### Penal sanctions

The previously persistent increase in drug-related crime has now flattened out. However, this type of crime remains the reason for most penal sanctions, accounting for 42 per cent of all criminal cases in 2003 (table 4). Drug-related crimes were followed by crimes for profit, which accounted for 28 per cent and by crimes of violence, which accounted for 16 per cent.

Table 4. Penal sanctions by crime type. Absolute figures and percentages. 2003

Crime type	Absolute figures			Per cent		
	Total	offences	Indictable	Minor offences Total	Indictable offences	Minor offences
Crimes, total	257 058	29 392	227666	100,0	100,0	100,0
Economic crime	1 696	1 382	314	0,7	4,7	0,1
Other crimes for profit	23 280	8 213	15 067	9,1	27,9	6,6
Crimes of violence	4 703	4 694	9	1,8	16,0	0,0
Sexual crime	581	575	6	0,2	2,0	0,0
Drug-related crimes	12 265	12 265	-	4,8	41,7	-
Vandalism	981	868	113	0,4	3,0	0,0
Environmental crime	826	7	819	0,3	0,0	0,4
Work place crime	112	-	112	0,0	-	0,0
Traffic offences	200 307	-	200 307	77,9	-	88,0
Other crimes	12 307	1 388	10 919	4,8	4,7	4,8

Source: SSB



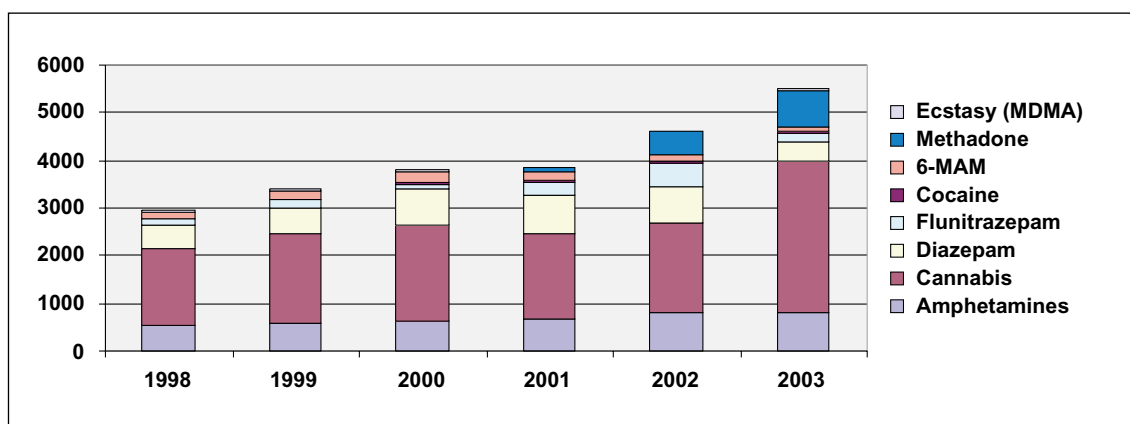
On behalf of the Police and Customs Coordinating Office, NCIS dealt with 385 drug cases in 2003, an increase of 70 cases compared with 2002. Several large drug cases in Norway in 2003 started as surveillance projects under the auspices of the police and customs authorities (NCIS Annual Report 2003).

### 8.3 Drug use in prison

See data in *Standard table 12*.

The number of cases sent for analysis by the Correctional services at the Ministry of Justice and Police to NIPH increased by 2,500 in 2003. Cannabis is still the most frequently found substance in urine samples of inmates of prisons and open institutions. A clear increase was also registered in the incidence of methadone in these tests. It has not been investigated whether this is due to an increased therapeutic use of methadone in medically-assisted rehabilitation of inmates. The greatest change is the incidence of flunitrazepam (the active agent found for example in Rohypnol) where a decline was registered in 2003, in line with the road traffic cases registered by the NIPH and the seizures registered by NCIS.

Figure 4. Substance findings in correctional services cases received in the period 1998 – 2003



Source: NIPH

### 8.4 Social costs

See NR 2003 chapter 4.3. No new surveys or data are available for the reporting period.

## **Chapter 9. Responses to Social correlates and consequences**

### **9.1 Social Re-integration**

This topic was thoroughly discussed in NR 2002 chapter 16. No new surveys are available for the period.

### **9.2 Prevention of drug-related crime**

#### **Assistance to drug users in prison**

See NR 2003 chapter 12.1. No new information is available.

#### **Alternatives to prison**

The topic is dealt with in chapter 12.

## Chapter 10. Drug markets

### 10.1 Availability/supply

Several factors must be emphasised when describing changes in availability. Seizures of illegal substances by the police and customs authorities provide a useful parameter. However, the number of actual seizures and the quantities involved are a function of the internal priorities and resources of the police and customs authorities, surveillance methods and international cooperation. The statistics may therefore show significant changes from one year to another, without this necessarily meaning that corresponding changes have occurred in terms of actual availability.

In 2003 the police prioritised the investigation of major drug cases and claim to have spent less time on users and minor cases. This may have resulted in fewer but larger seizures.

Seizure data from recent years clearly indicate that the sale of different drugs is becoming an increasingly nationwide phenomenon. Comparison of the data from the survey of selected municipalities (NR 2003 chapter 2.2.1) gives a good indication that the use and sale of drugs has spread to smaller towns, although most of the activity still takes place in the larger cities.

The trafficking of Rohypnol was markedly reduced in 2003. The most probable reason is that the police and customs authorities were able, through international cooperation, to stop the illegal importation of the drug to Norway and Sweden from Russia via Lithuania.

Most of the cannabis found on 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 linked to any particular ethnic group. In most cases Norwegians are responsible for both the importation and the receipt.

Most of the amphetamines seized in Norway are produced in Europe and originate mostly in the Netherlands, Belgium, Poland and Estonia. Most of the methamphetamines seized are produced in the Baltic countries and are imported by criminal gangs from those countries.

Developments in drug mortality statistics confirm, for example, that heroin is available in large areas of the country. Even though there was another significant fall in mortality in 2003, such drug deaths were nevertheless registered in 20 out of 27 police districts, with roughly 70 per cent of them occurring outside Oslo.

However, the black market prices for 2003 do not indicate increased availability. Prices have generally remained stable for all of the usual drugs with the exception of Rohypnol where prices have doubled in 2003 compared with 2002.

### 10.2 Seizures

For data see *standard table 13*.

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 authorities and the police are involved. The

number of seizures is defined on the basis of the number of times a substance is found and quantified according to differences in the type of substance, the time of the seizure and where the seizure took place. In other words, multiple seizures are registered for the same case if different types of substances are confiscated. The same holds true if the seizures are made at different locations or at different points in time.

**Main trends in 2003**

For the first time in over ten years there is a clear decline in the number of drug cases received by NCIS. In total, 20,319 drug cases were registered (-14.2 per cent) and 25,210 seizures (- 16.8 per cent) in the NCIS seizures database. There have been fewer seizures in the majority of police districts.

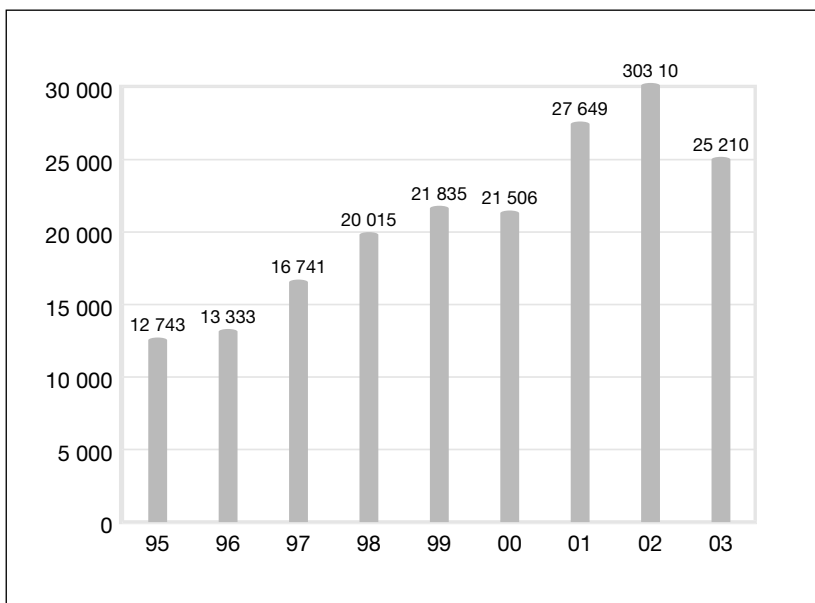
In 2003 there were 5,000 fewer seizures than in 2002. The decline was greatest for benzodiazepines which accounted for approximately 68 per cent of the total reduction. The most significant change is the huge decline in Rohypnol seizures, which alone accounted for 54 per cent of the total reduction. On the other hand, the figures for quantities seized are very high for many types of substance. This is due to record figures for total quantities, not necessarily record individual seizures.

**Trends in the first six months of 2004**

There has been a continued decline in the number of drug seizures, but a strong increase in the quantities of heroin, amphetamines and methamphetamines seized. Seizures of heroin have fallen by 23 per cent compared with the same period in 2003, ecstasy by 24 per cent, and cannabis by nine per cent. While seizures of GHB increased in 2003, there has been a very marked decline in the first half of 2004.

Figure 5 shows the development in the number of drug seizures for 1995 – 2003. Table 5 shows the distribution of the most common substance types.

Figure 5. Total number of drug seizures 1995 - 2003



Source: NCIS

Table 5. Number of seizures 2000 – 2002 broken down by the most common substances

Type of substance	2000	2001	2002	2003	Percentage change from 2002
Cannabis	9 224	10 844	10 921	10 411	-4.70 %
Amphetamines	3 077	4 596	5 035	4 614	-8.30 %
Methamphetamines	171	392	695	565	-18.70 %
Heroin	2 314	2 501	1 906	1 707	-10.40 %
Benzodiazepines	4 285	6 024	8 056	4 628	-42.60 %
Painkillers	845	1 109	1 237	1 190	-3.80 %
Doping	469	643	697	608	-12.80 %
Cocaine	390	496	577	492	-14.70 %
Ecstasy	783	837	716	414	-42.20 %
Khat	259	198	238	250	5.00 %
LSD	87	52	15	32	113.00 %
GHB	83	81	75	124	51.20 %
Opium	19	21	14	8	-42.80 %
Psilocybe mushrooms	50	45	46	57	23.90 %

Source: NCIS

### Cannabis

The quantity of cannabis seized, 2,292 kg, is the second largest ever recorded; only in 1995 was a greater amount seized. This may, however, be attributable to a single seizure of 19 tonnes of marijuana, which was not intended for the Norwegian market. Never before have as many “paragraph three” cases (usually cases involving more than 80 kilos of cannabis), been recorded as in 2003. The number of cannabis seizures has fallen, however, by more than 500, or 4.5 per cent.

### Amphetamines/methamphetamines

The total quantities of amphetamines and methamphetamines seized are 225 kg and 25.1 kg respectively – in a total of 4,614 seizures for the former and 565 for the latter. Both individually and in combination these figures are the highest ever recorded, but the number of actual seizures is approximately 9.5 per cent lower than in 2002. The largest single seizures in 2003 concern quantities far smaller than the record 98 kilos taken in a single seizure in 1998. There was, however, a record number of seizures between three and 20 kilos.

### Heroin

In 2003, the total quantity seized of substance mixtures containing heroin was 52.1 kilos; only on three previous occasions have larger quantities been seized. However, the number of seizures per year has fallen once again. We have to go all the way back to 1994 to find fewer seizures of heroin.

### Ecstasy

A total of 99,689 ecstasy tablets were seized in 2003. This is very close to the record set in 2002. Some large individual seizures were made in the first half of the year in particular, one of them involving all of 49,930 tablets, the largest seizure ever made in Norway.

The overall number of seizures has decreased. Taken together, the police districts made fewer seizures than in 2002. On a nationwide basis the decrease is over 40 per cent and for the Oslo police district as much as 52 per cent. This indicates that the spreading and use of ecstasy is declining.

### **Benzodiazepines**

In 2002, benzodiazepines were the group of substances that increased most in terms of both the quantities seized and the number of seizures throughout the country. In 2003 there were more seizures of very large quantities of benzodiazepines, primarily Rohypnol. In total, more than 545,500 tablets were seized in a total of 4,628 seizures. Nonetheless, both the quantities seized and the number of seizures has declined sharply. The quantity seized has more than halved since 2002, and the number of seizures has fallen by nearly 43 per cent.

For Rohypnol alone, the number of seizures over the whole year fell by 3,430 or 56 per cent. It was not until the second half of 2003 that the change really set in, after many years of record high figures for both quantities seized and numbers of seizures.

### **Cocaine**

The frequency of seizures appears to be declining. The total quantity of cocaine seized, approximately 30 kilos, is average seen in a ten-year perspective, while the total number of seizures is approximately 15 per cent lower than in 2002. The Oslo police district has made two seizures of "crack", one of 338 grams.

### **Other illicit substances**

#### **Khat**

A total of five tonnes was seized in 2003. This is three times the amount seized in 2002 and a new record. The number of seizures totalled 250, which is approximately the same as in 2002, and slightly lower than in the record year 1999.

#### **LSD**

LSD appears to still have a modest market share, with 148 single doses seized in a total of 32 seizures.

#### **GHB**

In total, 10 litres of GHB were seized in 124 seizures. This is a marked increase on the previous year. GHB was registered in 21 police districts. The most remarkable feature of 2003 was the many large seizures of gamma butyrolactone (GBL), an organic solvent used in the production of GHB; as many as 839 litres were seized in a single seizure. GBL is also classed as an illegal drug in Norway. Together with other industrial chemicals such as 1.4 butanediol, which also converts into GHB when ingested, this substance group is growing substantially.

#### **Opium**

In terms of both the volume seized and the number of seizures, the figures for opium are very low in comparison with heroin and medicinal painkillers. This substance seems to have more or less disappeared from the market. In total there were eight seizures of opium with a total seized weight of 395 grams.

#### **Other opioids**

A sharp decline was recorded in the number of tablets seized for drug-classified medicinal painkillers (opioids), and a smaller decline in the total number of seizures. However, both the quantity seized and the frequency of seizures of Dolcontin (morphine), and the number of seizures of Methadone and Subutex increased somewhat in 2003. In the period 1999 – 2002 the number of seizures of methadone tripled and the volume seized increased many times over (NCIS).

### 10.3 Purity

Both for amphetamines and methamphetamine the average purity for 2003 was estimated at roughly 50 per cent. Purity was high for amphetamines, but somewhat lower than in previous years for methamphetamines.

For heroin, the average purity for 2003 was estimated to be 23 per cent, the lowest ever recorded (29 per cent in 2002).

The average purity of cocaine was estimated to be approx. 63 per cent (51 per cent in 2002).

In the case of ecstasy, the active agent MDMA was found in 99 per cent of the seizures (*standard tables 14 and 15*).

### 10.4 Prices

The prices of different narcotic substances are based on information obtained from the drug squad in the Oslo police district. The prices of the different 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. The price level is generally the same as January 2003, with the exception of Rohypnol where prices have doubled (*standard table 16*).

The "price-list" is based on information from users and sellers at different levels, as well as information received from officers working in the narcotics section. Prices can vary widely on the basis of quality, contacts and quantity.

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

### **Chapter 11. Buprenorphine, treatment, abuse and prescription practices**

#### **11.1 Treatment with buprenorphine**

Substitution treatment in Norway was officially started in 1998 under the designation “Medication-assisted rehabilitation – MAR” with national guidelines stating that patients would be admitted through Government-approved MAR units.

Admission criteria to MAR are:

1. Age  $\geq$  25 years
2. Long-term drug abuse dominated by opiates
3. Reasonable amount of drug-free, abstinence-oriented treatment

Exceptions from these criteria are granted in cases of serious disease or when indicated by overall considerations. Pregnant women are given priority. The goal of the treatment is social and/or vocational rehabilitation and each patient will have a specified treatment plan based on his or her problems.

The MAR units process applications for treatment, register patients and coordinate regional MAR services. Some units also handle all aspects of MAR, including medical and psychosocial assessments, medication dispensing, urine testing and case management, while others rely on general practitioners, pharmacies, laboratories and social services to perform some or all these tasks. Patients registered in MAR units with service delivery are usually transferred to community-based services when stabilised on buprenorphine or methadone.

Methadone was the only substitution agent in use during the first three years of practice. Revised regulations opened for buprenorphine substitution treatment from January 1, 2001 (Skretting & Dammen, 2004), after which high-dose buprenorphine (Subutex) and methadone were to be prescribed on equal terms.

Once patients are admitted for MAR, physicians do not need any kind of accreditation to prescribe buprenorphine; nor are any training courses in buprenorphine prescription organised in Norway. However, the specialised MAR units provide supervision and guidance to general practitioners and other involved parties.

Aggregated data from unpublished national MAR surveys show a gradual increase in the number of MAR patients treated with buprenorphine: 115 in 2001 (10 per cent), 291 in 2002 (16 per cent) and 492 in 2003 (23 per cent). The 2003 figures reveal great regional variations in the proportion of MAR patients receiving buprenorphine treatment, from 9 per cent in the Eastern region to 61 per cent in the Western region. Individualised data that allow for the comparison of buprenorphine patients with methadone patients were only available for the Eastern region, which is where approximately half the Norwegian MAR patients live. These data showed that buprenorphine patients ( $n = 95$ ) were slightly, but significantly, younger than methadone patients ( $n = 904$ ) (38.9 vs. 40.8 years;  $p < 0.05$ ). The duration of the treatment was also slightly shorter for buprenorphine patients than for methadone patients (450 vs. 862.5 days;  $p < 0.001$ ). The differences can be explained by the practice of initiating MAR with buprenorphine for most patients, and the fact that buprenorphine was introduced to MAR three years later than methadone.



The data also indicated that, compared with methadone patients, a larger proportion of buprenorphine patients had had recent contact with their case workers, and were deemed to have fewer current drug problems.

Norwegian research on buprenorphine includes a crossover 'intention to treat' study comparing methadone with buprenorphine, a placebo-controlled trial for patients waiting for MAR admission, an evaluation of a community-based treatment model and an ongoing study of short-term buprenorphine substitution treatment.

In the crossover study (Espegren et al. 2004), 50 patients were randomised to either buprenorphine or methadone maintenance treatment for 26 weeks, after which the buprenorphine group was transferred to methadone and the methadone group to buprenorphine. The buprenorphine dosage was fixed at 16 mg, while methadone doses were flexible within an 80 – 160 mg range. The main findings during the first 26 weeks of the study were a significantly lower retention rate for the buprenorphine group (36 per cent) than for the methadone group (85 per cent;  $p < 0.01$ ), and higher rates of opiate-positive urine (24 per cent vs. 20 per cent;  $p < 0.01$ ) and cannabis (45 per cent vs. 33 per cent;  $p < 0.001$ ) among the buprenorphine patients.

The placebo-controlled trial (Krook et al. 2002) aimed to investigate the usefulness of buprenorphine stabilisation for patients on waiting lists. Fifty-five patients were assigned to buprenorphine and 51 to placebo for 12 weeks. No form of psychosocial intervention was offered. Compared with the placebo group, the buprenorphine group stayed longer in treatment (median 29 vs. 11 days;  $p < 0.001$ ), used fewer illicit drugs and were more satisfied with life. However, only 29 per cent of the buprenorphine group stayed in treatment throughout the 90-day trial period, and it was concluded that attrition tends to be high without psychosocial support.

In the community-based project (Haga et al. 2002) fifty-nine MAR applicants from a waiting list were included in a comprehensive approach in which buprenorphine treatment was instigated directly in primary social and health services. Some administrative problems were noted, but treatment outcomes were comparable to other studies.

The study of short-term buprenorphine treatment (Kornør et al. 2004) included 75 young opioid-dependent adults (mean age = 26.7 years) recruited from out-patient clinics. Forty patients (53 per cent) completed the buprenorphine programme. At 9 months, 67 patients (87 per cent) were still in counselling. Mean attendance rates for buprenorphine dosing and counselling sessions were 0.91 and 0.74, respectively. There were significant and persistent reductions in drug use. Psychiatric problems escalated at 9 months, and three patients died during the detoxification phase. Completion was predicted by fewer previous treatment episodes. Two-year follow-up assessments will be completed by March 2005.

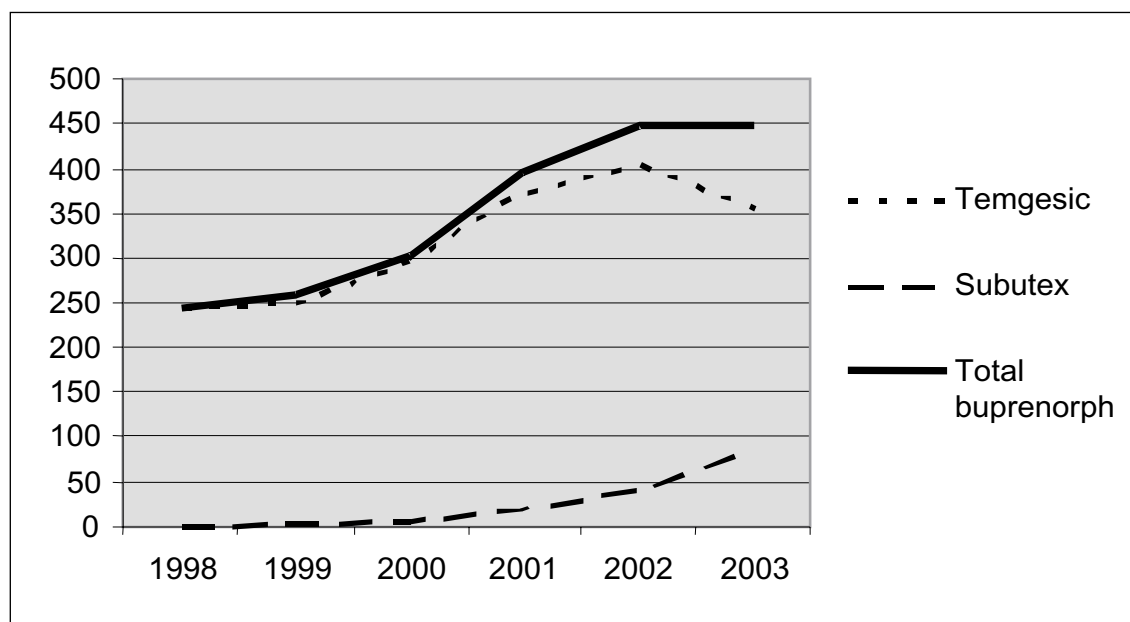
## 11.2 Abuse of buprenorphine

Buprenorphine abuse in Norway was described as early as 1989, when the first few cases were detected (Waal 1989). However, recent systematic documentation is limited to annual drug seizure reports from the NCIS and an ongoing treatment study (Kornør et al. 2004). SIRUS conducts annual surveys of drug use patterns among users of the needle exchange service in Oslo, but it has not yet added buprenorphine to its list of substances. Similarly, buprenorphine has not yet been included in the standard screening programme at the Norwegian Institute of Public Health's Division of Forensic Toxicology and Drug Abuse. However, the substance was detected in three autopsy cases in 2003, where buprenorphine screening was specifically requested. It is unknown whether the deceased were MAR patients or illicit buprenorphine users.

Unpublished data from the NCIS show a marked increase in the number of buprenorphine seizures from 1998 to 2003 (figure 6). It is assumed that these figures reflect the development of the illicit buprenorphine market, although the seizure-abuse ratio remains unknown. The number of tablets seized each year is variable, depending on the customs authorities' success in detecting attempts at illicit buprenorphine import (table 6). For instance, 1434 Subutex tablets were seized in one single case in 1999, and one of the 2002 Temgesic seizures contained 50,000 tablets. Suppliers of Subutex to the abuse arena seem to include opioid addicts who have had monthly supplies of Subutex prescribed in Denmark by Danish physicians. Many of these patients allegedly finance their trips to Denmark by selling part of their supply on the illicit market. Danish health authorities have recently put a stop to the practice of Danish Subutex prescription to Norwegian patients, and this is expected to have an impact on the NCIS statistics for 2004.

Preliminary 18-month follow-up data from the ongoing study of short-term buprenorphine maintenance treatment shows that twelve 12 out of 21 participants (57 per cent) who were not currently in any kind of substitution therapy and had submitted urine specimens, had tested positive for buprenorphine. According to self-reports, one half of the participants had taken buprenorphine sublingually only, while it was injected by the other half. Cannabis and sedatives seemed to be the most frequently used drugs together with buprenorphine.

Figure 6. Number of buprenorphine seizures in Norway 1998 – 2003



Source: NCIS

Table 6. Number of buprenorphine tablets seized in Norway 1998 – 2003

	1998	1999	2000	2001	2002	2003
Temgesic	514	5589	4096	7143	56919	3330
Subutex	0	1443	7	40	194	295
Total buprenorphine	5450	7286	4164	7192	57141	3677

Source: NCIS

## Chapter 12. Alternatives to prison targeting drug using offenders

### 12.1 Introduction

All illicit dealing with drugs is illegal in Norway. This applies to production, import, sale and use. Long prison sentences are imposed for the sale of large quantities of heavy illegal drugs, while the sale of small quantities is often penalised by a few months' imprisonment. Penalties for the possession of small quantities intended for personal use range from fines to suspended prison sentences. The most serious drug crimes involving the import or sale of large quantities of heroin or central stimulants are subject to the most severe penalty under Norwegian law, which is 21 years' imprisonment. The maximum penalty has very seldom been applied. However, sentences of several years in prison are handed down fairly frequently, often to people who themselves have a serious drug or alcohol problem. It is estimated that about 50 per cent of the prison population have serious drug problems.

### 12.2 Political, organisational and structural information

#### 12.2.1 National policy and strategy

The relationship between sanctions and treatment was a much-debated topic throughout most of the twentieth century. The treatment optimism of the 1950s and 1960s was superseded in the following decades by a clear desire to distinguish sanctions from treatment, partly because it was found that the provision of treatment within the penal context had no significant impact on recidivism compared with conventional incarceration (Hauge 2001). However, since 1970 there has been a clear growth in the crime rate in Norway, as in many other countries. This growth has been linked to both drug crimes and crimes against property, theft in particular. The increase in crimes against property is probably connected with, and to some extent secondary to, drug abuse. During the last decade this situation has led to growing support, in Norway as elsewhere, for sanctions that include treatment. Those providing treatment for drug and alcohol problems and employees in the judicial system discovered at an early stage that the same persons repeatedly appeared in both systems. The need for collaboration and coordination has been an issue for many years.

In recent years, such coordination seems to have become a distinct part of Government strategy. This is primarily evidenced in the Government's Action Plan 2003-2005 (chapter 1.2), which favours, among other things: *"increasing the number of sentences under section 12 of the Norwegian Act on the Execution of Sentences and considering the introduction of the "sentenced to treatment" option, c.f. the "drug courts" in the USA"*. However, such tendencies can hardly be regarded as "a national strategy". They are as yet no more than policy trends – which may eventually be developed into a clearer strategy.

The Department of Correctional Services at the Ministry of Justice and the Police, which also functions as the central administrative unit for correctional services, is responsible for the development of treatment options, both within the prison system and as an alternative to incarceration. A committee consisting of representatives from various ministries has been set up as part of the work to develop a model for "drug courts" in Norway (chapter 1.1).

There are no regional bodies working specifically on the coordination of punishment and treatment,

nor are there any specific strategies for such coordination in any of the regions. This may be a consequence of the relatively strong centralisation of criminal administration in Norway.

### **12.2.2 Legislation**

The following acts can provide the basis for alternatives to imprisonment:

1. Act no. 25 of 22 May 1981: Act relating to Legal Procedure in Criminal cases (Criminal Procedure Act)
2. Act no. 10 of 22 May 1902: The General Civil Penal Code (The Penal Code)
3. Act no. 21 of 18 May 2001: Act relating to the Execution of Sentences (Execution of Sentences Act)

The first of these acts regulates the possibilities before a case comes to court (pre-trial stage), the second regulates the actual adjudication (trial stage) and the third provides for alternatives after adjudication (post trial stage).

Section 69 of the Criminal Procedure Act permits waiver of prosecution if such special circumstances exist that the prosecuting authority on an overall evaluation finds that there are weighty reasons for not prosecuting the crime. Waiver of prosecution is contingent on the absence of disagreement on the question of guilt. Specific conditions may be stipulated of the type discussed below applying to suspended prison sentences, including mandatory treatment. The probation period is two years.

The Penal Code contains provisions governing the type of penalty, the most important ones in this context being community sentences and suspended prison sentences.

#### **Community sentences pursuant to section 28a**

The three main measures embraced by community sentences are: service that benefits the community and programmes and other measures conducive to the prevention of new crime. In the preparatory works to the Act, the Ministry of Justice stressed that the penal area in which community sentences could be imposed corresponded to the upper level of a suspended sentence and the lower level of a custodial sentence. Community sentences can be imposed for crimes carrying a maximum sentence of six years' imprisonment provided that the convicted person consents and that the penal intention does not contra-indicate the application of a non-custodial sentence. The court shall impose a sentence of between 30 and 420 hours and a maximum execution period of one year (unless there are strong grounds for extending the execution period).

To ensure optimum individualised solutions, the probation and aftercare service has been put in charge of deciding the exact content of the sentences on the basis of an assessment interview. The probation service shall place particular emphasis on measures that can develop the convicted person's ability to counteract his or her pattern of criminal behaviour. As a general rule, both the programme and the treatment will only be carried out if the convicted person so wishes.

#### **Suspended prison sentences pursuant to sections 52-54**

This form of penalty entails a deferment of the execution of the sentence – usually with a probation period of two years, during which the convicted person must not re-offend. Various additional conditions may also be stipulated; the convicted person may, for example, be required to abstain from taking drugs or alcohol and, if necessary, seek treatment for drug or alcohol problems. The intention is that community sentences will replace some of the previous suspended prison sentences.

The Execution of Sentences Act contains specific provisions relating to alternatives to incarceration and to community sentences (post-trial). Most important in this context are:

- Section 12: Serving of sentence in an institution
- Section 16: Serving of prison sentences outside an institution

- Section 42: Release on parole
- Sections 53-59: Closely regulate various factors regarding community sentences

The Execution of Sentences Act came into force on 1 March 2002 and replaced the former Prisons Act. Section 12 of the Act allows for the transfer of inmates from prisons to treatment institutions. This provision is not explicitly related to problems with drugs or alcohol but is in practice applied primarily to this group.

As a general rule, some of the sentence will have been served in prison prior to transfer to a residential treatment institution for completion of the sentence. In exceptional cases the convicted person will be allowed to serve the whole sentence in a treatment institution. The maximum institutionalisation period is normally 12 months, but exceptions may be made in special cases.

*Section 16* of the same Act allows for the serving of sentences outside a residential institution. The prerequisites for this are that at least half of the sentence has been served in prison and that the inmate has a fixed abode and is in employment, education or similar. Conditions such as remaining drug-free or seeking treatment during the sentence may be stipulated.

*Sections 42 – 45* concern parole. The granting of parole will depend on the inmate's behaviour while in prison. Prisoners will most often be released after two thirds of the sentence has been served, but may also be released half way through the sentence. The convicted person will be on parole for the remaining period of the original sentence. During the parole period, he or she may be required to keep appointments with a probation officer, in a sober and drug-free state. Conditions such as remaining drug-free or seeking treatment during the parole period may also be stipulated in this context.

*Section 53* specifies the content of community sentences. The correctional service has been given fairly extensive powers to determine an appropriate content, and will among other things "place particular emphasis on measures that may develop the convicted person's ability to counteract his or her pattern of criminal behaviour". Here too, drug use is often a central factor. *Section 55* allows for the prohibition of drug and alcohol use during the sentence and *section 56* allows for the control of this by urinalysis, blood tests or breathalysing. These control measures may also be used if a prohibition on drugs and alcohol prohibition is one of the conditions for suspending a prison sentence (*section 28* of the Penal Code).

None of these Acts deals specifically with alternatives to prison for people with drug or alcohol problems, but all of them can be applied to this group. *Section 12* of the Execution of Sentences Act is the provision that is primarily applied in practice.

### **12.2.3 Public debate**

In Norway there has been relatively little debate about the expediency of criminalising the use and sale of drugs. The matter has been raised in professional treatment and criminological circles, but only to a fairly limited extent in the public arena and to very limited extent in the Norwegian parliament, where there is a majority against any change of policy in this respect. The significant increase in intravenous drug use during the 1990s failed to generate any far-reaching public debate. There is unease in many quarters about the revitalisation in recent decades of the desire to link treatment to sanctions in the context of increasing drug and alcohol problems. This issue has been discussed in detail in the Nordic countries, with Norway contributing in NAD publication no. 40 (2001).

Proposals for drug courts have attracted interest during the past year and provoked both positive and negative reactions. Individual statements have been made both for and against the proposals, but there has been no clear-cut party-political debate on the matter. However, the proposals have not as yet been made public (1 September 2004). See Chapter 1.1.

### **12.2.4 Implementation structure**

The implementation of treatment as an alternative to incarceration depends on the alternatives involved. Overall responsibility lies with the central administration of the correctional services.

Transfer to a treatment institution pursuant to section 12 of the Execution of Sentences Act is subject to application from the client, often with the assistance of the prison's social counsellor. Decisions to transfer are made by the prisons, which follow up the clients if they violate the conditions, for example by taking drugs or absenting themselves from the institution without leave. In such cases measures are agreed on between the treatment institution and the prison, which often results in the client's return to prison for completion of sentence. If the client follows the treatment programme without relapse, there is little follow-up from the prisons and everything is left to the treating institution. The probation and aftercare service is very little involved in this type of transfer. Appeals can be made against rejections of applications for transfer pursuant to section 12.

Suspended sentences under the supervision of the probation service existed previously as a sanction but, with the exception of special programmes for persons convicted of drunk driving, they have been virtually discontinued following the reform of 2002. Today, drunk drivers are often given a suspended one-year sentence with a special treatment programme under the auspices of the probation service. At present there seems to be no systematic monitoring system for cases where sentences are suspended on the condition that the client seeks help for his or her drug or alcohol problem. Police follow-up is the nearest we get, but they are only involved in the event of criminal recidivism.

Community sentences are followed up by the probation service, which is also responsible for finding a suitable content for the sentence in the form of work or other programmes. Follow-up of community sentences now constitutes a major part of the probation service's work.

Waiver of prosecution is generally followed up by the police. In practice, no action is taken as long as the client is not apprehended for a new crime.

In some cases release on parole is followed up by the probation and aftercare service but in general there is no particular supervision.

### **12.2.5 Funding**

In cases where clients are transferred to a treatment institution pursuant to section 12 of the Execution of Sentences Act, the institution will finance the treatment if it is publicly financed. Treatment in other institutions is financed directly by the Department of Correctional Services.

Treatment in connection with waiver of prosecution, suspended prison sentences, community sentences and parole is financed by the entities that would have paid had the treatment not been an alternative to incarceration – primarily the public health service.

## **12.3 Interventions**

### **12.3.1 Pre-trial**

Section 69 of the Criminal Procedure Act authorises the prosecuting authorities to waive prosecution even where guilt has been proven. This may be conditional upon treatment and is never done without the consent of the person involved. Indirect pressure may, however, be exerted in that the prosecuting authority can decide to prosecute if the conditions are not accepted.

We have no good overview of the actual application of these conditions. A survey of crimes and offences reported in 1997 showed that six per cent of violations of the Act relating to Medicines

ended in waiver of prosecution, but we do not know to what extent this was linked to treatment – in which case it could be regarded as an alternative to incarceration. In all probability it concerns just a small number of cases (Hauge 2001). There is no systematic arrangement for this option, nor any follow-up other than that provided locally, in particular by the police. The probation service is rarely involved in monitoring compliance with the conditions stipulated for waiver of prosecution.

A trial project called “Ungdomskontrakt” (Youth contract) was conducted from May 2001 to December 2003 in six Norwegian towns and in a district of Oslo, following a Danish model. A total of 54 contracts were signed during this period. The youth contract was offered as a condition for waiver of prosecution. An agreement was entered into between the young person involved and a parent on the one hand, and the police and municipality on the other. The target group specified by the Director General of Public Prosecutions was young people between the ages of 15 and 18 who had committed several criminal offences (processed concurrently) for which the prosecution would have demanded a custodial sentence of less than six months. Drug use was the most usual offence, followed by theft or aggravated theft. The general terms and conditions of the contract bound the teenager not to commit further criminal offences for a period of two years. The contracts also contained specific terms and conditions adapted to the individual teenager’s problems, such as follow-up of school, leisure-time activities, urinalysis, curfew and conciliation in conflict resolution boards. Only in a few cases was treatment for drug or alcohol problems one of the conditions. The municipal authorities were in charge of most of the follow-up under way. If new offences were committed, a police lawyer would consider the question of prosecution. In the event of non-compliance with the individual terms and conditions, the teenager would first be given a caution and then, in the case of repeated breaches, the whole contract would be reassessed. Sixteen of the 54 contracts were broken.

The trial project was concluded and no further decisions have been made about keeping the youth contract as a future method of treating offences. An evaluation concluded that it was successful in many respects, but there was no possibility of comparison with corresponding groups without such contracts. In some places there were considerable problems recruiting clients due to police opposition (Egge 2004).

### **12.3.2 Trial stage**

Two legal provisions are applicable here: community sentences and conditional suspended prison sentence. As from 1 March 2002 community sentences have replaced suspended sentences under supervision and community service. Conditional suspended sentences are still applied independently.

#### **Community sentences**

Since community sentences are relatively new it is difficult to draw any conclusions regarding the extent to which they have been applied to drug users or the impact they have had on this group.

A report on these sanctions drawn up at the education centre for prison and probation staff (KRUS) (Højedahl and Kristoffersen 2004) provides some insight into their application and content. In 2003 a total of 1,352 community sentences were handed down, but only 22 per cent of these were for crimes in which the most serious offence was a drug offence. Of the 786 sentences completed in 2003 the average age of the convicted persons at the time of sentencing was 27. The average number of sentence hours imposed was 86 and the average execution period was 146 days.

The same report showed that almost 80 per cent of the hours imposed was used for service benefiting the community. Such service consists primarily of unpaid practical work such as maintenance, painting, carpentry and similar, for various organisations and for the public sector, municipal authorities in particular. Only six per cent of the community sentence hours were spent on programme activities, mostly implemented under the auspices of the probation service. These activities com-

prised education, structured interviews and/or training of skills, in particular through the use of manualised cognitive programmes for behavioural change, partly in relation to criminal behaviour and partly in relation to drug or alcohol problems. The remaining hours were used for individual interviews with probation service staff, assessment and treatment, the latter accounting for a mere two per cent.

The probation service is responsible for supervising the implementation of community sentences. If the conditions are not complied with, for example by failure to keep appointments, turning up under the influence of drugs or alcohol, leaving the country or displaying destructive behaviour in a group situation, the correctional service may impose sanctions, in the first instance summoning the offender for a serious talk and a caution. New conditions may also be set for execution of the sentence. In the event of further non-compliance the correctional service may bring the case before a court to decide whether to implement part of the subsidiary custodial sentence. While 786 sentences were registered as fully served in 2003, requests were made for 89 cases to be converted to imprisonment due to non-compliance with the conditions and/or new criminal acts.

Community sentences are not considered very relevant for heavy drug users in unstable life situations, partly because this form of penalty is contingent upon a relatively high degree of stability, and partly because the follow-up period is too short and has extremely limited treatment opportunities beyond those offered by the probation service.

Community sentences are primarily funded by the Department of Correctional Services. Treatment not covered by the correctional services – in this case out-patient treatment – is paid for in the normal manner by the health services.

### **Suspended prison sentences**

Today, suspended sentences have a somewhat narrower area of application since suspended sentences under supervision are now included under community sentences. Suspended sentences will therefore be used for less serious offences, i.e. the lower end of the scale for previously suspended sentences. The court determines a probation period, normally two years.

A fundamental condition of a suspended sentence is that the convicted person does not commit new criminal acts during the probation period. The convicted person may be ordered to report to the police at specified times. A number of special conditions may also be imposed. The most important in this connection are:

- that the convicted person abstain from using alcohol or other intoxicants or narcotic substances;
- that the convicted person undergo treatment to counteract the use of alcohol or other intoxicants or narcotic substances, in an institution if necessary;
- that the convicted person complete an alcohol treatment programme, cf. subsection 6 first paragraph second sentence;
- that the convicted person take psychiatric treatment, in an institution if necessary;
- that the convicted person stay in a home or institution for up to one year.

The prosecuting authorities are responsible for monitoring compliance with the conditions. Non-compliance may entail partial or complete serving of the prison sentence, or a new probation period decided by the court, with new conditions attached. The statistics for 2000 show that sentences with special conditions account for only a small percentage of total suspended sentences. This also applies to sentences for drug abuse. Out of a total of 1,772 suspended sentences for drug offences, abstinence conditions were attached to only five, while 20 were made conditional on treatment (SSB 2003a).

In 1996, a trial project was initiated in five counties in Norway involving an alcohol treatment programme as a possible condition for suspension of sentence. It is still a trial scheme and has been



nationwide since 2003. The target group consists of persons convicted of driving with a blood alcohol concentration of 0.15 per cent or higher or for repeated drunk driving, and who have a drinking problem. A total of 331 sentences conditional on alcohol treatment were executed in 2003. Nine per cent of these were terminated due to non-compliance with conditions. Alcohol treatment programmes are also offered as part of a prison programme (75 programmes completed in 2003). There are no corresponding programmes for persons arrested for driving under the influence of drugs.

### **12.3.3 Post-trial**

The most important alternative here is the possibility of transfer to a treatment institution pursuant to section 12 of the Execution of Sentences Act. Other options involving an alternative to prison are the possibility of serving part of the sentence outside an institution pursuant to section 16, and parole pursuant to sections 42-45 of the same Act.

#### **Transfer to a treatment institution**

Transfer is contingent on prior assurance of a place in the treatment institution in question and an assessment by the prison that takes account of safety and security and the inmate's ability to comply with the rules and conditions of a section 12 sentence. Transfers are normally made from prison, but in special cases a convicted person may be allowed to serve the whole sentence in a treatment institution. As a general rule, transfers are made towards the end of the sentence, but earlier transfers are also possible. Admission to treatment institutions must be on a residential basis and treatment will not normally last for more than one year. Exceptions may, however, be made.

The target group here is prison inmates with rehabilitation needs that cannot be met by the prison service. In practice this refers to all users of illegal drugs. A study of case processing and the administrative application of section 12 (Curtis and Øyen 1997) reviewed background data of section 12 sentences. The typical "section twelver" is described as: male, aged 31-45, sentenced to between six months and two years for a drug offence, and transferred from closed prison to a drugs treatment facility.

The prison system has no official approval scheme for section 12 institutions, but makes an individual assessment of each institution's ability to provide adequate treatment for the inmate in question and its suitability as part of the execution of a penal sentence. Factors to be evaluated when assessing an institution include the existence of adequate control procedures, 24-hour security, professional qualifications, a professionally sound structure and relevance for the applicant (Juss-Buss 2003).

When a convicted person is transferred to an institution, the institution takes over control. The institution's internal sanctions system is applied in the event of minor disciplinary offences. The institution has a duty to report any non-compliance with the conditions for the sentence (for example, the use of drugs or alcohol or late return from leave) to the prison. Serving the remainder of the sentence in prison is a possible sanction in such cases. There is no special arrangement for monitoring of the treatment by the correctional services.

It is not easy to draw any general conclusions about the methods of treatment used in section 12 sentences since decisions in this respect are left completely to the individual institutions and there are no guidelines. Substitution therapy with methadone or buprenorphine may be relevant in a section 12 sentence, but would be subject to the normal inclusion procedures for such treatment.

#### **Serving of sentences outside institutions**

Section 16 of the new Execution of Sentences Act was intended to introduce a more differentiated system of non-custodial options. The target group in this case is inmates who display a particularly positive development, have served at least half of their sentence in prison and have rehabilitation

needs that cannot be met in prison. A fixed abode and employment, education or similar are pre-requisites. Drug and alcohol use may be controlled by urinalysis and unannounced home visits. The threshold for return to prison will generally be low for this type of sentence.

This provision has rarely been applied. In 2003 only four transfers of this kind were made. This is probably due to the fact that the scheme was only introduced on 1 January 2003 and is still very new. In the longer term we may see much more extensive use of this scheme, which provides good opportunities for treatment, also outside institutions.

### **Parole**

Parole used to be granted regularly, but in 1999 certain restrictions were introduced. The most important one is the requirement for a concrete evaluation of the risk of re-offending, which means that inmates with many previous convictions will be denied parole more frequently than previously. Behaviour while serving the sentence also plays a role. Parole may also be denied if criminal acts are committed while in prison.

Parole may be made conditional on treatment, for example for drug and alcohol problems. We have found no statistics to indicate how often this happens, but we have a clear impression that it is unusual to stipulate treatment in an institution as a condition for parole.

It may also be made conditional on the client turning up sober and drug-free for appointments with the probation service. If this condition is not complied with, the conditions may be made stricter, with a prohibition against all use of drugs and alcohol. The extent to which such measures are used is unknown.

### **Treatment in prison**

Even if it is marginal to this report, we note that some prison units have been specially developed with a view to the treatment of inmates with drug abuse problems. This applies in particular to the open prison - Hassel prison – which has 26 places. The inmates themselves apply for places (Hammerlin and Kristoffersen 1998). Most of the staff there are prison officers with special training and instruction in this field, and the approach is largely group-based, with various manualised, solution-focused programmes for behavioural change. Non-compliance with the conditions will usually entail return to an ordinary prison.

In addition, a number of other prisons make increasing use of so-called programme activities. Two of the programmes explicitly target drug users: "My choice" (nine programmes implemented in 2003) and "Drug and alcohol programmes in prison" (12 programmes implemented in 2003). The latter is based on the Canadian programme OSAPP (Offender Substance Abuse Pre-Release Program).

Since 1992, Oslo prison has been running a special project with 20 places, in collaboration with the Tyrili treatment foundation. This project, called "the pathfinder", was made permanent in 1995. It allows for motivated inmates with drug abuse problems and serving long sentences to receive treatment in a special unit in the prison. The treatment is divided into three phases, with the first two (each lasting 3-4 months) being spent in prison (day release for work is allowed in phase 2). Phase 3 involves transfer to an external institution pursuant to section 12, followed where appropriate by voluntary treatment after release. For many this means a transfer to one of the Tyrili foundation's residential communities.

The treatment and control staff during the two prison phases are prison officers with special training and guidance from the Tyrili foundation.

**12.3.4 Scope of schemes providing alternatives to prison. Some trends**

Trends in sanctions pursuant to section 12 of the Execution of Sentences Act

Of the various options described above for treatment instead of prison, it is easiest to obtain an overview of the extent of use of the so-called section 12 sentence. Table 7 below shows the use of this type of sentence in recent years.

*Table 7. Number of days served, average daily number of persons serving sentences pursuant to section 12 and average number of transfers annually pursuant to section 12 in the period 2000-2003.*

Year	Number of days served pursuant to section 12	Average daily number of persons serving sentences pursuant to section 12	Average number of transfers annually pursuant to section 12
2000	28,148	77	167
2001	30,853	85	150
2002	35,397	97	252
2003	34,402	94	246

*Source Central Administration of the Department of Correctional Services*

The number of persons serving sentences pursuant to section 12 is small, possibly no more than a tenth of all those who could have benefited from this option (estimate made with ref. to Friestad C. Hansen 2004).

On the basis of the treatment statistics for 2002 it would seem reasonable to assume that in 2002 about 400,000 treatment days were used for the treatment of drug users in institutions qualified for the serving of section 12 sentences. This type of sentence is primarily given to offenders with drug problems, and less than 35,000 section-12 treatment days were served by drug users in the same year.

On this basis it may be assumed that about eight per cent of the treatment capacity in 2002 intended for long-term treatment of drug users in institutions was used for clients sanctioned pursuant to section 12 of the Execution of Sentences Act.

There may be several reasons for the infrequency of transfers pursuant to section 12. It may be difficult to find an appropriate treatment facility with available capacity. There is probably a great deal of scepticism in prisons about the benefits of such transfers, which may well restrict the number of inmates actually offered this option. It is also conceivable that many relevant imprisoned abusers are not motivated for admission to a treatment institution in view of the challenges this may involve. Some may wish to serve their sentence and get it over with. Very many receive short sentences and are used to serving them, and there is scarcely enough time for a transfer for treatment before the release date.

Politically, it has been stated on several occasions that section 12 sanctions are an important tool in the prevention of recidivism and relapse into drug use. There has been a strong desire to see the scheme used much more widely than has hitherto been the case. This was stated clearly in the Government's 2002 action plan to combat drug and alcohol-related problems, but the hoped-for increase does not yet seem to have been realised.

**Other significant trends**

It is difficult to assess developments in other types of alternatives to prison sentences. However, some information can be obtained indirectly by looking at developments in the penalties recently imposed for different types of drug crimes. We looked in particular at penalties for drug crimes sub-

ject to section 162 of the Penal Code, but not classified as serious. On the whole this concerns the sale of small quantities of drugs. Sentencing trends for these crimes are shown in Table 8 below.

Table 8. Sentencing trends for drug crimes pursuant to section 162 of the Penal Code, with the exception of serious drug crimes

	Total	Community service or community sentences per cent	Fines per cent	Suspended prison sentences per cent	Custodial prison sentences per cent	Combination of suspended/ custodial prison sentence per cent	Total custodial prison sentences per cent
1990	1326	-	6.0	51.5	29.8	10.9	40.7
1992	1497	6.2	14.2	44.6	25.5	6.9	32.4
1995	2060	4.5	18.7	44.0	24.0	6.6	30.6
1997	2512	4.1	19.7	49.0	20.3	4.5	24.9
1998	3614	2.4	39.0	36.0	14.3	5.1	19.4
1999	4292	2.5	42.7	34.4	13.4	4.8	18.3
2000	4106	3.4	44.3	30.0	14.5	5.6	15.3
2001	7065	2.4	54.9	28.0	10.4	4.1	14.5
2002	5382	3.1	54.3	25.0	10.9	4.7	15.6
2003	5710	5.4	49.6	26.8	12.3	3.8	16.1

Source: Statistics Norway, Criminal justice statistics

Table 8 shows that there has been a considerable increase in the use of fines. The percentage of prison sentences has fallen correspondingly. This applies in particular to suspended but also to custodial sentences. Since the same period also saw a considerable increase in the total number of cases, the relative reduction shown in the table is not reflected in the absolute figures. Most probably there has been a shift from custodial to suspended sentences, and from suspended sentences to fines for intermediate level drug crimes. In absolute terms the increase in the number of fines is formidable.

If this relative reduction had not taken place in the use of prison sentences for less serious drug offences, the number of drug users in prison would have been significantly higher. Thus, a gradual reduction in the use of prison sentences for certain types of drug crime appears in the statistics as a type of alternative to prison. In practice fines are given instead of prison. However, a fine is patently not treatment. Very many abusers are in an unstable financial situation based on crimes against property, the sale of illegal drugs, prostitution and/or social security. In view of this, it seems obvious that a fine will neither help drug users to deal with their problems nor will it reduce crime.

There have been no significant developments in respect of sanctions for the least serious drug-related offences, i.e. violation of the Act relating to Medicines. The percentage of these cases ending in fines has remained stable, at about 90 per cent.

Custodial sentences are still the rule for serious drug crimes and are handed down in about 90 per cent of all cases. There has, however, been a shift from purely custodial sentences to partial sentences, whereby part of the custodial sentence is suspended. The use of partial sentences in the case of serious drug crimes has increased from about five per cent ten years ago to 20 per cent in 2003. This too may indicate a shift from custodial sentences to penal sanctions outside prison as a real alternative. Even if no thorough survey has been carried out, it is generally assumed that a large number of persons convicted of serious drug crimes are themselves serious drug abusers.

## **12.4 Quality control**

### **12.4.1 Guidelines**

No central or regional guidelines have been drawn up for the various alternative forms of treatment to prison for drug users. There are, however, guidelines for persons convicted of drunk driving. These take the form of alcohol treatment programmes with well-monitored and relatively clearly described content and implementation. A report is currently being prepared for the Ministry of Justice, among other things with a view to drawing up guidelines for institutions admitting clients pursuant to section 12 of the Execution of Sentences Act.

### **12.4.2 Studies and research**

During the last ten years, there has been little research in Norway into the effect of treatment as an alternative to incarceration for offenders with drug problems. The most relevant work is a study of section 12 published in 1998. Persons convicted in the period 1980 -1984 were studied for criminal recidivism eight years later (Ødegård and Amundsen 1998). Clients who had received treatment in institutions pursuant to section 12 were compared with clients who had served normal prison sentences. The percentage convicted for violation of the Act relating to Medicines (an indicator of personal use) was roughly the same in both groups – about 95 per cent. The part of the study population transferred for treatment pursuant to section 12 had a slightly more charged criminal history in terms of the number of convictions and total time spent in prison than the others, but the difference between the groups was insignificant. The study showed a 90 per cent recidivism rate after eight years in section 12 clients, compared with 81 per cent in the non-treatment group. The conclusion was that transfer for treatment had no demonstrable effect on recidivism. What effect any transfer had on the incidence of drug use was not investigated directly. A weakness in the study was the absence of a control group of convicted drug users who had applied for, but not received, treatment during their sentences.

The education centre for prison and probation staff (KRUS) is a separate institution under the Department of Correctional Services' central administration. It has its own research division, which carries out studies and research into the various aspects of correctional services, including some of the measures that provide an alternative to prison. KRUS is currently engaged in analysing the different aspects of treatment as an alternative to prison pursuant to section 12 of the Executions of Sentences Act, and the implementation of community sentences pursuant to section 28a of the Penal Code. One of the objects is to identify what can be done to improve the efficacy of the treatment on both drug use and recidivism. There is political will to use this form of treatment more widely since similar measures have proven effective in other countries.

There is no research in Norway showing that treatment pursuant to section 12 has a different effect on the extent of drugs and alcohol use than any other type of drugs and alcohol treatment. The dropout rate from treatment pursuant to section 12 has been about 20 per cent, which is low compared with many of the voluntary treatment schemes.

We know little about the impact on crime trends of the various measures constituting alternatives to incarceration.

### **12.4.3 Training**

There is no centrally organised training of personnel for treatment institutions admitting clients on an alternative to prison basis. We assume that some of the institutions admitting these clients provide guidance and supervision for personnel in view of the special situation with clients who are receiving a form of enforced treatment. There is, however, no overview of this.

## **Chapter 13. Public nuisance: definitions, trends in policies, legal issues and intervention strategies**

### **13.1 Introduction**

Norway has a wide range of legislative provisions allowing for intervention vis-à-vis drug users. Unquestionably, the most important provision is the one making any association with substances classified by international conventions as narcotic or psychotropic a criminal offence – including use thereof and possession for personal use. This provision empowers the police to arrest, and the prosecuting authorities to instigate criminal proceedings against, drug users. This criminalising of drug use also sanctions surveillance and undercover work by the police in areas and public premises where they suspect that drugs are being used.

Other forms of undesirable behaviour on the part of drug users may also give the police grounds to intervene pursuant to general provisions that do not target drug users specifically. The Vagrancy Act of 1990 ordains that begging is a criminal offence, while the Police Act of 1995 authorises the police to issue exclusion orders for specific areas and expel or remove unwanted persons in the interests of public order. And of course, if drug users commit criminal acts, the police are empowered to take action against them as they would against others.

### **13.2 From drink problems to drug problems**

Drug use as a public nuisance problem is a relatively new phenomenon. Until the mid-1960s, drug use in Norway primarily involved the abuse of substances prescribed by doctors, in particular morphine and barbiturates. Chronic consumers of morphine and other pharmaceutical products obtained these substances legally and usually took them at home, thus posing no threat to public order. Until the mid-1960s – and throughout most of history – most public nuisance in connection with drugs and alcohol abuse had been related to alcohol, resulting in the enactment of several laws empowering the police to intervene to uphold public order. The consumption of alcohol in public places was (and still is) prohibited by the Alcohol Act, and until 1970, being under the influence of alcohol in public places was a criminal offence pursuant to the Vagrancy Act. The police were thus empowered by law to arrest anyone consuming or under the influence of alcohol in a public place. Until 1970, anyone with several arrests for intoxication in the course of one year could be sentenced to from one to three years in a forced-labour or treatment institution for alcoholics. Alcoholics could also be forcibly committed to a treatment institution pursuant to the Sobriety Act if their abuse was causing "obvious harm to themselves or their surroundings".

A legislative amendment in 1957 sanctioned decisions to commit abusers not only of alcohol but of "other intoxicant or narcotic substances" to treatment institutions pursuant to the Sobriety Act – which meant that also drug addicts could now be forcibly committed. The reason for the amendment was the major curtailment of doctors' prescription rights through an amendment of the Physicians Act in the same year, with the result that a number of people who had previously obtained the substances via their doctors now had to obtain them illegally. In 1961, a former hospital was converted into an institution for the treatment of people with such problem use. This institution admitted both compulsory and voluntary clients.

Right up until the latter half of the 1960s therefore, public nuisance cases were primarily linked to alcohol consumption, and only to a very minor degree to drugs. Subsequently, however, drug use – first by young people, later also by adults – and other drug problems have been perceived as the main problem, in terms of health, crime and public order. While alcohol-related problems have undeniably been perceived as being serious, they have nevertheless been overshadowed by drug problems.

The type of drug user in the public focus has varied over time, as has the type of behaviour specifically targeted by control measures, which we will discuss below. In general, this has been a function of what people have perceived as threatening or problematic behaviour at any given time, partly determined by the descriptions of the situation in the mass media. In the 1960s and the first half of the 1970s the use of drugs, especially cannabis, among young people was perceived to be the most serious problem. In the latter half of the 1970s and the early 1980s attention shifted to the somewhat older intravenous drug users – many of whom were recruited from among young drug users who had continued the habit into adulthood – and to problems relating to crimes against property and other forms of antisocial behaviour in this group. In the second half of the 1980s – after HIV became more widespread among needle users – the fight against infection became central, resulting in a certain redefinition of this group as care clients rather than antisocial and criminal cases. In the 1990s, with the eruption of the acid house scene, attention turned to the teenagers belonging to this scene. Today – now that the house scene has more or less died out – we are once again predominantly concerned with public order problems among those in an advanced phase of problem use, in the form of violence and drug pushing within the drug milieu, and the nuisance caused thereby to the public, who are exposed to begging and congregations of addicts in the city centres.

### **13.3 Cannabis use among young people**

Cannabis use gained its first foothold in Norway among a group of young people who had gathered in Slottsparken (park near the royal palace) in Oslo in the summer of 1966. In the following years it became a recurring pattern for groups of young people – including many from outside Oslo – to converge on Slottsparken during the summer months, indulging frequently in drug use. This was a source of irritation and anxiety to the public, not least because many of the young people involved seemed to lose all interest in school and work, and because cannabis was regarded as the gateway to other and more dangerous drugs. In an attempt to break up the scene and prevent the use of drugs, police and guardsmen would expel the young people from the park at regular intervals on the grounds that they were in a private, royal area. The young people, however, quickly returned.

In 1968 the use of narcotic substances was made a criminal offence, allowing the police to intervene and punish persons who only used the substances. However, this did not stop the young drug users congregating in the park, and other methods had to be resorted to. In the summer of 1971 the lawns were ploughed up and in 1972 they were temporarily fenced in, forcing the young people to find free areas in other parts of the city. Sporadically, however, they still congregated in Slottsparken, and to facilitate surveillance the police set up an observation post on the top floor of a neighbouring hotel.

By the beginning of the 1970s the use of drugs was an established part of the youth scene, and two user groups seemed to have taken form. On the one hand, there were the relatively well-adjusted young people using cannabis in protected environments, generally not visible to either the public or the police. Most of this group indulged only sporadically, and phased out the cannabis habit as they became older. On the other hand, there were the young people with less protected lives who come from more problematic backgrounds, who also used other substances than cannabis and often in public places under police surveillance.

The normal control measures of arrest and punishment were not considered adequate in respect of the latter group, and there were calls to provide treatment for members of this group in order to bring the problems under control. Traditional psychiatric treatment institutions and institutions treating alcoholics, however, were opposed to admitting young drug users as patients – because they often failed to comply with the institution's rules and were perceived as troublesome for both the other patients and staff. This situation led to the gradual appearance of other types of institutions and remedies for young drug users, such as farm communes, which aimed to provide housing, work, education and alternative living environments, work training measures under the auspices of the employment service or special young people's psychiatric departments attached to psychiatric hospitals. However, although these options attracted fairly large numbers of applicants, they were far too few in number and they were unable to address the needs of this group for help. Moreover, many young people – including those most in need of help – were unwilling to use them.

The fact that many of those most in need of help were excluded or excluded themselves from the available treatment options prompted a new wave of demands for compulsory treatment, in the early 1970s. The Mental Health Care Act, the Child Welfare Act and the Sobriety Act all include provisions for forcible commitment to institutions, but these provisions were seldom applied to drug users. Not until the advent of the new Social Services Act in 1991 and the new Child Welfare Act in 1992 was drug abuse mentioned specifically as grounds for commitment, and even these provisions were not very frequently applied.

The most usual form of compulsory treatment was through the criminal justice system, where people convicted of illegal association with drugs might be sentenced to custodial prison sentences, but the prison authorities were allowed to transfer the persons in question to treatment institutions after some of the sentence had been served in prison. However, many institutions were reluctant to admit patients of this type for the same reasons as they rejected their applications for admission on a voluntary basis, i.e. that they were not motivated for treatment and were a burden on the institution and the other patients. Thus, despite strong demands for the increased use of compulsory treatment, this option was rarely used. Compulsory measures were primarily administered by the criminal justice system – and the treatment apparatus was generally unwilling to take over this function.

### **13.4 Adult problem drug users**

Following the steep rise from the mid-1960s to the mid-1970s, youth drug use seemed to stagnate in the second half of the 1970s and the 1980s. It is true that the number of people charged with drug offences rose again from the late 1970s and almost quadrupled from 1979 to 1990, but it was adults over 21 who were responsible for this rise. There was in fact a decrease rather than an increase in the number of young people being charged for drug offences.

This reflected the change in the nature of the drug problem. In addition to the youngest drug users – many of whom only took drugs for recreational purposes on a few occasions during a short period in their youth – a group had emerged of young adult chronic users. Most members of this group had been recruited into drug use as teenagers during the 1960s and early 1970s and had continued the habit into their twenties and later. These drug users were harder cases than the younger users as they frequently had problems in relation to family, school and work, a longer history of drug abuse, and most had progressed to harder drugs, often taken intravenously.

This group was primarily perceived as a threat because its members were believed to be responsible for a substantial number of traditional crimes of theft. These chronic problem users were largely dealt with by measures meted out by the criminal justice system. Even if it could not be proven that they had committed a crime against property, they could still be arrested and punished for violation of the drugs legislation. In the case of female drug addicts yet another problem presented itself in



that many of them became pregnant. The amendment to the Social Services Act in 1995 allowed for pregnant drug users to be forcibly committed to an institution for the duration of their pregnancy if "the abuse is of such a nature as to make it highly probable that their child will have a birth defect." In practice this provision is rarely applied and, if applied, it is usually in connection with alcohol abuse.

In addition to the recruitment of younger drug users, this group of chronic adult drug addicts has also experienced a certain inflow of traditional alcoholics. The distinction between alcoholics and drug addicts has become increasingly blurred with the gradual intermingling of the two groups in the 1980s and a resultant major increase in so-called poly-drug users. They formed a lumpenproletariat perceived not so much as criminals but more as polluters of city centre areas. They drank and injected in back streets and parks, discarded their bottles and needles after use and spent the nights in stairways and doorways, constituting a nuisance and source of irritation to the general public. Though frequently arrested by the police they were usually let off with a fine and carried on as usual as soon as they were released from custody.

### **13.5 The HIV epidemic among intravenous drug users**

The first cases of AIDS were diagnosed in intravenous drug users in 1985, resulting in a change of attitude towards this group. The most important measure was to ensure the users access to clean needles. In Norway, disposable syringes can be purchased over the counter in pharmacies. The desire on the part of the police and others to make syringes a prescription product in the hope of preventing intravenous drug use failed to get the necessary support. In Oslo, however, where the majority of injecting users were to be found, some city centre pharmacies stopped selling disposable syringes to drug addicts, resulting in a run on syringes in other city centre pharmacies and inconveniencing other customers. Under this pressure the other pharmacies also stopped sales, and in 1988 it became extremely difficult to obtain syringes, and the practice of needle sharing became more prevalent.

In view of this and the rapidly increasing number of HIV-positive drug addicts, the executive committee of Oslo City Council decided in 1989 to establish a needle bus, which would provide information about how to prevent the transmission of HIV and distribute needles. However, drug addicts soon began to congregate in large numbers around the needle bus, many of them injecting their drugs in the surrounding area. This led to protests from local residents and the bus had to be moved regularly. The bus was closed down in 2003 and needles are now distributed from a fixed location in Oslo city centre in connection with a low-threshold health station. (See chapter 7.2).

Whatever the reasons, the spread of HIV among needle users seemed to be under control by the early 1990s. This problem was overshadowed in the late 1990s and early 2000s by growing overdose mortality. Compared with other countries, the overdose mortality in Norway seemed to be among the highest in Europe, and in addition, there was also widespread morbidity. In view of this, a special field health care service was established for drug addicts in Oslo with the aim of providing treatment for harm caused by drug use (chapter 7.2). Moreover – in the face of strong opposition – it was decided to establish an injection room scheduled to open in January 2005, where addicts may inject themselves under medical supervision. The main rationale for this was to limit the high morbidity and mortality rate among drug addicts due to the unhygienic use of needles and overdoses (chapters 1.1 and 1.4). However, the injection room is also seen as a way of limiting the injection of drugs and discarding of needles in public places, a practice causing nuisance and annoyance to the general public.

### 13.6 The 'house scene' and ecstasy use among young people

As stated above, from the mid-1970s onwards there was a shift in focus from young drug users, whose drug use seemed to have stabilised, to adult users, especially injecting drug users, and their problems. Towards the end of the 1990s, however, there was a new surge of teenage drug use with the arrival of the so-called "house scene" in Norway. Up to several hundred teenagers would gather for informal dance parties in closed-down factories or warehouses, where "new" drugs such as ecstasy, amphetamines and occasionally also GHB were consumed. These substances were, moreover, often referred to as "party drugs", making them seem like something harmless that teenagers could take when they got together for a party. There also seemed to be a simultaneous and growing acceptance among young people of the "most traditional" illegal drug, cannabis.

Even though these parties were held in isolated surroundings, causing little disturbance to the general public, they were nevertheless perceived as a public nuisance in themselves. They were organised in premises that were not designed for such events, without the necessary permits and with inadequate security. Accounts in the press generated great alarm about the use of drugs and the risks relating to the house scene. The police tried to keep an eye on these parties and arrest anyone selling or taking drugs, where necessary stopping the parties. However, by the beginning of the 2000s the house scene had died out by itself – as the hippy scene had done thirty years earlier.

### 13.7 Drug addicts as a pollution problem

Since the late 1980s, as drug use spread in the adult population, groups of adult users had taken to congregating in different parts of the city, including Oslo's main street, Karl Johans gate, which runs from the Royal Palace to the central station. At first they gathered in Egertorget, where drugs were sold as well. Local businessmen and passers-by found this troublesome and frightening, so, in order to break up the scene, the police intervened and chased away the drug users. However, this only led to them moving further down the main street until they were driven away again – to Kirkeristen and then to a location in front of a pharmacy in Jernbanetorget. From the late 1990s, they occupied a small park area near the central railway station, which gradually became a general gathering place. This was where they now injected – instead of in doorways and back streets as previously – and heroin and other drugs were sold. The authorities were aware of what was happening but this time decided to keep an eye on the scene through surveillance cameras and patrols, rather than break it up – although they did intervene in the event of open drug pushing. The fact that addicts gathered in a specific place under police surveillance was considered an advantage as it allowed ambulance personnel to get there quickly in the event of overdoses, the care organisations knew where the addicts were and could carry out their work there, and the police had an overview and could intervene if they deemed it necessary.

The "Plata", as the area was called, in many ways became what we call an "open drug scene" (chapter 1.4). There were, however protests from the businesses in the area, who thought it was frightening away customers, from people working in the neighbourhood who felt frightened and from the general public who considered it a legalisation of drug use. Moreover, some of the addicts started to spread into other, more frequented areas – not least the entrances to underground stations and the main streets of Oslo, to beg and finance their drug habit.

There were reactions from many quarters to the fact that the first thing tourists saw on arrival in Oslo was the "Plata" drug milieu and the large numbers of addicts begging in the city's most frequented areas. It was also claimed that other drugs, such as hashish and amphetamines, were being pushed, targeting young users in particular and making the area a recruitment centre for drug use. Furthermore, it was claimed that there were signs of increasing violence in the milieu.

In the late winter of 2004, Oslo City Council therefore decided that the area should be cleared and that something should be done about the beggars. One of the arguments for this was that other shelters had gradually been provided for addicts in other parts of the city and that they should be told to go there. In June of the same year, the police took action, arresting anyone found selling or in possession of drugs and ordering the rest to stay away – under threat of being arrested and punished for drug use or for begging, which was prohibited by the Vagrancy Act. The police also tried to prevent the addicts congregating in other places by ordering them to disperse, with reference to the Police Act of 1995, which authorised the police to issue exclusion orders for certain areas and refuse entry, expel and remove persons if they deemed it necessary to stop or prevent disturbances and keep the peace, or to stop or prevent law-breaking. The impact of this action is still uncertain – previously such actions have merely led to a relocation of the scene.

## References

### Chapter 1

- Justis- og politidepartementet. Ot. Prp. Nr. 56 (2003-2004). *Om midlertidig lov om prøveordning med lokaler for injeksjon av narkotika (sprøyteromsordning)*
- Justis- og politidepartementet. Ot.prp. nr. 90 (2003-2004) *Om lov om straff (straffeloven)*
- Ministry of Social Affairs, 2003. *The Norwegian Government's Action Plan to Combat Drug- and Alcohol related Problems 2003-2005* (Abbreviated, unofficial version)
- Sosialdepartementet, 2002. *Regjeringens handlingsplan mot rusmiddelproblemer 2003-2005*
- Sosialdepartementet, 2004 Redegjørelse: *Rusmiddelsituasjonen i Norge, juli 2004*

### Chapter 2

- Hordvin O. (edit.). *The drug situation in Norway 2003*. Annual report to the EMCDDA, SIRUS 2003
- Hordvin, O. (edit). *The drug situation in Norway 2002*, Annual report to the EMCDDA, SIRUS 2002
- Prosjektet, Oslo 2004. *Årsmelding 2003*
- Rusmiddelstaten i Oslo. *Rustrender i Oslo. Førre Var rapport nr.2 mai 2004*
- Stiftelsen Bergensklinikkene. *Rustrender i Bergen. Førre Var rapport nr. 3 mai 2004*

### Chapter 3

- Achenbach, T. M. (1991a). *Manual for the Child Behavior Checklist and 1991 profile*. Burlington: University of Vermont, Department of Psychiatry
- Achenbach, T. M. (1991b). *Manual for the Teacher's Report Form and 1991 profile*. Burlington: University of Vermont, Department of Psychiatry
- Bøe, B. (2001) *Kjentmann. Håndbok for skolefolk som møter elever med rusproblem*. Stiftelsen Bergensklinikkene, Bergen
- Belliveau, J. M. & Stoppard, J. M.(1995). *Parental alcohol abuse and gender as predictors of psychopathology in adult children of alcoholics*, *Addictive Behaviours*,20(5), pp.619-625
- Black, D., Bucky, S.& Wilder-Padilla, S. (1986).*The interpersonal and emotional consequences of being an adult child of an alcoholic*. *International journal of Addiction*,21, pp.213-231
- Christensen HB (1994). *Børn i familier med alkoholmisbrug -En redegjørelse for relationen mellem familieinteraktion og barnets psykosociale tilpasning*. Psykologisk skriftserie. Aarhus Universitet
- Gresham, F.M.,& Elliott,S.N. (1990). *Social Skills Rating System*. Circle Pines, MN: American Guidance Service
- Holth, P. Bye, E.K. *Evaluering av ansvarlig vertskap i Bergen 2000-2003* SIRUS rapport nr. 1/2004
- Kashubeck, S. (1994). *Adult children of Alcoholics and Psychological Distress*. *Journal of Counselling & Development*, vol.72, pp.538-543
- Miller, D. & Jang, M. (1977). *Children of alcoholics: A 20 year longitudinal study*. *Social Work Research and Abstracts*, 13, 2329

- Olson, D., Portner, J., & Lavee, Y. (1985). *FACES III*. University of Minnesota, Department of Family Social Service
- Stubbs, J., Crosby, L., Forgatch, M. S., & Capaldi, D. M. (1998). *Family and peer process code: A synthesis of three Oregon Social Learning Center behavior codes (Training manual)*. Available from Oregon Social Learning Center; 160 East 4th Avenue, Eugene, OR 97401
- West, M.O. & Prinz, R.J. (1987). *Parental alcoholism and childhood psychopathology* Psychological Bulletin, 102,204218

## Chapter 4

- Egeland, A. *Hepatitt C blant sprøytebrukere. En undersøkelse om forekomst og risiko for hepatitt blant sprøytebrukere i Oslo*. Rusmiddeletaten Oslo Kommune, 2003
- Ravndal E. Lauritzen G. Melberg H.O. *Hvilken nytte, for hvem og til hvilken kostnad? En prospektiv studie av stoffmisbrukere i behandling*. SIRUS rapport nr. 4/2003
- Strømsmo S. *Feltpleien i Oslo – en undersøkelse om brukertilfredshet Rusmiddeletatens kompetansesenter*. Oslo 2002

## Chapter 5

- Helsedepartementet 2004. *Bedre behandlingstilbud til rusmiddelmisbrukere. Perspektiver og strategier*
- Krook, A. L., Brors, O., Dahlberg, J., Grouff, K., Magnus, P., Roysamb, E. et al. (2002). *A placebo-controlled study of high dose buprenorphine in opiate dependents waiting for medication-assisted rehabilitation in Oslo*, Addiction, 97, 533-542
- Ravndal E. Lauritzen G. Melberg H.O. *Hvilken nytte, for hvem og til hvilken kostnad? En prospektiv studie av stoffmisbrukere i behandling*. SIRUS rapport nr. 4/2003

## Chapter 6

- SINTEF Unimed 2003. *Helsetilstand hos tunge rusmiddelmisbrukere*
- SINTEF Unimed 2003. *Helsetjenester for tunge rusmiddelmisbrukere*

## Chapter 7

- Rusmiddeletaten i Oslo. *Årsberetning 2003*

## Chapter 8

- Kriminalpolitisenralen. *Årsmelding 2003*
- Statistisk sentralbyrå. *Kriminalstatistikk 2002*
- Statistisk sentralbyrå. *Kriminalstatistikk 2003*

## Chapter 10

- Kriminalpolitisenralen. *Årsmelding 2003*
- Kriminalpolitisenralen. *Halvårsmelding 2004* (only web [www.kripos.no](http://www.kripos.no))

## Chapter 11

- Espgren, O. & Kristensen, Ø. (2004). *Methadone or buprenorphine to opioid addicts? A randomized controlled intention-to-treat clinical trial*. *Tidsskrift for Norsk Legeforening, in press (EN abstract)*

- Haga, W., Skutle, A. & Blix, O. (2002). *Subutex-supported rehabilitation in Health Region 3. Trying out a community-based model and 1-year follow-up* Stiftelsen Bergensklinikkene, Bergen (NO only)
- Kornør, H., Waal, H. & Ali, R. (2004). *Short term buprenorphine maintenance treatment for young adults in outpatient counselling*. Manuscript in progress
- Krook, A. L., Brors, O., Dahlberg, J., Grouff, K., Magnus, P., Roysamb, E. et al. (2002). *A placebo-controlled study of high dose buprenorphine in opiate dependents waiting for medication-assisted rehabilitation in Oslo, Norway*. *Addiction*, 97, 533-542
- Skretting, A. & Dammen, C. (2004). *From methadone- to medicine-assisted rehabilitation*. *Nordic Studies on Alcohol and Drugs* Nordic Studies on Alcohol and Drugs Vol. 21 2004 p. 162-166
- Waal, H. (1989). *Buprenorphine (Temgesic). A new agent for abuse* *Tidsskrift for Norsk Legeforening*, 109, 1326-1327 (EN abstract)
- Waal, H., Krook, A. L., Welle-Strand, G., Espegren, O., Hole, R., Lazaridis, K. B. et al. (2001). *A national model for drug-supported rehabilitation of opiate addicts*. *Tidsskrift for Norsk Legeforening*, 121, 2301-2305 (EN abstract)

## Chapter 12

- Curtis Y, Øyen M. *Fengselslovens §12 – en undersøkelse av saksbehandlingen og forvaltningens praktisering av fengselslovens §12*. Juss-Buss stensilserie nr. 73/1997
- Egge M. *Forsøk med ungdomskontrakten – en alternativ soningsform rettet mot unge lovbrøyttere*, Politihøgskolens Forskning, 2004
- Friestad C. Hansen, ILS. *Levekår blant innsatte*. FAFO-rapport 429. Oslo 2004
- Hauge R. *Behandling som alternativ til straff for rusmiddelmissbrukere i Norge*. NAD-publikasjon nr. 40. Nordiska nämnden för alkohol- och drogforskning. 2001
- Høj Dahl, T. og Kristoffersen R. *Evaluering av innføringen av samfunnsstraffen*. *Dokumentasjon & debatt nr 1/2003*. Kriminalomsorgens utdanningscenter 2003
- Høj Dahl, T. og Kristoffersen R. *Samfunnsstraffene 2003: resultater og utfordringer*. *Dokumentasjon & debatt nr 2/2004*. Kriminalomsorgens utdanningscenter 2004
- Juss-Buss 2003. *Fangehåndboka, 4. utg.* Oslo 2003
- Sosialdepartementet 2002. *Regjeringens handlingsplan mot rusmiddelproblemer 2003-2005*
- Skardhamar T. *Levekår og livssituasjon blant innsatte i norske fengsler*. Institutt for sosiologi og retts sosiologi, Universitetet i Oslo 2002
- Statistisk sentralbyrå. *Kriminalstatistikken 1990*. Tabell 38. 1992
- Statistisk sentralbyrå. *Kriminalstatistikken 1992*. Tabell 34. 1995
- Statistisk sentralbyrå. *Kriminalstatistikken 1995*. Tabell 43. 1997
- Statistisk sentralbyrå. *Kriminalstatistikken 1998*. Tabell 34. 2001
- Statistisk sentralbyrå. *Kriminalstatistikken 1999*. Tabell 34. 2002
- Statistisk sentralbyrå. *Kriminalstatistikken 2000*. Tabell 34. 2002
- Statistisk sentralbyrå. *Kriminalstatistikken 2000*. Tabell 40. 2002
- Statistisk sentralbyrå. *Kriminalstatistikken 2002*. Tabell 34. 2003
- Statistisk sentralbyrå. *Kriminalstatistikken 2003*. Tabell 34. 2004
- Statistisk sentralbyrå. *Statistisk årbok 2003* Tabell 167. 2004
- Sosialdepartementet 1996. *St. meld. Nr. 16 (1996-97) Narkotikapolitikken*
- Ødegård E. Amundsen A. *§12-soning – om effekten av å implantere behandling innenfor en straffekontekst*. *Nordisk alkohol- og narkotikatidsskrift* 1998 (1): 98:21-31

## Lists

### List of Standard Tables and Structured Questionnaires referred to in the text

St.table 05:	Acute/direct drug-related deaths
St.table 06:	Evolution of acute/direct drug-related deaths figures
St.table 07:	National prevalence estimates of problem drug use
St.table 08:	Local prevalence estimates of problem drug use
St.table 09:	Prevalence of hepatitis b/c and HIV infection among injecting drug users
St.table 10:	Syringe exchange, distribution and sale
St.table 11:	Arrests/reports for drug law offences
St.table 12:	Drug use among prisoners
St.table 13:	Quantity and number of seizures of illicit drugs
St.table 14:	Purity at street level of illicit drugs
St.table 15:	Composition of tablet sold as illicit drugs
St.table 16:	Price in euros at street level of illicit drugs
St.table 18:	Overall mortality and causes of death among drug users
St.table 21:	Drug-related treatment availability

Str. Questionnaire 22: Universal school-based prevention

Str. Questionnaire 23: Harm reduction measures to prevent infectious diseases in injecting drug users

### List of Graphs used in the text

Figure 1	Number of traffic cases received by the NIPH/SRI 1990-2003, where there was suspicion of being under the influence of alcohol or other drugs. ....	18
Figure 2	Drug finds (mainly illegal) in road traffic cases received 1990-2003. ....	18
Figure 3	Drug-related deaths 1996 – 2003 .....	33
Figure 4	Substance findings in correctional services cases received in the period 1998 – 2003. ....	40
Figure 5	Total number of drug seizures 1995 - 2003.....	43
Figure 6	Number of buprenorphine seizures in Norway 1998 – 2003.....	49

### List of Tables used in the text

Table 1	Percentage in age group 21-30 who have used different illegal drugs, ever or during the last six months, Norway .....	17
Table 2	Percentage of intravenous drug users of persons infected by HIV or AIDS, with injecting risk behaviour, by year of diagnosis .....	35
Table 3	Field health care activities in Oslo .....	38
Table 4	Penal sanctions by crime type. Absolute figures and percentages. 2003 .....	39
Table 5	Number of seizures 2000 – 2002 broken down by the most common substances.....	44
Table 6	Number of buprenorphine tablets seized in Norway 1998 – 2003.....	49
Table 7	Number of days served, average daily number of persons serving sentences pursuant to section 12 and average number of transfers annually pursuant to section 12 in the period 2000-2003. ....	58
Table 8	Sentencing trends for drug crimes pursuant to section 162 of the Penal Code, with the exception of serious drug crimes.....	59

## **Most common abbreviations used**

NCIS	The National Criminal Investigation Service
NIPH	Norwegian Institute of Public Health
SIRUS	Norwegian Institute for Alcohol and Drug Research
SSB	Statistics Norway



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