

The Drug Situation in Norway 2014

SIRUS

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

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Centre for Drugs and Drug Addiction –
EMCDDA

SIRUS Norwegian Institute for Alcohol and Drug Research

Oslo 2015

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Foreword

As in previous years, this 14th national report on the drug situation in Norway has been drawn up in accordance with the reporting guidelines common to all member states in the EMCDDA. In addition to the annual report we have submitted separately a number of standardised tables, mainly epidemiological data, as well as two comprehensive questionnaires, on treatment availability and on quality assurance of drug demand interventions. Because the report is intended to focus on news and to primarily cover important developments and trends, it may appear rather fragmentary. However, we hope that the content will prove useful to readers who wish to familiarise themselves with the drugs situation in Norway. SIRUS thanks the public institutions that have made information available for the preparation of the report. Our thanks go in particular to the co-authors who have made textual contributions.

Oslo, December 2014

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Contents

Foreword	3
Authors	4
1 Drug policy: legislation, strategies and economic analysis	9
1.1 Introduction	9
1.2 Legal framework	10
1.3 National action plan, strategy, evaluation and coordination	10
1.3.1 Action plan 2006–2012. Status.	10
1.4 Coordination arrangements.....	12
1.5 Other drug policy developments	12
1.5.1 New escalation plan for the drugs and alcohol field.....	13
1.5.2 User survey in interdisciplinary specialised treatment.....	14
1.5.3 Competence-raising measures and quality indicators	14
1.5.4 Research and dissemination	16
1.5.5 Grant schemes.....	17
1.6 Economic analysis	19
1.6.1 Public expenditure	19
2 Drug use in the general population and specific target groups	20
2.1 Drug use in the general population	20
2.1.1 Cannabis	21
2.1.2 Other illegal drugs	23
2.1.3 Anabolic steroids and new synthetic drugs	25
2.1.4 Prescription drugs	26
3 High-risk drug use	29
3.1 Prevalence of high-risk drug use.....	29
3.1.1 New guidelines – definitions	29
3.2 Prevalence estimates	30
3.2.1 Slight decline in injecting drug use.....	30
3.2.2 High-risk opioid use	31
3.2.3 High-risk stimulant use and polydrug use.....	31

3.2.4	High-risk cannabis use	32
3.2.5	Total number of high-risk drug users	32
3.3	Data on high-risk drug users in seven cities.....	32
4	Drug-related treatment: treatment demand and treatment availability.....	35
4.1	General description of systems	35
4.1.1	Challenges	35
4.2	Treatment admission	36
4.2.1	Data from the Norwegian Patient Register.....	36
4.2.2	Treatment demand indicator	37
4.2.3	About patients in OST in particular	38
4.2.4	The status survey for 2013.....	39
5	Health correlates and consequences.....	42
5.1	Drug-related infectious diseases.....	42
5.1.1	HIV and Aids	42
5.1.2	Hepatitis	43
5.1.3	Bacterial infections.....	44
5.1.4	Risk behaviour	44
5.2	Drug-related deaths and mortality of drug users	44
5.2.1	Methodological considerations.....	44
5.2.2	The situation in 2012.....	45
5.2.3	About povidone.....	50
5.2.4	Current research	50
6	Responses to health correlates and consequences	52
6.1	The national overdose strategy 2014–2017	52
6.1.1	Goals of the strategy	52
6.1.2	The pilot municipality project.	53
6.1.3	The nasal naloxone project	53
6.1.4	Change the user culture. SWITCH – from injection to inhalation	54
6.1.5	Prevention of overdoses following discharge from a drug/alcohol treatment facility / release from prison.....	54
6.2	Low-threshold health services	55

7	Social correlates and consequences	57
7.1	Housing	57
7.1.1	Homeless people in Norway 2012.....	57
7.1.2	Homeless people with concurrent drug/alcohol problems and mental illness	57
7.2	Housing First	58
7.3	Ambulant teams.....	59
7.4	ACT teams	60
8	Drug-related crime, prevention of drug-related crime and prison	62
8.1	Drug law offences	62
8.1.1	Legal basis and type of statistics	62
8.1.2	Crime statistics	63
8.1.3	Charges.....	64
8.2	Prevention of drug-related crime	67
8.2.1	Action plan for the prevention of crime (2013–2016)	67
8.3	Interventions in the criminal justice system.....	67
8.3.1	Units for mastering drug and alcohol problems	67
8.4	Alternatives to prison.....	68
8.4.1	Evaluation of drug courts	70
8.5	Driving offences	71
9	Drug markets	74
9.1	Availability.....	74
9.1.1	About amphetamine and methamphetamine in particular.....	74
9.2	Supply.....	75
9.2.1	Smuggling routes to Norway	75
9.2.2	Criminal networks	77
9.3	Seizure statistics.....	79
9.3.1	Main trends, as described by the National Criminal Investigation Service.....	80
9.3.2	Development in seizures for individual substance groups.....	81
9.3.3	New psychoactive substances (NPS)	84
9.4	Purity and potency of illegal drugs and tablets	85
9.5	Price of illicit drugs at retail level.....	86

The Drug Situation in Norway 2014

References	88
Lists of graphs.....	90
List of Tables.....	90
List of relevant websites in English:	91

1 Drug policy: legislation, strategies and economic analysis

1.1 Introduction

Norway's health and care policy emphasises universal welfare schemes, rather than special measures aimed at selected groups. Norway's drug and alcohol policy must be understood and evaluated in this context. It means that the drug and alcohol policy is integrated in and implemented through general health and welfare schemes that apply to everyone, regardless of status and diagnosis. Any action plans and/or strategies come in addition in those cases where special efforts are necessary.

The object of the health and care services is to prevent, treat and facilitate coping with disease, injury, suffering and disability. This responsibility has been clarified in the Act relating to Municipal Health and Care Services. Municipal services for people with mental illnesses and/or drug and alcohol problems are provided by several sectors and different professional groups. They are therefore dependent on close cooperation within municipalities, with relevant specialist health services and with the voluntary sector.

Based on the needs of its inhabitants, a municipality is required to offer necessary services and ensure that the people who live in the municipality are provided with the required health and care services. This includes preventive services, general practitioner services, habilitation, rehabilitation, health stations, the school health service, mental health services, drug/alcohol services and health services provided by the care services and in prison. The municipalities are also responsible for providing social, psychosocial and medical habilitation and rehabilitation services irrespective of diagnosis and health professions. In addition, the municipalities are responsible for ensuring that the general practitioner service has the required capacity and is of good quality.

The Act relating to Municipal Health and Care Services requires municipalities and regional health authorities/health trusts to cooperate on a number of tasks, including guidelines for cooperation on admission, discharge, habilitation, rehabilitation and learning and coping services where relevant, depending on the illnesses or problems concerned.

People with serious, prolonged drug and alcohol problems may need treatment and closer follow-up by the health and social services than the municipal services can offer. In such cases, an application for interdisciplinary specialist drug/alcohol treatment can be submitted in consultation with the person in question. In the specialist health service, it is mainly interdisciplinary specialised treatment that is offered. It consists of outpatient treatment

services, including opioid substitution treatment (OST), outpatient treatment and different types of residential treatment. Many people with drug/alcohol-related problems often have concurrent mental health problems. An offer of interdisciplinary specialised treatment will therefore often include treatment for mental health problems. A significant proportion of patients in mental health care receive treatment for drug/alcohol problems in addition to treatment for mental health problems. People with drug and/or alcohol problems have the same patient rights as other patients in the specialist health service.

1.2 Legal framework

See NR 2013 Chapter 1.1 for legislative amendments adopted in 2013: *New Regulations related to Narcotics* entered into force on 14 February 2013, while amendments to *the Act relating to Medicinal Products etc.* entered into force on 1 July 2013. No new legislative amendments that are relevant to the drugs field have been adopted during the period.

In 2013, a proposal to amend the *Drug Injection Rooms Act* (Act No 64 of 2 July 2004 relating to a Trial Scheme of Premises for Drug Injection) and pertaining Regulations No 1661 of 17 December 2004 was distributed for consultation, with a deadline for responding of 31 October 2013. The proposal suggested to allow municipalities to permit the inhalation of heroin in injection rooms. The proposal will not be followed up by the new Government that took office in autumn 2013, however.

1.3 National action plan, strategy, evaluation and coordination

1.3.1 Action plan 2006–2012. Status.

The most recent drugs and alcohol policy action plan – the escalation plan for the drugs and alcohol field – expired in 2012. See Chapter 1 of the National Reports for 2012 and 2013 for a more detailed description. A status review shows that, with a few exceptions, all 147 measures in the escalation plan have been implemented or initiated, and that many of the sub-goals in the plan have been achieved in whole or in part. The plan did not outline a new direction for the drugs and alcohol field, but it highlighted how complex the issues are and why broad collaboration is required between several ministries and bodies. The plan also gave a good picture of what is being done in the drugs and alcohol field and that work is continuing step by step on further developing and strengthening previous initiatives. Better municipal services,

more voluntary work and interdisciplinary specialised treatment, better dental health services for drug and alcohol users and more research in the field are some of the results of the plan.

During the plan period (2006–2012), an additional EUR 129.3 million (NOK 1.035 billion)¹ (price-indexed) was allocated to the drugs and alcohol field. The areas that were strengthened were primarily the municipal services, including voluntary work targeting drug and alcohol problems, and interdisciplinary specialised treatment in the specialist health service.

In order to get an overall picture of the efforts targeting drug and alcohol problems, allocations to other, partially overlapping areas must also be taken into consideration. Examples include action plans and strategies to combat poverty, to promote mental health, the integration and inclusion of immigrants, and housing strategies.

Even though the escalation plan helped to increase the focus on prevention, expertise and quality in the municipal services and in interdisciplinary specialised treatment, there are still problems that need to be solved. Poverty and social inequality play an important role in the development of drug or alcohol problems in the population. The development of drug or alcohol problems can be prevented to an even greater extent, among other things by ensuring good conditions for children and young people to grow up in, and by offering help at an early stage to those who are in the process of developing an abuse problem. The number of drug-related deaths is still very high, and improvements are needed as regards housing, meaningful activities and employment, and treatment capacity, as well as detoxification with the possibility of follow-up inpatient treatment. The status review also pointed out that, as regards people with concurrent mental illnesses and drug or alcohol problems, there is a big gap between the recommended treatment and actual practice, both in the specialist health service and in the primary health service.

Work on a new escalation plan is under way. See Chapter 1.3.1. Pending this, reference is made to the white paper on drugs and alcohol policy (Report No 30 to the Storting (2011–2012) ('See me!'))² which is the governing document for drugs and alcohol policy (see NR 2013 Chapter 1.2). The report was considered by the Storting in 2013. It sets out political goals for a comprehensive drugs and alcohol policy:

1. Prevention and early intervention
2. Coordination – services working together

¹ Conversion rate used: 1 EUR=NOK 8.00. Note: During 2013, the exchange rate has varied considerably, from approx. NOK 7.20 to 8.50.

² Report No 30 to the Storting (2011–2012) Se meg! ('See me!') A comprehensive drugs and alcohol policy – alcohol, drugs, illegal medicinal drugs and doping.

3. Greater competence and better quality
4. Help for those with severe dependency – reducing the number of overdose fatalities
5. Efforts aimed at next-of-kin and to combat passive drinking.

The report specifies the preventive efforts to be made in the drugs and alcohol field. However, these efforts must be seen in conjunction with general preventive measures targeting the population as a whole, as set out in public health policy. The public health strategy is described in Report No 34 to the Storting (2012–2013), the Public Health Report.³ As part of the follow-up of this report, the Government will further develop performance goals and indicators with a view to following up the goals of its public health policy, including mental health and drug and alcohol problems. Systematic development of public health work is also planned. Among other things, a report will be presented to the Storting every four years on the status of and further work on achieving Norway's public health goals. The Norwegian Institute of Public Health and the Directorate of Health will prepare reports that can form the basis for a political status assessment.

1.4 Coordination arrangements

Responsibility for various drug and alcohol policy goals is divided between several ministries, and the Ministry of Health and Care Services coordinates the work. The respective directorates have a more operational responsibility.

1.5 Other drug policy developments

A new Government took office after the general election in autumn 2013. This Government's political platform also indicates the direction of its health and social welfare policy, which includes the policy on drugs and alcohol. In order to ensure forward-looking and patient-oriented services, greater emphasis will be placed on prevention, proactive follow-up and good care pathways for patients than is the case today. Rather than having an individual perspective, where municipalities respond to demand, they shall be more proactive in relation to their inhabitants. The goal is to reach people who do not request services to a sufficient extent and to allocate resources to groups where the development of diseases and hospitalisation can be

³ Report No 34 to the Storting (2012–2013). Public Health Report: Good health – a common responsibility

prevented through preventive measures, training and targeted, planned and structured processes and measures. In addition, the Government's political platform states that:

- Illegal use of drugs and doping is not socially acceptable. The prohibition against possession and use is therefore upheld. At the same time, it is important to comply with the obligations under international law that follow from the three conventions on drugs that Norway has ratified. These conventions emphasise the need to protect 'human health and welfare', which is consistent with the Government's policy. The use of drugs shall therefore, in principle, be seen as a health issue, and people who use drugs shall primarily be met with health care. That will also be Norway's position at international meetings and negotiations.

1.5.1 New escalation plan for the drugs and alcohol field

The new Government aims to strengthen efforts in the drugs and alcohol field through a new escalation plan that is intended to contribute to increasing capacity and improving the quality of the services offered to people with drug or alcohol problems. The plan will adopt a long-term, comprehensive perspective, but the measures proposed will specifically target people who are in the process of developing or who already have a drug or alcohol problem, where the main effort will target the municipal sector. Measures targeting the general population are described in Report No 30 to the Storting (2011–2012). They will primarily be continued and followed up within the framework of general public health policy. The Government aims to present the escalation plan to the Storting in the course of 2015.

A new reform, *Free choice of treatment*, aims to reduce waiting times, provide greater freedom of choice for patients and stimulate public hospitals to become more efficient. The reform will include all patient groups. It is based on three pillars. The first introduces the right to free choice of treatment. The second is based on increasing the purchasing of treatment places through competitive tendering. The third aims to enable the regional health authorities/health trusts to treat more patients than today. The goal is to introduce free choice of treatment in interdisciplinary specialised drug/alcohol treatment, mental health services and some parts of somatic healthcare in 2015.

Many of the weakest patient groups are not receiving good enough help quickly enough. The Government wishes to strengthen the services offered to patients with drug or alcohol problems and patients with mental health problems. Allocations for the specialist health service have already increased, and the 'golden rule' has been reintroduced – i.e. that the growth in interdisciplinary specialised treatment and mental health services shall exceed growth in somatic healthcare at the regional level in all the health regions.

The process of co-locating and co-organising mental health services and interdisciplinary specialised treatment continues. This will help to ensure that patients with concurrent drug or

alcohol problems and mental health problems receive a coherent, comprehensive offer of treatment from the specialist health service – adapted to the patients' needs. A treatment outcome that benefits the individual patient will also depend on good cooperation and coordination between the specialist health service and the municipal services.

In 2013, the regional health authorities were asked to do the following:

- to establish low-threshold OST services for the group of opioid addicts with concurrent diseases who are most in need of help – in cooperation with the municipalities,
- to establish user-managed places in interdisciplinary specialised treatment.

All four health regions have established such services. In the course of 2014, the regional health authorities will also enter into agreements with private, non-profit institutions for 200 new inpatient treatment places, including long-term places.

1.5.2 User survey in interdisciplinary specialised treatment

In 2013, a nationwide user survey was conducted at residential interdisciplinary specialised treatment institutions. The response rate was 91 per cent. It was the first time a survey of this kind was carried out. The survey showed that most patients were satisfied with their stay, and that they benefited greatly from the treatment. Most of the respondents also stated that they had been treated well by the treatment providers/staff. At the same time, many respondents stated that they had to wait for a long time before the treatment started. The majority also stated that they had received little help with mental and physical problems. In addition, most of them stated that they had received inadequate help from the institution to prepare for discharge and with follow-up upon their release.

The plan is to conduct annual user surveys at residential institutions in interdisciplinary specialised treatment. The survey underlines the need to help patients with concurrent problems to prepare for discharge to a greater extent – in cooperation with the municipalities.

1.5.3 Competence-raising measures and quality indicators

Efforts in the drugs and alcohol field in recent years have contributed to increasing knowledge about the problem, but there is still a lack of good quality indicators and information about the services, and about the use of resources. Competence-raising measures implemented through the escalation plans for the drugs/alcohol and mental health fields have been retained and

integrated in the ‘quality boost’ in the drugs/alcohol and mental health fields.⁴ The quality boost has three focus areas:

1. Competence plan for the drugs/alcohol and mental health fields (recruitment and qualification etc.)
2. A better basis for management, knowledge about health challenges and treatment
3. Research, development and knowledge support.

Through the competence plan for the drugs/alcohol and mental health fields, the Government wishes to ensure the necessary expertise in the services offered to people with drug or alcohol problems and people suffering from mental illness. Key measures in the plan include:

- Strengthening continuing and further education
- Establishing a medical speciality in addiction medicine
- Facilitating good management
- A better basis for management, knowledge about health challenges and treatment.

Work is under way on monitoring the development of consumption, and to acquire more knowledge about the services offered. Annual municipal reports have been submitted on the number of full-time equivalents and the development of services in mental health care and municipal efforts in the drugs/alcohol field in recent years. Further developing these reports is a priority task. A separate KOSTRA⁵ working group has also been appointed in the mental health and drugs/alcohol fields with a view to obtaining more relevant data at the municipal level, and to improve the availability of existing relevant data.

The Directorate of Health has also appointed two working groups to develop quality indicators in the mental health and drugs/alcohol fields; one for specialist health services and one for primary health services. The goal of these groups is to establish a national system of quality indicators for the specialist and primary health services.

⁴ Report No 30 to the Storting (2011–2012) Se meg! (‘See me!’) Chapter 8. Quality boost in the drugs/alcohol and mental health fields – greater competence and better quality.

⁵ KOSTRA: Municipal-State-Reporting. Statistics on the use of resources, priorities and goal attainment in municipalities, city wards and county authorities.

BrukerPlan ('user plan') is a tool that maps the prevalence and characteristics of people with drug or alcohol problems who are known to the support services in the municipalities. The Directorate of Health has signed a three-year contract for further development and implementation of BrukerPlan, so that all municipalities can use the tool free of charge. During the course of 2014, all Norwegian municipalities should have received an offer to use the BrukerPlan tool. Work is also being done to be able to use BrukerPlan to map people with mental health problems, but no drug or alcohol problems.

1.5.4 Research and dissemination

Through the escalation plans for mental health and the drugs/alcohol field, endeavours have been made to strengthen research and the dissemination of research-based knowledge, at both the Institute of Public Health and the Norwegian Institute for Alcohol and Drug Research (SIRUS), and through the Research Council of Norway's Programme on Alcohol and Drug Research and Research Programme on Mental Health, and in the regional health authorities.

One of the main tasks of the seven regional drug and alcohol competence centres (Korus) is to stimulate the development of drug and alcohol prevention measures in the municipalities. The competence centres administer grant schemes whereby the municipalities are allocated funds to stimulate the introduction of measures aimed at preventing drug and alcohol problems. The competence centres also engage in some research in areas for which they have national responsibility.

Dedicated user experience surveys will be introduced in connection with interdisciplinary specialist treatment, and separate key figure reports will be prepared in this field in order to monitor developments and to increase knowledge about the users' own experience of and need for the services.

In Report No 30 to the Storting (2011–2012), the former Government proposed a national strategy to combat overdose fatalities. The Storting endorsed this strategy. It was also decided to adopt a zero-vision goal for overdose fatalities, cf. Recommendation No 207 to the Storting (2012–2013). The Directorate of Health was tasked with drawing up the strategy, and EUR 1.25 mill (NOK 10 mill.) was allocated for this work. The national five-year overdose strategy was launched in spring 2014. It contains both a strategy element and an action plan. See more details in Chapter 6.

The Directorate of Health has been assigned the task of carrying out a survey of the housing situation of people with drug or alcohol problems, including people who complete treatment according to plan, those who interrupt the treatment themselves and those who have special needs for help (see also Chapter 7).

Medical expertise in the drugs and alcohol field is to be strengthened, both in the specialist health service and in the municipalities. A medical speciality in addiction medicine has therefore been established. The Directorate of Health is assisting the Ministry of Health and Care Services in this work, which must be seen in conjunction with the general review of the specialist field that the Directorate of Health is currently carrying out.

In order to strengthen efforts aimed at family members of people with drug or alcohol problems, two living conditions surveys were initiated in 2013. They target children and adults, respectively, as next-of-kin. The objective is to learn more about their experiences, and how they cope with everyday life. The results are intended to form the basis for further measures. Both the living conditions surveys will be seen in conjunction with a large-scale survey on children as next-of-kin led by Akershus University Hospital. The final report will be presented in 2014.

1.5.5 Grant schemes

There are a number of financial support schemes in the drugs and alcohol field for municipalities and non-profit organisations. They are intended to stimulate engagement and activity in relation to drugs and alcohol policy, both nationally and locally, through operating grants and grants for projects. The schemes are intended to promote knowledge-based strategies and democratic work by organisations based on voluntary effort and local involvement, for example:

The prevention of drug and alcohol-related problems – to help to limit drug and alcohol use and the harm caused by drugs and alcohol. The grant scheme covers reports, evaluations, trial schemes, international cooperation, information and awareness-raising campaigns, including the development and dissemination of methods for early intervention and mini-interventions.

Drug and alcohol measures – aimed at stimulating high-quality, coordinated drug and alcohol prevention work in the municipalities, including work to stimulate drug and alcohol action plans and better coordination and utilisation of local resources.

The scheme also covers:

- the establishment and continuation of a system of municipal drugs/alcohol and crime-prevention coordinators, in cooperation with the Norwegian National Crime Prevention Council (KRÅD);
- operating grants for organisations engaged in drug and alcohol policy issues;
- project grants for the development of voluntary drug and alcohol prevention projects and activity grants for voluntary drug and alcohol prevention measures;

- grants for the regional drug and alcohol competence centres and their work on preventive strategies targeting the municipalities;
- grants for the ‘doping helpline’;
- operating grants for the Workplace Advisory Centre for Issues related to Alcohol, Drugs and Addictive Gambling in the Workplace (AKAN);
- grants for the prevention of drug and alcohol-related problems in the workplace;
- grants for the development and dissemination of knowledge about national public health measures;
- operating grants for Anti-Doping Norway’s work targeting doping as a social problem.

Grants for municipal work in the drugs/alcohol and mental health fields – to stimulate the development of services at the local level – are awarded to various coordination and competence-raising measures. Various grants are also awarded for:

- Greater coordination between the different service levels in the mental health and drugs/alcohol field, and the development and dissemination of knowledge about coordinated and comprehensive services.
- Raising the level of expertise in drug and alcohol problems among doctors and other health personnel, including by developing and using new mapping tools, courses in motivational interviewing and parental prevention work.
- User and next-of-kin organisations to promote increased user participation at both the individual and system level, and to contribute to the development of arenas and tools for user participation. Grants are also awarded to next-of-kin centres.
- Increased capacity in municipal work targeting drug and alcohol problems through the development and testing of coordination models, and cooperation on patients who are ready to be discharged.
- Stimulation grants for continuing and further education, and training in the use of mandatory treatment and coercion.
- Non-profit and voluntary organisations that, in cooperation with the municipalities, run institution-based services and inpatient treatment with follow-up and rehabilitation of people with drug/alcohol problems or experience of prostitution, organisational development, competence-raising and quality development in the drugs and alcohol field, among other things via:
 - The regional drugs and alcohol competence centres.

- Management, knowledge and organisational development.
- Projects relating to prisons, prostitution and human trafficking.

1.6 Economic analysis

1.6.1 Public expenditure

As stated in the introduction, the municipalities have a considerable responsibility for preventive work in the drugs and alcohol field and for health and care services for persons with drug or alcohol problems. General preventive measures are wide-ranging and in principle not symptom-specific. There are 428 municipalities in Norway, which vary greatly in both their size and organisation. It is, at best, very difficult, therefore, to isolate the amounts that are allocated specifically to the drugs and alcohol field. Municipal (and partly also central government) health, care and welfare services are not registered on the basis of diagnoses, but on the basis of needs. There is therefore no overview of the total local expenditure. However, work is now under way to develop calculation models that will make it easier to estimate the allocated amounts. Moreover, central government transfers to the municipalities are very often made in the form of block grants, not earmarked funds.

Since 2005, central government allocations to the drugs and alcohol field have increased by approximately EUR 145.6 million (NOK 1.165 billion). Increased allocations to the municipalities and the specialist health service come in addition. This has made it possible to develop services in the municipalities and the specialist health service for people with drug and alcohol problems. Moreover, through increased general allocations to the regional health authorities, steps have been taken to ensure that greater efforts are made to help people with drug or alcohol problems. In the draft national budget for 2015, it is proposed to allocate more than EUR 225 million (NOK 1.8 billion) for various drug/alcohol and mental health measures via the Ministry of Health and Care Services' budget.

In 2013, the cost of the specialist health service's interdisciplinary specialist drug and alcohol treatment amounted to approximately EUR 187.5 million (NOK 1.5 billion), and grant funding for various drug/alcohol and mental health measures amounted to almost EUR 225 million (NOK 1.8 billion). In addition comes (part-)financing of various government institutions such as SIRUS and the Norwegian Centre for Addiction Research (SERAF), and the seven drugs and alcohol competence centres. In total, this amounts to approximately EUR 25 million (NOK 200 mill.).

2 Drug use in the general population and specific target groups

2.1 Drug use in the general population

SIRUS has conducted surveys of the Norwegian population's use of alcohol and drugs from 1968. The surveys have normally been carried out every five years. The drugs questionnaire was part of a more comprehensive survey that was mainly concerned with alcohol consumption and attitudes to alcohol policy issues. Data collection in these surveys was carried out in the form of face-to-face interviews. The data concerning drugs were later linked to the other data from the interview survey. The last survey using this method was carried out in autumn 2009, and the data were presented in the National Report for 2010, Chapter 2. However, one should be aware that prevalence figures from these surveys are probably biased due to a problematic sampling procedure and declining response rates. In the 2009 survey, the response rate was as low as 18 per cent.

Population surveys, 2012 and 2013

As a result of declining response rates in previous surveys, SIRUS entered into a collaboration with Statistics Norway on an annual national population survey using a different approach in order to measure the use of tobacco/moist snuff, alcohol, illegal drugs and medicines. This approach involves drawing a representative sample from the population register and conducting phone interviews with the subjects after they have received an information letter in advance. The sample is drawn from the 16–79 age group, with oversampling from the 16–30 age group. In order to adapt the survey to the classification that the EMCDDA uses, only respondents in the 16–64 age group are asked about the use of illegal substances.

The 2012 survey had a response rate of 53 per cent and consisted of 1,947 respondents, 1,668 of whom were in the 16–64 age group. Since the approach and method differ, the data in the old and new series of population surveys are not directly comparable. Comparability across data waves from the new series of surveys are much easier. An error was made in the 2012 survey, however, so that only those who stated that they had ever used hash/marijuana were asked about other illegal substances. This means that no data are available for 2012 on other drugs than cannabis.

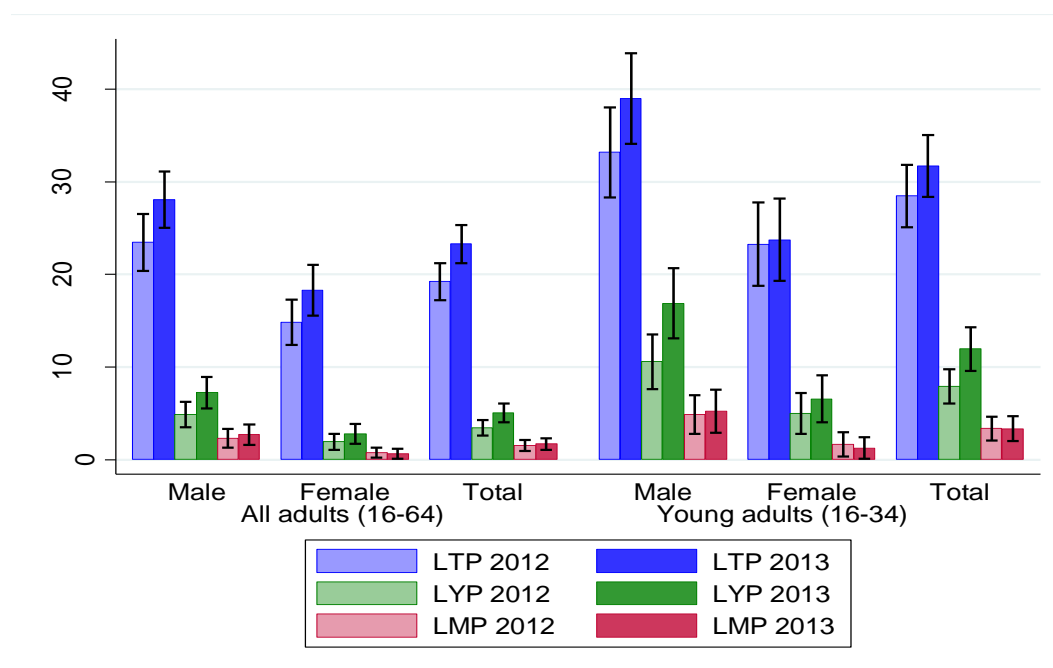
The 2013 survey includes all of the most frequently used illegal substances. It had a response rate of 57.3 per cent and there were 2,101 respondents, 1,790 of whom were in the 16–64 age group.

2.1.1 Cannabis

In the 2012 survey, approximately 19 per cent of the 16–64 age group reported having ever used cannabis (lifetime prevalence – LTP), while 3.4 per cent stated that they had used it during the last 12 months (last year prevalence – LYP) and 1.5 per cent reported use during the last four weeks (last month prevalence – LMP). The corresponding figures from the 2013 survey are somewhat higher: 23 per cent LTP, 5 per cent LYP and 1.7 per cent LMP.

Higher estimated prevalence levels are obtained from the 2013 data in several subgroups as well (Figure 1). For example, the LYP rate among young adults (aged 16–34) was eight per cent in 2012, compared with 12 per cent in 2013. However, because the confidence intervals for the estimated prevalence levels are mostly overlapping, since only two comparable surveys are currently available and since the surveys were conducted only one year apart, it is too early to say anything about changes and trends in drug use in the general population in Norway. Such statements can be made with greater confidence as data from more data collection waves start to accumulate. At present, our best guess is that the true prevalence levels lie somewhere between the estimated levels from the two surveys. Even though the differences between the two surveys are fairly small, it is worth noting that, if the prevalence estimates for cannabis use are biased upwards, then the prevalence estimates for other drugs are probably also slightly biased upwards.

Figure 1: Cannabis use in 2012 and 2013*

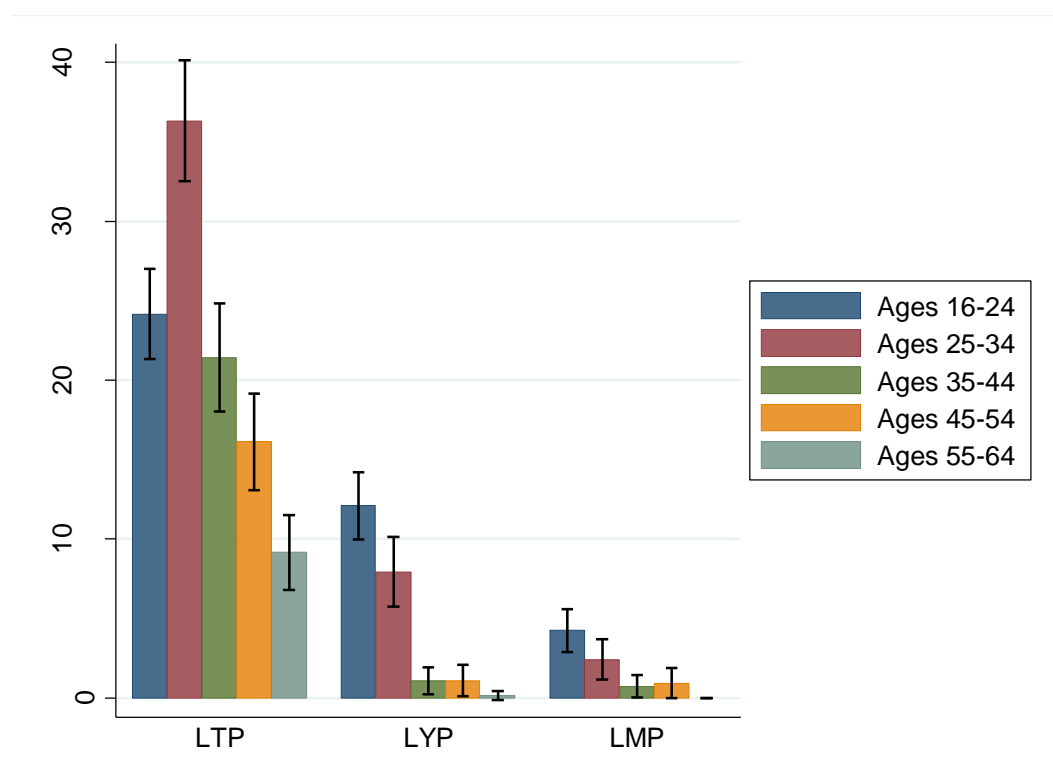


* Lifetime prevalence (LTP), last year prevalence (LYP) and last month prevalence (LMP). Population-weighted proportions. The error bars indicate 95 per cent confidence intervals for the proportions. The net response was 3,444 (all adults) and 1,667 (young adults). Source: SIRUS/Statistics Norway

By combining the data from 2012 and 2013, we can obtain more precise estimates of prevalence levels for cannabis use and differences between subgroups. The estimated LTP, LYP and LMP rates among all adults (aged 16–64) were 21.3 per cent, 4.3 per cent and 1.6 per cent, respectively. Among young adults (aged 16–34), the corresponding LTP, LYP and LMP estimates are 30.2 per cent, 10 per cent and 3.4 per cent.

There are significant gender differences in cannabis use, with males having higher prevalence rates than females. Using the combined data from 2012 and 2013 for all adults, the estimated LTP rate was 25.9 per cent for males and 16.6 per cent for females, while the LYP rate was 6.1 per cent for males and 2.4 per cent for females and the LMP rate was 2.5 per cent for males and 0.7 per cent for females. Among young adults, the estimated LTP rate was 36.2 per cent for males and 23.5 per cent for females, while LYP was 13.9 per cent for males and 5.8 per cent for females and LMP was 5.1 per cent for males and 1.4 per cent for females (all gender differences were significant at $p < .05$).

Figure 2: Cannabis use across age groups*



* Lifetime prevalence (LTP), last year prevalence (LYP) and last month prevalence (LMP). Population-weighted proportions. The error bars indicate 95 per cent confidence intervals for the proportions. Data from 2012 and 2013 combined. The net response was 3,444.

Source: SIRUS/Statistics Norway

Cannabis use also varies across age groups (Figure 2). Both LYP and LMP rates decline with age. The LYP rate was estimated to be 12.1 per cent for persons in the 16–24 age group, 7.9 per cent in the 25–34 age group and around one per cent or less in the three oldest age groups (35–44, 45–54 and 55–64). The LMP rate was 4.2 per cent in the 16–24 age group, 2.4 per cent in the 25–34 age group and less than one per cent in the three oldest age groups. Even though the biggest differences are between the youngest and the three oldest age groups in relation to both LYP and LMP, the LYP rate in the 25–34 age group is significantly lower ($p < .05$) than in the 16–24 age group.

To some extent, this is the same pattern as for lifetime prevalence (LTP). The LTP rate also declines with age: 25–34 (36.3 per cent), 35–44 (21.4 per cent), 45–54 (16.1 per cent) and 55–64 (9.2 per cent). The LTP rate is significantly lower among people in the 16–24 age group than among people in the 25–34 age group, however ($p < .05$). One interpretation of this is that it is mainly the result of a cohort effect. It is not possible to distinguish age and cohort effects using cross-sectional data, and the age profiles in cannabis use that are shown in Figure 2 are likely to be the result of both effects. Individual ageing and maturation processes typically lead to reduced cannabis use as people grow older, however. Previous studies have also shown that cannabis use increased among teens during the 1990s and decreased during the 2000s in Norway (<http://www.espad.org/en/Participating-countries/Norway/>). An increasing trend in cannabis use across birth cohorts is consistent with a declining trend across age groups in cross-sectional data, particularly if there is also a tendency towards decreased use with age. It is not surprising, therefore, that all indicators of cannabis use decline with age (Figure 2). It may also be that age profiles in current cannabis use (LYP and LMP rates) are more closely related to individual ageing and maturation processes, while a larger proportion of the age profile for the LTP rate can be interpreted as a cohort effect. People in the 25–34 age group are more likely to have been part of the increasing trend in cannabis use during the 1990s (they were born between 1978 and 1988, and most of them were in their teens during the 1990s), than people in the 16–24 age group (who for the most part did not become teenagers until after the year 2000). This may explain the relatively lower LTP rate in the 16–24 age group compared with the 25–34 age group.

2.1.2 Other illegal drugs

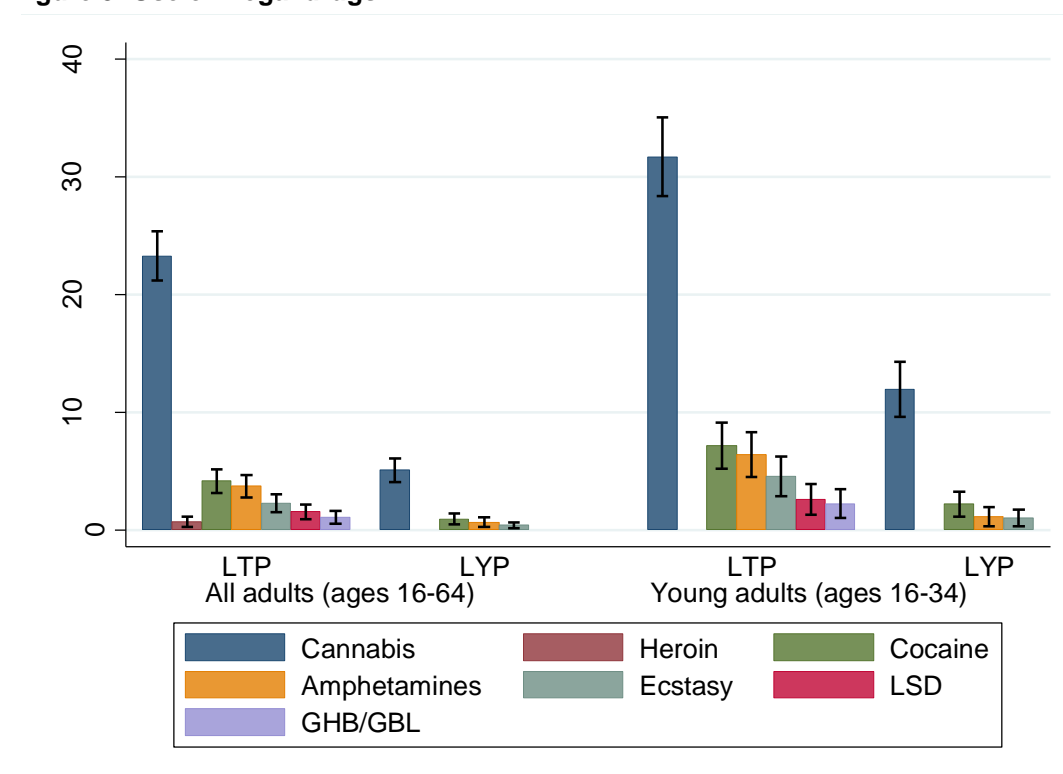
In line with a number of other studies, the 2013 survey shows that cannabis is by far the most common illegal drug in Norway. As shown in Figure 2, the LTP rate for cannabis use among all adults was 23.3 per cent, while the LYP rate was 5.1 per cent. By comparison, the LTP rate was estimated to be 4.2 per cent for cocaine, 3.7 per cent for amphetamines, 2.3 per cent for ecstasy, 1.5 per cent for LSD, 1.1 per cent for GHB/GBL and 0.7 per cent for heroin for all

adults (Figure 3). The LYP rate was estimated to be less than one per cent for cocaine, amphetamines and ecstasy.

Among young adults, the LTP rate for cannabis use was 31.7 per cent, while it was 7.2 per cent for cocaine, 6.4 per cent for amphetamines, 4.6 per cent for ecstasy, 2.6 per cent for LSD and 2.2 per cent for GHB/GBL. While the estimated LYP rate was 12.0 per cent for cannabis, it was 2.2 per cent for cocaine, 1.1 per cent for amphetamines and 1.0 per cent for ecstasy. The proportion who had used heroin, LSD and/or GHB/GBL during the past year was not significantly different from zero ($p > .05$), neither among young adults nor among all adults. Among young adults, the LTP rate for heroin was also so small that it was not statistically different from zero ($p > .05$), again proving that it is not possible using such methods to estimate the real prevalence of heroin use.

For the first time, reported use of cocaine is on a par with (slightly above) the level for amphetamines, unlike all previous national surveys that have been undertaken. More surveys are needed before we can say that this is a trend, however.

Figure 3: Use of illegal drugs*

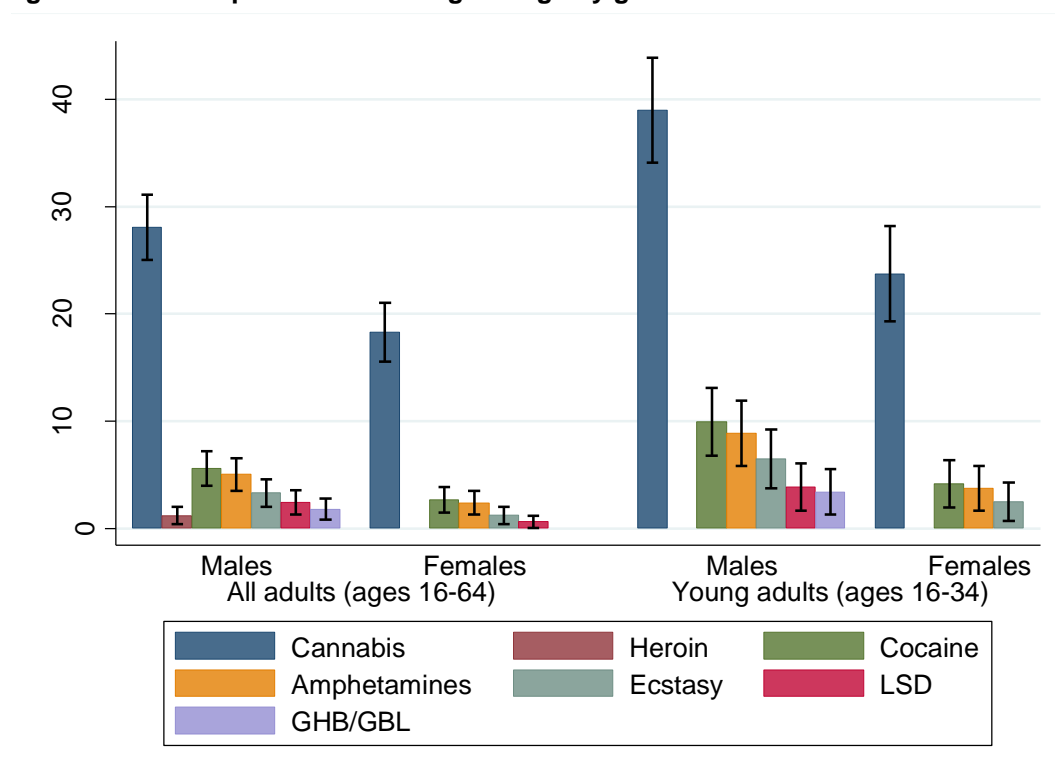


* Lifetime prevalence (LTP) and last year prevalence (LYP) in 2013. Population-weighted proportions. The error bars indicate 95 per cent confidence intervals for the proportions. Proportions that are not significantly different from zero ($p > .05$ in Wald test) are not shown. The net response was 1,783 (all adults) and 871 (young adults).

Source: SIRUS/Statistics Norway

There were also significant gender differences here. The LTP rate for all other illegal drugs than cannabis was around twice as high for males than for females, as shown in Figure 4. For cocaine, it was 5.6 per cent for males and 2.7 for females. For amphetamines, it was 5.0 per cent for males and 2.4 for females, while for ecstasy it was 3.3 per cent and 1.2 per cent, respectively. Among young adults, the LTP rate for cocaine was 9.9 per cent for males and 4.1 per cent for females. For amphetamines, it was 8.8 per cent for males and 3.7 for females. For ecstasy, it was 6.5 per cent for males and 2.5 per cent for females. All gender differences were significant at $p < .05$.

Figure 4: Lifetime prevalence of illegal drugs by gender*



* Data from 2013. Population-weighted proportions. The error bars indicate 95 per cent confidence intervals for the proportions. Proportions that are not significantly different from zero ($p > .05$ in Wald test) are not shown. The net response was 1,783 (all adults) and 871 (young adults).

Source: SIRUS/Statistics Norway

2.1.3 Anabolic steroids and new synthetic drugs

The 2013 survey also asked questions about the use of anabolic steroids and new synthetic drugs. Anabolic steroids are synthetic steroid hormones designed to mimic testosterone. Use and possession of anabolic steroids became illegal in Norway in 2013. Many new synthetic substances are chemically designed to mimic the effects of traditional illegal drugs such as

cannabis (synthetic cannabinoids) and cocaine (synthetic cathinones), to mention two, but they are often many times more potent.

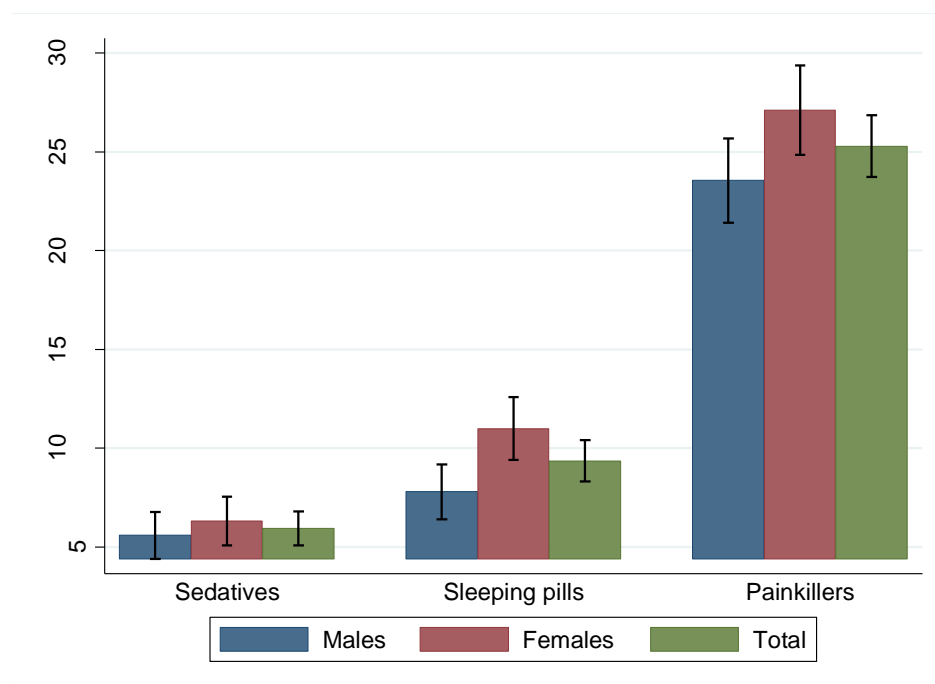
The prevalence of anabolic steroids use was very low, according to the survey. None of the female respondents had ever used anabolic steroids, and the prevalence of use was also very low among males (last year prevalence was not significantly different from zero). The estimated lifetime prevalence of anabolic steroids use was 1.9 per cent (95 % confidence intervals from 0.9 to 2.9 %) for all adult males (aged 16–64) and 3.0 per cent (95 % confidence intervals from 1.1 to 4.9 %) for young adult males (aged 16–34). The prevalence rates should be halved to find the prevalence rates for the general population.

The prevalence of new synthetic drug use was also very low. None of the female respondents had ever used such substances. Among all adult males, the LTP rate was estimated to be 1.7 per cent (95 % confidence intervals from 0.9 to 2.5 %), while LYP was 0.5 per cent (95 % confidence intervals from 0.0 to 0.9 %). Among young adult males, the LTP rate was estimated to be 4.4 per cent (95 % confidence intervals from 2.2 to 6.5 %), while LYP was 1.3 per cent (95 % confidence intervals from 0.1 to 2.4 %). Again, the rates should be halved if interest lies in prevalence rates for the whole population.

2.1.4 Prescription drugs

The survey also contained questions about the use of prescription drugs. The respondents were given examples of trade names of drugs that may lead to dependence, have an intoxicating effect and that are often bought and sold on the illegal drug market. For sedatives, the example names given were Sobril, Valium and Vival, which are all benzodiazepines. For sleeping pills, the example names given were Imovane, Zoplicon, Stilnoct, Apodorm and Flunipam, which are either benzodiazepines or drugs that have similar effects as benzodiazepines. For painkillers, the example names given were Paralgin Forte and Nobligan, which are opioids. It should be noted that the survey does not distinguish between prescribed and non-prescribed use of these drugs, so we cannot say anything about the abuse or misuse of prescription drugs.

Figure 5: Use of prescription drugs*

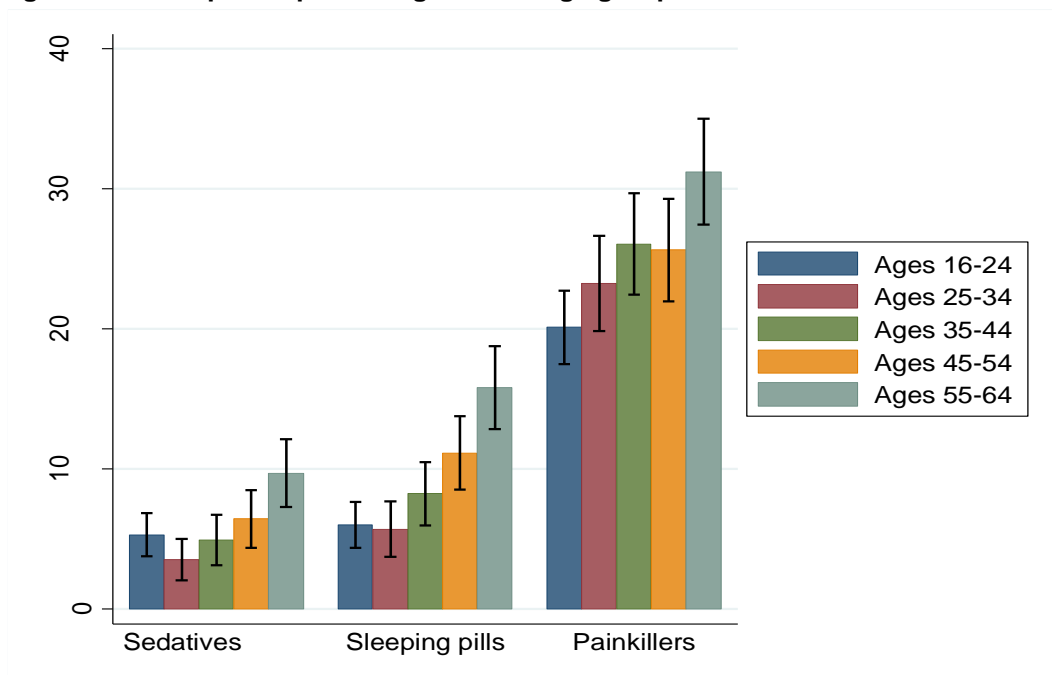


*Last year prevalence among all adults (aged 16–64). Population-weighted proportions. The error bars indicate 95 per cent confidence intervals for the proportions. Data from 2012 and 2013 combined. The net response was 3,445.

Source: SIRUS/Statistics Norway

Last year prevalence rates are much higher for prescription painkillers than for sleeping pills and sedatives (Figure 5). Among all adults (aged 16–64), the estimated LYP rate for sedatives was 5.9 per cent, for sleeping pills 5.1 per cent and for painkillers 25.3 per cent. There were significant gender differences in LYP rates for sleeping pills and painkillers, with females having higher LYP rates for both classes of drugs ($p < .05$). The LYP rate for sleeping pills was 7.8 per cent for males and 11.0 per cent for females. For painkillers, the LYP rate was 23.6 per cent for males and 27.1 per cent for females. The use of prescription drugs also varies across age groups, with prevalence rates increasing with age for all three classes of drugs (Figure 6).

Figure 6: Use of prescription drugs across age groups*



* Last year prevalence. Population-weighted proportions. The error bars indicate 95 per cent confidence intervals for the proportions. Data from 2012 and 2013 combined. The net response was 3445.

Source: SIRUS/Statistics Norway

3 High-risk drug use

3.1 Prevalence of high-risk drug use

3.1.1 New guidelines – definitions

The EMCDDA revised the former set of indicators describing ‘problem drug use’ in 2012, and this is the first year we report in accordance with the new guidelines. The new set of indicators will describe ‘high-risk drug use’ and focus on ‘recurrent drug use that is causing actual harms (negative consequences) to the person (including dependence, but also other health, psychological and social problems) or is placing the person at high probability/risk of suffering such harms’.

Since many drugs, as well as polydrug use and how the drugs are administered, can cause such harm, several indicators have been established. The number of injecting drug users was an important indicator before, and it still is after the revision.

Heroin is often categorised as the single most harmful drug due to the high risk of death to the user. However, other opioids, both natural (opium, morphine) and synthetic opioids (such as methadone, buprenorphine), can also be misused and cause deaths as well as health problems (see Chapter 5.2). An indicator measuring the prevalence of high-risk opioid use is therefore an important indicator of drug-related harm. Stimulants such as amphetamines and cocaine cause fewer deaths than opioids, but excessive use combined with personal and societal problems can contribute to severe health consequences and amplify personal and social problems.

High-risk cannabis use was not included in the former ‘problem drug use’ set of indicators, but, over the years, cannabis has become a more prevalent diagnosis among users seeking treatment. High-risk cannabis use (daily or almost daily) has thereby become an indicator after the revision. Finally, polydrug use is common and may increase the consequences caused by the use of a single substance. High-risk drug use therefore also encompasses an indicator of polydrug use after the revision.

These indicators cannot be estimated using direct methods, such as a single population survey or register, since a substantial part of the population of interest is difficult to reach for various reasons and is thus rarely included in such data sources. Frequency of use (weekly or more frequently for at least six of the last 12 months, or 26 days or more in the last 12 months) defines high-risk use for each substance. Substances used in accordance with a prescription are not included. An alternative is having a medical diagnosis according to current Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD) criteria. For injecting behaviour, any injection in the last 12 months not made in accordance

with a prescription is included, regardless of the illegal drug. If no such data options are available for estimation, any other best proxy can be used.

High-risk cannabis use is the exception from indirect estimation. The prevalence is estimated by general population surveys and includes daily or almost daily use of cannabis 20 days or more in the preceding 30 days. An alternative definition is daily or almost daily cannabis use in the preceding 12 months. Another alternative is to use medical diagnoses in the same way as for other substances (see above).

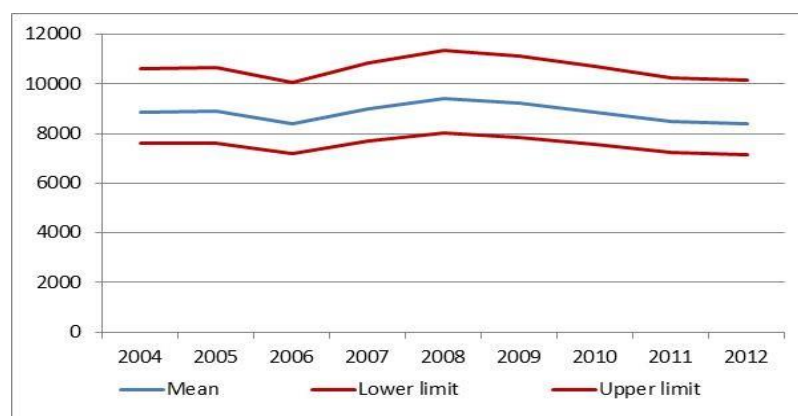
3.2 Prevalence estimates

3.2.1 Slight decline in injecting drug use

The estimated number of injecting drug users in Norway was also reported prior to the revision, using the mortality multiplier method. This method divides the number of drug-related deaths by the likelihood of dying of a drug-related diagnosis in the population of injectors in the 15–64 age group. First, an estimate of the number of recreational users was subtracted from the nominator because they are less likely to have injected the substance that caused the death. The probability of dying of drug-related causes among injecting drug users has been set to 2.03 per 100 person-years, based on cohort studies among such users.

The estimate for injecting drug users in 2012 was 8,400 persons, with a sensitivity interval of 7,200–10,100. Figure 7 shows a stable trend in the number of injecting drug users since 2004, with a possible decline since 2008. With a growing population of 15–64-year-olds, however, the possible decrease in numbers is shown as a decline in the proportion of injecting drug users per 1,000 capita. Based on the method used, the decline was 15 per cent from 2008 to 2012; from 3.0 to 2.5 injecting drug user per 1,000 capita.

Figure 7: Estimated injecting drug use 2004–2012



Source: *Sirus*

3.2.2 High-risk opioid use

High-risk opioid users are a heterogeneous group that includes marginalised drug users with long-standing ‘careers’ of heroin use, as well as socially included persons who became addicted to opioids through excessive consumption of prescribed pharmaceuticals. The description of high-risk opioid use does not include stable patients in opioid substitution treatment (OST) or others using pharmaceutical opioids in accordance with a doctor’s prescription. Patients in OST who misuse prescribed drugs or other opioids than the prescribed one(s) shall be included, however. Furthermore, persons not included in OST who misuse prescribed opioids shall be included.

In the Norwegian context, the mortality multiplier method was also used to estimate the number of high-risk opioid users, even though the method is not optimal. The definition will then be indirect: It is assumed that, for high-risk users of opioids, the risk of dying an opioid-related death is between 1.5 or 2.5 per 100 person-years. This is similar to the risk of dying a drug-related death among injecting drug users. The reason for this choice is that many injecting drug users are also high-risk opioid users. The number of opioid-related deaths was restricted to the 15–64 age group and excluded intentional deaths (suicides) and recreational users. The average for the years 2010 to 2012 shows that heroin was the cause of death for 47 per cent, methadone for 27 per cent, while, for 26 per cent, other opioids were the cause of death.

Some patients in OST may have been included, but they cannot be identified. Around 9–10 per cent of OST patients reported having used morphine/heroin substances recently in addition to OST medication (Waal et al. 2013). With a total of 7,450 persons in OST in 2012, this amounts to approximately 700 persons with risky morphine/heroin use in OST. We do not know whether they were high-risk users, however, and we do not know the proportion of high-risk use of other opioids among patients in OST.

The number of high-risk opioid users was estimated to be 7,700 persons, with a sensitivity interval from 6,200 to 10,300 persons. The estimate includes those with the highest risk of death or other serious consequences.

3.2.3 High-risk stimulant use and polydrug use

The use of amphetamines (both amphetamine and methamphetamine) and other stimulants is common among drug users in Norway, while cocaine use is less common. The number of persons admitted to drug treatment with amphetamines or other stimulants than cocaine as the primary diagnosis was 16 times higher than the number of persons admitted to treatment with cocaine as the primary diagnosis. For the time being, it is more relevant to monitor high-risk amphetamine use in Norway than high-risk cocaine use, but so far, there is no adequate way of estimating the number of users in the Norwegian context. Further work will be carried out on exploring the Norwegian Patient Register.

3.2.4 High-risk cannabis use

In the general population surveys, the definition of high-risk cannabis use was use 20 or more days during the last four weeks. Two population-based surveys have been carried out (in 2012 and 2013), with 3,470 respondents in the 16–64 age group (see Chapter 2).

Approximately 10,300 persons in the 16–64 age group were defined as high-risk cannabis users, estimated on the basis of the number of persons in the population. The 95 per cent confidence interval was wide, however, from 4,200 to 16,400 persons. Only 11 persons reported a high level of cannabis use. The figures do not include high-risk cannabis users who were socially marginalised and who did not receive or answer the questionnaires. Such users will usually also experience problems with other substances and may be included in other high-risk indicator estimates.

3.2.5 Total number of high-risk drug users

It is not possible to make a well-defined estimate or even a qualified guess, of the total number of high-risk drug users in Norway. Some people will be covered by several individual indicators, for example as injectors and as high-risk opioid users. The work on arriving at such a measure will continue, however.

3.3 Data on high-risk drug users in seven cities

In autumn 2013, a study was carried out among 1,020 drug users in seven Norwegian cities: Oslo, Kristiansand, Sandnes, Stavanger, Bergen, Trondheim and Tromsø (Gjersing & Sandøy, 2014). The study included people who had used illegal opioids and/or stimulants in the four weeks prior to the study. Participants were recruited in or outside various low-threshold services and on the street. The sample cannot be regarded as a representative national sample, but it is the biggest one established so far. There were some distinct differences in drug consumption patterns between the cities, which supports notions and findings in previous smaller studies.

The proportion of women was 23 per cent. The mean age was 39.5 years for women and 41.8 years for males. Forty per cent were 45 years or older, while 27 per cent were 16 to 34 years of age.

Sixty-three per cent stayed in their own apartment or house (owned or rented), while 29 per cent were homeless or lived in shelters. The remaining proportion lived in institutions.

Forty per cent were in opioid substitution treatment (OST) at the time of the interview, while six per cent were in other types of drug treatment.

Financing the consumption of drugs came from various sources and often from more than one source. While only ten per cent reported income from work, 85 per cent received social benefits, 29 per cent reported drug sales and 11 per cent other criminal activity as their source of income.

Injection was the most common route of administration. Eighty-five per cent of the female respondents and 79 per cent of the males had injected drugs during the past four weeks (Table 1). Sixty per cent had injected amphetamines and 43 per cent had injected heroin. Even though amphetamines were injected by a larger proportion of persons, daily or almost daily, injection was more common among heroin users. Twenty-six per cent injected heroin this often, while 21 per cent injected amphetamines this often. Thus 35 per cent of those injecting amphetamines did so daily or almost daily, while 60 per cent of those injecting heroin did so daily or almost daily. No gender differences were found regarding such figures. Injection of amphetamines was more common among those under 45 years of age than in the older age group.

Table 1: Injected/not injected amphetamines and/or heroin last four weeks. In numbers.

	Not injected heroin	Injected heroin	Total
Not injected amphetamines	259	144	403
Injected amphetamines	321	296	617
Total	580	440	1,020

Source: *Sirus*

The debut age for injection varied by the decade in which the debut took place. The average age of users who debuted in the 1970s was 15.5, while the average age of users who debuted in the 1990s was 20.7, and users who started injecting after 2009 were on average 27.5 years at the time of their debut. The results must be interpreted carefully since the survey is a cross-sectional study. The increase in age at the time of recruitment to injecting drugs can be an actual change, or those with later debut may have had a higher chance of quitting the use of drugs again. Most likely, both factors have played a role.

Overdoses, defined as situations where the respondent needed help from others to regain consciousness, were common. Sixty-five per cent had overdosed ever, 21 per cent in the past year and seven per cent in the last four weeks.

Smoking and snorting heroin rather than injecting it can reduce the risk of overdoses. In all, 19 per cent reported such use in the last four weeks. More males (21 %) used such routes of administration than females (13 %). Smoking and snorting heroin were more common routes of administration among persons under 35 years of age. Among those in the sample who started using heroin in the 1970s, only a small proportion started by smoking it. The proportion who

smoked it increased with time; up to more than 40 per cent of those who started using the drug in the period 2000–2010.

Smoking and snorting amphetamines were reported by 22 per cent of the sample, while daily or almost daily such use was reported by three per cent. There were no gender or age differences. Oral ingestion or snorting morphine was less common. Nine per cent reported such use in the last four weeks, while two per cent reported such use daily or almost daily. Illegal use of methadone or buprenorphine was present, but not very common. Eleven per cent had used methadone and 16 per cent buprenorphine in the last four weeks, while two per cent and eight per cent, respectively, had used such substances daily.

Cannabis use was common: 82 per cent had taken cannabis in the last four weeks. Daily or almost daily use was more frequent among male respondents (36 %) than among females (27 %). Fewer had consumed alcohol. In the last four weeks, 57 per cent had consumed alcohol (60 % of male respondents and 48 % of females), while eight per cent consumed alcohol it daily or almost daily (9 % of male respondents and 5 % of females). The use of pharmaceuticals was also common. 83 per cent of the respondents had taken pills at least once during the past four weeks, while 32 per cent did so daily or almost daily.

The survey showed that injection is still very common among drug users in low-threshold services in Norway. The ‘heroin epidemic’ may have declined, while the use of amphetamines may have increased. In addition, the use of pharmaceuticals (pills) was common, as well as the use of cannabis.

4 Drug-related treatment: treatment demand and treatment availability

4.1 General description of systems

The treatment systems and its organisation were described in more detail in NR 2011 Chapter 5.3. Residential treatment was thoroughly dealt with in a selected issue in NR 2012. See also Chapter 1. With the exception of opioid substitution treatment (OST), the treatment systems have not changed in recent years.

The state has overriding responsibility for providing necessary specialist health services for the public. This also applies to people with drug or alcohol problems. The Administrative Alcohol and Drug Reform of 2004 stipulates that the four regional health authorities shall provide outpatient and inpatient interdisciplinary specialised treatment, either through their own health trusts or through private partners. Inpatient treatment includes detoxification, stabilisation and assessment services as well as short-term and long-term inpatient treatment. Interdisciplinary specialised treatment also covers treatment with methadone or Subutex, in addition to other treatment and follow-up services. See also Chapter 1 for more information.

The national OST programme was run by 14 centres in the four health regions until 2010. Special guidelines were introduced from 1 January 2010, which emphasised, among other things, that OST should be integrated in the ordinary specialist health service (see NR 2010 Chapter 11). OST centres are no longer a separate type of measure, and the system of special decision-making powers has been discontinued. The four regional health authorities have established assessment units that make an overall assessment of what type of treatment is needed for the person in question, whether he/she needs OST or non-medical treatment.

4.1.1 Challenges

In the white paper on alcohol and drug policy of June 2012 (Chapter 1.3), the Government stated that ‘extensive efforts have been invested in the drugs and alcohol field in recent years, both in the municipalities and in the specialist health service. However, user organisations and experts point out that the services must be involved at an earlier stage and that the availability of the services must be improved. Lack of coordination is another important challenge. Many clients and patients experience problems when responsibility for further follow-up is transferred to new services. This is a problem both within and between sectors and levels.

Evaluations indicate that coordination between the administrative levels, the specialised and the municipal services is not good enough. The services are perceived as fragmented, often with long waiting times for treatment. The time spent in inpatient treatment has also been reduced compared with what used to be the norm. Following a stay in the specialist health service,

patients shall be followed up by their municipality. The transition from state to municipal services often leads to interruption of treatment, which results in a poorer health situation for the users. Cooperation between the first and second-line services is often based on personal relations, not the structure of the treatment chain.

There is a need to clarify the individual services' tasks and responsibilities. The biggest challenges for people with drug/alcohol dependency who need extensive help are to get sufficient care for somatic and mental illness, a lack of suitable housing and coping with their daily life and living conditions. Other challenges include a lack of participation in meaningful activities, work and a social network.

4.2 Treatment admission

4.2.1 Data from the Norwegian Patient Register

The Norwegian Patient Register (NPR) is authorised by the regulations of 2009 to collect personally identifiable information about patients receiving treatment for drug/alcohol abuse in the interdisciplinary specialist health service. Patients are identified by a unique number across centres.

From 2010, it became possible to retrieve the number of patients with a drug problem who started inpatient or outpatient treatment in the year in question, as well as some information about these patients. The individual data are aggregated and reported to the EMCDDA. So far, only treatment started during a calendar year can be reported, without knowing whether this is first-time treatment or whether the patient has undergone treatment before.

Table 2 shows that, according to the NPR, a total of 26,443 patients received treatment during the 2013 calendar year. Of those, 16,892 received treatment for drug problems as their primary condition, on a par with the number in 2012 (16,778). Patients in OST are included here. Sixty-nine per cent were men. The number includes patients in both inpatient and outpatient treatment, and the sample is based on ICD-10 F codes. The biggest group, 42 per cent (out of 16,892), had problems relating to the use of opioids as their primary diagnosis. The second biggest diagnosis category was cannabis at 19 per cent, followed by multiple drug use at 14 per cent and stimulants at 12 per cent. Two-thirds of the patients were in outpatient treatment. Addictive medicinal drugs accounted for almost seven per cent, but the type of use is not shown in the statistics, since no distinction is made between medicinal drugs prescribed by a doctor and medicinal drugs acquired in another manner.

Table 2: Patients in specialised treatment during 2013. Number.

Primary diagnosis	Inpatient	Outpatient	Total
Alcohol (F 10)	3,698	5,853	9,551
Opiates (F11)	1,983	5,168	7,151
Cannabis (F12)	653	2,610	3,263
Prescriptive drugs, BZD (F13)	455	661	1,116
Cocaine (F14)	24	115	139
Other stimulants (F15)	678	1,216	1,894
Hallucinogens (F16)	10	15	25
Solvents (F18)	2	5	7
Multiple drugs (F19)	1,345	1,952	2,297
Total	8,848	17,595	26,443
Total, alcohol excluded	5,150	11,742	16,892

Source: The Norwegian Patient Register

4.2.2 Treatment demand indicator

As for those who started treatment for drug-related problems in 2013, reports were submitted from 143 units concerning a total of 8,412 patients. This represents a slight decline compared with the previous two years (2012: 8,891 patients from 146 units; 2011: 8,817 patients from 159 units). Of the total number, 3,604 were in inpatient treatment and 4,808 in outpatient treatment, including OST. Comparative figures for 2012 were 3,691 and 5,200. Around 69 per cent of patients starting treatment were men. The average age of patients in inpatient treatment was 34.9 years for men and 36.7 years for women, while in outpatient treatment it was 33.4 years for men and 35 years for women.

Where the primary drug was identified, problem opioid use was the most frequently reported diagnosis in both outpatient and inpatient treatment. The second most frequent diagnosis was the use of stimulants for patients in residential treatment and cannabis upon admission to outpatient treatment. The latter accounted for as much as 36 per cent of the patients where a single primary drug could be identified, up from 31 per cent in 2012. The proportion with cannabis as their primary drug upon admission to inpatient treatment was 18 per cent, the same as in 2012. However, for as many as 30 per cent of the patients entering treatment, both outpatient and inpatient treatment, multiple drug use was their primary diagnosis (ICD 10 F19).

4.2.3 About patients in OST in particular

See also ST24.

According to the status report for 2013 from the Norwegian Centre for Addiction Research (SERAF, 2014), there were a total of 7,055 patients in OST at the end of 2013, an increase of only 18 from 2012. In 2012, the number increased by 384, and in 2011 by 625. Part of this slow-down is due to previous errors in reporting. The reasons are complex. One of the reasons is that the OST service at Oslo University Hospital has checked the treatment of patients who have been transferred to their GP without receiving follow-up from OST. Relatively many of them had dropped out of treatment without this having been reported. The other health trusts in the region still showed a significant increase. Even though the decline was due, in part, to structural and organisational difficulties, there are also signs that OST as a system has stopped growing, as it did for many years.

Admissions

The number of admissions to OST in 2013 was 845, on a par with 2012 (823). Of this number, 494 were first-time applications, while 351 had undergone such treatment before. The reduction from the 'peak years' of 2010 and 2011, when there were more than 1,100 admissions, is significant.

At the end of 2013, it was reported that 65 persons were waiting to be admitted to OST, nearly 50 per cent fewer than the year before (125). It seems as though the statutory assessment deadline of 30 days for ordinary applications and 10 days for applications concerning young people is being met. Admission takes place in the course of a few days in some health trusts and in the course of a few weeks in others. The waiting time may be longer, however, where the patient wishes to be admitted to other residential institutions as part of OST and rehabilitation.

Discharges and retention

The number of discharged patients from OST in 2013 was 711, higher than in previous years (409 in 2012, 487 in 2011). The number is 9.2 per cent of all patients in treatment during the year, compared with 5.8 per cent in 2012. In 2011, the proportion was 10 per cent, while in 2010, 9.4 per cent of patients terminated their treatment. In other words, about one in ten patients terminate the treatment, but, more importantly, nine out of ten seem to have settled in the treatment and stay for a long time. In general, the main reason for interrupting treatment is that the patient him/herself leaves the treatment. This concerns patients who stop showing up and patients who state that they no longer wish to continue. Some patients specifically request other types of treatment or wish to stop using morphine substances.

The number of deaths among OST patients in 2013 was 98. Converted into patient-years, calculated as the average number of patients at the start and end of the year, it was 1.3/100 (Table 3). The number has increased over years, but so has the number of patients in treatment. Deaths largely occur among the oldest and sickest patients. Information has been obtained about cause of death for 96 deaths. The dominant cause of death is serious somatic illness, which accounts for 41 deaths in total. Liver failure, cancer and lung disease are particularly frequent causes of death. There are as many as 24 deaths that are perceived as being caused by overdoses, and a further eight cases where the information is sparse, so that the cause of death is described as unknown. In reality, some of the cases designated as overdose deaths, and some of the cases where the cause of death is described as unknown, are suicides. Violent deaths accounted for 13 cases, and here, the prevalence of suicides is considerable. Most cases involve drastic methods such as hanging, shooting and jumping in front of a train or off a bridge.

Table 3: Annual occurrence of deaths during treatment in the OST programme 2003–2013. Number and converted in proportion to the number of patients in OST (deaths per 100 patient-years).

Year	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Norway	31	21	30	15	32	39	63	54	54	84	98
% of all patients in treatment/year	1.4	0.8	0.9	0.4	0.8	0.8	1.3	0.9	0.8	1.2	1.3

Source: The Norwegian Centre for Addiction Research – SERAF

4.2.4 The status survey for 2013

Data about clients' current situation, such as health and social conditions and functional level, psychosocial treatment, crime and drug and alcohol use, are reported annually in the form of status surveys. A total of 5,972 forms were completed. Including 604 persons who had left treatment and 98 who died, this represents around 80 per cent of all patients in treatment in 2013, or a total of 7,747 persons. The average age of clients (for whom a form has been completed) was 42.7, and the proportion of women was 30 per cent, on a par with 2012. The average age and the gender distribution have been more or less unchanged in recent years. Although the lower age limit for admissions has been abolished following the introduction of new guidelines (previously 25 years), this does not appear to have affected the average age. A total of 148 patients (2.6 %) were in the 21–25 age group, and only one was under 21. A total of 1,187 (19.2 %) patients were in the 51–60 age group, while 102 (2.4 %) patients were over the age of 60. Compared with 2011 and 2012, the proportion over the age of 50 has increased

considerably, which indicates that there will be an increasing number of OST patients in care for the elderly in the years ahead.

The proportion treated with methadone was 43 per cent, while 57 per cent were treated with buprenorphine-based medication. The proportion treated with methadone has been steadily declining in recent years. This is related to the fact that the guidelines for OST do not recommend methadone as the first choice. About two-thirds had their medication prescribed by their GP, showing that GPs still play a key role in OST. GPs can take over responsibility for prescribing the medication once treatment has been initiated by the specialist health service. Just above half of the patients got their medication from pharmacies.

Social function and rehabilitation

Occupational rehabilitation is not showing progress. In 2013, four-fifths (82 %) were not employed either full-time or part-time, or in education. The corresponding proportions in 2012 and 2011 were 80 and 78 per cent. Forty-four per cent had benefits as their main source of income, most of them disability benefit. In other words, nearly half receive disability benefit, which shows a high degree of morbidity. The proportion who live on temporary social security benefits is low (9 %), as is the proportion who are financially independent (14 %). There are considerable differences between the health trusts, however.

The proportion who have their own apartment or house is nonetheless high. According to the status overview, an average of 75 per cent of patients rented or owned their own home. Lower proportions were found in the two largest cities, Oslo and Bergen.

Drug use

The findings on drug use are based partly on positive findings from urine tests and partly on reported use during the last 30 days. The levels are overall quite similar to 2012. A proportion of 10 per cent reported having used an illegal morphine substance during the past month, 33 per cent cannabis, 16 per cent stimulants and as many as 42 per cent benzodiazepines. This figure includes both prescribed and non-prescribed benzodiazepines. Twenty-five per cent of all patients report having been prescribed the drug by a doctor. In other words, the others must have used illegal sources. There is a clear tendency for high levels of illegal use among patients in units where a lot of medicinal drugs are prescribed. This means that there is nothing to indicate that legal prescription reduces illegal use.

The situation was also measured by calculating the overall score for frequency of drug use and the severity of ongoing use during the past month. Forty-one per cent had not used illicit substances at all, 12 per cent only sporadically, while 38 per cent reported frequent use. This

means that the proportion who use illegal substances regularly has increased from 2012, when 28 per cent reported such use (SERAF, 2014).

5 Health correlates and consequences

5.1 Drug-related infectious diseases

5.1.1 HIV and Aids

In 2013, 233 cases of HIV infection were reported to the Norwegian Surveillance System for Communicable Diseases (MSIS). Eight of the cases were among injecting drug users: six men and two women. The median age was 31 years (30 to 37 years). Five of the eight injecting drug users who were diagnosed as HIV positive in 2013 were persons of foreign origin (mostly Eastern European) who had been infected before arriving in Norway.

As of 31 December 2013, a total of 604 persons had been diagnosed as HIV positive with injecting use as a risk factor. This amounts to 11 per cent of all reported cases of HIV since 1984. In 155 of the cases, the patient had developed Aids (Table 4). No information is available regarding how many of the HIV positive injecting drug users are still alive.

Table 4: Reporting of HIV infection and Aids, Norway 1984–2013. Percentage of injecting drug users by year of diagnosis.

	HIV total	HIV injecting drug use	Percentage HIV injecting drug use	Aids total	Aids injecting drug use	Percentage Aids injecting drug use
1984–1999	2,018	442	22 %	675	112	17 %
2000	175	7	4 %	35	5	14 %
2001	157	8	5 %	33	8	24 %
2002	205	16	8 %	34	4	12 %
2003	238	13	5 %	53	6	11 %
2004	251	15	6 %	36	4	11 %
2005	219	20	9 %	32	4	13 %
2006	276	7	3 %	32	4	13 %
2007	248	13	5 %	11	0	0 %
2008	299	12	4 %	18	2	11 %
2009	282	11	4 %	18	1	6 %
2010	258	11	4 %	22	3	13 %
2011	268	10	4 %	19	0	0 %
2012	242	11	5 %	25	1	4 %
2013	233	8	3 %	29	1	4 %
Total	5,371	604	11 %	1,073	155	14 %

Source: The Norwegian Surveillance System for Communicable Diseases (MSIS); the Norwegian Institute of Public Health

The incidence of HIV among injecting drug users has remained at a stable, low level for many years, with about 10 to 15 cases reported per year. The number was eight in 2013. The reason for this is not entirely clear, but a high level of testing, great openness regarding HIV status within the drug user community, combined with a strong fear of being infected and strong internal justice in the community, are assumed to be important factors. In addition, many of the sources of infection in the drug user community have disappeared due to overdose deaths, and some have been rehabilitated through substitution therapy or other forms of rehabilitation. However, the extensive outbreaks of hepatitis A and B in the late 1990s and early 2000s, and the high incidence of hepatitis C, show that there is still extensive needle sharing in this group. In the last few years, the majority of injecting drug users diagnosed with HIV have been persons of foreign origin (mostly Eastern European) who had been infected before arriving in Norway.

5.1.2 Hepatitis

During the nationwide outbreak of hepatitis A from 1996 to 2000, 1,360 drug users were diagnosed with acute hepatitis A. Since then, only sporadic, individual cases of hepatitis A have been reported among injecting drug users. Hepatitis A vaccination has been offered free of charge to injecting drug users since 2000.

In the period 1995–2008, a considerable increase in hepatitis B among drug users nationwide was reported to MSIS. In 2013, four of a total of 30 reported cases of acute hepatitis B involved injecting drug users. During the period 1995–2013, the total number of reported cases of acute hepatitis B infection among injecting drug users was 1,980. Hepatitis B vaccination has been offered free of charge to injecting drug users since the mid-1980s.

The monitoring of hepatitis C in Norway was intensified from 1 January 2008. The notification criteria were changed so that all laboratory-confirmed cases of hepatitis C must now be reported to MSIS. Previously, only acute illness had to be reported, and this resulted in a very inadequate overview of the real incidence of the disease in the country. In 2013, 1,318 cases of hepatitis C (both acute and chronic cases) were reported. In 47 per cent of the reported cases, no information was provided about the presumed mode of transmission, but in the cases where the mode of transmission is known, 91 per cent were infected through the use of needles. For the time being, data from MSIS cannot distinguish between cases involving new infection with hepatitis C and cases where the infection occurred many years ago. It is therefore not known whether the number of cases of newly acquired hepatitis C infection has declined or increased among drug users in recent years.

Among OST patients, the status survey for 2013 (see Chapter 4.2.2) shows that 63 per cent of the clients were hepatitis C antibody positive, roughly the same proportion as in 2012. This is lower than expected, and the explanation is probably that the percentage with unknown status was as high as 18 per cent.

Since 2002, small-scale prevalence surveys have been carried out in connection with needle distribution and the drug injection room in Oslo in order to register the prevalence of several infectious diseases among injecting drug users. These surveys are the only prevalence surveys that are carried out regularly among a sample of drug users in Norway. The 2012 survey showed that 62 per cent of the injecting drug users tested had had a hepatitis A infection or had been vaccinated against the disease, while 35 per cent had had a hepatitis B infection and 64 per cent had had a hepatitis C infection. Forty-one per cent had hepatitis B markers, indicating that they had been vaccinated against hepatitis B. No survey was carried out in 2013.

5.1.3 Bacterial infections

In the period 2000–2012, six sporadic cases of botulism were reported among injecting drug users. In addition, one case of anthrax and one case of *Clostridium novyi* were reported among injecting drug users in the same period. In October and November 2013, six cases of wound botulism were diagnosed among injecting drug users in the Oslo area. Contamination of heroin with *Clostridium botulinum* spores or other substances mixed with the drug were the most likely sources of this outbreak. In recent years, five to ten cases of methicillin-resistant *Staphylococcus aureus* (MRSA) have been reported annually among drug users. There is insufficient data on the incidence of other bacterial infections among drug users in Norway. Tuberculosis is very rare among drug users in Norway.

5.1.4 Risk behaviour

In connection with the 2012 prevalence study among injecting drug users attending needle distribution facilities and the drug injection room in Oslo, questions about risk behaviour were included as part of the survey. Ninety-one currently injecting drug users replied. Results: 13 per cent reported having shared used needles and syringes in the last four weeks, 34 per cent reported having shared used injecting paraphernalia in the last four weeks, 35 per cent had taken an HIV test in the 12 months preceding the survey, and 36 per cent had taken an HCV antibody test in the 12 months preceding the survey. No behavioural survey was carried out in 2013.

5.2 Drug-related deaths and mortality of drug users

5.2.1 Methodological considerations

Until 2010, there were two bodies that registered drug-related deaths in Norway: Statistics Norway and Kripas (the National Crime Investigation Service). Kripas based its figures on reports from the police districts, while Statistics Norway prepared figures on the basis of medical examiners' post-mortem examination reports and death certificates in accordance with the WHO's ICD 10 codes in a General Mortality Register (GMR). With effect from 2010,

Kripos stopped publishing figures for drug-related deaths. Hence, the 2009 figures were the final year of reporting from that source.

With effect from 1996, Statistics Norway's figures have been based on the EMCDDA's definition of drug deaths. This broadened the inclusion criterion that had been used until then. In the period since 1996, Statistics Norway's figures have been consistently higher than the figures from Kripos. However, if suicide (by means of drugs) and drug-related deaths among elderly people above the age of 65 are eliminated from Statistics Norway's statistics, the difference is smaller, although still considerable in some years. The trends (up to 2009) were largely identical in both series of figures, however.

5.2.2 The situation in 2012

Table 5 shows that the figures for drug-related deaths peaked in 2000/2001. In the ensuing years, there has been a considerable reduction in the number of registered drug deaths. The reduction since the turn of the millennium is most probably due to the strong increase in the number of clients in OST. Both the Statistics Norway figures and the Kripos figures appear to indicate that, after the reduction following the peak years of 2000 and 2001, the number of mortalities has stabilised somewhat. The number remains relatively high, however.

Table 5: Drug-related deaths 1991–2012. Total number of deaths and deaths broken down by gender. Figures from Kripos and Statistics Norway (underlying cause of death).

1991–2012	Number of deaths according to Kripos			Number of deaths according to Statistics Norway		
	Men	Women	Total	Men	Women	Total
1991	74	22	96	66	22	88
1992	78	19	97	81	23	104
1993	77	18	95	76	17	93
1994	102	22	124	105	19	124
1995	108	24	132	114	29	143
1996*	159	26	185	173	31	204
1997	149	28	177	160	34	194
1998	226	44	270	228	54	282
1999	181	39	220	191	65	256
2000	264	63	327	302	72	374
2001	286	52	338	327	78	405
2002	166	44	210	240	67	307
2003**	134	38	172	193	62	255
2004	168	55	223	220	83	303
2005	146	38	184	176	58	234
2006	152	43	195	187	64	251
2007	162	38	200	217	58	275
2008	148	31	179	210	53	263
2009	146	37	183	222	63	285

The Drug Situation in Norway 2014

2010	n/a	n/a	n/a	181	67	248
2011	n/a	n/a	n/a	201	61	262
2012	n/a	n/a	n/a	185	61	246
2013	n/a	n/a	n/a	***	***	***

Source: Kripas and Statistics Norway

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

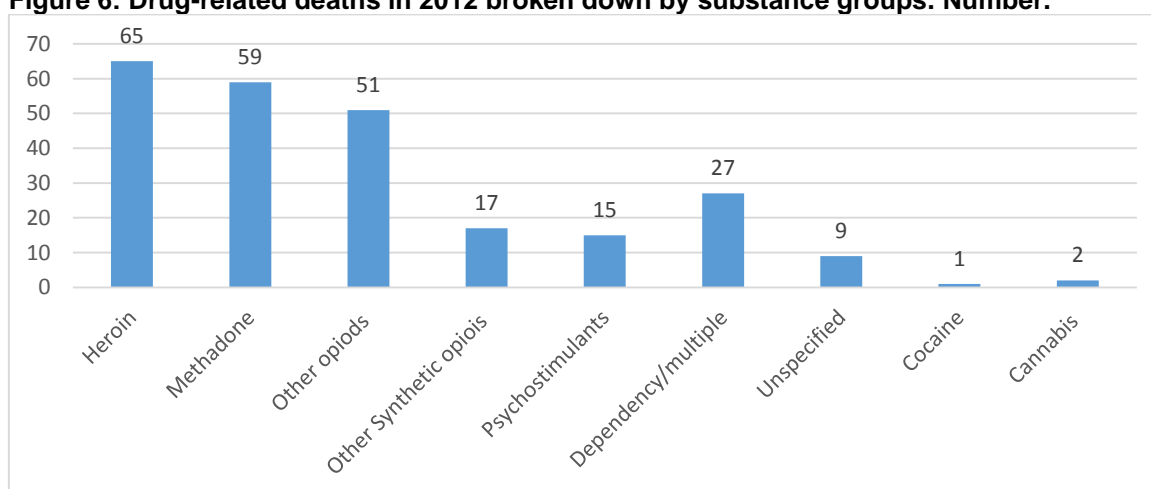
** Statistics Norway's figures from 2003 onwards are based on the WHO's revised coding of causes of death.

***Figures for 2013 are not yet available.

Of the 246 drug-related deaths in 2012 that were recorded by Statistics Norway, 192 (78 %) deaths involved opioids with or without additional drugs. Sixty-five deaths were due to heroin (X42, X44, X62, X64 + T401 or F11.2), while 59 deaths were recorded with methadone poisoning as the underlying cause (X42, X44, X62, X64 + T403), and 51 with other opioids (X42, X44, X62, X64 + T402 or T400). In addition, there were 17 deaths coded as related to 'other synthetic opioids' (X42, X44, X62, X64 + T404). The remaining 54 deaths broke down as follows: 15 psychostimulants (X41, X44, X61 + T436), nine unspecified narcotic substances (X42, X44 + T406 or T409), 27 cases of dependency on other stimulants and dependency on multiple/other drugs (F152, F192), one death from cocaine (T405) and two deaths from cannabis (T407). The cannabis-related deaths have most likely been caused by use of synthetic cannabinoids, but this has not been verified. The ICD-10 does not have specific codes for this, and synthetic cannabinoids would be reported under cannabis.

In 2012, 29 (11.8 %) of the included deaths were coded as suicides (X62, X64), which is higher than the 10 per cent reported for 2010, but lower than the 16.8 per cent in 2011.

Figure 6: Drug-related deaths in 2012 broken down by substance groups. Number.



Source: SIRUS and Statistics Norway

Comments

- Many of the drug-related deaths are believed to be due to extensive multiple drug use.
- In recent years, the average purity of heroin seized by the police in Norway has decreased significantly, from 36 per cent in 2007 to 13 per cent in 2012 (see Chapter 9.4). During the same period, the proportion of heroin as the main intoxicant has been almost halved. However, four out of five drug-related deaths are still due to opioids. It seems that there may be a gradual change in the preference for and/or availability of opioids among opioid users, and that this is also reflected in causes of death. Amphetamine and/or methamphetamine and/or cocaine were detected in seven per cent of the deaths.
- 59 deaths in 2012 were reported to be due to methadone, which is higher than the level in 2010 and 2011, and it now seems to be an increasing trend. The number of overdose deaths from methadone is now almost on a par with the number of deaths from heroin. This is a challenge for patients and treatment providers in OST, and particular caution is called for in connection with methadone treatment. Improved follow-up of patients in methadone treatment is encouraged. The majority of methadone-related deaths in Norway occur among persons not enrolled in the OST programme. An effort to reduce methadone diversion is needed. However, it is generally a challenge to differentiate between deaths caused by methadone and deaths where methadone was present in the blood at the time of death, but was not necessarily the cause of death.
- In 2013, there were 98 deaths (2012:84) from all causes among patients in OST, indicating a total mortality rate of about 1.3 per 100 person-years while in OST (Table 3 in Chapter 4.3.2). The majority of deaths in OST were due to somatic causes and injuries. Suicide was reported as the cause of death in eight per cent of the cases, whereas an overdose was the cause of death for 24 per cent of cases involving patients in OST.

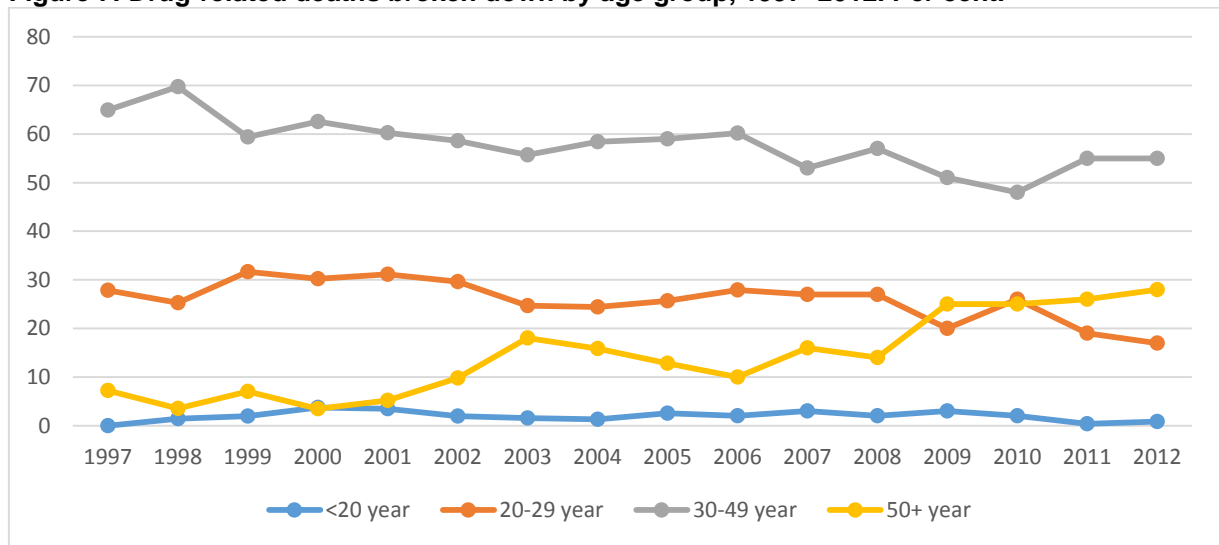
Age: increasing

Figure 7 shows that the proportion of drug-related deaths among people over the age of 30 has increased steadily over the years. In the 1990s, it had reached 60 per cent, according to Statistics Norway. These statistics show that, for the years 2000 to 2009, the proportion of drug-related deaths in the 30-plus age group was approximately 70 per cent on average. In 2012, this age group accounted for 82 per cent of the drug-related deaths (202 persons). During the same period, the proportion over the age of 50 was 28 per cent of the total number of deaths (68 persons). Fourteen of the deaths (6 %) occurred in the 65-plus age group. The youngest age

groups' proportion of drug-related deaths has remained relatively stable, and two deaths (1 %) were registered among persons under the age of 20 this year.

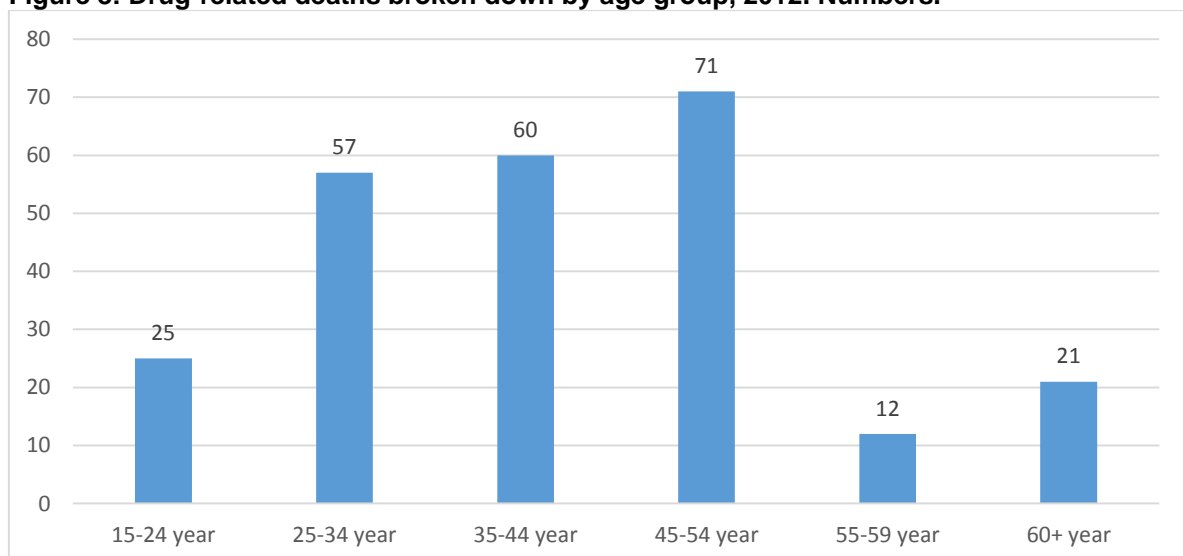
For drug-related deaths, the mean age at the time of death has increased steadily in recent years, from around 35 years in the period 1996–2002 to 41,5 years in 2012. The increase in mean age at the time of death coincides with an expansion in the provision of OST in Norway, but the number of drug-related deaths has stabilised. It could be that OST contributes to the increase in the mean age, and, in that sense, increased age at the time of death can be seen as another positive outcome of the OST programme.

Figure 7: Drug-related deaths broken down by age group, 1997–2012. Per cent.



Source: SIRUS and Statistics Norway

Figure 8: Drug-related deaths broken down by age group, 2012. Numbers.

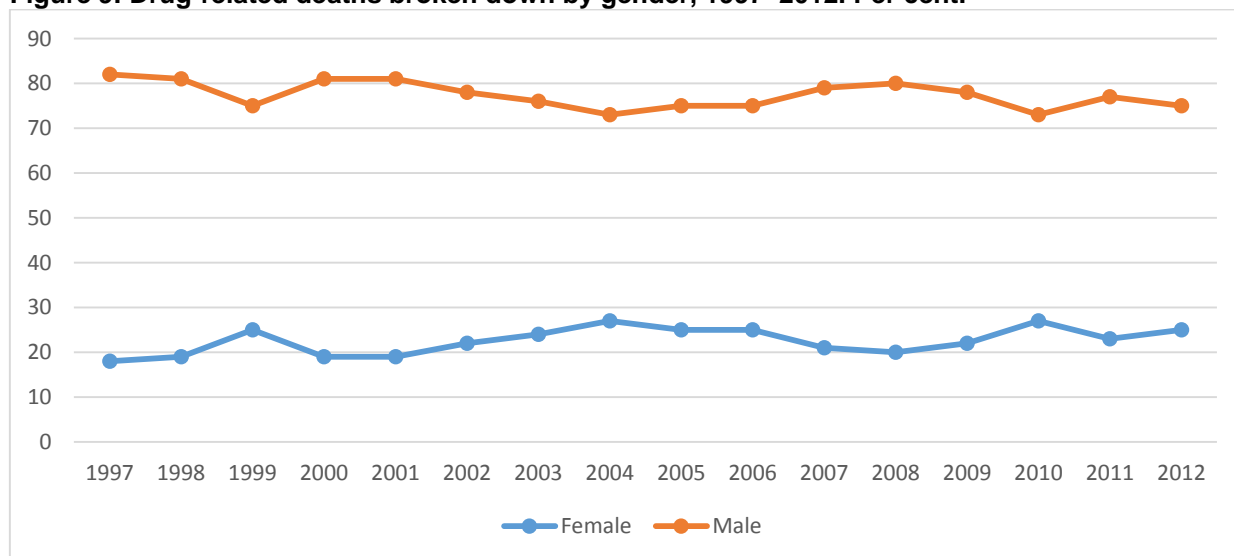


Source: SIRUS and Statistics Norway

Gender distribution: stable

In 2012, 185 victims of drug-related deaths were male and 61 were female. The proportion of females was 25 per cent, which, seen in a longer-term perspective, seems to be within the ‘normal range’. During the period 1997 to 2012, the proportion of women has varied between 18 and 27 per cent (Figure 9). During the period 1980 to 1990, the average proportion of women was close to 22 per cent.

Figure 9: Drug-related deaths broken down by gender, 1997–2012. Per cent.



Source: SIRUS and Statistics Norway

Confirmation of cause of drug-related deaths – high autopsy rate

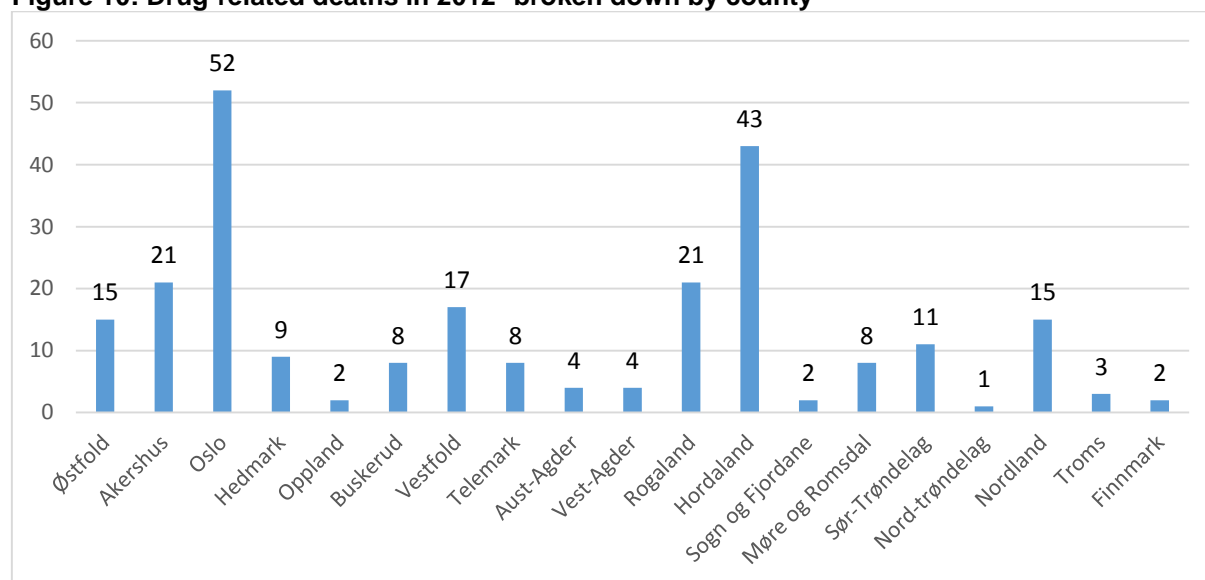
In 2012, there were 41,900 deaths in total in Norway. Of these, 3,000 underwent post-mortem examinations (autopsies). This means that Norway had an overall autopsy rate of about 72 per 1,000 deaths this year. Among the 246 deaths recorded as drug-related deaths in this report, however, 211 victims (86 %) underwent an autopsy, down from 89 per cent in 2011. Deaths with ‘F-codes’ only have an autopsy rate of 47 per cent, compared with 91 per cent for X-code deaths. In most cases, however, the reported figures are based on toxicological confirmation of the drug-related death. This underlines that, in Norway, ‘unnatural deaths’ among young adults are typically investigated by means of an autopsy (including toxicology) in order to confirm the cause of death.

Geographical distribution

In 2012, drug-related deaths were recorded in all the 19 counties in Norway, making them both a national challenge and national concern (Figure 10). The concentration is particularly high in the Oslo area (Oslo and Akershus), accounting for 30 per cent of the total numbers (73). The

situation seems to have gradually improved in Oslo in recent years. The number of drug-related deaths in Hordaland county has increased significantly in recent years, and is now almost as high as in Oslo. This probably reflects the situation in Bergen, the second biggest city in Norway.

Figure 10: Drug-related deaths in 2012* broken down by county



N=246

Source: SIRUS and Statistics Norway

5.2.3 About povidone

In April 2014, methadone from Martindale Pharma was suspended in Norway by the Norwegian Medicinal Agency (NOMA), and by July 2014, the European Medicines Agency (EMA) had also suspended Martindale oral methadone solutions that contained povidone (K90). The oral methadone from Martindale for the Scandinavian market contains povidone (K90), which may have caused severe and irreversible organ failure in drug users who injected the oral methadone.

In Norway, primarily in Western Norway, at least 15 current or former drug users who have injected methadone from Martindale have suffered severe organ failure, probably as a result of povidone accumulating in their kidneys and bone marrow. Martindale methadone has now been replaced by other oral methadone solutions that do not contain povidone.

5.2.4 Current research

A recently published study (Lund, Brendryen, Ravndal, 2014) showed that Norwegian mothers in OST used little drugs four years after the birth of their child. The low levels of drug use were consistent during the pregnancy as well as one year and four years after giving birth. About one out of three reported moderate alcohol use at the four-year follow-up point.

A study of Norwegian OST and retention was conducted for the period 1997–2003 (Bukten, Skurtveit, Waal, Clausen, 2014). The 18-month retention rate among patients admitted to OST in Norway (n=2,431) was 65.8 per cent. Younger age, high levels of pre-treatment criminal offences and drug offences during the 30 days prior to dropout were associated with treatment dropout. There was no association between gender and treatment dropout or re-entry in this study. The study investigated changes in treatment practices in a national OST programme during a ten-year period (2002–2011), especially in relation to the prescription of methadone and buprenorphine.

A paper has been published that shows the shift from methadone to buprenorphine medication during a 10-year period in the national OST programme (Riksheim, Gossop, Clausen, 2014). In 2002, only 16 per cent of the OST patients received buprenorphine as their maintenance medication in Norway. By 2011, this percentage had increased significantly to just over 50 per cent. In the same period, the number of patients more than tripled (from 1,984 to 6,640), and the attrition rates decreased. This shows that OST programmes change over time and that this change can be influenced by national strategies implemented by the government.

A retrospective review has been undertaken of patient records at Sørlandet Hospital in the city of Kristiansand for patients who underwent OST in the period 1998–2009 (Clausen, Åsland, Kristensen, 2014). Of the 469 patients who started in OST during the period, a total of 103 patients (22 %) terminated the treatment. The rate of mortality was high among the OST patients who terminated the treatment. However, approximately 10 per cent of those who were discharged lived stable, drug-free lives without OST medication during the period of observation.

6 Responses to health correlates and consequences

6.1 The national overdose strategy 2014–2017

The white paper on drugs and alcohol policy – *Report No 30 to the Storting (2011–12) Se meg!* ('See me!') – proposed to the Storting that a five-year strategy should be implemented aimed at reducing the number of drug overdoses year by year. In the Storting's consideration, a zero-vision goal was also adopted for the work on reducing the number of overdose deaths. The committee's recommendation states: *The committee also wishes to set a zero-vision goal for overdose deaths. Every person who dies from an overdose is one too many. Our goal is that no one should die from an overdose.* The Storting unanimously endorsed this vision.

The annual allocations to the strategy amount to EUR 1.25 million (NOK 10 mill.) over the four-year period, or a total of EUR 5 million (NOK 40 mill.). The work on preventing overdoses and the funds allocated to the work must be seen in conjunction with the Government's other efforts in the drugs and alcohol field. The Directorate of Health has initiated measures in cooperation with a broadly composed working group. The Directorate will also ensure that existing measures have a stronger focus on prevention. It is emphasised that the strategy should lead to permanent changes in the services.

6.1.1 Goals of the strategy

The main goal of the strategy is to reduce the number of fatal overdoses, among other things by initiating life-saving measures as quickly as possible after an overdose has occurred. Other goals are to contribute to

- empowerment of the users
- reducing the number of overdoses, also non-fatal ones
- reducing serious harm to health as a result of overdoses
- improving follow-up after non-fatal overdoses
- improving the assessment of suicide risk and suicide prevention measures in connection with overdoses
- improving the help services offered to next-of-kin and other related parties who need assistance after an overdose death

Some of the most important measures in the strategy are:

6.1.2 The pilot municipality project.

The nine municipalities/cities with the highest number of overdose deaths in recent years are invited to adopt local action plans and measures to prevent future overdoses in their local communities. These are Oslo, Bergen, Drammen, Fredrikstad, Asker, Porsgrunn, Arendal, Stavanger and Trondheim. The Directorate of Health recently established a dedicated grant scheme that will provide the municipalities with funding and resources in their work on reducing overdoses. The work is now under way.

6.1.3 The nasal naloxone project

During the spring of 2014, a project was established for a take-home nasal naloxone programme. A 1 mg/ml injectable naloxone solution prepared in prefilled syringes (Martindale Pharma) has been developed to enable nasal application using a mucosal atomisation device (MAD300). The kits have been approved by the Norwegian Medicinal Agency (NOMA) for nasal application and for use in a trial project in Oslo and Bergen. The project is supported and sponsored by the Ministry of Health and Care Services, and nasal naloxone kits are being distributed to users free of charge. After NOMA had approved the nasal naloxone project, Martindale Pharma decided to increase the price by 50 per cent for its prefilled syringes with naloxone to be sold to the Norwegian market, compared with the market price in, for example, the UK.

Currently, more than 300 drug users carry nasal naloxone kits in Norway, and several users have requested a refill and reported successful overdose rescues. The Norwegian Centre for Addiction Research (SERAF) has been assigned the task of developing and evaluating the project, which will run until the end of 2016. The plan is that SERAF will submit recommendations on both a possible continuation of the project and possible national expansion in good time before the project ends. Status of the project as of September 2014:

Training the trainers:

Existing staff in 11 low-threshold facilities in Oslo and Bergen have attended a two-hour training session to become instructors at their centres. Over the past four months, 172 staff members have been trained to be instructors. The centres include drop-in day facilities, short-term housing, a consumption room and other relevant services

Training the participants:

- Peer-administered naloxone training sessions are brief and flexible, lasting 5–10 minutes, tailored to the participants' most pertinent needs.
- The participants complete a one-page questionnaire that contains questions about risk factors and previous experiences with overdoses.

- They receive information about overdose prevention, and how to recognise and respond to an overdose using naloxone.
- As of 29 September, 374 naloxone sprays had been distributed, and 67 reports of returns for refills have been registered since June 2014. The latter number includes returns for any reason, whether the spray was used for an overdose, lost or stolen.

Next steps:

- The project intends to expand by increasing the number of distribution centres in Bergen, training the police, security staff, staff at detoxification centres, emergency centres and in prisons.
- Continue to cooperate with the ambulance services in Oslo and Bergen to monitor the impact of the project, as well as working closely with staff and clients at the low-threshold facilities to receive input and contributions.

6.1.4 Change the user culture. SWITCH – from injection to inhalation

In Norway, injection is the most common way of taking heroin. As an attempt to change the user culture, health personnel can recommend inhalation as an alternative route of administration to individual injecting users, and provide user equipment for inhalation and information. Such efforts can take place in parallel with the distribution of injection equipment and information about injection techniques to avoid harm. The strategy is currently linked to what is called the SWITCH campaign, initiated by the low-threshold service Funkishuset in Sandnes in Rogaland county.

6.1.5 Prevention of overdoses following discharge from a drug/alcohol treatment facility / release from prison

It has been documented that the risk of overdoses is greatest shortly after discharge from treatment in a residential institution and upon release from prison. The prevention of overdoses following discharge from an institution in the specialist health service is attended to by the Patient Safety Campaign. The campaign is organised by the Norwegian Knowledge Centre for the Health Services, and its goal is to reduce the number of incorrect treatment cases in the health service. In this context, lack of knowledge on the part of the patient about how to prevent an overdose can be seen as a form of incorrect treatment. Overdose prevention is one of the measures that have received the most positive feedback, from both staff and patients. The prison health service will now be initiating measures to prevent overdoses upon release from prison. The purpose is to ensure that people who are discharged from an institution or released from prison receive enough information from health personnel about the risk of overdosing.

The part of the campaign that includes overdose prevention at residential institutions was first tested at Oslo University Hospital, the Bergen Clinics Foundation and the University Hospital of Northern Norway. In January 2014, it went from a project to a permanent measure called ‘I trygge hender 24-7’ (‘In safe hands 24-7’). The measures will now be implemented at all treatment institutions in Norway (Directorate of Health, 2014 www.helsedir.no).

6.2 Low-threshold health services

Government grant schemes have resulted in more municipalities establishing low-threshold health services for drug and alcohol users. An overview from 2010 showed that 48 municipalities had established such services. The range of available services varies, but some of the cities offer very comprehensive services. The organisation, work methods and range of services vary from place to place, depending on the need and the available resources.

A vast number of the low-threshold services in the municipalities also distribute syringes. Based on a survey conducted in 2012, it was estimated that more than three million syringes were distributed, just over half of them in Oslo. Sales through pharmacies come in addition to this. In 2013, nearly two million syringes were distributed in total in Oslo (approx. 1,337,000), Bergen (approx. 483,500) and Trondheim (approx. 137,400). The number of distributed syringes has probably declined somewhat in the last two or three years, in Oslo in particular.

Injection rooms

In 2009, the Storting decided to make the provisional Act relating to drug injection rooms permanent, which means that municipalities that wish to establish injection rooms have a legal basis for doing so. However, only Oslo has so far made use of the Act. Table 6 shows a strong increase in the number of registered users since the injection room opened as a trial scheme in 2005. The same applies to the number of injections per year. The increase is probably mostly related to the increased capacity and extended opening hours. Very few overdoses have occurred in the injection room seen in relation to the high number of injections. This only applies to overdoses recorded while the users were on the injection room premises, however.

Table 6: The injection room in Oslo. Statistics 2005–2013.

Year	2005	2006	2007	2008	2009	2010	2011	2012	2013
Number									
of registered users	300	400	674	1,224	1,665	2,211	2,556	2,775	2,838

The Drug Situation in Norway 2014

of users per year	277	297	486	923	-	1,484	1,539	1,557	1,339
of injections per year	8,318	8,101	11,654	19,480	25,940	28,368	29,204	33,791	36,138
of emergency calls (113)	35	36	70	122	155	164	155	196	221
% overdoses of all injections	0.4	0.4	0.6	0.6	0.6	0.6	0.5	0.58	0.61

Source: Agency for Welfare, the City of Oslo

7 Social correlates and consequences

7.1 Housing

7.1.1 Homeless people in Norway 2012

A new mapping of homeless people in Norway was carried out in 2012 (Dyb & Johannessen, 2013). Similar surveys were conducted in 2008, 2005, 2003 and 1996. Data were obtained by distributing questionnaires to municipal bodies and public and private organisations that are in contact with, know of or are assumed to know of homeless people. They are the respondents in the survey. The mapping was carried out in 124 municipalities, in all municipalities with 40,000 inhabitants or more, and in a representative selection of municipalities with fewer than 40,000 inhabitants.

The definition of homeless is based on a person's position in the housing market:

A homeless person is a person who does not have their own accommodation, whether rented or owned, but who must rely on random or temporary housing, stay temporarily with close relatives, friends or acquaintances; and persons detained by the correctional service or at an institution who are to be released or discharged within two months and who do not have a place to stay. Persons without a place to stay the next night are also deemed to be homeless.

The number of homeless people in Norway in 2012 was estimated to be around 6,200. This is a small increase from 2008, but the population in Norway has grown during this period, and per 1,000 inhabitants, the proportion of homeless people is just below the 2008 level.

7.1.2 Homeless people with concurrent drug/alcohol problems and mental illness

In total, 54 per cent of all homeless people in the survey are said to be dependent on drugs or alcohol, while 38 per cent are said to have mental health problems. Two out of three people with mental health problems are said to also be dependent on drugs or alcohol. In this survey, this amounts to 1,611 people.

There is reason to believe that this group may be somewhat bigger, as it may be difficult for the help services to assess whether a person has mental health problems unless it is apparent or they know that the person has a diagnosis. The same applies to dependency on drugs or alcohol. It may be difficult for the help services to know until the dependency becomes a big part of the homeless person's life. Persons with concurrent drug/alcohol dependency and mental health problems are a group who often fall between two stools in relation to the help services. Some of them have periods where they are very ill and need psychiatric treatment and periods where they use drugs/alcohol uncritically. Some of them primarily have mental health problems but

use drugs or alcohol from time to time. They do not 'fit into' the drug and alcohol care services, although it is often such services that take responsibility for this group. It can be very difficult to find appropriate housing for some people in this group, but the most disadvantaged group is not necessarily very large.

As regards the problems experienced by people who are homeless for a prolonged period (defined as more than six months), as many as 79 per cent state that they are addicted to drugs or alcohol. This is far higher than the average for all homeless people. Nearly half of this group also have mental health problems. This is also far higher than the average for all homeless people. Nearly a quarter were discharged from an institution in the last six months. This is a much higher proportion than in the homeless population as a whole (15 %). The same applies to the group who are 'waiting to enter treatment'. Twenty-two per cent of long-term homeless people are waiting to be admitted to treatment, while the proportion is 15 per cent for all homeless people.

The analysis of the problem situations confirms that people who experience long-term homelessness are a group facing big, complex challenges in addition to being marginalised in the housing market. The fact that such a large proportion have either been in treatment at an institution and/or are waiting to be admitted to treatment shows that many people in this group are in a situation where they need assistance from the help services to overcome basic problems. The situation described in the report for long-term homeless people is very similar to the profile that has previously been used for homeless people: a single man who resides temporarily in temporary housing/emergency accommodation, has drug/alcohol problems and has been homeless for several years (Dyb & Johannessen, 2013).

7.2 Housing First

The Housing First model was developed by the voluntary organisation 'Pathways to Housing', which was founded by psychiatrist Sam Tsemberis in 1992 in New York. The Housing First model helps homeless people with drug/alcohol problems and mental illness to find their own place to live (Tsemberis, 2010). An important principle in this approach is that all homeless people shall be offered interdisciplinary follow-up over time. The most important premises for the Housing First model is user control, independent apartments in ordinary living environments, distinguishing between housing and services, following up the client for as long as there is a need and facilitating positive change. Since its establishment, the model has spread to other parts of the USA, to Europe and now also to Norway.

In Norway, homeless people with drug/alcohol problems and mental illness have been an important target group for two key initiatives, namely the *Homeless people project (2000–2004)*

and the strategy *Obtaining housing for oneself* (2005–2007). One of the key goals of the *Homeless people project*, which was coordinated by the State Housing Bank, was to develop methods and models for organising housing and other services for homeless people. The background to the project was the recognition that the municipalities' work on social housing was fragmented and unsystematic, and that there was a need for stable, long-term plans for permanent, stable housing. The strategy *Obtaining housing for oneself* sets concrete goals for social housing work, e.g. reducing the use of temporary housing.

Snertingdal & Bakkeli (2013) underline that there are parallels between the Housing First model, the *Homeless people project* and the *Obtaining housing for oneself* strategy. This applies in particular to the recommendation to reduce the use of temporary housing and the importance of follow-up work. Correspondingly, Hansen & Øverås (2007) underline that, even though a step-by-step philosophy was part of the idea behind the *Homeless people project*, where the user is gradually given more responsibility for a house, the Norwegian authorities abandoned this philosophy because the most marginalised users did not manage to proceed to the next step. Similarly, Housing First projects were developed as a response to this step-by-step thinking. The dominant model in Norwegian work on social housing is the normalisation model. The key idea behind the model is that everyone shall be offered permanent housing, and that it is the municipalities that must provide the follow-up services to make this possible (Hansen & Øverås, 2007). At the same time, it is a fact that, even after the establishment of the *Homeless people project* and the *Obtaining housing for oneself* strategy, there are still as many homeless people today as there were ten years ago (Snertingdal & Bakkeli 2013). Johannessen & Dyb (2011) also find that the use of temporary housing is on the increase throughout Norway, and that temporary housing is often used longer than the recommended three months. See also NR 2012 Chapter 8. Based on this, four Housing First projects have been planned and initiated in 12 Norwegian municipalities.

7.3 Ambulant teams

More than 150 ambulant teams have been established in Norway in mental health care and interdisciplinary specialised treatment for drug and alcohol problems. They work in close cooperation with municipal agencies to help the most disadvantaged group to cope with living in a home of their own. The municipalities and health trusts cooperate on the establishment and running of such teams. The team members visit, meet with and follow up the clients. The use of ambulant and outreach services shall be given priority in all the health regions to ensure better, more coordinated and more accessible services. It is a goal that ambulant and outreach services be introduced in more places and further developed in the years ahead (Norwegian

Ministries, 2014: Housing for welfare. National strategy for housing and support services (2014–2020)).

7.4 ACT teams

ACT stands for ‘assertive community treatment’. Between 2007 and 2012, 14 ACT teams were established in Norway. The evaluation of the escalation plan for mental health (1998–2008) showed that there was a group of people who were unable to make use of the existing treatment and follow-up services. People with serious mental illness, often in combination with other problems such as drug or alcohol abuse, were particularly at risk. The lack of coherence and continuity in the services was emphasised, and a lack of coordination between the municipal health and care services and the specialist health service. One of the measures that was proposed for this patient group was testing the assertive community treatment team (ACT team) model. The ACT model seemed to be the best evaluated model in the international context, with the best results for the target group. It was estimated that 4,000–5,000 people in Norway were in the target group for ACT teams.

Midway report on the ACT teams

The Eastern Norway Drug and Alcohol Addiction Service Competence Centre has been assigned the task of evaluating the 12 ACT teams. The evaluation will be carried out in cooperation with the R&D department at the Division of Mental Health at Akershus University Hospital. Since the last team started up in March 2011, the evaluation period will last until 2014.

A midway report based on the first year of operation (2010) was published in November 2012 (KO-Rus Øst, 2012). The report shows that 533 users were referred to the 12 ACT teams during the teams’ first year of operation. Of these, 152 persons were not accepted by the teams. Half of them had a drug or alcohol diagnosis, but they did not meet the admission requirement for a serious mental illness. A total of 381 users were taken on by the ACT teams and have received services. Thirty-two users terminated contact in the first year of operation. In all, 349 users received services from the 12 ACT teams during the first year the teams were in operation.

User characteristics

Based on information from 186 users, we find that the teams primarily deal with people with serious mental health problems. Almost 90 per cent suffer from schizophrenia/schizotypal/paranoid disorders or bipolar disorder. About 60 per cent are also problem users of one or more substances. The results from the scores on the Brief Psychiatric Rating Scale (BPRS) show that 82 per cent of the users have at least one moderately serious to very serious symptom. The target group for ACT are people with significant functional impairments who

are in need of long-term, complex services. The results of the mapping instruments for functioning show that this is true for the users who were taken on by the team. The average score on the Global Assessment of Functioning (GAF) measure was 39, which indicates major functional impairments in several areas.

As regards the use of municipal and specialist health services in the last twelve months before admission to the ACT team, about a fifth of the users had been in contact with emergency teams and/or psychosis teams. A quarter had been in contact with the municipal home care service, while approximately half had been in contact with the psychiatric service. A large proportion had been in inpatient mental health care. Based on this, it seems as though the ACT teams have included users in the manner the model intends. They are people who have been unable to make use of or to have their needs covered by the existing services in the past year before admission to the team. About 81 per cent of the users had also been admitted to mental health care in the year before being accepted by the ACT teams.

8 Drug-related crime, prevention of drug-related crime and prison

8.1 Drug law offences

8.1.1 Legal basis and type of statistics

Norway does not have separate legislation relating to drugs. Two acts apply in connection with the reporting, charging and prosecution of drug crimes: the Medicinal Products Act and the General Civil Penal Code.⁶ Statistics Norway is the Norwegian institution responsible for keeping statistics on drug-related crime in the judicial system. Four types of crime statistics are published annually (<http://www.ssb.no/kriminalitet/>):

- Offences reported to the police
- Offences investigated – clear-up rate – persons charged – recidivism figures
- Penal sanctions – persons convicted – previous criminal offences
- Imprisonments⁷

The statistics do not contain information about the types and quantities of narcotic substances involved in prosecutions, however.

Since 2010, statistics have been published about *charges brought against persons*, in addition to the two other main categories *criminal offences* and *persons charged*, which are already included in the statistics. The statistics for charges contain a complete overview of all criminal offences with which the persons in question were charged during the year.

The police and the prosecuting authorities must have made a legally binding decision concerning a specific perpetrator (before any indictment and before a case comes to court), in

⁶ Minor drug offences that involve the use or possession of drugs are punished pursuant to Section 24 of the Act relating to Medicinal Products (Act No 132 of 4 December 1992), which provides for a maximum sentence of up to two years' imprisonment. Other drug crimes are punishable pursuant to Section 162 of the General Civil Penal Code (Act No 10 of 22 May 1902 with subsequent amendments). Section 162 of the General Civil Penal Code distinguishes between four degrees of gravity, depending on the drug and amount involved and the nature of the offence in other respects. If a small quantity is involved, the offence is punishable by fines or imprisonment for up to two years. Aggravated drug crimes include the three other degrees of gravity. If a somewhat larger quantity is involved, the offence is punishable by imprisonment for up to ten years; if a substantial quantity is involved, the offence is punishable by imprisonment for between three and 15 years, and, under particularly aggravating circumstances, the punishment can be up to 21 years' imprisonment, which is the maximum sentence under Norwegian criminal law.

⁷ There are three key categories in these statistics: Prison population/inmates; new imprisonments, e.g. by type of offence and type of imprisonment; discharges, e.g. by prison time.

order for Statistics Norway to define a charge and a person charged. A person suspected of having committed a crime may be given legal status as ‘charged’ at different times during an investigation. Persons who have been charged during an investigation but who did not have the status of perpetrator when the investigation was concluded are not included in the statistics.

Since 2010, tables have also been published showing *all persons charged in each crime category*. Normally, the persons charged and information about them are broken down by *their primary offence*, i.e. the offence that, pursuant to the law, can lead to the most severe penalty. The new statistics show everyone charged with one or more offences, and not just those with a primary offence, in each of the crime categories. If a person is charged with more than one offence in a crime category, the person is classified on the basis of the primary offence in the individual crime category.

8.1.2 Crime statistics

Reported crimes

According to Statistics Norway, a total of 49,400 drug crimes were reported in 2013. This is 3,500 more than in 2012 and corresponds to 9.8 reported drug offences per 1,000 population. This is the highest level of drug offences since 2002.

Compared with the year before, more violations were registered in 2013 in relation to both the General Civil Penal Code and the Act relating to Medicinal Products. It is the latter that regulates illegal involvement with drugs, mostly use and possession of small quantities (Figure 11). In total, the almost 24,100 drug offences relating to the General Civil Penal Code represent an increase of just over seven per cent from 2012. These offences include 1,171 serious drug crimes, however, which is a nine per cent decrease from the year before.

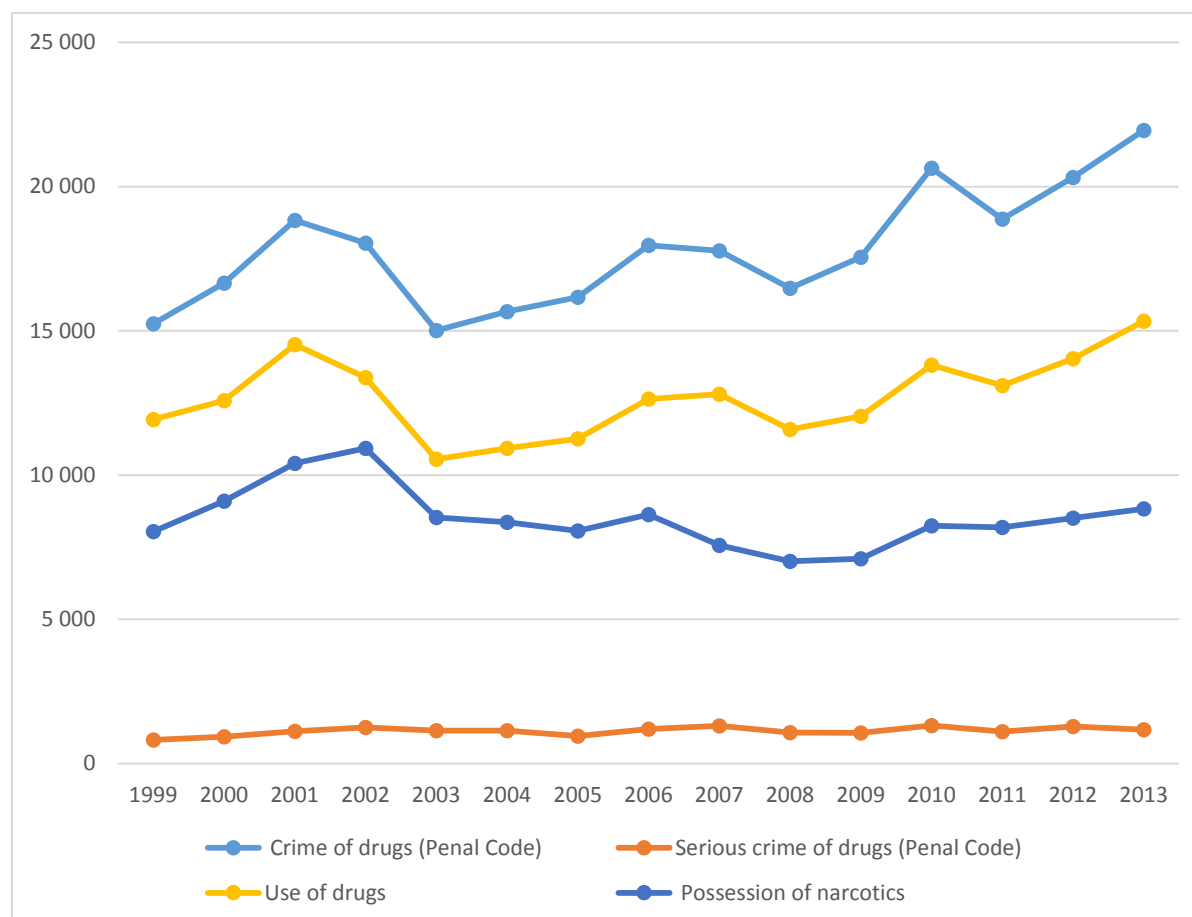
In addition, 25,300 violations of the Act relating to Medicinal Products were reported in 2013. They mainly concern the use and possession of small quantities of illegal drugs. This is almost an eight per cent increase from 2012, and in the last few years, there has been an increase in offences involving the use of illegal drugs in particular. The 15,300 reported incidents of drug use in 2013 represent an increase of more than nine per cent from the year before, and the number is higher than in all the previous years .

Geographically, Oslo was the county with the highest level of reported drug offences in 2013, both in terms of absolute numbers and adjusted for population size. In Oslo, however, the number of reported drug offences was the same as in 2012, while most other counties recorded fairly large increases.

Drug crimes have the highest clear-up rate of all the crime categories, with an annual rate of nearly 90 per cent. This can be explained by the many cases involving the use and possession

of small quantities of drugs. In such cases, the offender often confesses to the crime ‘on the spot’ without further investigation being required.

Figure 11: Offences reported to the police, by type of drug offence, 1999–2013. Absolute figures



Source: Statistics Norway

8.1.3 Charges

More charges and persons charged, especially with drug offences

In 2013, investigations by the police and prosecution authorities resulted in a total of 174,700 charges against 82,300 different persons. That is almost 1,200 more charges and 1,350 more persons charged than in 2012. The increase was largest for drug offences. A total of 19,623 persons were charged with more than 39,300 drug offences in 2013. This is an increase of nine and eight per cent, respectively, from 2012. A large proportion of those charged with drug offences, 26 per cent, were also charged with other offences that carry a higher maximum sentence. These are classified under another primary group of offences, which means that 14,538 persons were charged with a drug offence as their primary offence, as shown in Table 7. This is 1,450 more than in 2012, and a considerably higher figure than in all previous years for which statistics are available. The increase, and the historically high numbers, relate to

persons charged with violations of the General Civil Penal Code and persons charged with violations of the Act relating to Medicinal Products. Persons charged with drug offences as their primary offence accounted for 39 per cent of all persons charged with crimes in 2013.

Increasing number of young people charged with drug offences

Table 7 shows that as many as 84 per cent of those charged with drug offences as their primary offence in 2013 were men. The increase from 2012 is clearly greater for men than for women. In relation to the previous year, the increase is greatest among young people in the 15–20 age group, with almost 22 per cent more persons being charged. The increase is greater for Norwegian nationals in absolute figures, but, as a percentage, the increase was greater for non-Norwegian nationals. In 2013, non-Norwegian nationals accounted for one-fifth of all persons charged with drug offences as their primary offence.

Table 7: Persons charged with a drug crime as their primary offence 2004–2013

Year	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Men	8,093	8,049	8,357	8,657	8,560	8,777	10,102	10,938	10,857	12,217
Women	1,825	1,853	2,053	2,200	1,996	1,954	2,098	2,247	2,232	2,321
Total	9,921	9,902	10,410	10,857	10,556	10,731	12,200	13,185	13,089	14,538

Source: Statistics Norway

Recidivism – lower proportion but still highest for drug offences

The statistics for recidivism among people resident in Norway show that 45 per cent of the 79,000 persons charged in 2008 were charged once or more in the next five-year period. This proportion has steadily decreased in recidivism surveys in the last six years. For persons charged in 2002, it was almost 50 per cent.

Broken down by crime category, the highest recidivism rate, almost 67 per cent (out of 9,600 persons in 2008), is found among persons charged with drug crime as their primary offence. The corresponding proportions among persons charged with violence or crimes against property were 55 per cent and 53 per cent, respectively.

Penal sanctions

The number of sanctions for crime in 2012 was 31,400. The number of cases was 5.3 per cent fewer than the year before. In absolute figures, the biggest decrease was for sanctions for drug crime as the primary offence. In 2012, 14,750 sanctions were imposed for this type of crime, which was 900 fewer than in the peak year of 2011 (15,700), but still on a par with 2010. Drug crime as the primary offence still accounted for 47 per cent of all penal sanctions in criminal cases, however, roughly the same proportion as in 2011.

Fewer unconditional sentences for drug crimes

In total, almost 10,000 unconditional sentences were imposed in 2012, which is 3.4 per cent fewer than the year before. Unconditional sentences for drug offences as the primary offence, mainly relating to Section 162 of the General Civil Penal Code, fell by far the most, decreasing by as much as 16 per cent.

Drug crime as the primary offence accounted for 1,670 of the unconditional prison sentences (both unconditional and partly unconditional/partly suspended/others). Of the offenders (cases, not persons), 194 were sentenced to imprisonment for use and possession of small quantities, mainly pursuant to the Act relating Medicinal Products, whereas use as the primary offence accounted for 160 sentences (Table 8). These are often complex cases, however, where other, less serious offences are taken into consideration in the overall sentencing (Statistics Norway, 2014).

Table 8: Unconditional prison sentences* as a sanction for use and possession as the primary offence, 2005–2012

Year	2005	2006	2007	2008	2009	2010	2011	2012
Drug use	142	122	156	167	94	187	205	160
Drug possession	37	39	20	32	25	46	47	34
Both	179	161	176	199	119	233	253	194

*Total unconditional sentences, partly unconditional/partly suspended/others
 Source: Statistics Norway

The report *Organised crime in Norway – trends and challenges 2012–2014* (Kripas, 2013) states that the majority of registered offenders in the less serious drug offences are Norwegian nationals, while foreign nationals are behind most of the aggravated drug offences. As of October 2012, 1,394 offences (suspected, charged or convicted) were related to Section 162 second and third paragraphs of the General Civil Penal Code. Of these, 79 were related to Section 162 third paragraph, which concerns the most serious drug crimes. The offenders were Norwegian nationals in 942 of these cases, 28 of which were related to Section 162 third paragraph. Foreign nationals were responsible for 452 offences, 51 of which were related to Section 162 third paragraph.

8.2 Prevention of drug-related crime

8.2.1 Action plan for the prevention of crime (2013–2016)

The action plan emphasises the prevention of crime committed by children and young people. The goal is to prevent children and young people from developing negative behaviour and committing crimes. If a crime has already been committed, the goal is to prevent a recurrence.

The action plan, which was drawn up by the Ministry of Justice and Public Security in cooperation with six other ministries, takes a broad approach. The plan contains 31 measures, such as strengthening the municipal police councils (crime prevention partnerships between the police and the municipalities), increasing knowledge about prevention and improving follow-up of young offenders. Several of the measures have been systematically tested, including follow-up teams for young offenders. The same applies to the more specific measures in the drugs and alcohol field mentioned in the plan, early intervention in relation to children and young people who can be at risk of developing problems (described in NR 2012 and 2013, Chapter 3) and measures aimed at improving the quality of drug and alcohol prevention work in schools. Moreover, emphasis is placed on increasing efforts to combat bullying, measures to ensure that people complete upper secondary school and follow-up of young people in the transitional phase between education and work.

To follow up the work on the action plan, annual reports will be prepared and published on the status of the measures in the plan. The status report for the first implementation year is not yet available (Ministry of Justice and Public Security, 2013).

8.3 Interventions in the criminal justice system

As of 1 January 2012, there were a total of 4,052 inmates in Norwegian prisons, including those serving their sentences at home with electronic monitoring and those remanded in custody. Of all inmates at the start of the year, 29 per cent were serving sentences for drug offences (2011: 30 %), 22 per cent for crimes against property and 21 per cent for violent crimes as their primary offence. Of the 910 persons held on remand at the start of 2012, 36 per cent had drug crime as their primary offence, approximately the same proportion as in 2011 (37 %).

8.3.1 Units for mastering drug and alcohol problems

A unit for mastering drug and alcohol problems is a reinforced unit in a prison. It functions as a separate unit that is specially adapted for inmates with drug or alcohol problems. The units are tasked with ensuring good cooperation between the correctional service, the specialist health service and the health and care services in prison. Steps also have to be taken to facilitate

coordination between the correctional service, the specialist health service and the municipal services when inmates return to society.

The specialist health service shall ensure that inmates' patient rights are safeguarded through continued treatment in an institution or an outpatient clinic upon their release. The unit for mastering drug and alcohol problems shall motivate and prepare people with drug or alcohol problems for continued treatment after their release from prison. Rehabilitation can continue either by the inmate being transferred to serve his/her sentence pursuant to Section 12 of the Execution of Sentences Act in a treatment or care institution, or by the inmate receiving treatment at an outpatient drug or alcohol clinic upon his/her release. Fourteen Norwegian prisons now have such units. The most recent one was opened in spring 2012.

Experience from the establishment of the units indicates that they need both a clearer framework and better professional follow-up. The then Ministry of Justice and the Ministry of Health and Care Services therefore started work in 2011 on a joint circular that clarifies the framework conditions and contains references to central regulatory provisions. In parallel, the correctional service's central administration and the Directorate of Health have appointed a select committee that has produced a professional guide for the units for mastering drug and alcohol problems. In order to monitor developments more closely, key figures are reported by the units on a monthly basis. The correctional service's education centre has started the work of evaluating the units.

In addition to units for mastering drug and alcohol problems, there is one Pathfinder unit for female inmates at Bredtveit prison (six places) in Oslo and one for men (20 places) in Oslo prison. The Pathfinder units offer rehabilitation and treatment for problem drug and alcohol users. They are a collaboration between the health authorities, the Tyrili foundation and the correctional service.

8.4 Alternatives to prison

Serving of sentences outside institutions pursuant to Section 12 of the Execution of Sentences Act ⁸

In 2013, 394 persons were serving sentences under this system, nine per cent of them women (Table 9). This figure is substantially lower than in previous years. A total of 236 persons started

⁸ Section 12 states that 'A sentence may in special cases be wholly or partly executed by 24-hour detention in an institution if such detention is necessary for improving the convicted person's capacity to function socially and law-abidingly, or there are other weighty reasons for doing so. The convicted

servicing their sentence in prison and were later transferred to an institution. The other 158 started servicing their sentence directly in a treatment institution. It must be assumed that the majority had a drug problem at the time of imprisonment.

In 2013, 30,837 days were served in an institution pursuant to Section 12, which is also a substantial decrease compared with all years in the period 2005–2012 (Table 10).

Table 9: Number of sentences started pursuant to Section 12, 2005–2013

Year	2005	2006	2007	2008	2009	2010	2011	2012	2013
Men	379	388	396	431	457	443	466	396	359
Women	59	51	61	74	84	68	60	56	35
Total	438	439	457	505	541	511	526	452	394

Source: Directorate of Norwegian Correctional Service

Table 10: Number of days served pursuant to Section 12, 2005–2013

Year	2005	2006	2007	2008	2009	2010	2011	2012	2013
Men	34,474	37,137	37,835	40,150	35,651	35,981	41,343	36,974	28,272
Women	3,786	4,347	4,224	4,841	5,963	4,796	4,344	4,516	2,565
Total	38,260	41,484	42,059	44,991	41,614	40,777	45,687	41,490	30,837

Source: Source: Directorate of Norwegian Correctional Service

Suspended sentence with a programme for driving under the influence

This sanction replaces the previous alcohol treatment programme. During the course of 2013, a total of 565 (2012: 523) suspended sentences were imposed on condition that the offender completed a programme for driving under the influence. A total of 85 per cent of the sentences were completed, and 77 per cent (2011: 81 %) were completed without the conditions being

person may be restrained against his or her will and brought back in case of escape, if necessary by force and with the aid of public authorities. The Correctional Services shall not decide on such execution if it is opposed to security reasons or there is reason to assume that the convicted person will evade the execution.'

breached or new crimes being committed. The statistics do not specify the types of drugs involved, however.

Suspended sentence with drug courts

In 2013, a total of 23 new sentences were imposed in Oslo and Bergen, while the number in 2012 was 29.

8.4.1 Evaluation of drug courts

The Norwegian drug courts trial scheme has been evaluated by SIRUS. A report was published in November (Falck, 2014).

Background

In 2006, a trial scheme of suspended sentences with court control was started in Oslo and Bergen. The programme was initially intended as a three-year trial project, but it has been prolonged until the end of 2014. The model is based on similar models with drug courts in Ireland, Scotland and the USA, with some modifications. Drug courts are an alternative criminal sanction for drug users who are recidivists in the criminal justice system. The district courts in Oslo and Bergen can decide to impose a conditional sentence as an alternative to unconditional imprisonment. The condition is that the offender attends the drug programme for a minimum two-year probationary period. The convicted person avoids imprisonment, but dropouts from the programme must normally serve their sentence in prison.

The purpose of the programme is to prevent new crimes and promote the rehabilitation of convicted persons. The drug courts programme is both a separate programme and a treatment facilitator. The courts' role has primarily been to impose the sentence, decide changes during the course of the programme (everyone had to complete four phases before they had finished) and, at the end of the probationary period, decide whether the programme had been satisfactorily completed or whether it had to be prolonged. The court decides whether dropouts from the programme have to serve the whole or parts of their conditional sentence in prison. The judges play a less active role in the day-to-day process than in most other countries.

Fewer participants than expected

Fewer participants than expected were recruited to the drug courts programme. Before the start-up in Bergen and Oslo, the programme expected about 100 participants a year, but the result was approximately 25. The explanations are mainly to be found outside the actual operation of the programme. It is partly due to restrictions on who could be sentenced to serve under the programme, and whether the convicted person accept the option as an alternative. The number of participants has been too small to have a substantial impact on the number of prison sentences imposed for drug-related crime. The low number also makes it more difficult to draw statistically generalised conclusions.

Results

The evaluation of the programme includes 115 of the first participants. They were interviewed after admission to the programme, and then followed up after one year (106 participants, 92 %) and after two years (96 participants, 83 %). The interviews addressed substance abuse, crime, physical and mental health problems and social issues of importance to integration.

Around one-third (34 %) of the participants completed the programme. The result can be seen as satisfactory and is on a par with results from other treatment programmes for heavy drug users. Those who dropped out tended to have more serious and complex problems than those who completed.

The follow-up survey, in which the participants reported on their own progress over two years, revealed the following:

More than four out of five of those who completed the programme were not in a controlled environment (prison or institution) after two years, while the same was true for only about 40 per cent of those who dropped out. Eight per cent (three persons) of those who completed the programme were in prison after two years, compared with half of those who dropped out.

All variables investigated based on the participants' self-reporting showed a positive trend (time in controlled environment, drug abuse, crime, psychiatric and somatic health, education, work and social relations). Those who completed the programme had better results than those who dropped out. Those who dropped out also showed a positive trend, but it was weaker than for those who completed the programme.

Two unfortunate factors placed limits on the evaluation. As mentioned, the programme had fewer participants than expected. Secondly, the research design was not optimal. For ethical and practical reasons, it was decided not to include a control group of prisoners in the study. The questionnaires were not adjusted or specially adapted to the drug court programme as a criminal sanction.

The project period runs until the end of 2014, but, in the proposed national budget, the Government proposes prolonging the trial period for the programme until the end of 2015. It also states that it is being considered whether to make the programme permanent from 2016.

8.5 Driving offences

In 2013, drug analyses were carried out by the Norwegian Institute of Public Health (NIPH) in 8,550 cases where drivers were suspected of driving under the influence (2012: 9,717 cases). In addition comes 1,368 breath tests for alcohol that were taken by the police locally. About 3,200 blood samples were analysed by the NIPH for alcohol only, while about 5,300 blood

samples were analysed for alcohol, intoxicating drugs and narcotic substances. The NIPH routinely looks for over 40 different intoxicating drugs and narcotic substances and detects an average of three drugs in the same blood sample. For several of the substances, the detection limit has been lowered since legal limits for driving under the influence of substances other than alcohol were introduced on 1 February 2012. See NR 2012 Appendix 1.

In 2012, clonazepam was for the first time the second most commonly found substance (38 % of all cases) after alcohol. Clonazepam maintained its “top position” in 2013, together with THC, each accounting for 35 per cent of the cases (Table 10). This may be partly explained by the lowering of the detection limit. This means that clonazepam is now found in some cases where the substance would not previously have been detected. The NIPH most often finds clonazepam in combination with illegal substances (methamphetamine/amphetamine etc.), which indicates that the substance is increasingly being sold and used as a drug. Other substances that were frequently found were amphetamine (32 %) followed by methamphetamine (29 %) and diazepam (20 % of all cases). The analysis findings do not necessarily indicate whether or not the substance was unlawfully obtained.

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

The fact that THC is found in a blood sample usually means that cannabis has been taken (usually smoked) relatively shortly before the sample was taken (Norwegian Institute of Public Health, www.fhi.no).

Table 11: Some findings of substances other than alcohol in blood samples from drivers suspected of driving under the influence, 2013. Number of blood samples for which a broad analysis was carried out.

Name of substance	Example of name of medicine Explanation	Number	Per cent
THC	Tetrahydrocannabinol, active agent in cannabis	1,897	35 %
Clonazepam	Rivotril ®	1,895	35 %
Amphetamine		1,726	32 %
Methamphetamine		1,526	29 %
Diazepam	Valium ® Vival ® Stesolid ®	1,061	20 %
Morphine	Heroin, Dolcontin®	196	4 %

The Drug Situation in Norway 2014

Codeine	Paralgin Forte®, Pinex Forte®		
Methadone	Methadone®	166	3 %
Buprenorphine	Subutex®, Temgesic®, Subuxone®	163	3 %

Source: the Norwegian Institute of Public Health

9 Drug markets

9.1 Availability

Several factors must be emphasised when describing 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, as well as by surveillance methods and international cooperation. Big seizures in particular can be the result of surveillance and investigations carried out over time. 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. The number of seizures must be deemed to be a better indicator of availability than the amount seized.

Measured by seizures, the most common illegal substances are still geographically widespread. In 2013, all the 27 police districts made seizures of cannabis, heroin, BZD and amphetamines, whereas cocaine was seized in 26 districts. It must be emphasised, however, that the quantities vary greatly between the different police districts. For cocaine and heroin, the seizures are often small. For example, the amount of heroin seized was around ten grams or less in eight of the police districts, and in three of these, the total seizure amounted to as little as a user dose or less. The biggest markets are still the Oslo area and its surrounding regions, and in the counties of Hordaland and Rogaland, including the cities of Bergen and Stavanger. Moreover, the customs authorities in Østfold county make many large seizures, which can largely be explained by its proximity to the most important border crossings to Sweden, where large parts of the drug trafficking to Norway take place by road and by train from Denmark and the continent.

9.1.1 About amphetamine and methamphetamine in particular

The relationship between amphetamine and methamphetamine in Norway has been the subject of attention for several years. The seizure figures are a clear indication that methamphetamine has partly taken over the market for amphetamines (Chapter 9.3). Norway seems to be among the European countries with the biggest market for methamphetamine, and Norway has topped the EMCDDA's statistics for the number of seizures for several years running. Moreover, analyses of wastewater in Oslo carried out in 2011 by the Norwegian Institute for Water Research (NIVA) show a high incidence of methamphetamine, higher than in all the 19 European cities that were part of the survey, except two (Thomas et al., 2012). A similar study (Ort et al., 2014) carried out in 2012 (25 cities in Europe) and in 2013 (42 cities) shows that methamphetamine use decreased considerably in the period 2011–2013. However, with the exception of cities in the Czech Republic, Slovakia and Eastern Germany, the survey showed

that Oslo still has a high level of consumption compared with cities in other countries included in the survey.

Next to THC (cannabis), amphetamine and methamphetamine are the illegal substances that were most often found in traffic cases in 2013 (Chapter 8.5).

Based on other parameters, however, there is scant knowledge about the prevalence measured. Prevalence surveys among young people/young adults and the general population do not ask about methamphetamine in particular. This is because it is assumed that the respondents are unable to distinguish between the two amphetamines to any great extent. The purity of analysed seizures varies considerably. The effect of strong amphetamine can therefore feel like methamphetamine, and vice versa. There are still very few, if any, indications that methamphetamine is in particular demand in a market in which amphetamine and methamphetamine are sold interchangeably and where users do not know what they get. The seizure figures can be interpreted to mean that methamphetamine mostly comes in addition to all the amphetamine that is smuggled in every year, and not so much as a replacement.

9.2 Supply

9.2.1 Smuggling routes to Norway

Updated information from Norwegian Customs and Excise is available as of the first half-year 2014. See also NR 2013 for information about the first half-year 2013.

Seizures of *amphetamine* made by the customs service in the first half-year 2014 decreased somewhat in quantitative terms compared with the first half-year 2013, but the number of seizures remained stable.⁹ The trend whereby amphetamine is sent in the post continued. The customs service made several seizures of liquid amphetamine/methamphetamine during the period. This included amphetamine oil/base and amphetamine solution. The shipments in question came from Poland or Lithuania. *Methamphetamine* in crystallised form is probably a Norwegian phenomenon, seen in relation to the other Nordic countries, and the drug has mainly been manufactured in and smuggled from the Czech Republic.

The customs service has no information to indicate that there are any changes in producing countries for *hash* smuggled to Norway. Big, individual seizures affect the statistics, and in the first half-year 2014, approximately 250 kg more hash was seized than in the corresponding

⁹ Seizures made by the customs service are included in the overall national statistics prepared by Kripos. See Chapter 10.3.

period the year before. The Netherlands is an important transit/shipping country for hash to Norway, and two big seizures hidden in goods shipments were seized in the first half-year. Denmark continues to be an important reloading country for hash to Norway. The trend of airline passengers smuggling hash inside their bodies from North Africa via Spain continued, which means that Spain is still an important source country.

As regards *marijuana*, the customs service made several seizures, but the quantities were smaller than in the same period the year before. Most of the seizures came from Sweden and Poland, from passengers crossing the border. Unlike in 2013, no seizures from South-East Europe were made in the first half-year 2014 that would have confirmed the theory that it is largely marijuana produced in Albania that is smuggled to Norway.

The customs service recorded a marked increase in the amount of *GBL* seized in the period. It mainly came from Poland, Sweden and China, but also Denmark and the Netherlands. The two biggest seizures were made from passengers arriving by train and bus from Denmark and Sweden, while postal shipments were the most common method. *GHB* is smuggled in small quantities from Denmark, the Netherlands and the UK.

Heroin is primarily smuggled to Norway from transit countries in Northern Europe. Two of the biggest seizures made in the first half-year came from Hungary and Macedonia, however. This confirms that the Balkan route is also an important smuggling route to Norway. Some seizures were made of heroin smuggled inside the bodies of couriers from Poland and Belgium.

In total, there was only a small increase in the number of seizures of *khat* and in the quantities seized in the first half-year 2014 compared with the corresponding period the year before. Since *khat* was banned in the Netherlands in 2013, the UK has maintained its status as the most important source country for *khat* to Norway. More than 50 per cent of the seizures made were smuggled by airline passengers, primarily from London. The biggest quantities were smuggled in passenger cars via Sweden, Denmark and the Netherlands, with the UK as the European transit country. The UK introduced a ban that entered into force on 24 June 2014. This immediately affected smuggling to Norway, and lasting changes are expected in the smuggling situation.

The quantities of *cocaine* seized increased from an unusually low level in the first half-year 2013 to a level on a par with previous years in the first half-year 2014. The smuggling situation is as before, with shipments via the European continent, where Poland, Sweden and Spain are the main transit countries. Cocaine is produced in South America and it has often been smuggled via Africa in recent years. Seizures from this route are seldom made, but, in the first half-year 2014, the customs service made at least one seizure of a considerable quantity of cocaine from West Africa.

The customs service still uncovers large quantities of *sedatives*, but not quite as much as in the first half-year 2013. The seizures mainly concern clonazepam and diazepam. The first has been smuggled from Romania and is most probably produced in Hungary. Most seizures are made of shipments in the post from Hong Kong, Thailand and from passengers travelling from Spain and Sweden.

The amount of ecstasy tablets seized in the first half-year 2014 was stable compared with the corresponding half-year 2013. Most seizures were made from shipments sent by post from Germany. The customs service also seizes MDMA in powder form. These seizures were almost exclusively made from shipments sent by post from Belgium, the Netherlands and Spain. It has been uncovered that ecstasy tablets, but also amphetamine and MDMA in powder form, are being produced in the Netherlands and sent from Germany. Intelligence has found that an organisation in the Netherlands is intentionally shipping its products from Germany since there is less risk of shipments from Germany being checked than shipments from the Netherlands. Internally, the customs service refers to this as 'laundering the route'.

New psychoactive substances are still a priority area for the customs service. The substantial decrease in numbers and quantities continues for synthetic cannabinoids. As a result of the generic scheduling of synthetic substances that entered into force in February 2013, the number of seizures and the quantity of other synthetic psychoactive substances seized have increased. The seizures mainly concern shipments by post or courier, primarily from the Netherlands, Hungary, Poland and Spain (Personal communication, Directorate of Customs and Excise Enforcement Department, Anti-Smuggling Section).

9.2.2 Criminal networks

The report *Den organiserte kriminaliteten i Norge – trender og utfordringer 2013–2014* ('Organised crime in Norway – trends and challenges 2013–2014') (Kripas, 2013) describes different international groups that, in the police's opinion, are behind a large part of the importation and distribution of drugs in Norway.

Baltic and Polish networks

Lithuanian groups seem to be the main suppliers of methamphetamine to Norway, while they are also associated with other drugs. Extensive sales of amphetamine and/or methamphetamine by Lithuanian and Polish nationals are reported by many police districts. People from Lithuania and Poland who have permanent residence and legitimate work in Norway are deemed to be important points of contact for Lithuanian and Polish criminal networks.

Networks from the Balkans

The Balkans are known as a hub for the smuggling of different types of drugs to and from the EU, especially heroin, but increasingly also other types of drugs. Europol reports that Albanian-

speaking groups collaborate with Lithuanian groups on heroin smuggling from Central Asia to Western Europe. Several police districts report activities relating to the import and distribution of hash, marijuana, amphetamine, cocaine and heroin that can be linked to networks from the Balkans. Criminal networks from the West Balkans and Turkey could become more active in other European countries as a result of Bulgaria and Romania's accession to the Schengen Area.

Moroccan networks

Moroccan networks have a central role in the importation of hash to Norway. They have proved adept at collaborating with different criminal gangs in Norway.

Vietnamese networks

The Vietnamese community in Europe is involved in extensive marijuana cultivation in several European countries, and indoor plantations are traditionally organised in a hierarchic structure. Several Norwegians nationals of Vietnamese origin have been known to cultivate marijuana in Norway. Close ties have also been found between the Vietnamese communities in Norway and the Czech Republic. People of Vietnamese origin who cultivate marijuana usually run several small plantations.

Somali networks

Use of the stimulant khat is part of the Somali culture. The use of khat in the Nordic countries and north-western Europe is most widespread in areas in which large Somali communities have settled. Khat is usually smuggled to Norway by Somali couriers by land, while couriers who arrive by plane are often European nationals. The Somali community is also associated with the sale of relatively large quantities of heroin to the open drug scene in Oslo.

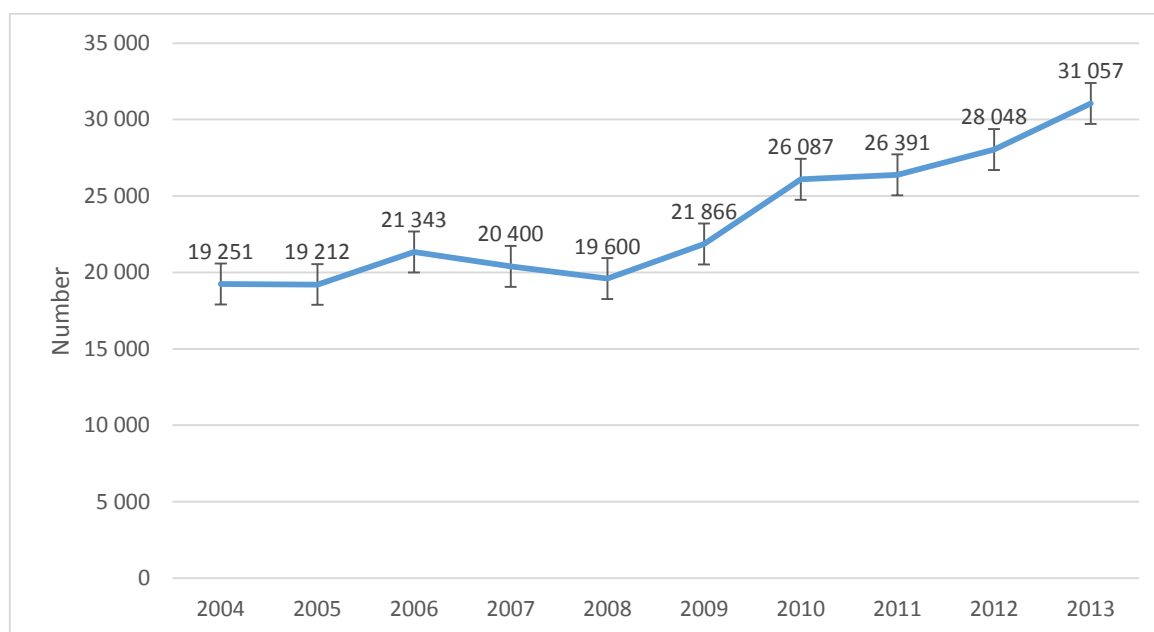
West African networks

Criminal groups from West Africa, especially Nigeria, have been associated for many years with the smuggling of cocaine and heroin in particular. Statistics showed a ten-fold increase from 2000 to 2009 in the number of drug offences for which people of West African descent were either suspected, charged or convicted. The number of cases doubled from 2008 to 2010 (Kripos, 2013).

9.3 Seizure statistics

Drug statistics from the National Crime Investigation Service (Kripas) are national statistics of seizures made by both the customs service and the police. The number of drug cases¹⁰ has never been higher, representing an increase of nearly 11 per cent from 2012, which was also an all-time high (Figure 12). There were 31,057 cases in 2013, compared with 28,048 in 2012. Since the mid-2000s, the number has increased by more than 50 per cent. The fact that the number of cases has increased may be due to increased importation and availability, but it is probably also a result of the police and customs service's activities and priorities during the year in question. Some uncertainty is attached to the figures. Approximately 65 per cent of the drug cases are minor cases that are settled by a fine without the type of substance being verified by analysis. In these cases, the assumed drug type forms the basis for the statistics. In today's drug market, with many new psychoactive synthetic substances, however, the sources of error in connection with this information will be greater than before.

Figure 12: Number of drug cases registered by Kripas, 2004–2013.



Source: Kripas

¹⁰ By case is meant an assignment logged by Kripas. The number of cases is irrespective of the use of the terms use, possession, sale and import in the prosecution. This means that an offence is only registered as one case by Kripas.

9.3.1 Main trends, as described by the National Criminal Investigation Service

Cannabis

The number of cannabis seizures has increased every year since 2008. In 2013, a total of approximately 16,300 seizures were made of hash, marijuana and cannabis plants. This is an increase of 12 per cent compared with 2012. While the number of hash seizures has been relatively stable in recent years, the number of seizures of cannabis plants and marijuana has increased considerably. In the early 2000s, marijuana and cannabis plants accounted for 10–12 per cent of the total cannabis seizures. In recent years, this proportion has steadily increased, and marijuana and cannabis plants now account for approximately one-third of all cannabis seizures. The extent of cannabis cultivation in Norway is probably considerable. In total, almost three tonnes of hash, marijuana and cannabis plants have been seized, the same as in the record year 2011.

Amphetamine/methamphetamine

A total of 535 kg of amphetamine and methamphetamine have been seized in approximately 7,200 seizures. These are very high figures, as regards both the quantity and the number of seizures. Only in 2007 and 2010 were the quantities seized and the number of seizures higher. In the last two years, several relatively big seizures have been made of ‘crystal meth’, a very pure methamphetamine quality with a purity of more than 90 per cent. Some seizures have also been made of amphetamine oil, intended for conversion into amphetamine in powder form.

Cocaine

A total of 200 kg of cocaine was seized in almost 1,100 seizures. Both the amount seized and the number of seizures are the highest ever recorded. The number of seizures is almost 20 per cent higher than in 2012.

Heroin

In 2013, the number of heroin seizures decreased for the third year in a row, to around 1,200 seizures. The quantity seized – approximately 55 kg – is higher than in the two preceding years, however.

Ecstasy (MDMA)

Following a strong decline in the number of seizures and the quantity seized in 2009–2010, ecstasy (MDMA) is now being seized more and more often. In addition, the substance is significantly more frequently seized as a powder than as tablets. All the seizures of powder where the potency has been determined involve very pure qualities of 85–95 per cent MDMA. Based on the assumption that a traditional tablet contains 100 mg of MDMA, even a few grams

of powder contain many user doses. Seizures have also been made of precursors for the production of MDMA in Norway.

Benzodiazepines

The number of benzodiazepine seizures and the quantities seized remain high. Benzodiazepines are the third most commonly seized drug after cannabis and amphetamine/methamphetamine. In Oslo, however, benzodiazepines are in second place, after cannabis but ahead of amphetamine/methamphetamine. Of the benzodiazepines, it is clonazepam tablets (primarily Rivotril) that dominate. The seizures of clonazepam account for 62 per cent of the quantity seized and 50 per cent of the number of seizures of benzodiazepines.

GHB/GBL

For the first time since 2008, there has been a slight decrease in the number of seizures of GHB/GBL, from 559 seizures in 2012 to approximately 520 seizures in 2013. The quantity seized in 2013 was approximately 175 litres, which is considerably less than the 400–500 litres seized each year in the three preceding years.

Doping

Approximately 120,000 units (tablets, ampoules, vials) and 4.7 kg of powder have been seized in just over 560 seizures of anabolic androgenic steroids. That is on the same level as in the last few years. The use and possession of doping substances was criminalised on 1 July 2013, but last year was too early to say whether this has had an effect on the development of seizures. Seizures of active agents, ampoules and other items that can be linked to illegal domestic manufacturing and the sale of doping substances were made in both 2012 and 2013 (Kripós, 2014).

9.3.2 Development in seizures for individual substance groups

The development in the number of seizures¹¹ and quantities seized for individual substance groups is shown in the tables below. The data are based on information available as of September 2014, but uncertainty is still attached to some of the figures, since not all analyses have been completed for the 2013 drug cases. In general, however, little change is expected in

¹¹ Seizure: A case can often involve several seizures. It may involve different types of substances, or the seizures have been made in different places and at different times. Individual packages containing the same type of drug are regarded as one seizure if the seizures were made at the same time and place, however.

the quantities and number of cases when the seizures are verified by chemical analyses, and the effects on the main trends are expected to be negligible.

Table 12: Amounts seized for the most relevant drugs 2011–2013*

Year	2011	2012	2013
Cannabis resin (kg)	2,548	1,612	2,283
Herbal cannabis (kg)	219	329	491
Cannabis plants (kg)	214.1	141.9	159
Amphetamine (kg)	72	177.4	318.2
Amphetamine (tablets (units))	64	23,830	128
Methamphetamine (kg)	156.6	131.3	195.5
Methamphetamine (tablets (units))	2,159	269	298
Ecstasy-type substances (kg)	0.35	1.67	2.71
Ecstasy-type substances (tablets (units))	5,497	6,610	7,298
Cocaine (kg)	46.2	47.5	187.7
Heroin (kg)	13.3	44.5	55.1
Benzodiazepines (units)	803,653	1,331,553	1,152 931
LSD (units)	885	1,404	5,782
GHB/GBL (ltr)	524	402	168
Synthetic cannabinoids (kg)	10.4	5.2	2,7

* The data have been corrected as of September 2014 for several drugs after final analyses have been carried out.

Source: Kripas

Table 13: Number of seizures in the period 2011–2013 broken down by type of drug*

Drug type	2011	2012	2013
Cannabis resin	11,131	11,102	11,875
Herbal cannabis	3,629	4,471	5,444
Cannabis plants	381	384	386
Amphetamine	2,497	2,344	3,019
Methamphetamine	3,997	3,890	4,210
Ecstasy-type substances	201	285	411

The Drug Situation in Norway 2014

Cocaine	815	912	1,086
Heroin	1,314	1,262	1,192
Benzodiazepines	5,185	5,830	5,857
LSD	31	85	97
GHB/GBL	524	559	523
Synthetic cannabinoids	199	313	285

*The data have been corrected as of September 2014 for several drugs after final analyses have been carried out.

Source: Kripos

Table 14: Number of seizures in the period 2006–2010 broken down by type of drug

Drug type	2006	2007	2008	2009	2010
Cannabis	11,221	9,952	10,599	11,754	14,372
Amph./methamph.	5,819	5,507	5,153	5,775	7,714
Heroin	1,087	1,204	1,145	1,430	1,575
Benzodiazepines	4,500	4,058	3,451	3,796	5,089
Painkillers/ opioids	1,161	959	936	1,078	1,223
Cocaine	726	909	854	804	877
Ecstasy	411	421	309	110	79
LSD	28	13	15	26	30
GHB/GBL	122	188	173	321	432
Psilocybin mushrooms	82	77	54	75	114
Synthetic cannabinoids					9

Source: Kripos

Table 15: Proportion of seizures of methamphetamine in relation to amphetamine

Year	2006	2007	2008	2009	2010	2011	2012	2013
% Methamph.	26 %	35.3 %	43.5 %	64.3 %	56 %	60 %	62.4 %	58.3 %

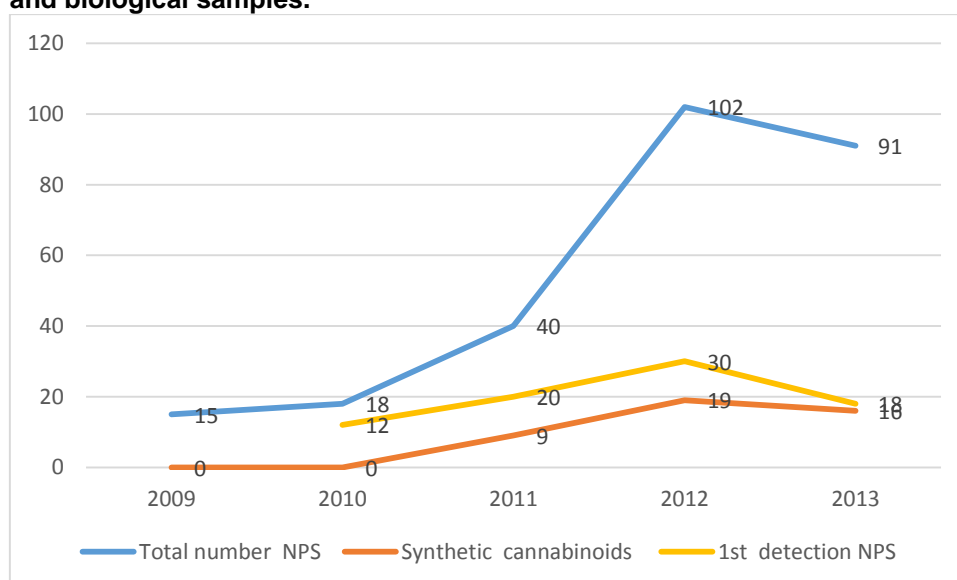
Source: Kripos

9.3.3 New psychoactive substances (NPS)

A total of 620 seizures were made in 2013 of what can be designated new psychoactive substances, divided between 91 different substances. Some of these are on the list of narcotic substances or covered by the group definition, while several others are not yet regulated. The vast majority are new chemical compounds.

In 2013, 81 newer *synthetic* substances were reported by the Norwegian Focal Point to the EMCDDA's Action on New Drugs programme. The data are based on analyses of seizures by the police and customs service, and biological samples analysed by the Institute of Public Health. The figure does not include GHB, GBL, MDMA and ketamine, which can no longer be regarded as new substances in this context. The number is slightly lower than in 2012 (90), but four times as high as in 2010. Eighteen of the synthetic substances were reported from Norway for the first time, which is lower than in 2012 (30). Figure 13 shows the development.

Figure13: New psychoactive substances 2009–2013. In Numbers. Based on analyses of seizures and biological samples.



Source: Kripos, the Customs and NIPH

Many of the new substances fall under the group definitions in the new Regulations relating to Narcotics that entered into force in February 2013 (discussed in NR 2013 Chapter 1.1), but some also fall outside these groups. The new psychoactive substances that were most frequently seized in 2011 and 2012, including JWH-018 and AM-2201, were included on the list of narcotic substances in 2012. These substances are now in decline. New substances keep emerging, however, but, in general, few seizures are made of each individual drug. The provisional seizure figures for the first half-year 2014 show that there is a clear tendency for substances that are regulated by law to lose popularity, while some substances that are neither on the list of narcotic substances nor covered by the new group definitions are gaining ground.

Of the ten most frequently seized new psychoactive substances, half are not regulated by the Regulations relating to Narcotics.

9.4 Purity and potency of illegal drugs and tablets

The average purity of the traditional powder substances has shown a general decline since the early 2000s. However, variants of traditional substances of particularly high potency have also emerged, such as ‘crystal meth’ with a purity of more than 90 per cent. Another example is crystalline MDMA with a purity of 85–95 per cent. Several seizures have also been made of top shoots of cannabis plants and hash with a particularly high potency.

Table 16 shows that the average purity of brown *heroin base* is still low, with an average of 15 per cent in the last three years. A typical mixture can contain 5–10 per cent heroin and a large proportion of alprazolam, which causes stronger and more untraditional intoxication symptoms. Such mixtures are registered in both heroin seized at the border and in seizures made in the user milieu.

Table 16: Average purity of brown heroin 2005–2013

Year	2005	2006	2007	2008	2009	2010	2011	2012	2013
Purity percentage	26 %	30 %	36 %	31 %	25 %	21 %	15 %	13 %	17 %

Source: Kripas

The average purity of *amphetamine* was about 30 per cent in 2013, while it was 35 per cent for *methamphetamine*, with an average of 25 per cent and 35 per cent, respectively, in the last three years. This is a considerable decline in purity for both substances compared with the average for the years before (Table 17). The purity of analysed seizures can vary substantially, however, from less than one per cent to more than 90 per cent.

Table 17: Average purity of amphetamine and methamphetamine 2005–2013

Year	2005	2006	2007	2008	2009	2010	2011	2012	2013
Amphetamine	45 %	43 %	38 %	34 %	29 %	28 %	25 %	20 %	30 %
Methamphetamine	50 %	55 %	44 %	39 %	44 %	44 %	38 %	33 %	35 %

Source: Kripas

The average purity of *seized cocaine* decreased steadily until 2009, from as much as 69 per cent in 2000 to 25 per cent in 2009 (Table 18). The level has since been between 31 and 37 per cent. Phenacetin, xylocain and caffeine are often found as additives.

Table 18: Average purity of cocaine 2000 and 2005–2013

Year	2000	2005	2006	2007	2008	2009	2010	2011	2012	2013
Purity percentage	69 %	50 %	35 %	39 %	37 %	25 %	37 %	31 %	33 %	34 %

Source: Kripas

As regards the average THC content in the cannabis seizures, there are unfortunately insufficient data for 2013 concerning both cannabis resin and herbal cannabis. In 2012, the average THC content for herbal cannabis was estimated to nearly 11 per cent, while it was around six per cent in 2010–2011.

9.5 Price of illicit drugs at retail level

Stable nominal prices for user doses – decline in real prices

The latest overview of estimated drug prices from Oslo Police District is from around December 2013. Compared with the previous overviews from May 2010 and October 2008, the nominal price of a typical user dose for the most common drugs in the Oslo area has remained relatively stable. Corrected for inflation, however, this indicates lower real prices compared with price overviews from the same source in 2008 and 2010.

The estimated prices in 2013 were¹²: EUR 25 (NOK 200) for 0.2 grams of heroin, EUR 12.5–18.75 (NOK 100) for 0.2 grams of amphetamine, EUR 37.5–50 (NOK 300–400) for 0.5 grams of cocaine. For cannabis resin, however, the price varied between EUR 12.5 and 18.75 (NOK 100–150) for 0.7 grams, while it has been stable at EUR 12.5 for a number of years. The prices vary with the quality to some extent. This applies to cannabis products in particular, where there are many different qualities on the market.

The nominal prices of larger quantities of cannabis (5–10 grams) seem to have increased for high qualities. For example, the price of 10 grams of cannabis resin was estimated to be EUR 87.5–187.5 (NOK 700–1,500) in 2013, while it was EUR 87.5–100 (NOK 700–800) in 2010. The same applies to herbal cannabis, where the price of 10 grams was estimated to be EUR 125–187.5 (NOK 1,000–1,500) in 2013, while it was around EUR 125 (NOK 1,000) in 2010.

For heroin, the nominal price of 5–10 grams seems to have been relatively stable since 2010, but it is falling compared with 2008. For example, the price of five grams is now estimated to be EUR 225–375 (NOK 1,800–3,000), while it was between EUR 313 and 438 in 2008. For

¹² Conversion rate used: 1 EUR=NOK 8.00. Note: During 2013, the exchange rate has varied considerably, from approx. NOK 7.20 to 8.50

cocaine, the price of five grams has dropped from EUR 438 to EUR 250–375 (NOK 2–3,000). For amphetamines, the changes are only marginal. As regards ecstasy, the price level as a whole has remained stable. The price per tablet was around EUR 12.5–25 (NOK 100–200), and EUR 3.75–8.75 (NOK 30–70) per tablet when purchasing 100 tablets. As mentioned before in this context, price lists of this kind must be treated with considerable caution. However, since the data have been collected from the same source for several years, some comparison is possible.

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Lists of graphs

Figure 1: Cannabis use in 2012 and 2013*	21
Figure 2: Cannabis use across age groups*	22
Figure 3: Use of illegal drugs*	24
Figure 4: Lifetime prevalence of illegal drugs by gender*	25
Figure 5: Use of prescription drugs*	27
Figure 6: Use of prescription drugs across age groups*	28
Figure 7: Estimated injecting drug use 2004–2012	30
Figure 6: Drug-related deaths in 2012 broken down by substance groups. Number	46
Figure 7: Drug-related deaths broken down by age group, 1997–2012. Per cent	48
Figure 8: Drug-related deaths broken down by age group, 2012. Numbers	48
Figure 9: Drug-related deaths broken down by gender, 1997–2012. Per cent	49
Figure 10: Drug-related deaths in 2012* broken down by county	50
Figure 11: Offences reported to the police, by type of drug offence, 1999–2013. Absolute figures ...	64
Figure 12: Number of drug cases registered by Kripos, 2004–2013	79
Figure 13: New psychoactive substances 2009–2013. In Numbers. Based on analyses of seizures and biological samples.	84

List of Tables

Table 1: Injected/not injected amphetamines and/or heroin last four weeks. In numbers	33
Table 2: Patients in specialised treatment during 2013. Number	37
Table 3: Annual occurrence of deaths during treatment in the OST programme 2003–2013. Number and converted in proportion to the number of patients in OST (deaths per 100 patient-years)	39
Table 4: Reporting of HIV infection and Aids, Norway 1984–2013. Percentage of injecting drug users by year of diagnosis	42
Table 5: Drug-related deaths 1991–2012. Total number of deaths and deaths broken down by gender. Figures from Kripos and Statistics Norway (underlying cause of death)	45
Table 6: The injection room in Oslo. Statistics 2005–2013	55
Table 7: Persons charged with a drug crime as their primary offence 2004–2013	65
Table 8: Unconditional prison sentences* as a sanction for use and possession as the primary offence, 2005–2012	66
Table 9: Number of sentences started pursuant to Section 12, 2005–2013	69
Table 10: Number of days served pursuant to Section 12, 2005–2013	69
Table 11: Some findings of substances other than alcohol in blood samples from drivers suspected of driving under the influence, 2013. Number of blood samples for which a broad analysis was carried out.	72
Table 12: Amounts seized for the most relevant drugs 2011–2013*	82

Table 13: Number of seizures in the period 2011–2013 broken down by type of drug*	82
Table 14: Number of seizures in the period 2006–2010 broken down by type of drug	83
Table 15: Proportion of seizures of methamphetamine in relation to amphetamine.....	83
Table 16: Average purity of brown heroin 2005–2013	85
Table 17: Average purity of amphetamine and methamphetamine 2005–2013	85

List of relevant websites in English:

Ministry of Health and Care Services:

<http://www.regjeringen.no/en/dep/hod.html?id=421>

Norwegian Directorate of Health:

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

Norwegian Institute of Public Health:

<http://www.fhi.no/eway/?pid=238>

Norwegian Centre for Addiction Research:

<http://www.seraf.uio.no/eng/>

Statistics Norway:

<http://www.ssb.no/english/>

Norwegian Institute for Alcohol and Drug Research:

<http://www.sirus.no/internett/OmSirus?language=en>



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