SIRUS
Norwegian Institute for Alcohol and Drug Research

European Monitoring Centre
for Drugs and Drug Addiction

2010 NATIONAL REPORT (2009 data) TO THE EMCDDA
by the Reitox National Focal Point

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

Authors

Editor:

Odd Hordvin, SIRUS

Reference group:

Astrid Skretting and Jostein Rise. SIRUS.

Co-authors:

Chapter 1: Ministry of Health and Care Services

Chapter 2: Sturla Nordlund, SIRUS

Chapter 3: Maj Berger Sæther, Directorate of Health

Chapter 4.1: Ellen J.Amundsen, SIRUS

Chapter 6.1: Hans Blystad, Norwegian Institute of Public health

Chapter 6.2: Einar Ødegård, SIRUS

Chapter 7: Hilgunn Olsen, SIRUS

Chapter 9.1: Reid Stene, Statistics Norway

Chapter 10: Tormod Bønes, National Criminal Investigation Service

Authors of selected issues:

Chapter 11: Gabrielle Welle- Strand and Martin Blindheim, Directorate of Health

Chapter 12: Helge Waal, Norwegian Centre for Addiction Research

Translation: Allegro Language Services, Bergen

Contents

Summary–main findings

Legal framework

A new framework consisting of regulations and guidelines for opioid substitution treatment of heroin addicts, as laid down in the Act relating to specialist health services, entered into force on 1 February 2010. The new framework is intended to contribute to equal provision of opioid substitution treatment throughout the country, and to help to integrate such treatment with the rest of the health service. The age limit no longer applies, but before someone is offered opioid substitution treatment, an assessment must always be carried out of whether the patient will benefit from treatment without such medication.

The Health Personnel Act and the Act relating to specialist health services were amended with effect from 2010. The amendments, which concern the follow-up of children as family members, have strengthened children's legal status and ensured that minor children of parents with mental illness, drug/alcohol dependency, serious somatic illnesses or injuries receive better follow-up when their parents receive medical help. In 2009, the Directorate of Health produced a circular on the amendments concerning children as family members and an information brochure for children.

In 2010, the Norwegian Medicines Agency has added eleven new drugs to the list of narcotic substances, cf. the Regulations relating to narcotics. These are: GBL, 1,4 –butandiol, fenazepam, Bentazepam, Bk-MBDB, Bromo-Dragonfly, 4-fluoride amphetamine, mCPP, MBDB, mefedrone and PMMA. With the exception of mCPP, all the drugs were previously covered by the derivative rule in the same regulations.

National strategies, policies and interventions

Norway's drugs and alcohol policy is set out in the Government's action plan for the drugs and alcohol field. The plan, which was introduced in 2008, was intended to run until 2010. However, this autumn the Government proposed extending the plan period until the end of 2012. The plan covers a broad range of measures, from universal and early prevention to treatment, rehabilitation and harm reduction, as well as addressing problem drug and alcohol users' need for complex and coherent services over time. The overriding goal is to reduce the negative consequences of drug and alcohol use for individuals and for society as a whole. The Directorate of Health publishes an annual status report on the progress of the Action Plan, and it will sum up the plan period as a whole when it is over. All in all, the plan covers 147 concrete and relatively extensive measures that address the challenges in the drugs and alcohol field. Almost all of these measures will be initiated in 2010.

Drug and/or alcohol dependency involves complex problems and a need for long-term follow-up. This requires cooperation within and between agencies. Unfortunately, however, treatment is often interrupted when it is necessary to move from one level to the next and between sectors. A trial system involving coordinating representatives has proven to help ensure more coherent, accessible and individually-adapted services for persons with drug and/or alcohol problems. This leads to greater social inclusion and improves the ability to cope with life. The trial will continue until the end of 2011.

Through a number of municipal services and voluntary services, the Government has intensified its efforts to help those with drug and/or alcohol dependency who are most in need of help. The same applies to early intervention measures targeting people who are at a particular risk of developing drug or alcohol problems. All the regional health authorities have adopted regional plans that describe the long-term overriding goals for the services and the way they are organised.

The grant scheme for municipal efforts in the drugs and alcohol field has been substantially strengthened in recent years. The purpose is to encourage increased efforts and more

targeted services in the municipalities. Funding has been allocated for the establishment of emergency drug and alcohol treatment facilities in three counties. In Bergen, Oslo and Drammen, the emergency facilities will be aimed at the target group as a whole. The treatment facility at the Oslo accident and emergency service will also include a service targeting young people under the age of 23.

Major shortcomings were pointed out in connection with the Norwegian Board of Health's nationwide inspection of municipal provision of social services for people with drug and alcohol dependency. System audits carried out by the Board of Health in 2009 uncovered that the Internal Control Regulations are not complied with in many cases, which results in users not receiving decisions about services, and statutory measures such as individual plans not being implemented. Lack of cooperation results in users not receiving coordinated help, so that neither individual users nor society as a whole benefit sufficiently from the efforts of the various agencies involved.

Economic analysis

There is no comprehensive overview of the total cost of measures relating to drugs and alcohol. Among other things, this is due to the fact that expenses are registered according to needs, not diagnoses. In 2010, the state and the municipalities will have direct expenditure totalling EUR 625 million on the drugs and alcohol field. This amount does not include expenditure on social benefits, National Insurance benefits and expenses relating to crime. Up to and including 2010, the Action Plan has resulted in an overall increase in allocations to the drugs and alcohol field of EUR 104 million.

Further follow-up of the drugs and alcohol field

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

The Government will present a white paper in 2011 that will address the main challenges and strategies in relation to drugs and alcohol policy and form the basis for further efforts. The white paper will discuss important issues, including prevention and early intervention, the treatment of people with drug and alcohol dependency, penal sanctions, activation measures and housing initiatives. The Coordination Reform will also be very relevant to the contents of the white paper, including the reform's proposals to increase the focus on the role of the municipalities and strengthen preventive services.

Drug use in the general population

The surveys of the Norwegian population's use of alcohol and drugs are normally carried out every five years. The most recent survey was carried out by SIRUS in autumn 2009. The proportion of respondents who answered that they had ever tried cannabis increased from 8.5 per cent in 1985 to more than 16 per cent in 2004, but it had fallen again to less than 15 per cent in 2009. The fact that lifetime prevalence has fallen during the past five years is very surprising given the cumulative nature of the variable.

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

since 2004 in the proportion that have used cannabis during the last 30 days in the under-35 age group. In 2004 it was 4.5 per cent, while in 2009 it was reduced to 2.1 per cent. This percentage seems to have increased among those over the age of 35. Furthermore, the last year prevalence has also decreased in the 15-34 age group, from a proportion of 9.6 per cent in 2004 to 7 per cent in 2009. The decline in the youngest group could also be a sign of a change in the longer term and it may be a contributory factor to the above-mentioned observed decline in lifetime prevalence at the population level.

For the other drugs, the lifetime prevalence has been more stable and at a relatively low level. In 2009 the prevalence for amphetamine is highest, almost four per cent, followed by cocaine at 2.5 per cent. The proportions that state that they have taken drugs other than cannabis during the last year have also been relatively stable during the period 1994 to 2009. The figures are very small, however, which means chance can result in relatively large changes. In 2009 the prevalence of all drugs did not exceed one per cent.

Among problem drug users

So far, Norway only has estimates for problem users of heroin. In 2008, the estimate was 9,450 (lower limit 5,600, higher limit 10,400). About 15 per cent of these only smoked the drug. The number of injecting users has been stable. For 2009 the estimate is around 10,000 (8,700 – 12,300). Heroin is still the most common drug injected, but, for some, amphetamine is the main drug. Work has now started on calculating how many problem users there are according to the general definition from the EMCDDA. This means that an estimate must be produced of the number of prolonged/regular users of opioids, cocaine or amphetamines who do not inject these drugs.

Drug-related infectious diseases

The incidence of HIV among injecting drug users has remained at a stable, low level, with about 10 to 15 cases reported per year. A high level of testing, great openness regarding HIV status within the drug user community, combined with a strong fear of being infected and strong internal justice in the milieu, are assumed to be important factors. In addition, many of the sources of infection in the milieu have disappeared due to overdose deaths or have been rehabilitated through substitution therapy or other forms of rehabilitation. However, the extensive outbreaks of hepatitis A and B in the late 1990s and early 2000s, and the high incidence of hepatitis C in particular, show that there is still extensive needle sharing among this group.

Among patients included in the national substitution programme, the status survey for 2009 shows that, for the country as a whole, an average of 61 per cent were hepatitis C antibody positive, roughly the same proportion as the year before. This is lower than expected, and the explanation is probably that the percentage with unknown status was high. In two regions where the percentage with unknown status was low, the proportion of hepatitis C-infected was almost 80 per cent.

Drug-related deaths

Both the figures from Statistics Norway (SSB) and the National Crime Investigation Service (Kripos) figures appear to indicate that a certain stabilisation of the number of drug-related deaths has occurred in the last five to six years. The number of overdose deaths per year remains high, however. Even though the number of clients in opioid substitution treatment has increased strongly during the same period, this has not led to a marked decline in the number of deaths.

The proportion among those over the age of 50 appears to have increased, while the proportion of deaths among the youngest age groups has remained stable. In 2008, the 30-plus age group accounted for 72 per cent of the deaths, while 48 per cent of the deaths were among those aged 40 years or more, and 14 per cent of the deaths were among those aged 50 years or more.

One of the main questions relating to the high overdose figures in Norway is why so many people inject opioids – and what to do about it. One factor is the large proportion that use other intoxicants such as alcohol and benzodiazepines in addition to heroin, which increases the risk of an overdose. Another is the weak tradition for initiating targeted measures to prevent overdoses in Norway. The use of maintenance treatment with methadone and/or buprenorphine has primarily been linked to rehabilitation. In addition, the fact that Norway introduced opioid substitution treatment relatively late can also be an important explanation. When the programme started in Norway in 1998, several large Western European countries had already been offering such treatment for more than 10 years, some even longer. A fourth factor that could be significant is that very few people die of HIV/AIDS in Norway. According to Statistics Norway, only nine fatalities in the period 2006 to 2008 were caused by AIDS with problem drug use as the underlying cause. In other countries, far more drug users die of HIV/AIDS.

Drug crimes

In 2009, 39,280 drug crimes were registered, which is an increase of five per cent from 2008, but down in relation to 2006-2007. The different types of violations of the Act relating to medicines and the General Civil Penal Code increased, except for the most serious types of drug crimes, which remained relatively stable at around 1,100 cases.

As regards penal sanctions, drug crime is still the biggest group of crimes, and drug crime was the primary offence in 43 per cent of all types of criminal cases in 2009, a slight reduction from 2008. However, this percentage can result in a skewed picture of the prevalence of this type of crime. The clear-up rate for drug crimes is higher than for all other types of crime, which means that drug crimes account for a far bigger proportion of crimes among convicted persons. Reported violations of the Act relating to medicines, which account for about half of all drug cases every year, (almost) always lead to criminal prosecution of the offender, which entails a charge and results in some form of penal sanction. On the other hand, many judgments may serve to conceal drug crimes, also relatively serious ones, for which the person in question is not sentenced because only the primary offence, i.e. the most serious offence, is identified in the statistics.

In 2009, 12,862 penal sanctions were imposed with drug crime as the primary offence. Of these, 57 per cent were penal sanctions imposed pursuant to the General Civil Penal Code, while 43 per cent were imposed pursuant to the Act relating to medicines. The latter mainly relate to the use and possession of small quantities of drugs. Only 1,191 were convictions by a court resulting in unconditional prison sentences, while 335 convictions resulted in partly unconditional and partly suspended sentences. As regards use as the primary offence, the proportion resulting in prison sentences was three per cent (94 of 3,383 penal sanctions), while it was four per cent in 2007. Even if only a small proportion are given prison sentences for the use of drugs, they are as many as 100 to 150 annually in absolute figures.

Drug markets

On the basis of seizures, the availability of cannabis still appears to be great. The number of seizures is higher than ever before and the geographical spread seems to be great. Cannabis was seized in all the 27 police districts in 2009, and twenty police districts have made more seizures than in 2008.

In 2009, the number of seizures of methamphetamine was higher than for amphetamine. This situation has never been registered before. Furthermore, methamphetamine was for the first time the second most commonly found substance after alcohol in blood samples from drivers suspected of driving under the influence. Methamphetamine was found in 32 per cent of all the blood samples that were analysed for alcohol, intoxicating medicinal drugs and narcotic substances. This represents a fourfold increase since 2001. There is still reason to believe that amphetamine and methamphetamine are used interchangeably, depending on what is available on the market. There are no clear indications of a particular demand for methamphetamine.

Although the number of seizures of heroin is far lower than at the turn of the millennium, there was an increase of 25 per cent from 2008 to 2009. This increase took place in a period in which approx. 5,000 people are being treated for heroin addiction with methadone and Subutex. It cannot be precluded, therefore, that new users are being recruited to the heroin market. Heroin was found in 26 police districts, which indicates that it is widespread in the country as a whole.

As in the last few years, cocaine was seized in nearly all police districts, but the number of seizures declined from 2008 to 2009 in the majority of them. The National Crime Investigation Service claims that the decline is probably not due to changes in resource management and the targeting of typical cocaine milieus alone, and it therefore believes that the supply and geographical spread of cocaine declined in 2009 in real terms.

As for new drugs, CPP (mainly 1.3-chlorphenylpiperazine or mCPP) appears to have gained in popularity. With more than 48,000 tablets seized in 143 seizures in 2009, it has become the dominant substance in this sector. A total of 20 police districts made seizures of the drug in 2009.

The average purity of heroin base has remained largely stable in recent years. However, a potency of 25 per cent in 2009 is historically very low. Even more remarkable is the fact that the average purity of cocaine has been halved in four years, from 50 per cent in 2004 to 25 per cent in 2009. The average purity for amphetamine was about 29 per cent, and 44 per cent for methamphetamine. This represents a decline for amphetamine and an increase for methamphetamine. The purity varied greatly in 2009, from about one per cent to as much as 97 per cent.

An overview of stipulated drug prices as of May 2010 has been obtained from Oslo police district. Naturally, a price list of this kind must be treated with considerable caution. On the other hand, since the data have been collected from the same source for several years, a certain amount of comparison is possible. Compared with the previous overview from October 2008, the nominal price of a typical user dose in the Oslo area has remained relatively stable. However, there seems to have been a marked drop in price for quantities of up to five grams for both heroin and cocaine in the same period. For hash and amphetamine, the changes are only marginal.

Part A: New Developments and Trends

1. Drug policy: legislation, strategy and economic analysis

1.1 Legal framework

In order to strengthen the legal status of children whose parents suffer from mental illness, drug/alcohol dependency, serious illness or injury, the Storting passed an amendment to the *Health Personnel Act*[1] in 2009. It requires health personnel to help to identify such children at an early stage and offer them necessary follow-up. The amendments entered into force in 2010. A circular has been produced specifying and explaining the new changes. Pursuant to amendments to the Act relating to the specialist health service, health enterprises are now obliged to have personnel with special responsibility for children on wards.

In 2009, the Storting decided to make the temporary *Act relating to injection rooms*[2] permanent. Making the act permanent means that municipalities that wish to establish injection rooms have a legal basis for doing so. However, only Oslo has made use of the temporary act, and it has continued to run its injection room.

A new framework[3] consisting of *regulations and guidelines for medication-assisted treatment of heroin addicts,* hereinafter called opioid substitution treatment – OST, as laid down in the Act relating to specialist health services, entered into force on 1 February 2010. The new framework is intended to contribute to equal provision of OST treatment throughout the country, and to help to integrate such treatment with the rest of the health service. It is also a goal to strengthen user participation in OST. The age limit no longer applies, but before someone is offered OST, an assessment must always be carried out of whether the patient will benefit from treatment without OST medication. This applies in particular to young patients. The guidelines are described in more detail in Chapter 11.

New drugs regulated as narcotic substances
With effect from 24 March 2010, the Norwegian Medicines Agency has added ten new drugs to the list of narcotic substances, cf. the Regulations relating to narcotics (Regulations of 30 June 1978 on narcotic substances etc.) section 2, cf. section 3 no 2 second paragraph. The ten drugs are:

- Bentazepam
- Bk-MBDB
- Bromo-benzodifuranyl-isopropylamine (Bromo-Dragonfly)
- 1.4-butandiol
- fenazepam
- 4-fluoride amphetamine

[1] Proposition no 84 to the Odelsting (2008-2009) concerning the Act amending the Health Personnel Act etc. (follow-up of children as family members).

[2] Proposition no 59 to the Odelsting (2008-2009) concerning the Act amending temporary Act no 64 of 2 July 2004 relating to a Trial Scheme of Drug Injection Rooms (the Act relating to injection rooms) etc.
[3] National guidelines for opioid substitution treatment of opioid dependency (the Directorate of Health 2010).

- Gamma-Butyrolactone (GBL)
- 1-(3-chlorphenyl)piperazine (mCPP)
- MBDB (N-methyl-1-(3.4-methylenedioxyphenyl)-2-butanamine)
- 4-methylmethcathinon (mefedrone).

With effect from 12 November 2010 Para-methoxymethylamphetamine (PMMA) has also been added to the same list of narcotic substances.

With the exception of mCPP, all these drugs were previously covered by the derivative rule (generic approach) in the same regulations. All eleven drugs require a certificate in connection with importation or exportation. Bk-MBDB, Bromo-Dragonfly, 4-fluoride amphetamine, mCPP, MBDB, mefedrone and PMMA are prohibited pursuant to the Regulations on narcotics section 4. The fact that a drug/plant is listed as prohibited pursuant to section 4 means that it cannot be manufactured, imported, sold, used etc. unless a special permit is granted by the responsible authority.

1.2 National action plan, strategy, evaluation and coordination

1.2.1 Institutional framework, strategies and policies

The Ministry of Health and Care Services has overall responsibility for drugs and alcohol policy in Norway and for coordinating efforts involving several sectors. In addition, the Ministry of Labour, the Ministry of Children, Equality and Social Inclusion, the Ministry of Justice and the Police, the Ministry of Local Government and Regional Development, the Ministry of Education and Research, the Ministry of Transport and Communications, the Ministry of Foreign Affairs and the Ministry of Finance, plus the respective directorates and subordinate agencies, all have important responsibilities in the field.

The municipalities have a statutory responsibility for providing health and care services for their inhabitants. The framework for the municipal services is set out in the Act relating to municipal health services, the Social Services Act and the Patients' Rights Act.
Responsibility for the treatment of people with drug or alcohol problems rests with the state represented by the regional health authorities. This entails responsibility for the provision of interdisciplinary specialist treatment for problem drug and alcohol use:

- Detoxification, diagnosis, treatment (in-patient and outpatient treatment)
- Opioid substitution treatment
- Coerced treatment and the implementation of decisions on coerced treatment.

Interdisciplinary specialist treatment for problem drug and alcohol use is part of the specialist health service on a par with somatic services and mental health care services, and the Patients' Rights Act also applies to people with drug and alcohol problems.

In order to prevent drug and alcohol-related problems in Norway, emphasis is placed on binding international collaboration targeting the whole distribution chain from production to the use of drugs. The framework for Norway's international engagement is set out in a

separate position paper[4], and a dedicated strategy will be drawn up on the basis of the position paper.

The Directorate of Health is an executive and advisory body in the drugs and alcohol field. It is responsible for implementing large areas of drugs and alcohol policy. Moreover, it shall ensure that an overview of the drugs and alcohol policy is available at the regional and local level. It also administers substantial grant funding.

1.2.2 Norwegian National Action Plan on Alcohol and Drugs

Norway's drugs and alcohol policy is set out in the Government's escalation plan for the drugs and alcohol field, hereinafter called the Action Plan. The plan and its priority areas have been described in several previous national reports. See in particular NR 2008. The plan, which was introduced in 2008, was intended to run until 2010. However, this autumn the Government proposed extending the plan period until the end of 2012. The plan covers a broad range of measures, from universal and early prevention to treatment, rehabilitation and harm reduction, as well as addressing problem drug and alcohol users' need for complex and coherent services over time. The overriding goal is to reduce the negative consequences of drug and alcohol use for individuals and for society as a whole. The Directorate of Health publishes an annual status report on the progress of the Action Plan, and it will sum up the plan period as a whole when it is over.

In the following, the overall status of the Action Plan is described. Efforts in the drugs and alcohol field must be seen in conjunction with efforts to combat poverty, the Coordination Reform, the Care Plan 2015, efforts to improve housing services and efforts in the mental health field. The Action Plan has five main objectives:

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

All in all, the plan covers 147 concrete and relatively extensive measures that address the challenges in the drugs and alcohol field. Almost all of these measures will be initiated in 2010.

A clear public health perspective

The public health perspective is a key element of Norway's drugs and alcohol policy. There is a clear relationship between the use of drugs and/or alcohol and the extent of harm. The extent of negative social and health-related consequences, including illness and accidents, increases in step with the use of drugs and alcohol. Alcohol causes most harm, both socially and in terms of health. The use of illegal drugs is also associated with considerable morbidity and a high mortality rate. It is estimated that the alcohol consumption of between 66,500 and 123,000 people in Norway is high-risk, and the number of injecting drug users is estimated to be between 8,700 and 12,300.

[4]Norwegian drugs policy in international forums

Regulatory measures targeting the population, such as age limits, sales and licensing hours, taxes and sale through the State Wine Monopoly have a documented effect on alcohol consumption. A restrictive alcohol policy that regulates price and availability and covers the whole population will continue to be pursued.

The goal is to reduce the population's use of drugs and alcohol overall, with a view to reducing the total amount of harm caused. Efforts will be aimed at reducing the availability of alcohol and drugs and limiting demand for them. Early intervention targeting potential drug and/or alcohol problems will be emphasised.

Better quality and increased competence

Research and teaching in the field of drug and alcohol problems will be strengthened through the Action Plan. An alcohol and drug research programme (2007-2011) has been established under the auspices of the Research Council of Norway.

Grants are awarded to competence-raising measures for health and social service personnel and correctional service staff. In 2008, a system of dedicated drugs and alcohol advisers was established at all the county governor offices.

The seven regional drugs and alcohol competence centres and the country governors are tasked with providing, developing and disseminating expertise in the drugs and alcohol field and initiating and implementing government measures in the field in relation to municipalities, the specialist health service, the correctional service and educational institutions. As a result of the Coordination Reform,[5] the role of the municipalities will be strengthened. The competence centres have a responsibility to contribute in this context.

Interdisciplinary specialised treatment (TSB) is now included in the Norwegian Patient Register. In addition to data about individual patients in treatment, the register contains comparable data about waiting lists and activity figures.

In order to contribute to better quality and competence, the Directorate of Health has prepared guides and guidelines for the drugs and alcohol field. In addition to guidelines for opioid substitution treatment (OST), there is a guide relating to referrals to interdisciplinary specialist treatment for drug and/or alcohol problems and a guide relating to early intervention.[6]

The Directorate has also started work on developing guidelines for following up pregnant women in OST and for following up their children until they reach school age, guidelines for mapping, treating and following up patients with concurrent mental illnesses and drug and/or alcohol problems, and a guide to preventive work in schools. The Directorate of Health will also prepare guides for municipal work in the drugs and alcohol field and national guidelines for other types of treatment methods in TSB, including acute treatment and abstinence treatment.

[5] White Paper no 47 (2008-2009) the Coordination Reform. The right treatment – in the right place – at the right time.

[6] From concern to action (Fra bekymring til handling.). A guide to early interventions in the drugs and alcohol field.

Research in health and health services is one of the Government's priority areas.[7] On assignment for the Ministry of Health and Care Services, the Research Council of Norway was asked to set up a dedicated *alcohol and drug research programme* in March 2006. The overriding goal of the programme is to contribute to the development of relevant knowledge about drugs and alcohol with a view to reducing drug and alcohol problems in society. The research involves disciplines ranging from basic biomedical research to treatment and rehabilitation research and social science research. The programme has five priority research areas:

- drugs and alcohol and the workplace
- harm caused by drugs and alcohol, and consequences for third parties
- early intervention
- addictive medicinal drugs
- cannabis.

As part of the programme, an invitation to tender was issued for the establishment of a university-affiliated research centre for alcohol and drug research. The University of Oslo was awarded the assignment of establishing SERAF – the Norwegian Centre for Addiction Research affiliated to the Department of Psychiatry (affiliated to the Faculty of Medicine from 2010).

SERAF's main focus will be on clinic-based alcohol and drug research, and it will also offer teaching and academic supervision in the field. Through recruitment and education, the centre will have a national role and act as network builder in relation to alcohol and drug research in Norway (discussed in NR 2008 Chapter 1.2.2). Under the auspices of the centre, a number of research projects will contribute to increased knowledge about topics such as substitution treatment for heroin addicts, pregnant women in OST and patients with dual diagnoses.

Clinical patient-oriented research, including alcohol and drug research, is an important strategic priority area for all the regional health authorities. Combined with earmarked and, in part, performance-based research grants, this has resulted in increased research activity and researcher training in the health authorities. In 2009, the health authorities spent a total of approximately EUR 2.62(NOK 21 million)[8] of their own funds on such purposes.

Research and development work is also conducted by the National Institute of Public Health and the Norwegian Institute for Alcohol and Drug Research (SIRUS).

The Ministry of Children, Equality and Social Inclusion, the Directorate of Health/the Ministry of Health and Care Services and the Norwegian Directorate for Education and Training/the Ministry of Education and Research have joined forces to establish and finance a behavioural centre – *the Norwegian Centre for Child Behavioural Development*. The centre will engage in research, implementation, training and further development of new methods for use in work on serious behavioural problems, including drug and alcohol problems, research relating to the evaluation and development of new methods, and research on the extent and development of behavioural problems among children and young people. Through its activities, the centre shall help children with serious behavioural problems and their families to get help that is research-based, relevant, adapted to the individual and that produces effective results in relation to the current level of knowledge.

[7] White Paper no 30 (2008-2009) Klima for endring ('*Climate for change')* (the Research Report)
[8] Conversion rate: 1 EUR = NOK 8.

More accessible services and greater social inclusion

The Action Plan aims to contribute to improving services for people with drug and alcohol problems and to support the Government's work on the Coordination Reform. To make services more accessible, the capacity of interdisciplinary specialised treatment in the municipalities must be improved, including residential follow-up services, activation measures and emergency services.

Figures from the Norwegian Patient Register show an increase of 14 per cent in the number of new referrals to interdisciplinary specialist treatment from 2008 to 2009. The number of outpatient consultations and the number of people who have received in-patient treatment has never been higher than in 2009. However, the waiting time for patients with a right to interdisciplinary specialist treatment increased by seven days from 2008 to 2009. The waiting time was 78 days in 2009. A waiting list guarantee was introduced in 2008 for children and young people under the age of 23 with mental health problems or drug and/or alcohol problems. The average waiting time in 2009 was 71 days – a reduction of four days compared with 2008. In the same period, the number of new referrals increased by five per cent. In the last four months of 2009, 85 per cent of this patient group received treatment within the waiting list guarantee limit of 65 working days.

The grant scheme for municipal efforts in the drugs and alcohol field has been substantially strengthened in recent years. See Chapter 1.3. The purpose is to encourage increased efforts and more targeted services in the municipalities. Funding has been allocated for the establishment of emergency drug and alcohol treatment facilities in three counties. In Bergen, Oslo and Drammen, the emergency facilities will be aimed at the target group as a whole. The treatment facility at the Oslo accident and emergency service will also include a service targeting young people under the age of 23.

Through a number of municipal services and voluntary services, the Government has intensified its efforts to help those with drug and/or alcohol dependency who are most in need of help. The same applies to early intervention measures targeting people who are at a particular risk of developing drug or alcohol problems. All the regional health authorities have adopted regional plans that describe the long-term overriding goals for the services and the way they are organised.

The correctional services have adopted a comprehensive drugs and alcohol strategy for 2008-2011. The goal is to ensure better rehabilitation and treatment of inmates and convicted persons with drug and/or alcohol problems. By the end of 2010, a total of eleven units aimed at mastering drug and alcohol problems will have been established in Norwegian prisons. The staff of each unit is reinforced by staff from the correctional services and health personnel from the specialist health service. During stays in these units, inmates' right to necessary medical help is assessed, so that they are guaranteed further treatment for their drug and/or alcohol problems upon release.

The number of sentences served pursuant to the Execution of Sentences Act section 12[9] (see Chapter. 9.3) has also increased. In 2009, a Pathfinder prison project[10] was started for women in Bredtveit women's prison. The project will continue in 2011. It has been decided to

[9] Act no 21 of 18 May 2001 relating to the Execution of Sentences etc.

[10] Pathfinder is a project for inmates with drug or alcohol problems who wish to start a process of change while in prison. The project emphasises creating a drug and alcohol-free environment that inspires learning, growth and development. The project is run by Oslo prison and the Tyrili foundation.

extend the trial scheme of suspended sentences with a drug programme under court control (Drug Courts) until the end of 2012 in Oslo and Bergen. The legal basis for the scheme is set out in the Execution of Sentences Act. The programme is currently being evaluated.

Binding cooperation

Drug and/or alcohol dependency involves complex problems and a need for long-term follow-up. This requires cooperation within and between agencies. Unfortunately, however, treatment is often interrupted when it is necessary to move from one level to the next and between sectors. A trial system involving coordinating representatives has proven to help ensure more coherent, accessible and individually-adapted services for persons with drug and/or alcohol problems. This leads to greater social inclusion and improves the ability to cope with life. The trial will continue until the end of 2011, and 28 municipalities are participating. Work has started on documenting good models and methods that are suitable for implementation in municipal efforts in the drugs and alcohol field. The county governors' drug and alcohol advisers have been assigned particular responsibility for providing professional advice and follow-up to the municipalities. The coordination scheme for doctors is also important in relation to offering more coordinated treatment to patients and improving collaboration across disciplines and levels.

It is a goal to increase the use of municipal networks in order to facilitate the transfer of experience between municipalities. Under the auspices of the Norwegian Association of Local and Regional Authorities, a network has been established that includes the drugs/alcohol and mental health fields. The national strategy 'Obtaining housing for oneself' (2005–2007) has led to the establishment of 18 municipal networks. All of the State Housing Bank's regional offices have networks up and running that will be continued as part of the work on preventing and combating homelessness.

The use of individual plans[11] must be increased in order to ensure more coordinated services for users. The Directorate of Health has published a tips brochure that focuses, among other things, on the importance of individual plans to people with drug and/or alcohol problems. The drug and alcohol advisers are also tasked with helping the municipalities to increase their use of individual plans.

Increased user influence and greater attention to the interests of children and other family members

Family members, and children as family members in particular, are a vulnerable group. The Health Personnel Act and the Act relating to specialist health services were amended with effect from 2010. The amendments, which concern the follow-up of children as family members, have strengthened children's legal status and ensured that minor children of parents with mental illness, drug/alcohol dependency, serious somatic illnesses or injuries receive better follow-up when their parents receive medical help. In 2009, the Directorate of Health produced a circular on the amendments concerning children as family members and an information brochure for children.

Work with users and family members has been strengthened in 2010. The user organisations have been given funds to draft learning material for user representatives. On assignment for

[11] The right to an individual plan is laid down in the Act relating to social services from 1 January 2004. Both health and social services are obliged to draw up such plans when people require long-term, coordinated services.

the Directorate of Health, the Nodal Point of Self-Help has mapped and described self-help services in the drugs and alcohol field and summarised relevant research that documents the benefits of participation. There are more than 400 self-help groups in the drugs and alcohol field. The self-help services and methods will be made known among users, in the municipalities and in the specialist health service.

Expectations of the municipalities

The municipalities must view their efforts in the drugs and alcohol field in the context of work on mental health, child welfare, social housing and health and care services, as well as public health and prevention work. Efforts are now being made to make the Directorate of Health's guide to early intervention, *From concern to action* (Fra bekymring til handling), known in all municipal services, including kindergartens and schools.

Experience from inspections

Major shortcomings were pointed out in connection with the Norwegian Board of Health's nationwide inspection of municipal provision of social services for people with drug and alcohol dependency in 2005. System audits carried out by the Board of Health in 2009 uncovered that the Internal Control Regulations are not complied with in many cases, which results in users not receiving decisions about services, and statutory measures such as individual plans not being implemented. Lack of cooperation results in users not receiving coordinated help, so that neither individual users nor society as a whole benefit sufficiently from the efforts of the various agencies involved.

1.2.3 Evaluations

A number of evaluations have been initiated of grant schemes and services in the drugs and alcohol field. The results make an important contribution to the work of further developing efforts in the field. This applies to:

- Evaluation of retention in an institution without the patient's/client's consent.
- Evaluation of grants for voluntary work in the drugs and alcohol field.
- Evaluation of grants for municipal measures in the drugs and alcohol field
- A follow-up evaluation of the trial scheme involving coordinating representatives.
- Evaluation of the regional drug and alcohol competence centres.

1.3 Economic analysis

There is no comprehensive overview of the total cost of measures relating to drugs and alcohol. Among other things, this is due to the fact that expenses are registered according to needs, not diagnoses. In 2010, the state and the municipalities will have direct expenditure totalling EUR 625 million (NOK 5 billion) on the drugs and alcohol field. This amount does not include expenditure on social benefits, National Insurance benefits and expenses relating to crime. Up to and including 2010, the Action Plan has resulted in an overall increase in allocations to the drugs and alcohol field of EUR 104 million (NOK 835 million).

In 2010, EUR 8.6 million (NOK 69 million) was allocated to quality and competence-raising measures, and the following measures have been initiated or carried out:

- Drugs and alcohol advisers have been appointed at all the country governor offices. The county governor offices cooperate with the regional drug and alcohol competence centres, and the offices' efforts in the drugs and alcohol field are seen in conjunction with mental health care, public health efforts, work on social housing,

NAV's qualification programme[12] and health and care services.

- The Directorate of Health has initiated several measures to ensure better documentation and statistics relating to services for people with drug and alcohol dependency.
- A total of EUR 1.25 million (NOK 10 million) was allocated to further/continuing education in the drugs and alcohol field for municipal health and social services personnel, correctional service staff and the police. Measures have been initiated to strengthen user participation and the family member perspective in the drugs and alcohol context, including efforts to boost self-help and work among family members of problem users.
- The number of courses for doctors and psychologists at the Norwegian Centre for Addiction Research (SERAF) has been increased. A training course will be developed to make it easier to identify and treat concurrent mental illnesses and drug/alcohol problems. Work is also being carried out to improve knowledge about addictive medicinal drugs, their prescription and use.
- The lack of coordination within and between municipalities, specialist health services and other sectors is perhaps the biggest challenge we are facing. During 2010, the Directorate of Health will initiate measures aimed at boosting and spreading expertise in the provision of coordinated and comprehensive services for people with mental illnesses and/or drug or alcohol dependency. Emphasis will be placed on the interdisciplinary aspect, cooperation between health and care services and other important sectors, and user participation. The development of individual plans as a tool for achieving comprehensive and coordinated services will be important.

Municipal efforts in the drugs and alcohol field

In 2010, EUR 40 million (NOK 323 million) was allocated to municipal efforts in the drugs and alcohol field, which is an increase of EUR 7.4 million (NOK 59 million) compared with 2009. The purpose of these allocations is to increase the municipalities' capacity in the field, in order to ensure that the services offered to people with drug/alcohol problems are coordinated, accessible and individually-adapted. The grants can be spent on measures such as contact persons/coordinating representatives and follow-up services, work-related measures, residential follow-up services, local medical centres and acute services of various kinds.

The target group consists of young people with incipient drug or alcohol problems and adults and older people with extensive drug or alcohol problems. Cities and neighbouring municipalities are given priority.

The grants for municipal efforts in the drugs and alcohol field must be seen in conjunction with other measures aimed at strengthening quality and competence development.
The grants must also be seen in conjunction with mental health care, health and care services, NAV's qualification programme and social housing efforts. The Directorate of Health collaborates with the county governor offices on the allocation of grants.

It is a requirement that a plan has been drawn up for the work during the grant period. It is recommended that the plan for how the grants will be spent is integrated with the

[12] The Norwegian Labour and Welfare Service

municipality's overall drugs and alcohol policy action plan[13] and that it is seen in conjunction with the municipality's ordinary planning systems. With a view to improving the municipality's overall services, it is also a requirement that grants aimed at increasing municipalities' capacity are seen in conjunction with grants for competence-raising measures in the drugs and alcohol field and related areas.

In 2009, the allocations covered four different areas:

- approximately EUR 16.3 million (NOK 130 million) for measures targeting young people at risk and persons who need follow-up before, during and after stays in an institution or in prison,
- approximately EUR 6.3 million (NOK 50 million) for municipal OST measures aimed at improving follow-up in connection with opioid substitution treatment,
- approximately EUR 6.9 million (NOK 55 million) for low-threshold health services, including EUR 0.63 million (NOK 5 million) for dental health services,
- approximately EUR 2.9 million (NOK 23 million) was allocated to the trial scheme involving coordinating representatives in 2009.

The content of the different measures varies from early intervention to harm reduction, and it is decided on the basis of local needs and challenges. Many measures target people with a need for comprehensive, accessible services before, during and after treatment/rehabilitation or stays in an institution/prison.

About 295 municipalities and more than 500 measures were allocated funding for 2010. The establishment of emergency drugs and alcohol treatment facilities can be achieved in collaboration with the specialist health service. Grants became available in 2010 for the establishment of emergency treatment facilities under the scheme in the big towns and cities. Two cities, Bergen and Oslo, have been awarded grant funding. The facility in Oslo has already opened, while Bergen is planning to open its facility by the end of the year. The emergency drug and alcohol treatment facilities will offer treatment, observation and follow-up services that aim to meet the patients' need for coordinated services. The target group will consist of people with problems relating to drugs and/or alcohol and a need for acute help.
Funding has also been awarded for an emergency drug and alcohol treatment facility for young people in Oslo. The goal is early intervention and prevention. The scheme targets people under the age of 23 who are brought to the accident and emergency unit due to drug or alcohol poisoning. The grant scheme will be subject to a follow-up evaluation.

Voluntary work etc.

In 2010, EUR 20 million (NOK 160 million) was allocated to voluntary work, an increase of EUR 3.8 million (NOK 30 million) compared with 2009. The purpose is to support the work of voluntary and charitable organisations with persons with drug or alcohol problems. The funding is earmarked for follow-up, care and rehabilitation services run by voluntary organisations and private charitable organisations. Self-help groups and interest groups and work among family members will also receive funding. The intention is that the initiatives that receive funding will supplement public services and contribute to improving and coordinating the overall efforts aimed at the target groups. Emphasis will be placed on the organisations' ability to document cooperation with the municipality, which will have chief responsibility for services for people with drug and alcohol problems.

The total allocation covers more than 110 initiatives, and the organisations cover the whole range of measures, with the main emphasis on rehabilitation, follow-up/motivation and social

[13] Guide to municipal drugs and alcohol policy action plans, the Directorate of Health (2006)

participation/aftercare. Grants are also awarded to a number of projects and organisations run by and for users, including several interest organisations.

In 2009/2010, grants have been awarded to care services and 24-hour services, assistance targeting individuals, meeting places, street-level initiatives, qualification work and network-building. User organisations and work among family members have also received support. The grant scheme has been evaluated and the final report was submitted in spring 2010. The evaluation shows that the grant scheme achieves its aims. The initiatives represent increased capacity, i.e. they both supplement and complement the services offered by the municipalities and the specialist health service. The evaluation will form the basis for a review of the grant scheme in 2011.

In 2009, the Church City Mission in Oslo was given the task of opening a 24-hour service (24SEVEN) to provide health and care services for drug addicts and alcoholics with the greatest problems (see also Chapter 7.1). EUR 7.5 million (NOK 60 million) was allocated for a period of two years. The objective is to improve users' health and promote social inclusion. The same project has also started initiatives in Bergen. SIRUS will evaluate the project.

The *Street Hospital*, which is run by the Salvation Army, offers health services for drug addicts and alcoholics who need treatment and care but not specialist health services. The Street Hospital cooperates with the specialist health service and the City of Oslo. In 2009, the Street Hospital opened a separate women's department and it now has a total of 18 beds. The project received funding of approximately EUR 2.5 million (NOK 20 million) in 2010. In the prostitution field, funds have been allocated to health-promoting measures under the auspices of several organisations, including the Church City Mission and the Red Cross.

Competence centres etc.

For 2010, EUR 15.2 million (NOK 121.8 million) has been allocated to:

- Seven regional drugs and alcohol competence centres
- Management, knowledge and organisational development
- Measures relating to prisons, prostitution and human trafficking.

The grants aim to improve organisation, competence and quality development in the drugs and alcohol field. The grants will also be used for measures relating to prisons, prostitution and human trafficking. The regional drugs and alcohol competence centres have three main tasks:

- To stimulate the development of preventive measures in the municipalities
- Competence-building in the municipalities and the specialist health service
- To develop national areas of expertise.

In 2009/2010, the centres have focused on three priority areas in particular: improving coordination of the municipalities' work in the drugs and alcohol field based on action plans for drugs and alcohol; improving the municipalities' competence in local preventive measures, and; raising awareness of the possibility of using methods provided for in the Norwegian Alcohol Act to raise competence in early intervention. Implementation of the guide *From concern to action* is an example of such methods.

The centres and the county governor offices work closely together to develop joint regional competence-raising plans. The competence centres also assist the municipalities in developing comprehensive drugs and alcohol policy plans. The vast majority of municipalities have now developed such plans. SIRUS has initiated a survey to find out how the

municipalities work on action plans for drugs and alcohol and the extent to which they have the desired effect.Each competence centre has been assigned responsibility for one or two national areas of expertise. The competence centres will be evaluated and a report completed in 2011.

Management, knowledge and organisational development

The municipalities are working on further developing services for people with mental health and drug and/or alcohol problems. To support this work, the Norwegian Association of Local and Regional Authorities has developed a management programme. The programme has previously received grants via the Escalation Plan for Mental Health and the Action Plan. It is important to see the drugs and alcohol field and mental health in conjunction, and to consider intermunicipal collaboration on certain services and further strengthening of the municipalities' role in this area. On assignment for the Ministry of Labour and the Ministry of Health and Care Services, a five-year project was initiated in 2006 to strengthen knowledge-based practice and practice-based research. The Directorate of Labour and Welfare is cooperating with the Directorate of Health on implementation of the project. The total allocation for 2010 amounts to EUR 2.4 million (NOK 18.8 million).

Projects relating to prisons, prostitution and human trafficking

The purpose of the grant scheme is to improve follow-up of and services offered to people in prison-related and prostitution-related measures, including victims/possible victims of human trafficking. In 2009, the prison and prostitution projects received grants totalling EUR 0.84 million (NOK 6.7 million).

1.4 Further follow-up of the drugs and alcohol field

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

Based on inspection reports, statistics, reports from the Office of the Auditor General, evaluations and other available documentation, it is evident that continued strengthening of the drugs and alcohol field is necessary. Thorough consideration of the challenges we are facing is required.

On this basis, the Government will present a white paper in 2011 that will address the main challenges and strategies in relation to drugs and alcohol policy and form the basis for further efforts. The white paper will discuss important issues, including prevention and early intervention, the treatment of people with drug and alcohol dependency, penal sanctions, activation measures and housing initiatives. The Coordination Reform will also be very relevant to the contents of the white paper, including the reform's proposals to increase the focus on the role of the municipalities and strengthen preventive services.

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

2.1 Drug use in the general population

See the data in Standard table 01.

Background and methods
SIRUS has conducted surveys of the Norwegian population's use of alcohol and drugs since 1968. The surveys are normally carried out every five years. The most recent survey was carried out by SIRUS in autumn 2009.

While the methods employed have changed little over time, the questions that are asked have been changed to a certain extent. The surveys were carried out as part of wider surveys that were mainly concerned with alcohol consumption and attitudes to alcohol policy issues. Data collection in these surveys is carried out in the form of face-to-face interviews, but the questions about drugs were answered on a separate sheet that the respondent gave to the interviewer in a sealed envelope. The data concerning drugs were later linked to the other data from the interview survey. Surveys containing questions about drug use were carried out using the same method in 1985, 1991, 1994, 1999, 2004 and 2009.

The respondents are selected through a three-step procedure: a master sample of municipalities is first selected following stratification of all Norwegian municipalities into 17 strata by region, number of inhabitants and main source of employment. In each municipality, a random selection is made of a number of start addresses, and from each start address the interviewers go to four new addresses following a specified system. They endeavour to interview the person over the age of 15 who had most recently had a birthday. Addresses where the interviewers do not succeed in carrying out interviews are not revisited; the interviewers just continue until the desired number of interviews has been completed. The number of interviews in each stratum has to be proportional to the number of inhabitants.

In principle, this method will result in a relatively representative sample of the population aged 15 years and older, but, in the most recent survey in 2009 no one was at home at roughly half of the visited addresses, while, at about a third of the addresses, people refused

to be interviewed. The samples are weighted on the basis of gender, age and type of municipality (stratum) in order to correct known biases in the sample. It cannot be assumed, however, that this is sufficiently representative in relation to drug use. The changes that are reported here are thus changes relating to the sample in question, and generalisations to the 'general population' must therefore be made with reservations.

In line with the EMCDDA norm, 'the general population' is defined here as persons between the ages of 15 and 64. Other definitions and age groupings may be used in other presentations of these data.

Changes in prevalence 1985-2009

Table 1 shows that the proportion of respondents who answered that they had ever tried cannabis increased from 8.5 per cent in 1985 to more than 16 per cent in 2004, but it had fallen again to 15 per cent in 2009. The fact that lifetime prevalence has fallen during the past five years is very surprising given the cumulative nature of the variable: if you have taken cannabis once, you will always thereafter 'have ever tried it'. If this finding were accurate, it would either mean that the new age group included in the 2009 survey (those aged between 10 and 14 at the time of the previous survey) has a significantly lower prevalence of cannabis use than 15 to 19-year-olds in 2005 or that cannabis users have a particularly high mortality rate. It is more probable that this development is the result of a sample that is more biased than previously.

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

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

- = no data available
Source: SIRUS

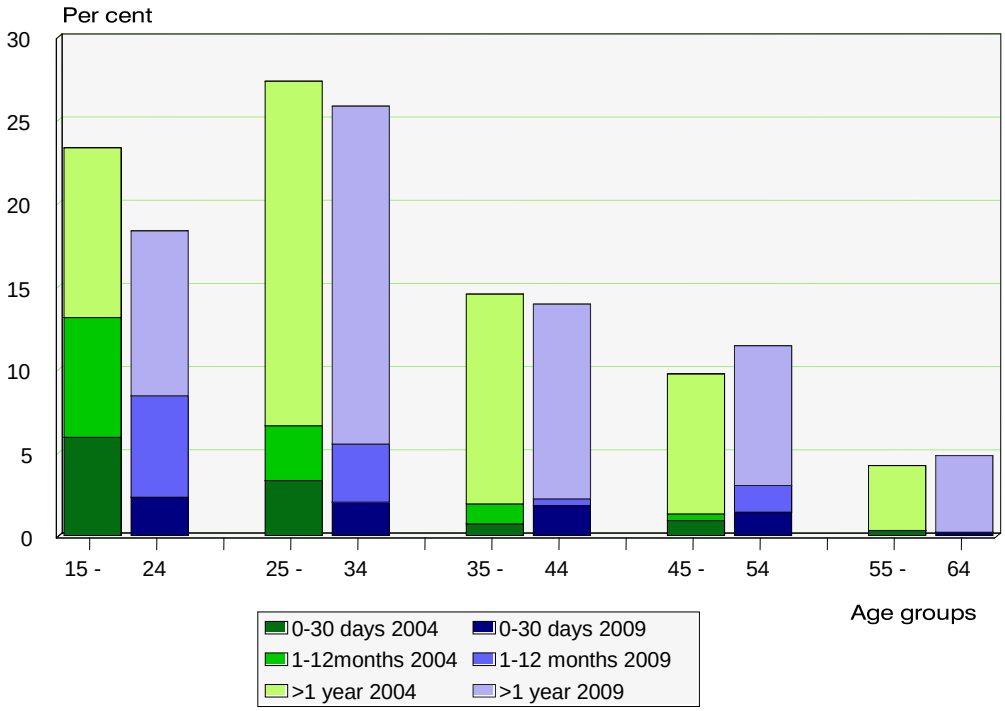
A better measure of the actual use of cannabis is the proportion that have taken it during the last year. The table shows that this group increased from 1985 to 1994, that it remained stable at around 4.5 per cent until 2004, but that it has fallen in 2009. Since 1994, we have also had data for the proportion reporting that they have taken cannabis during the last 30 days. This percentage would seem to have been at its highest around the turn of the millennium and to have decreased in 2009.

Figure 1 shows how the proportions who state that they have taken cannabis: ever, during the last 12 months and during the last 30 days, vary by age. The situation in 2009 is compared with the situation in 2004. The whole coloured column represents lifetime prevalence, the two darkest fields *combined* represent the proportion that have taken cannabis during the last year and the darkest part shows the proportion that have taken cannabis during the last 30 days.

Lifetime prevalence is greatest in the 25-34 age group, while both the proportion that have taken cannabis during the last year and the last 30 days is highest in the 15-24 age group. This applies to both 2004 and 2009. What is more surprising is the relatively strong decrease since 2004 in the proportion that have used cannabis during the last 30 days in the under-35 age group. In 2004 it was 4.5 per cent, while in 2009 it was reduced to 2.1 per cent. This percentage seems to have increased among those over the age of 35. Furthermore, the last year prevalence has also decreased in the 15-34 age group, from a proportion of 9.6 per

cent in 2004 to 7 per cent in 2009. The decline in the youngest group could also be a sign of a change in the longer term and it may be a contributory factor to the above-mentioned observed decline in lifetime prevalence at the population level.

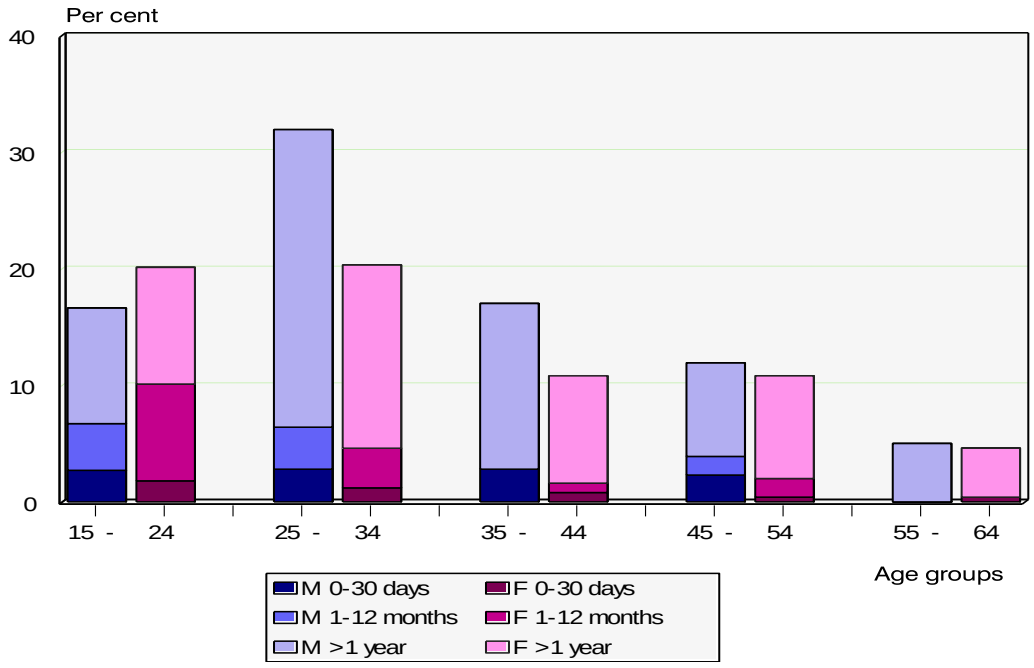
Figure 1: Percentage in different age groups in 2004 and 2009 who have taken cannabis: ever, during the last year and during the last 30 days, respectively.



Source: SIRUS

The difference between the genders as regards cannabis use appears to have decreased during the last five years. For the whole 15 to 64 age group, the percentage who answered that they had ever used cannabis was 13 per cent in both 2004 and 2009, while lifetime prevalence for men had fallen from almost 20 per cent to 16 per cent. The proportion who had used cannabis during the last year has increased from 3.2 per cent to 3.6 per cent, while for men it has declined from six to four per cent. The change for women is not significant, however. Figure 2 shows the gender difference in the different age groups and how it has changed since 2004.

Figure 2: Percentage of women and men in different age groups in 2009 who have taken cannabis: ever, during the last year and during the last 30 days, respectively.

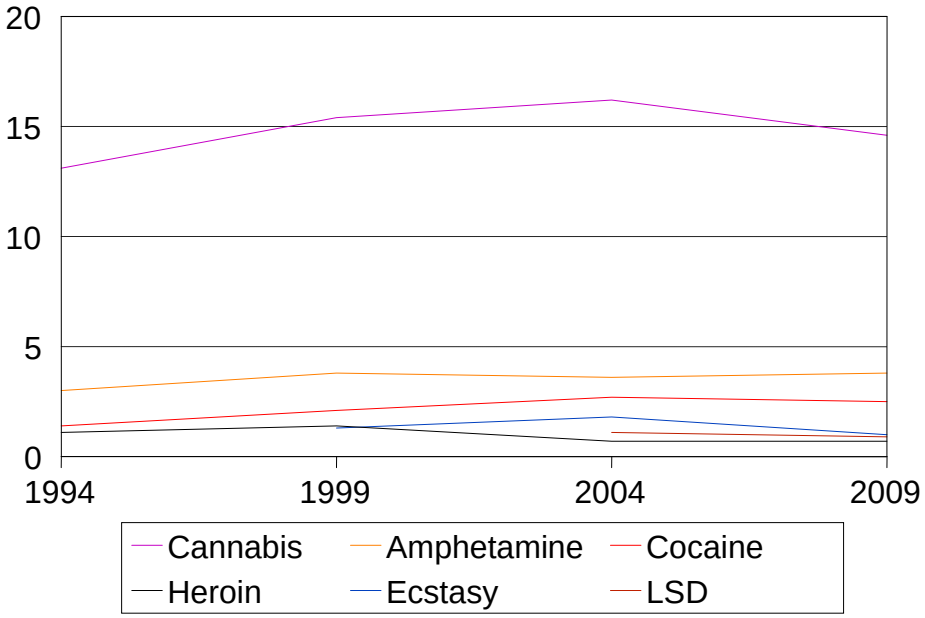


Source: SIRUS

The figure shows that lifetime prevalence (all the coloured columns) is higher among men than among women in all age groups, except among the youngest. This is a change since 2004, when lifetime prevalence among men was also highest in the youngest age group. The same structure, and the same change in the youngest age group, also applies to the proportion who have used cannabis during the last year (the two darkest areas of the columns). The proportion who have taken cannabis in the last 30 days, however, is highest among men in all age groups, as was also the case in 2004.

In the last four surveys (1994, 1999, 2004 and 2009), questions were also asked about the use of other drugs, and Figure 3 shows the lifetime prevalence for these drugs. Cannabis has been included for comparison purposes. While the lifetime prevalence for cannabis has decreased since 2004, it has been more stable and at a relatively low level for the other drugs. The prevalence for amphetamine is highest, almost four per cent, followed by cocaine at 2.5 per cent. No questions were asked about methamphetamine in the surveys, since it is assumed that the respondents would not be able to distinguish between the two types of amphetamine.

Figure 3: Percentage of the population aged between 15 and 64 who have ever used various drugs.

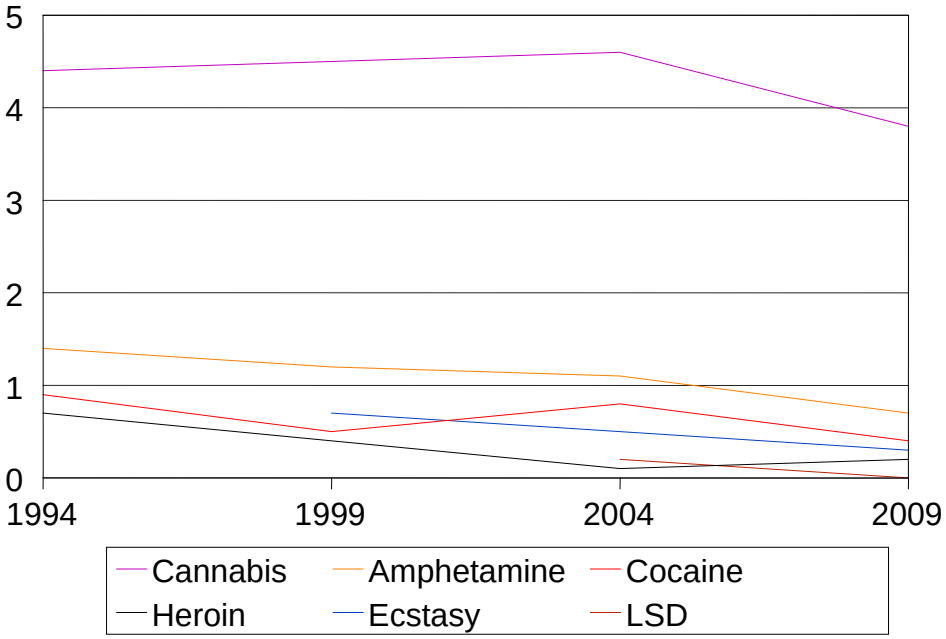


Source: SIRUS

The proportions who state that they have taken the different drugs during the last year are shown in Figure 4. Here too, the prevalence for cannabis has been included for the sake of comparison. The proportions that have used drugs other than cannabis have largely been relatively stable during the period 1994 to 2009. The figures are very small, however, which means chance can result in relatively large changes. With the exception of amphetamine, which was as high as 1.4 per cent in 1994, the prevalence of all drugs is under one per cent.

The figures for use during the last 30 days are so small for all the drugs (except for cannabis) that it is not possible to say anything about developments.

Figure 4: The percentage of the population aged between 15 and 64 that have used various drugs during the last twelve months.



Source: SIRUS

3. Prevention

In recent years, prevention in Norway has been rooted in the Government's Action Plan. The plan includes efforts to raise professional standards in preventive work . One of the five main goals is a clear focus on public health. Information work will be strengthened, with more targeted information and more participation by young people and parents. Knowledge must be increased and attitudes changed in order to reduce the harmful effects. Public support for the voluntary sector will continue as part of the effort to improve quality. Preventive measures will be coordinated, and work on drug and alcohol prevention in the workplace will be intensified. The seven regional competence centres for the alcohol and drugs field are key partners in coordinating and improving local prevention efforts in the municipalities. Preventive work of a varying nature and scope is ongoing in almost all municipalities.

3.1 Universal prevention

3.1.1 Community

Competence-building in the municipalities
The Directorate of Health and the seven regional competence centres are cooperating to increase competence in drug and alcohol prevention work in the municipalities in general. The county governors are also contributing to this work. One important goal is to coordinate and strengthen local prevention efforts. Competence-building measures target key personnel in the municipalities (administrative decision-makers, politicians, relevant sector managers, the retail and licensed trades, the police service, health personnel, local school managers, teachers, parents/guardians and voluntary organisations).

Action plans in the field of drugs and alcohol policy
Pursuant to the Norwegian Alcohol Act, the municipalities are required to prepare alcohol policy action plans. Several other laws also require the municipalities to carry out tasks in the drugs and alcohol field. Based on the intention of these acts and local needs, the municipalities are encouraged to pursue a coherent drugs and alcohol policy. They should view licensing arrangements and other preventive work in conjunction with rehabilitation. The Directorate of Health, the regional competence centres and the county governors assist the municipalities in the development and implementation of such plans.

In 2009, a study was initiated of the framework conditions and practice in the municipalities in the drugs and alcohol field. It will focus in particular on action plans for drugs and alcohol. The study, which is being conducted by the Norwegian Institute for Alcohol and Drug Research (SIRUS), is expected to be completed in spring 2011.

The municipalities' control of the sale and serving of alcohol
Norwegian legislation relating to alcohol contains many provisions aimed at limiting accessibility, including a licensing requirement, age limits for the sale and serving of alcohol, sales and serving times and restrictions on serving/selling alcohol to people who are clearly under the influence of alcohol or other drugs. It is the municipalities' responsibility to enforce the provisions of the law in this context. Surveys show that municipal control of the sale and serving of alcohol is not good enough. In cooperation with the seven regional competence centres, the Directorate of Health has carried out a project aimed at developing methods the municipalities can use to improve this work. The project was concluded in the first six months of 2010, and the six project groups will all report on their work to the Directorate of Health.

The project will provide the Directorate with experience-based knowledge about the municipalities' control activities.

3.1.2 Family

Parents' role in drug prevention
Much research identifies home and family as crucial arenas affecting young people's behaviour as regards alcohol and drug use, although they are not by any means the only factor (Henriksen 2000, Kelly et al. 2007, Saether 2007).

One important aim of the Action Plan is to raise the general public's level of knowledge and to make people aware of the link between the age at which people start drinking and alcohol consumption in adult life. The initial target group consists of young people and parents, who are to be given a more active role as contributors and mediators in local preventive work. One important goal is to help develop good, safe local communities.

One of the regional competence centres has been charged with collecting more information and know-how about this topic. The centre has drawn up a plan for this work in a five-year perspective. Conferences, seminars and various programmes will contribute to spreading information and involving parents more in preventive work.

3.1.3 School

For several decades, drug and alcohol prevention work has been based on various documents governing the school sector, such as legislation, national curricula and subject-specific curricula. Based on recent relevant research in the field (Babor et al. 2003; Foxcroft et al. 2002; Giesbrecht 2007; Nordahl et al. 2006), the Directorate of Health is working with the Norwegian Directorate for Education and Training on a new guide for schools' drugs and alcohol prevention efforts. The guide will be published in late autumn 2010.

The guide focuses on important elements that form the basis for coherent, knowledge-based prevention: a good learning environment, cooperation between the home and school, adapted tuition, social competence, methods that activate pupils and authoritative classroom leadership. The efforts that are implemented must be theoretically well-founded, have a clear implementation strategy and a long-term perspective. The guide is linked to national curricula, which, in some subjects for selected years, have clearly defined competence goals relating to drugs and alcohol. The home/parents and the school medical service are key partners.

3.2 Selective prevention in at-risk groups and settings

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

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

- Raise competence in the municipalities, for example through guidance from expert teams in the child welfare service.
- Improve competence in early identification and early intervention among staff who come into contact with children and young people at risk.
- Improve the municipalities' low-threshold services and outreach activities.
- Introduce a specific waiting time guarantee for children and young people with mental health problems and young alcoholics and drug addicts under the age of 23.
- Ensure that GPs have the tools they need to assess problem alcohol use among patients.)

- Study the prevalence of mental health problems and drug and alcohol problems among children and young people and their treatment and follow-up needs.

Four of the measures had been started in 2009. One central and five regional coordinators have been appointed under the auspices of the Directorate for Children, Youth and Family Affairs to advise the municipalities and implement mapping tools in the child welfare service. Among other things, a training package has been produced for child welfare service staff. The guide *From Concern to Action* (*Fra bekymring til handling*) was launched in autumn 2009. It makes an important contribution to early intervention efforts by providing action guidance for service staff and managers. See also Chapter 3.3.1.

Low-threshold services and outreach activities have been strengthened, for example through grant schemes for municipal drugs and alcohol work and grants for other measures. A waiting time guarantee has been introduced that will ensure that children and young people under the age of 23 with drug or alcohol problems or mental health problems do not have to wait for more than ten days to have an application for help considered, and not have to wait for more than 65 days for treatment.

A study will be carried out in 2010 of the prevalence of mental health and drug and alcohol problems among young people and their further treatment and follow-up needs.

3.2.1 At-risk groups

About 25 methodology development projects have been initiated in different municipalities. The projects largely target at-risk young people aged between 11 and 23, children of problem drug or alcohol users and mentally ill parents, and early intervention in relation to pregnant women and parents of infants and small children. Two examples are described below.

Children aged 9 to 13 years with behavioural problems – the town of Narvik
The aim of the project is to develop and test early intervention measures aimed at children who are at particular risk of developing behavioural and drug and/or alcohol problems, with concurrent efforts targeting the home and school.

The primary target group consists of children and young people (+/- 9 to 13 years) with an accumulation of risk factors and lack of protective factors. The secondary target group consists of teachers/parents. The measure addresses the secondary target group directly in order to reach the primary target group – direct contact with parents and teachers to reach the children/pupils. The project will run until 2012.

Both qualitative and quantitative data are being collected in connection with testing of the measure. Interviews will be conducted with parents and teachers. The project is also based on:

- self-assessment forms from parents/teachers
- records of meetings with parents and teachers on the topics concerned,
- records from collaborative meetings relating to each topic on which the school/home will cooperate,
- profiles/data collection through the use the mapping tools CBCL and SDQ.

The 'Ut av tåka' (Out of the fog) quit smoking hash course in Oslo
The course is a continuation of the Outreach Service's stop smoking hash course in Oslo in 2006/2007. It is based on intersectoral support and cooperation, and on systematic

development of local methodological competence based on experience from Sweden and Denmark. There are two target groups: youth aged between 15 and 25 who are motivated to stop using cannabis, and first-line employees in the urban districts whose day-to-day work involves contact with these young people. The measure has contributed to the development of a model to get young people to stop using hash. Professionals have developed their competence and are able to offer young people in the urban districts an opportunity to stop, on both a group and individual basis. Young people are reached earlier than before.

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

In 2006, the then Directorate for Health and Social Affairs – now the Directorate of Health - gave the Oslo Drug and Alcohol Addiction Service Competence Centre the task of mapping available knowledge about immigrant youth and their use and problem use of drugs and alcohol.

The intention was to examine whether and to what extent youth from immigrant backgrounds need special measures to prevent them developing drug and alcohol problems, and whether or not various immigrant youth groups need separate early intervention measures in the drugs and alcohol field. A report was published in 2008 (Bergengen and Larsen, 2008). See also NR 2008, Chapter 3.2. Based on the report, there are plans to produce information about drugs and alcohol adapted to youth from different ethnic backgrounds, for example through adapting drug and alcohol prevention programmes in lower secondary schools.

There is a group of marginalised youth in Oslo from immigrant backgrounds whose income is based on selling drugs, cannabis in particular (Sandberg and Pedersen 2006). There is reason to believe that certain groups of children and young people from immigrant backgrounds are at particular risk of developing a drug problem. A project supported by the Directorate of Health during the period 2006 to 2008 targeted young people from immigrant backgrounds who sell drugs in Oslo. The experience from this project will be followed up.

In cooperation with the City of Oslo's Health and Welfare Service, the Oslo Drug and Alcohol Addiction Service Competence Centre is carrying out a project where the topic of drugs and alcohol is the focus for ICDP groups. The aim of ICDP (International Child Development Programme) is to influence the carer's positive experience of the child/youth in order to help the carer to more readily identify and empathise with him or her. The idea is that strengthening the relationship between parents and children, which in turn can help to improve the basis for good communication, can prevent the development of drug and alcohol problems. This method has been used in relation to parents of children with functional impairments, parents in asylum reception centres, the child welfare service etc.

The point of departure is that many immigrant families are concerned about how their children experience their encounter with a culture about which the parents themselves know little. Like most young people, these children encounter many challenges, and their parents can feel powerless at times because of their lack of knowledge about their children's experiences. Myths arise, and conflicts develop between parents and children. An important part of the method is to have two counsellors. One of them speaks the language in question (in this case Somali or Urdu). The other can be tasked with interpreting cultural conflicts or misunderstandings, or with debunking myths. In addition, two drugs and alcohol counsellors are employed to whom both the counsellors and course participants have access. The project will be concluded in December 2010, and an experience booklet will be produced.

3.2.2 At-risk families

Screening and mapping tools
In 2009, the Directorate for Children, Youth and Family Affairs and the Directorate of Health established a website containing an overview of screening and mapping tools for use in work with parents, pregnant women and children of parents with mental health problems and/or drug or alcohol problems in order to uncover such problems at an early stage: http://www.helsebiblioteket.no/microsite/Kartleggingsverktøy.

In connection with the Government's focus on early intervention in relation to children of parents who are mentally ill or are alcoholics or drug addicts, the Directorate for Children, Youth and Family Affairs and the Directorate of Health have now initiated a collaboration on a training programme for GPs, health stations, midwives and child welfare staff. The programme provides training in the use of the screening tools EPDS, TWEAK and a newly developed tool from the *Norwegian Centre for Violence and Traumatic Stress Studies* that helps staff to discover violence in close relationships.

EPDS (Edinburgh Postnatal Depression Scale), with a pertaining follow-up conversation, is a self-reporting form targeting pregnant women and women who have just given birth. The form is intended as an aid for health personnel to help them to uncover postnatal depression. TWEAK (Tolerance – Worried – Eye Opener – Amnesia – Cut-down), with a pertaining follow-up conversation, is a screening tool for uncovering risky use of alcohol among pregnant women. It can also be used in relation to parents of infants and small children and the general population.

3.3. Indicated prevention

3.3.1 Early intervention

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

The report 'Early intervention in the drugs and alcohol field. Central perspectives - relevant target groups and arenas', published in 2007, presented proposals for a national strategy (discussed in NR 2007, Chapter 3).

As part of this national strategy, the Directorate of Health has, as mentioned, prepared the guide *From concern to action – A guide to early interventions in the drugs and alcohol field (Fra bekymring til handling – En veileder om tidlig intervensjon på rusområdet)*. The aim is to increase knowledge about what public service managers and staff should look for in order to identify a nascent drug and/or alcohol problem in children, young adults or older people. The guide also provides concrete advice about what can be done to solve a potential problem as early as possible. In 2009, the guide was marketed in the municipalities, and work will be done to follow up municipalities so that they can improve their practices in accordance with the recommendations in the guide.

During the period 2007 to 2009, funding was allocated to 25 methodology development projects in the early intervention field. Most of them target children and young people. Another priority group consists of pregnant women. Funding has also been given to projects targeting arenas that are particularly well suited to early interventions, such as GPs, hospitals, workplaces and schools. Most of the projects run for several years.

3.3.2 Outreach work

Outreach social work targeting youth is an important part of preventive efforts in Norway. It primarily focuses on early intervention. In this context, early intervention means reaching at-risk youth as early as possible. While outreach work among young people in high-risk milieus is part of the municipality's general responsibilities, it is not a statutory responsibility.

Topics relating to outreach work are now part of further education programmes at several university colleges. A methodology textbook has also been published by Oslo Drug and Alcohol Addiction Service Competence Centre.

In spring 2010, another large-scale international conference was held in Oslo on Outreach Work. The topic was *Perspectives on Outreach Work in Europe.* The conference highlighted early intervention and outreach social work among at-risk youth aged between 13 and 25.

3.4 National and local media campaigns

No recent media campaigns have been aimed at the use of drugs in particular. Several extensive information campaigns have been carried out in connection with alcohol. They were described in NR 2009.

4. Problem drug Use

4.1 Prevalence and incidence estimates of Problem Drug Use (PDU)

See data in Standard tables 07 and 08.

Definitions

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

Despite a fairly strict regime, experience and results are nonetheless variable. Status surveys among OST patients show that around 13 to 14 per cent use morphine substances in addition to the OST medication and that 16 per cent have been found to use central stimulants (Waal et al. 2010). This justifies their inclusion among problem users.

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

In Norway, we mainly have estimates of the injecting drug users group, but Chapter 4.2.1 in last year's report also contained an estimate for problem users of heroin in the period 2000 to 2008 (Bretteville-Jensen and Amundsen 2009). In 2008, the estimate was 9,450 (5,600-10,400) problem users of heroin, 1,450 (1,000-1,900) of whom only smoked the drug. Work has now started on calculating how many problem users we have according to the general definition. This means that an estimate must be produced of the number of prolonged/regular users of opioids, cocaine or amphetamines, who do not inject these drugs. In order to be able to compare problem use with other countries in Europe, Norway must also include participants in OST.

Calculating the number of injecting drug users

Table 2 shows estimates of the number of injecting users in Norway, estimated using the Mortality Multiplier. The calculations include figures for overdose fatalities from the Norwegian Cause of Death Register supplied by Statistics Norway until 2008 and from Kripos (the National Crime Investigation Service) up until 2009. The estimate of the number of injecting drug users is provisional. The number of injecting drug users in Norway increased from the 1970s until 2001, with a subsequent reduction until 2003. Since then, the figures remained stable until 2008/2009.

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

Year	Lower limit – upper limit
2002	10,500 -14,000
2003	9,200 – 12,800

2004	8,700 – 12,200
2005	8,900 – 12,400
2006	8,400 – 11,700
2007	8,600 – 12,000
2008	8,800 – 12,500
2009 (provisional figures)	8,700 – 12,300

Source: SIRUS. Round figures

The estimate of the number of injecting users in 2008 has been adjusted somewhat in relation to the provisional figures published before. The figures include all injecting use. Heroin is still the most common drug injected, but, for some, amphetamine is the main drug injected. The proportion of injecting users in Oslo who inject amphetamine has been increasing and it was around 17 per cent in the period 2000-2004 (Bretteville-Jensen 2005).

Recruitment to injecting use

Norway does not have data for how many new users are recruited to injecting use every year because underlying data for such information are not available. However, calculations have been made of the total number of new injecting users and relapses after an injection-free period of more than a year (Amundsen, Bretteville-Jensen, Kraus, unpublished manuscript).

On this basis, total recruitment and relapse into injection appears to have increased steadily from the 1980s until 2000. Recruitment accounted for a large proportion of the total figure. The total recruitment and relapse figures then fell until 2003, after which they again rose somewhat before stabilising in the period up until 2008. The reduction is seen as being related to the large increase in OST for persons injecting heroin. Relapse into heroin use was low in the first few years, but it has since increased. There has also been an increase in the number of persons admitted to OST for the second time or more often (Waal et al. 2010). The increase in the total recruitment and relapse figures from 2003 and their stabilisation may be related to an increasing trend for people to be in OST for periods and inject for periods.

Problem users

As part of the work of calculating the number of problem users, a pilot survey was conducted in 2010 of persons who had used opioids/amphetamines/cocaine during the past 12 months in Arendal, a medium-sized urban municipality (42,000 inhabitants). Corresponding surveys are planned in Tromsø and Oslo. The survey was conducted as 'Respondent-driven sampling' or a network-based survey in which users recruited other users to interviews in their social networks.

A total of 45 persons were interviewed in Arendal, which was 10 per cent of the estimated 400 to 500 persons who are assumed to use such drugs. Most of those interviewed were in the marginalised users group who use drugs frequently and had done so for many years. But there were also some younger, non-marginalised users and some older marginalised users who used the drugs in question at weekends or more sporadically. Those interviewed do not

constitute a representative sample of all users of opioids/amphetamines/cocaine in Arendal. Sporadic use is clearly underrepresented.

Pursuant to the EMCDDA's definition of problem users, terms such as 'regularity' and 'prolonged period' can be specified to mean persons who have used at least one of the four drugs at least once a week during the past 12 months. By this definition, 40 of the 45 interviewees in the survey from Arendal will be problem users. Of these, nine were persons who had not injected any drugs during the past 12 months. We must therefore add 30 per cent to the number of injecting users in order to arrive at the total number of injecting users in the data from Arendal. That is a not inconsiderable addition to the number of injecting users.

The proportion who use opioids, amphetamine or cocaine regularly over a prolonged period, but who do not inject, will probably vary considerably between Norwegian towns and cities. To be able to calculate the number of problem users for the country as a whole based on the number of injecting users and an estimate of the number of other problem users, more surveys must be conducted to establish whether the 30 per cent addition made in Arendal also reflects the situation in other Norwegian towns and cities.

Problem users who are in OST or who are given opioids on prescription from a doctor in another context amounted to 27 per cent of the 45 persons interviewed in Arendal. Some persons in this group reported frequent use of other drugs. Roughly a quarter had used amphetamine and a quarter heroin in addition to prescription drugs during the past 30 days. Moreover, 75 per cent of the group reported using cannabis/hash, and more than 80 per cent reported using benzodiazepines during the past 30 days. These results cannot be generalised to the whole group of persons in OST in Arendal or the country as a whole. However, the results show that many of those in OST use drugs that mean that they can be regarded as problem users.

4.2 Data on problem drug users from non- treatment sources

4.2.1 Drug use among Norwegian women in prostitution milieus

A survey of the prostitution market in 2009 (Norli 2009) shows that 75 per cent of Norwegian women in Oslo who engage in street prostitution take drugs daily.

The survey is based on questionnaires. The sample consisted of 75 women from Oslo: 23 from the indoor market, 28 active street prostitutes and 24 who are no longer engaged in street prostitution. However, the survey cannot automatically be regarded as representative of the whole population of prostitutes in Norway.

Eighty-one per cent of the women who are active in street prostitution and who use drugs daily state that they use heroin. Of these, two state that they only use heroin. The others supplement their heroin use with amphetamine, hash and various types of benzodiazepines. Of the 19 per cent who state that they do not use heroin, drug use largely consists of amphetamine, hash and pills or methadone and pills. Of the Norwegian women who are no longer engaged in street prostitution and who use drugs daily, 44 per cent state that they use heroin. None of them use heroin exclusively; they supplement heroin with hash and pills.

Of the 21 women who are actively engaged in street prostitution and who state that they take drugs daily, 19 have been treated for their drug problem and have tried many different treatment measures ranging from outpatient follow-up to lengthy stays in institutions. Only five of the 19 state that they have only undergone one course of treatment; the others state that they have undergone between two and six kinds of drug treatment, both voluntary and

under coercion. Only five of the 28 women who are still actively engaged in street prostitution state that they are given methadone/Subutex, and only seven of the women state that they would like to be.

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

There are few changes as regards strategies and policies relating to treatment. The implementation of strategies relating to the Action Plan is described in Chapter 1. The

regulations and guidelines for opioid substitution treatment (OST), which entered into forced at the beginning of 2010, are also discussed under the topic *national treatment guidelines* in Chapter 11.

5.1 Characteristics of treated clients

5.1.1 Profiles of clients in opioid substitution treatment

See also the data in Standard table 24.

The Norwegian programme for opioid substitution treatment (OST), which was established in 1998, currently comprises 14 regional outpatient centres. Some patients are admitted as in-patients for an initial period for examinations and for escalation and adjustment of the medication. Some patients also experience recurring crises that require them to be admitted.

Key data
At the end of 2009, there were 5,383 patients in treatment, an increase of 425 (4,913) since 2008. The number of admissions was 978, 63 per cent of whom were new admissions. The number awaiting treatment was 279. There has for many years been a steady annual increase of about 500 persons beginning treatment.

Data are reported annually in the form of status surveys from the 14 centres. For 2009, a total of 4,730 forms were completed, or 79 per cent. The average age of clients (for whom a form has been completed) was around 41 years, and the proportion of women was approximately 29 per cent. The average age is increasing slightly and the gender distribution has been more or less unchanged in recent years. A total of 571 patients completed treatment during the year, but 78 of them were discharged in connection with moving house and were still in substitution treatment in another region.

Sixty-three deaths were registered during the year, largely caused by various diseases. Very few die of overdoses while in treatment, but overdoses are the most common cause of death before and after treatment.

The proportion being treated with methadone was 56 per cent. Since Subutex was approved as OST medication, the use of buprenorphine has increased: 2004: 23 per cent, 2005: 31 per cent, 2006: 36 per cent, 2007: 39 per cent, 2008: 40 per cent, and 2009: 44 per cent.

Retention
The status survey shows a high retention rate of 91 per cent measured by the proportion in treatment at the end of 2009 in relation to the total number at the beginning of 2009 and the number of new admissions to treatment during the year.

Social conditions
The status surveys have shown that a high proportion live in independent living arrangements, while a low proportion have been rehabilitated in relation to the employment market, and a significant percentage have disability benefit as their primary source of income.

More than three-quarters are not in employment or in education. The survey also shows a high proportion of benefit recipients. In 2009, 79 per cent had disability or rehabilitation benefit as their most important source of income.

The percentage of people who are dependent on social security has also varied considerably between the centres in 2009, the highest percentage being in Oslo. On the other hand, eight out of ten have their own house or apartment.

State of health

The survey describes patients' status as regards infections and mental and physical health using rough and fairly uncertain measures. Just over two per cent are HIV positive, but Oslo and the surrounding county had approx. five per cent. The survey also reports the percentage who are hepatitis C antibody positive. The average for the country as a whole was 61 per cent, roughly the same as in 2008. This figure is lower than expected, and the explanation can probably be found in the substantial proportion for whom this status is unknown (16%). The highest percentage was found in two regions with approx. 77 per cent. These regions had a low percentage of unknowns. It is therefore reasonable to assume that the real figure for hepatitis C infection is close to 80 per cent.

More than a quarter suffer from illnesses or injuries that are sufficiently serious to affect their quality of life. Sixteen per cent show signs of serious depression and 21 per cent of serious anxiety. These findings are more or less unchanged from previous years and confirm that, as a group, patients in OST are characterised by considerable morbidity, both mental and somatic. This largely involves enduring and, in part, chronic conditions.

Drug use

The reporting was carried out by combining information about drug use and results from urine sample controls. The measure used is any use of other substances than those prescribed by the programme during the last 30 days, confirmed by at least one positive urine sample and/or information about use of the drug. The same person may test positive for more than one substance. The percentages are calculated separately for each substance.

About 13 per cent have used opioids and approximately 16 per cent have used other central stimulants. The use of cannabis is higher (34%), but the biggest problem, as in 2008, is the use of benzodiazepines. Approx. 42 per cent have used such substances during the last 30 days. Less than half of them had been legally prescribed the substance, while more than half obtained all such substances from illegal sources. The variation in this area is still great. One centre detected the use of benzodiazepines in 18 per cent of its patients, while the highest proportion at another centre was 59 per cent. A high proportion of legal prescriptions does not seem to prevent the use of medicinal drugs from illegal sources (SERAF 2010).

6. Health correlates and consequences

6.1. Drug-related infectious diseases

See data in Standard table 09.

6.1.1 HIV and AIDS

In 2009, 282 cases of HIV infection were reported to the Norwegian Surveillance System for Communicable Diseases (MSIS). Eleven of the cases were among injecting drug users: seven men and four women. The median age was 36 years (25 to 48 years). Four of the eleven who were diagnosed as HIV positive in 2009 were persons of foreign origin. They had probably been infected abroad before coming to Norway for the first time. The number of HIV cases among injecting drug users remains relatively low, and little new infection is detected in this group.

As of 31 December 2009, a total of 564 persons had been diagnosed as HIV positive with injecting use as a risk factor. This amounts to 13 per cent of all reported cases of HIV since 1984. Development into AIDS has been reported in 150 of the cases (Table 3). No information is available regarding how many of the HIV-positive injecting drug users are still alive.

Table 3: Notifications of HIV infection and AIDS, Norway 1984-2009. Percentage of injecting drug users by year of diagnosis.

	HIV total	HIV injecting drug use	Percentage HIV injecting drug use	AIDS total	AIDS injecting drug use	Percentage AIDS injecting drug use
1984-99	2,018	442	22%	675	112	17%
2000	175	7	4%	35	5	14%
2001	157	8	5%	33	8	24%
2002	205	16	8%	34	4	12 %
2003	238	13	5%	53	6	11%
2004	251	15	6%	36	4	11%
2005	219	20	9%	32	4	13%
2006	276	7	3%	32	4	13%
2007	248	13	5%	11	0	0%
2008	299	12	4%	18	2	11%
2009	282	11	4%	18	1	6%
Total	**4,368**	**564**	**13%**	**978**	**150**	**15%**

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

The incidence of HIV among injecting drug users has remained at a stable, low level, with about 10 to 15 cases reported per year. The reason for this is not entirely clear, but a high level of testing, great openness regarding HIV status within the drug user community, combined with a strong fear of being infected and strong internal justice in the milieu, are assumed to be important factors. In addition, many of the sources of infection in the milieu have disappeared due to overdose deaths or have been rehabilitated through substitution therapy or other forms of rehabilitation. However, the extensive outbreaks of hepatitis A and B in the late 1990s and early 2000s, and the high incidence of hepatitis C, show that there is still extensive needle sharing among this group.

6.1.2 Hepatitis

During the nationwide outbreak of hepatitis A from 1996 to 2000, 1,360 drug users were identified as having acute hepatitis A. Since then, only sporadic, individual cases of hepatitis A have been reported among injecting drug users.

In the period 1995-2008, a considerable increase in hepatitis B among drug users nationwide was reported to the Norwegian System for Communicable Diseases. In 2009, 23 of a total of 57 reported cases of acute hepatitis B involved injecting drug users. During the period 1995-2009, the total number of reported cases of acute hepatitis B among injecting drug users was 1,947.

The monitoring of hepatitis C in Norway was intensified from 1 January 2008. The notification criteria were changed so that all laboratory-confirmed cases of hepatitis C must now be reported to MSIS. Previously, only acute illness had to be reported, and this resulted in a very inadequate overview of the real incidence of the disease in the country. In 2009, 2,323 cases of hepatitis C (both acute and chronic cases) were reported. In about half of the reported cases, no information was provided about the presumed mode of transmission, but in the cases where the mode of transmission is known, 90 per cent were infected through the use of needles. For the time being, data from MSIS cannot distinguish between cases involving new infection with hepatitis C and cases where the infection occurred many years ago. It is therefore not known whether new infection of hepatitis C among drug users has declined or increased in recent years.

Among OST patients, the status survey for 2009 (see Chapter 5.2.2) shows that, for the country as a whole, an average of 61 per cent were hepatitis C antibody positive, roughly the same proportion as in 2008. This is lower than expected, and the explanation is probably that the percentage with unknown status was as high as 16 per cent. In two regions where the percentage with unknown status was low, the proportion of hepatitis C-infected was almost 80 per cent.

In recent years, small-scale prevalence surveys have been carried out in connection with needle distribution in Oslo in order to register the incidence of, for example, hepatitis among injecting drug users. These surveys are the only prevalence surveys that are carried out regularly among a sample of drug users in Norway. The 2009 survey showed that 76 per cent of the 179 persons included in the survey had experienced a hepatitis A infection or been vaccinated against the disease, 37 per cent had had a hepatitis B infection and 65 per cent had experienced a hepatitis C infection. Thirty-five percent had hepatitis B markers indicating that they had been vaccinated against hepatitis B.

6.1.3 Bacterial infections

In the period 2000-2009, five cases of botulism have been notified among injecting drug users. In addition, one case of anthrax and one case of *Clostridium noyvi* were reported in injecting drug users in the same period. In recent years, five to ten cases of methicillin resistant *Staphylococcus aureus* (MRSA) have been reported annually among drug users. There is insufficient data about other bacterial infections among drug users in Norway. Tuberculosis is very rarely seen in drug users in Norway.

6.2 Other drug-related health correlates and consequences

6.2.1Traffic accidents

A new survey (Bogstrand, abstract 2010) from Oslo University Hospital, Ullevål and the Norwegian Institute of Public Health shows that one in four drivers of cars and motorcycles who were injured in serious accidents had alcohol, tranquilisers or narcotic substances in their blood.

For a whole year, all patients admitted with injuries resulting from road accidents at the emergency admission department at Oslo University Hospital Ullevål were asked whether they were willing to take part in a study of drugs and alcohol and the risk of accidents.

Approximately 90 per cent of those asked agreed to participate and a total of 2,000 people have taken part in the study, which is being conducted by the Norwegian Institute of Public Health in cooperation with Oslo University Hospital Ullevål and SIRUS.

The first results from 132 injured drivers of cars and motorcycles became available in August 2010. The analyses of the 132 blood samples show that 26 per cent had large or small amounts of psychoactive substances in their blood – either alcohol, tranquilisers/soporific drugs, narcotic substances or a combination of substances.

A total of approx. 30 substances were tested for. A third of those who had psychoactive substances in their blood had a combination of two or more substances. The following substances were found most frequently among the 26 per cent who tested positive:

- Alcohol alone or in combination with other substances: 50 per cent
- Diazepam (Stesolid, Valium) alone or in combination: 30 per cent
- The soporific zopiclone (Zopiclone, Imovane) alone or in combination: 12 per cent
- Amphetamine alone or in combination: 24 per cent
- Hash/marijuana alone or in combination: 15 per cent

The blood samples were taken on admission and stored at the hospital until the patient had given his/her consent. The sample was sent to the Norwegian Institute of Public Health, and the analysis results were de-identified before the researchers saw them.

The extent to which the drugs and/or alcohol may have contributed to each accident will be studied at a later date.

The analysis of blood samples from people injured in road accidents is part of a large project – Medicinal drugs, drug and alcohol use and injuries. The project started in December 2007. The results from Norway will be compared with similar studies in other countries.

6.3 Drug-related deaths and mortality of drug users

See data in Standard tables 05 and 06.

Methodological considerations

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

With effect from 1996, Statistics Norway's figures have been based on EMCDDA's definition of drug deaths. This broadened the inclusion criterion that had been used until then. In the

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

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

Situation and development

The figures from both SSB and Kripos peak in 2000/2001. In the ensuing years, there has been a considerable reduction in the number of registered drug deaths. The reduction since the turn of the millennium is most probably due to the strong increase in the number of clients in OST. Both the SSB figures and the Kripos figures appear to indicate that, after the reduction following the peak years of 2000 and 2001, a certain stabilisation of the number of mortalities has occurred. However, the number of mortalities remains high. See the comments in Chapter 12.

Table 4: Drug-related deaths 1991-2009. Total number of deaths and broken down by gender. Figures from Kripos and Statistics Norway (underlying cause of death).

1991-2009	**Number of deaths according to Kripos**			**Number of deaths according to Statistics Norway**		
	Men	**Women**	**Total**	**Men**	**Women**	**Total**
1991	74	22	96	66	22	88
1992	78	19	97	81	23	104
1993	77	18	95	76	17	93
1994	102	22	124	105	19	124
1995	108	24	132	114	29	143
1996*	159	26	185	173	31	204
1997	149	28	177	160	34	194
1998	226	44	270	228	54	282
1999	181	39	220	191	65	256
2000	264	63	327	302	72	374
2001	286	52	338	327	78	405
2002	166	44	210	240	67	307
2003**	134	38	172	193	62	255
2004	168	55	223	220	83	303
2005	146	38	184	176	58	234
2006	152	43	195	187	64	251
2007	162	38	200	217	58	275
2008	148	31	179	210	53	263
2009	146	38	183	***	***	***

Source: Kripos and Statistics Norway

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

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

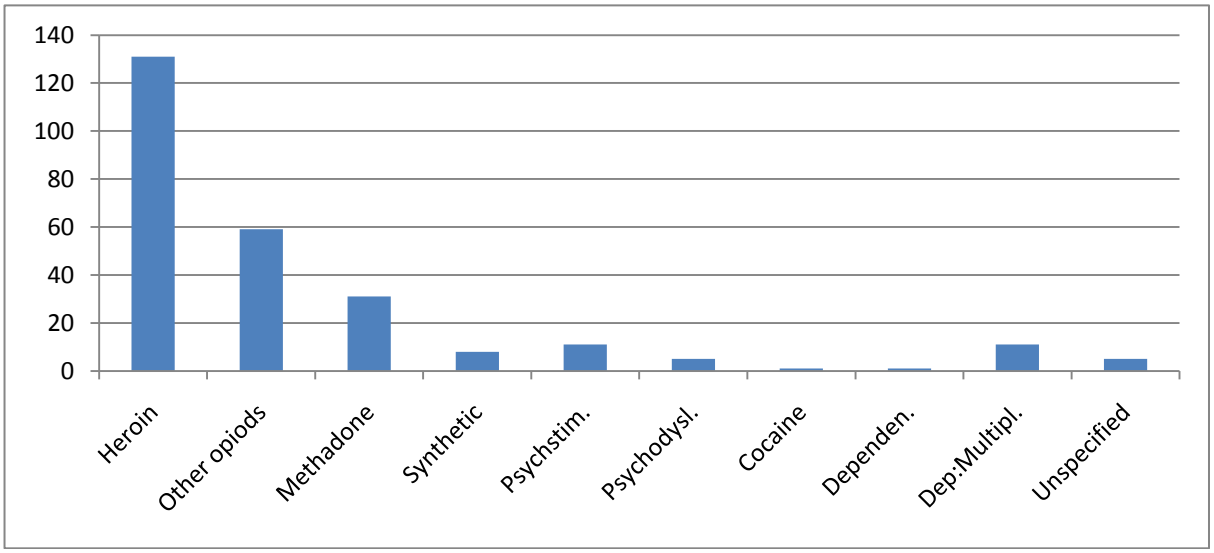
**** Figures for 2009 are not yet available.*

Concerning the 263 drug induced deaths in 2008 that were recorded by Statistics Norway, nearly half, 131 deaths, were deaths where heroin poisoning was recorded as the underlying cause of death (X42, X44, X62, X64 + T401).

Thirty-one deaths were recorded with methadone poisoning as the underlying cause (X42, X44, X62 + T403), 59 with other opioids, either as poisoning or dependency (X42, X44, X62, X64 + T402, F112).

The rest, 42 deaths, brokw down as follows: eight other synthetic narcotics (X42, X44, X64 + T404), five other/unspecified psychodysleptics (X42 + T409), 11 psychostimulants (X41, X44, X61 + T436), five unspecified narcotics (X42, X44 + T406), 12 dependence other stimulants and dependence multiple/other (F152, F192), and one death from cocaine (X44 + T405). (Figure 5)

Figure 5: Drug-related deaths in 2008 broken down by specific causes of death.



Source: SIRUS and Statistics Norway

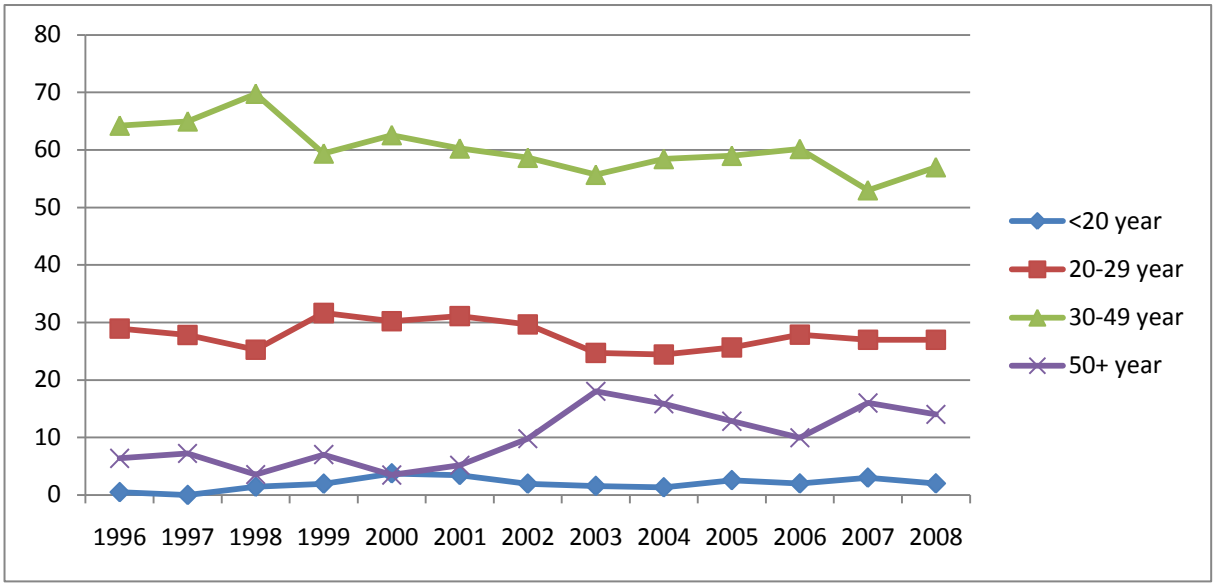
In 2009, Kripos recorded 183 deaths, where 11 were non-Norwegian citizens. This is on a par with the year before. Many of the deaths are believed to be due to extensive multiple use. In 60 per cent of the deaths, the heroin-specific metabolite monoacetylmorphine was detected, and morphine was found in a further 15 per cent of deaths. Methadone was detected in 16 per cent. Amphetamine and/or methamphetamine and/or cocaine were detected in 28 per cent of the deaths.

Oslo is the police district with most deaths 73 (40%). The proportion is somewhat higher than in 2008 (34%). In a longer-term perspective, the proportion in the metropolitan region has declined. Up until 1999, Oslo accounted for more than 50 per cent of the deaths. The figure then dropped and, since 2000, the proportion has varied between 30 and 40 per cent.

In the early 1980s, the proportion of drug-related deaths among those over the age of 30 was less than 20 per cent. This proportion has increased steadily, and in the 1990s it had reached 60 per cent according to SSB's statistics. The SSB statistics show that, for the years 1996 to 2008, the proportion of drug deaths involving the 30-plus age group was approximately 70 per cent on average. During the same period, the proportion among those

over the age of 50 appears to have increased. The proportion of deaths among the youngest age groups has remained stable during the period 1996 to 2008. In 2008, the 30-plus age group accounted for 72 per cent of the deaths, while 48 per cent of the deaths were among those aged 40 years or more, and 14 per cent of the deaths were among those aged 50 years or more. Five of the deaths were among those aged 65 years or more. (Figure 6).

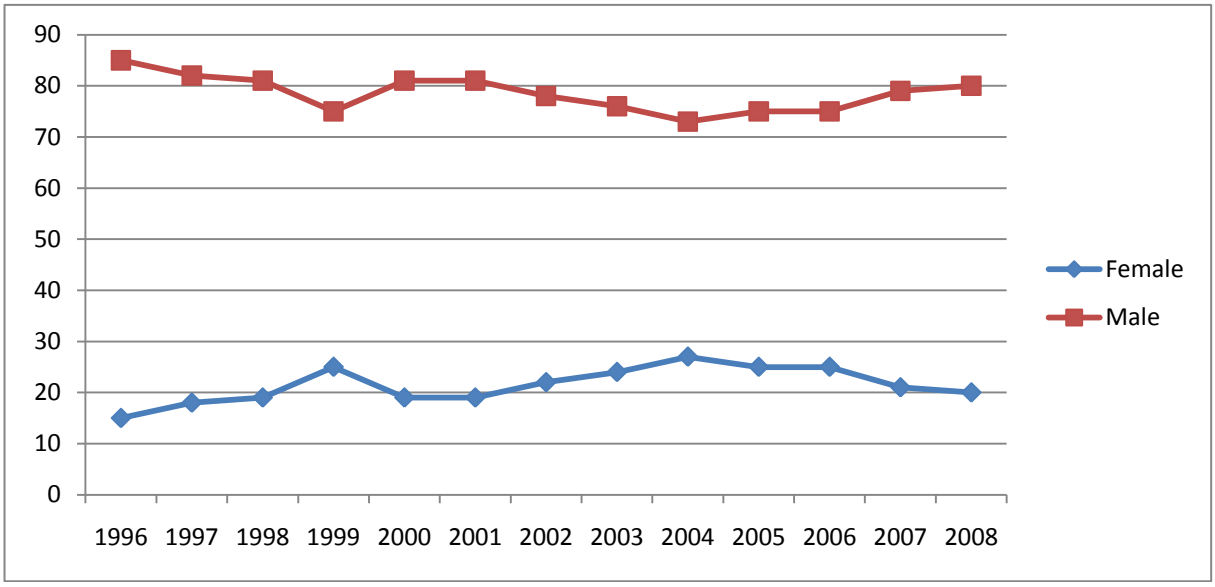
Figure 6: Drug-related deaths broken down by age group, 1996-2008.



Source: SIRUS and Statistics Norway

In 2008, 210 of the deaths were males and 53 females. In a longer-term perspective, the figure for females of 20 per cent seems to be within the 'normal range'. During the period 1996 to 2008, the proportion of women among mortalities varied between 15 and 27 per cent. It was close to 22 per cent on average (Figure 7).

Figure 7. Drug-related deaths broken down by gender, 1996-2007



Source: SIRUS and Statistics Norway

7. Responses to health correlates and consequences

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

7.1.1 Opioid substitution treatment

Opioid substitution treatment (OST) can undoubtedly be argued to be an important factor in the effort to prevent overdoses. The design of and participation in the Norwegian programme probably contribute to reducing the annual number of overdose deaths to a considerable extent. The OST programme is big in the Norwegian context, with around 5,500 patients as of August 2010.

According to the status report for 2009 (Chapter 5.1), some three per cent of the patients experienced one or more non-fatal overdoses during the year. Slightly more than two per cent have attempted suicide. Some of the cases are assumed to be overdose cases without a clear suicidal intent. In 2009, 63 deaths were registered among the patients. That is higher than in 2008, when the figure was 39. Converted into patient years calculated as the average of patients at the beginning and end of the year, the mortality rate in 2009 was 1.3/100. Except in one year when few deaths were registered, the mortality rate has been between 0.8 and 1.5. Very few die of overdoses while in treatment, while this is the most important cause of death before and after treatment. However, the group has elevated mortality because of the very high incidence of various diseases, as is also the case in other countries (Waal et al., 2010).

7.1.2 Low-threshold services

Some of the services run by the Alcohol and Drug Addiction Service in Oslo are described below.

Low-threshold health services
The project includes; Nutrition, Protection against Infection, Field Nursing Stations and a Low-threshold Dental Service. The services are offered to hardcore drug and alcohol users living in Oslo. The services are at street level, non-bureaucratic, easily accessible and free of charge for users. The users are given information and referred to the appropriate help service if necessary.

Most of the costs of low-threshold health services are spent on running field nursing stations. The Alcohol and Drug Addiction Service now runs nine field nursing stations in Oslo, six of its own and three in cooperation with others. The field nursing service provides simple treatment, offers vaccination and attempts to arrange contact with the established health service. There were a total of approx. 15,000 consultations in 2009.

The infection protection units are largely organised together with the field nursing stations. They are decentralised to the service's accommodation services and short-term low-threshold services. The units hand out needles, pre-injection swabs and condoms in exchange for used needles. They also focus on giving users information and advice about how to detect and prevent modes of infection, safer injection technique and safe storage and destruction of used equipment.

An annual health survey/vaccination campaign is also carried out in collaboration with the infection prevention authorities in Oslo. Field nursing services, access to clean injection equipment and nutritious food are a means for other help services to reach many users with their services.
The basic services are partly organised through the Alcohol and Drug Addiction Service itself, partly through grants to other municipal services aimed at the target group and partly through grants to private organisations. The Salvation Army, Fransicushjelpen and the Church City Mission have cooperated with low-threshold services for drug and alcohol users since their inception in 1999.

7.1.3 Injection rooms

As the only municipality in Norway, the city of Oslo has run an injection room since 2005. It is in a central location in the city. The injection room and the evaluation of it have been discussed in previous national reports, see in particular NR 2008, Chapter 7. As of 15 December 2009, the injection room had 1,664 registered users. The number of injections during one day can vary from 30 to 100.

Data for the first four years show that 1,203 different users used the service 49,272 times. Only 0.65 per cent of visits resulted in an overdose situation in which staff or ambulance personnel had to intervene in order to prevent respiratory arrest in the client, but none of the overdoses were fatal. Most users of the injection room have never experienced an overdose in the injection room, although a relatively small group has done so repeatedly. Continuous efforts are made to prevent overdoses.

In the injection room, heroin doses for injection are reported at the entrance. When entering the facility, staff ask the clients for their user number and fetch their files. Clients then tell the staff what heroin dose they plan to inject during the visit in question, and staff fill in the amount in a form that clients take with them into the room where the injections take place. Staff will, however, assess clients' intoxication level when they enter, by asking them what other intoxicants and what amount they have consumed during the last 24 hours, and how much they have eaten and slept. The amount of heroin injected during previous visits and overdose incidents on the premises will also be taken into account when assessing whether the reported injection dose can be accepted. Such interventions are also made by staff in the room where injections take place.

The staff have built up considerable expertise about when there is a risk of an overdose, and active efforts are made in relation to users who are deemed to constitute a major risk. The most important strategy is to ask the user to only take half the planned dose, and then take the other half afterwards if he/she is good shape after the first dose. For example, when users ask for extra water vials, this often puts staff on the alert as regards what is to be injected. Even though it has been registered how much the client has stated he or she intends to inject, the staff will ask again or examine the mixture and assess the amount. The fact that a client needs more water than the 'standard amount' usually handed out, *can* mean that the amount of heroin to be dissolved is greater than usual, but there can also be other reasons, for example that the drug is particularly difficult to dissolve.

7.1.4 Needle exchange programmes in Norway

See the data in Standard Table 10.

The primary objective of needle exchange programmes is to reduce the risk of infectious diseases associated with the sharing of injection equipment. Approximately 3.3 million needles were handed out in Norway in 2007, largely through low-threshold services. In a follow-up survey carried out by SIRUS, 13 towns/municipalities – including the three biggest

cities, Oslo, Bergen and Trondheim – reported that almost 3.1 million needles were handed out in 2009. More than 1.9 million needles were handed out in Oslo alone. Sales through pharmacies come in addition, but we lack an overview of sales to drug users in this context. Since some municipalities that run needle exchange programmes did not respond to the survey, the actual number is even higher. Norway is assumed to have +/- 10,000 injecting users. To give an example, 3.3 million needles means 330 per person per year, which appears to be the highest needle distribution frequency in Europe in relation to population size.

7.1.5 Nursing and care services for drug addicts and alcoholics

On assignment for the then Ministry of Health and in collaboration with the City of Oslo, the Salvation Army set up the so-called Street Hospital in 2005 as a three-year project (see NR 2007, Chapter 7.2). Government grants for the Salvation Army's Street Hospital have continued after the project period and the service has now been expanded to include a separate women's department.

In September 2009, the Church City Mission opened 24/SEVEN, a 24-hour low-threshold service in Oslo city centre, that aims to provide health and welfare services for those drug addicts and alcoholics who are most in need. The service is staffed by professionals who work on both an ambulant and outreach basis round the clock all year. The staff cover a wide range of fields, including social workers, child welfare officers, doctors, psychiatrists, psychiatric nurses and others. Most of them have extensive experience in the fields of drugs and alcohol and psychiatry. Efforts were made in spring 2010 to establish a team of volunteers. In August/September 2010, the team consisted of 17 persons who are mostly present during the afternoon and evening shifts when the influx of users is at its peak. In addition, 24/SEVEN has a doctor who works as a volunteer one day a week and two medical students doing practical training. 24/SEVEN will be evaluated by SIRUS and the final report will be completed in 2012.

8. Social correlates and social reintegration

8.1 Social reintegration

See also information in Structured Questionnaire 28.

8.1.1 Housing

A survey from 2008 estimates that the number of persons with no fixed abode in Norway is 6,100, which is an increase from a corresponding survey in 2005. It is reported that approximately 60 per cent of homeless people have drug or alcohol problems and that 32 per cent have mental health problems. The survey also showed that homelessness is mainly a problem in cities. In recent years, a range of housing and service models have been developed, such as the *Homeless people project* and *Obtaining housing for oneself*. The Action Plan specifies that these initiatives will be further developed and that experience from them will be spread to more municipalities.

The following four measures in the Action Plan aim to strengthen housing services for people with drug or alcohol problems:

• Increase efforts to eradicate homelessness – with particular focus on homelessness in small municipalities
• Increase efforts to prevent homelessness, including reducing the number of evictions and temporary housing arrangements
• Develop methods and procedures for following up people in temporary housing so that they can be offered permanent housing
• Introduce a new investment grant for nursing homes and sheltered housing.

All four measures were initiated in 2009.

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

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

Housing on release from prison
Efforts to obtain housing for inmates on their release are dependent on whether the municipality has suitable accommodation to offer. At the end of 2008, more than half of all

inmates had no accommodation upon their release. It was also reported in 2009 that many municipalities had no housing to offer these groups.

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

8.1.2 Employment

The qualification programme aimed at strengthening efforts for persons with significantly impaired work capacity and earning ability who have limited or no National Insurance rights.

The qualification programme was described in NR 2009 chapter 8.1.3. The programme, and the pertaining benefits, targets persons with significantly impaired work capacity and earning ability who have limited or no rights to National Insurance benefits. The purpose is to help more people in the target group to find employment. The programme must be individually-adapted and work-related, so that it supports and paves the way for the transition to employment. Persons with drug or alcohol problems are part of the target group provided that they meet the conditions for participation. There are no figures available to indicate how many of the participants have drug or alcohol problems, but feedback from the local NAV[14] offices shows that they are included among the participants.

Convicted persons' connection to the employment market

It is an express goal of the Action Plan that more convicted persons who are serving prison sentences succeed in finding employment or join a qualification programme on their release. There are eight NAV advisers in Norwegian prisons. They cooperate with the NAV offices in connection with prisoner releases. All the regions have entered into agreements with NAV at the regional level. A number of local agreements between prisons and NAV offices are also in place.

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

Work training etc.

As part of the Government's efforts to combat poverty, the Ministry of Labour awards grants to voluntary organisations with the aim of strengthening and developing activation and work training models. The target group consists of people who are highly marginalised in relation

[14] The Norwegian Labour and Welfare Service

to the employment market and in many ways excluded from the social arena. Persons with drug or alcohol problems are a prioritised target group. The scheme received EUR 1.25 million(NOK 10 million) in additional funding in 2009, increasing its budget to EUR 2.7 million(NOK 21.5 million). A total of 34 projects received grants in 2009.

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

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

9.1 Drug law offences

9.1.1 Legal basis and type of statistics

Norway does not have separate legislation relating to drugs. Two acts apply in connection with the reporting, charging and prosecution of drug crimes: the Act related to medicines and the General Civil Penal Code.[15] Statistics Norway (SSB) is the Norwegian institution responsible for keeping statistics on drugs in the judicial system. Four types of crime statistics are published annually (http://www.ssb.no/kriminalitet/):

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

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

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

- Offenders with drug offences as their primary offence[16]
As a *minimum*, these statistics show the number of persons who are prosecuted for the different types of drug crime.

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

9.1.2 Statistics

Reported crimes

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

[16] Only the primary offence, the most serious crime, is registered in the statistics

In 2009, 39,280 drug crimes were registered, which is an increase of five per cent from 2008, but down in relation to 2006-2007. The different types of violations of the Act relating to medicines and the General Civil Penal Code increased, except for the most serious types of drug crimes, which remained relatively stable at around 1,100 cases (Table 5).

Table 5: Number of reported drug crimes 2003-2009*.

Year	2003	2004	2005	2006	2007	2008	2009
Drug crimes (section 162)	15,009	15,671	16,163	17,966	17,779	16,475	17,556
Aggravated drug crimes (section 162)	1,143	1,143	955	1,190	1,307	1,072	1,060
Other drug-related [17]crimes	524	441	419	533	642	750	765
Total pursuant to the General Civil Penal Code section 162	**16,676**	**17,255**	**17,537**	**19,689**	**19,728**	**18,297**	**19,381**
Drugs, use	10, 547	10,925	11,259	12,635	12,806	11,585	12,040
Drugs, possession	8,533	8,364	8,070	8,627	7,562	7,005	7,100
Drugs, miscellaneous	901	715	731	747	659	601	
Total pursuant to the Act related to medicines	**19,981**	**20,004**	**20,060**	**22,009**	**21,027**	**19,191**	**19,899**
Total number of drug cases reported	36,657	37,259	37,597	41,698	40,755	37,488	39,280

* Number of cases
Source: Statistics Norway.

Charges

No full count of all persons charged with drug crimes based on the underlying data and including concluded investigations of offences is available for the period after 2005. Data from 2005 show that, in total, 15,600 persons were charged with 63,900 crimes, 37,300 (58%) of which were drug crimes. Of the drug crimes, 19,700 were violations of the Act relating to medicines, 12,000 of which for the use of drugs. Forty-two per cent of the charges thus also relate to other crimes than drug crimes. Those charged with drug crimes have many different combinations of offences. Theft and other crimes against property are more predominant than for those not charged for drug crimes. There is also a high proportion of charges relating to certain types of minor offences:

- drink driving (32%)
- driving without a valid licence (41%)
- breach of the peace offences (48%)

Penal sanctions

[17] Includes doping crimes and aggravated receiving of the proceeds of drug crimes

As regards penal sanctions, drug crime is still the biggest group of crimes, and drug crime was the primary offence in 43 per cent of all types of criminal cases in 2009, a slight reduction from 2008 (Figure 8). However, this percentage can result in a skewed picture of the prevalence of this type of crime. The clear-up rate for drug crimes is higher than for all other types of crime, which means that drug crimes account for a far bigger proportion of crimes among convicted persons. Reported violations of the Act relating to medicines, which account for about half of all drug cases every year, (almost) always lead to criminal prosecution of the offender, which entails a charge and results in some form of penal sanction. On the other hand, many judgments may serve to conceal drug crimes, also relatively serious ones, for which the person in question is not sentenced because only the primary offence, i.e. the most serious offence, is identified in the statistics.

Figure 8: Number of penal sanctions for drug crime as the primary offence 1999-2009.

Source: Statistics Norway.

In 2009, 12,862 penal sanctions were imposed with drug crime as the primary offence. Of these, 7,279 were penal sanctions imposed pursuant to the General Civil Penal Code while 5,583 were imposed pursuant to the Act relating to medicines. The latter mainly relate to the use and possession of small quantities of drugs. It is worth noting that only 1,191 were convictions by a court resulting in unconditional prison sentences, while 335 convictions resulted in partly unconditional and partly suspended sentences. The total number of fines was 9,212, while community sentences were imposed in 463 cases, almost all of them pursuant to the General Civil Penal Code. Other sanctions included conditional waivers of prosecution (293), court-imposed fines (173), suspended prison sentences (381) and suspended prison sentences and a fine (813) (SSB).

Inmates with drug crimes as their primary offence
In 2007, drug crimes accounted for:

- 17 per cent of all new imprisonments in Norwegian prisons during the course of the year (1,900 of 11,600),

- 29 per cent on a given day (990 of 3,400)[18],
- 32 per cent of all those imprisoned on remand on a given day (180 of 575)

About sanctions for the use and possession of drugs

As mentioned, 5,583 penal sanctions were imposed pursuant to the Act relating to medicines in 2009. It must be assumed that almost all of them were related to the use or possession of small quantities of drugs as the primary offence. As regards possession, 24 convictions resulted in unconditional prison sentences and one in a suspended/unconditional sentence, 1.1 per cent (of 2,187 sentences) in all. The numbers are very small, but, with the exception of cannabis (15 g), this can partly be explained by the small quantities required for a conviction pursuant to the Act relating to medicines (up to two user doses for heroin, cocaine and amphetamines). The General Civil Penal Code section 162 usually applies to quantities greater than this.

As regards use as the primary offence, the proportion was 2.8 per cent (94 of 3,383 penal sanctions), while it was four per cent in 2007 (See NR 2008, Chapter 11.4 for more information). In other words, only a small proportion are given prison sentences for the use of drugs, although they are as many as 100 to 150 annually in absolute figures. Most of them are probably repeat offenders in the criminal justice system.

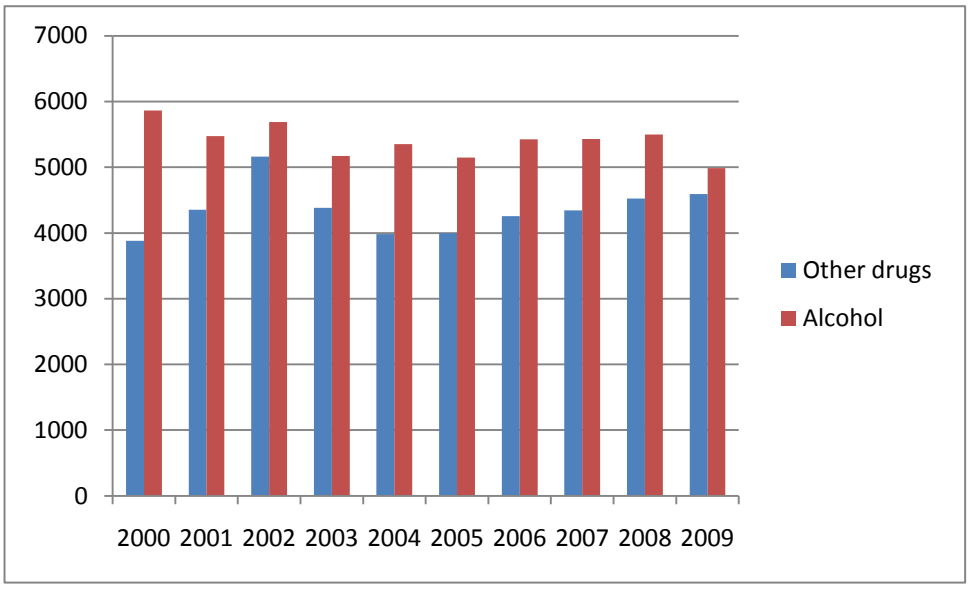
Fines are the most commonly used sanction when use is the primary offence. Fines were imposed in 2,981 (88%) cases in 2009. However, fines are also registered in criminal records, which may make it difficult to get certain jobs or to be admitted to certain study programmes that require a certificate of good conduct, or to be issued a visa to some countries or to be issued a driving licence.

9.2 Driving offences

In 2009, the Norwegian Institute of Public Health carried out 9,577 analyses of samples from drivers suspected of driving under the influence. This is a slight reduction from 2008 (10,025). Of these, 1,700 were breathalysers taken locally by the police using an Intoxylizer device, approximately 3,300 were blood samples that were only analysed for alcohol, and 4,590 were blood samples on which the Institute of Public Health conducted analyses of both alcohol, intoxicating medicinal drugs and narcotic substances (Figure 9). As a matter of routine, the institute checks for over 30 different intoxicating medicinal drugs and narcotic substances, and it usually finds several substances in the same blood sample.

Figure 9: The number of road traffic cases received involving suspicion of being under the influence of either alcohol or other substances.

[18] Given day = 1 January 2007. Persons serving prison sentences in lieu of payment of a fine, in total 870 new imprisonments in 2007, are not included.



Source: Norwegian Institute of Public Health

Alcohol is still the most commonly found substance in blood samples from drivers suspected of driving under the influence (approx. 4,600). In 2009, methamphetamine was for the first time the second most commonly found substance after alcohol. Methamphetamine was found in 1,480 (32%) of all the blood samples that were analysed for alcohol, intoxicating medicinal drugs and narcotic substances. This represents a fourfold increase since 2001.

Table 6 shows which narcotic substances/intoxicating medicinal drugs that were found in blood samples of drivers arrested by the police in 2009 on suspicion of driving under the influence. Both illegal narcotic substances and medicinal drugs that can be prescribed (e.g. codeine and diazepam) are included. The analysis findings do not necessarily tell us whether the drug was taken illegally. As a rule, several substances are found in the same blood sample.

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

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

Benzodiazepines may have been legally prescribed and used in correct doses, but many of the findings are due to the use of illegally obtained tablets. The tablets can also contain far higher doses of the active agent than the legal tablets. Blood samples from these drivers often also contain other substances, such as (meth)amphetamine, hash, heroin and cocaine in addition to one or more types of benzodiazepines (Norwegian Institute of Public Health 2010).

Table 6: Some finds of substances other than alcohol in blood samples from drivers suspected of driving under the influence in 2009. The number and percentage of blood samples on which a broad analysis was carried out.

	Name of substance	Example of name of medicine Explanation	N= 4,590	Percentage
1	Methamphetamine		1,480	32%
2	THC	Active agent in cannabis	1,252	27%
3	Diazepam	Valium ® Vival ® Stesolid ®	1,084	24%
4	Amphetamine		1,071	23%
5	Clonazepam	Rivotril ®	894	19%
7	Morphine	Heroin Dolcontin® Paralgin forte®	349	8%
10	Codeine	Paralgin forte®	206	4%
11	Methadone	Methadone®	145	3%
13	Flunitrazepam	Flunipam® Rohypnol®	85	2%
14	Buprenorphine	Subutex® Temgesic® Subuxone®	75	2%
15	Fenazepam		69	2%
17	GHB		50	1%
18	Cocaine		22	0.5%
20	MDMA		12	0.3%

Source: Norwegian Institute of Public Health

Roadside testing

From April 2008 to March 2009, the Institute of Public Health, in collaboration with the Institute of Transport Economics and the Mobile Police Service, took more than 9,000 samples of Norwegian drivers as part of the European roadside survey DRUID (Driving under the Influence of Drugs, Alcohol and Medicines). A total of 94 per cent of the drivers asked gave saliva samples, which were analysed for approximately 30 different intoxicants and medicinal drugs deemed to constitute a road safety hazard.

Preliminary results

In total, substances hazardous to road safety were found in 6.7 per cent of the saliva samples. Medicinal drugs hazardous to road safety were found in 4.5 per cent of the samples, narcotic substances in 2.0 per cent and a blood alcohol level over 0.2 mg/ml in 0.3 per cent of the samples. Most of the cases concerned small quantities that would not entail an increased risk of traffic accidents.

- The most commonly used medicinal drug hazardous to road safety was the soporific drug zopiclone, which is found in Imovane, among other substances. Tranquilisers and strong painkillers were also common.
- Cannabis was the most frequently found narcotic substance (1.2%), followed by cocaine (0.5%) and amphetamines (0.5%).
- Findings of cocaine had almost tripled in relation to 2005-2006.
- It is still mostly men under the age of 35 who use illegal substances. In this group, approximately five per cent of the saliva samples tested positive for narcotic substances.

9.3 Interventions in the criminal justice system

9.3.1 Alternatives to prison

See also information in Structured Questionnaire 31.

Serving of sentences outside institutions pursuant to the Execution of Sentences Act section 12.

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

In 2009, 541 persons were serving sentences under this system, 15 per cent of whom were women. The total number had increased steadily during the past six years (Table 7). A total of 295 persons started serving their sentence in prison and were later transferred to an institution. The other 246 started serving their sentence in a treatment institution.

In 2009, 41,641 days were served in an institution pursuant to section 12, which is a reduction in relation to the previous two years (Table 8). The number of days served by female inmates pursuant to section 12, however, has increased significantly in the same period .

Table 7: Number of sentences started pursuant to section 12, 2004-2009.

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

Source: The central administration of the correctional services

Table 8: Number of days served pursuant to section 12, 2004-2009.

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

Source: The central administration of the correctional services

9.4 Drug use and problem drug use in prison

A survey of living conditions carried out by FAFO (the Institute for Labour and Social Research) in 2004 showed that approximately 60 per cent of all inmates have a drug or

alcohol problem before they are imprisoned. No new surveys have been conducted that provide an estimate of the extent of the problem.

Finds of drugs/user equipment

The number of drug seizures in Norwegian prisons has increased significantly, from 653 in 2008 to 1,095 in 2009. Almost all the user doses that were found were small. Cannabis and amphetamine/methamphetamine dominate the finds. The number of seizures of user equipment increased from 941 in 2008 to 1,042 in 2009. Very few seizures of needles were made compared with previous years. The number of cases involving illegal drug use declined, from 2,704 instances in 2008 to 2,645 instances in 2009.

A total of 26,235 urine samples were taken in prison during 2009, and drugs were found in 16 per cent of the cases. In some cases, the finds concerned lawful medication. The proportion of finds of illegal substances was around 10 per cent.

The statistics include both high-security prisons (previously called closed prisons), low-security prisons (previously called open prisons) and halfway houses (the central administration for the correctional service, 2010).

10. Drug markets

10.1 Availability

10.1.1 Availability based on seizures

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

On the basis of seizures, the availability of cannabis still appears to be great. The number of seizures is higher than ever before and the geographical spread seems to be great. Cannabis was seized in all the 27 police districts in 2009, and twenty police districts have made more seizures than in 2008.

As in the last few years, cocaine was seized in 26 police districts, but the number of seizures declined from 2008 to 2009 in 21 of them. Kripos claims that the decline is probably not due to changes in resource management and the targeting of typical cocaine milieus alone, and it therefore believes that the supply and geographical spread of cocaine declined in 2009 in real terms.

The number of seizures of amphetamine, and methamphetamine in particular, is clearly higher than the level in recent years, except for 2006. Measured in terms of the number of seizures, these two drugs are the second most widespread in Norway after cannabis. All the police districts made seizures of both amphetamine and methamphetamine in 2009, and 20 districts made more seizures than the year before. However, amphetamine and methamphetamine are still used interchangeably, depending on what is available on the market. There are no clear indications of a particular demand for methamphetamine.

Although the number of seizures of heroin is far lower than at the turn of the millennium, there was an increase of 25 per cent from 2008 to 2009. This increase took place in a period in which more than 5,000 people are being treated for heroin addiction with methadone and Subutex. It cannot be precluded, therefore, that new users are being recruited to the heroin market. Heroin was found in 26 police districts , which indicates that it is widespread in the country as a whole. Yet again, Oslo police district and Hordaland police district, which includes Bergen, the second biggest city in Norway, made most seizures. Oslo's share of the heroin seizures has decreased dramatically, however, from 74 per cent in 1994 to 36 per cent in 2009.

As regards ecstasy, the market is primarily characterised by a decline in both the quantity and number of seizures of tablets. We have to go all the way back to 1994 to find a lower number of seizures, i.e. to a time when ecstasy had barely been introduced in Norway. A total of 21 police districts make seizures, but, in 15 of them, the number of seizures was lower than ten.

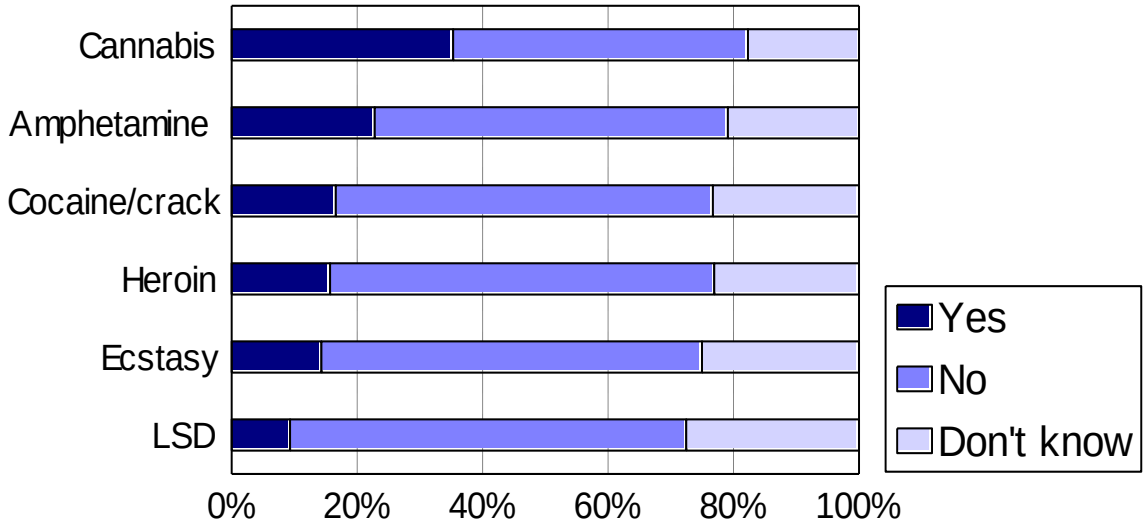
GHB and GBL are not widespread compared with the most common illegal substances. However, we cannot exclude the possibility that the chances of GHB/GBL being detected is lower than for other drugs since the appearance and effect of GHB/GBL and alcoholic beverages are very similar. This may mean that the seizure statistics do not reflect the actual prevalence of the drug to the same extent as for other drugs. Based on information received from the police districts, plus statistical data, one can get the impression that GHB and GBL

are drugs that 'come and go'. There have been many overdoses in Bergen, recently, especially involving GBL. In the period from October 2009 to March 2010, Bergen Hospital Trust's Section for Acute Medicine registered 166 GHB/GBL-related overdose call-outs, compared with 98 in the six previous months.

10.1.2 Availability based on questionnaire surveys

In population studies from 1994, 1999 and 2004, respondents were asked whether they could obtain various substances in the space of two to three days. As an adaptation to the European Model Questionnaire (EMQ), the question in the population survey for 2009 (see Chapter 2) was changed to 'in the space of 24 hours'. Figure 10 shows the results for all the illegal substances concerned. The proportion of 'yes' answers seems high considering that the survey also includes small places with, presumably, poorer access to narcotic substances.

Figure 10: Percentage 'yes' answers in 2009 to the question: Do you believe that you could obtain any of the following substances in the space of 24 hours?



Source: SIRUS

10.2 Supply

10.2.1 Smuggling routes to Norway

According to the customs service, most of the *amphetamine/methamphetamine* on the Norwegian market comes from illegal laboratories in the Netherlands, Poland and Lithuania. Lithuanian criminals have had a dominant role for several years as suppliers of synthetic drugs to Norway, and the proportion of methamphetamine seized from Lithuania is significant. The main routes go by ferry via Sweden or through Germany and Denmark. Cars with concealed cavities still seem to be the most frequently used method.

Cannabis (*hash and marijuana*) seized in Norway mainly comes from Morocco via the Netherlands. From the Netherlands, hash is transported via Denmark to Norway by car, bus,

train or plane. The customs service uncovers large quantities of cannabis in passenger cars and heavy goods vehicles. The proportion of smuggled marijuana is stable.

GHB and GBL are smuggled to Norway from the Netherlands, Poland, Germany and the UK. Most of the seizures are dispatched by post and as courier shipments, while attempts are made to smuggle larger shipments by car. The customs service has uncovered an increasing amount of GBL lately. GBL was included on the Norwegian list of narcotic substances on 24 March 2010 (Chapter 1.1).

Heroin sold in Norway mainly comes from Afghanistan via Turkey along the so-called Balkan route to Western Europe. The customs service uncovers large quantities in prepared cars from the Netherlands and Germany. The number of couriers who smuggle heroin inside their bodies is increasing.

Khat is transported from production areas in Africa to Europe. It is smuggled on to Norway from the Netherlands and the UK by plane and car. Most of the seizures are made from airline passengers who arrive from the Netherlands and the UK. The largest quantities, however, are transported by road in cars from the Netherlands via Germany, Denmark and Sweden.

Cocaine sold in Norway comes from production areas in South America. It is then transported via Africa or directly to ports and airports in Europe. Cocaine is smuggled to Norway using various means of transport and couriers. The number of couriers who smuggle cocaine inside their bodies is increasing.

The customs service uncovers an increasing amount of drugs in the post and as courier shipments. This applies in particular to narcotic tablets ordered online. (Personal communication, Directorate of Customs and Excise Enforcement Department, Anti Smuggling Section).

10.3 Seizure statistics for 2009

See also the data in Standard table 13.

Data basis and sources of error

The annual report from the National Criminal Investigation Service (Kripos) on the status of and developments in drug trafficking contains national data that include all seizures by the police, the customs service, the prisons and the Armed Forces. The data are based on verified analysis results for use in ordinary criminal cases, as well as on information from the police districts when drug offences are decided locally through fines or by summary trial based on a plea of guilty. The latter categories are decided without the seizures being tested at the Kripos laboratory. In these cases, relevant information is usually given about what the seizures probably contain. The sources of error are not deemed to have a significant bearing on the main trends, but experience indicates that some of the minor seizures may include other types of drugs than those stated in statements to the authorities. This may apply in particular to the ratio between amphetamine and methamphetamine or to so-called 'ecstasy tablets' that no longer always contain MDMA or analogues.

Main features of the drug statistics for 2009

In 2009, 21,866 drug cases and 26,480 seizures were registered. Of the total number of drug cases, 8,866 were analysed, while 12,980 were fixed-penalty cases. The increase in the number of cases since 2008 is 11 per cent – an increase of 6 per cent for the analysis cases

and 16 per cent for fixed-penalty cases. In reality, more than two-thirds of all drug cases in 2009 were decided without a chemical analysis being carried out.

The quantities seized will naturally vary considerably from one year to the next. As an indicator of the size of individual seizures, based on quantitative criteria for prosecution that meet the definition of aggravated drug crime in the General Civil Penal Code section 162, third paragraph, as many as 64 such large drug seizures were made in 2009 (Table 9). There has been a particularly large increase in the number of heroin cases, which has doubled since 2008.

Table 9: Large drug seizures pursuant to General Civil Penal Code section 162 third paragraph in 2008 and 2009.

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

Source: Kripos

As Table 10 shows, the amount of drugs seized varies greatly from one year to the next, without the number of seizures changing significantly. Seizures of heroin made during the period 2007 to 2009 can serve as an example: while a strikingly small amount was seized in 2007 (8 kg), the number of seizures increased for the first time in ten years. In 2008 and 2009, however, the quantities of heroin seized increased significantly, to 55 kg and 130 kg, respectively, without affecting the number of seizures correspondingly. A larger quantity of heroin has never before been seized.

Never before has a larger amount of hash been seized or more seizures made than in 2009, and never before have more seizures been made of cannabis products overall.

As in 2007 and 2008, very large quantities of amphetamine (approx. 197 kg), methamphetamine (approx. 234 kg) and cocaine (approx. 61 kg) were seized in 2009, a total of 492 kg in more than 6,500 seizures. Although this is 25 per cent less than in the record year 2007, it is nonetheless a large quantity of drugs, both in the Nordic and in the European context, especially as regards methamphetamine.

Since the police's reporting procedures for khat failed in both 2008 and 2009, Kripos does not have traditional seizure information for these years from the police districts. Based on information from the Directorate of Customs and Excise, the customs service seized 8,842 kg gross in 259 seizures in 2008. This is roughly the same status as in 2007.

The number of seizures of benzodiazepiner (BZD) increased again. However, both the quantities seized and the number of seizures are far lower than at the turn of the millennium.

Table 10: Amounts seized for the most relevant drugs 2004-2009.

Year	2004	2005	2006	2007	2008	2009
Cannabis (kg)	2,242	1,439	1,544	853	1,732	2,588
Amp/methamphetamine (kg)	293	156	386	559	363	431
Heroin (kg)	129.1	36.4	93.0	8.0	55.2	130.1
BZB (units)	542,100	571,400	1,001,700	733,000	311,000	671,236
Opioids (units)	15,100	14,500	16,600	16,500	11,200	15,186
Cocaine (kg)	38.3	177.0	40.5	95.0	76.8	61.3
Ecstasy (units)	53,561	16,034	28,636	78,725	30,790	22,465
Psilocybe mushrooms (kg)	5.1	1.2	0.85	1.4	0.45	1.6
Khat (kg)	3,668	2,768	2,781	7,747	3,104*	3,071*
LSD (units)	616	125	226	26	245	510
GHB (ltr)	4.3	12.3	31.3	58.6	36.5	66
GBL (ltr)	5.4	0,9	14.2	42.3	220.8	128

**Data are incomplete*

Source: Kripos

Table 11 shows the changes in the number of seizures during the period 2003 to 2009. Figure 11 shows the market share in 2009 for the most common substances.

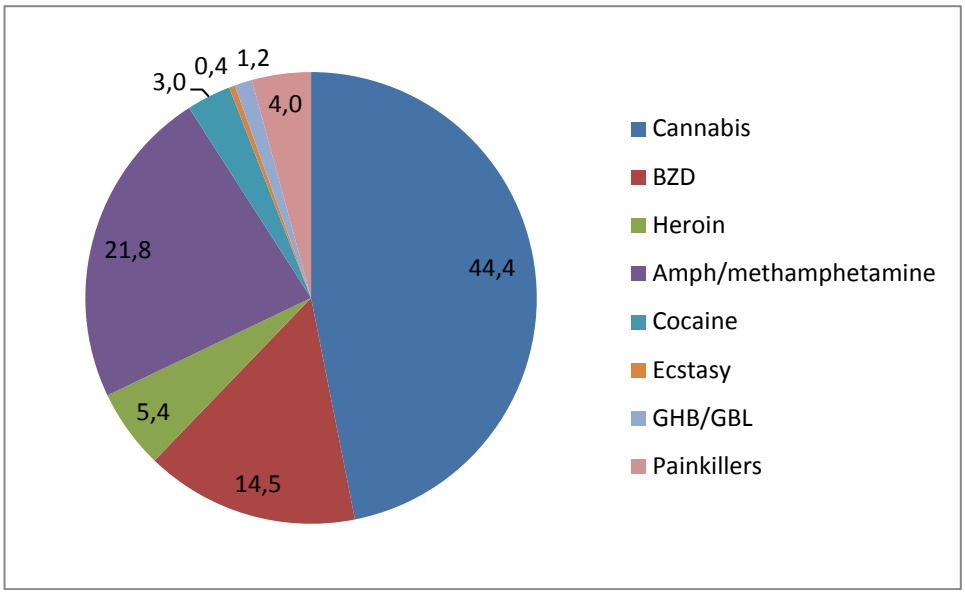
Table 11: Number of seizures in the period 2003-2008 broken down by some types of drugs.

Drug type	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**
Cannabis	10,397	10,097	10,128	11,221	9,952	10,591	11,754
Amph/methamph	5,218	4,933	5.361	5,819	5,507	5,161	5,775
Heroin	1,709	1,399	1,151	1,087	1,204	1,147	1,430
Benzodiazepines	4,700	4,358	3,929	4,551	4,088	3,490	3,840
Painkillers/ opioids	1,216	1,146	1,319	1,161	959	936	1,078
Cocaine	504	464	685	726	909	854	804
Ecstasy	405	452	341	411	421	310	109*
LSD	31	30	34	28	13	15	26
GHB	120	28	46	65	163	134	218
GBL	21	11	3	11	24	40	103
Psilocybe mushrooms	89	77	75	82	77	54	75

**Estimated number of seizures based on verified results.*

Source: Kripos

Figure 11: Market share for different drugs in 2009. Number of seizures. Percentage.



Source: Kripos

Comments on the individual drugs

The amount of *cannabis* seized, 2,587 kg, breaks down into about 2,417 kg of hash (93%), 122 kg of marijuana (5%), 55 kg of cannabis plants (2%) and 0.016 kg of cannabis extract. The corresponding figure for hash in 2008 was only 71 per cent. The record quantity of hash can primarily be explained by three large individual seizures of 417, 361 and 333 kg, respectively.

The number of cannabis seizures, 11,766, breaks down into about 84 per cent hash, 14 per cent marijuana and two per cent cannabis plants.

The number of seizures of cannabis plants, 203, was more or less unchanged from 2007 and 2008, but the quantity seized, 55 kg, was far lower (2007:119 kg, 2008: 347 kg). Cultivation activity thus seems to be on a par with previous years, but the 'plantation activity' that was uncovered seems to have more or less disappeared. The quantity seized is again at a more traditional level.

In 2009, the number of seizures of *methamphetamine* was higher than for *amphetamine*. This situation has never been registered before. The proportion of methamphetamine has tripled in four years, as illustrated by Table 12.

Table 12: Propotion of seizures of methamphetamine in relation to amphetamine*.

Year	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
% Meth.	6.2	10.8	15.4	21.1	22.0	26.0	26.1	34.4	43.6	64.3

**The proportions for some years have been adjusted in relation to the same table in the national report for 2009.*

Source: Kripos

Source: Kripos

Following a strong increase in seizures and quantities of *cocaine* since the turn of the millennium, particularly since 2005, both the quantity and the number of seizures culminated in 2007. In both 2008 and 2009, the quantity and number of seizures dropped significantly. Cocaine also shows a downward trend in relation to the number of seizures of all other drugs, from 3.6 per cent in 2008 to three per cent in 2009.

As regards *ecstasy*, the proportion of MDMA has been strongly reduced in the past two years. MDMA has almost completely dominated seizures of ecstasy tablets for many years. Until 2008, no other agent accounted for a substantial part of this tablet market. In 2006, nearly 100 per cent of the tablets contained MDMA, while in 2009 this proportion had been reduced to around 20 per cent. MDMA has largely been replaced by other intoxicants, primarily mCPP (1.3-chlorphenylpiperazine), or other isomers. In addition, quite considerable amounts of other substances were seized in this tablet sector, carrying the same logo as ecstasy:

PCP ('angel dust')

In total, 22,044 tablets of PCP combined with methamphetamine or methcathinon were seized in five seizures. Although the geographical spread of tablets containing PCP is probably limited, it is worrying that individual seizures are made of a drug whose use is considered to be particularly risky.

CPP (mainly 1.3-chlorphenylpiperazine or mCPP)

This substance was first registered in Norway in 2005, but it was not included on the list of narcotic substances until March 2010 (Chapter 1.1). The drug has a relatively weak hallucinogenic effect, but, with more than 48,000 tablets seized in 143 seizures in 2009, it has become the dominant substance in this sector. The geographic spread is also considerable, as shown by Table 13. A total of 20 police districts made seizures of the drug in 2009.

Table 13: Seizures of CCP in the period 2005 to 2009.

Year	2005	2006	2007	2008	2009
Number of tablets	10,490 +2g	16+0.18g	1,953	3,757	48,205
Number of seizures	11	3	32	50	143
Number of police districts	3	3	9	14	20

Source: Kripos

Painkillers, medicinal drugs classified as narcotics

A total of 14,799 tablets were seized in 1,078 seizures. Both the quantities and the number of seizures were markedly higher than in 2008. No major seizures were made of these medicinal drugs in 2009. Several of the cases concerned the illegal importation of such medicinal drugs via internet shopping, but the number of tablets in each seizure is relatively small. Based on the number of seizures, buprenorphine (Temgesic, Subutex and Subuxone) predominates this year as well. The frequency of seizures of buprenorphine and methadone seems to be increasing, and in 2009 they account for more than 50 per cent of all seizures in this class of medicinal drugs.

Benzodiazepines (BZD)

Based on seizure data, there is little doubt that demand for this type of medicinal drug appears to remain great on the illegal market. As regards the frequency of seizures, BZDs once again take third place behind cannabis and amphetamine/methamphetamine. However, the proportion in relation to all other drugs is smaller than for several years. Diazepam (Valium, Stesolid) accounts for almost a third of the seizures. Both the quantity and the number of seizures indicate that illegal trafficking of clonazepam, primarily Rivotril, is on the increase. Rohypnol was de-registered as a medicinal drug in Norway on 1 August 2004. All the Rohypnol seizures must therefore come from illegal imports.

GHB and GBL

The total number of seizures of GHB and GBL exceeded 300 for the first time in 2009. Seen in conjunction with other drugs, however, this only accounted for one per cent of registrations of substances classified as narcotics.

LSD and other hallucinogenic drugs
Seizures of LSD have remained at a stable low level for the past ten years. Since LSD is easy to conceal, however, we cannot exclude the possibility that the seizure statistics do not given an accurate picture of the actual situation.

Psychoactive plants and plant parts that are not classified as narcotics are regularly seized on the grounds that their importation is not normally permitted. Much of this traffic is probably the result of information and offers on the internet. Kripos has primarily registered seeds of *Argyreia nervosa* (Hawaiian Baby Woodrose), *Salvia divinorum*, *Peganum harmala*, seeds of peyote cactus and peyote cactus containing mescaline.

More psychoactive substances were registered in 2009, primarily substances with a hallucinogenic effect, both substances that are included on the list of narcotic substances and substances not classified as narcotics. Examples include fluorine amphetamine, mefedrone, 2,5-dimethoxy amphetamine, 4-chlorine-2,5-dimethoxy amphetamine, DPT, 5-MeO-DIPT and piperazine derivatives.

10.4 Price of illicit drugs at retail level

See the data in Standard table 16.

An overview of stipulated drug prices as of May 2010 has been obtained from Oslo police district. Naturally, a price list of this kind must be treated with considerable caution. However, since the data have been collected from the same source for several years, a certain amount of comparison is possible. Compared with the previous overview from October 2008, the nominal price of a typical user dose in the Oslo area has remained relatively stable: EUR 25 (NOK 200) for 0.2g of heroin, EUR 12.5 (NOK 100) for 0.2g of amphetamine, EUR 37.5-50 (NOK 300-400) for 0.5g of cocaine, and EUR 12.5 (NOK 100) for 0.7g of hash.

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

The price also seems to have dropped for purchases of 10 grams. The estimated price of 10 grams of heroin is between EUR 450 and EUR 688 in 2010 (NOK 3,600 and NOK 5,500). In 2008, the price level was EUR 625-750 (NOK 5,000-6,000). The price of 10 grams of cocaine and amphetamine is also markedly lower, approximately 18 per cent lower for cocaine and as much as 25 per cent for amphetamine. There are no such changes in relation to hash.

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

10.5 Purity/potency/composition of illicit drugs and tablets

See data in Standard tables 14 and 15.

Heroin
Table 14 shows that the average purity of heroin base has remained largely stable in recent years. However, a potency of 25 per cent in 2009 is historically very low. The lowest and highest content of heroin has been stipulated at one per cent and 55 per cent, respectively. For six seizures of drug mixtures containing heroin chloride, the average purity was stipulated at 44 per cent. As in previous years, paracetamol and caffeine were found in a number of seizures, in addition to depressants such as benzodiazepines. In Oslo, for example, a number of seizures were made that contained heroin combined with alprazolam. A typical mixture would contain 8-10 per cent heroin and a large proportion of alprazolam, which causes stronger and more untraditional intoxication symptoms.

Table 14: Average purity of heroin 2004-2009.

Year	2004	2005	2006	2007	2008	2009
Purity percentage	27	26	30	36	31	25

Source: Kripos

Cocaine
The average purity of cocaine has been halved in four years, from 50 per cent in 2004 to 25 per cent in 2009.

Table 15: Average purity of cocaine 2000-2009.

Year	2000	2005	2006	2007	2008	2009
% cocaine	69	50	35	39	37	25

Source: Kripos

Amphetamine/methamphetamine
The average purity in 2009 was about 29 per cent for amphetamine and 44 per cent for methamphetamine. This represents a decline for amphetamine and an increase for methamphetamine. As for heroin, the purity varied greatly in 2009, from about one per cent to as much as 97 per cent. Crystalline methamphetamine chloride ('ice') was seized on two occasions – for the first time in Norway. The seizures of 6 and 7.7 grams, respectively, had a purity of almost 100 per cent.

Cannabis

As in 2008, several quantitive measurements of THC were carried out in connection with the prosecution of cannabis cases. A total of approximately 50 quantitative measurements of THC were carried out, both for whole plants, for isolated top shoots and hash. Whole plants usually contained three to seven per cent THC, and isolated top shoots usually contained 11 to 22 per cent. For hash, on the other hand – which dominates the Norwegian market – the average THC purity is roughly seven per cent, as it has been for many years. The results of measurements vary greatly, however.

Part B: Selected Issues

11. History, methods and implementation of national treatment guidelines

Senior adviser Gabrielle Welle-Strand and senior adviser Martin Blindheim, Norwegian Directorate of Health

11.1. History and overall framework

Up until 2004, the legal basis for treatment for drug and alcohol problems in Norway was the Act relating to social services. In 2004, treatment for drug and alcohol problems was transferred to the specialist health services with the aim of integrating and normalising such treatment in the general health services on a par with other treatment at specialist level. At the same time, persons with drug or alcohol problems were given status as patients and thus acquired statutory patient rights.

In 2005, the Storting(Parliament) and the Ministry of Health assigned the Directorate of Health the task of drawing up guidelines for all drug and alcohol treatment at specialist level. The Directorate plans to complete this work in 2015. Guidelines will be prepared on the basis of the principles of evidence-based medicine following set criteria.

Work on the first guidelines, the National guidelines for opioid substitution treatment – OST, was initiated in 2006. The main reason why substitution treatment was the first topic chosen was the amount of attention it received in the media and from politicians and experts. This is partly because of the disproportionally high number of overdose fatalities in Norway. At the same time, however, substitution treatment has been a very controversial treatment form. An evaluation of the treatment offered in OST in 2003 uncovered undesirable regional differences. This was an important reason for work on the guidelines being initiated.

Methadone treatment was tentatively tested in a few projects around 1970, but, for the most part, Norway chose to develop a treatment system without the use of medication and characterised by an unwillingness to regard addiction as an illness. It was not until the HIV epidemic was detected among injecting users that a serious debate about substitution treatment started. On the basis of two Oslo-based trial projects, methadone treatment was made nationwide in 1998, following a decision by the Storting in 1997. From 2002, buprenorphine was also used systematically. The decision made it clear that substitution treatment was intended to be limited to a small number of hardcore heroin addicts, and as a supplement to other treatment without substitute medication. The reality proved to be different, and by the end of 2009, nearly 5,400 patients were receiving substitution treatment in Norway.

Norway was thus relatively slow to develop guidelines for drug and alcohol treatment.[19] The first guidelines for OST were completed in 2010 after more than four years' work. A further three guidelines are being developed; one on detoxification, one on the treatment of persons with drug or alcohol problems and concurrent mental illness, and one on substitution treatment for pregnant women and follow-up of children and families until the children reach school age. All the work on the national guidelines is based in the Directorate of Health, and all the guidelines contain knowledge-based recommendations.

11.2. Existing guidelines: narrative description of existing guidelines

National guidelines for opioid substitution treatment of opioid dependency

The target group for the guidelines consists of service providers who work with patients receiving substitution treatment from the specialist health service, both in municipalities and at pharmacies, correctional service staff, patients in OST and other drug addicts, plus their

[19] However, several guides have been produced for the municipalities and health service, including a guide relating to referrals to interdisciplinary specialist treatment for drug and/or alcohol problems and a guide to early intervention.

family members. The patient target group consists of opioid addicts. The objective of the guidelines is to make OST a normal, integrated part of the health service, to ensure that patients receive comprehensive treatment, and to help to ensure that the treatment offered is the same throughout the country. The guidelines have been prepared on the basis of the collation of international research and on clinical experience from Norway. The Regulations relating to OST issued by the Ministry of Health and Care Services on 1 January 2010 form the legal basis for the OST guidelines (see Chapter 1.1). The Regulations regulate the objective, admissions, discharges and control measures. OST is an interdisciplinary specialised treatment that includes substitution treatment as one of several measures in a comprehensive rehabilitation process. The substitute medications used are buprenorphine (preferably with naloxone) and methadone. The guidelines entered into force on 1 February 2010.

11.3 New guidelines under preparation

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

The target group for the guidelines consists of service providers working with pregnant women in OST and families with children who have been exposed to OST medication during pregnancy, both in the municipalities (health, social and child welfare services) and in the specialist health service (obstetrics, neonatal medicine, child and youth psychiatry, and interdisciplinary specialised treatment). The purpose is to provide clear, knowledge-based recommendations for the treatment and follow-up of pregnant patients in OST during pregnancy and while in hospital, and for follow-up/treatment of the child and the family from the time of birth until the child reaches school age. The main goal is for the family to receive individually-adapted and knowledge-based follow-up from a support system that provides professional and respectful follow-up, to ensure an optimal development process and a safe care situation for the child and the family. The guidelines will be completed during the first six months of 2011.

National professional guidelines for examining, treating and following up persons with drug or alcohol problems and concurrent mental illness

The guidelines will primarily target professionals and managers in the municipalities, plus health personnel and managers in the specialist health service, especially in the areas of mental health care and interdisciplinary specialised treatment. The guidelines will also be useful to other services such as the prison health service, the State Housing Bank and voluntary organisations. In addition to patients with serious mental problems with concurrent drug or alcohol problems, the guidelines will also address hyperkinetic disorders/ADHD, eating disorders and serious anxiety and personality disorders. The guidelines will cover three main areas:

1) Information about mental health problems and concurrent drug or alcohol problems
2) Recommended methods for mapping and diagnosing mental health problems and concurrent drug or alcohol problems
3) Recommended psychosocial treatment and follow-up.

The guidelines will be completed during the first six months of 2011.

National professional guidelines for detoxification in connection with different forms of drug or alcohol dependency

The target group for the guidelines consists of employees in interdisciplinary specialised treatment services and other parts of the specialist health service, employees in the primary social and health services, managers/administrators in the social and health services and users/family members. The guidelines aim to describe the various purposes of detoxification, what types of substances (including addictive medicinal drugs) require detoxification, and at what level of the service detoxification shall/can be offered. The guidelines will also contain a description of which detoxification methods should be used in connection with various conditions, and when there is a risk of serious drug/alcohol-induced poisoning conditions that require treatment/monitoring by ambulance personnel and in an observation ward/intensive care unit, plus therapeutic measures that support the detoxification process. Work on the guidelines started in autumn 2010.

11.4 Implementation process

The implementation of national guidelines starts as soon as a group has been appointed to work on them. When appointing a working group that will develop guidelines together with the Directorate of Health, it is emphasised that the members of the group represent the most important target groups for the guidelines. At the same time, the participants must also come from different parts of the country, different professions and different service levels, including research and user organisations. Similar considerations form the basis for the appointment of reference groups, but these groups can be put together on an even broader basis. Consultations are held when it is necessary to discuss specific areas in connection with guidelines. During work on the guidelines, information about how the work is progressing will be distributed on a broad basis, and a dedicated website will be established in connection with the work on the guidelines. Once the guidelines are completed, the implementation work is intensified by holding seminars and lectures for relevant target groups around the country.

In connection with the guidelines on drug or alcohol problems and concurrent mental health problems, a more systematic implementation project was conducted. The first part of the project involved identifying professional groups and organisations responsible for following up and treating this group of patients. It was then analysed how these professionals handle this patient group today and how big a change the new guidelines will entail (a GAP analysis). A national survey was conducted, and 154 managers and 1,047 clinicians were interviewed. On the basis of this survey, possible obstacles and enablers were identified in relation to the implementation of the guidelines.

11.5 Comparison with the WHO guidelines

The national professional guidelines for OST differ from the WHO guidelines on a few important points(see annex 1):

Substitution is not the first choice in the treatment of opioid dependency

The Regulations state that: *'Opioid substitution treatment shall not, as a rule, be the first choice of treatment for opioid dependency unless it is the most appropriate and adequate treatment option based on a professional assessment.'*

This provision must be seen as a statutory requirement that has been incorporated into the guidelines, but without a knowledge-based assessment.

The reason for not choosing substitution treatment as the first option is based on

- the extensive opposition to substitution treatment that has traditionally existed in Norway, and the decision by the Storting that such treatment was to be a supplement to treatment without substitute medication,
- relatively good access to long-term in-patient treatment,
- the view that substitution treatment in many cases represents a life-long treatment form that is demanding, especially for young people.

Choice of medication

The guidelines state: *'Buprenorphine should be the first choice in substitution treatment. Buprenorphine should be prescribed in combination with naloxone.'*

The reason for this is a wish to limit the number of overdose fatalities resulting from use of the substitute medication. Overdose fatalities involving buprenorphine are unusual compared with methadone. Based on an assessment of what is justifiable in relation to both the patient's safety and the safety of third parties, increased use of buprenorphine is preferred to methadone. An individual assessment, including consideration of justifiability, will nonetheless form the basis for the choice of substitute medication. The increased costs incurred in connection with such a recommendation are deemed to be counterbalanced by lower overdose fatality rates. Another reason why buprenorphine is the first option is that it is much easier to change from buprenorphine to methadone than vice versa, should that be an option.

Choice of dose

The choice of start-up regime and dose of substitute medication differs somewhat from the WHO guidelines:

In treatment with methadone, a daily increase in dosage of 10 mg is recommended during escalation. A lower dose than 60 mg is not recommended. There is no specific recommendation for the upper dosage limit. However, the dosage issue is considered in connection with the annual national monitoring of substitution treatment. A daily dose of between 60 and 120 mg is recommended in that connection. In treatment with buprenorphine, 16 mg is recommended as a daily stabilisation dose.

Apart from the above-mentioned recommendations, the recommendations in the Norwegian guidelines correspond well with the WHO guidelines. See Annex 1.

12. Mortality related to drug use: a comprehensive approach and public health implications

Helge Waal, professor emeritus, Norwegian Centre for Addiction Research, University of Oslo

12.1 Overall drug-related mortality among problem drug users

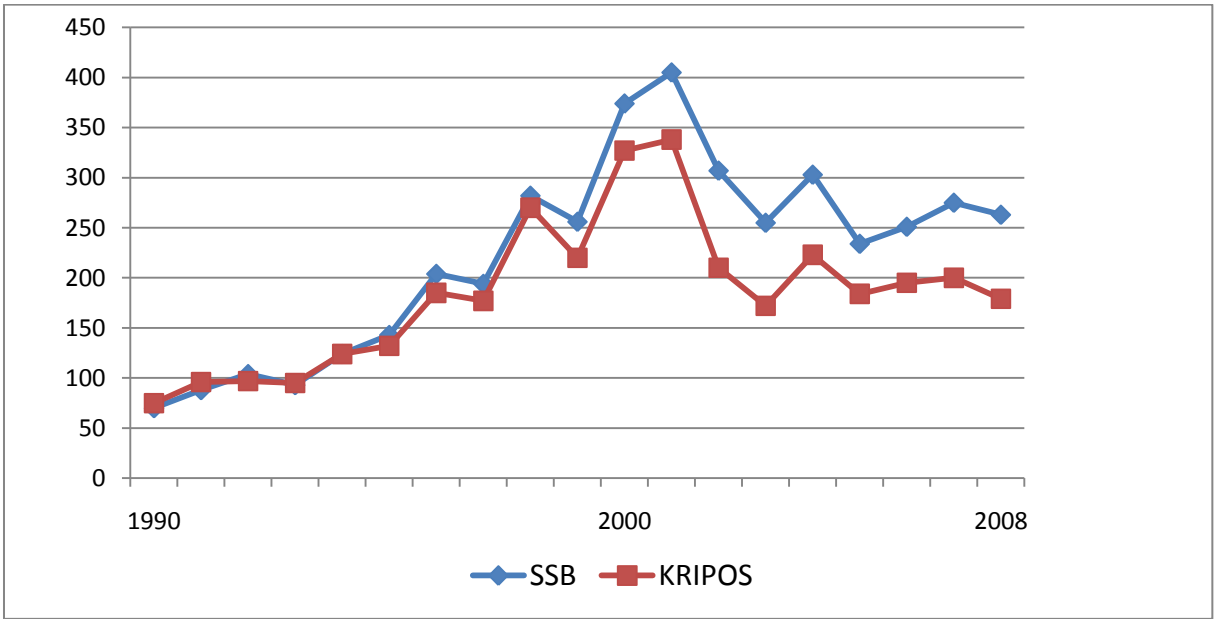
Introduction

Norway has a high number of drug-related deaths per million inhabitants between the ages of 16 and 64 compared with other European countries. The available data show that the number of such deaths increased steadily from the early 1990s, peaking in 2001-2002 (Figure 12). Since then, the annual mortality rate has decreased. The figures for the past five to six years show a relatively stable but still high mortality rate. See Chapter 6.3 for more detailed information about the gender and age distribution.

Drug-related deaths are reported by Statistics Norway (SSB) via the Norwegian Causes of Death Register. They correspond to Selection B in the EMCDDA's set of codes. Since 2003, the figures have been based on an extended list of codes in accordance with WHO's recommendations. This has resulted in significantly higher figures being reported than the overdose fatalities figures reported by the Norwegian Criminal Investigation Services (Kripos), which are defined as poisoning fatalities (Selection D). According to SSB, there were 263 fatalities in Norway in 2008, while Kripos reported 179 overdose fatalities, i.e. around a third fewer.

Annex 2 contains a description of an investigation of causes of deaths in the overdose statistics from the police. Annex 3 shows the development of the HIV epidemic in Norway and data relating to injecting users.

Figure 12: Overdose fatalities (Kripos) and drug-related deaths (SSB) 1990-2008.

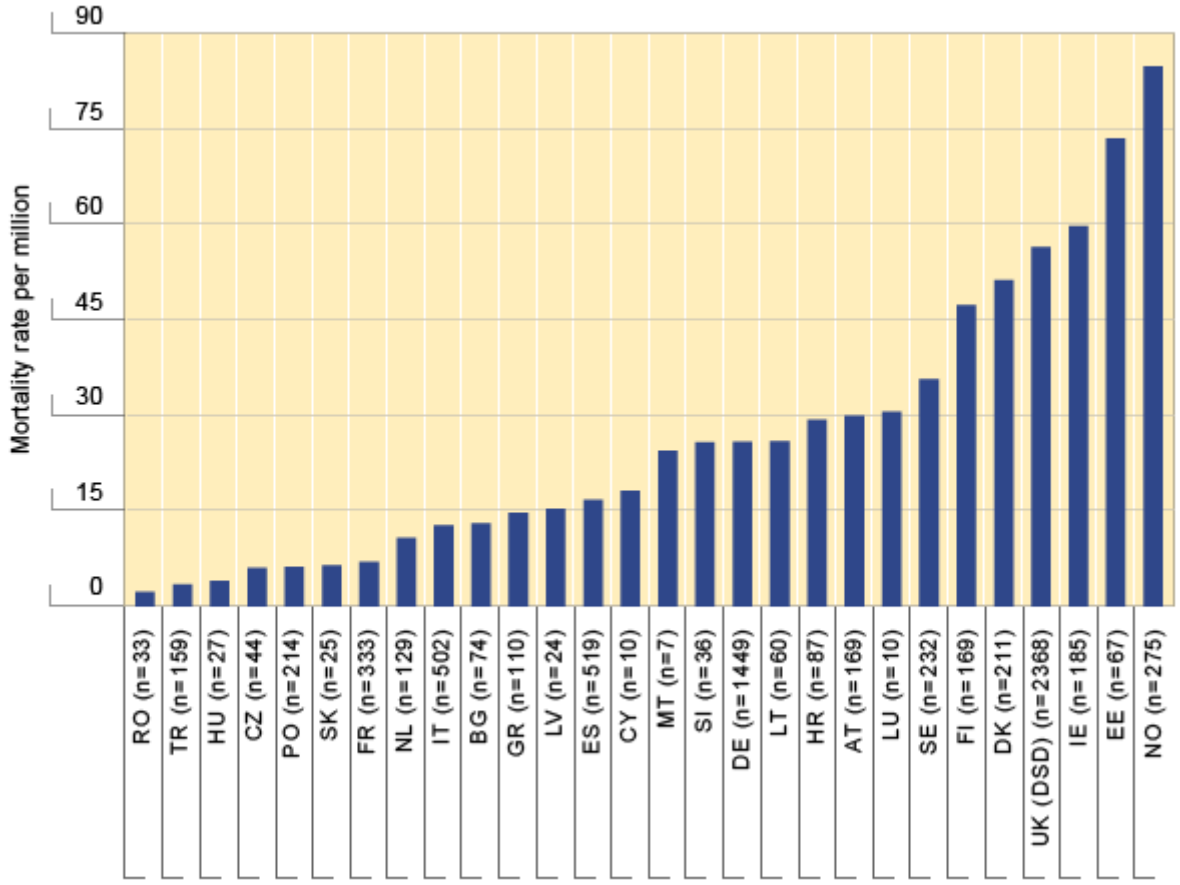


Sources: Kripos and SSB

Some comparisons with other countries

Figure 13 shows the proportion of drug-related deaths in the population in European countries (EMCDDA 2010). Most of the data are from 2008, while the Norwegian figure, 275 fatalities, is from 2007 (SSB's statistics). The figure shows that Norway is at the top of the list with 85 fatalities per million inhabitants in the age group 15 to 64, which is four times the European average. At the other end of the scale, the figures for most of the former Soviet states are very low. These countries have had a different development in relation to problem use and they probably also have other traditions as regards reporting.

Figure 13: Drug-related deaths per million in the 15 to 64 age group in European countries. Data from 2008 or earlier.



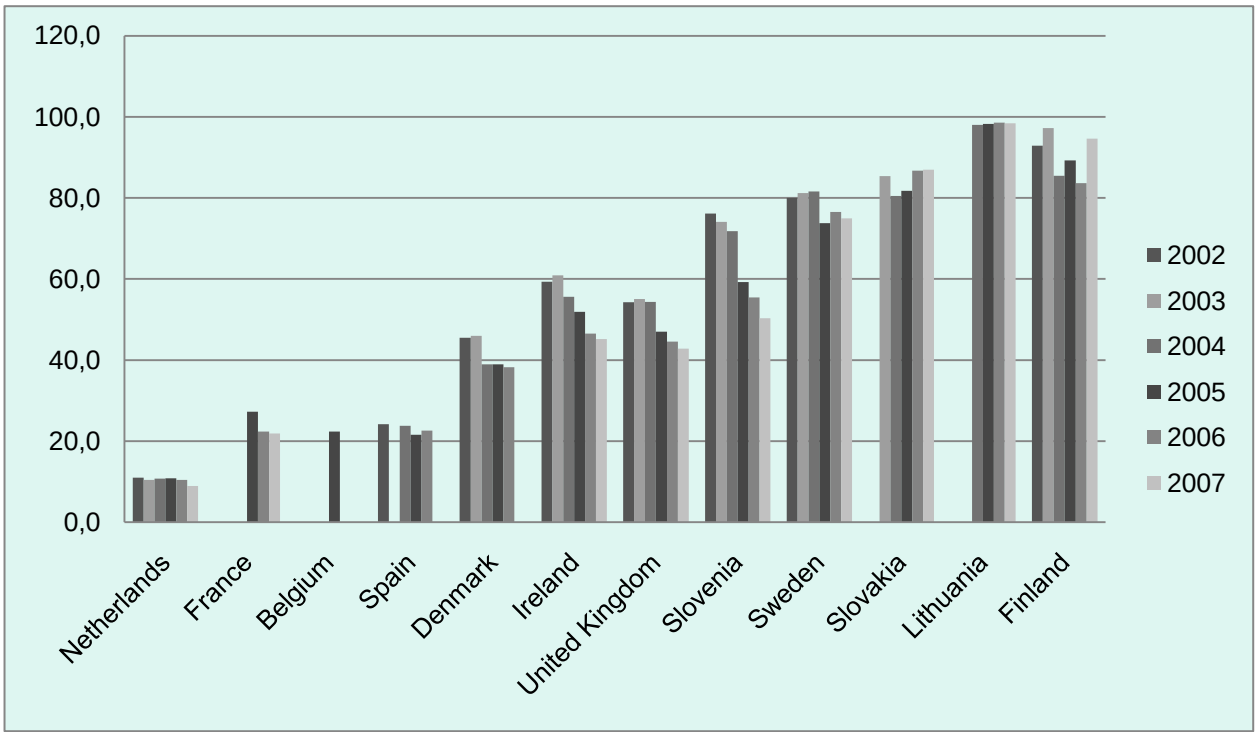
Source: EMCDDA

In Western Europe, the figures for the Netherlands and France are particularly low. In these countries, there is a small percentage who inject opioids and a high proportion who take opioids orally or by inhalation (Figure 14). The mortality risk associated with injecting use is assumed to be more than twice as high as for other methods of use. Some countries, such as Finland and Sweden, have a high proportion of injecting users but a relatively low number of fatalities. In these countries, problem users traditionally use amphetamine and methamphetamine, which have a low fatality risk.

There is also a question relating to the reliability of the causes of deaths statistics and police reporting in the different countries. Such questions are important in relation to our knowledge

of the overall mortality rate. Information about all deaths in a population could help to reduce this uncertainty.

Figure 14: Overview of high and low proportions of injecting use in relation to overall problem use in some European countries.



Source: EMCDDA

12.2 Cause-specific mortality among problem drug users

Almost all countries report on the use of opioids as a whole. So far, only estimates relating to heroin use are available in Norway, which means that it is difficult to say whether the prevalence of opioid use as a whole in Norway is particularly high. We are probably somewhere in the middle in a European context. The prevalence of problem use of heroin in Norway is approximately three per 1,000 inhabitants. The vast majority are injecting users, which probably results in a particularly high proportion of injecting heroin users compared with other countries.

One of the main questions relating to the high overdose figures in Norway is why so many people inject opioids – and what we should do about it. One factor is the large proportion that use other intoxicants such as alcohol and benzodiazepines in addition to heroin, which increases the risk of an overdose. Another factor is the weak tradition for initiating targeted measures to prevent overdoses in Norway. The use of maintenance treatment with methadone and/or buprenorphine has primarily been linked to rehabilitation. In addition, the fact that Norway introduced opioid substitution treatment (OST) relatively late can also be an important explanation. When the programme started in Norway in 1998, several large Western European countries had already been offering such treatment for more than 10 years, and some for 30 years.

A fourth factor is that very few people die of AIDS in Norway, and almost no one dies of tuberculosis. According to Statistics Norway, only nine fatalities in the period 2006 to 2008 were caused by AIDS with problem drug use as the secondary diagnosis (underlying cause) (see Annex 3). In other countries, far more drug users die of HIV/AIDS. Italy, Spain and Portugal, for example, have had very high mortality rates relating to AIDS. This primarily concerns people with a destructive injecting use associated with a high overdose risk (Ødegaard et al. 2007).

Moreover, the statistics from SSB and Kripos do not include all the deaths that are directly or indirectly related to the use of illegal substances. A significant percentage die of infections that they may have contracted from injecting use in particular, or as a result of injuries, violence and accidents and various diseases caused by excessive strain on internal organs. To gain an overview of this, we need to be able to follow a group of problem drug users over time and register diseases and fatalities – so-called longitudinal cohort studies.

12.3 Mortality among PDUs – based on cohort studies

See also data in Standard table 18.

The following cohort studies are relevant in this context:
1. Ødegård E, Amundsen EJ, Kielland KB: *Fatal overdose and deaths by other causes in a cohort of Norwegian drug abusers – A competing risk approach.* Drug and alcohol dependence 2007:89; 176-182

2. Ravndal E, Amundsen EJ: *Mortality among drug users after discharge from inpatient treatment*. Drug and alcohol dependence 2010:108; 65-69.

3. Mortality related to drug use: a comprehensive approach and public health implications. The Norwegian Opioid Maintenance Treatment (OST) cohort.

Publications:

- Clausen T, Anchersen, K., Waal, H. *Mortality prior to, during and after opioid maintenance treatment (OST): A national prospective cross-registry study.* Drug & Alcohol Dependence. 2008;94:151-57.
- Clausen T, Waal H, Thoresen M, Gossop M. *Mortality among opiate users: opioid maintenance therapy, age and causes of death.* Addiction. 2009 Aug;104(8):1356-62.
- Anchersen K, Clausen T, Gossop M, Hansteen V, Waal H. *Prevalence and clinical relevance of corrected QT interval prolongation during methadone and buprenorphine treatment: a mortality assessment study.* Addiction. 2009 Jun;104(6):993-9.

4. Comprehensive outcome in drug addicts. A study following the course of hepatitis and other conditions over 25 years. Dissertation: Dudman S Gjerduldsen, University of Oslo 2002.

Publications:

- Gjeruldsen S, Abdelnoor M, Opjordsmoen W, Myrvang B: *Death rates and causes of death in a cohorts of serum hepatitis patients followed up for more than 20 years.* Epidemiol. Infect 2001:126:89-96
- Gjeruldsen S, Myrvang B: *Hepatitis B virus infection in drug addicts: no acute fatalities, no chronicity and could have benefits.* APMIS 2002;110:1-5
- Gjeruldsen RS, Myrvang B, Opjordsmoen S. *A 25-year follow-up study of drug addicts hospitalised for aucte hepatitis: Present and past morbidity.* Eur Addict Res 2003;9:80-86

Design

Study 1
This is a follow-up survey of all patients who received treatment at the National Clinic for Drug Abusers (Statens klinikk for narkomane) during the period 1981 to 1991, a total of 501 patients. The survey is based on national registration figures for causes of death up until 2003. It is a longitudinal cohort study with death or emigration as its end-points. The clinic used a standardised evaluation form on admission with information about the type of substances used and the duration of use. Normal demographic data are available. A certain degree of caution is advised when making comparisons, as the patients are generally poly-drug users, partly with a background from iatrogenic[20] use and a development from alcohol to the use of medicinal drugs.

In Norway, heroin only became widespread during the 1980s, which means that a significant percentage of the patients have had limited experience of this drug. The extent of injecting use also varies. However, with a few exceptions, it is correct to describe the sample as consisting of persons with serious problem use, by which is meant several years of use dominated by central stimulants and/or opioids. It is also possible to calculate the relative mortality risk with respect to both the characteristics of the problem use and causes of death. The study uses a definition of overdose that is in accordance with relevant ICD-10 codes, and drug-related deaths also included fatalities where drug diagnoses in ICD8-9 or ICD-10 were registered as the underlying cause. The mortality ratio is not standardised.

Study 2
This is a prospective longitudinal cohort study of patients who were successively admitted to 11 in-patient institutions in 1998, 300 persons in all. Seventy per cent were men, and the average age on admission was 31 years. The treatment was abstinence-oriented and the patients were discharged to long-term aftercare.

All the patients were examined on admission using EuropASI, SCL25 and MCMI II. The mortality study is based on an eight-year follow-up of all deaths in the Causes of Death Register, on the basis of personal ID numbers. The overdose category is coded pursuant to F11 and X42. This means that the study uses a definition that corresponds to poisoning fatalities among opioid addicts. It should also be noted that relatively many of the patients had a history of multiple use that was not necessarily dominated by opioids. A total of 73 per cent had used heroin during the last 30 days before being admitted and 83 per cent had injected drugs. The patients therefore met a definition based on multiple-year harmful use of amphetamine and/or opioids. The mortality ratio is not standardised.

Study 3
This is a register-based study of mortality among all those who applied for opioid substitution treatment in Norway during the period 1998 to 2003, 3,789 persons in all. Seventy-one percent were men, and the average age was 38.5 years. Their personal ID numbers were cross-referenced with the causes of death register for the years up to and including 2006, and the mortality was calculated in relation to time prior to treatment, in treatment and post-treatment, registered as mortality per 100 patient-years. The overdose category is defined in accordance with ICD10 codes. All types of deaths are registered. The criterion for receiving OST treatment in Norway is serious opioid dependency for several years, and almost all those treated have injected heroin. The definition of problem use of drugs is clearly met.

Study 4

[20] Iatrogenic means that the condition has developed or originates from medical treatment.

This is a 25-year follow-up study of all patients who were diagnosed with hepatitis on admission to the Department of Infectious Diseases at Oslo University Hospital (Ullevål) during the period 1972 to 1976, 407 patients in all. The patient records contain information about infection through the use of needles and the type of substance used. A total of 214 persons were registered as drug users, 60 per cent of whom were men. The cohort study has been followed up by cross-referencing with the causes of death statistics.

Discussion

Study 1
The main finding is that overdose mortality increases in step with the duration of the problem use but not with age. Other forms of mortality are related to both age and the duration of problem use. Overdose mortality is higher among men and among those who have used opioids. The overdose fatalities account for just under half of all deaths, 46.6 per cent. Mortality relating to problem use accounts for two-thirds. In other words, there is a significant difference in the prevalence of these forms of premature deaths. There is also a substantial proportion of deaths, a third, that are not related to the use of narcotic substances. Groups of problem drug users are probably an at-risk group in relation to many types of deaths. The findings are largely in agreement with what other studies have found. The long follow-up time is a strong point of the study, as is the fact that it is based on national causes of death statistics that cover the whole population and are of reasonable good quality.

Study 2
The main finding of this study is that there is a high mortality rate in the first month following discharge from abstinence-oriented treatment. The average mortality for the whole follow-up period is 2.1 per 100 patient-years, while it is 29.9 per 100 patient-years during the first four weeks. The importance of the time spent in treatment was uncertain, while there was no difference regardless of whether the treatment was completed or interrupted. The only patient characteristic that had any bearing was gender; men have a significantly higher mortality risk. The findings largely accord with other studies and underline the importance of close follow-up during the first month after medication-free treatment.

Study 3
The main results are that all-cause mortality rates (per 100 person-years) for the entire OST cohort were: 2.4 pre-treatment, 1.4 during treatment and 3.4 post-treatment. The overall effect of the provision of OST regardless of whether or not patients were retained in treatment was a mortality of 1.8 per 100 person-years (intention-to-treat), compared with a rate of 2.4 prior to treatment. In relation to the overall effect of treatment, almost identical rates were observed for both genders.

Of the 213 registered deaths in the cohort study, 53 per cent were recorded as overdose deaths (90% confirmed by autopsy) in the Norwegian Causes of Death Register. Whereas the overall mortality risk was reduced to 0.5 during treatment compared with the pre-treatment level, the risk of overdoses was reduced to 0.2 compared with pre-treatment levels.

The risk of overdose deaths and all-cause mortality levels was similarly reduced for all age groups while in OST, compared with mortality levels outside OST. Age had a differential effect on the risk of overdose deaths while outside OST; young persons (below 35 years) had a higher risk of overdose prior to treatment, whereas older persons (50 years and older) were at greatest risk of overdose during the post-treatment phase compared with the other age groups. Other than overdoses, deaths due to somatic causes were found in 32 per cent of cases and deaths due to traumatic causes in 14 per cent of the cases. Somatic causes of death were dominated by HIV/AIDS (8% of the total) and liver failure (typically hepatitis C-related) in six per cent of the cases. Somatic deaths occurred more often among older (45+) persons while in treatment. The standardised mortality ratios by age group experienced by

the entire OST-cohort were: less than 35 years: 26; 35-39 years: 16; 40-44 years: 11; 45-49 years: 8; and for those above 50 years: 5.

As part of a project estimating methadone-related QTc-prolongations[21], the maximum mortality attributable to QTc-prolongation was low: 0.06 per 100 patient-years. Only one death was registered during the first four weeks of OST initiation among 3,850 treatment initiations. The first deaths during the post-treatment period occurred 55 days after treatment. This indicates a possible protective effect of the opioid tolerance acquired during OST in the first weeks following drop-out from OST.

Overall, the results based on the Norwegian OST cohort show a clear and significant effect of OST in terms of mortality reduction, and, in an intention-to-treat perspective, somewhere in the region of a 25 per cent reduction compared with pre-treatment levels. Overdoses are reduced to one fifth while in treatment compared with periods outside OST. Efforts to reduce the time spent on waiting lists and to reduce the number of drop-outs from treatment are deemed to be important, as in-treatment mortality is significantly lower than mortality levels outside OST. OST-cohorts are 'growing older', and more chronic and somatic conditions causing morbidity and mortality must therefore also be anticipated while in OST.

Study 4

The main finding of this study is that there is a significant difference between patients with hepatitis who are hardcore injecting users of opioids and/or amphetamines and patients without known illegal use. In the first group, the mortality rate was 32 per cent, while it was 20 per cent in the second group. Problem drug users do not die more often of liver diseases than the other group. It is almost exclusively overdose mortality and suicide by use of drugs that separate the groups. In addition, the other group will have various other diseases that contribute to raising the mortality rate. Men have a higher mortality rate than women, but the mortality rate among young women was found to be relatively high. A secondary finding is that the group consisting of problem drug users has a significantly poorer quality of life than the other group.

Hepatitis is a very frequent disease among problem drug users, but few studies have been carried out of whether it causes an increased fatality risk. The fatalities are primarily related to the use of drugs, which is the most important issue to address in order to reduce mortality. In this survey, there were very few instances of fatalities relating to liver disease, but it must be emphasised in this context that the surveyed group primarily suffered from hepatitis B and not so much from hepatitis C. It therefore does not tell us much about the biggest problem, which is the high prevalence of hepatitis C among problem drug users.

Brief summary of discussions

The four studies mainly support earlier findings. Male, injecting heroin users are at particular risk of overdose deaths, while other types of death increase with age. For OST patients, being in treatment reduces total mortality, and overdose mortality in particular. Other causes do not decrease in prevalence to the same extent, reflecting the high somatic morbidity in the

[21] QTc is a measurement from ECG examinations. It registers the contractions of the heart, measured by electrical readings on the ECG. A prolongation of the QTc interval means that something is disrupting the contractions of the heart and the preparation for a new contraction. If the prolongation is substantial, it can cause the heart to stop, usually only for a while, and the person will temporarily lose consciousness. High doses of methadone and certain other medicinal drugs can cause such problems, primarily in persons who are predisposed.

population. The first month is a particularly high-risk period after in-patient treatment but not after OST. Ending OST does, however, increase both overdose mortality and total mortality. One of the main implications is that abstinence-oriented therapy should take particular care to protect patients following discharge. It is important that patients who are heroin addicts start treatment and are retained in treatment.

Annex 1.

WHO guidelines coherence

	Name of Assessors: Martin Blindheim, Directorate of Health mb@helsedir.no	Yes	No	Not Applicable specify	No answer
1.	**Choice of treatment**				
1.2	For the pharmacological treatment of opioid dependence, clinicians should offer opioid withdrawal, opioid agonist maintenance and opioid antagonist (naltrexone) treatment, but most patients should be advised to use opioid agonist maintenance treatment. Do the present guidelines include this recommendation?	□	x	□	□
1.3	For opioid-dependent patients not commencing opioid agonist maintenance treatment, consider antagonist pharmacotherapy using naltrexone following the completion of opioid withdrawal. Do the present guidelines include this recommendation?	□	x	□	□

2	**Opioid agonist maintenance treatment**	□	□	□	□
2.1	For opioid agonist maintenance treatment, most patients should be advised to use methadone in adequate doses in preference to buprenorphine. Do the present guidelines include this recommendation?		x		
2.2	During methadone induction, the initial daily dose should depend on the level of neuroadaptation; it should generally not be more than 20 mg, and certainly not more than 30mg. Do the present guidelines include this recommendation?	x	□	□	□
2.3	On average, methadone maintenance doses should be in the range of 60–120 mg per day. Do the present guidelines include this recommendation	x	□	□	□
2.4	Average buprenorphine maintenance doses should be at least 8 mg per day. Do the present guidelines include this recommendation?	x	□	□	□
2.5	Methadone and buprenorphine doses should be directly supervised in the early phase of treatment. Do the present guidelines include this recommendation?	x	□	□	□
2.6	Take-away doses may be provided for patients when the benefits of reduced frequency of attendance are considered to outweigh the risk of diversion, subject to regular review. Do the present guidelines include this recommendation?	x	□	□	□
2.7	Psychosocial support should be offered routinely in association with pharmacological treatment for opioid dependence. Do the present guidelines include this recommendation?	x	□	□	□

Annex 2

Investigation of causes of death in the overdose statistics from the police

In collaboration with Kripos, the Norwegian Centre for Addiction Research (SERAF) has examined the lists of deaths that were sent from the police districts as overdose reporting in

2009. Among other things, the report shows that 250 deaths were reported. A critical review of the reports led to 66 (26%) cases being removed and reclassified as deaths from other causes. The biggest group consisted of poisoning from substances not classified as narcotics (anti-depressants etc.), which accounted for 21 cases (8%). Suicide using violent methods, i.e. not poisoning fatalities, accounted for 15 cases (6%). Some cases were borderline cases. Unspecified drug use, unspecified 'overdoses' and unknown causes accounted for a total of 10 cases (4%). In 51 per cent of the cases, one or more benzodiazepine substances were found. Alcohol was found in ten per cent of the cases, very often together with benzodiazepines.

There is therefore real uncertainty in the police statistics, but probably not enough to explain the difference in reporting based on causes of death statistics from SSB. Table 16 contains an overview of the opioids involved. Table 17 contains cases involving finds of only one morphine substance.

Table 16: Overview of opioids involved in Kripos's overdose statistics 2009*.

Type of drugs	Overdose fatalities – Norway		Overdose fatalities – Oslo	
	Number	%	Number	%
Heroin	112	60.9	53	72.6
Morphine	52	28.3	7	9.6
Codeine	25	13.6	2	2.7
Methadone	32	17.4	13	17.8
Buprenorphine	5	2.7	2	2.7
Fentanyl	7	3.8	-	-
Other	10	5.4	3	4.1
No opioids	11	6.0	5	6.8

Table 17: Cases involving finds of only one morphine substance

Type of drugs	Number-Norway	%	Number-Oslo	%
Only heroin reported	81	44.0	46	63.0
Only methadone	22	12.0	9	12.3
Only buprenorphine	3	1.6	1	1,4

*One case can involve several substances

Source: SERAF/Kripos

Annex 3

Reporting of epidemic diseases (EMSIS)

The development of HIV infection is monitored through mandatory reporting to the Institute of Public Health. The reports specify how the infection was spread and developments from year to year. The causes of death statistics provide an overview of the development of AIDS-related deaths. The table below shows how the epidemic has developed.

Table 18: Overview of the development of the HIV epidemic in Norway, 2000-2009.

Mode of transmission	<00	00	01	02	03	04	05	06	07	08	**09**	Total	%
Heterosexual	733	131	105	151	153	163	134	164	141	185	**172**	*2232*	51.1
-infected while in Norway	*316*	*38*	*27*	*28*	*34*	*43*	*33*	*42*	*41*	*46*	***43***	*691*	-
-inf. pre-arrival in Norway	*417*	*93*	*78*	*123*	*119*	*120*	*101*	*122*	*100*	*139*	***129***	*1541*	-
Homosexual	735	32	39	30	57	70	56	90	77	92	**87**	*1365*	31.2
Injecting use of drugs	442	7	8	16	13	15	20	7	13	12	**11**	*564*	12.9
Via blood/blood product	46										**1**	*47*	1.1
From mother to child	22	3	2	2	5	1	5	6	9	4	**4**	*63*	1.4
Other/unknown	40	2	3	6	10	2	4	9	8	6	**8**	*98*	2.2
Total	2,018	175	157	205	238	251	219	276	248	299	**283**	4,369	100.0

Source: Norwegian Institute of Public Health

The table shows that 564 persons (13%) became HIV-infected through the use of unclean needles. The majority of them were infected before 2000. Since then, the annual incidence has been just over 10 cases, less in some years. The vast majority were infected before 1987, when extensive preventive measures were initiated.

In this population, very few people die of immune deficiency. According to Statistics Norway, only nine fatalities in the period 2006 to 2008 were caused by AIDS with drug use as the secondary diagnosis (underlying cause). This amounts to three per year of a population of 528 to 553 HIV-infected problem drug users, and three per year of a population of 8,200 to 12,500 hardcore drug users. AIDS is therefore not a significant cause of death among Norwegian drug users even though AIDS may be an underlying case of suicide and self-destructive behaviour.

References:

Chapter 1:

Ministry of Health and Care Services(2008): *Norwegian Action Plan on Alcohol and Drugs*

Directorate of Health(2010): *Opptrappingsplanen for rusfeltet. Statusrapport 2009*

Chapter 3:

Babor, T. et al. (2003): *Alcohol no ordinary commodity. Research and public policy*. Oxford: Oxford University Press

Bergengen,B og Larsen Y.(2008): *Innvandrerungdoms bruk av rusmidler. En kunnskapsoversikt*.Rusmiddeletaten I Oslo

Ferrer-Wreder, L., N. Koutakis og H. Stattin (2002). Alkoholprevention i familjen. I: Andréasson, S. (red.). *Den svenska supen i det nya Europa. Nya villkor för alkoholprevention: en kunskapsöversikt.* Rapport 2002/11, s.111–116. Stockholm: Statens folkhälsoinstitut.

Foxcroft DR, Ireland D, Lowe G, Breen R (2002): Primary prevention for alcohol misuse in young people. *Cochrane Database of Systematic Reviews* 2002, Issue 3. Art. No.: CD003024. DOI: 10.1002/14651858.CD003024

Giesbrecht, N. (2007): *Reducing alcohol-related damage in populations: rethinking the roles of education and persuasion interventions* Addiction 102 (9), 1345–1349.

Henriksen, Øystein 2000: *Ikke som jeg gjør, men som jeg sier. Om rus, kommunikasjon og oppdragelse*. Tano Aschehoug

Kelli A. Komro, Mildred M. Maldonado-Molina, Amy L. Tobler, Jennifer R. Bonds, Keith E. Muller (2007*): Effects of home access and availability of alcohol on young adolescents' alcohol use* Addiction 102 (10), 1597–1608.

Nordahl, T. m. fl. 2006: *Forebyggende innsatser I skolen. Rapport fra forskergrupper oppnevnt av Utdanningsdirektoratet og Sosial- og helsedirektoratet om problematferd, rusforebyggende arbeid, læreren som leder og implementeringsstrategier.* Sosial- og helsedirektoratet og Utdanningsdirektoratet, Oslo. (English version: http://www.skolenettet.no/moduler/templates/Module_Article.aspx?id=39401&epslanguage=NO

Saether, M.B 2007: *Parenting – an element in drug prevention,* in Daly, M. (ed.), *Parenting in contemporary Europe:a positive approach.* Strasbourg 2007. Council of Europe
Sandberg, S. and Pedersen, W (2006): *Gatekapital.* Universitetsforlaget, Oslo.

Chapter 4:

Bretteville-Jensen, A.L., Amundsen, E.J. (2006): *Omfang av sprøytebruk i Norge.* Sirus rapport 5/2006. Oslo (EN summary)

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

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

Kimber, j., Palmateer, N., Hutchinson, S., Hickman, M., Goldberg, D., Rhodes, T. (2010): *Harm reduction among injecting drug users – evidence for effectiveness.* In Rhodes, T., Hedrich, D. (eds.): *Harm reduction: evidence, impacts and challenges.* EMCDDA Monographs, 10. Lisbon

Waal, H., Clausen, T., Håseth, A., Lillevold, P.H. (2010): *Statusrapport 2009.* Senter for rus og avhengighetsforskning, Rapport 1/2010, Universitetet i Oslo

Norli, Bjørg(2009): *En kartlegging av norske kvinner i prostitusjon* www.prosenteret.no

Chapter 5:

Waal, H., Clausen, T., Håseth, A., Lillevold, P.H. (2010): *Statusrapport 2009.* Senter for rus og avhengighetsforskning, Rapport 1/2010, Universitetet i Oslo

Chapter 9:

Kriminalomsorgens sentrale forvaltning(2010): *Kriminalomsorgens årsstatistikk 2009.*

Chapter 10:

Kriminalpolitisentralen(2010): *Narkotikastatistikk 2009*

Chapter 12:

EMCDDA(2010): *Annual report 2010, statistical bulletin*

Ødegård E, Amundsen EJ, Kielland KB: *Fatal overdose and deaths by other causes in a cohort of Norwegian drug abusers – A competing risk approach.* Drug and alcohol dependence 2007:89; 176-182.

Ravndal E, Amundsen EJ: *Mortality among drug users after discharge from inpatient treatment*. Drug and alcohol dependence 2010:108; 65-69.

Mortality related to drug use: a comprehensive approach and public health implications. The Norwegian Opioid Maintenance Treatment (OST) cohort.

Comprehensive outcome in drug addicts. A study following the course of hepatitis and other conditions over 25 years. Dissertation: Dudman S Gjerduldsen, University of Oslo 2002.

Annex 2:

Bønes T., Waal H.: *Hvor mange dør hvor av hva? Hva sier politistatistikken 2009. Rapport til Kripos*. SERAF rapport nr 2/2010 http://www.seraf.uio.no/publikasjoner/rapporter/

Annex 3:

Senior Adviser Olav Nilsen, the Norwegian Institute of Public Health. *The HIV situation 2009.* Lecture given on 26 May 2010.

Information from SSB, 7 September 2010

Lists

List of tables

List of Graphs

List of Standard tables to be submitted in 2010:

ST 01:	Basic results and methodology of population surveys on drug use
ST 05:	Acute/direct related deaths
ST 06:	Evolution of acute/direct related deaths
ST 07:	National prevalence estimates on problem drug users
ST 08:	Local prevalence estimates on problem drug use
ST 09:	Prevalence of hepatitis B/C and HIV infection among injecting drug users
ST 10:	Syringe availability
ST 11:	Arrests/Reports for drug law offences
ST 12:	Drug use among prisoners
ST 13:	Number and quantity of seizures of illicit drugs
ST 14:	Purity at street level of illicit drugs
ST 15:	Composition of tablets sold as illicit drugs
ST 16:	Price in Euros at street level of illicit drugs
ST 18:	Overall mortality and causes of deaths among drug users(still to be sent)
ST 24:	Access to treatment

List of structured questionnaires to be submitted in 2010:

SQ 25:	Universal prevention(still to be sent)
SQ 26:	Selective and indicated prevention(still to be sent)
SQ 28:	Social reintegration
SQ 31:	Treatment as an alternative to imprisonment

List of relevant websites in English:

Ministry of Health and Care Services:
http://www.regjeringen.no/en/dep/hod.html?id=421

Norwegian Directorate of Health:
http://www.shdir.no/portal/page?_pageid=134,112387&_dad=portal&_schema=PORTAL&language=english

Norwegian Institute of Public Health:
http://www.fhi.no/eway/?pid=238

Norwegian Centre for Addiction Research:
http://www.seraf.uio.no/eng/

Statistics Norway:
http://www.ssb.no/english/

Norwegian Institute for Alcohol and Drug Research:
http://www.sirus.no/internett/OmSirus?language=en