



European Monitoring Centre
for Drugs and Drug Addiction



**2006 NATIONAL REPORT (2005 data)
TO THE EMCDDA**

by the Reitox National Focal Point

“NORWAY”

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

Norwegian Institute of Alcohol and Drug Research - SIRUS

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Summary – Main trends and developments

Policies/strategies/organisation

With effect from 17 October 2005, the Minister of Health and Care Services has overall responsibility for coordinating drug and alcohol policy.

In October 2006, the Ministry of Health and Care Services followed up the action plan to combat drug and alcohol-related problems 2003-2005 by publishing a comprehensive status report on the drug and alcohol situation in Norway.

The new Government, elected in September 2005, has announced a new national binding action plan in order to step up, coordinate and increase efforts aimed at combating alcohol and drug problems. The plan will be published in November 2006. The tradition of a common strategy for alcohol and drugs will be upheld.

The Directorate for Health and Social Affairs appointed a working group, which has drawn up a strategy for quality improvement in the social and health services for drug and alcohol users. In the strategy, science, knowledge-based practice and efforts that aim to achieve a more holistic approach are combined to create good and safe services.

In cooperation with the regional drug and alcohol competence centres, the Directorate for Health and Social Affairs will draw up a national strategy for early intervention. A system for increasing competence in the help services among personnel who come into contact with children and young people who are at risk will be a central element of the strategy.

Epidemiology

In the general population

No new survey of the adult population has been carried out in 2005. On the basis of the most recent survey in 2004, it is clear that a steady, but not particularly marked, increase has taken place in lifetime prevalence for the use of cannabis. As regards the use of other drugs, there has overall been no significant increase in reported lifetime prevalence. However, the 25 – 34 age group shows a considerable increase in reported cocaine use from 1999 to 2004, exceeding the level of amphetamine use.

The annual questionnaire survey of the 15-20 age group shows a decrease in the reported use of cannabis in recent years. After increasing in the late 1990s, the proportion that state that they have used other drugs than cannabis has also stagnated or declined.

Since 2002, SIRUS has carried out annual questionnaire surveys on the drug situation in all Norwegian municipalities. Although the situation varies somewhat for different drugs, the estimated number of drug users in the municipalities appears to have been stable for the last three years.

Problem drug use

The number of injecting drug users in Norway most probably increased until 2001, after which it declined until 2003 and then flattened out. For 2004, a conservative estimate is that there were between 8 200 and 12 500 injecting drug users in Norway, a decline from the estimated 11-15 000 injecting drug users in 2002. The rise in the number of patients in substitution treatment in recent years could explain the fall.

Drug- related deaths

There are two bodies that register drug deaths, Statistics Norway and the National Crime Investigation Service - Kripos. Both series of figures peak in 2001. They decline sharply thereafter. According to the statistics from Kripos, 184 persons died as a result of drug use in 2005. Twenty-two of twenty-seven police districts registered drug-related deaths in 2005. Oslo had most: 78 deaths (38 per cent). Very many of the deaths are due to extensive multiple use of heroin, but also including amphetamine, benzodiazepines and methadone. The 2005 figures from Statistics Norway are not yet available.

Drug- related infectious diseases

The number of HIV cases among injecting users remains relatively low. In 2005, 20 new cases (9 per cent of the total number of HIV cases) concerned injecting users. The proportion that has developed AIDS is somewhat higher (13 per cent), but the number remains low and stable.

The hepatitis B outbreak continued in 2005, and 89 of a total of 147 cases of acute hepatitis B in 2005 were among injecting drug users. During the period 1995-2005, the total number of reported cases of acute hepatitis B among injecting drug users was 1 738.

Drug markets

The most unusual development is the strong reduction in heroin seizures. The number of seizures has fallen steadily during the past five years, and it has been more than halved since 2001. Kripos believes that there is no reason to believe that availability has fallen, but that the big change over a number of years is an indication of reduced demand. This may be correct. The price of heroin has been strongly reduced during the last five to ten years, which indicates that supply has been ample, with the exception of price-driving shortfall periods which we saw most recently in the hardcore drug milieu in summer 2006. The statistical connection between the increasing use of methadone and the decline in the number of seizures of heroin is also striking. If the assumption of a genuine reduction in demand is correct, it would appear that a substantial part of the explanation is the increasing use of medically-assisted treatment using methadone and Subutex.

For 2005 as a whole, the police note that amphetamine/ methamphetamine account for approx. 22 per cent of the total number of drug seizures, which is a higher proportion than ever before. In the European context, the large number of seizures of methamphetamine is rather unusual. The number of seizures of methamphetamine has tripled since 2001.

On the basis of the seizure figures, cocaine appears to be more in demand and more widespread than previously. For ecstasy, both supply and demand appear to have been reduced. The number of seizures of cannabis has been stable for several years and the amount seized in 2005 was lower than in the previous two years.

The most marked price change in the market has been for cocaine. The fall in the estimated price of cocaine (when purchasing one gram) has been approx. 40 per cent during the last two to three years. The estimated price of amphetamine has also fallen, but not to the same extent.

Part A: New developments and trends

1. National policies and context

See information in Structured questionnaire 32¹

1.1 Legislative changes in 2004/2005

The establishment of a trial scheme for injection rooms

The Act relating to injection rooms (Temporary Act no. 64 of 2 July 2004 relating to a trial scheme for premises for the injection of drugs (the injection room scheme) etc. and the Regulation relating to detailed rules for the injection room scheme entered into force on 17 December 2004. Oslo municipality has been approved as a trial municipality, and it opened the first injection room on 1 February 2005. (NR² 2005 chapter 1.1). The scheme is to be evaluated by SIRUS. The evaluation will provide the Government with a basis for deciding whether to propose to the Storting that the scheme be introduced on a permanent basis.

Trial scheme for drug courts

The Act relating to changes in the penal code (trial scheme for a drug programme under court control) was adopted on 17 June 2005 (NR 2005 chapter 1.1). The scheme entered into force in the municipalities of Oslo and Bergen in early spring 2006. The trial scheme will be evaluated by SIRUS before the Ministry of Justice and the Police decide whether to propose making it permanent.

Testing for drugs and alcohol in the workplace

In Norway, testing for drugs and alcohol in the workplace is regulated by section 9-4 of Act no. 62 of 17 June 2005 relating to the working environment, working hours and employment protection etc. (the Working Environment Act). This section, which entered into force on 1 January 2006, is a codification of currently applicable law.

The Working Environment Act lays down that an employer can require medical examinations of employees in three cases:

- a) when provided by statutes and regulations
- b) in connection with posts involving particularly high risks
- c) when the employer finds it necessary in order to protect the life and health of employees or a third party

It has been assumed that “medical examinations” here include both drug and alcohol testing and other types of medical examination. Moreover, the provision applies to both employees and job applicants, cf. the heading of the section. The consent of the employee or job applicant is not deemed to constitute sufficient authority for drug and alcohol testing. The requirements in the Working Environment Act section 9-4 must be satisfied.

¹ All Structured questionnaires referred to in the text have been submitted to the EMCDDA separately.

² NR=National report

1.2 Institutional framework, strategies and policies

Organisation and coordination

With effect from 17 October 2005, the Minister of Health and Care Services has overall responsibility for coordinating drug and alcohol policy. Detailed information about the areas of responsibility and the structure at national and regional level was provided in NR 2005 chapter 1.2.1.

The Ministry of Health and Care Services followed up the action plan to combat drug and alcohol-related problems 2003-2005 by publishing a comprehensive status report on the drug and alcohol situation in Norway in autumn 2006.

New action plan to combat drug and alcohol-related problems

The former Government's action plan to combat alcohol and drug-related problems 2003- 2005 has expired. The new Government, elected in September 2005, has announced a new national binding action plan in order to step up, coordinate and increase efforts aimed at combating alcohol and drug problems. The plan will be published in November 2006, and it cannot, therefore, yet be quoted. The tradition of a common strategy for alcohol and drugs will be upheld.

Main objective:

To reduce the negative consequences of alcohol and drug use for individuals and society.

Important strategic goals (tbc):

- To strengthen the public health perspective in drug policy
- To improve quality and competence in the drug field
- To contribute to social inclusion and greater availability of services
- To facilitate more coordinated services and collaboration
- To empower the users of public services and ensure family members better care

Focus will still be on efforts aimed at early intervention, treatment and rehabilitation, and research and international cooperation will be strengthened.

The action plan is a framework plan that sets out the Government's priorities. Chief responsibility for follow-up lies with the relevant individual ministries. The work will be coordinated by the Ministry of Health and Care Services.

A proposal for increased allocations or re-allocations between prioritised areas will be presented during the ordinary budget process. Close collaboration is planned between ministries and directorates in order to ensure that strategies and interventions are as well coordinated as possible.

National strategy for quality improvement in the drug and alcohol field

The Directorate for Health and Social Affairs appointed a working group, which has drawn up a strategy for quality improvement in the social and health services for drug and alcohol users. In the strategy, science, knowledge-based practice and efforts that aim to achieve a more holistic approach are combined to create good and safe services. The working group has also proposed quality indicators for the drug and alcohol field and pointed out areas in which professional guidelines are required. The Directorate for Health and Social Affairs is responsible for preparing professional guidelines in the health and social services field, and it will also be in charge of the work on producing guidelines for the drug and alcohol field.

Knowledge base for drug and alcohol education in schools

In 2003, the then Ministry of Health and Social Affairs initiated a knowledge base for drug and alcohol education in schools (NR 2005 1.2.4).

The knowledge base will make recommendations for the use of effective strategies and measures, and how they can best be implemented. The development of the knowledge base will take place in collaboration with the Directorate for Primary and Secondary Education and the regional drug and alcohol competence centres, and it is scheduled for completion in autumn 2006.

National strategy for early intervention

In cooperation with the regional drug and alcohol competence centres, the Directorate for Health and Social Affairs will draw up a national strategy for early intervention. A system for increasing competence in the help services among personnel who come into contact with children and young people who are at risk will be a central element of the strategy. Early intervention is relevant in relation to children, young people and adults. The strategy will outline methods for working with selected target groups. Work with different target groups requires different working methods. The work on a national strategy for early intervention will address goals and measures in the coming escalation plan in the drug and alcohol field, and it must be seen in conjunction with other efforts to strengthen drug and alcohol prevention work.

Guaranteed access to treatment for young people

In December 2005, the Minister of Health and Care Services appointed a working group to consider the possibility of establishing a guarantee of quick access to health care for young people suffering from substance addiction or mental illness. The working group delivered its recommendations in June 2006, focusing on three issues in particular:

- To strengthen patients' right to necessary specialist health services both in terms of a time limit for considering applications and a treatment guarantee
- To improve collaboration between municipal services and services at the specialised level
- To increase the productivity and efficiency of municipal and specialised services

The report has been circulated for public comment. The submissions will be followed up by the Ministry of Health and Care Services. The Minister has already asked the regional health authorities to prioritise mental health services and to increase the opening hours of outpatient clinics.

Better follow-up of drug-addicted prisoners

The justice and health authorities have increased their cooperation in order to ensure substance addicts better follow up during and after imprisonment. Guidelines have been drawn up and distributed for cooperation between municipal health and social services, the specialised health services and the probation services who provide services for imprisoned and sentenced substance addicts (see Structured Questionnaire 31). The guidelines clarify each sector's responsibility for substance addicts, strengthen cooperation between the services and contribute to better solutions for cooperation, common plans or agreements at the regional and local levels.

1.3 Budgets and public expenditure

Several ministries and directorates have budget allocations that are spent in part on preventive measures aimed at young people in particular and in part on measures aimed at people in difficult situations who also have a drug or alcohol problem. It is not possible to provide a comprehensive overview here. See also chapters 7.1 and 9.1.

In law enforcement: No comprehensive overview is available.

In social and health care: No new overview is available.

Research (alcohol, drugs and tobacco): SIRUS. Allocation for 2005: EUR 3.4 million³ (NOK 27.4 million) in operating funds:

National strategies:

The action plan to combat drug and alcohol-related problems 2003-2005. The regional project for improved prevention in nine municipalities: Amount: EUR 1 million (NOK 8 million) per year over a three-year period.

Campaign to influence attitudes to alcohol: Amount: EUR 1.88 million (NOK 15 million) in 2005.

1.3.1 Funding arrangements

In addition to the normal funding of operations through block grants to the municipal sector and the health authorities, the Ministry of Labour and Social Inclusion and the Ministry of Health and Care Services have extraordinary funds at their disposal for the development of special high priority efforts in the areas of epidemiology, research, prevention and treatment. These funds are channelled through SIRUS, the Directorate for Health and Social Affairs, the regional drug and alcohol competence centres and specialised centres for substitution therapy and low-threshold measures. Since funds are allocated to a large number of public bodies, institutions and organisations, either for the funding of ordinary operations or as project allocations, it is very difficult to provide exact figures for specific areas.

In 2005, EUR 25.44 million (NOK 203.5 mill) was allocated from the budget of the then Ministry of Social Affairs to drug and alcohol-related measures and EUR 18.4 million (NOK 147.2 million) to voluntary drug and alcohol prevention work. Among other things, the allocations are spent on:

- Measures to prevent and reduce the use of drugs and alcohol
- Treatment and rehabilitation of people with alcohol and drug problems and prostitutes
- Trial schemes and development work relating to the social services
- Voluntary organisations and private foundations that work for disadvantaged groups
- Voluntary preventive efforts to promote a drug and alcohol-free lifestyle and drug and alcohol-free milieu

Funds for trial schemes and development work are not earmarked exclusively for drug and alcohol measures, but a large portion of the funds are spent on measures targeting drug and alcohol users. Moreover, a significant proportion is spent on measures that indirectly benefit the target group, for example measures targeting prostitutes or other measures aimed at the development of social services in general. The Directorate for Health and Social Affairs administers the grant arrangements for voluntary organisations whose goal is to prevent drug and alcohol-related problems (cf. the allocation of EUR 18.4 million).

In 2005 the Directorate for Health and Social Affairs allocated a total of EUR 7.5 million (NOK 60 million) to the seven drug and alcohol competence centres. The allocations are intended to cover normal running expenses and the development of interventions.

³ Conversion rate: 1 EUR = NOK 8.00

2. Drug use in the Population

2.1 Drug use in the general population

The most recent survey of the general population's drug use was carried out in autumn 2004. The main results were discussed in NR 2005, chapter 2.1 (Standard table 014).

Since 2002, SIRUS has carried out annual questionnaire surveys on the drug situation in all Norwegian municipalities. The methodology was discussed in NR 2005 chapter 2.3. The bulk of the municipalities state that no change has occurred in the use of the different drugs from 2002 to 2004. However, development trends vary somewhat for the different drugs. Although most of the municipalities in the country probably have a certain amount of drug abuse, the problem appears to be of limited extent in most of these municipalities. The estimated number of drug users in the municipalities has been stable for the last three years. The uncertainty attached to the estimates is so great, however, that the differences described between the different years, also with respect to municipalities of different sizes, cannot be said to show changes. (www.sirus.no)

Data from the Municipal Survey provide a basis for a new method of calculating the extent of injecting drug abuse in Norway. See chapter 4.1 and annex 1.

2.2 Drug use in the youth and school population

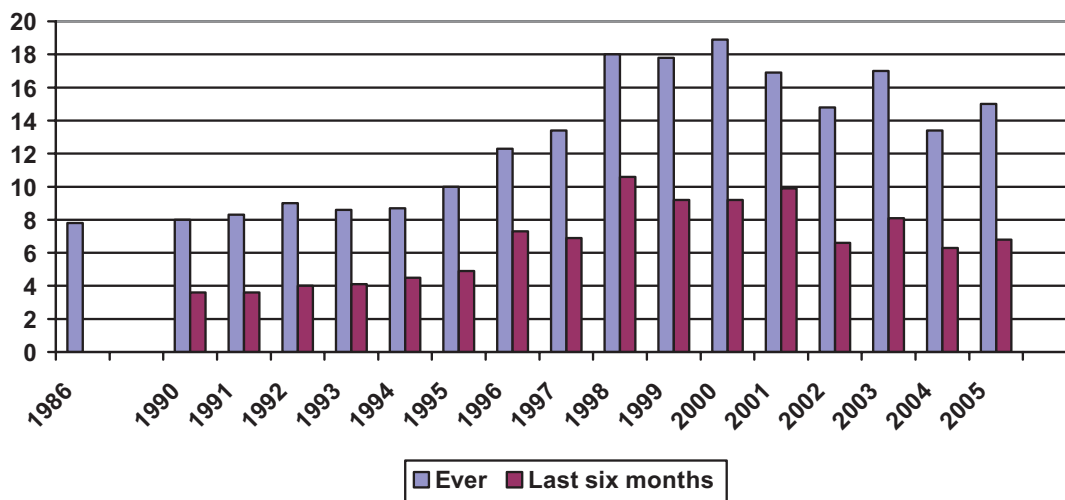
The youth survey 2005

SIRUS conducts an annual questionnaire survey on the use of drugs among young people aged 15-20. See the discussion in NR 2005 chapter 2.2.

Figures 1 and 2 show the number of young people aged 15-20 in Norway who report using illegal drugs. Cannabis, primarily in the form of hash, is the drug most young people report having used. After the percentage who reported using both cannabis and other drugs had remained stable during the first half of the 1990s, it increased in the years up to the turn of the millennium. In recent years, however, there has been a reduction, and it appears that the percentage has again stabilised, although at a somewhat higher level than in the early 1990s.

4 All Standard tables referred to in the text have been sent separately to EMCDDA.

Figure 1 The percentage of youth between the ages of 15 and 20 who state that they have taken cannabis: ever and during the last six months, respectively, 1986 - 2005.

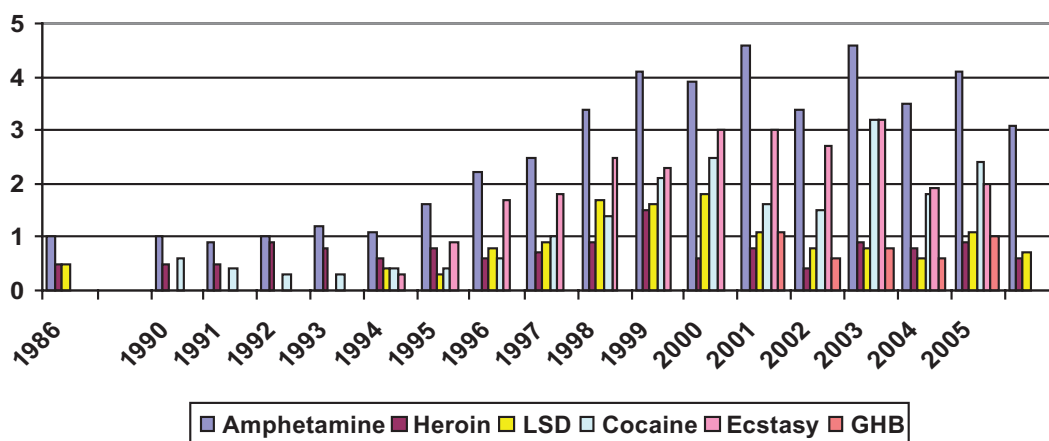


Source: SIRUS

The percentage of 15-20 year-olds in Norway who state that they have ever used cannabis has been around 15 per cent during the last five years, while the proportion reporting having used the drug during the last six months has been around six per cent. The corresponding percentages around the turn of the millennium were around 18 and 9-10 per cent. If we look exclusively at those who live in Oslo in the same age group, the percentage reporting having ever used cannabis has been around 22 per cent during the past two years, while around 12 per cent report having used cannabis during the past six months. At the turn of the millennium, the corresponding percentages were 28 and 16 per cent.

After increasing in the late 1990s, the proportion that state that they have used other drugs has also stagnated/ declined in recent years (Figure 2). For example, the proportion of 15-20 year-olds in the country as a whole that state that they have ever used amphetamine has been around 4 per cent, while the proportion stating that they have ever used ecstasy has remained at around 2-3 per cent for several years. The corresponding figures for Oslo are 4-6 per cent for amphetamine and 2-4 per cent for ecstasy. The decline appears to be somewhat greater among young people in Oslo than in the country as a whole.

Figure 2 Percentage of youth between the ages of 15 and 20 in Norway who have ever used other drugs, 1986 - 2005.



Source: SIRUS

There does not seem to have been any increase in the availability of illegal drugs in recent years as measured by questions about whether young people had been offered various drugs. The proportion of 15-20 year-olds in the country as a whole who state that they have ever been offered cannabis has been around 40 per cent for the last five years, while the proportion who believe that they could obtain cannabis in 2-3 days if they so wished was around 60-65 per cent. The proportion in the country, as a whole, who state that they have been offered amphetamine and ecstasy, was around 13-17 and 9-14 per cent, respectively.

Otherwise, the 2005 survey confirms the tendency we have seen in recent years that the proportion expressing a positive attitude to drugs is no longer increasing. During the last two to three years, 8-10 per cent of 15-20 year-olds in the country as whole and 10-13 per cent in Oslo have expressed the view that they believe that it should be possible to sell cannabis freely here in Norway.

Statistical margins of error

The figures are subject to statistical margins of error and must be interpreted with care. Moreover, it is important to bear in mind that questionnaire surveys are always susceptible to certain sources of error (not everyone responds, some responses may contain deliberate or inadvertent errors etc.) and that the surveys referred to here target young people in general. There is reason to believe that young people who regularly use drugs, either cannabis or stronger substances, will be underrepresented in the surveys.

In the annual youth surveys up until the mid-1990s, approximately 70 per cent answered the questionnaire, but the response rate has fallen to slightly below 50 per cent in recent years. This is worrying, and it is probably related to the fact that very many questionnaire surveys have been carried out among young people in recent years. It is not unlikely, therefore, that a certain 'fatigue' arises among respondents. On the basis of the falling response rate, there is further reason to emphasise that there is uncertainty attached to the results from one single year. The purpose of the surveys is primarily to serve as a tool for examining trends over time. Given that the youth surveys have been carried out for so many years, they represent time series that are relatively unique in the international context, and they are therefore assumed to be useful even though the response rate has been relatively low in recent years.

3. Prevention

3.1 Prevention in general, policy and organisation

The principle that prevention should take place at the local level is a central tenet of Norwegian drug prevention efforts. In cooperation with the regional drug and alcohol competence centres, the municipalities therefore play an important role. While regulatory measures such as the Alcohol Act are not discussed in this chapter, other forms of preventive activity under the auspices of state/municipal bodies or voluntary organisations are discussed.

The responsibilities of the Directorate for Health and Social Affairs include contributing to a reduction in the harm caused to individuals and society by drug use through preventive efforts. The Directorate is responsible for developing strategies for knowledge-based and more effective prevention. The Directorate shall stimulate drug and alcohol preventive efforts, among other things, through providing grants for voluntary efforts. The Directorate also carries out nationwide information and opinion-building campaigns.

The Directorate for Health and Social Affairs gives financial support to organisations and interventions under the auspices of voluntary organisations in the form of operating and project grants. The aim is to strengthen voluntary drug and alcohol prevention work. Support is only given to programmes that are knowledge-based and which can substantiate their preventive effect. This requirement has resulted in the evaluation of more interventions in 2005. In chapter 3.2, some of these are presented, as well as the main conclusions from the evaluations. Most of the interventions are included in or are in the process of being included in the EDDRA database.

The regional competence centres

The seven regional drug and alcohol competence centres (see NR 2005 chapter 1.2.1) had three main tasks according to the Directorate of Health and Social Affairs' letter of assignment for 2005: preventive measures; competence-building in the municipalities and specialist services; and national responsibility for a specialised area.

The individual competence centres were supposed to themselves take the initiative for the instigation of drug and alcohol preventive measures in the municipalities on the basis of research-based knowledge about prevention strategies. Local drug and alcohol prevention work was emphasised as a priority area, and the centres were therefore asked to continue their collaboration with the municipalities on the development of competence, methods and measures.

Joint projects for the centres in 2005 included: The Regional Project (NR 2005 chapter 3.3) and the media campaign "Seriously speaking" under the auspices of the Directorate for Health and Social Affairs. Several of the competence centres are involved in further education in drug and alcohol prevention work. The study is a collaboration between University College Narvik and the individual competence centres. The target group consists of professionals who work in drug and alcohol prevention or health-promoting activities, either under public or private auspices. The goal is to develop theoretical and practical competence.

In 2005, five of the competence centres collaborated on the project "Occasionally (Av og til)" The project, which is run by *AlkoKutt*, is a nationwide one whose goal is to increase support for abstain-

ing in certain situations and for alcohol-free zones. The alcohol-free zones focused on are traffic, working life, sport and outdoor pursuits, pregnancy, situations in the company of children and young people, and boats and bathing. The method is based on national campaigns focusing on the different zones with local adjustments/ efforts, mobilisation of the local community and cooperation between national and local players.

In 2005, all the centres reported that, in addition to being involved in existing measures or measures developed by the centres themselves, they had organised different competence-raising measures in the form of courses, guidance and conferences in cooperation with the municipalities.

The national prevention database (www.forebyggingstiltak.no) is part of the website www.forebygging.no, which in turn is an interactive arena for preventive and health-promoting work in Norway. The database provides an overview of prevention measures in Norway. See also NR 2005 chapter 3.5. So far, the database contains 117 measures. The majority (70 per cent) focus mainly on alcohol and drugs. The remainder are spread between mental health, problem behaviour, models and methodology, and on tobacco. Most of the measures are carried out in schools and/or leisure arenas. The vast majority (3/4) of the measures target young people. As regards which organisation is in charge, approx. 1/3 are run by voluntary organisations, 1/3 by municipal agencies and a little more than 1/5 by state bodies. Thirty-eight per cent of all the measures have been evaluated (evaluated externally: 28 per cent, evaluated internally: 10 per cent) (Lauritzen, 2006).

3.2 Universal prevention

3.2.1 Schools

Drug and alcohol education is based on a set curriculum and it is an integrated part of ordinary tuition. The Directorate for Health and Social Affairs has produced a report on effective preventive measures and strategies in schools. The aim is to make drug and alcohol prevention efforts in schools more cohesive and to ensure that the methods used are based on knowledge about effective prevention strategies. The overriding goal is that by the end of 2008 all Norwegian schools shall have carried out an educational programme about drugs and alcohol that is in line with research-based knowledge. In that connection, the national drug and alcohol competence centres shall coordinate their advice and recommendations to schools. The report will be completed in cooperation with the Directorate for Primary and Secondary Education and it will be published in autumn 2006.

Evaluation of FREE STYLE: An Anti Drug Intervention

FREE STYLE, which is run by the youth organization Juvente, aims to influence knowledge about, attitudes to and the use of drugs and alcohol among 9th year students. The programme includes an introductory course which prepares participants for carrying out a preventive programme at their own schools for their fellow students. The course is based on the “young-to-young” method.

In 2005, NOVA (Norwegian Social Research) carried out an evaluation of the effects, focusing mainly on whether it succeeded in increasing knowledge about the harmful effects of drugs and alcohol, whether it contributed to changed attitudes to the use of drugs and alcohol and finally, whether it helped to change actual patterns of use of drugs and alcohol among young people (Moshuus 2005). The evaluation showed that the programme succeeded in recruiting young leaders in schools and that the participants’ knowledge of drug and alcohol-related matters was strengthened. Many of the participants also seemed to have drug and alcohol-critical attitudes of their own. It awakened interest in drug and alcohol-critical involvement among participants, who will later hold courses in their own school classes. In relation to changing the use of drugs and alcohol, there are very few participants who had drunk alcohol before the course and it was therefore meaningless to try to identify changes. On the other hand, the evaluation showed that the participants had talked to friends about their participation and put young people’s use of drugs and alcohol on the agenda.

Evaluation of "KOLON"

KOLON is a theatre production produced by Juvente. The target group consists of students in upper secondary schools and in the 10th year of lower secondary schools. The goal is to focus on drug and alcohol use among young people, and in particular in relation to the social contexts in which drugs and alcohol are used, as well as focusing on the situations in which young people are subjected to pressure to drink.

Rogalandsforskning (now IRIS), carried out an evaluation of KOLON during the period 2004/2005 (Befring & Allred 2005). The goal was to examine what effect the theatre production had on students, and the students' reported attitudes to the use of drugs and alcohol. The evaluation showed that KOLON has succeeded in making a relatively lasting and positive impression on young people who have seen the play. They have to a certain extent succeeded in creating greater understanding for young people who do not drink among those who drink, and in inspiring some students to think through their own attitudes to alcohol. The play thus helps to put the topic on the agenda and to create debate. It appears to a certain extent to have a greater impact on girls than on boys, as well as on those whose alcohol consumption is moderate or low. It also appears that the play loses some of its effect on the older students and those who use alcohol fairly frequently.

Evaluation of "UNMASKING (KAST MASKEN)"

"Unmasking" is a nationwide schools programme for 10th year students run by Norwegian abstinence organisation for motorists. The programme includes both students and parents. The goal is to raise consciousness among young people about own choices and attitudes and to challenge young people to work actively on issues relating to their own everyday lives. The means by which this is to be achieved is the play "I grøfta (In the ditch)", which describes a youth milieu in which it is relatively common to drink alcohol, but in which one of the young people experiences problems managing his drinking.

In 2005, the Bergen Clinics Foundation carried out an evaluation of the programme using written questionnaires distributed to students and parents who took part (Bolstad, Skutle & Iversen 2005). Interviews were also carried out of key persons and observations made of the most central parts of the implementation of the programme.

The evaluation showed a well thought-out preventive measure containing detailed and exact instructions, which was largely implemented in accordance with the intentions. The participants reported that "Unmasking" had made them think more thoroughly through their attitude to alcohol, had improved their understanding and, in part, influenced their decision about their own alcohol use. Those who initially did not drink or drank little alcohol, were most susceptible to influence. Among those who drank, roughly one out of five believed that the measure had influenced them to drink less. Repeated measurements of young people's alcohol use showed small changes before and after the measure. The strong point of 'Unmasking' is that it appears to reach young people and that it succeeds in involving people and creating enthusiasm.

Evaluation of "YOUTH & ALCOHOL"

The goal of the "Youth & Alcohol" project, which is run by the Northern Norway competence centre, is to postpone the debut age for alcohol, reduce alcohol consumption, prevent the development of problems relating to drugs and alcohol and prevent the use of illegal drugs. The programme is based on social cognitive methods and the intention is to influence the social environment to reduce its use of drugs and alcohol. Eighth-year students are the primary target group for the measure, but the programme also includes both teachers and parents. The goal is to involve the participants through collaborative learning, communication and discussion. Central educational tools include problem-based learning and the use of information and communications technology.

The evaluation of the web version was carried out by the Norwegian Centre for Telemedicine in 2005 (Trondsen 2005). The intention was to gain an understanding of users' experiences of the web-based version so that it can be developed into a user-friendly and expedient tool. The evaluation takes a qualitative approach in the form of participatory observation, individual interviews and group interviews.

The evaluation showed that, overall, teachers and students had positive experiences of using "Youth & Alcohol" as a web-based concept. It was emphasised that the web solution played an important role as a motivating factor and that the users still wanted a web-based solution. Some elements were in need of improvement. This applied to practical training and to adaptation of the language and content to the target group. The evaluation did not focus on goal attainment, but both classes state that the work on the programme was a good learning process with respect to reflection and the raising of consciousness about the use of alcohol.

Evaluation of COURAGE in lower secondary schools

COURAGE (MOT) is a non-profit organisation that aims to prevent bullying, violence and the use of alcohol and drugs. *COURAGE* in lower secondary schools is defined as a method of working that consists of local informants who are trained and complete a three-year programme in school. The programme also includes parents and staff at the schools.

Since 2003, annual national surveys have been carried out under the auspices of NTNU Samfunnsforskning AS (Ingebrigtsen, Sæther, 2006). The evaluation wished to examine lower secondary students' understanding of *COURAGE*, their relationship to drugs and alcohol, bullying and happiness, and the influence the programme had on the students and on the youth environment.

The results of the evaluation showed that more than half of the respondents believed that they had been influenced by *COURAGE*, and almost half agreed strongly that the programme contributed to a better environment. In general, the results showed that lower secondary school students were happy and active and that most of them seldom or never used drugs and alcohol. Students who answer that they have been influenced by *COURAGE* use drugs and alcohol more seldom and they intervened to a greater extent when someone was being bullied than those who reply that they have not been influenced by *COURAGE*. They are also somewhat happier at school and in their spare time, and they take part in organised activities to a greater extent. However, there was no basis on which to evaluate whether *COURAGE* influences young people to change their behaviour or to postpone changing their behaviour (use of drugs and alcohol). It is highly probable, however, that *COURAGE* contributes to confirming and reinforcing values young people already have. The main conclusion of the evaluation was that lower secondary school students greatly appreciated *COURAGE*'s work. The evaluation clearly shows that it is important to root *COURAGE* in the municipalities and in the individual schools. The better it is rooted, the greater its influence.

Evaluation of Drug and Alcohol-Free Deal (RUSFRI DIIL)

Drug and Alcohol-Free Deal is a national prevention programme under the auspices of Juvente. The programme targets young people aged between 13 and 18 and entails signing an agreement to abstain from alcohol and other drugs for a year. The methods consist of distributing a school diary to 8th year students throughout the country, a membership database, the member magazine *Magazin Big Diil* and a website: www.diil.no.

The evaluation under the auspices of Rogalandsforskning concluded in 2005 (Olsen & Befring, 2006). A questionnaire survey forms the main basis for the evaluation. The evaluation wished to find out whether the participants had different attitudes to drugs and alcohol than other young people, different behaviour in relation to drugs and alcohol, different networks, whether, through its products, Drug and Alcohol-Free Deal influenced participants, whether they appeal to a certain type of

young people who wish to stay clear of drugs and alcohol, whether participation makes it easier to be drug and alcohol-free and whether social fellowship and norms can contribute to more positive attitudes to a drugs and alcohol-free lifestyle.

The evaluation showed that members vary fairly substantially in relation to the extent to which they use Drug and Alcohol-Free Deal's products. In general, the use of the products reflects the fact that the programme has a certain power of attraction, which in turn is a good basis for creating reflection on drug and alcohol use, and thereafter a change in attitudes and behaviour.

A desire not to use drugs and alcohol is an important reason why many people wish to become members. This desire influences the extent to which members make use of and are positive to the Drug and Alcohol-Free Deal products. Roughly two-thirds of all the members believe that they would not have used drugs or alcohol even if they had not been part of Drug and Alcohol-Free Deal. Members who had already decided that they would not use drugs or alcohol had to a certain extent become even more confident in their view after becoming members. Drug and Alcohol-Free Deal primarily has a positive effect on members who are already motivated not to use drugs or alcohol, and less effect on young people without such motivation.

The report points to certain challenges in connection with Drug and Alcohol-Free Deal's prevention strategy. The most obvious challenge is that of reaching young people who do not have a conscious attitude to whether they wish to use drugs or alcohol. In 2006, Drug and Alcohol-Free Deal won the European Prevention Prize for its work on reducing drug and alcohol problems among young people. The prize is awarded by the Council of Europe's Pompidou Group.

3.3 Family

See chapter 3.5.

3.4 Community

Evaluation of the "Seriously Speaking" alcohol policy awareness campaign

"Seriously Speaking" was a national alcohol awareness campaign run by the Directorate for Health and Social Affairs in 2004. It consisted of a PR campaign and a mass communications campaign including television sketches and advertisements in the weekly press and on websites. The goal was to reduce the harmful effects of alcohol by increasing knowledge about its harmful effects and raising awareness of the contribution made to reducing the harmful effects of alcohol by instruments such as age limits, regulations for the serving of alcohol, drink driving limits, taxes and sale through the state wine and spirits monopoly. The campaign also aimed to give advice to parents about how they can talk to their children about alcohol. The campaign was evaluated by SIRUS (Rise, Natvig, Storvoll, 2005).

The "Dare to set limits (Tør å sette grenser)" alcohol campaign

In 2005, the Directorate for Health and Social Affairs carried out a campaign to influence attitudes to alcohol with the aim of limiting young people's alcohol consumption through influencing parents' setting of limits and responsibility as role models. As was the case with "Seriously Speaking", the campaign aimed to raise awareness about the harm caused by alcohol, to increase knowledge among the population about what instruments are most effective, as well as increasing awareness of the importance of parents as role models and setters of limits. The plan also included following up the campaign with local activities, including involving parent committees in lower secondary schools. The campaign followed up with information on the website established in connection with the campaign in 2004.

3.5 Selective/indicated prevention

National strategy for early intervention

The Ministry of Health and Care Services assigned the Directorate for Health and Social Affairs the task of developing a national strategy for early intervention in the field of drugs and alcohol in cooperation with the drugs and alcohol competence centres. Early intervention is relevant in relation to children, young people and adults. These could include FAS/FAE children, children of parents with drug or alcohol problems, young people who demonstrate risk behaviour, adults identified in the workplace or in the primary health service. The report from the work will describe potential target groups and arenas for early identification and intervention. The focus will both be on risk groups before they develop drug or alcohol problems (selective strategies) and on identification and intervention in relation to experienced or observed drug or alcohol problems (indicative strategies). The report will propose goals and strategies for future early intervention efforts at the national level, and it will have to be followed up by more concrete action plans in relation to the different arenas and target groups identified by the strategy.

Recreational settings

The topic was thoroughly discussed in NR 2005 chapter 13.

At risk groups

Evaluation of "The Hidden and Forgotten Children (De gjemte og glemte barna)"

The goal of the project is to highlight issues relating to children of problem drug and alcohol users, both in the public sphere and in the various public agencies who are in contact with children and young people, as well as to establish contact with and offer support to children and young people. The intervention is based on educational principles and experiences gained through various self-help groups. Courses are offered to children and young people in order for them to learn about feelings, defence mechanisms, drug and alcohol dependency and how the family is affected when someone in the family uses drugs or alcohol to excess.

Parts of the intervention were evaluated by FAFO in 2005 using qualitative interviews (Gautun, 2006). The evaluation was aimed at seeing how the groups and networks around them functioned, but it proved difficult to establish groups. The project has nonetheless succeeded in turning the spotlight on children and young people who live in families with drug or alcohol problems. A website has also been set up (www.Barnogunge.no) where those working on the project can give these children other kinds of support.

At risk families

The Ministry of Children and Family Affairs has been working for a long time on implementing family and local community-based methods for the treatment of serious behavioural problems. The use of drugs and alcohol is often part of this problem. Parental coaching (PMTO) is a treatment method aimed at children aged between 4 and 12 years. The intention behind the method is to change deadlocked negative patterns of behaviour. Training in the method started in 1999 in Norway. The parental coaching is provided by the child, youth and family services or by the mental health care service for children and young people. The method is being evaluated in Norway, and the results so far are very promising. Work is being done on further implementation of the method in municipal services.

Multisystemic Therapy (MST) is a method of treatment that targets young people aged between 12 and 18. The method entails close follow-up of the individual youths involved, their families and the local community. The treatment is provided through the five regional child welfare and family welfare services. Training started in 1998, and so far the evaluation results are positive. Research from the USA shows a considerable reduction in behavioural problems, including drug and alcohol prob-

lems, both at home and in school. In Norway, multisystemic teams attached to the child welfare service have been established. See NR 2005 chapter 3.4.

MultifunC is the name of a service currently under establishment in the child welfare service. Six open institutions will be established aimed at young people with behavioural problems who cannot be helped through home-based measures. As of 31 July 2006, four institutions have opened. The young people in the target group have problems in several areas, and drug or alcohol problems may be among them. These young people need intensive, coordinated measures from the child welfare service.

The service in the new institutions will consist of a stay for a limited time in an institution followed by a follow-up period after the young people have moved back home. Cooperation with the families and with the young people themselves will be emphasised throughout. Motivation and involvement of the family in the decisions that are made is an important part of the treatment. Staff at the institutions will be ensured good training in the methods to be used. Systems for evaluation of the measure will be integrated into the treatment process through guidance and registration.

4. Problem Drug Use

4.1 Prevalence and incidence estimates

See the data in Standard tables 07 and 08.

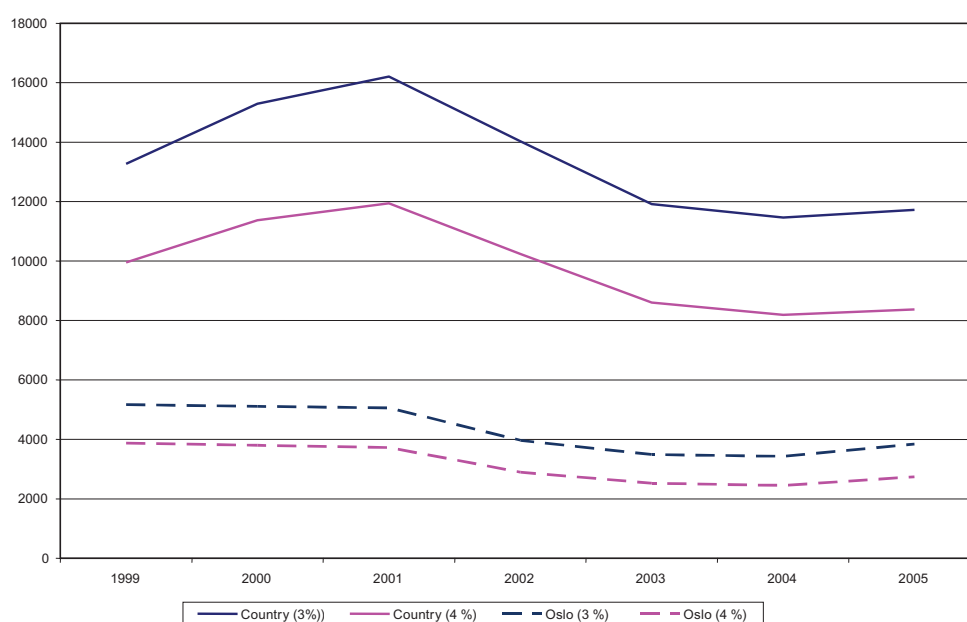
During the last two years, SIRUS has worked on developing and applying three alternative ways of calculating the prevalence of injecting drug use. Previously, the so-called Mortality Multiplier was the only method used. Calculations based on this method have now been revised because of lack of agreement between the figures for drug fatalities from Kripis and Statistics Norway and the need for documentation of the change in mortality and causes of death among injecting drug users since 2000.

One of the new alternative methods consists of questionnaire surveys of the police and social services in the municipalities (Amundsen, Lalla, 2005). EMCDDA has contributed to the development of the other method, the Multiple Indicator Method (MIM). The latter two methods can only be applied from 2002 because the data basis was not available until then. All the methods calculate injecting use, i.e. persons who have injected drugs at least once during the relevant period, irrespective of what drug was involved. The methods are described in *Annex 1*.

The three methods produce somewhat different results for the period 2002-2004, and they must therefore be seen in conjunction with an overall assessment of the number of injecting drug users in Norway.

The number of injecting drug users in the country as a whole increased throughout the 1990s. Figure 3 shows that the figure continued to increase from 1999 to 2001, then declined until approx. 2003, since when it has remained stable. Since the calculation employs a three-year sliding average, the figures for 2004 and 2005 will be based on an assumption of a stable number of drug deaths from 2004 to 2005 and 2006 (Statistics Norway) and from 2005 to 2006 (Kripis), respectively.

Figure 3 The number of injecting drug users in Norway 1999-2005*. The Mortality Multiplier.



Source: SIRUS

*The respective values of 3% and 4% in the explanation apply to mortality in 1999.

This development is supported by other indicators of drug use/ injecting drug use for the same period: the number of seizures of heroin (Kripas), positive findings of morphine among drivers (the Norwegian Institute of Public Health), official complaints for drug-related offences (Statistics Norway) and cannabis use among young people aged 15-20 (SIRUS).

Corresponding calculations for Oslo show a somewhat different trend. There was a slight decline in the number of injecting drug users in Oslo from 1999 to 2001, then a more pronounced decline until 2003 and thereafter a flattening out. In the rest of the country, developments were the same as those for the country as a whole.

Table 1 shows previous and revised figures from 2000. The revision of the assumptions in the Mortality Multiplier resulted in approx. 1 000 fewer injecting drug users in 2002 than in previous estimates. The difference is due both to the presumed change in mortality and to the fact that the percentage of drug deaths was changed from 65 to 70 per cent (chapter 1.1).

Table 1 Previous and revised estimates of the number of injecting drug users in Norway 2000-2005. The Mortality Multiplier. Rounded off.

	2000	2001	2002	2003	2004	2005
Previously published estimates	12000– 16000	10500– 14000	11000– 15000	-	-	-
Revised estimates	11400- 15300	12000- 16200	10200- 14000	8600- 12000	8200- 11500	8400- 11700

Source: SIRUS

The two new methods indicate stability during the period, but, given the broad confidence intervals, one cannot preclude the decline shown until 2003 by the estimates based on the Mortality Multiplier. Nor does the breadth of the intervals for the Mortality Multiplier in 2003 preclude the possibility that the number of injecting drug users was stable from 2002 to 2004. It is always a problem to determine when a change takes place in situations in which uncertainty is as great as it is in this case. However, all three methods show stability from 2003 to 2005.

Table 2 The number of injecting drug users in Norway 2002-2004. Three methods.

	Municipal Survey*	Multiple Indicator Method*	Mortality Multiplier
2002	15 394 (12 889-18 513)	15 456 (11 885-19 027)	10 238 - 14 030
2003	15 322 (12 911-18 306)	16 215 (14 801-17 629)	8 604 - 11 914
2004	16 335 (13 460-20 099)	15 690 (14 062-17 319)	8 190 - 11 467

* Figures for Oslo have been estimated using the Mortality Multiplier.

Source: SIRUS

In our view, the method in the Municipal Survey will have a tendency to produce too high figures. We believe that some people who have been outside the target group for some time have inadvertently been included, for example people in treatment, including medically-assisted treatment (MAT), people in prison and also people who have completely stopped injecting. Since the Multiple Indicator Method is based on the values for selected counties from the Municipal Survey, it will also follow that this method may have a tendency to overestimate the number of problem users. One possible explanation (hypothesis) for the difference between the estimates in 2003 and 2004 in rela-

tion to the Mortality Multiplier may be that one of these two methods does not register that so many people are being admitted to MAT.

The Mortality Multiplier will be a good method if there is a good overview of mortality and the percentage that drug deaths constitute of all deaths among injecting drug users. The evaluation on which the values in Table 1 are based will be maintained until better information becomes available that indicates other values for mortality and the percentage of drug deaths.

The number of injecting drug users per thousand inhabitants between the ages of 15 and 64 was 3.6 in 2002-2004, estimated using the Mortality Multiplier. Although Oslo's percentage of the number of injecting drug users has fallen since 1999, the extent of the problem was still greatest in Oslo. There, the number of injecting drug users per thousand inhabitants between the ages of 15 and 64 was 8.4.

Summary

The number of injecting drug users in Norway increased until 2001, after which it declined until 2003 and then flattened out. For 2004, our conservative estimate is that there were between 8 200 and 12 500 injecting drug users in Norway. The estimate has an upper limit higher than that which results from the Multiplier Method, but lower than that which resulted from the Multiple Indicator Method and the Municipal Survey. This is because the latter two methods probably produce figures that are too high. This estimate will probably also apply to 2005 because the number of drug deaths from Kripos for 2005 shows little change from 2004 (Bretteville-Jensen, Amundsen, 2006).

4.2 Profiles of clients in treatment

See NR 2005 chapter 4.2.

4.3 Main characteristics and patterns from non-treatment sources

See NR 2005 chapter 4.3.

5. Drug-related treatment

5.1 Treatment systems

NR 2005 chapter 5.1 gave a fairly detailed account of the changes in the treatment systems and in the organisation and division of responsibility for both in-patient services and outpatient services.

Responsibility for the treatment of people with drug or alcohol problems was transferred from the county authorities to the state represented by the regional health authorities with effect from 1 January 2004. The five regional health authorities are responsible for ensuring that the population in their respective regions has the necessary specialist health services, cf. the Act relating to specialist health services section 2-1a), including interdisciplinary specialist treatment for drug and/or alcohol use. The Ministry of Health and Care Services prepares a so-called requisition document every year for the regional health authorities, in which, among other things, the Ministry's governing requirements in relation to interdisciplinary specialist treatment for drug and alcohol abuse are included.

After the amendments to the Act relating to patient rights that came into effect on 1 September 2004, a time limit of 30 working days for assessment applies on referral to public and private hospitals, and to specialist outpatient clinics that are part of the free choice of hospitals scheme. An assessment of whether the patient is entitled to necessary health care or treatment must be made within the time limit. If such an entitlement is granted, an individual time limit shall be set for when, at the latest, the health care is to be provided. Exceeding this time limit for treatment triggers an entitlement for the patient to receive health care without delay, irrespective of the capacity of the public health service. If necessary, the patient is entitled to receive the health care from private service providers or from service providers abroad.

In 2004, a project was initiated to ensure that interdisciplinary specialist treatment is included in reporting in the specialist health service. The system for registering waiting lists has been drawn up and it is scheduled for implementation during 2006.

The regional health authorities report expected waiting times, i.e. the time it is expected to take from a decision on treatment has been made until admission for treatment can take place. A review of the reports as of April 2006 shows great variation in waiting times for each treatment level, both within and between the health regions.

Municipalities' follow-up of problem drug and alcohol users

The municipalities are responsible for following up people with drug and alcohol problems, before, during and after treatment. The social services in the municipalities shall provide advice, guidance and help so that individuals can stop their abuse of alcohol and other drugs. Advice, guidance and help shall also be given to the families involved. Similarly, GPs have an important responsibility to prevent, identify and treat the abuse of drugs and alcohol. The social services in the municipalities shall ensure good inclusion of problem drug and alcohol users in ordinary community activities. This means, among other things, preventing social anxiety, loneliness, difficulties in establishing drug and alcohol-free networks and access to the employment and housing market from limiting the motivation for, and possibility of, successful rehabilitation. This requires extensive cooperation between different agencies in the municipalities and between the municipality and the voluntary sector. In some

cases, contact with the specialist health service will have to be maintained. Several ongoing measures have been initiated in order to strengthen the municipalities' work with problem drug and alcohol users. Individual plans (see below) are an important tool if the municipalities are to succeed in this work.

In 2004, the Norwegian Board of Health carried out a nationwide review of how the municipalities provide advice and guidance, support measures and temporary housing as well as follow-up during and after treatment in institutions. The report points out that many problem drug and alcohol users do not receive the social services they need and are entitled to, and that follow-up of those under treatment is also deficient in several municipalities.

Individual plans

Holistic chains of measures, as required by the Administrative Alcohol and Drugs Treatment Reform, require good coordination between the different measures at the local level and between measures at the local and state level. The right to an individual plan is laid down in the Act relating to social services from 1 January 2004. Previously, this right was only stipulated in health legislation. This means that both the health and social services are now obliged to draw up such plans when people require long-term, coordinated services. The Ministry of Health and Care Services followed this up on 23 December 2004 with joint regulations authorised by health legislation and the Act relating to social services. The regulations entered into force on 1 January 2005.

Joint regulations for individual plans will contribute to a greater extent to ensuring coordination of services provided pursuant to health legislation and the Act relating to social services. Among other things, the purpose of drawing up an individual plan is to contribute to the recipient of the service receiving holistic, coordinated and individually-adapted help. Individual plans are an important tool for health and social service personnel in that they can improve coordination between the municipal health and social services and the individual health authority (Ministry of Health and Care Services; 2006).

5.2 Drug-free treatment

See data and information in Standard table 24. See also chapter 7.

No major new evaluations or studies of treatment services were conducted in 2005.

5.3 Medically-assisted treatment

See the data and information in Standard table 24.

Medically-assisted treatment – MAT – is one of several possible treatments for heroin addicts under the area of responsibility of the regional health authorities. Since the treatment became available nationwide in 1998, there has been a steady annual increase in the number of persons in treatment. On start-up, it was estimated that 700 to 800 persons in Norway were suitable for substitution therapy. At the turn of the year 2005/2006, 3 614 patients were included in MAT while 430 persons were on the waiting list. A certain reduction in the waiting lists has been registered during the past five years.

Evaluation

The results of an overall evaluation of MAT were made available in November 2004 (See NR 2005 chapter 3.2). The evaluation revealed that many MAT users have succeeded in leaving behind hardcore drug milieus, many of them have experienced improved health and quality of life, and MAT has also saved many lives. According to the evaluation, there is potential for improvement in several areas, including the rehabilitation offered to many users. The importance of a holistic service that

includes good psychosocial and medical follow-up is emphasised. The evaluation reports include recommendations relating to further development.

The Directorate for Health and Social Affairs is working on new professional guidelines for MAT which are expected to enter into force in 2007.

6. Health correlates and consequences

6.1 Drug-related deaths and mortality of drug users

See the data in Standard table 05.

Methodological considerations

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

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

Situation and development

Both series of figures peak in 2001 (table 3). They decline thereafter. In 2004 and 2005, the number of deaths has been almost halved compared with 2001.

According to Kripos' statistics, 184 persons died as a result of drug use in 2005. Twenty-two of twenty-seven police districts registered drug-related deaths in 2005. Oslo had most: 78 deaths (38 per cent). Very many of the deaths are due to extensive multiple use of heroin, amphetamine, benzodiazepines and methadone. The 2005 figures from Statistics Norway are not yet available.

Table 3 Drug-related deaths 1991-2005. Total number of deaths and broken down by gender. Figures from the Kripos and Statistics Norway (underlying cause of death).

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

Source: Kripos and Statistics Norway

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

** Figures for 2005 are not yet available.

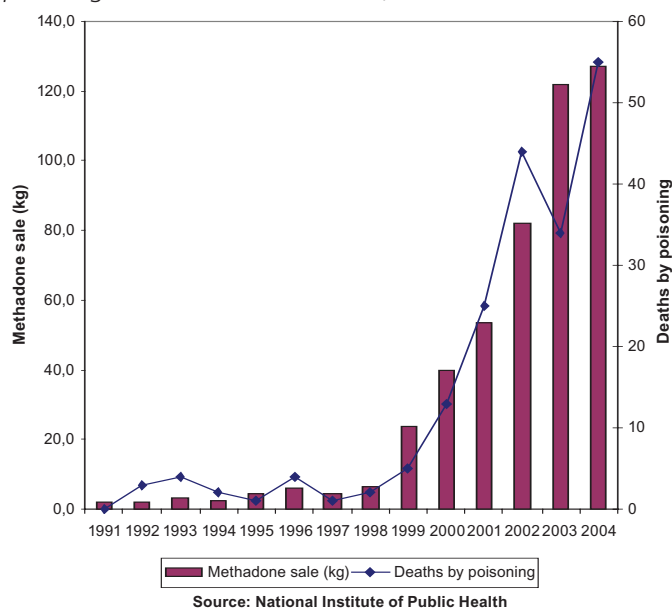
There is a higher proportion of deaths in older age groups in the figures from Statistics Norway than in the figures from Kripos. This proportion has also increased in recent years. During the period 1996 – 2002, the proportion of deaths in which the deceased was over the age of 50 amounted to between 5 and 10 per cent according to Statistics Norway. In 2003 and 2004 this proportion had increased to 16 and 15 per cent, respectively.

The proportion of women also increased during the same period. Both series show the proportion of women to be more than 20 per cent in recent years.

Deaths by poisoning where methadone is detected

An undesired corollary of the quite dramatic expansion of methadone treatment in Norway in recent years is the leakage/sale of methadone on the illegal market. Methadone clients may also continue to use other drugs, which represent a continued mortality risk. One indication of this would be if mortalities from drugs ingestion also showed traces of methadone in the blood of the victim. In 2004 55 autopsies revealed traces of methadone(in 2003: 34; in 2002: 44). Figure 4 compares data on legally sold methadone with mortality data where autopsies revealed traces of methadone. We are unable here to separate registered methadone patients from illegal users, but the figure shows a positive and increasing correlation between amounts sold and recorded methadone traces in drugs-related deaths.

Figure 4 Deaths by poisoning relative to methadone sale, 1991-2004



Norwegian register of drug-related deaths

The Division of Forensic Toxicology and Drug Abuse Research at the National Institute of Public Health carries out the vast majority of forensic toxicological analyses in connection with forensic post-mortem examinations in Norway. In 2002, the National Institute of Public Health was assigned the task of establishing a register of drug-related deaths (NR 2005 chapter 6.1), and during this process analysis data from the National Institute of Public Health was coordinated with cause of death codes from the Cause of Death Registry by Statistics Norway. Of 223 reported deaths in 2003 which satisfy the EMCDDA requirements for drug-related deaths, forensic toxicology findings were made in 168 deaths (75 per cent), and narcotic substances were found in 161 of these.

In addition to these 168 cases, the National Institute of Public Health had found one or more narcotic and/or hallucinogenic substances (T40.1 – T40.9) in a further 104 deaths for which forensic post-mortems were carried out. Morphine is not included in this figure, since morphine may have been used in pain treatment. There is evidence, however, to suggest that approx. 30 deaths involving finds of morphine, without other narcotic substances being found, may be due to the illegal use of opiates shortly before death. Thus, finds of drugs have been made in a substantial number of deaths over and above those that satisfy the EMCDDA requirements.

The figures give grounds for asking whether it is only deaths whose underlying cause is addiction or poisoning that are to be included in the monitoring of drug-related deaths.

Studies

Two Norwegian studies which calculated the percentage of poisoning fatalities arrived at relatively similar estimates. Andersen et al. (1996) found that poisoning fatalities account for 63 per cent of the mortalities and Eskild et al. (1993) found that the percentage of poisoning fatalities in their sample was 67. Two later studies arrive at a somewhat lower proportion of poisonings, 56 per cent (Gjeruldsen et al., 2000), and 47 per cent (Ødegård et al., 2006). The preliminary results from two ongoing studies, on the other hand – a follow-up study of injecting drug users recruited through needle distribution and a study of clients in treatment, both studies conducted by SIRUS – show a higher proportion of poisonings. The former study shows a poisoning proportion of 70 per cent and the latter as high as 82 per cent.

The proportion of poisoning deaths in the studies referred to differs. This may be related to the fact that relatively small and limited samples are studied. An additional factor is the fact that the proportion of poisonings is not uninfluenced by circumstances which may change. For example, it

would be reasonable to assume that the poisoning percentage will be reduced if the average age of the users, and thereby the risk of serious diseases, increases.

As regards other causes of death uncovered in these studies, it is especially the category violent death (suicide, murder, accidents) which contributes to high mortality.

6.2 Drug-related infectious diseases

See the data in Standard table 09.

HIV and AIDS

In 2005, 219 cases of HIV infection were reported to the Norwegian Notification System for Infectious Diseases (Table 4). Only 20 of these cases concerned injecting users. Of the 20 cases in 2005, fourteen were men and six were women and the average age was 33 (19- 43). Ten of the injecting users were infected in Oslo, five were infected in Stavanger and the remainder in other parts of the country. In one case an immigrant was infected abroad before arriving in Norway. The number of HIV cases remains relatively low and few cases of new infection are reported in the group.

As of 31 December 2005, a total of 521 persons had been diagnosed as HIV positive with injecting use as a risk factor. This amounts to 16 per cent of all reported cases of HIV since 1984. Development into AIDS has been reported in 148 of the cases.

Table 4 Percentage of injecting drug users of persons infected by HIV and AIDS, with injecting risk behaviour, 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
1984-89	894	315	35 %	144	8	6 %
1990	90	22	24 %	59	13	22 %
1991	142	16	11%	59	16	27 %
1992	105	12	11%	50	8	16 %
1993	113	13	12 %	64	13	20 %
1994	94	12	13 %	74	19	26 %
1995	105	11	10 %	67	8	12 %
1996	116	9	8 %	56	12	21 %
1997	113	11	10 %	34	8	24 %
1998	98	8	8 %	39	5	15 %
1999	147	12	7 %	29	7	24 %
2000	176	7	4 %	38	6	16 %
2001	158	8	5 %	27	5	18 %
2002	205	16	8 %	33	3	9 %
2003	238	13	5 %	43	7	16 %
2004	252	15	6 %	34	4	12 %
2005	219	20	9 %	32	4	13 %
Total	3 263	521	16 %	898	148	17 %

Source: Norwegian Institute of Public Health

The incidence of HIV among injecting drug users in the group has remained at a stable low level over the last decade with about 10-15 cases of HIV infection a year. The reason for this is not entirely clear, but a high level of testing, great candour regarding HIV-status within the user milieu, combined with a strong fear of being infected and self-imposed rules, are assumed to be important fac-

tors. In addition, many of the sources of infection in the milieu have disappeared due to overdose deaths or been rehabilitated through substitution therapy or other forms of rehabilitation. However, the extensive outbreaks of hepatitis A and B in recent years, and the high incidence of hepatitis C, show that there is still extensive needle sharing. The HIV situation is therefore unpredictable.

Hepatitis

During the nationwide outbreak of hepatitis A from 1995 to 2000, 1 360 injecting drug users were identified as having acute hepatitis A. Since then, only individual, sporadic cases of hepatitis A have been reported among injecting users. The hepatitis B outbreak continued in 2005, and 89 of a total of 147 cases of acute hepatitis B in 2005 were among injecting drug users. During the period 1995-2005, the total number of reported cases of acute hepatitis B among injecting drug users was 1 738.

The high incidence of hepatitis B among injecting drug users in recent years has resulted in increased sexual transmission, often to younger women in the user milieus. The outbreaks have demonstrated that injecting drug use is no longer limited to the big towns and cities, but that it has also spread to smaller municipalities all over the country. These outbreaks have resulted in hepatitis A vaccination being offered free to all users of illicit drugs in Norway since 2000. Hepatitis B vaccinations have been offered free to problem drug users since 1984. In 2003, an estimated 800 drug users in Norway were vaccinated for hepatitis A and 900 for hepatitis B.

In recent years, in connection with needle distribution in Oslo, small-scale prevalence surveys have been carried out to register the incidence of hepatitis among injecting drug users. The 2005 survey showed that 73 per cent of the 258 persons included in the survey had had a hepatitis A infection, 42 per cent a hepatitis B infection and 69 per cent a hepatitis C infection. In Norway, hepatitis C is not monitored to the same extent as hepatitis A and B, and hence the number of new cases of drug users being infected with the hepatitis C virus is not known. These Oslo surveys are the only prevalence surveys that are carried out regularly among drug users in Norway.

In connection with the annual prevalence surveys, drug users are also offered X-ray examinations to check for tuberculosis as well as vaccination against hepatitis A and B. The interview surveys carried out in connection with the prevalence survey in Oslo in 2004 show that around half of injecting drug users were still not infected with hepatitis C three to four years after starting to inject. Similar surveys in other Western European countries have shown the same tendency. This is fresh information, as it was previously assumed that most injecting drug users became infected by hepatitis C shortly after starting to inject. This means that hepatitis C prevention work in drug user milieus is helpful, although it is still important to reach users with preventive measures as soon as possible after they have begun injecting drugs. The Alcohol and Drug Addiction Service in Oslo started a major campaign in 2003 called "Stop Hepatitis C" in user milieus using newly-developed information material.

Other infections among problem drug users

Syphilis, gonorrhoea and other sexually transmitted diseases are very seldom reported among drug users in Norway. Outbreaks of tuberculosis have never been registered among drug users here in Norway. Skin infections and abscesses are not uncommon among problem users. In some cases, they can develop into serious septic/toxic infections. Infectious endocarditis is a well-known consequence of injections. Every year, a small number of cases of such infections is reported among drug users, but it is clear that many such infections are under-reported to the Norwegian Notification System for Infectious Diseases .

Prevalence surveys among problem users in Oslo in 2004 showed that only 10 per cent of those surveyed lacked sufficient protection against tetanus. The results indicate that protection against tetanus is good among drug users and that separate vaccination campaigns targeting tetanus are unnecessary.

6.3 Psychiatric co-morbidity (dual diagnosis)

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

A new study

An epidemiological study has been carried out to find out what characterises drug users who attempt to take their own lives (Landheim, Bakken, Vaglum, 2006). The study covered 206 patients from two Norwegian counties. All of them were receiving treatment for drug or alcohol abuse. Nine out of ten had a mental illness in addition to drug or alcohol problems.

The study shows that almost half of the participants have attempted to commit suicide. Patients who use several different drugs and/or alcohol are at much higher risk compared with patients who only abuse alcohol. Being a woman also increases the risk of attempting suicide. In addition, the study also shows that those who started to take alcohol or drugs before reaching the age of 18 and those who have used drugs and/or alcohol for more than 15 years are particularly at risk. Nine out of ten participants had a mental illness in addition to drug or alcohol problems. Having a mental illness significantly increases the risk of attempting suicide. Illnesses involving anxiety particularly increase the risk.

The study was carried out after a new mapping tool was taken into use in 1998 at institutions that treat problem drug and alcohol users in Norway. This tool has been used to estimate how representative the relatively small group included in the material is in relation to problem drug and alcohol users in treatment in general. The comparison shows that the participants in the study are somewhat older than the average Norwegian problem drug and alcohol user, and that they use heroin to a lesser extent.

The study is based on lifetime data. It is not possible, therefore, to determine whether mental illness and attempted suicide have occurred simultaneously. The study design is also unsuited to explaining why and how the dual diagnosis of drug and alcohol problems and psychiatric problems increases the risk of suicide.

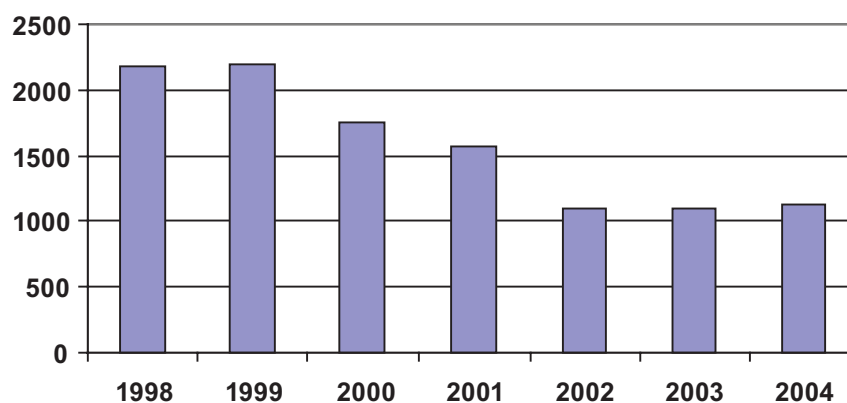
The conclusion is that treatment programmes that focus on drug and alcohol problems and concurrent mental illness are necessary in order to prevent suicides. It is emphasised that patients who use several drugs and/or alcohol must not be ignored.

6.4 Other drug-related health correlates and consequences

Non-fatal drug emergencies

Some data are available from Oslo. The ambulance service in Oslo carries out continuous registration of call-outs in connection with overdoses. In most cases, the person survives after having been administered an antidote. The ambulance service's overview shows that the highest numbers of overdose call-outs were in 1998 and 1999 (Figure 5). The number of call-outs then declined somewhat during the next two years and it remained stable between 2002 and 2004. No figures are available for 2005.

Figure 5 Number of overdose call-outs for the ambulance service in Oslo*.



* both fatal and non-fatal

Source: Oslo accident and emergency service

6.4.1 Pregnancies and children born to drug users

A study

SIRUS has produced the report "Children admitted together with parents who are in treatment for drug and/or alcohol problems" ("Barn innlagt sammen med foreldre som er i behandling for rusmiddelproblemer") (Solbakken, Lauritzen, Ødegård Lund, 2005). The report is Part I of two reports written on assignment for the Ministry of Children and Family Affairs. Part II "Services aimed at children of parents with drug and/or alcohol problems" ("Tilbud til barn av foreldre med rusmiddelproblemer") is discussed in chapter 7.4.

The report covers the 11 institutions which have stated that they offer services to children and parents together. A total of 161 children were admitted in 2004, 93 per cent of whom were under the age of three and 64 per cent younger than one year old. Twenty-five per cent were born during their mothers' stay at the institution. Only two per cent of the children were older than two years old. Half of the institutions state that they map children's problems using standardised tools. Those who use such tools report more injuries and difficulties in the children. In general, a high incidence of functional difficulties is described, which appears to be related to exposure to drugs and/or alcohol use during pregnancy and to difficulties during the first few years of life.

The institutions report the following problems in children admitted in 2004:

Withdrawal symptoms, sensitivity to sensory impressions; motor restlessness; sleep disturbances; interaction disturbances; insecure attachments to carers; physiological difficulties; delayed language development; insecurity; various behavioural deviations; traumatising; uncritical behaviour in relation to others; problem behaviour such as biting, hitting, kicking of both adults and children and the testing of limits.

7. Responses to Health Correlates and Consequences⁵

7.1 Low-threshold health services

During the last four or five years, low-threshold health services for addicts have been established in more and more municipalities with the help of earmarked state funds. The extent and size of the grants for such services has been expanded from 11 municipalities and EUR 1 million (NOK 8 million) in 2001 to 34 municipalities and EUR 5.5 million (NOK 43.5 million) in 2006. The purpose is to improve the health and life situation of, and reduce the risk of overdoses, for persons with particularly extensive drug and alcohol problems. Many problem drug and alcohol users are unable to use ordinary health services. The services are also intended to play a coordinating role in relation to the health and social services and thus act as a gateway to the ordinary health services.

The municipalities have chosen to organise their low-threshold services on the basis of local needs and challenges. Some of them have developed the services in cooperation with voluntary organisations, while others are based in the health and social services. Several municipalities have established a field nursing service involving considerable outreach activity. The services offered are health checks, nursing of sores, vaccinations, distribution of user equipment, nutritional and hygiene guidance, prevention of overdoses, advice and guidance, follow-up and referral to other parts of the health service etc.

According to the reports from the municipalities, these services have succeeded in reaching the target groups. They report large, and, in many cases, increasing demand for the services. The low-threshold services have also uncovered much greater and more extensive health problems⁶, as well as more extensive malnutrition and undernourishment than expected.

Injection rooms

The Act relating to injection rooms and the pertaining Regulations on detailed rules for the injection rooms scheme entered into force on 17 December 2004 (chapter 1.1). The Act authorises the implementation of a three-year trial period to evaluate the effects of injection rooms. The Regulations stipulate detailed rules for the trial scheme. The purpose of the injection rooms trial is “to contribute to enhancing the dignity of hardcore drug addicts, to provide an opportunity for contact and conversation between drug addicts and the support services, to contribute to preventing infections and the spread of infections and to reduce the number of overdoses and overdose fatalities.” The purpose is also “to evaluate the effect of freedom from prosecution for the possession and use of drugs” in the injection rooms. The target group consists of hardcore heroin addicts over the age of 18. Freedom from prosecution in injection rooms only applies to heroin. The Regulations also list more detailed requirements concerning premises, opening hours, content and staffing requirements. Municipalities that wish to establish injection rooms must be approved by the Ministry of Health and Care Services. Oslo municipality has been approved as a trial municipality, and it opened an injection room on 1 February 2005.

⁵ The guidelines have only been followed in part in this chapter.

⁶ Hepatitis, HIV, infections, chronic illnesses, mental illnesses, dental health and nutrition problems.

In May 2006, Oslo municipality submitted a one-year report. The report shows that, during one year of operation, the injection room has had 314 different users, one-third of whom are women, and an average of 24 injections have been made daily. During the course of the year, staff had had to call an ambulance 36 times due to overdoses. In all the cases, the ambulance arrived in less than 10 minutes, and the patients received the necessary assistance. The one-year report shows that wear and tear on members of staff has been greater than expected on start-up.

The injection room scheme will be evaluated by SIRUS. The evaluation will reveal whether the trial scheme has attained its goals, and it will provide a basis for the government to assess whether to propose to the Storting that the scheme should be continued.

Street hospital

Planning started in 2003 for a specialist somatic clinic for hardcore drug users inspired by the Forchhammervej clinic in Copenhagen. Experiences from low-threshold health services, SINTEF reports which have pointed to the poor health of problem drug and alcohol users and the disparity between demand and services, as well as the Salvation Army's report "Det verste er å skrive dem ut – til gata", have also provided motivation for the work on the establishment of a low-threshold clinic. In cooperation with Oslo municipality, the Salvation Army was asked to plan and establish a specialist clinic for the target group.

The street hospital, which was officially opened in January 2005, is a health and care service for problem drug and alcohol users with major, compound health problems. The service is a three-year project fully-financed by the state. The street hospital consists of one ward with 10 beds and a few emergency beds. Here, problem users who do not need to be admitted to an ordinary hospital receive care and in-patient medical nursing in the event of prolonged illnesses. The service has served as a supplement to existing health services. The plan is that experiences from low-threshold health services in general, and the establishment of the street hospital in particular, will be reviewed and evaluated in more detail. This will be form the basis for, among other things, evaluating whether these types of service are to be continued as a special measure outside, and as a supplement to, the existing health and social services or whether they are to be integrated into established services.

Dental health services

Hardcore problem users have poorer dental health than the rest of the population. They also have poor finances, which often means that they are unable to make use of available services. In 2006, as part of the efforts targeting the drugs and alcohol field, a total of EUR 7.88 million (NOK 63 million) was allocated on an annual basis to dental treatment for problem drug and alcohol users. The funds are intended to help drug and alcohol users to receive dental treatment, either as part of a low-threshold service or from the ordinary municipal service, a municipal service as part of another treatment if they are in prison or if they are under treatment by the specialist health service.

The Storting has decided that dental health services shall be initiated for problem drug and alcohol users in municipal drug and alcohol care in the whole country. EUR 4.69 million (NOK 37.5 million) has been allocated for this purpose in 2006.

Action plan for alternatives to drug and alcohol milieus in Oslo city centre

During the period 2003 to 2006, Oslo municipality, in cooperation with Oslo Police District and five ministries, implemented the "Action plan for alternatives to drug and alcohol milieus in Oslo city centre". The goal was to establish satisfactory alternatives for hardcore drug addicts and alcoholics

with extensive problems and help requirements. In this way, one wished to split up milieus in public areas where drugs were openly sold and which acted as gathering places for drug addicts and alcoholics.

The action plan mobilised all the care and rehabilitation services in Oslo in an intensified effort aimed at drug and alcohol users in the municipality. A system was also established to ensure follow-up and re-settling of problem drug and alcohol users who come from Oslo's neighbouring municipalities. The state allocated annual funding of EUR 625 000 (NOK 5 million) for three sub-projects within the action plan. This funding is being continued and it is now administered by the Directorate for Health and Social Affairs. The plan was concluded in 2005, but is being continued under the auspices of Oslo municipality in close cooperation with Oslo Police District (Ministry of Health and Care Services, 2006).

The action plan has been evaluated by SIRUS (Olsen, Skretting, 2006). The evaluation concludes, among other things, that Oslo municipality has put a lot of effort into realising the many individual measures in the plan. The overriding goal of breaking up the hardcore drug and alcohol milieu in the city centre cannot, however, be said to have been attained. The action plan has become a supplement rather than an alternative to the city centre milieus. Determined efforts with greater emphasis on providing individual help through the establishment of individual plans will be a future challenge. The collocation of a café, needle distribution, field station and injection room is regarded as a paradox seen in light of the goal of breaking up the milieu.

Results – individual measures

The many individual measures included in the action plan were largely initiated as planned. Although the plan period has expired, many of the measures continue on a project basis or as part of ordinary operations. The in-patient institutions have provided a food service for residents, although to a varying extent. Similarly, the in-patient institutions have taken the initiative for various activities for residents, but participation has been limited. Other measures that have been carried out:

- Five so-called “shelters” have been established.
- The decentralised distribution of needles has become more organised.
- The provision of low-threshold health services was expanded.
- Simplified procedures have been established for assisting in sending home problem drug and alcohol users who are not from Oslo municipality.
- Problem drug and alcohol users have taken part in tidying up campaigns to remove used needles from streets and parks. Few such campaigns have been carried out, however.
- Oslo municipality has made some progress in “cleaning up” its use of unreliable and expensive private providers of accommodation for drug and alcohol users. The adopted quality agreements are being sidestepped, however, by landlords redefining their operations from the provision of 24-hour accommodation to more long-term leases.
- The moving on of problem drug and alcohol users who are admitted to acute places in three residential shelters has been given special priority.
- A special project has been instigated for the follow-up of problem drug and alcohol users living in residential training flats/ municipal flats.
- A special project has been instigated with a view to establishing individual plans for 25 selected problem drug and alcohol users (Olsen, Skretting 2006).

7.2 Prevention and treatment of drug-related infectious diseases

See chapter 7.1. Some data about needle distribution are supplied in Standard table 10.

7.3 Interventions related to psychiatric co-morbidity

An increasing percentage of patients at psychiatric hospitals have co-morbidity (dual diagnosis). Today, treatment is often piecemeal in that the drug and alcohol problems are treated first before addressing the other part of the dual diagnosis. Surveys, from the USA among others, clearly show that a much greater effect can be achieved when both main diagnoses are treated concurrently in an integrated treatment (www.dobbeltdiagnose.no).

People with a dual diagnosis should be offered a broad range of treatment, not just treatment that is limited to individual psychotherapy and/or medication. Group treatment is given too little emphasis in Norwegian specialist health services aimed at patients with a dual diagnosis. Help and support from others is also one of the cornerstones of most drug and alcohol treatments. Group treatments offered to patients during the active phase, and which focus on reducing use or stopping completely, all place great emphasis on mastering drug and alcohol abuse. This applies in particular to identifying situations where there is a risk of a relapse or use and to the mastering of warnings signs of use. In addition, there are some group treatments that emphasise psycho-education, i.e. connections between drug and alcohol use and mental illness, social skills training or psychological processes. (Gråwe,2006)

The “On the Road to a Better Life (På Vei til et Bedre Liv)” programme

In Norway and Denmark, a group-based rehabilitation programme is used called *On the Road to a Better Life* (Gråwe & Espeland, 2002), which is designed for those with a dual diagnosis who are in the active drug and alcohol treatment phase. In terms of content, it has a broad focus since it is not only psycho-educational but also has motivation-promoting elements, focuses on mastering drug and alcohol use and, not least, training social skills.

It takes around 40 course meetings to complete the better life course, and during that period participants must play an active role in connection with role-playing, exercises and homework. The better life programme consists of a course leader manual, a workbook for each participant and a DVD which demonstrates some of the central social skills in which training is given.

A Norwegian-Danish multicentre implementation study of the better life course has been carried out which shows that it is associated with significantly improved motivation and a reduction in drug and alcohol use (Gråwe et al., under publication). In the study, 43 per cent have psychotic disorders and 31 per cent personality disorders, while 16 per cent of the course participants were classified as drop outs (participated in less than 40 per cent of the course meetings). If the better life course is offered as part of a broader and more integrated treatment, the number of drop outs will probably be lower.

Another type of measure which is often included in integrated treatment programmes is participation in voluntary humanitarian help organisations run by users and family members. Examples include *Alcoholics Anonymous*, *Narcotics Anonymous*, *self help groups*, *Rusmisbrukeres Interesseorganisasjon* (interest group for problem drug and alcohol users (RIO) etc. Longitudinal studies show that patients who participate in this type of support organisation make better progress in terms of their illness than those who do not. This means that the specialist health service should refer patients to these organisations and cooperate actively with them during treatment (Gråwe,2006).

New research project

The Research Council of Norway has allocated EUR 0.54 million (NOK 4.3 million) to a research project whose goal is to improve the treatment of patients with a dual diagnosis. The project, which has a total budget of slightly more than EUR 1 million (NOK 8 million), will last for three years.

The project, entitled “Effekten av integrert og helhetlig behandling av personer med psykiske lidelser og rusmiddelmissbruk som mottar behandling ved Distriktpspsykiatriske Sentra i Helse Øst (The effect of integrated holistic treatment of persons with mental illnesses and drug and alcohol abuse who receive treatment at Psychiatric District Centres in Health Region East)”, is concerned with testing simultaneous treatment of drug and alcohol problems and mental illnesses. The project starts in autumn 2006.

7.4 Interventions related to other health correlates and consequences

7.4.1 Interventions concerning pregnancies and children born to drug users

See also chapter 3.5 National strategy for early intervention.

A new study

SIRUS has produced the report “Services aimed at children of parents with drug and/or alcohol problems” (“Tilbud til barn av foreldre med rusmiddelproblemer”) (Solbakken & Lauritzen, 2006). Sub-report I is discussed in chapter 6.4. The background to these reports is the need to increase knowledge about the whole spectrum of support and treatment services developed in Norway for children of parents with drug and alcohol problems.

In order to be sure to include all the services developed, a comprehensive questionnaire was distributed to all the country's health stations, child welfare departments and social security offices, school psychological services, mental health care services for children, young people and adults, treatment facilities in the drug and alcohol field and to voluntary organisations. It was the specific services offered that were the subject of the study, i.e. where the parents' drug or alcohol problem is the most important criterion for recruiting the children to the service.

The survey covers information from 821 respondents. Of the first-line services' 18 reported services, it is the efforts of the health stations that stand out, both ordinary health stations with specific follow-up of pregnant women with drug or alcohol problems and children, and special strengthened health stations with a broad-based interdisciplinary team and intensified efforts in families and in a coordinated network collaboration. The follow-up period for these strengthened services is often two years after the birth of the child. Health stations in various parts of the country also act as bases for group-based services for children and young people from the age of 7 or 8, and several of them have groups specifically for young people. Recognised group programmes with psycho-educational elements and pedagogical support approaches etc. are often used.

An incidence of specific measures in the first-line services of slightly less than 3 per cent (18 of 821) is low. At the same time, it is probably these services which primarily reach the drug and alcohol exposed children through their general efforts. The question is to what extent the first-line health and social services and specialist health services discover drug or alcohol problems in the home, thus ensuring that the problems trigger adequate help measures for children who show signs of developing serious illnesses or varying degrees of maladjustment. Few specific measures were registered in these services, the exception being group-based measures based on different professional and theoretical approaches and organisation. It is thus group-based measures which have largely been employed in relation to children of school age and young people.

Of the treatment institutions for drug and alcohol problems, 22 per cent state that they have specific treatment for children. At in-patient institutions, two main types of treatment are offered:

1. Children are admitted together with their parents who are in treatment for drug or alcohol addiction.

2. Parents are admitted for treatment and the institution invites the children to take part in family therapy and/or accept an offer aimed at families of problem users. Children's participation can be on an outpatient basis or they can stay for short or long periods at the institution.

Within the voluntary/ non-profit organisations, there are many general measures that can reach children of parents with drug or alcohol problems, but few of them offer services aimed specifically at the target group.

8. Social correlates and consequences

8.1 Social exclusion

Homelessness

Based on those persons who were in contact with the help services in a certain week in December 2005, the Norwegian Building Research Institute studied and calculated the extent of homelessness in Norway. This was done in the same manner in 1996 and 2003. In 1996, it was calculated that 6,200 persons were homeless. In 2003, the number had been reduced to 5 200 persons. In the last study the extent of homelessness had risen somewhat, and in 2006 there are approximately 5 500 homeless people.

The study from 2003 also showed that the percentage of homeless people with drug or alcohol problems had increased. Roughly 70 per cent had such problems. In 2005, the percentage of homeless people with drug or alcohol problems had again fallen, to 60 per cent. In most municipalities, work on combating homelessness has targeted homeless people with drug or alcohol problems. However, there are still a large number of homeless people with drug or alcohol problems and/or mental illnesses.

No surveys exist of the extent of housing problems among persons with drug or alcohol problems, but a survey by FAFO (Institute for Labour and Social Research) from 2004 shows that drug addicts and alcoholics stand out as the most disadvantaged group in the municipalities' social housing efforts. In this survey, employees also assessed what can be done to ensure a stable housing situation. More than 60 per cent believe that better follow-up services in residential provision is a prerequisite.

8.2 Drug-related crime

There is reason to believe that a relatively large percentage of all crimes against property are committed by people with drug and alcohol problems as a means of financing their own abuse. Since the crime statistics are organised on the basis of the individual offences, they do not provide information about how large a percentage of, for example, thefts and vandalism can be linked to problem drug and alcohol users. The available crime indicators with respect to drugs are thus limited to those crimes that are related to violation of drug laws, i.e. the Penal Code and the Act relating to medicine. Table 5 shows the number of penal reactions for violation of drug laws.

Table 5 The number of penal reactions for violation of drug laws 1996 – 2004.

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

Source: *Crime statistics, Statistics Norway.*

So far, figures for the number of people charged with drug offences are only available up to and including 2001. On introduction of the police reform, changes were made to the police's IT systems. This has resulted in the data basis deviating from previous years, which has delayed the production of statistics in this area.

8.3 Drug use in prison

According to a survey carried out by FAFO in 2004, at any given time there are roughly 1 800 persons in prison with drug or alcohol problems, and about 60 per cent of all those imprisoned have a drug or alcohol problem. The majority of them used opiates or central stimulants on an almost daily basis prior to imprisonment. Most of the inmates with drug or alcohol problems have a chronic illness and many of them have mental health problems. A majority of the recidivists in prison are problem drug and alcohol users. The FAFO survey documents the strong correlation between drug abuse and crime and shows that it is necessary to improve the rehabilitation of inmates with drug or alcohol problems.

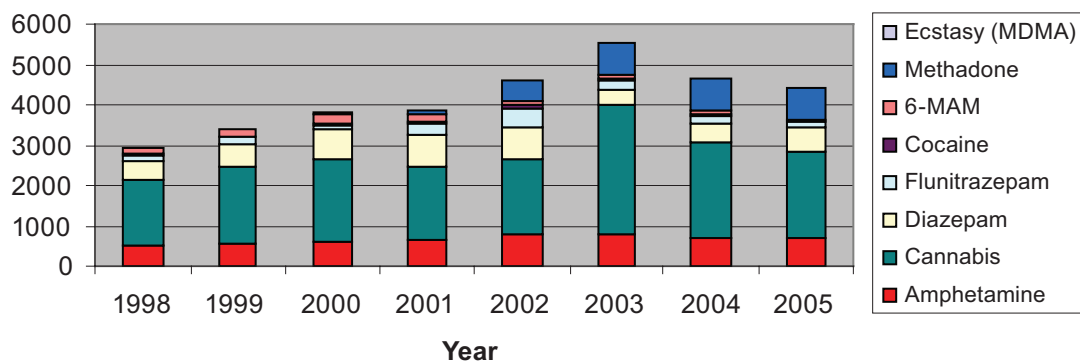
The number of inmates imprisoned for violation of drug laws has been increasing. In 2004, roughly 30 per cent of inmates in Norwegian prisons at any given time had been convicted of various types of drug crimes. In addition there are some inmates who have been convicted of drug-related crimes which have a direct connection with problem drug and alcohol use, for example theft and crimes against property committed to finance drug abuse. This is not registered by the statistics.

Substance findings in correctional services cases

The National Institute of Public Health has national responsibility for securing evidence, analysis and interpretation of drugs, medicines and poisons in samples from persons for whom the analysis results may have consequences in criminal law or corresponding consequences. The clients largely consist of the police and prosecuting authorities, the armed forces, medical examiners, the correctional service, social services and child welfare services, and some private companies.

Figure 6 shows an overview of the number of cases from prisons in which illegal narcotic substances or medicinal drugs have been found. The figures for 2005 show small changes in findings of the different substance types from 2004. The number of cases has fallen during the last two years.

Figure 6 The number of cases in which narcotic substances or medicinal drugs were found in correctional service cases 1998-2005



Source: Norwegian Institute of Public Health

9. Responses to social correlates and consequences

9.1 Housing

“Obtaining housing for oneself” is the name of the Government’s strategy for preventing and combating homelessness. The Storting endorsed the strategy in connection with consideration of White paper no 23 (2003-2004) *Om boligpolitikken - On Housing Policy* and decided to continue the efforts and utilise the experiences gained through the “Homeless people project” (2001-2004). See also NR 2005 chapter 9.2.

It is the State Housing Bank that has national coordination responsibility for the strategy. The State Housing Bank coordinates these efforts in close cooperation with the Directorate for Health and Social Affairs and the County Governors. The State Housing Bank also administers a number of funding instruments such as grants for rented accommodation, rent support, competence grants for development projects, start-up loans etc. This is intended to contribute to enabling the municipalities to strengthen their housing efforts for problem drug and alcohol users.

Five concrete targets have been defined which are to be reached by the end of 2007:

- The number of petitions for eviction shall be reduced by 50 per cent and the number of actual evictions shall be reduced by 30 per cent
- No one shall have to spend time in temporary solutions on release from prison or discharge from an institution
- No one shall be offered 24-hour accommodation unless quality agreements have been signed with the accommodation providers
- No one shall stay for more than three months in temporary housing facilities

Grants for residential follow-up services

In connection with White paper no 6 (2002-2003) *Tiltaksplan mot fattigdom – Action plan to combat poverty*, a grant scheme was established in 2003 for the purpose of strengthening and developing residential follow-up services for homeless people and problem drug and alcohol users. As of 31 December 2005, a total of 81 municipalities in 18 counties had received grant funding. In 2005, slightly more than 2 500 persons received help as a result of the scheme. The financial framework for the grant scheme is EUR 6.5 million (NOK 52 million) in 2006. An additional EUR 1.3 million (NOK 10.5 million) is available for measures in connection with the implementation of the strategy “Obtaining housing for oneself”.

9.2 Prevention of drug-related crime

Information about policy and measures is given in Structured questionnaire 31.

The correctional service has a scheme for the serving of sentences aimed at inmates with drug and alcohol problems in particular. Various programmes are offered that address issues relating to the drug and alcohol problems of convicted persons. See NR 2005 chapter 9.3.

In 2005, trials were also carried out that involved providing extra support and rehabilitation as a

reaction to drug or alcohol use in prison. This was an alternative to sanctions and punishment. The trials will be evaluated. The establishment of drug and alcohol coordination teams in all the major prisons has started. These teams will have particular responsibility for information and coordination of work on drug and alcohol problems in prisons and for taking initiatives to increase competence in the field. Drug and alcohol programmes, social environmental programmes and plan work shall be included in the overall services available to problem drug and alcohol users in prisons.

Convicted persons are entitled to specialist health services on a par with other people. Being able to serve sentences pursuant to section 12 of the Execution of Sentences Act is an important alternative for inmates who need to stay in a treatment or care institution.

In 2005, 38 260 days were served pursuant to section 12, 27 413 days of which were in treatment institutions. The statistics for 2005 show an increase compared with 2004 when 28 537 days were served in section 12 institutions.

Collaboration between the correctional service, the health service and the social services

Work has been initiated on improving access to effective counselling and treatment for inmates and convicted persons with drug or alcohol problems. A collaborative circular on the division of responsibility between the health service, social services and the correctional service has been distributed. The circular must be followed up by joint plans or cooperation agreements at the regional and local levels. This applies in particular to inmates and convicted persons who have a combination of mental health problems and drug or alcohol problems.

In cooperation with the health and social service sector, the prisons and the probation service will take steps to ensure that those with relevant needs will have their right to health assistance assessed. Steps will be taken to ensure that those who need and are entitled to interdisciplinary specialist treatment for drug and alcohol problems, including medically-assisted treatment, shall be given an opportunity to undergo such treatment also during the serving of their sentences. For problem drug and alcohol users who have a right to an individual plan, it must be ensured that the plans are also implemented and followed up during the serving of sentences.

Drug programme under court control

A three-year trial scheme for a drug programme under court control (drug courts) was introduced on 1 January 2006 (chapter 6.1.1). The programme is an individually adapted rehabilitation scheme for hardcore drug and alcohol users that forms part of the penal reaction. The point of departure for the scheme is drug-related crime. The aim of the programme is to prevent new crime and promote control of problem drug and alcohol use. According to the plan, 30 convicted persons will be offered places in newly established centres in Oslo and Bergen in 2006. There, problem drug and alcohol users will be offered individually adapted rehabilitation as an alternative to punishment. The rehabilitation will be followed up by an interdisciplinary team. The scheme will be evaluated by SIRUS (Ministry of Health and Care Services 2006).

10. Drug Markets

10.1 Availability and supply

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.

Kripos believes that major changes in registered seizures of individual substances reflect an actual change in importation and abuse, but that a reduction in the number of seizures cannot be interpreted as a sure indication that the drug problem in Norway is less extensive than previously. When the police and customs authorities have succeeded in seizing large quantities of drugs, this may have had an effect on the spreading of the drugs, thus helping to explain the reduction in the number of seizures.

The police statistics show that seizures of the most common narcotic substances are made across the whole country, which indicates that geographical availability is continuing to increase. In 2005, all the 27 police districts made seizures of cannabis and amphetamine; cocaine was seized in 26 districts, heroin in 25 and ecstasy in 21 districts. The number of seizures and amounts seized vary strongly of course between the police districts. Oslo Police District's share of the total number of seizures amounted to almost 25 per cent, roughly the same proportion as in 2004. Otherwise, most seizures were made in police districts with high population density and in customs regions with extensive border controls.

The most unusual development is the strong reduction in heroin seizures. The number of seizures has fallen steadily during the past five years, and it has been more than halved since 2001 (Table 6). Kripos believes that there is no reason to believe that availability has fallen, but that the big change over a number of years is an indication of reduced demand. This may be correct. The price of heroin has been strongly reduced during the last five to ten years, which indicates that supply has been ample, with the exception of price-driving shortfall periods which we saw most recently in the hardcore drug milieus in summer 2006. The statistical connection between the increasing use of methadone and the decline in the number of seizures of heroin is also striking. If we assume that a genuine reduction in demand has taken place, it would appear that a substantial part of the explanation is the increasing use of medically-assisted treatment using methadone and Subutex.

For 2005 as a whole, the police note that amphetamine/ methamphetamine account for approx. 22 per cent of the total number of drug seizures, which is a higher proportion than ever before (Figure 8). In the European context, the large number of seizures of methamphetamine is rather unusual. The number of seizures has tripled since 2001.

On the basis of the seizure figures, cocaine appears to be more in demand and more widespread than previously. For ecstasy, both supply and demand appear to have been reduced. The number of

seizures of cannabis has been stable for several years and the amount seized in 2005 was lower than in the previous two years.

There are no indications from other data sources or surveys of a marked general change in availability during the reporting period.

10.1.1 Production, sources of supply and trafficking patterns

Previously, it has been assumed that approx. 90 per cent of all hash seized in Europe originates in North Africa, primarily Morocco. Analyses have been carried out, by the UN among others, to map the situation in Morocco, and there are no indications that production has declined in recent years despite international pressure on the authorities in the countries in question.

The Spanish authorities seized approx. two tonnes of hash every day in 2005, and they assume that somewhere between 8 and 15 per cent of the amount smuggled is seized. Once the drug has arrived in the EU, it is very difficult to trace and it is assumed that there are many storage facilities for hash around Europe. Although the drug originates in Morocco, one should regard the whole of Europe, and perhaps the Netherlands in particular, as a risk area. It is not easy to draw any conclusion with respect to the means of transport used, as this varies a great deal. In Europe, many seizures are made in cargoes, either in containers or articulated lorries. The biggest seizures in Norway in 2004 were of this type, and it is probable that the big consignments arrive in goods shipments.

Of seizures made by the customs service in 2005, the Netherlands was the country from which heroin was sent most often to Norway. The biggest seizures in Norway can be linked to criminal ethnic Albanians, Turks, Iranians and West Africans. There is also information that criminal networks of Moroccans and Kurds are involved in organising the importation of large amounts of heroin to Norway.

As with previous years' assessments of seized amphetamine and methamphetamine, there are many indications that amphetamine produced in the Netherlands and Belgium accounts for most of the supply to the Norwegian market. Amphetamine and methamphetamine from Poland and from the Baltic countries are also assumed to account for a large proportion. The Dutch police state that the illegal amphetamine business in the country is to a large extent aimed at the UK and the Scandinavian countries. Criminal Polish and Baltic individuals and organisations are highly visible in connection with the importation of substances containing amphetamine to Norway.

The Polish communications authorities state that amphetamine and heroin are smuggled via Slovakia, the Czech Republic, Germany and Denmark to Sweden and Norway in addition to the normal smuggling route via the ferry connection between Poland and Sweden.

Seizures of amphetamine and methamphetamine in central areas of Eastern Norway indicate that shipments from Lithuania can be linked to Lithuanian nationals resident here in Norway. Further distribution is often undertaken by Turks or people from other ethnic groups. Estonians appear to be in the process of regaining their previous position as regards serious crime in Norway. Amphetamine and methamphetamine are no exception. Information about the criminal networks in the Netherlands and Belgium appears to be more scarce. It seems, however, that Norwegians resident in the Netherlands are active in criminal Dutch organisations. (Directorate of Customs and Excise, internal annual report for border control, 2005).

10.2 Seizures

See data in Standard table 13.

The statistical data from Kripas are based on information from the police districts in connection with requisitions of analyses or destruction (fixed penalty cases) or on verified analysis results. Destruction and analysis cases are thus included together in the statistics. The figures also include all seizures made by the customs authorities. The seizures are registered under the police districts where the actual seizures took place. The seizures are distributed between the country's 27 police districts.

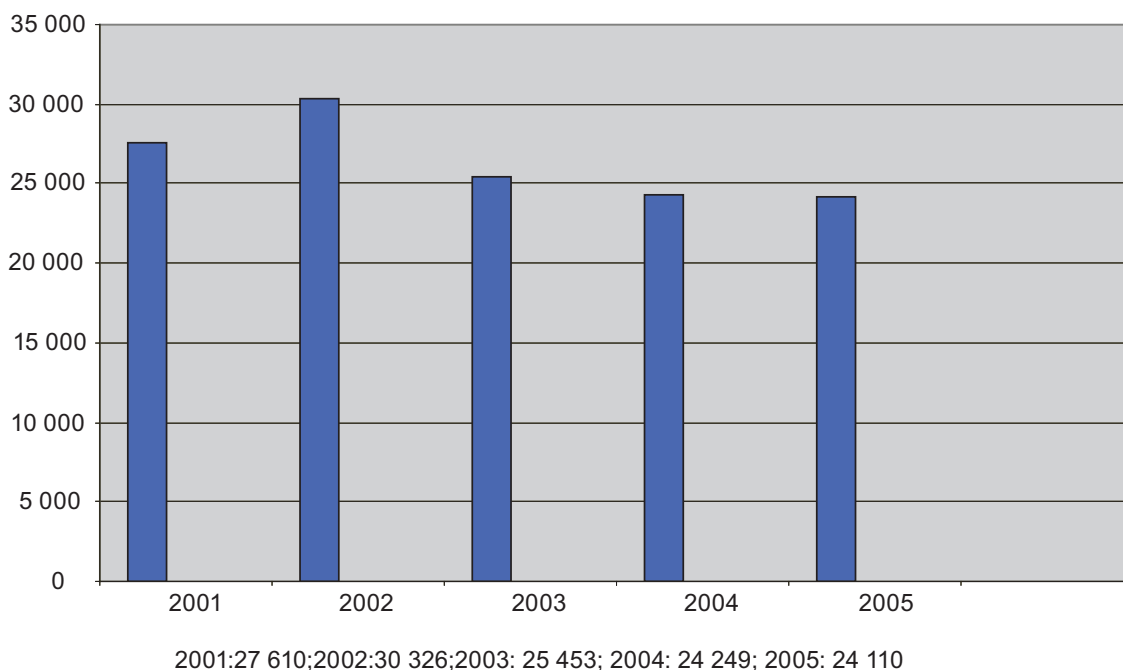
Sources of error

The statistics are based on figures that include many seizures of drugs that have not been analysed. These seizures relate to fixed penalty and destruction cases, as well as seizures of drugs for which chemical analysis had not commenced at the time the statistics were prepared. Analysis cases that were decided administratively come in addition, which has increased both the qualitative and quantitative errors. The sources of error are not deemed to have a significant bearing on the main trends in the presentation, but experience indicates that some of the minor seizures may include other types of drugs than those stated in statements to the authorities.

Main trends

Figure 7 shows that the number of cases remains stable in relation to 2004, while there is a slight decline in the number of drug seizures. In 2005, 19 279 drug cases were registered and 23 754 seizures. The sharp decline in the number of seizures registered since the peak year of 2002 therefore appears to have stagnated. A reduction in the number of seizures has been registered in most of the police districts. The drug cases are divided between 11 541 analysis cases and 7 738 fixed-penalty and destruction cases. The number of fixed-penalty cases has declined for the fourth consecutive year.

Figure 7 Number of drug seizures 2001-2005*.



*The figures for all years were adjusted as of September 2006. Source: Kripas

Table 6 Number of seizures 2001-2005 broken down by the most discussed types of drugs.* Percentage change.

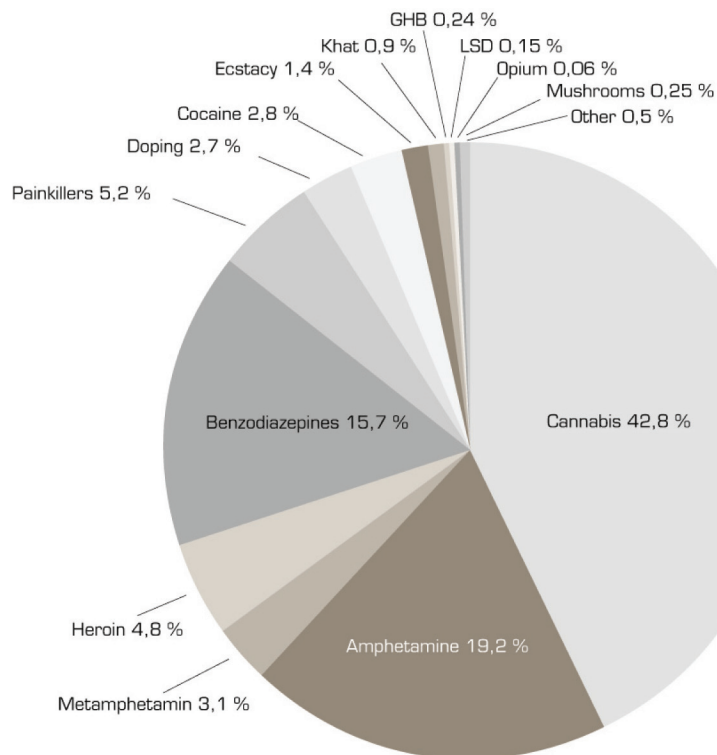
Type of substance	2001	2002	2003	2004	2005	% change 2004-2005	% change 2001-2005
Cannabis	10 838	10 921	10 397	10 066	10 129	+0.6 %	- 6.5 %
Amphetamine	4 283	5 037	4 578	4 149	4 410	+6.3 %	+ 2.9 %
Methamphetamine	392	696	640	830	950	+14.5 %	+ 142.3 %
Heroin	2 501	1 906	1 709	1 390	1 151	- 17.2 %	- 54.0 %
Benzodiazepines	6 006	8 058	4 700	4 393	3 928	- 10.6 %	- 34.6 %
Painkiller opioids	1 109	1 237	1 216	1 179	1 319	+ 11.8 %	+ 18.9 %
Doping	643	697	726	755	713	- 5.6 %	+ 10.9 %
Cocaine	496	577	504	489	684	+ 39.9 %	+ 37.9 %
Ecstasy	837	693	405	456	341	- 25.2 %	- 59.3 %
Khat	198	238	249	305	210	- 31.1 %	+ 6.1 %
LSD	52	15	31	31	34	+ 9.7 %	- 52.9 %
GHB	81	75	120	28	46	+ 64.3 %	- 43.2 %
Opium	21	14	7	18	16	-11.1 %	- 23.8 %
Psilocybe mushrooms	59	66	89	77	75	- 2.6 %	+ 21.3 %

*Figures adjusted as of September 2006.

Source: Kripas

The pie chart, Figure 8, illustrates the share of each substance based on the parameter: number of seizures.

Figure 8 Share of the number of seizures by different types of substances.



Source: Kripas

Heroin

Both the amount of and number of seizures of heroin have declined. With an amount of around 36 kg divided between 1 151 seizures, comparable figures have not been seen since 1993. It must be emphasised, however, that there are large variations between the police districts. The decline in the country as a whole in relation to the number of seizures of heroin is largely due to the big reduction in Oslo Police District. The decline for heroin is large, not just in absolute figures but also in relation to other drugs. In 1998, the proportion of heroin was 20 per cent in relation to the total number of seizures, while in 2005 it had fallen to less than 4.8 per cent (Figure 8). Heroin was seized in 25 of the country's 27 police districts in 2005, and in 12 of them more seizures were made than in 2004, although the changes are small.

Cannabis

At 1 440 kg, the amount of cannabis seized is considerably lower than the amount seized in the previous two years. However, cannabis was seized in all the country's police districts, and in 14 of the districts more seizures were made in 2005 than in 2004. A total of 10 129 cannabis seizures were registered in 2005, and this fits the pattern of stable and high seizure figures registered for cannabis since 2000. The amount of cannabis seized breaks down into 1 293.2 kg of hash, 37.7 kg of marihuana, 28.7 kg of cannabis plants and 0.01 kg of cannabis extract.

Amphetamine and methamphetamine

Despite the fact that the amount of amphetamine and methamphetamine seized has been halved in one year, an increase has been registered in the total number of seizures. A total of 118.8 kg of amphetamine and 37.5 kg of methamphetamine was seized in 4 410 and 950 seizures, respectively.

In addition, a total of 2 990 tablets containing amphetamine were seized in 23 seizures. Two of them (2 800 tablets) had the same logo as ecstasy tablets. The amphetamine content in these two seizures has been stipulated to be 46 and 95 mg, respectively. The other seizures appear to be of legally-produced medicinal drugs.

Ecstasy

The illicit traffic in ecstasy appears to have culminated at the turn of the millennium. In 2005, only 16 034 tablets were seized in 341 seizures. This means that the frequency of seizures has been reduced to one-third and the amounts seized reduced to one-sixth of the amounts in 2001. In addition, 251 g of powder containing ecstasy were seized. Most police districts have made markedly fewer seizures than previously. In relation to the year 2000, when 253 seizures of ecstasy were made in Oslo, only 66 seizures were registered in Oslo in 2005. There is little doubt that ecstasy is less widespread than previously.

Benzodiazepines (BZD)

The total of 571 000 seized tablets in approx. 3 900 seizures shows that this class of medicinal drugs has in no way disappeared from the substance abuse market, but it is deemed to be considerably less widespread than in 2002, when more than 8,000 seizures of BZD were made.

The number of seizures was reduced by 13 per cent from 2004 to 2005, while the amount of BZD substances seized was approximately the same as in 2003 and 2004. However, one seizure consisted of 268 000 tablets, i.e. almost half the total amount of BZD seized in 2005. The tablets in this seizure had the same appearance as Rohypnol 1 mg, but the analyses detected the active agent nitrazepam. The seizure is the biggest ever made in Norway. Roughly 100 other seizures of this imitation were registered in 2005.

The situation in 2005 is that diazepam has overtaken flunitrazepam, with respect to both the

amount and number of seizures, something that has not been registered during the past ten years, and that the number of seizures of other BZD substances is increasing. The latter is probably due to an increase in the prescribing of such alternative medicinal drugs, since Rohypnol is currently de-registered in the medical context.

Cocaine

The year 2005 was a special year since one single seizure of 152 kg of cocaine was made on a boat in one police district. This is without parallel the biggest seizure ever made in Norway. The investigation has shown that this consignment was intended for a more southerly destination and not Norway.

Besides this seizure, slightly less than 23 kg of cocaine were seized in 2005. That is less than the average for recent years. The large number of seizures in 2005 is also striking. A total of 684 seizures in one year is markedly higher than in the previous year.

Cocaine was seized in 26 of the country's police districts and as many as 24 of them made more seizures than the year before. Cocaine base (crack) was not detected in 2005. One seizure of coca leaves was made, in an amount of 0.7 g.

Other substances

Khat

More than 2.7 tonnes of khat was seized in 2005 in 210 seizures. This is 1.2 tonnes less than in 2004 and 2.1 tonnes less than in 2003. The number of seizures has also declined strongly, from 305 in 2004 to 211 in 2005.

LSD

The seizure figures are small, and none of Kripos' data indicate that LSD's market share is increasing, in fact quite the reverse. A total of 125 doses were seized in 34 seizures.

Opium

Both the amount seized and the number of seizures of opium in recent times have always been modest in relation to heroin and medicinal painkillers. In 2005, 2 020 grams were seized in 16 seizures.

Drug-classified medicinal painkillers

A total of 13 900 tablets were seized in 1 319 seizures. The number of seizures is at roughly the same level as it has been for several years, while the number of tablets is less than at any time during the last ten years. The data indicate that the cases increasingly concern illegal importation of such medicinal drugs via internet shopping, while the number of tablets in each seizure is relatively small. It is primarily medicinal drugs containing buprenorphine, codeine, methadone and morphine that dominate the statistics, with a total of approx. 98 per cent of all seizures. Although methadone is now used medically on a large scale, methadone does not figure to any great extent in the seizures. The number of methadone seizures has nonetheless quadrupled in 10 years. No particularly large seizures of tablets were made in this category in 2005.

Of tablets containing buprenorphine, Temgesic dominates, both with respect to the amount and the number of seizures. A total of seven seizures of between 40 and 250 tablets were made, while 16 seizures of between 100 and 500 tablets containing codeine were made.

GHB

Since it was first registered in the drug abuse context in 1997, the number of seizures of GHB has been small compared with other established drugs. Even if we include seizures of the industrial

chemicals GBL and 1.4 butandiol, substances not included on the list of narcotic substances, the figures are marginal, with a total of 67 seizures. The total amount of fluids containing GHB was registered at approx. 8.5 litres in 2005. The amount of GBL seized was approx. 0.89 litres. The amount of 1.4 butandiol seized was 14.3 litres.

Other hallucinogenic drugs

The substance psilocybe has been included on the list of narcotic substances since 1971, and since 15 April 2004, all fungi containing psilocybin have been criminalised. Although these fungi have never figured prominently in the statistics, Kripos does receive some information that these hallucinogenics are still of interest as drugs.

In 2005, minor seizures were made of the hallucinogenic substance diemethyltryptamine (DMT). The substance, a viscous brown liquid, may be an extract from plant material. DMT was also found in 2003.

A completely new development in 2005 was the seizure of tablets containing the synthetic substance 1-(3-chloride phenyl) piperazin, also called mCCP. The substance is not on the list of narcotic substances. mCCP cannot be said to have industrial or medicinal applications. A total of 10,485 tablets were seized in eight seizures.

Psychoactive plants and plant parts that are not classified as drugs are regularly seized on the grounds that their importations are not normally permitted. Much of this traffic is probably the result of information and offers on the internet. This concerns in particular seeds of *Argyrea nervosa* (Hawaiian Baby Woodrose), *Salvia divinorum*, seeds of peyote cactus, peyote cactus containing mescaline and *Peganum harmala*.

10.3 Purity

See the data in Standard table 14.

At 25 per cent, the average purity of heroin is at the same low level as in recent years, but there are still great variations in purity from seizure to seizure. Paracetamol and caffeine are detected in very many seizures. Intoxicating substances such as phenobarbital, diazepam and alprazolam were also found in many drug mixtures containing heroin.

For *cannabis* it is hash that 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.

For *amphetamine* and *methamphetamine*, the average purity in 2005 was estimated to be 45 per cent for amphetamine and 50 per cent for methamphetamine, but it still varies greatly, from one per cent to more than 70 per cent in individual seizures.

For *ecstasy*, MDMA was shown to be the only active agent in 98 per cent of the seizures. MDEA was found in one seizure, and combinations of MDA and MDMA or MDEA and MDMA in the other seizures.

For *cocaine*, the average purity was estimated to be 45 per cent. There is still considerable variation in the results.

10.4 Prices

See the data in Standard table 16.

Estimates of the prices of various drugs are based on information from drug users and sellers at different levels obtained by officers in the section for organised crime in Oslo Police District as of September 2006. The previous estimate was made in April 2005. Naturally, a “price barometer” for such goods only gives an indication, to which a degree of uncertainty is attached. Prices will also vary considerably on the basis of the quantity being sold. The price of a gram will be lower when one gram is purchased than when single user doses are purchased. Moreover, the price per gram will be considerably lower when quantities of 10 grams or more are purchased.

The most marked price change has been for cocaine. The fall in the price of cocaine (when purchasing one gram) has been approx. 40 per cent during the last two to three years, from an average of approx. EUR 175 (NOK 1 400) to approx. EUR 106 (NOK 850). The price of amphetamine has also fallen, but not to the same extent. The price level of cannabis and heroin, again based on the purchase of one gram, appears to have remained stable.

Part B. Selected issues

11. Cocaine and crack – situation and responses

Odd Hordvin, SIRUS

11.1 Prevalence, patterns and trends in cocaine use

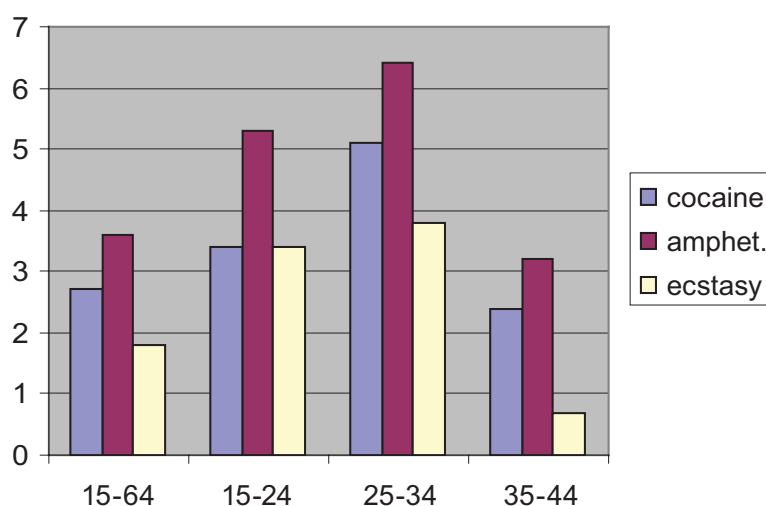
Cocaine use among the general population

The most recent survey of the population's use of drugs was carried out by SIRUS in autumn 2004. The survey was part of a series of wide-ranging surveys which mainly deal with alcohol use and attitudes to alcohol policies. The survey and methodology were described in more detail in NR 2005 chapter 2.1.

Lifetime prevalence (LTP) in the population between 15 and 64 years for other drugs than cannabis is largely stable and at a relatively low level compared with previous surveys. The highest LTP is for amphetamine, which was almost 4 per cent in 1999, somewhat higher than in 2004. For cocaine, the prevalence was slightly less than 3 per cent in 2004, a marginal increase from 1999. However, the LTP of cocaine use has overtaken ecstasy and it is currently approaching the level for amphetamine. The questions also included crack, but it is assumed that crack only accounts for a very marginal proportion of cocaine use.

It is more relevant to look at the LTP of cocaine in a narrower age sample of young adults. Figure 9 shows the highest LTP in the 25-34 age group, at approx. 5 per cent. This group had the biggest increase in reported cocaine use from 1999 to 2004, slightly more than 2 per cent. The 15-24 age group also had a higher LTP than the average.

Figure 9 Lifetime prevalence 2004 for cocaine, amphetamine and ecstasy in different age groups. As a percentage.*

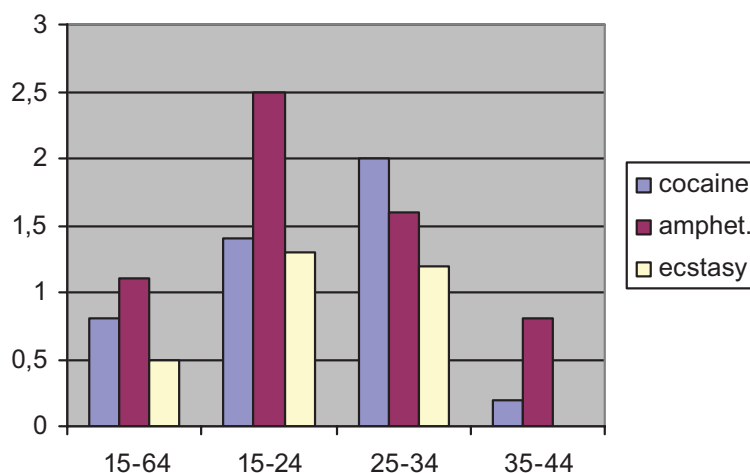


Source: SIRUS

* N: 15-64 2669, 15-24 645, 25-34 593, 35-44 535

The proportions stating that they have used central stimulants during the last 12 months show marginal changes for the period 1999-2004 (figure 10). This also applies to cocaine. The numbers are very small, however, and random factors may result in relatively large changes. With the exception of amphetamine (1.2 per cent in 1999), the other prevalences in the population as a whole (15-64) are less than 1 per cent. Again, however, the age groups < 35 years are not surprisingly highest here as well. The use of cocaine is most reported among 25-34 year-olds, and in this age group it exceeds the level for amphetamine.

Figure 10 The use of cocaine, amphetamine and ecstasy during the last 12 months in various age groups. 2004. As a percentage.



Source: SIRUS

The proportion reporting use during the last 30 days is so small for all the drugs (except for cannabis) that it is not possible to say anything about developments. In 2004, the proportion for all the drugs was below 0.3 per cent.

Registration of the drug situation in Norwegian municipalities

Since 2002, SIRUS has carried out nationwide questionnaire surveys directed at the health and social services and police stations/ the rural police service in all municipalities (434). See NR 2005 chapter 2.3. The proportion of municipalities that report an increase in the number of drug users in relation to the previous year was lower in 2003 than in the previous year for nearly all drugs. For amphetamine, however, a significant increase was observed both years, while the use of cocaine has increased least. A relatively large proportion of municipalities report that cocaine has not been detected in the municipality. The use of ecstasy is increasing in some municipalities, but there is also a relatively large proportion of municipalities which report fewer users or that such drugs do not occur. Even though the police and health and social services have a similar assessment of the tendencies for most drugs, their views on the increase in the use of cocaine diverge to a certain extent (Amundsen, Lalla, 2005).

Cocaine use among school students and youth

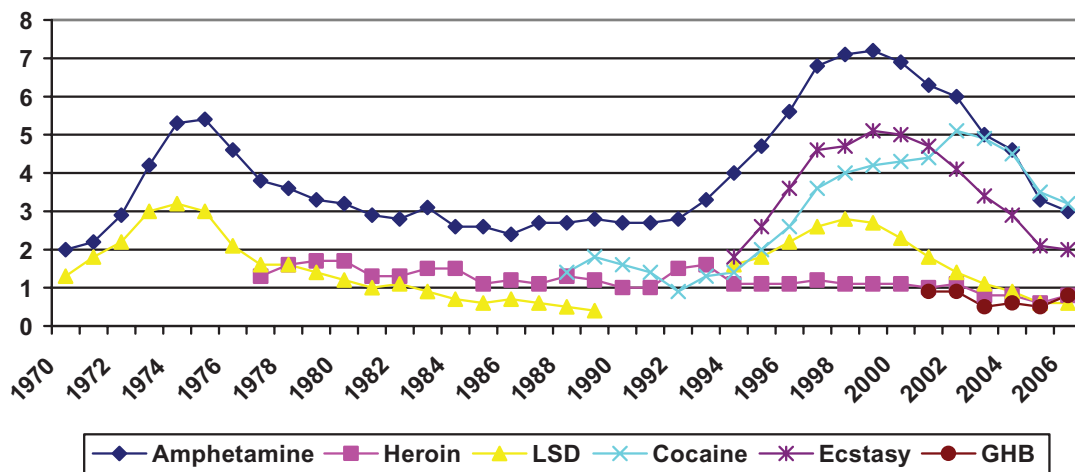
Surveys among young people aged 15-20

SIRUS carries out annual questionnaire surveys on the use of drugs and alcohol among young people aged 15 – 20 registered as resident in Oslo and in the country as a whole. Chapter 2.2 deals with this in more detail.

Cannabis is the most common illegal drug. After increasing in the late 1990s, the proportion that state that they have used other drugs has also largely stagnated/ declined in recent years (Figure 1 in chapter 2.2). For example, the proportion of 15-20 year-olds who state that they have ever used amphetamine remained at approx. 4 per cent, while the proportion stating that they have used ecstasy appears to have stabilised at 2 to 3 per cent over several years. For cocaine, the level has varied between 1.5 and 3 per cent for the last five-year period.

The LTP for the capital city, Oslo, is higher and shows more marked changes. Figure 11 shows that the proportion of 15-20 year-olds who state that they have ever used amphetamine has declined from approx. 7 per cent at the turn of the millennium to approx. 3 per cent during the last two years. The proportion that states that they have ever used ecstasy has fallen from 4-5 per cent to approx. 2 per cent in the period 2001-2006. For cocaine, there appears to have been a flattening out to approx. 3-4 per cent in recent years. The decline appears to be somewhat greater among young people in Oslo than in the country as a whole.

Figure 11 Percentage of youth between the ages of 15 and 20 in Oslo who have ever used other drugs than cannabis, 1970 – 2006 (three-year sliding average).



Source: Sirius

The figures must be interpreted with care. Moreover, the response rate is less than 50 per cent. Since the figures for other drugs than cannabis are small, margins of error and chance can result in relatively large changes (www.sirus.no).

Young adults aged 21 – 30

In parallel with the annual questionnaire surveys in the 15-20 age group, SIRUS carried out corresponding surveys in the 21-30 age group in **1998**, **2002** and **2006**. The surveys show that the proportion that reported that they had ever used cocaine increased from 3 per cent in 1998 to 6 per cent in 2002 and 8 per cent in 2006. For Oslo, the proportion increased from 7 per cent in 1998 to 10 per cent in 2002 and 13 per cent in 2006.

The proportion that have used cocaine during the last six months has also increased from a level of 2 per cent in 2002 to 4.6 per cent in 2006 for the country as a whole. Figures are not available for 1998.

However, the figures must be interpreted with care since the response rate here is also less than 50 per cent (SIRUS, unpublished material).

School surveys

In 2002, Norwegian Social Research (NOVA) carried out a nationwide questionnaire survey “Ung i Norge 2002 (Young in Norway 2002)” aimed at lower and upper secondary schools. A total of 11 928 young people between the ages of 13 and 19 took part. The data were used in a separate survey on Oslo youth and problem drug and alcohol use (Storvoll, Krange 2003). The response rates in these surveys were very high at 92 per cent for Norway and 94 per cent for Oslo. The same type of survey was also carried out in Oslo in 1996, but since it did not include the oldest students where prevalence is of course highest, the comparison of LTP is problematic.

In the survey for Norway, 2.1 per cent answered that they had used cocaine, 2.7 that they had used ecstasy and 3.4 per cent amphetamine. For Oslo, 4.1 per cent of the young people confirmed that they had ever used cocaine, 4 per cent that they had used ecstasy and 4.3 per cent that they had used amphetamine. The figures are in broad agreement with SIRUS’s survey of 15-20 year-olds for the same year (chapter 2.2). This is despite a considerably lower response rate.

In the ESPAD survey (European School Survey Project on Alcohol and Other Drugs), three data collections have been made: 1995 – 1999 – 2003. The Norwegian part includes slightly less than 4 000 15-16 year-olds each year. The survey was conducted in March/ April in each of the respective years. There was a decline for central stimulants from 1999 to 2003. One to two per cent state that they have ever used amphetamine, ecstasy and cocaine, which is lower than in the youth surveys. This is due to the low age of the respondents and the fact that the survey only covers a one-year cohort. Again, the prevalence is low and the figures must be interpreted with care.

Gender and ethnicity

Since cocaine use in Norway is still a low-prevalent phenomenon, it is problematic to study it in conjunction with other characteristics of young people (such as gender and ethnic background). The groups are often too small and chance plays too great a part for this purpose. None of the following examples is statistically significant.

The gender differences were small in NOVA’s 2002 survey of young people in Norway aged between 13 and 19 (2.6 per cent of boys, 1.6 per cent of girls). In SIRUS’s last population survey (2004), the difference between boys and girls was also small, 3.8 per cent and 3.1 per cent, respectively, in the 15-24 age group, while in the 25-34 age group there was a more marked gender difference with 6.1 per cent of men and 4 per cent of women. SIRUS’s material for the 21-30 age group (2006) shows an even clearer preponderance of men. For the country as a whole, the proportion of men who reported that they had ever used cocaine was 12 per cent and 6 per cent of women. The corresponding proportions for Oslo were 18 per cent of men and 10 per cent of women.

In NOVA’s survey on Oslo youth and problem drug and alcohol use, 4.3 per cent of Norwegian and 2.5 per cent of immigrant youth stated that they had used cocaine. The data also show that fewer students from immigrant backgrounds (3.8 per cent) than ethnic Norwegian students (6.9 per cent) stated that they had used any other drugs than cannabis (Storvoll, Krange, 2003).

Trends

The Earlier Warning, Project(Føre Var) is a mapping system that aims to detect new patterns of drug and alcohol use in some towns. Routine indicators are compiled as well as factual data and statistics and information from various informants. These informants include professionals from various agencies/ bodies, adults who are in close contact with youth cultures. Young people who are either users themselves or who there is reason to believe are familiar with general drug and alcohol use and/or new trends on the nightlife scene are also included (see NR 2005 chapter 2.4 for a more detailed discussion).

For Bergen, the Bergen Clinics Foundation has published such six-monthly trend reports since 2002. From autumn 2004 until spring 2006, a gradual to strong increase was reported in cocaine use among key informants from the nightlife scene (7-8 persons). These informants rank cocaine as the third most used drug in their social circle, ahead of amphetamine. On the other hand, informants from hardcore drug milieus report no change or no increase.

Two anecdotal statements from the six-monthly reports for 2006 from Bergen:

“It looks like cocaine is becoming more and more common and accepted in groups who have not used the drug before” (informant from the nightlife scene).

“The situation has progressed from using cocaine once at a party to its being used a lot on a daily basis. They’ve replaced alcohol with cocaine, which means that now they might take cocaine when watching football. That says a lot about how common it’s become” (informant from the nightlife scene).

For amphetamine, on the other hand, the situation has fluctuated somewhat, although it has generally been stable, while the use of ecstasy has long shown a downward trend according to key informants from various milieus (Mounteney, Leirvåg, 2006).

FUTURE is an opinion-building measure aimed at combating the use of illegal drugs on the nightlife scene. Future is run by the outreach services in the three biggest cities, Oslo, Bergen and Trondheim, with a lot of help from young volunteers. In Oslo, they also cooperate with nightspots and clubs. They also have stands at small and large events.

Future Oslo’s assessment is as follows:

“Cocaine is most used in the cities: Oslo, Bergen and Trondheim and Stavanger. Other types of party drugs such as amphetamine and ecstasy are used instead of cocaine in smaller places. Possibly because of price and availability and milieu and the cultural context. In terms of music/club culture, none of them stand out in particular as regards the use of drugs. The milieus overlap and illegal drugs are found in many of them. The “wild” partying that was associated with the house scene is “out”. We see few really dilated pupils, grimaces and wild dancing nowadays. It is difficult to identify those who take drugs in nightspots, even for the trained eye.

Cocaine users are often in regular employment or education and have an active social life and contact with their families. They get high together at parties, but do it discretely.

A great deal of cocaine is taken at certain get-togethers for people who work in the restaurant industry and among people who go out a lot. Many people mix it with alcohol, but they seldom appear to be visibly intoxicated.

Many of the users manage to avoid developing dependency problems with cocaine, since they often get high at parties and perhaps a couple of times a month. The distinction between recreational use and abuse is clear in this context.

Those over the age of 25 are difficult to reach and no agencies target this group. It often takes a long time before they seek help for cocaine use; it is very much a taboo subject.

Some of the users may be in contact with hardcore criminal milieus (debt-collecting with menaces).

Previously, the cannabis user and heroin user milieus in Oslo were separate, while we now see a blurring of the boundaries between them. And that cocaine is also bought in the heroin milieu. These

young people are involved in more serious abuse, many of them are unemployed, not in school, homeless and have mental health problems, and they are also involved in the sale of drugs themselves.

Another group that uses cocaine is ethnic minority youth – here we see an increase in smoking cocaine and marihuana, perhaps in African milieus in particular. We have observed that young people smoke cocaine, marihuana and heroin openly beside the Akerselva river and along the quays and on the lawns around Skippergata. Often combined with alcohol.

Crack-cocaine is only registered sporadically.”

(Memo from the head of Future Oslo)

Prevalence and patterns of use among specific populations

A study: *Financial aspects of injecting drug users' use of drugs* was discussed in NR 2005 chapter 4.3. This study, which was published recently, is part of a larger project aimed at studying the illegal drug market in general and the heroin market in Oslo in particular. Recruitment took place through the central needle distribution facility in Oslo. Unlike studies based on prison or treatment populations, the users here are recruited from what is called a non-controlled environment. The purpose has been, among other things, to describe the group of active injecting drug users and their drug use, and to analyse how financial and other factors affect their use. It focused on buyers/ users of so-called “hard” drugs.

The study shows that 84 per cent of the sample mainly inject heroin, 12 per cent amphetamine, 3 per cent inject both and 1 per cent inject other drugs.

The study also shows that the proportion that have used cocaine has significantly increased during the survey period from 1993 to 2004. From a level of around 7 per cent in 1993, the proportion that had recently used cocaine (during the last 30 days) increased to almost 25 per cent in 2001, before declining to 15 per cent in 2004 (from an average of 8 to an average of 19 per cent during the survey period).

The proportion of women stating that they use cocaine was the same as the proportion of men. The proportion of those under the age of 25 is 4 percentage points higher than among those over the age of 35 (15 versus 11 per cent). As expected, since the effects of cocaine and amphetamine are comparable, there was a higher proportion of amphetamine users than heroin users who reported cocaine use, but the difference was only 5 percentage points (16 versus 11 per cent).

Few injecting drug users, however, are high-frequency users of cocaine. Around 3 per cent reported using the drug once a week or more. Injecting cocaine together with heroin (“snowballs”) does not appear to be a widespread phenomenon in Norway. Only a few interviewees have reported such a practice (Bretteville-Jensen,2005).

11.2 Problems related to cocaine use

Treatment demand for cocaine use

The Bergen Clinics Foundation operates a nationwide client mapping system in Norway on assignment from SIRUS (NR 2005 chapter 4.2). Queries about cocaine and amphetamine-related problems are registered together on the registration form which the institutions have used so far. It is thus not possible to isolate cocaine as a drug profile, nor to state the number of patients who request treatment for cocaine-related problems. The revised form that has now been introduced has separate questions about cocaine and amphetamine. Data collected using the new form will not be available,

however, until the end of 2006 at the earliest. Registrations for the last 4-5 years show small changes in the proportion who, on admission, state that central stimulants are their main drug.

Cocaine and driving

Statistics for suspected driving under the influence are kept by the National Institute of Public Health. Cocaine only accounts for a very small proportion of such cases compared with, for example, amphetamine and cannabis. The number of drivers in whom cocaine was detected has not increased during the last five years.

Cocaine-related deaths

In cooperation with Statistics Norway, the National Institute of Public Health has sampled the national Cause of Death Registry for the period 2000-2004. As Table 7 shows, there was only one death during this period in which cocaine was the sole stated cause. In addition, there were two deaths (in 2002 and 2004) which were coded with cocaine as a contributory cause. In addition, cocaine was found in connection with several other deaths. For most deaths in which cocaine was found in the forensic toxicological examination, it was found in combination with opiates and other psychoactive substances. The average age of those who died during the period 2000-2004 with cocaine in their bodies was 30 years and the proportion of women was 15 per cent. The forensic toxicological examination showed that, on average, the deceased had taken 3-4 opiates, other psychoactive substances and/or alcohol in addition to cocaine.

Table 7 Cocaine-related deaths, poisonings and intoxications

Year	Due to cocaine*	Other poisonings where cocaine was present (an eventual ICD-10 indicated cocaine related intoxication is indicated by a footnote)				Total cocaine-related deaths
		Cocaine alone	Cocaine with alcohol only	Cocaine with opiates	Cocaine with other psychoactive substances	
2000	0	1	0	7	5	13
2001	0	0	0	9	4	13
2002	0	0	1	3	7	11
2003	1	0	0	5**	5	11
2004	0	0	1	1	4***	6

* Cause of death ICD10 code X42 with cocaine intoxication (T40.5) as multiple coding.

** Cause of death ICD10 code X42 with heroin intoxication (T40.1) and cocaine intoxication (T40.5) as multiple coding.

*** Cause of death ICD10 code G409 (= Epilepsy, unspecified) and cocaine intoxication (T40.5) as multiple coding.

Sources: Norwegian Institute of Public Health and Statistics Norway

11.3 Responses and interventions in connection with cocaine and crack use

Treatment for cocaine

We are not aware of any separate treatment programmes for cocaine addicts. No studies or evaluation reports are available.

Drug and Alcohol Helpline

The Drug and Alcohol Helpline was discussed in NR 2005 chapter 3.2. The helpline covers the whole country. The total number of queries about cocaine increased considerably from 2004 to 2005.

There were also far more problem drug and alcohol users who contacted the helpline for information, advice and/or help concerning cocaine in 2005 than in the previous year. The tendency continued in the period January to March 2006, when there were almost twice as many callers as in the same period in 2005 and a corresponding increase in the number of problem drug and alcohol users. It must be emphasised here that the drug/alcohol profile of the callers is unknown. They are probably not all cocaine users.

The number of queries concerning crack-cocaine, on the other hand, was low. Only a very small number of such queries have been registered.

Availability of information material for cocaine/crack users

The Future groups (see above) have produced a facts brochure about cocaine and crack that is distributed at events they visit. Otherwise, several organisations and the Directorate for Health and Social Affairs have produced information material, both in printed and internet versions. So far, no major campaigns targeting cocaine and crack-cocaine have been carried out in Norway.

Law enforcement activities in response to cocaine use

We have little surveillance information about milieus in which cocaine is used. Oslo Police District reports that their efforts are largely directed at organised criminal networks and they claim that the “backers” are potential investors in drugs in general, i.e. they can smuggle/sell cannabis, heroin, amphetamine and cocaine depending on what is available on the market. The Oslo Police have seen no signs that crack is more used than previously.

As regards smuggling, the customs authorities believe that focus should still be on South America, but that there are also reasons for focusing on the traffic from Southern Europe, and Spain in particular, since cocaine is in ample supply there.

Policies and strategies in response to cocaine use.

No national strategies have been developed that target cocaine in particular.

11.4 Cocaine-related crime and cocaine and crack markets

Cocaine-related crime

The crime statistics provide an overview of reported offences, investigated offences, charges and convictions relating to drug crime. However, the statistics are not specified for the individual drugs and the number of cases in which cocaine is involved cannot therefore be reported (Standard table 11).

Seizures, geographical spread

The statistics for seizures from Kripos show that 23 kg of cocaine⁷ was seized in 2005. That is less than the average for recent years. The number of individual seizures – 684 – is the highest ever, however. But the number of seizures of amphetamine was seven times as high. As a proportion of seizures of all other drugs, seizures of cocaine have increased from 0.5 per cent to 2.8 per cent during the past 10 years. By comparison, seizures of amphetamine in 2005 accounted for 19.2 per cent. The geographical spread is high. In 2005, cocaine was seized in 26 (of 27) police districts, and 24 of them made more seizures than they year before. This indicates that cocaine is spread more and is more widely used than previously. The largest quantities were seized by the police and customs

⁷ In November 2005, the customs authorities made a single seizure of as much as 153 kg of cocaine from a boat in Central Norway. The investigation has shown that the consignment was not intended for Norway. This seizure has not been included, therefore.

authorities in Oslo and neighbouring municipalities. Although this does not necessarily mean that all the drugs were intended for sale in Oslo, there is reason to believe that the Oslo area is a focal point. Roughly three-quarters of the quantity of cocaine seized in 2005 was seized by the customs authorities.

Kripos reports that the number of seizures of cocaine in the first six months of 2006 is roughly the same as during the corresponding period in 2005, when more seizures were made than in any previous 6-month period. And only in two previous 6-month periods has a greater quantity of cocaine been seized. Roughly 40 per cent of the seizures were made in Oslo Police District.

The customs authorities in Østfold have discovered several large consignments of cocaine in August in routine checks of trains from abroad and buses arriving via Sweden. The police believe they can see a clear trend: African couriers who swallow the drugs in the Netherlands/ Germany and then get on the train to Norway. The influx of cocaine is so pronounced that it most probably concerns distribution in milieus of which the police do not have a full overview at present.

Availability

In population studies from 1994, 1999 and 2004 respondents were asked whether they would manage to obtain various substances in the space of 2 to 3 days. The answers show that people believe it is easiest to obtain cannabis, more difficult to obtain amphetamine and ecstasy and most difficult to obtain cocaine and heroin. A more interesting finding is that availability appears to have increased relatively strongly during the period. Relatively speaking, the increase is greatest for cocaine and heroin. In 2004 twice as many people as in 1994 stated that they could obtain these drugs in the space of 2 to 3 days (see NR 2005 chapter 10.1).

Concluding comments

Cocaine use is still not widespread in the population as a whole and no marked increase has been found. Various surveys show, however, that there has been a significant increase among young adults. During the five-year period 1999-2004, the increase was strongest in the 25-34 age group. The seizure figures are also increasing and they also show a greater geographical spread. The focal point for cocaine use, however, is still in the biggest cities and Oslo in particular, where the prevalence (ever used) among 20-30 year-olds appears to have doubled during the last eight years. However, there are no grounds for claiming that use is increasing in towns in general.

Does cocaine replace other use or does it come in addition to other drugs? A study of the illegal drugs market in Oslo points to the latter. Relatively many people in the hardcore drug milieus use cocaine in addition to other drugs, and use in these milieus has increased significantly during the last 10 years. On the other hand, data from various surveys show that cocaine has overtaken ecstasy and is now approaching the level of amphetamine, the prevalence of which has not increased in recent years. This may indicate that some people have "switched" from ecstasy and that more people prefer cocaine to amphetamine when the availability of cocaine is great and the prices are competitive. A more curious explanation may be that less experienced users do not know what they are taking; what they believe to be cocaine may be amphetamine since the effect is quite similar.

Police statistics of seizures are one of the parameters for estimating prevalence. Given that the number of seizures for amphetamine is seven times higher than for cocaine, one could well ask where all the amphetamine not seized ends up. Or whether there is far more cocaine in circulation than proven. Dealing in cocaine is still so off-street that the police, on the basis of their priorities, do not come down on the retail link in the chain in the same way as they do when they observe open small-scale dealing on the street.

There are no studies or surveys from the nightlife scene and the more closed party scenes. It is most probably here, among the 25 + age group, that a large number of unreported cases can be found,

both with respect to cocaine use and associated problems. So far, we know very little about the extent to which these users seek help.

12. Drugs and driving

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12.1 Policy

Norway was the first country in the world to set a limit (0.5 o/oo BAC) in its Road Traffic Act⁸ for driving under the influence of alcohol (1936). In 2001 the limit was lowered to 0.2 o/oo. In 1959 the scope of the Road Traffic Act had been extended to include driving under the influence of drugs other than alcohol, including illegal substances and psychoactive medicinal drugs. The police were consequently authorised to carry out blood (and urine) tests combined with a clinical examination by a doctor, to assess whether or not a person had been driving under the influence of drugs or alcohol. Norway thus has statutory provisions relating to drugs other than alcohol that may impair driving. Moreover, the use of illegal substances and medicinal drugs may also be a penal offence under the Medicinal Products Act⁹. Consequently, a driver of a motorised vehicle suspected of impaired driving may be liable to prosecution under the Medicinal Products Act if such substances are found in his or her blood or urine samples and the detected drugs have not been prescribed by a doctor. The Medicinal Products Act may thus be applicable even if the quantity of the detected substances and the clinical examination would not lead to conviction under the Road Traffic Act.

12.2 Detection, measurement and law enforcement

From the police's initial suspicions on the road to court proceedings

The most common grounds for suspecting a person of impaired driving are accidents, unsteady or risky driving, reports from other road users, or roadside controls. The latter applies only in a minority of cases (approx. 10 – 15 per cent). The police are authorised to perform a breath alcohol test even if there is no suspicion of drunk driving. If the test shows a negative or low alcohol level, but impaired driving is still suspected, the police are entitled to carry out various tests to further investigate their initial suspicion. These include measuring eye responses, taking the pulse, conversing with the driver and assessing gait. Most police officers who work in traffic controls have received training in these examinations, in programmes comparable to the American DRE-program (Drug Recognition Expert Program). Any discovery of drugs, tablets or related equipment will reinforce the suspicions of the police. The chief duty officer will make a final decision to uphold the suspicion before the suspect can be subjected to blood (and urine) tests and clinical examination by the police surgeon or the doctor on duty at the hospital or A&E unit (who then will act as police surgeon). The clinical examination follows a standard programme consisting of approximately 25 observations including consciousness, time and place orientation, general behaviour, counting backwards, articulation, ability to participate in a normal conversation, evaluation of mental state, pulse, examination of eyes (pupil size, response to light, nystagmus), normal gait, the Romberg balance test and other coordination tests, involuntary movements and squinting, memory and cognitive tests. Any use of drugs and alcohol or medicinal drugs (stating doses), and disease, must be recorded. On the basis of the examination, the doctor will conclude whether or not the suspect is impaired.

8 Act no. 04 of 18 June: Road Traffic Act.

9 Act no. 132 of 4 December 1992 relating to Medicines etc. Hereinafter called the Medicinal Products Act.

Blood and urine analyses – interpreting results

Blood and urine samples are sent to the Norwegian Institute of Public Health, Division of Forensic Toxicology and Drug Abuse, for analysis and interpretation. The Institute has national responsibility for such cases. All samples are analysed using a standard programme regardless of primary suspicion. The programme includes approximately 25 substances/ groups of substances: alcohol, cannabis (tetrahydrocannabinol – THC), amphetamines including ecstasy, cocaine, benzodiazepines and related substances, opioids¹⁰, muscle relaxants and some antiepileptics. Supplementary analyses for substances not included in the standard programme are carried out by special request from the police, or when the results of the analysis programme are all negative but the clinical examination concludes that the person is impaired. All positive analysis findings are reported on the basis of two independent analysis methods: screening methods using immunology and liquid chromatography/ mass spectrometry (LC/MS) followed by confirmation/ quantification analyses using gas chromatography/ mass spectrometry (GC/MS) and LC/MS(MS).

When all the analyses have been completed, the results and interpretations are reported to the police, with a conclusion of probable or not probable impairment. The conclusion is based on the concentration(s) of the active substance(s) in the blood and the results of the clinical examination. If the police decide to bring charges, the case and documents are often returned, with a request for an expert opinion, before the case comes to court. In some cases the expert will be required to be available for examination by telephone or to appear in court.

Conviction – repeated arrests

Norway has relatively severe penalties for driving under the influence of alcohol or other drugs: fines and suspended or custodial prison sentences combined with loss of driving licence for at least two years. Earlier studies have shown that over 90 per cent of the cases in which the experts concluded that the person was “in all probability impaired”, or “very probably impaired” ended in conviction (Mørland and Christophersen, 1999). There are no specific national statistics for the number of convictions per year involving substances other than alcohol, but on the basis of the above results an estimated 2,500 – 3,000 drivers per year have been convicted of driving under the influence of drugs other than alcohol.

Despite the relatively severe penalties and the large number of convictions, many people are re-arrested for the same offence. A study of drugged drivers (n=1102) followed up prospectively for 7.5 years showed that almost 50 per cent of the drivers are re-arrested in the course of three years and 57 per cent during the whole follow-up period (average of four re-arrests). The re-arrest rate was twice as high as for drunken drivers (n=850) who were followed during the same period (28 per cent in 7.5 years, with an average of three re-arrests) (Christophersen et al, 2002).

In another study, drivers in whom benzodiazepines had been detected (either alone or in combination with alcohol or other drugs) were followed retrospectively for an eleven-year period. The results showed that more than 60 per cent had previously been arrested for the same reason and that alcohol was the most frequently detected substance at the first arrest (Skurtveit et al, 2002). The results indicate that a large percentage of drivers with previous arrests for drunken driving have changed their pattern of use, in many cases to benzodiazepines.

¹⁰ Heroin intake is confirmed by identification of 6-MAM in the urine sample

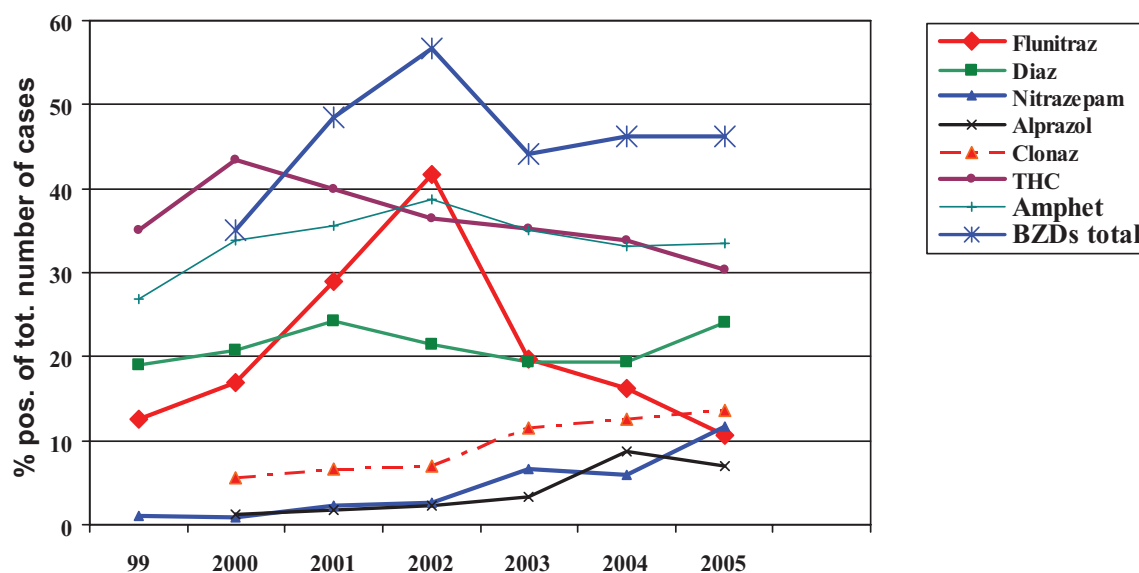
12.3 Prevalence and incidence. Epidemiological methodology

Data collected since 1985 about all traffic cases involving drugs other than alcohol, the number of cases and the results of analyses is stored in the national register at the Norwegian Institute of Public Health. From the beginning of the 1990s (approx. 2 000 cases) until the turn of the century, a steady increase was recorded in the number of cases in which the use of drugs other than alcohol was suspected. During the last five years the sample has varied between approx. 4 000 – 5 100 cases per year (population of approx. 4.5 million) (www.fhi.no/rusmidler/statistikk). The number of cases in which alcohol alone was suspected fell in the early 1990s (almost 9 000 cases per year), and has subsequently remained relatively stable at about 5 000 – 5 500 cases per year. Analyses were positive for one or more substances in about 80 per cent of the cases involving suspicion of drugs other than alcohol, despite the fact that the police do not have equipment for primary screening of drugs in saliva¹¹. By comparison, alcohol levels above the legal limit were detected in 85-90 per cent of cases in which the primary suspicion was linked to alcohol, for which the police do have equipment for primary screening.

Typical characteristics of drugged drivers

Most cases (approx. 85 per cent) involve men aged 20–35 who use several substances at the same time (2.5 – 3 on average), often a mixture of illegal substances and psychoactive medicines. The latter are generally detected in blood concentrations far in excess of recommended therapeutic doses. The most frequently detected illegal substances are cannabis and amphetamine (Figure 12). The most frequently detected medicinal drugs are benzodiazepines, represented by diazepam, flunitrazepam, nitrazepam and clonazepam. As a group, benzodiazepines are detected more frequently than any individual illegal substance.

Figure 12 Some frequently detected drugs in blood samples from apprehended drivers in Norway. Percentage positive of all samples analysed



Source: Norwegian Institute of Public Health

Increased mortality

Two studies show a greater incidence of prospective mortality in persons arrested for driving under the influence of drugs and/or alcohol. A follow-up study (7.5 years) of two selected groups of per-

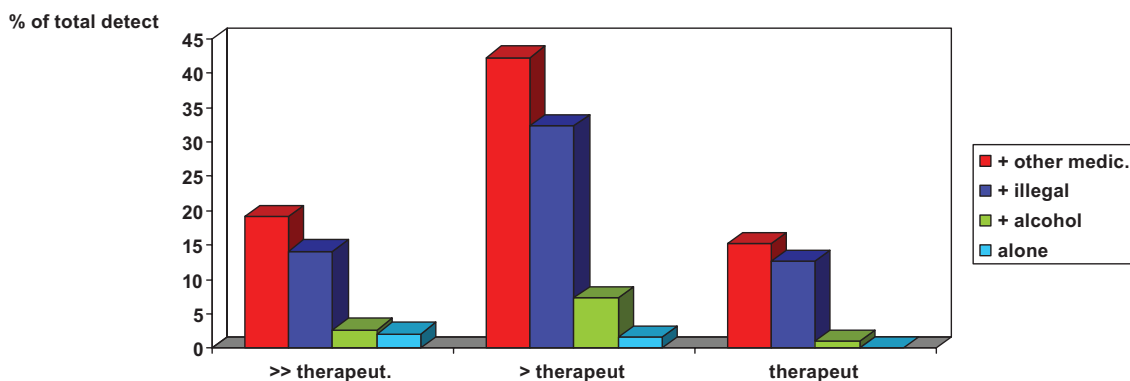
¹¹ Norway has participated in the EU projects ROSITA-I and ROSITA-II for the evaluation of equipment for primary screening of drugs in saliva. The available equipment has not been satisfactory for use by Norwegian traffic police.

sons arrested for driving under the influence of either alcohol (n=2531) or other drugs (n=918), all aged 20-39 at the time of their arrest, showed a higher mortality rate in these groups than in their same-age peers in the general population of Norway. The standardised mortality ratio (SMR) for drivers under the influence of drugs was approx. 20 and for the alcohol group 3.7 (Skurtveit et al, 2002). A corresponding study which was carried out to establish mortality rates in subjects aged 20 – 39 years previously apprehended for driving under the influence of medicinal drugs, alone or in combination with alcohol, with benzodiazepines being the predominant drug, showed corresponding SMR values (Hausken, Skurtveit. et al, 2004)

Benzodiazepine detection in arrested drivers

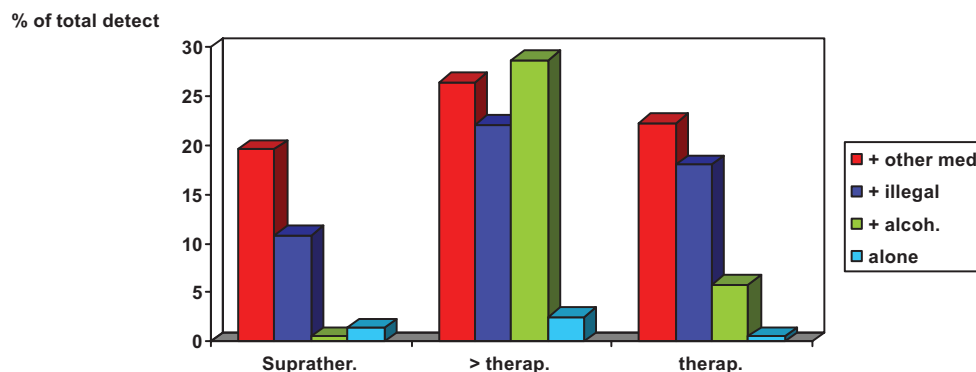
In less than five per cent of the cases in which benzodiazepines are detected will it be possible to conclude that the blood concentrations are an expression of therapeutic use. Results from analyses of remaining samples show benzodiazepines in combination with illegal substances, other psychoactive drugs (often other benzodiazepines), and measured blood concentrations corresponding to an intake 10 – 20 times in excess of the recommended therapeutic dosage (Skurtveit et al, 2002). There is therefore reason to assume that problem drug and alcohol users are overrepresented in this group. Figures 13 and 14 illustrate examples recorded in 2004 of detections of flunitrazepam and alprazolam, in suprathereapeutic, high therapeutic and therapeutic blood concentrations, and combinations with other psychoactive drugs, illegal substances and alcohol.

Figure 13 Flunitrazepam (n=672) in blood samples from apprehended drivers – different blood concentrations



Source: Norwegian Institute of Public Health

Figure 14 Alprazolam (n=362) in blood samples from apprehended drivers (6 months 2004) – different concentration levels



Source: Norwegian Institute of Public Health

Benzodiazepine source for arrested drivers – illegal sales or sales from pharmacies

There are several indications that substantial quantities of the benzodiazepines detected in the blood samples of arrested drivers are procured on the illegal market. This is apparent from the variation in the number of flunitrazepam detections in recent years. In the mid-1990s, flunitrazepam was detected in approx. eight per cent of all blood samples (n=270). The number of detections increased until 2002, when flunitrazepam was detected in a good 40 per cent of the samples (n=2092), i.e. there were more positive detections of flunitrazepam than of THC and amphetamine (Figure 12). In 2003, the number of detections fell substantially, a trend that continued in 2004 and 2005, when the substance was detected in barely 11 per cent of the samples (n=430).

One important reason for this was the arrest of an international group that had been smuggling large quantities of benzodiazepines, mainly flunitrazepam, for a long time. There was corresponding variation in the seizure statistics registered at Kripos during the same period. The fall in flunitrazepam sales from pharmacies had started several years before the decrease was registered in traffic samples (Norsk Legemiddelstatistikk, 2004). Since the deregistration of RohypnolR (active agent flunitrazepam), sales of products containing flunitrazepam have fallen to a minimum (Norsk Legemiddelstatistikk, 2004), while in blood samples from arrested drivers the substance still accounts for about 10 per cent of detections.

After the availability of flunitrazepam was restricted in 2003, there was an increase in the number of other benzodiazepines, such as klonazepam, nitrazepam and alprazolam, detected in analysed samples, constituting a partial replacement for flunitrazepam (Figure 12). Currently, more samples test positive for nitrazepam (11.5 per cent) than for flunitrazepam. In the late 1990s nitrazepam was detected in approx. one per cent of the analysed samples. In recent years an increase in seizures of other products containing BZDs has also been recorded by Kripos whereas sales from pharmacies did not change substantially during the same period (Norsk Legemiddelstatistikk, 2004). The analysis of seizures of tablets containing benzodiazepines at our laboratory has revealed quantities 10 – 20 times in excess of those normally found in tablets with a corresponding active substance on sale in pharmacies. Fenazepam was detected for the first time in 2004, with several seizures being recorded at the same time. Fenazepam has not been registered in Norway – only in some Eastern European countries.

The examples described in which benzodiazepines have been detected in blood samples of arrested drivers substantiate the belief that problem drug and alcohol users are overrepresented, and that normal patients are in the minority.

Relationship between blood concentrations and impairment of driving

The Norwegian Institute of Public Health's national database of traffic cases dating back to 1985 has been an important source for various research projects. Studies have been carried out on the relationship between drug and alcohol concentrations in the blood and the probability of a conclusion after clinical examination that the driver is "impaired". Such studies have been conducted with diazepam and with THC as the only detected substances, and likewise with a large number of other substances. Both studies showed a correlation between levels of the substance in the blood and the probability of being assessed as impaired at the clinical examination (Bramness et al, 2003, Khiabani et al., 2006).

Procedures for the investigation of traffic accidents linked to drugs and alcohol

Police instructions recommend securing blood samples from all drivers involved in traffic accidents resulting in serious injury, to be sent for drug and alcohol analysis. In many cases the instructions are not followed, probably due to inadequate police resources or a belief that drugs and alcohol can be disregarded, or because drivers are sent for medical treatment before samples have been obtained.

A study of all the drivers killed on Norwegian roads in 2001 and 2002 showed that blood samples had been secured for drug and alcohol analysis in a good 70 per cent of the cases, while forensic post-mortems were carried out on about 50 per cent only (www.nmr.dk).

A 1993 study showed that blood samples for drug and alcohol analysis were secured from less than ten per cent of drivers involved in accidents resulting in personal injury (Christophersen et al 1995). There has probably been no real improvement in this low investigation frequency. Work is currently ongoing to establish a national road traffic accident register, to secure the results of drug and alcohol analyses and other factors linked to the accident. This may be an important tool for following developments for accidents involving drugs and alcohol, for deciding on measures to be taken and evaluating the results of these measures.

Alcohol and other drugs in drivers killed in single vehicle accidents

Drivers killed in single vehicle accidents, where responsibility for the accident can be linked to the single driver, were studied during 2001 and 2002 (n=92) with respect to the involvement of alcohol and other drugs. All samples were analysed in an extensive programme for alcohol, illegal substances and medical drugs (benzodiazepines and related substances, opioids, muscle relaxants and a selection of antiepileptics, antidepressants and antipsychotics). In two out of three cases, alcohol, other drugs or a combination of these were detected. Table 8 shows that the most frequently detected substances were alcohol, benzodiazepines (primarily diazepam, flunitrazepam), THC and amphetamines. The majority of the samples in which the analyses produced positive results contained several substances, of which benzodiazepines and THC were the most frequently detected. The results represent minimum values, since the blood volume of the individual samples was insufficient to carry out a full analysis programme, with confirmation analyses.

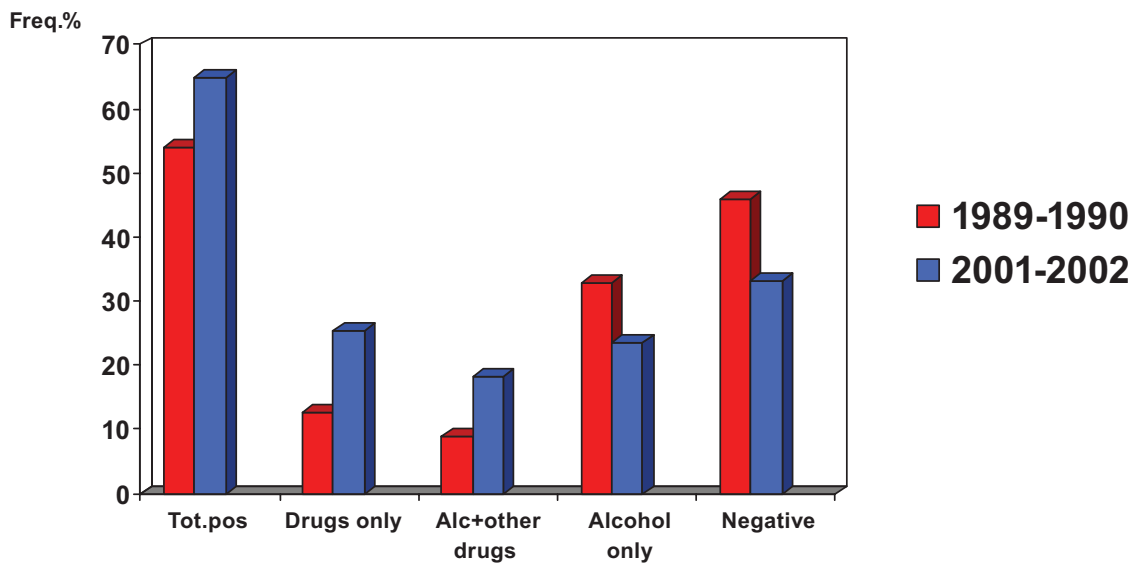
Table 8 Incidence of drugs and alcohol in blood samples from drivers (n=92) killed in single vehicle accidents 2001-2002.

	Total number positive % (n)	Cases involving several substances % (n)	Combination with BZDs % (n)	Combination with THC % (n)	Combination with alcohol % (n)
Total no. of positive results	64 (59)	31.5 (29)			
Alcohol	41.3 (38)	17.4 (16)	9 (9.8)	6 (7.6)	
BZDs	23.9 (22)	20.7 (19)	5 (5.4)	10 (10.9)	9 (9.8)
THC	14 (15.2)	13 (14.1)	10 (10.9)		6 (7.6)

Source: Norwegian Institute of Public Health

A corresponding study from 1989-1990, showed an incidence of alcohol or drugs in the blood samples of 54 per cent of the drivers killed in single vehicle accidents (n=79), in which benzodiazepines and THC represented the most frequently detected substances after alcohol. The greatest difference between the studies was the doubling of the relative incidence of other drugs, either alone or in combination with alcohol, while the total incidence of cases involving alcohol (> 0,2 o/oo) remained unchanged – disregarding cases in which alcohol was detected in combination with other drugs (1989-90: 8.9 per cent, 2001-2002: 18.1 per cent) (Figure 15). Most of the accidents involved persons in the 20-29 and 30-39 age groups, with one or more drugs and/or alcohol being detected in over 60 per cent of the samples from both age groups. Approx. 15 per cent of the accidents involved women.

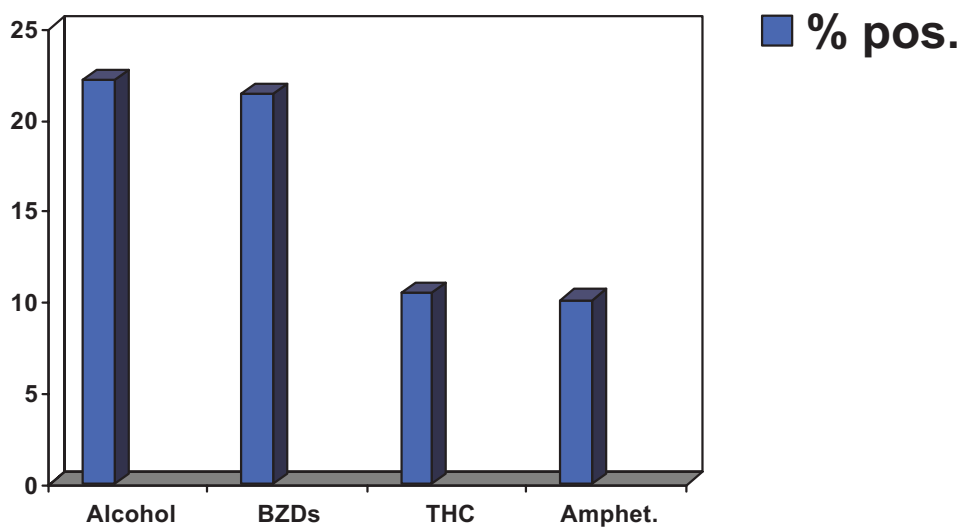
Figure 15 Alcohol and other drugs among single vehicle accident drivers in Norway – comparison between 1989-1990 (n=79) and 2001-2002 (n=92)



Source: Norwegian Institute of Public Health

For the total population of drivers involved in fatal accidents (n=243), alcohol, other drugs and/or a combination of these were detected in 43.6 per cent of the cases. The frequency of samples in which benzodiazepines were detected was almost as high as that of alcohol (21.4 per cent and 22.2 per cent respectively). Apart from alcohol, the most frequently detected single substances were THC, amphetamines, diazepam and flunitrazepam (Figure 16).

Figure 16 Frequency (%) of benzodiazepines (BZDs), THC, amphetamines and alcohol among fatal accident drivers in Norway (n=243) 2001 – 2002



Source: Norwegian Institute of Public Health

12.4 Summing up – proposals for action

The systematic national registration of all arrests on suspicion of impaired driving has revealed that cases involving drugs other than alcohol present an increasing problem. Despite the lack of screening equipment for detecting drugs other than alcohol, the police achieve high accuracy (approx. 80 per cent of those suspected). In view of the potentially large number of unreported cases, however, the Norwegian police have expressed a wish for detection equipment. Benzodiazepines in particular may be difficult to discern. Experience from participation in both the ROSITA projects has shown that the tests also have poor sensitivity for both benzodiazepines and cannabis. The high incidence of recidivism (57% during the course of approx. 7 years) in this group of drivers highlights the importance of establishing other measures than prison, fines and loss of licence. Most offenders use several drugs at the same time, including psychoactive medicinal drugs in doses far in excess of recommended therapeutic levels, and therefore represent a high-risk group with a drug and alcohol problem. A few years ago a drug treatment and rehabilitation programme (“promilleprogram”) was established as an alternative to prison sentences for persons convicted of driving under the influence of alcohol. There is no corresponding alternative for persons convicted of driving under the influence of other drugs.

Last year, a committee appointed by the Norwegian Ministry of Transport and Communication submitted proposals for a number of actions to reduce the incidence of drugged driving. Among other things, the committee recommends the setting of fixed limits for some of the most frequently occurring substances (illegal substances and some medicinal drugs). For the police and the judicial system, this measure could save considerable resources, releasing them for other traffic safety work. Although the substantial amount of documentation available today would justify the setting of such limits, the committee also points out the need for supplementary studies. In addition, it proposes a treatment and rehabilitation programme with extensive controls for recidivists and multi-drug users, for young drivers in particular. Better information and follow-up by prescribing doctors and pharmacists is also recommended. The challenge lies in identifying measures to prevent the taking of drugs in combination with driving, and selecting the groups at greatest risk for treatment and preventive measures. Successful actions should benefit both the health services and the legal system and reduce the number of accidents and the tragedy involved for the individuals concerned.

13. Drug use and related problems among very young people (<15 years)

Use of drugs by 13-15 year-olds in Norway¹²

Anders Bakken, Norwegian Social Research - NOVA

13.1 Data and method

The analyses of the use of drugs by 13-15 year olds are based on data collected by NOVA (Norwegian Social Research) for its "Young in Norway" study. This study is a general survey of schoolchildren aged between 13 and 19 and involves the participants completing a self-administered questionnaire in school hours with a teacher present. One of the objects of the study is to describe the prevalence of drug use among young people. The data are collected from a nationally representative sample of the age group concerned. The study is conducted at ten-year intervals and was carried out for the first time in 1992. Using the same design for sample and question structure allows for valid interpretations of changes. The response rate for this study of 13-19 year olds was 97.0 per cent in 1992 and 92.3 per cent in 2002 (N:11 928).

13.2 Prevalence

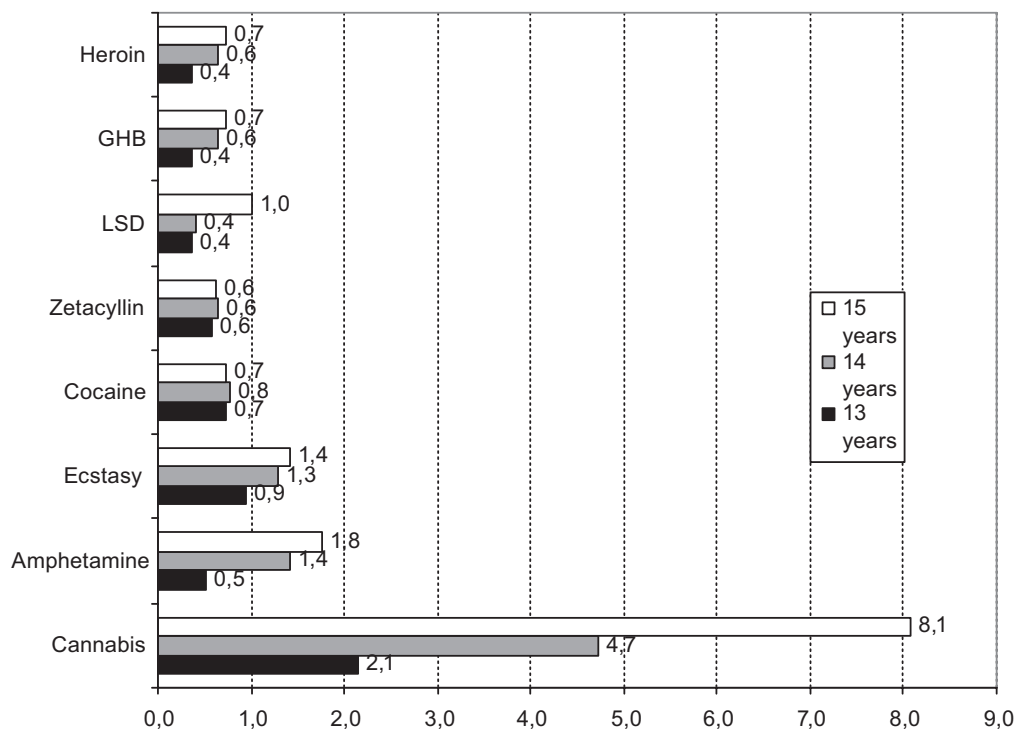
Figure 17 shows that lifetime prevalence is generally low for all types of drugs. This applies in particular to the 13 and 14 year olds. The prevalence rate was highest for cannabis, rising from two per cent among 13 year olds to eight per cent among 15 year olds. In the youngest age group the prevalence rate was about the same as for the fictive drug Zetacyllin¹³. After cannabis, amphetamine is most prevalent among 15 year olds, followed by ecstasy. All other drugs are on a level with the fictive drug, which means that the estimates must be viewed with considerable scepticism.

Boys have used all the types of drugs more often than girls. The gender differential is smallest for cannabis, with 50 per cent more boys than girls reporting having used it. For the other drugs, use by boys is up to treble that of girls. However, the fact that the boys tend to over-report use of the fictive drug indicates that the gender differential is smaller than the responses would suggest.

¹² The response is limited in relation to the topics in the EMCDDA Guidelines.

¹³ Zetacyllin is a fictive drug, used in control questions to check that the young people are not making up their answers.

Figure 17. Lifetime prevalence for different drugs (including the fictive drug Zetacyllin) in different age groups between 13 and 15 years old. Percentages.

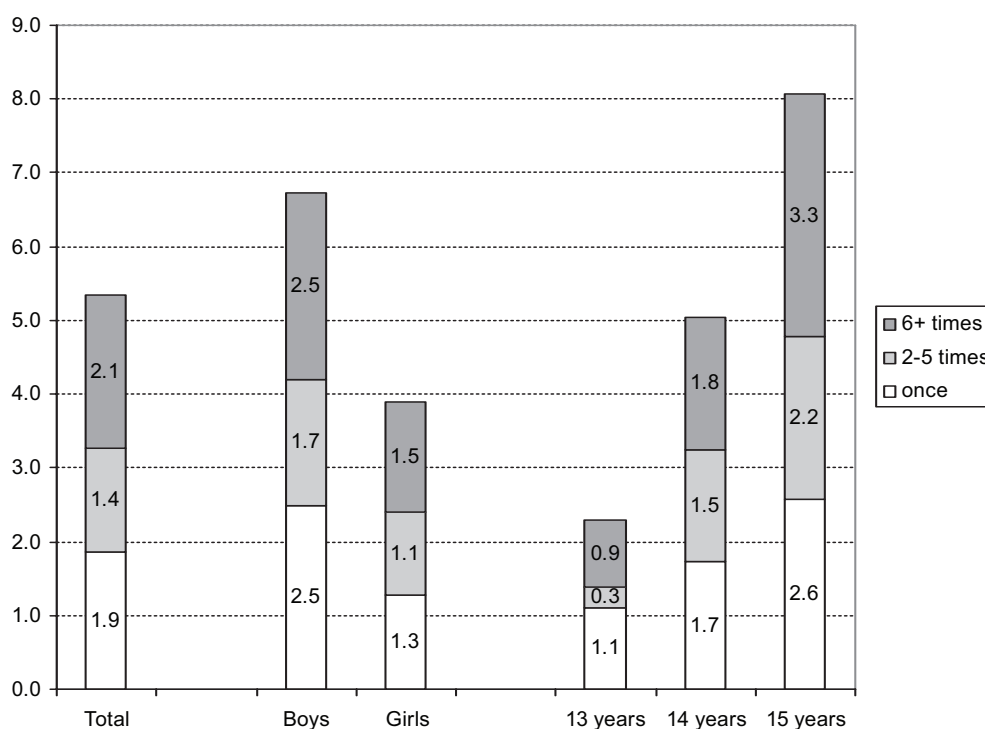


Source: NOVA (Young in Norway 2002)

13.3 Frequency

Frequency rates for the use of cannabis during the last year show a fairly even distribution between the following groups: used once, used one to five times, and used more than five times (figure 18). This is true for both boys and girls and for the 14-15 year olds. Among the 13 year olds, one-time users constitute a relatively higher percentage of those having tried the drug, as do those who have used it more than five times. The picture is more evenly distributed when it comes to the use of the other drugs in the last year. Most are either one-time users or they report having used the drug in question more than five times.

Figure 18 Frequency of last year's use of cannabis in boys and girls in different age groups. Percentages.



Source: NOVA (Young in Norway 2002)

13.4 Geographical profile

The correlation between urbanity and cannabis use follows traditional patterns. Prevalence is highest in the big cities and lowest in small places. The most widespread use is in Oslo, with 10.5 per cent reporting they had used cannabis during the last year. It is not possible to demonstrate the same trend in the use of other drugs. Even though the lowest prevalence tends to be found in sparsely populated areas here as well, the correlation is not significant.

13.5 Social profile

The use of drugs in this age group is closely associated with other problem behaviour. Young people who are in opposition to school, involved in crime against property and/or violent crime are far more likely to have used different types of drugs during the last year. For example, only one per cent of those who never played truant from school during the last year had used cannabis, compared with 32 per cent of those who had played truant more than five times. There is also a clear correlation between the use of alcohol and tobacco and drug-taking. Less than one per cent of the respondents who had never been drunk and/or tried tobacco had tried drugs. The percentage was thirty-fold in young people who smoked tobacco daily and those who had experienced repeated episodes of drunkenness. This applies to all three age groups (13-15).

There is no clear correlation between drug use and social background. There is a tendency for drug use to be greatest in those whose parents ended their education after compulsory schooling, but otherwise there are no great differences. In young people from ethnic minorities the prevalence is more or less the same as in the majority population, despite the fact that they usually live in urban areas where prevalence is generally highest.

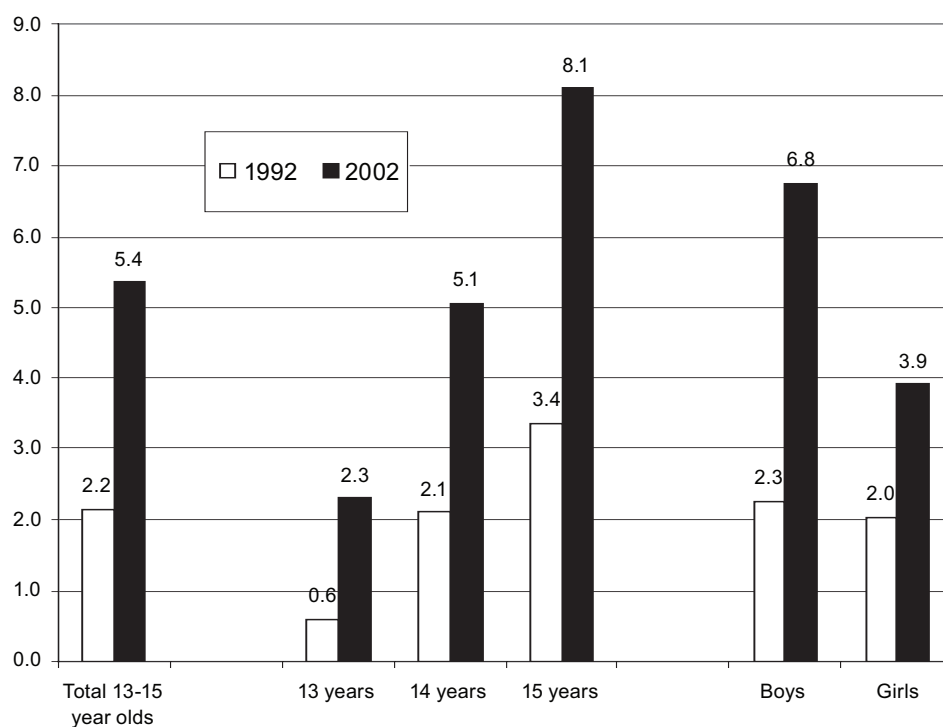
13.6 Changes from 1992 to 2002

Compared with "Young in Norway 1992" we see a marked increase in the use of drugs in the 13-15 age group. The percentage who have used cannabis in the last year increased from 2.2 per cent in 1992 to 5.4 per cent in 2002. The prevalence of other drugs also increased, from 0.9 to 2.5 per cent (Figures 19 and 20).

In terms of percentage points the greatest increases were in the 15 year olds for cannabis and 14 year olds for other drugs.

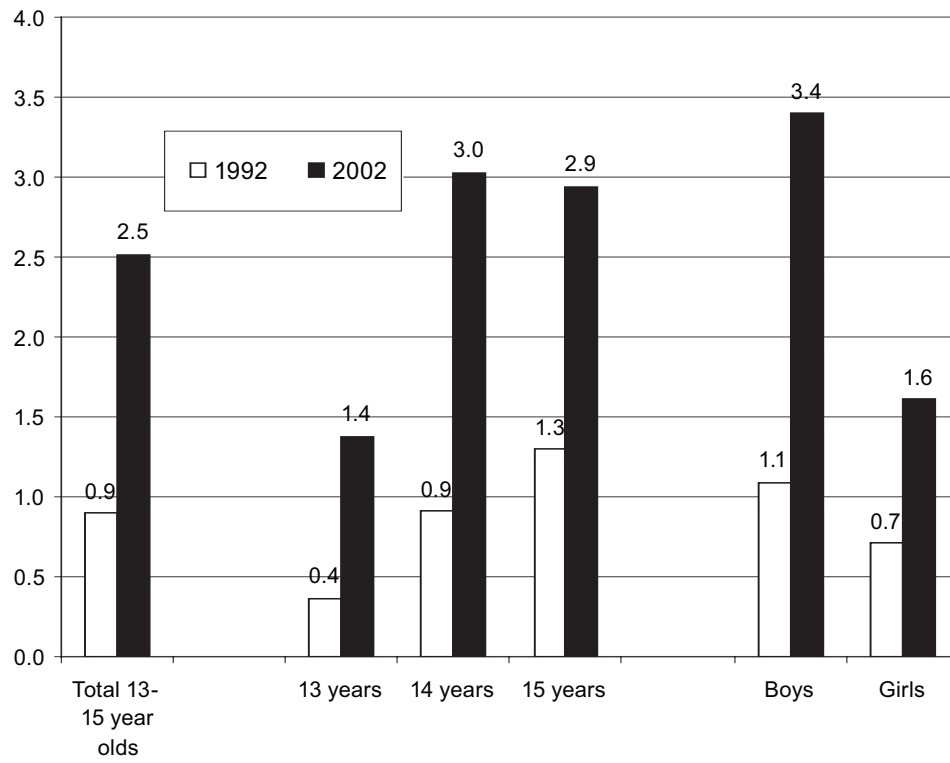
In 1992 there was virtually no gender differential. This means that most of the increase is due to changes in the boys' behaviour. The percentage of boys who have tried cannabis and other drugs during the last year tripled during this ten-year period. In the case of girls, there has been a doubling of the percentage who have used drugs. However, once again, the numbers are small and the differences may be partly due to chance.

Figure 19 Percentage who have used cannabis during the last year. 1992 and 2002



Source: NOVA (Young in Norway 2002).

Figure 20 Percentage who have used other drugs than cannabis during the last year. 1992 and 2002



Source: NOVA (Young in Norway 2002).

Annex 1. Estimation of injecting use in Norway. About the methods.

1.1. The Mortality Multiplier Method

The Mortality Multiplier Method (MMM) is based on relatively certain figures being available for the number of drug deaths during a year. In Norway, both Kripos and Statistics Norway register such data. The last available data for drug deaths from Statistics Norway are from 2004 and from Kripos from 2005. In the estimates, an average of the figures for drug deaths from Kripos and Statistics Norway is used. Certain adjustments are first made, however, in Statistics Norway's figures for drug deaths because they apply the EMCDDA definition, which is more wide-ranging than what we normally mean by drug deaths. Registered suicides are excluded. Moreover, the few deaths among persons over the age of 60 are excluded from both sets of statistics. This is because there are few people over the age of 60 who can be deemed to be in the group of injecting drug users whose size we aim to estimate.

The figures for drug deaths are relatively small in the statistical context and they will be subject to a certain random variation. In order to avoid chance playing too great a role in individual years, the number of deaths is measured using a three-year sliding average of the adjusted figures from Kripos and Statistics Norway. The number of overdose deaths for 2004 is based on deaths in the period from 2003 to 2005, and in 2005 on the number of deaths from 2004 to 2006. Overdose fatalities from Statistics Norway for 2005 and 2006 are assumed to be identical to the figure for 2004, and Kripos' overdose figure for 2006 is assumed to be identical to 2005. The tendency in available indicators supports this assumption. The estimates for 2004 and 2005 will be revised when the final published figures are available in 2007 and 2008.

A change in the number of deaths may be due both to a change in mortality and a change in the number of injecting drug users who inject heroin. A change in mortality can arise if the proportion who inject heroin changes or if drug users change their risk behaviour when injecting (for example, inject less on their own). In order to obtain good figures with the help of MMM, the mortality rate must apply to the injecting drug users in the year in question. But since good surveys are not available every year, other information about the situation for injecting drug users must also be used.

The annual mortality rate in 10 relevant studies (SIRUS report no 5/2006) varies from 1.6 to 5.3 per cent. Studies of heroin users or injecting drug users are more relevant than studies of drug users in general. Even small changes in the choice of annual mortality rate have a major impact on the estimate of the number of injecting drug users. Two estimates for the annual mortality rate are used, therefore. We have chosen to set the lower and upper limit for annual mortality in the target group at 3 and 4 per cent, respectively, in 1999. We assume that the mortality rate among injecting drug users declined by 0.1 per cent annually from 2000 to 2004, so that for 2004 we use 2.5 and 3.5 per cent annual mortality in the calculation formula. The reduction in annual mortality in recent years is linked to the fact that the number of patients in LAR has increased significantly during the same period. LAR has resulted in approx. 3,600 persons with a presumed high risk of drug death now being more or less out of the group of injecting drug users. Although the risk of death is still high among all remaining injecting drug users, it has probably declined somewhat overall during recent years. Another reason for the presumed decline in mortality is that the proportion of injecting drug users who only inject amphetamine has probably increased, from approx. 10 per cent at the turn of the millennium to approx. 15 per cent in 2004 (Bretteville-Jensen 2005). There is little risk of overdosing in connection with amphetamine use.

The proportion drug deaths constitute of all deaths among injecting drug users will depend, among other things, on the drug culture, the conditions under which the drug users live, registration practice etc. We have chosen to emphasise the Norwegian studies in the area. Andersen et al. (1996) found that drug deaths amounted to 63 per cent of all deaths in their sample, while in Eskild et al. (1993), the corresponding proportion was 67 per cent. See also chapter 6.1. In SIRUS's follow-up study of injecting drug users recruited through needle distribution in Oslo, we find a proportion of drug deaths of 70 per cent, while in the cost-benefit study the proportion is 82 per cent (unpublished work). Interviews in connection with needle distribution have shown that injecting drug users have increased their average use of injecting substances since 1993 (Bretteville-Jensen 2005), which theoretically may have caused more overdose deaths than previously. However, we are unable to document any changes in the risk of fatal overdoses over time. We therefore choose to use an average of the figures in the four studies and set the proportion of overdose deaths at 70 per cent. This calculation method can also be used for smaller geographical areas in which the number of deaths is not too low. Figures for Oslo are estimated on the basis of the same assumptions as for the country as a whole.

1.2 The Municipal Survey

In the questionnaire distributed to the municipalities, an estimate of the number of injecting drug users in the municipality is requested. In addition, respondents are requested to indicate on a scale from 0 to 10 how certain they believe the estimates to be. The following six factors are important in assessing whether the answers will produce a biased and/or uncertain picture in relation to the actual drug situation.

1. The answers will often be coloured by the respondents' subjective perception of the situation. There will be variation as to whether the person answering the questions consults others in the municipality/ the police so that a consensus on the answers can be established.
2. The respondent or the person responsible for returning the form is not necessarily the same person from year to year. If the form is completed by different persons, a more or less unchanged situation may be assessed differently. Different bodies and persons will have different areas of responsibility and different observations of drug use locally.
3. There may be different thresholds for reporting changes in the drug situation in the municipalities. In many contexts, it has been shown that people tend to answer in line with a general perception or what is deemed to be socially desirable. In light of the general perception that drug problems in society are increasing, it is probably more difficult to report an improvement than a worsening of the situation.
4. It may also be deemed to be less desirable to underestimate problems than to overestimate them. Some of the respondents will probably overestimate the extent of the problems rather than estimating figures that are too low. On the other hand, injecting drug use may occur that is as yet unknown to the respondents, and they may therefore underestimate the real problems. The average figures for large groups of municipalities may produce a sensible picture of the situation even if each individual municipality does not answer correctly.
5. There is a certain chance that some injecting drug users are counted several times if they are known in more than one municipality and move across municipal boundaries, often to high-population municipalities, without notifying the authorities that they have moved. Persons who inject illegal substances will also have periods of "abstinence" (imprisonment, periods in treatment etc.) or stop, and thereby no longer belong to the population whose size we wish to estimate. It is possible that a certain proportion of such periods of "abstinence" or quitting are not

registered by the respondents. Both these factors suggest that estimates are more likely to overestimate the size of the population of injecting drug users than to underestimate it.

6. In big towns and cities, it is difficult to maintain an overview of the number of injecting drug users. The services are often decentralised and none of them has a full overview. It is also easier to be an anonymous drug user in big towns and cities than in smaller places. The figures for big towns and cities will therefore be highly uncertain.

The response rate for the surveys was high in all the three years. In 2002, at least one agency in 370 municipalities (of the total of 434) answered the question about the number of injecting drug users, 398 municipalities in 2003 and 388 municipalities in 2004. The number of injecting drug users had to be estimated for the remaining municipalities in order to arrive at an estimate for the whole country. Various methods have been tried for such calculations, and they produce almost the same result. The simplest method is to use the average proportion of injecting drug users in the population from municipalities of corresponding size. For Oslo, the figure from the Mortality Multiplier has been used.

The uncertainty in Table 2 has been calculated by assuming that the natural logarithm for the proportion of injecting drug users is normally distributed for four groups of municipalities grouped by size. The confidence interval for each of the four groups of municipalities is 95 per cent. Normally, a total for several groups will be deemed to be more certain than figures for each group on its own. But for this method we have chosen to add up the upper and lower limit in 95 confidence intervals for the individual groups to arrive at a confidence interval for the total. Approximately 70 per cent of those who report figures from the municipalities are more or less uncertain about their estimates, and this should be reflected in the reported uncertainty.

1.3 The Multiple Indicator Method

The method is based on dividing Norway into smaller geographical entities. The value of several indicators for injecting drug use should be known for all the entities. For some areas, called anchor points, the number of injecting drug users should also be known, or estimated using a good method. For the anchor points, it is possible to find a correlation between the number of injecting drug users and the values of the indicators. It is assumed that this correlation also applies to the rest of the areas, and the number of injecting drug users can thus be estimated using this correlation and indicator values.

For example, in the literature the correlation has been a regression equation in which the number of injecting drug users is the dependent variable and the indicator values are the independent variables. Another example is to summarise the indicators in one or more components carried out by principal component analysis. The calculations are based on standardised values of the number of cases per inhabitant.

The method takes account of situations in which the value of the indicator is low in one area compared with another, so that this will be reflected in the estimate of the number of injecting drug users in the two areas.

It is an advantage to have several indicators which can register geographical variation in injecting drug use in different ways. But geographical variation in the indicators should at the same time be a good measure of geographical variation in injecting use.

In the calculations presented here, counties were chosen as geographical areas. The alternatives are larger geographical areas, but it will then be difficult to obtain good estimates of the number of

injecting drug users in the areas which are to be anchor points. Three indicators were used: Drug-related deaths (Statistics Norway and Kripos), patients in medically-assisted treatment (LAR) and findings of morphine in drivers in road traffic cases.

One main feature of all the indicators is that Oslo has a higher indicator value than other counties. It is not very probable, therefore, that the correlation we find for the anchor points will also apply to Oslo. It may be doubtful whether Oslo will have a natural place in the same correlation as for the rest of the counties. Oslo is therefore left out of the calculations, and estimates for Oslo are carried out separately using the Mortality Multiplier.

The Municipal Survey contains an estimate of the number of injecting drug users for all the municipalities. Estimates for the number of injecting drug users in the anchor counties are found by summing up the municipal figures from the Municipal Surveys. We must be very confident that the counties chosen as anchor points have good data. But counties at both ends of the scale for the indicator values must be chosen so that a line of regression can be reasonably certain. We first chose two counties with mainly small municipalities. There the situation is most transparent and reporters in municipalities with lower populations have more trust in their estimates than those reporting in large municipalities. The choice of counties with high indicator values was more difficult. Two counties were chosen in 2002 which did not show extreme values and which expressed the correlation for all counties in an average good manner. For 2003 and 2004, we also used the same four counties as anchor points.

The uncertainty in the calculations of the Multiple Indicator Method was arrived at by selecting 1,000 random figures for each county with an expectation equal to the estimated value and estimated standard deviation. Each such selection is summed up to national level and after 1 000 selections the standard deviation for the totals is calculated. The method for calculating uncertainty is provisional and it may be revised (Bretteville-Jensen, Amundsen, 2006).

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Abbreviations

SIRUS – Norwegian Institute for Alcohol and Drug Research
 Kripos – National Crime Investigation Service
 NOVA - Norwegian Social Research
 FAFO - Institute for Labour and Social Research