European Monitoring Centre for Drugs and Drug Addiction

Norway

Norway Country Drug Report 2019

This report presents the top-level overview of the drug phenomenon in Norway, covering drug supply, use and public health problems as well as drug policy and responses. The statistical data reported relate to 2017 (or most recent year) and are provided to the EMCDDA by the national focal point, unless stated otherwise.

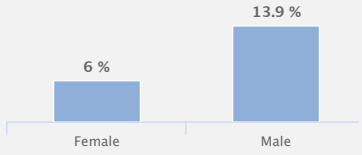
THE DRUG PROBLEM IN NORWAY AT A GLANCE

Drug use

in young adults (16-34 years) in the last year

Cannabis

10.1 %



Other drugs

MDMA	2.2 %
Amphetamines	0.8 %
Cocaine	2.1 %

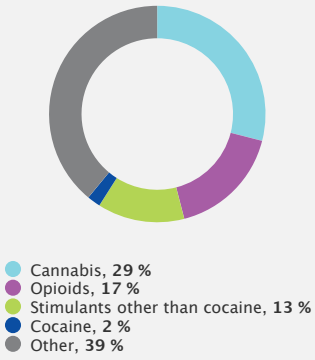
High-risk opioid users

9 015

(6 708 - 13 977)

All treatment entrants

by primary drug



Opioid substitution treatment clients

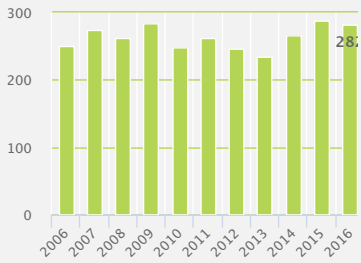
7 622

Syringes distributed

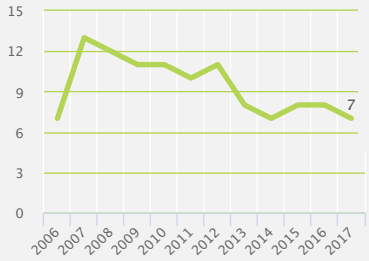
through specialised programmes

2 884 230

Overdose deaths



New HIV diagnoses attributed to injecting



Source: ECDC

Drug law offences

33 585

Top 5 drugs seized

ranked according to quantities meas
kilograms

1. Cannabis resin
2. Amphetamine
3. Herbal cannabis
4. Heroin
5. Cocaine

Population

(15-64 years)

3 445 785

Source: Eurostat Extracted on: 18/03/2019

NB: Data presented here are either national estimates (prevalence of use, opioid drug users) or numbers reported through the EMCDDA indicators (treatment clients, syringes, deaths and HIV diagnoses, drug law offences and seizures). Detailed information on methodology and caveats and comments on the limitations in the information set available can be found in the EMCDDA Statistical Bulletin. Other substances under treatment entrants include clients entering treatment because of poly-drug use, which accounts for 27 % of treatment entrants. Estimate of high-risk opioid users is from 2013.

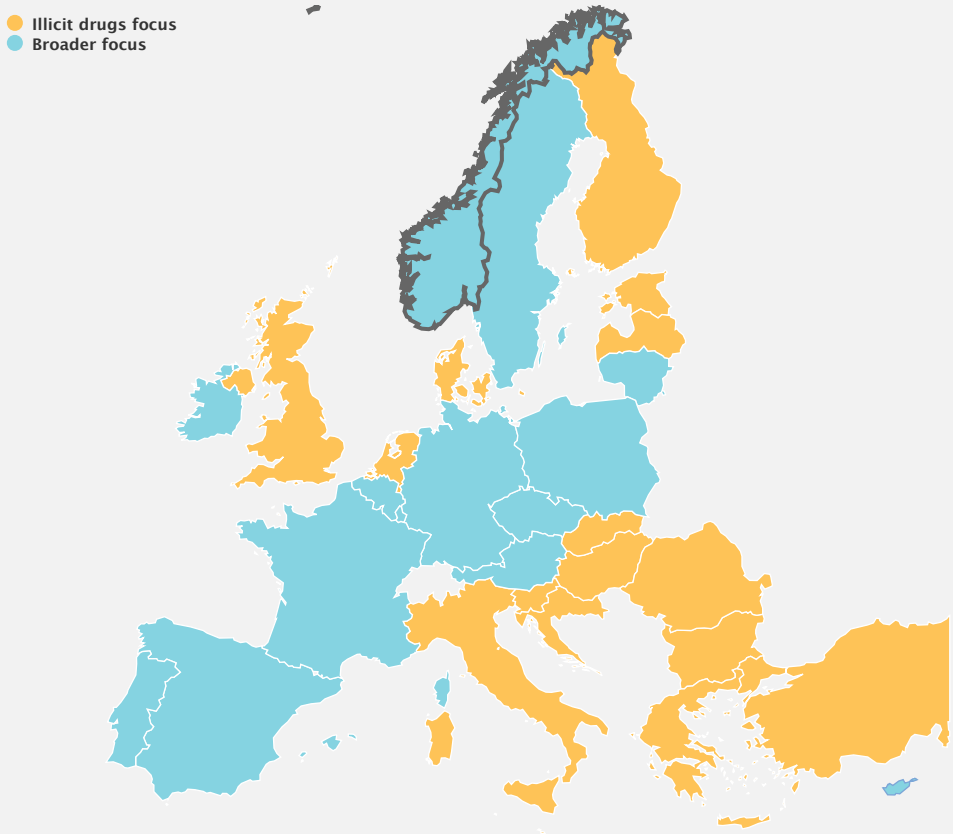
National drug strategy and coordination

National drug strategy

In 2015, the Norwegian government presented a new action plan addressing substance use and addictions: 'Prop. 15 S: The Action Plan for the Alcohol and Drugs Field (2016-20)'. This plan, which succeeded white paper no 30 (2011-12), serves as the current national drugs strategy document; it has retained the fundamental principles, which promoted a comprehensive alcohol and drug policy covering alcohol, illicit drugs, addictive medications and doping. The integrated action plan comprises and prioritises activities for prevention, early intervention, treatment and aftercare for individuals with substance abuse problems. It has five main goals: (i) ensure that individuals at risk of developing a substance use problem are identified and given timely assistance; (ii) ensure genuine user influence through free choice of treatment institution, more user-driven solutions and stronger user involvement in the design of services; (iii) ensure that all individuals have access to diversified, integrated services; (iv) ensure that all individuals lead an active and meaningful life; and (v) develop and increase the use of alternative penal sanctions. The Norwegian drug prevention policy is based on the fundamental principle of an inclusive society. Health promotion and prevention principles are regarded as key elements of this, and priority is given to early interventions. This policy includes restrictions on alcohol consumption, combating drugs through prohibition and targeting drug trafficking and organised crime. The national drugs strategy has been supported by other white papers and strategies with a more targeted focus. These include the prevention-focused 2014 public health white paper 'Coping and opportunities' and the National Overdose Strategy (2014-17).

Like other European countries, Norway evaluates its drug policy and strategy through ongoing indicator monitoring and specific research projects. A final internal evaluation of the National Action Plan for the Alcohol and Drugs Field (2007-12) was completed in 2012. It found that nearly all of the 147 measures outlined in the plan had been undertaken. In 2018, a process evaluation of Norway's National Overdose Strategy 2014-17 was completed. A process and outcomes evaluation of the Action Plan for the Alcohol and Drugs Field (2016-20) is being undertaken between 2017 and 2021.

Focus of national drug strategy documents: illicit drugs or broader



NB: Data from 2017. Strategies with a broader focus may include, for example, licit substances and other addictions.

National coordination mechanisms

The Ministry of Health and Care Services is responsible for the strategic and operational coordination of alcohol and drug

policy, while each ministry is responsible for the areas falling within its own remit. The Directorate of Health is responsible for the overall day-to-day coordination of alcohol and drug policy and is the government's primary adviser on health and social affairs matters. It is responsible for coordinating national prevention efforts and ensuring that health and social affairs policies are adopted and implemented in accordance with the Ministry's guidelines. The municipalities are responsible for drug prevention and healthcare services for drug users. Four regional health authorities are responsible for providing the necessary specialist health services to the population in their regions. Seven regional drug and alcohol competence centres are responsible for carrying out a broad range of activities. Their main tasks are to stimulate the advancement of substance use prevention in the municipalities.

Public expenditure

Understanding the costs of drug-related actions is an important aspect of drug policy. Some of the funds allocated by governments for expenditure on tasks related to drugs are identified as such in the budget (‘labelled’). Often, however, most drug-related expenditure is not identified (‘unlabelled’) and must be estimated using modelling approaches.

There were no associated comprehensive budgets for the Norwegian National Action Plan on Alcohol and Drugs (2007-12); however, the government estimated that, between 2007 and 2011, approximately EUR 125 million of public funds was allocated to drug-related activities. Neither the method nor the data used to calculate this estimate could be assessed.

In the action plan for 2016-20, a budget of EUR 252 million (NOK 2.4 billion) was allocated to the drugs and alcohol field. In 2016 and 2017, the grant was increased by EUR 56 million (NOK 541 million) and EUR 46 million (NOK 446 million), respectively. In addition, around EUR 16 million (NOK 150 million) has been budgeted for interdisciplinary specialised treatment for illicit drugs and alcohol use in 2018.

Over the last decade, because of the decentralised health and social service systems in Norway, a large number of authorities, institutions and organisations have been involved in drug policy funding. The total size of and trends in drug-related public expenditure have not been estimated.

Drug laws and drug law offences

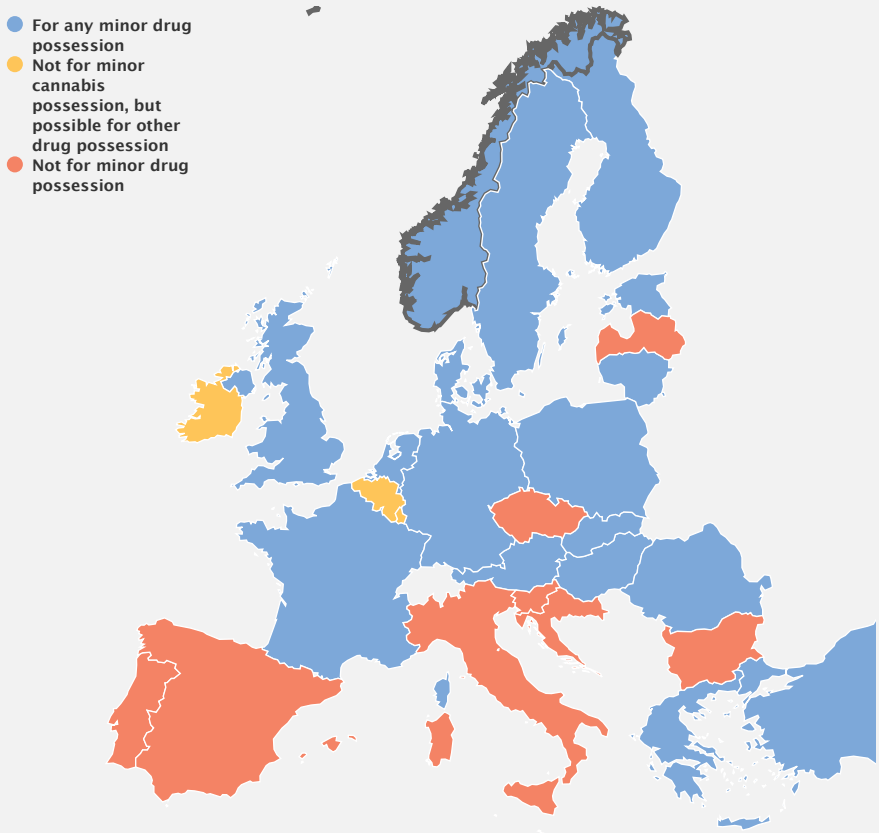
National drug laws

In Norway, there are no separate laws that relate only to illicit drugs. The use and possession of minor quantities of drugs fall under the provision of the Act on Medicinal Products. Penalties comprise fines or imprisonment for up to 6 months.

The manufacture, acquisition, import, export, storage and trafficking of narcotic drugs are prohibited by Penal Code § 231 and are punishable by a fine and/or imprisonment for up to 2 years. An offence may also be deemed aggravated by taking into consideration the type of substance involved, its quantity and purity, and the nature of the offence. As stated in Penal Code § 232, aggravated drug felonies are punishable by up to 10 years' imprisonment. If a 'considerable quantity' is involved, the term of imprisonment may be 3-15 years, and 'very aggravating' circumstances may result in a term of up to 21 years' imprisonment. The Act on Sentence Execution § 12 allows for voluntary treatment as an alternative to a prison sentence. This decision is made by the governor of the Prison Service Institutions, while the overriding responsibility lies with the Correctional Services of the Ministry of Justice. A drug treatment programme under court control has been in place since 2006.

Since 2013, controlled substances may be scheduled as groups of similar substances (generic scheduling) and/or as individual substances. Some substances are included on the list both as individual substances and as one of a group of substances.

Legal penalties: the possibility of incarceration for possession of drugs for personal use (minor offence)



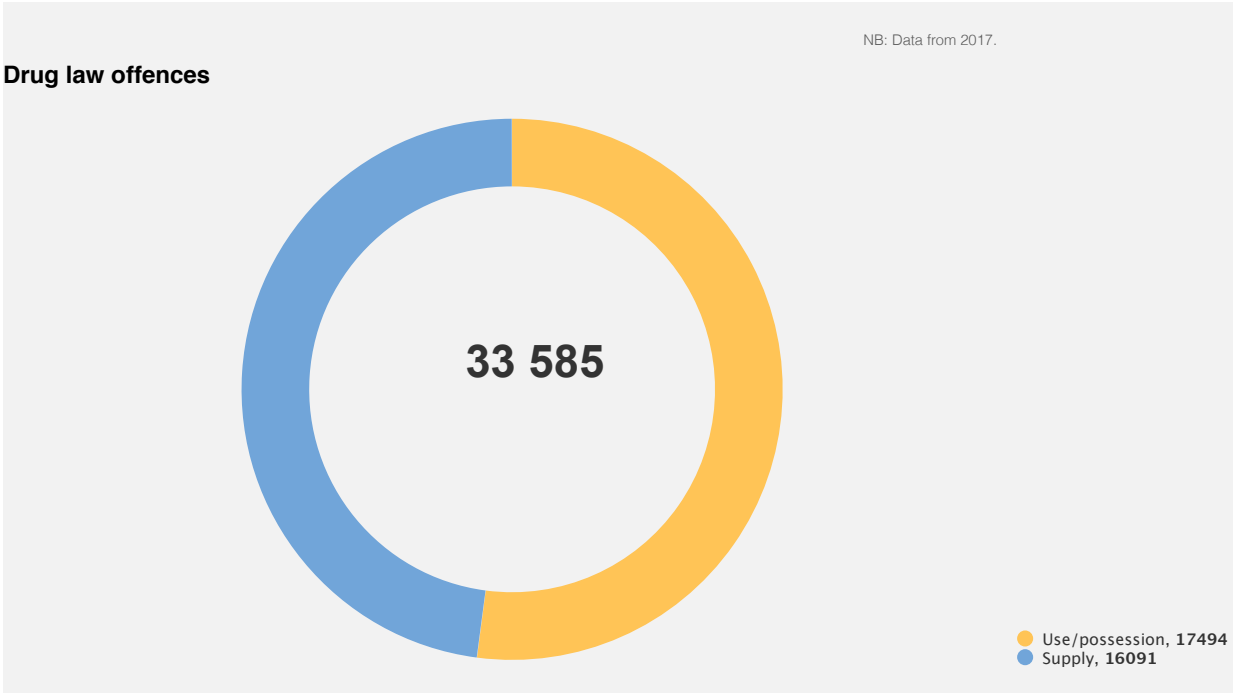
NB: Data from 2017.

Drug law offences

Drug law offence (DLO) data are the foundation for monitoring drug-related crime and are also a measure of law enforcement activity and drug market dynamics; they may be used to inform policies on the implementation of drug laws and to improve strategies.

The number of reported DLOs increased in Norway up to 2014, when over 48 000 DLOs were reported. In the following years, the number of reported DLOs reduced, reaching 33 585 in 2017. The available data indicate that 52 % are use- and possession-related offences and 48 % are supply-related offences.

Reported drug law offences in Norway



Drug use

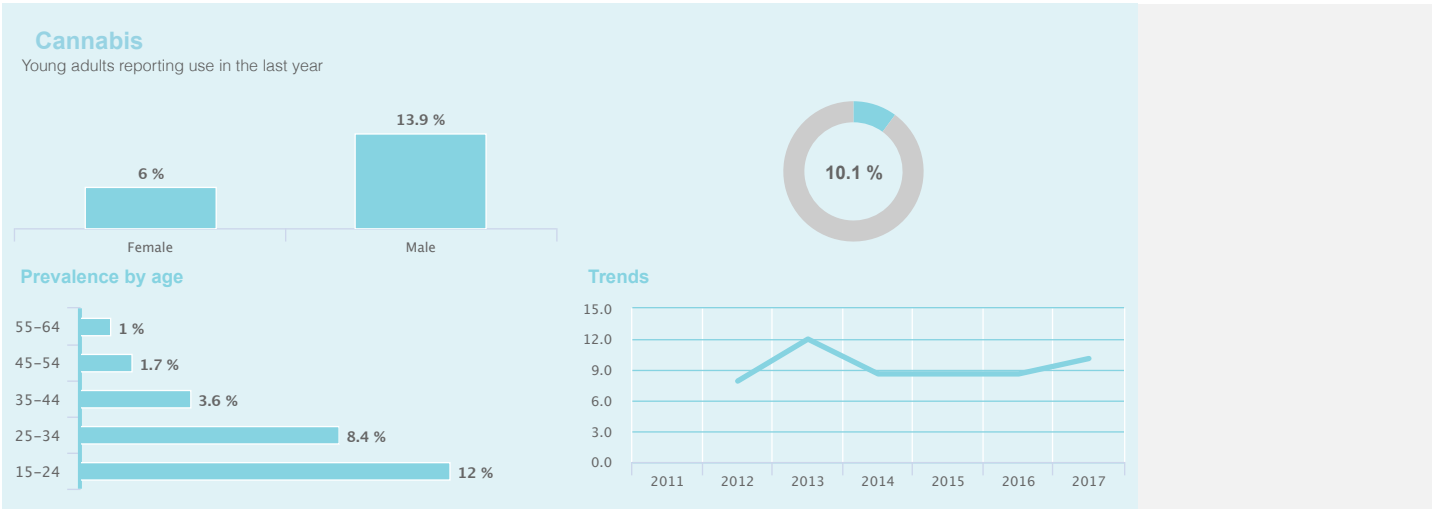
Prevalence and trends

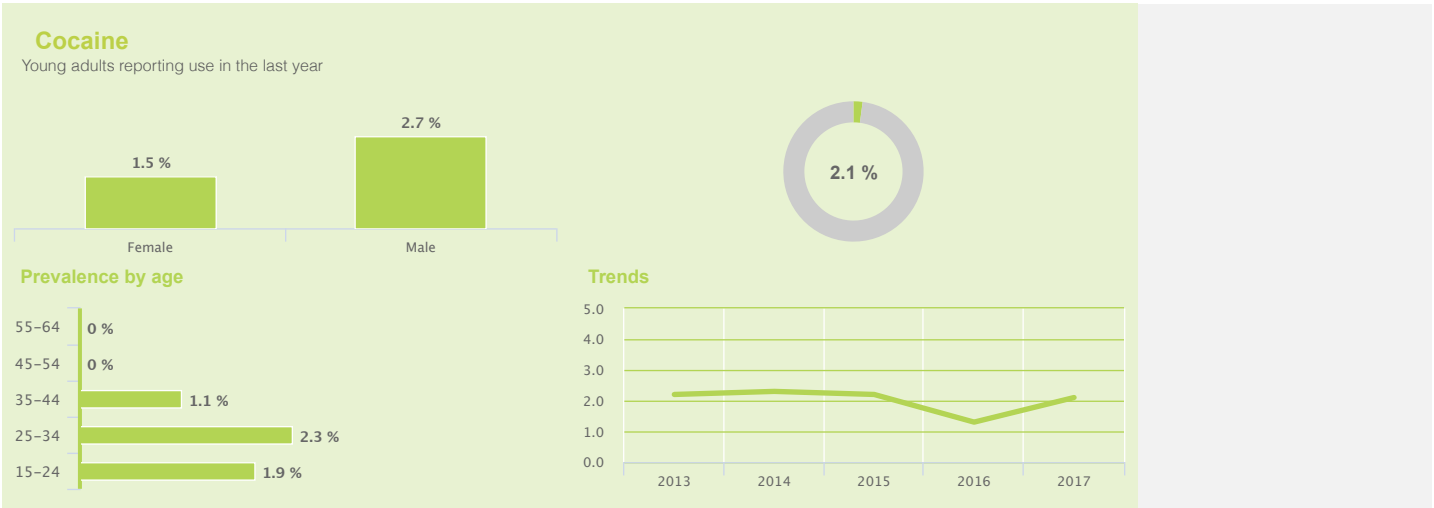
Data from the annual general population surveys carried out since 2012 indicate that cannabis is the most commonly used illicit drug among the general population in Norway, and its level of use has been relatively stable in recent years. In 2017, about 1 in 10 young adults reported having used cannabis in the last 12 months. Use of all other substances is reported to be lower, with MDMA/ecstasy being the most prevalent illicit stimulant drug used, though at similar levels to cocaine. The use of illicit drugs is concentrated mostly among young adults, and with reported prevalence rates generally higher among males than among females.

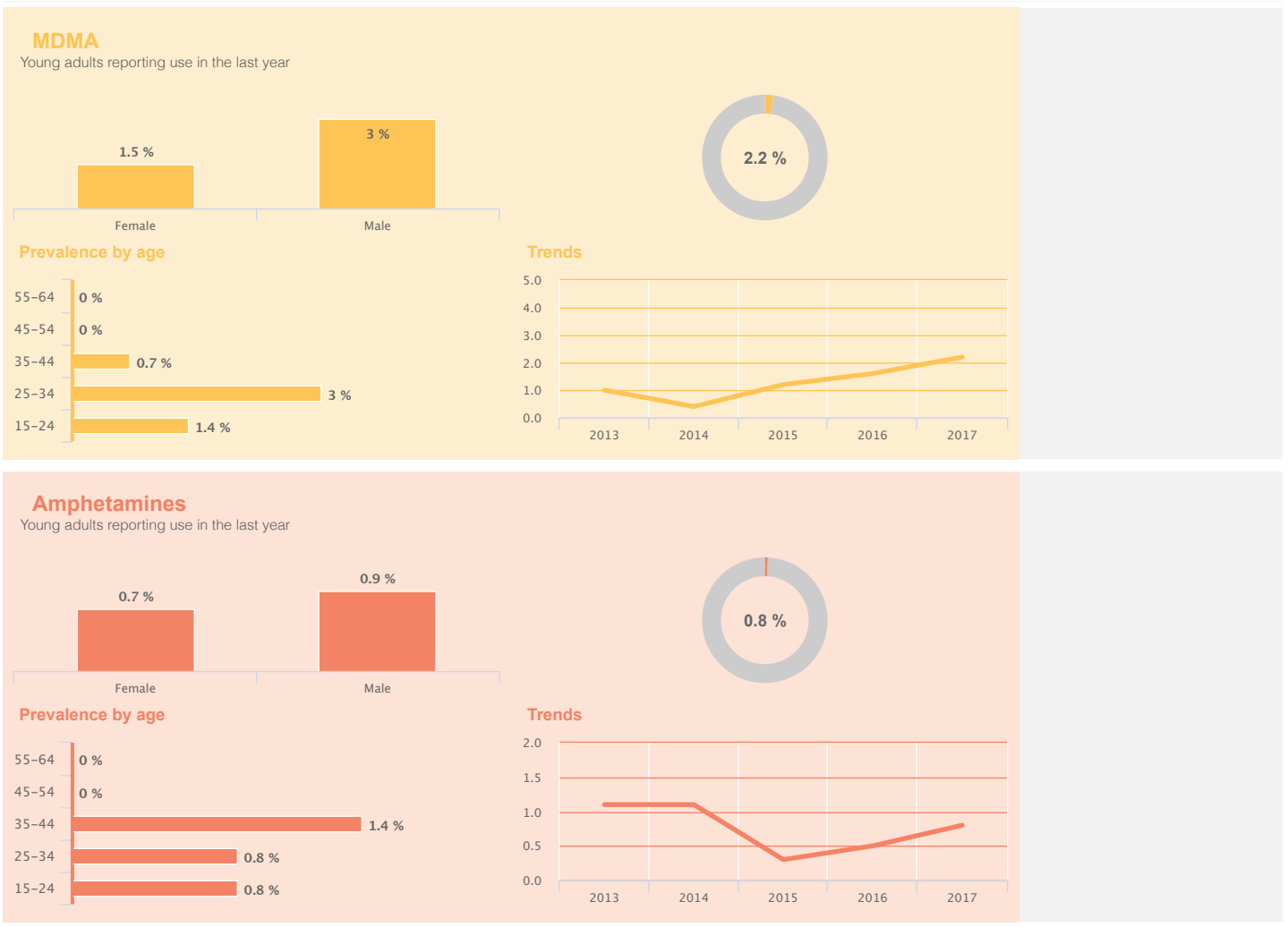
The prevalence of use of new psychoactive substances (NPS) is very low among the adult general population, and studies indicate that experimentation with these substances may be more common among young people in nightlife settings. In a targeted survey in the nightlife scene, 7 % reported lifetime use of new psychoactive substances, while 1 % reported having used such substances in the past year.

The city of Oslo participates in the Europe-wide annual wastewater campaigns undertaken by the Sewage Analysis Core Group Europe (SCORE). This study provides data on drug use at a municipal level, based on the levels of illicit drugs and their metabolites found in wastewater. The increase in levels of the stimulant MDMA reported in 2016 was followed by a sharp decrease in 2017. In 2018, a very slight increase was observed. Oslo was among the European cities with relatively high methamphetamine levels in wastewater. A decreasing trend was observed between 2014 and 2016, but an increase in the levels of metabolites found was reported in 2017, although levels remained lower than in 2011-14. In 2018, the levels of metabolites found were the lowest ever. However, amphetamine levels seem to be increasing.

Estimates of last-year drug use among young adults (16-34 years) in Norway

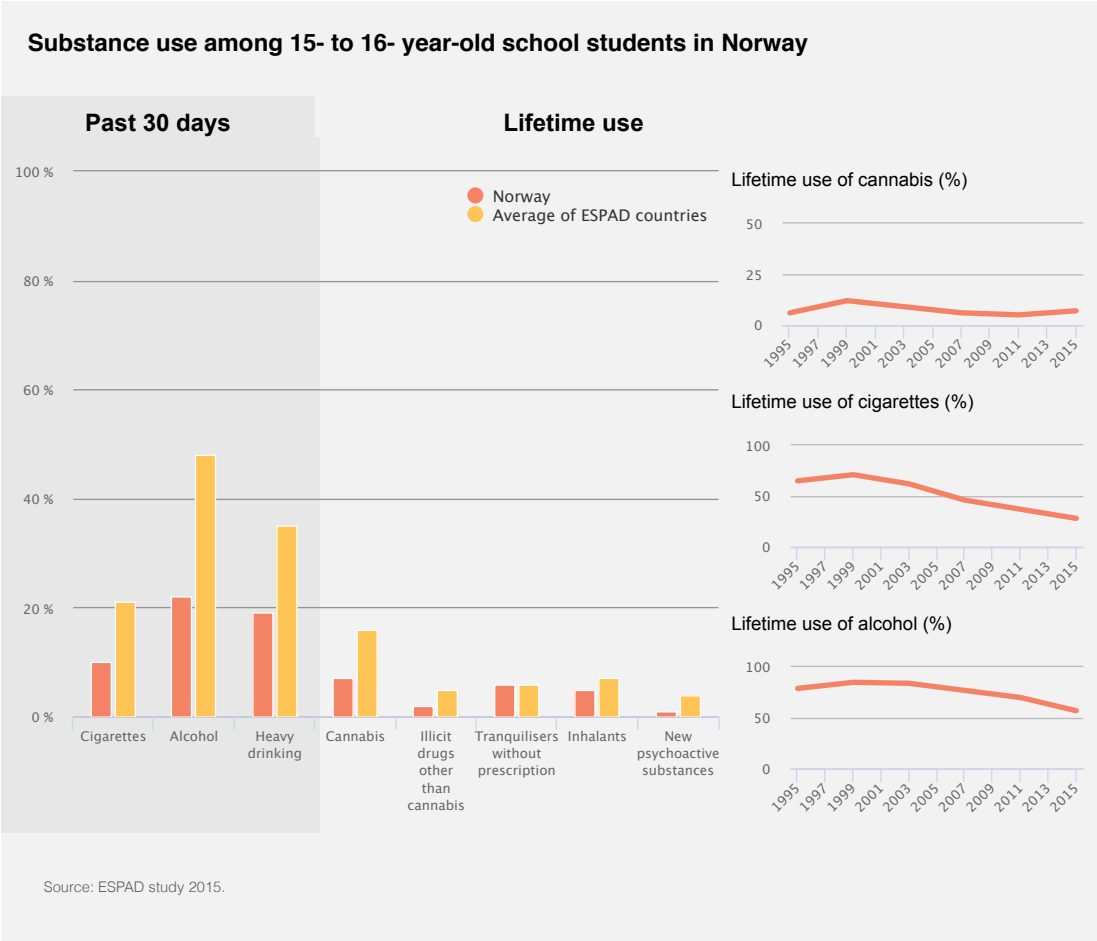






NB: Estimated last-year prevalence of drug use in 2017. Data under the label 15-24 years corresponds to 16-24 years.

Drug use among students aged 15-16 years is reported in the European School Survey Project on Alcohol and other Drugs (ESPAD), which has been conducted in Norway since 1995, and the latest data available are from 2015. Compared with the ESPAD averages (based on data from 35 countries), Norway has a low prevalence of substance use. Norwegian students reported lower than average prevalence rates for lifetime use of cannabis, lifetime use of illicit drugs other than cannabis and lifetime use of NPS. The proportions of students reporting alcohol use in the last 30 days, heavy episodic drinking and cigarette use in the last 30 days are all less than half the ESPAD average.



High-risk drug use and trends

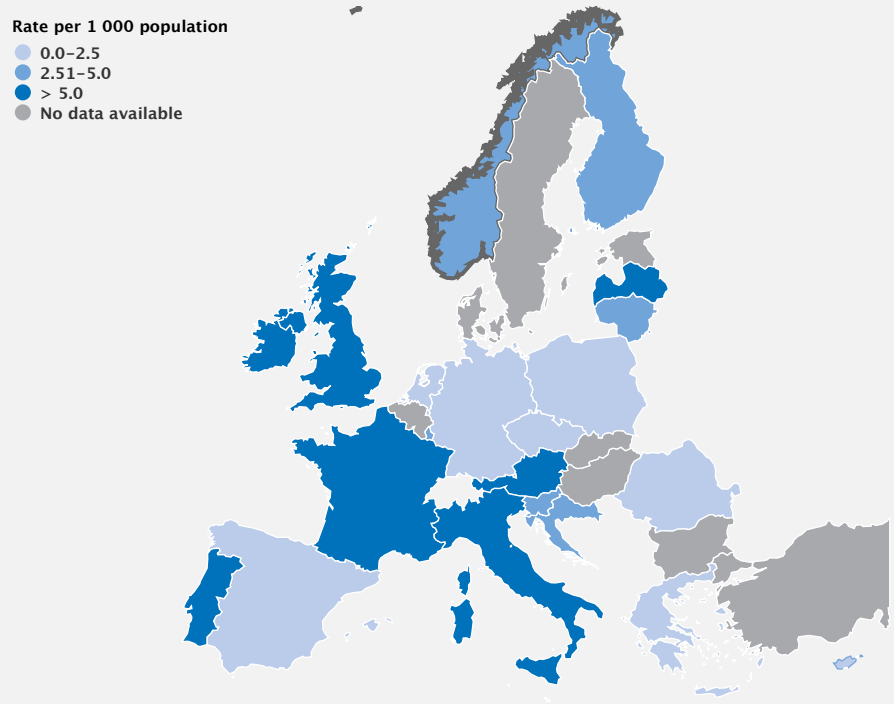
Studies reporting estimates of high-risk drug use can help to identify the extent of the more entrenched drug use problems, while data on first-time entrants to specialised drug treatment centres, when considered alongside other indicators, can inform an understanding of the nature of and trends in high-risk drug use.

High-risk drug use in Norway is linked mainly to injecting amphetamines and opioids, primarily heroin. The estimated number of people who inject drugs (PWID) has stabilised since 2012, following a decline during 2008-12. The PWID population was estimated at around 8 700 in 2016 (2.5 per 1 000 inhabitants aged 15-64 years). Injecting is very common among marginalised amphetamine users.

Based on data from the general population surveys, it has been estimated that 0.3 % of 16- to 64-year-olds in Norway use cannabis daily or almost daily, although daily or almost daily cannabis use is far more common among vulnerable groups, such as homeless drug users.

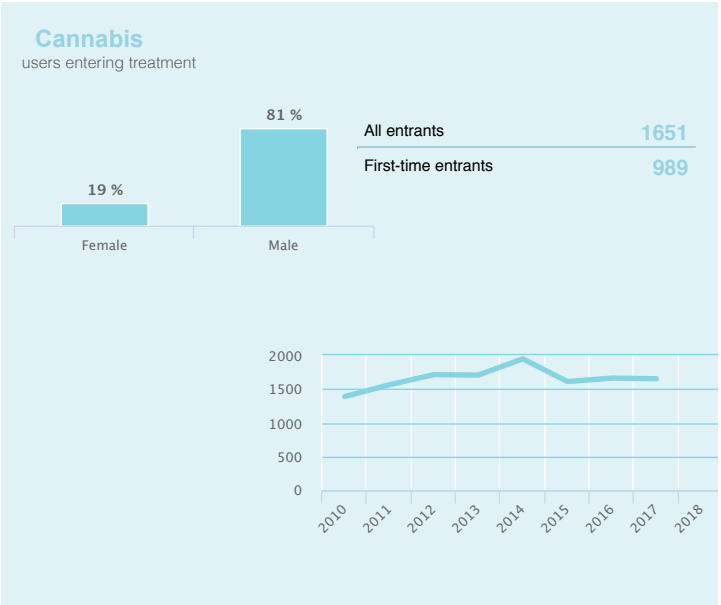
The long-term analysis indicates that there has been a decrease in the number of clients seeking treatment as a result of opioid and amphetamines problems and an increase in clients entering treatment for cannabis-related problems. Few clients have entered treatment for use of cocaine. In addition, a substantial proportion of clients entering treatment report more than one problem drug, and opioids are frequently reported in a polydrug context. The proportion of females entering treatment varies by type of primary drug used and by type of programme.

National estimates of last year prevalence of high-risk opioid use



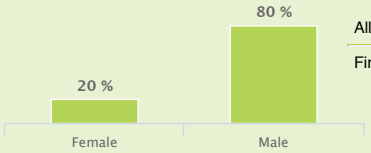
NB: Data from 2017, or the most recent year for which data are available.

Characteristics and trends of drug users entering specialised drug treatment in Norway

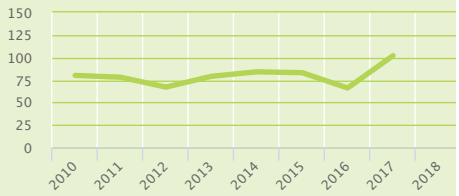


Cocaine

users entering treatment

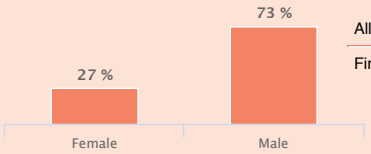


All entrants	102
First-time entrants	72

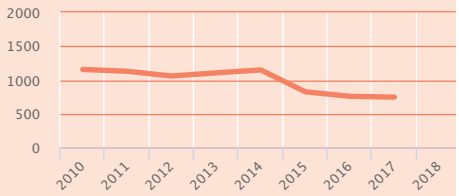


Stimulants other than Cocaine

users entering treatment

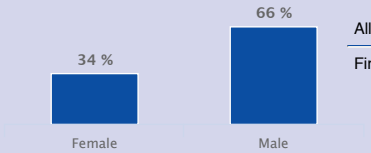


All entrants	744
First-time entrants	277

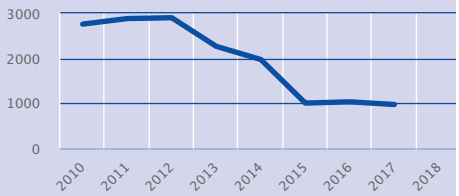


Opioids

users entering treatment



All entrants	973
First-time entrants	302



NB: Data from 2017.

Drug-related infectious diseases

In Norway, drug-related infections are notified through the Norwegian Surveillance System for Communicable Diseases (MSIS), and these results are complemented by the results of infectious disease testing among people who inject drugs (PWID) in various treatment and harm reduction settings at national and sub-national levels.

The number of newly diagnosed cases of human immunodeficiency virus (HIV) infection among PWID remains relatively low and has remained stable over recent years. Overall, the reported number of (both acute and chronic) cases of hepatitis C virus (HCV) infection has been in decline since 2008; however, the available data suggest that around 8 out of 10 cases of HCV infection in which the transmission route is known are linked to drug injecting. The most recent data on HIV and HCV prevalence among clients tested in treatment and harm reduction settings confirm that the prevalence of HIV infection is low, whereas the prevalence of HCV antibodies remains high.

Prevalence of HIV and HCV antibodies among people who inject drugs in Norway (%)

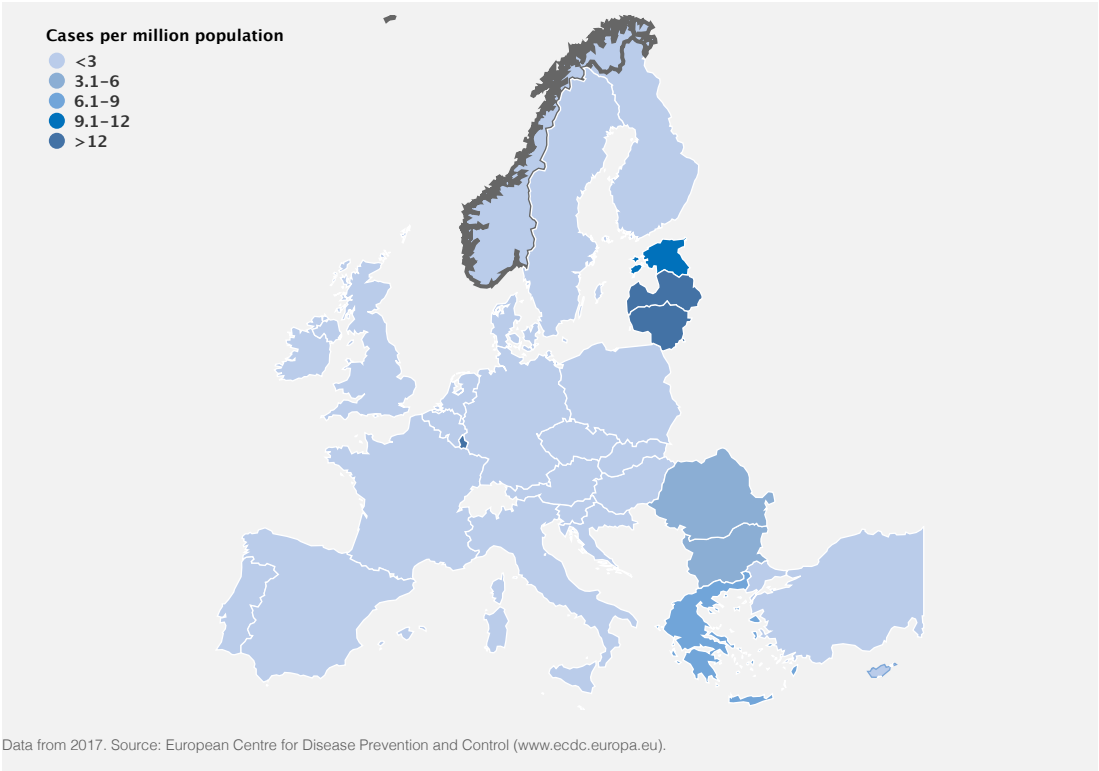
	Region	HCV	HIV
	National	49.7	1.43
	Sub-national	:	:

Data from 2017. Source: national opioid substitution treatment programme.

The number of reported cases of acute hepatitis B virus (HBV) infection among PWID increased between 1995 and 2008, but it has remained stable and low since then. Free-of-charge HBV vaccination has been offered to PWID since the mid-1980s. The latest prevalence estimate of chronic infection among PWID (2015) was 1 %.

Injecting remains the most common route of administration among high-risk drug users, who as a result are more susceptible not only to viral but also to bacterial infections, such as botulism. Between 1997 and 2015, a total of 27 cases of wound botulism were reported, including sporadic cases and minor outbreaks in the Oslo region in 2013, 2014 and 2015. Contamination of heroin or other substances mixed with the drug was considered the likely source of the infection.

Newly diagnosed HIV cases attributed to injecting drug use



Data from 2017. Source: European Centre for Disease Prevention and Control (www.ecdc.europa.eu).

Drug-related emergencies

In Norway, information on acute drug-related emergencies is available for Oslo and Bergen. Two hospitals from Oslo participate in the European Drug Emergencies Network (Euro-DEN) project, which was established in 2013 to monitor acute drug toxicity in sentinel centres across Europe. A recent analysis from the Euro-DEN project shows that co-use of heroin and benzodiazepines is common in patients presenting to emergency departments following acute drug toxicity across Europe,

but that there are regional differences in the kind of benzodiazepines that individuals report co-using. The most common benzodiazepine in the Norwegian cases (Oslo) was clonazepam. In another study on recreational drug toxicity in Oslo, new psychoactive substances were found in around 8 % of the cases, though they were not clinically suspected. However, it remains the case that majority of patients treated for recreational drug toxicity have consumed traditional drugs (amphetamines, heroin, benzodiazepines, etc.). The blood samples in this study were not screened for gamma-hydroxybutyrate (GHB), but several sources confirm the presence of GHB in drug-related acute emergencies. About a third (123 out of 361) of the drug-related call-outs registered by the Section for Acute Medicine (AMK) in Bergen between October 2016 and September 2017 were related to GHB/gamma-butyrolactone (GBL), and 118 out of 361 cases (33 %) were related to opioids.

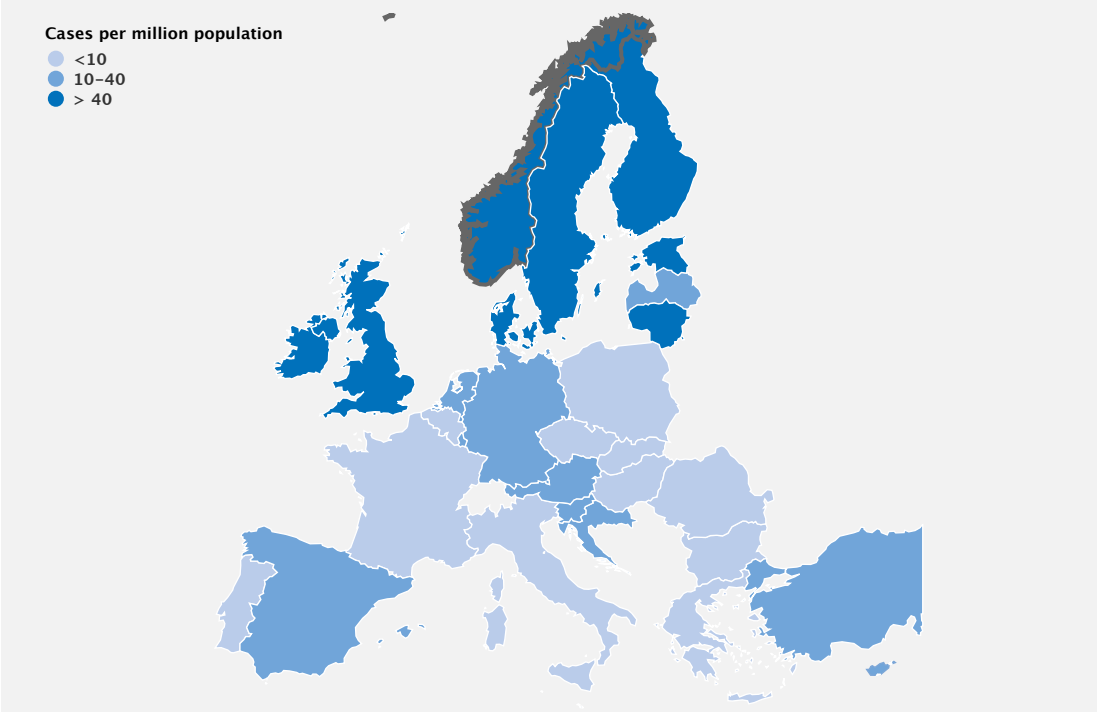
Drug-induced deaths and mortality

Drug-induced deaths are deaths that can be attributed directly to the use of illicit drugs (i.e. poisonings and overdoses).

In 2016, the Cause of Death Register reported a stabilisation in the number of drug-induced deaths compared with 2014 and 2015. The majority of deaths occurred in males. In recent years, there has been an increase in the age of those dying as a result of overdoses in Norway, and in 2016 the average age at time of death was 44 years. All 19 counties registered at least one overdose death in 2016, with the two biggest cities, Oslo and Bergen, accounting for the highest numbers. The main intoxicant in drug-related deaths was 'other opioids', such as the prescription opioids morphine and oxycodone (36 %), surpassing heroin as the most common opioid in overdose deaths.

In Norway, the latest average drug-induced mortality rate among adults (aged 15-64 years) was 75 deaths per million in 2016. Considering developments between 2003 and 2016, and the gradual population growth during the observed period, the trend is considered stable or slightly decreasing in terms of rate per capita. Comparisons between countries should be undertaken with caution. The reasons for this include different reporting systems, case definitions and registration processes, as well as under-reporting in some countries.

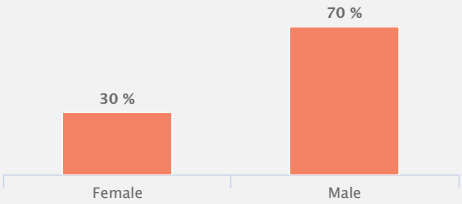
Drug-induced mortality rates among adults (15-64 years)



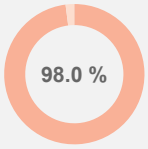
NB: Data from 2017, or the most recent year for which data are available. Comparisons between countries should be undertaken with caution. The reasons for this include systematic under-reporting in some countries, and different reporting systems, case definitions and registration processes. Data for Greece are for all ages.

Characteristics of and trends in drug-induced deaths in Norway

Gender distribution

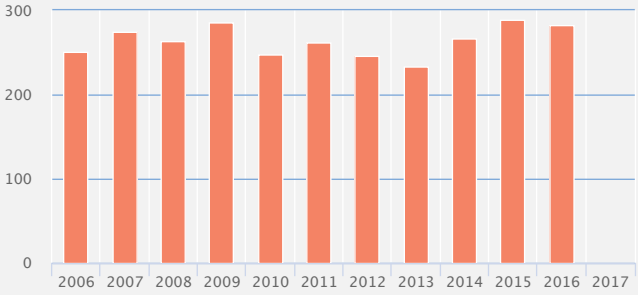


Toxicology

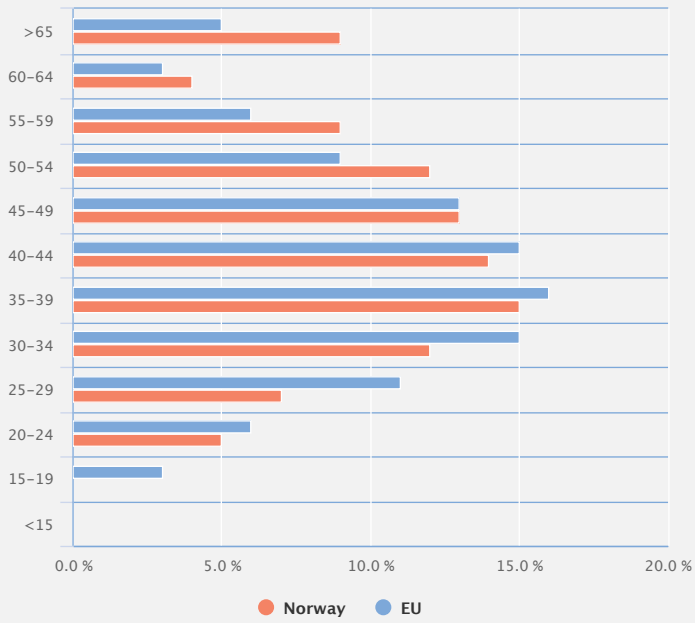


Deaths with opioids present among deaths with known toxicology

Trends in the number of drug-induced deaths



Age distribution of deaths in 2016



NB: Year of data 2016

Prevention

In Norway, the prevention of drug and alcohol use is an important public health priority that is emphasised in the white paper 'See me! A comprehensive drugs and alcohol policy' and is further elaborated in the National Action Plan for the Alcohol and Drugs Field 2016-20 and other policy documents that guide drug and alcohol prevention at the national level. The Norwegian drug prevention policy is based on the fundamental principle of the inclusive society, in which health promotion and prevention principles are embedded in all areas of society. The municipal sector and the Ministry of Health and Care Services have established the Public Health Programme 2017-27, with the aim of integrating mental health and drug prevention in public health work. An important aspect of the Norwegian prevention policy is the promotion of high-quality approaches and evaluations and a focus on the continuous development of the professional competencies of prevention workers.

The Norwegian Directorate of Health contributes to the local implementation of prevention activities, while the municipalities are responsible for local drug and alcohol prevention and county councils have a statutory responsibility for public health work at the regional level. Seven regional competence centres are key partners in coordinating and improving local prevention in the municipalities. Prevention is funded by public funds allocated to policies at a local level through various grant schemes.

Prevention interventions

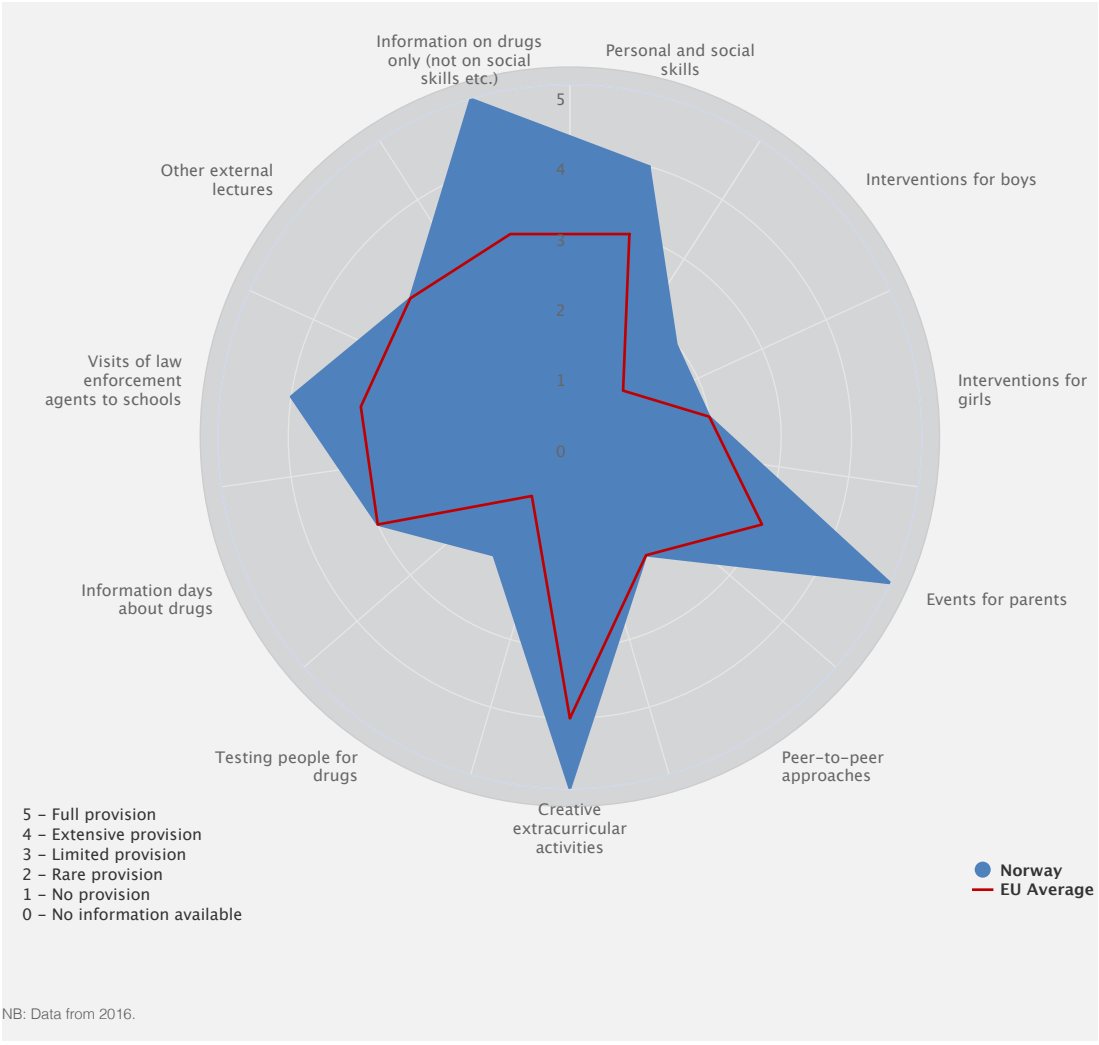
Prevention interventions encompass a wide range of approaches, which are complementary. Environmental and universal strategies target entire populations, selective prevention targets vulnerable groups that may be at greater risk of developing substance use problems and indicated prevention focuses on at-risk individuals.

Environmental prevention measures in Norway are mostly based on the municipalities' administration of the Alcohol Act, particularly in the work related to responsible handling of alcohol. The municipalities play an important role in law enforcement and are responsible for making their own alcohol policy, processing licence applications and providing supervision to licence holders.

In schools, priority is given to universal prevention activities that are comprehensively integrated into a learning environment, while the implementation of curricular school-based prevention programmes is decreasing. A particular Norwegian feature is the Ungdata survey, a comprehensive source of information on adolescent health and well-being at the municipal and national levels. It informs municipal planning and developmental work related to public health and preventive measures aimed at young people. Programmes to integrate parents into prevention activities are also supported. The 'Love and limits' programme aims to enhance cooperation between school and home and strengthen the social skills of adolescents. Employees and elderly people are other target groups for universal prevention.

Selective prevention targets mainly young people outside the school environment, through outreach work, the integration of prevention activities into child welfare services and the promotion of early access to healthcare services. Specific programmes have concentrated on the needs of immigrants, asylum seekers, children with behavioural problems, young cannabis smokers and elderly people. More than 100 municipalities have established outreach services working with vulnerable young people. Training programmes developed for staff members of child welfare services and specialised health services focus on how to implement early interventions. Work has also been undertaken to develop tools and methods for early interventions that target pregnant women and their partners, and parents of small children. Many municipalities and community associations carry out selective prevention activities in recreational settings, with a focus on health promotion, through peer approaches and the provision of alternative leisure activities. While outreach work remains the most widely applied model for reaching vulnerable young people and the implementation of indicated prevention activities, innovative approaches are continuously being researched and introduced into practice.

Provision of interventions in schools in Norway (expert ratings)



NB: Data from 2016.

Harm reduction

The harm reduction goals within Norway's alcohol and drug policy were defined in the 2011-12 white paper 'See me! A comprehensive drugs and alcohol policy' and are confirmed in the current national action plan. The aim of harm reduction measures is to improve health and allow people who use substances a more dignified life, including the prevention of harms such as overdoses and drug-related infectious diseases. The national overdose strategy for 2014-17 provided a background to scale up activities to prevent overdose risks and to promote emergency assistance and treatment for drug users. Low-threshold services and harm reduction are further addressed in the National Action Plan for the Alcohol and Drugs Field 2016-20. In November 2018, the government presented a revised national strategy on hepatitis that prioritises the prevention and treatment of the infection among vulnerable groups, including people who inject drugs (PWID). In Norway, the municipalities are responsible for the organisation of harm reduction measures on the basis of local needs. A 2017 national electronic survey among all Norwegian municipalities suggests that around 22 % currently provide syringes to PWID. While cooperation between local public health and social services constitutes the backbone of service provision, private non-profit organisations are important partners for municipalities in the implementation of harm reduction interventions.

Harm reduction interventions

Low-threshold facilities offer a broad range of services, such as health checks, vaccinations (including the provision of free hepatitis A and B vaccines), distribution of clean injecting equipment and foil, overdose prevention interventions, nutritional and hygiene guidance, and follow-up and referral to other parts of the health service.

A national survey estimated that 2.9 million syringes were distributed through low-threshold facilities in 2017, the majority being given out in Oslo, Bergen and Trondheim.

The 14 municipalities with the highest burden of drug-related deaths participated in the implementation of the national overdose strategy 2014-17, introducing overdose prevention programmes funded by dedicated grants from the Directorate of Health. The strategy is currently being re-drafted to be renewed for the period 2019-22, building on successful measures, addressing new challenges and aiming, among other things, to provide all municipalities with naloxone funded by the state. Several municipalities have also adopted local overdose action plans and measures. By the end of 2017, more than 6 300 naloxone kits had been distributed in the participating municipalities.

Two supervised injection rooms were operational in Norway by the end of 2017, in Oslo and Bergen. Since the one in Oslo was established, nearly 330 000 injections have been supervised in the supervised injection room, with no fatalities.

Availablity of selected harm reduction responses in Europe

Country	Needle and syringe programmes	Take-home naloxone programmes	Drug consumption rooms	Heroin-assisted treatment
Austria	Yes	No	No	No
Belgium	Yes	No	Yes	No
Bulgaria	Yes	No	No	No
Croatia	Yes	No	No	No
Cyprus	Yes	No	No	No
Czechia	Yes	No	No	No
Denmark	Yes	Yes	Yes	Yes
Estonia	Yes	Yes	No	No
Finland	Yes	No	No	No
France	Yes	Yes	Yes	No
Germany	Yes	Yes	Yes	Yes
Greece	Yes	No	No	No
Hungary	Yes	No	No	No
Ireland	Yes	Yes	No	No
Italy	Yes	Yes	No	No
Latvia	Yes	No	No	No
Lithuania	Yes	Yes	No	No
Luxembourg	Yes	No	Yes	Yes
Malta	Yes	No	No	No
Netherlands	Yes	No	Yes	Yes
Norway	Yes	Yes	Yes	No
Poland	Yes	No	No	No
Portugal	Yes	No	No	No
Romania	Yes	No	No	No
Slovakia	Yes	No	No	No
Slovenia	Yes	No	No	No
Spain	Yes	Yes	Yes	No
Sweden	Yes	No	No	No
Turkey	No	No	No	No
United Kingdom	Yes	Yes	No	Yes

Treatment

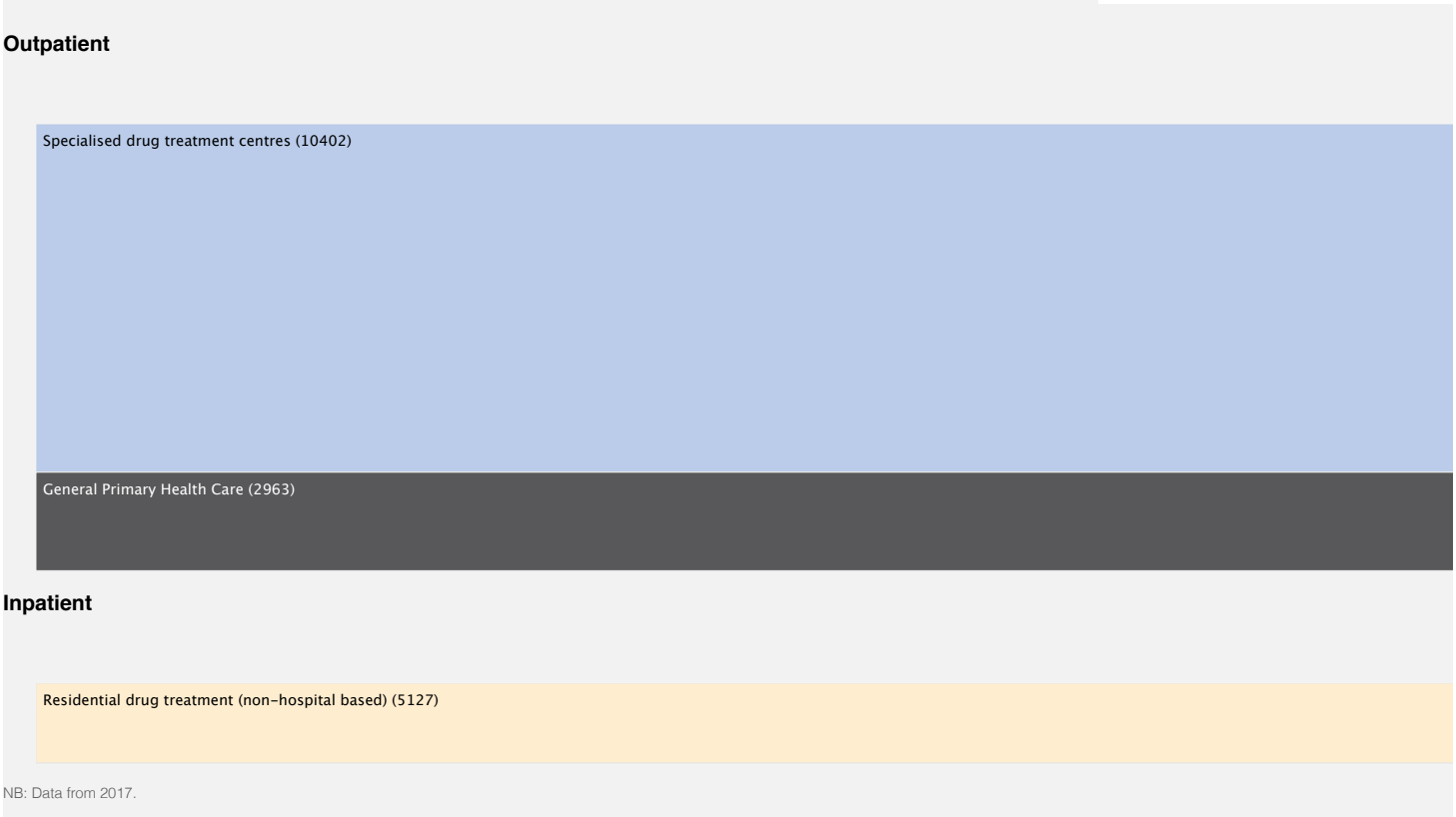
The treatment system

The Norwegian state has overarching responsibility for the provision of specialised health services. The treatment-related objectives of the current national action plan emphasise a client-oriented approach, early interventions, diversification of services, reintegration and expanding alternative measures to incarceration. The Ministry of Health and Care Services is responsible for the overall implementation of those objectives. In addition, the drug policy reform of 2004 stipulates that the four regional health authorities in Norway are responsible for the specialist treatment of drug and alcohol users, while the municipalities bear overall responsibility for providing general and mental healthcare services, outreach outpatient services/community teams, services for next of kin, low-threshold services, assessment and referral to treatment, and follow-up during and after treatment in the specialist health services or in prison. Treatment is financed mainly by public funds. In addition, the Ministry of Labour and Social Inclusion and the Ministry of Health and Care Services have funds at their disposal for the development of special high-priority work in the areas of epidemiology, research, prevention and treatment.

Drug treatment in Norway encompasses a range of services including assessment, detoxification, stabilisation, short- and long-term residential treatments and medication-assisted treatment, such as opioid substitution treatment (OST). The majority of treatment services available to drug users, whether outpatient or inpatient, treat drug dependence in general and are not specifically designed for users of illicit drugs. Most services are delivered through specialised treatment units, while general practitioners are mainly involved in the prescribing of OST medication.

In Norway, OST has been available through a nationwide programme since 1998. Its provision is integrated into health trusts and the specialist care services under the auspices of the regional health authorities. The health trusts either organise the provision of OST through units that have separate management and a dedicated team or integrate OST as part of an interdisciplinary specialist treatment team that does not have separate management. In general, OST provision follows a basic model of a tripartite collaboration comprising social security offices, general practitioners and the specialist health services. The specialist health services are given authority to assess the need for OST, whereas general practitioners can operate only within strict, shared arrangements with specialised drug treatment centres.

Drug treatment in Norway: settings and number treated



NB: Data from 2017.

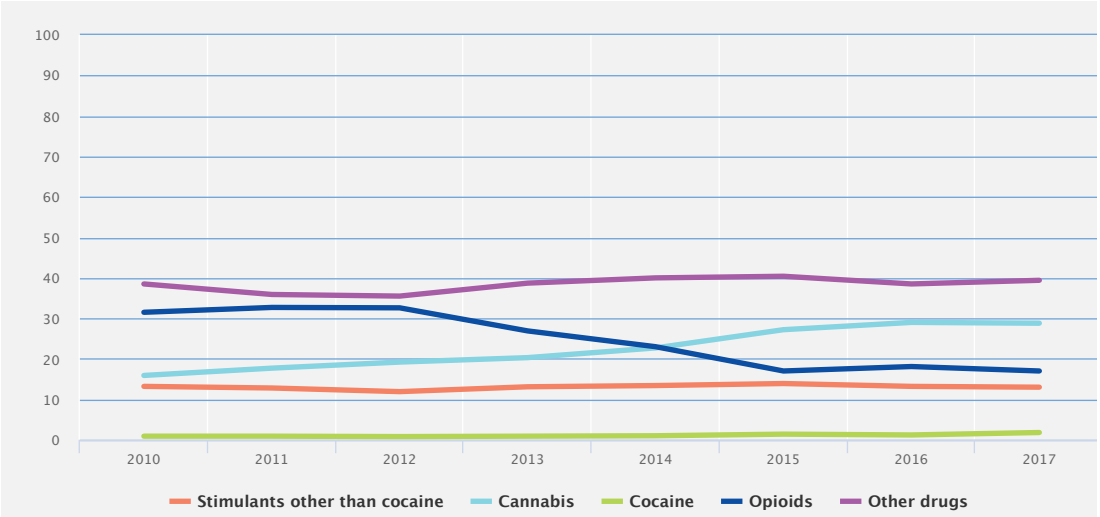
Treatment provision

In 2017, close to 18 500 clients were treated in Norway, the majority of whom were treated in outpatient settings. Patients with

multiple drug use as their main diagnosis form the largest proportion of clients entering treatment, followed by those entering treatment for primary use of cannabis and those entering treatment for opioid dependency alone. The percentage of clients entering treatment for opioid-related problems is a minimum value; it does not include opioid clients registered as polydrug users.

The proportion of clients treated with methadone has been declining in recent years, as methadone is no longer recommended as the first-choice option in Norway. In 2017, 7 622 clients received OST. Approximately 6 out of 10 clients were treated with buprenorphine-based medications, while the remainder were treated with methadone, and slow-release morphine was prescribed to a small proportion of clients. Overall, very few people are now waiting to initiate OST, and it is assumed that the system is approaching saturation in terms of numbers of current opioid users seeking treatment.

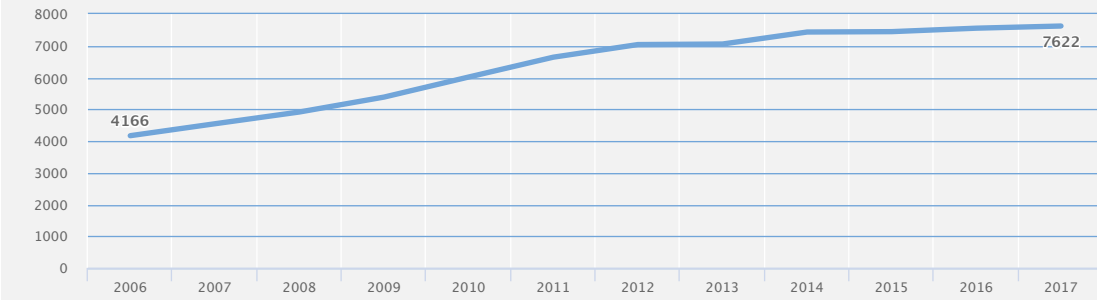
Trends in percentage of clients entering specialised drug treatment, by primary drug, in Norway



NB: 'Other drugs' refers to patients with multiple drug use as their main diagnosis. The percentage of clients in treatment for opioid-related problems is a minimum value and does not account for opioid clients registered as polydrug users.

Opioid substitution treatment in Norway: proportions of clients in OST by medication and trends of the total number of clients

Trends in the number of clients in OST



NB: Data from 2017.

Drug use and responses in prison

The Directorate of the Norwegian Correctional Service is responsible for the professional and administrative management of the correctional service. Several studies conducted among the Norwegian prison population indicate that the levels of drug use and drug-related problems are high, especially when comparing prisoners with the general population. Around 1 in 10 prisoners are infected with hepatitis C virus. A recent study documented a particularly high overdose mortality rate in the first days and the first weeks following release. A 2-year project that was funded in 2017 aims to provide training and guidance to prison staff regarding measures that can reduce the risk of overdoses upon release from prison.

Norwegian inmates have the same rights as other citizens, and the healthcare services during the serving of a sentence should be identical to the conditions outside. Inmates on remand will largely continue to use the health and welfare services they had prior to detention, and convicted persons have access to services in prison that are organised by the same agencies as outside prison. The 'import' model is a distinctive feature of the provision of interventions within the Norwegian correctional service, which means that external providers are responsible for offering the same type of services to inmates in prison as to other citizens outside prison. It is often the municipality in which the prison is located that is responsible for such 'imported' services and decides on how health and care services are to be organised. The public health regions are responsible for the specialised health services, including interdisciplinary specialised drug and alcohol treatment. A guide has been produced to organise the cooperation between the correctional service and the prison health service. Efforts have also been made to ensure continued collaboration upon release from prison.

More than half of the healthcare staff in prisons have been trained on drug- and alcohol-related problems or the treatment of mental disorders. A psychologist is available in more than half of the prisons. All prisons and probation offices are required to use a joint mapping system for inmates and convicted persons, which assesses their health and social needs. Drug treatment available in Norwegian prisons includes motivational interviewing, opioid substitution treatment (OST), testing and counselling for infectious diseases, education and training, and preparation for release. The correctional service has 13 units for addressing drug and alcohol problems. OST is offered by the prison health and care services. Available data indicate that 315 prisoners received OST in 2017, a slight increase compared with 2016. The number varies greatly by prison. Prisoners are tested for blood-borne diseases and sexually transmitted diseases. Vaccination programmes are available for inmates at high risk. Needle and syringe programmes do not exist in Norwegian prisons; however, inmates are given access to chlorine or chloramine as disinfectant material.

Drug programmes under court supervision are implemented in Norway with the objective of contributing to the prevention of new crime in a high-risk group of relapse. In 2017, 131 new drug programmes under court supervision were initiated on a national basis.

Quality assurance

The current National Action Plan for the Alcohol and Drugs Field specifies the following quality assurance-related objectives: (i) increase the expertise on drug and drug dependence problems in all sectors; (ii) establish a separate national quality register within the interdisciplinary specialised treatment of substance use problems; (iii) increase expertise and establish fixed procedures relating to the exposure and monitoring of drug problems in the municipalities and somatic hospital wards; and (iv) increase competence among municipal healthcare services.

The Ministry of Health and Care Services is responsible for overall alcohol and drug policy, and for coordinating governmental efforts to combat substance use problems. The Directorate of Health is responsible for making guidelines/instructions for relevant healthcare and social services. The primary objective of the regional competence centres in the alcohol and drugs field is to assist municipalities in the development of drug prevention expertise/competence in their region, whereas the national competence service for interdisciplinary specialised treatment is responsible for building up and disseminating expertise in interdisciplinary specialised treatment for substance abuse problems. The Norwegian Institute of Public Health is responsible for producing, summarising and communicating knowledge to contribute to good public health and healthcare services.

Although there is no specific education system to prepare professionals for working in the area of drug demand reduction, universities offer a number of educational programmes that target employees of services dealing with drug problems. A specialised course in drugs and drug dependence medicine for physicians was implemented in 2017. The regional competence centres in the alcohol and drugs field, as well as the national competence service for interdisciplinary specialised treatment for substance use problems, offer training in the form of various courses and seminars or conferences.

Drug-related research

In Norway, drug-related research covers drugs, alcohol, tobacco and, to a certain extent, gambling and performance-enhancing drugs. The drugs and alcohol field is a priority of the government's investment in research and falls within the objectives of improving quality and developing skills in the alcohol and drugs field. The National Action Plan for the Alcohol and Drugs Field 2016-20 defines a strategy for developing drug-related research and sets a concrete budget to implement it. In general, the government assesses the need to increase knowledge about the effectiveness of the interventions and treatment that are offered to people with drug dependencies. In addition, the government has launched different Research Council programmes to increase research on substance use and related problems.

Recent studies include population-based and clinical epidemiology research, and basic biological, neurobiological, behavioural, social scientific and drug policy research. The main sources of funding for these research activities are government departments, partly through the Research Council of Norway and partly through the Directorate of Health. Studies are mainly conducted by the Norwegian Centre for Addiction Research and the Norwegian Institute of Public Health, as well as university departments and privately funded research institutes. Research findings are disseminated on websites and through scientific and non-scientific (national and international) journals.

Drug markets

Cannabis is the most commonly seized drug in Norway. The Netherlands, Denmark, Sweden and Germany are important countries in relation to cannabis resin distribution to Norway, but Poland has recently also emerged as a transit country for this drug, with customs reporting large seizures arriving from Poland via Sweden. Herbal cannabis is reportedly smuggled from Sweden, Poland and Denmark. In addition, some domestic cultivation of herbal cannabis takes place indoors. While no direct evidence exists of domestic production of amphetamines, amphetamine liquid (base), which can easily be processed into amphetamine sulphate, continues to be seized.

Heroin seized in Norway is brought to the country mainly via the Balkan route through Germany and the Netherlands. Cocaine also enters Norway through other European countries in vehicles or using 'drug mules'. Most amphetamines (predominantly methamphetamine) seized in 2017 in Norway came via Germany, Poland and Sweden. The MDMA/ecstasy that is available on the Norwegian market comes mainly from the Netherlands, via Germany and Poland.

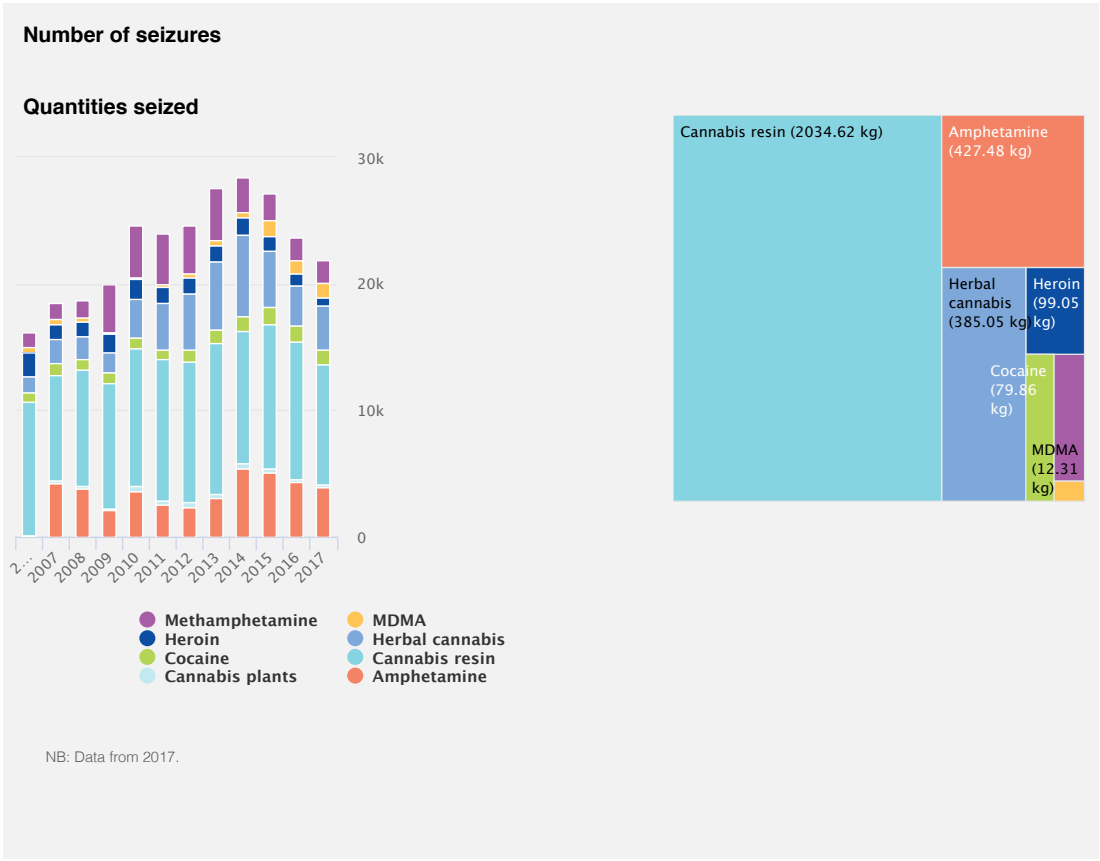
The long-term trend in drug seizures reported by the National Crime Investigation Service indicates an increase in the total number of seizures between 2007 and 2014, followed by a decrease in the following three years (2015, 2016 and 17). The number of cannabis seizures is stable compared with 2016; however, the seized amount was significantly less. In 2017, the quantities of cocaine, MDMA and amphetamines (including methamphetamine) seized remained stable. The quantity of heroin seized was the highest since 2010, although the number of seizures decreased in 2017.

After years of significant increases in the number of new psychoactive substances (NPS) seizures, there has recently been a large decrease. NPS are mainly smuggled into Norway via postal packages, mostly from Spain, Germany and the Netherlands. The most recent data indicate that benzodiazepine-like substances are the most frequently seized NPS, followed by synthetic cannabinoids. Although there is a significant decrease in the number of NPS seizures, new and extremely potent fentanils have emerged on the market.

With regard to law enforcement activities, considerable resources have been allocated to investigations into international trafficking of drugs to Norway and local distribution. This includes extensive international cooperation and information-sharing.

Data on the retail price and purity of the main illicit substances seized are shown in the 'Key statistics' section.

Drug seizures in Norway: trends in number of seizures (left) and quantities seized (right)



NB: Data from 2017.

Key statistics

Most recent estimates and data reported

			EU range	
	Year	Country data	Min.	Max.
Cannabis				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	6.510	6.51	36.79
Last year prevalence of use — young adults (%)	2017	10.1	1.8	21.8
Last year prevalence of drug use — all adults (%)	2017	5.3	0.9	11
All treatment entrants (%)	2017	28.8	1.03	62.98
First-time treatment entrants (%)	2017	36.8	2.3	74.36
Quantity of herbal cannabis seized (kg)	2017	385.1	11.98	94 378.74
Number of herbal cannabis seizures	2017	3 473	57	151 968
Quantity of cannabis resin seized (kg)	2017	2 034.6	0.16	334 919
Number of cannabis resin seizures	2017	9 533	8	157 346
Potency — herbal (% THC) (minimum and maximum values registered)	n.a.	n.a.	0	65.6
Potency — resin (% THC) (minimum and maximum values registered)	n.a.	n.a.	0	55
Price per gram — herbal (EUR) (minimum and maximum values registered)	2017	16.19 - 16.19	0.58	64.52
Price per gram — resin (EUR) (minimum and maximum values registered)	2017	5.4 - 21.58	0.15	35
Cocaine				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	0.85	0.85	4.85
Last year prevalence of use — young adults (%)	2017	2.1	0.1	4.7
Last year prevalence of drug use — all adults (%)	2017	1.1	0.1	2.7
All treatment entrants (%)	2017	1.8	0.14	39.2
First-time treatment entrants (%)	2017	2.7	0	41.81
Quantity of cocaine seized (kg)	2017	79.9	0.32	44 751.85
Number of cocaine seizures	2017	1 185	9	42 206
Purity (%) (minimum and maximum values registered)	n.a.	n.a.	0	100
Price per gram (EUR) (minimum and maximum values registered)	2017	43.17 - 161.88	2.11	350
Amphetamines				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	0.91	0.84	6.46
Last year prevalence of use — young adults (%)	2017	0.8	0	3.9
Last year prevalence of drug use — all adults (%)	2017	0.6	0	1.8
All treatment entrants (%)	2017	13	0	49.61
First-time treatment entrants (%)	2017	10.3	0	52.83
Quantity of amphetamine seized (kg)	2017	427.5	0	1 669.42
Number of amphetamine seizures	2017	3 913	1	5 391
Purity — amphetamine (%) (minimum and maximum values registered)	n.a.	n.a.	0.07	100
Price per gram — amphetamine (EUR) (minimum and maximum values registered)	2017	14.57 - 43.17	3	156.25
MDMA				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	0.95	0.54	5.17
Last year prevalence of use — young adults (%)	2017	2.2	0.2	7.1
Last year prevalence of drug use — all adults (%)	2017	1	0.1	3.3
All treatment entrants (%)	2017	0	0	2.31
First-time treatment entrants (%)	2017	0	0	2.85
Quantity of MDMA seized (tablets)	2017	33 657	159	8 606 765
Number of MDMA seizures	2017	1 122	13	6 663
Purity (MDMA mg per tablet) (minimum and maximum values registered)	n.a.	n.a.	0	410
Purity (MDMA % per tablet) (minimum and maximum values registered)	n.a.	n.a.	2.14	87
Price per tablet (EUR) (minimum and maximum values registered)	n.a.	n.a.	1	40
Opioids				
High-risk opioid use (rate/1 000)	2013	2.68	0.48	8.42
All treatment entrants (%)	2017	17	3.99	93.45
First-time treatment entrants (%)	2017	11.2	1.8	87.36
Quantity of heroin seized (kg)	2017	99	0.01	17 385.18
Number of heroin seizures	2017	628	2	12 932
Purity — heroin (%) (minimum and maximum values registered)	n.a.	n.a.	0	91
Price per gram — heroin (EUR) (minimum and maximum values registered)	2017	75.55 - 107.92	5	200
Drug-related infectious diseases/injecting/death				
Newly diagnosed HIV cases related to injecting drug use (cases/million population, Source: ECDC)	2017	1.3	0	47.8
HIV prevalence among PWID* (%)	2017	1.43	0	31.1
HCV prevalence among PWID* (%)	2017	49.7	14.7	81.5
Injecting drug use (cases rate/1 000 population)	2016	2.52	0.08	10.02
Drug-induced deaths — all adults (cases/million population)	2016	74.87	2.44	129.79
Health and social responses				
Syringes distributed through specialised programmes	2017	2 884 230	245	11 907 416
Clients in substitution treatment	2017	7 622	209	178 665

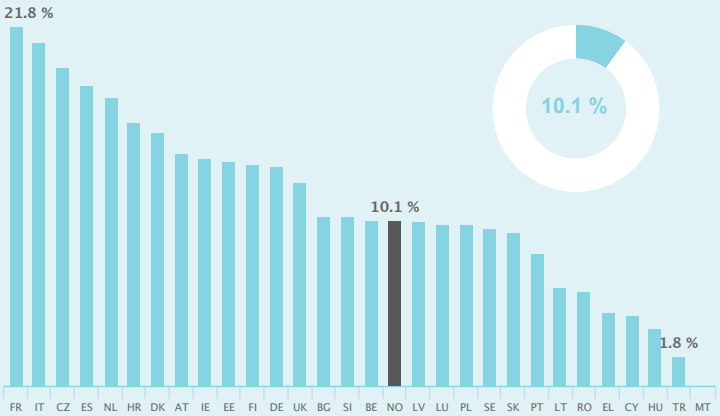
Treatment demand				
All entrants	2017	5 728	179	118 342
First-time entrants	2017	2 690	48	37 577
All clients in treatment	2017	18 492	1 294	254 000
Drug law offences				
Number of reports of offences	2017	33 585	739	389 229
Offences for use/possession	2017	17 494	130	376 282

The percentage of clients in treatment for opioids is a minimum value and does not account for opioid clients registered as polydrug users. The source for HIV and HCV prevalence among PWID is the national opioid substitution treatment programme.

EU Dashboard

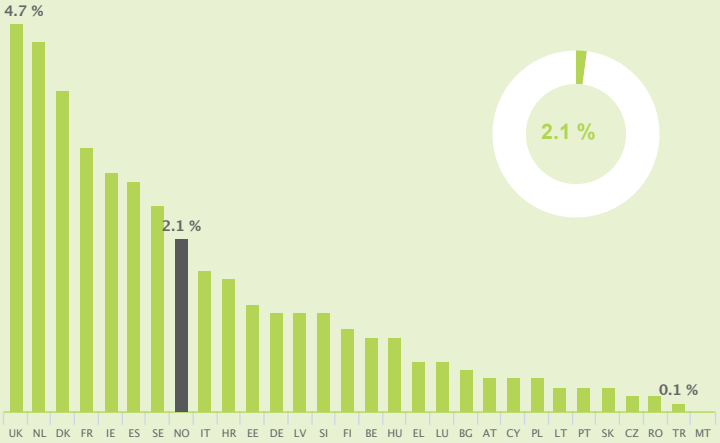
Cannabis

Last year prevalence among young adults (16-34 years)



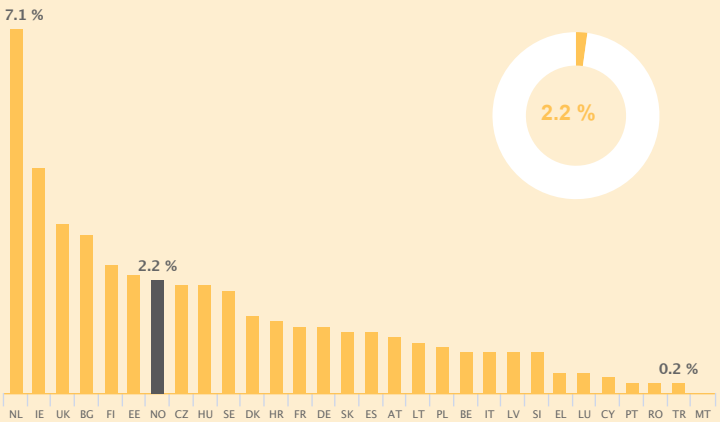
Cocaine

Last year prevalence among young adults (16-34 years)



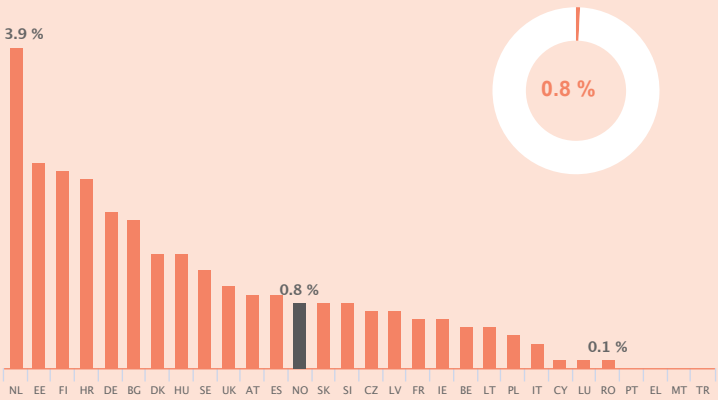
MDMA

Last year prevalence among young adults (16-34 years)



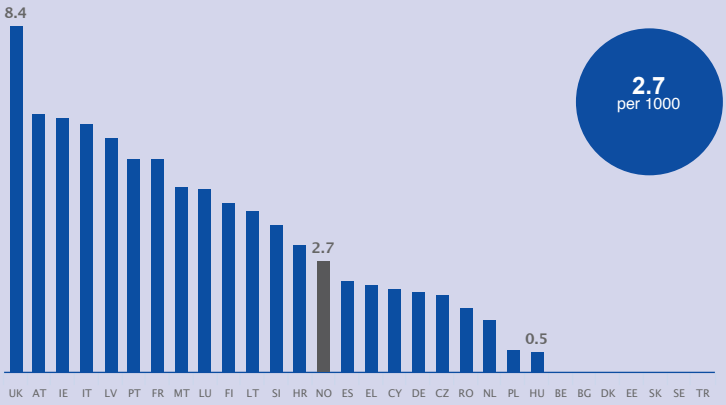
Amphetamines

Last year prevalence among young adults (16-34 years)



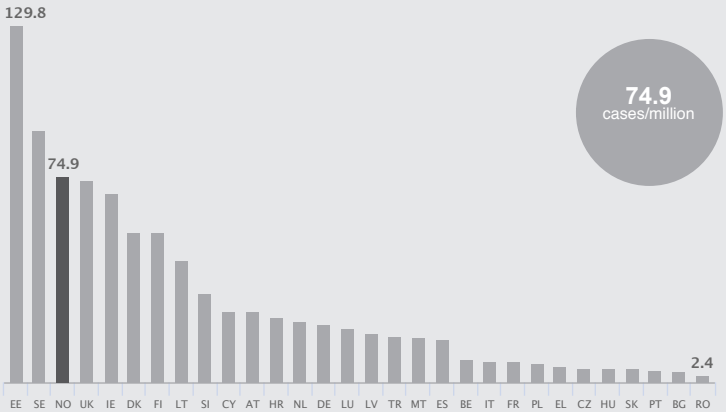
Opioids

High-risk opioid use (rate/1 000)



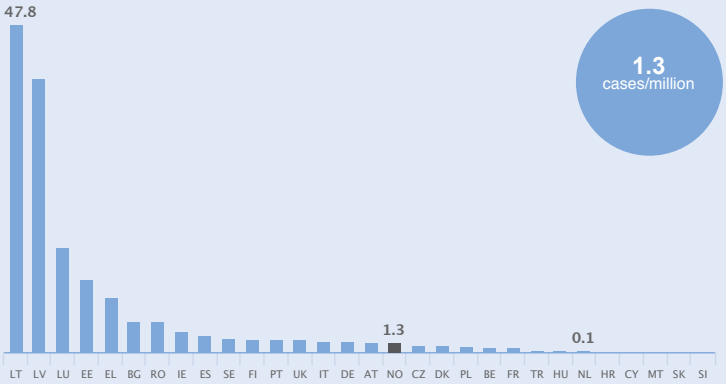
Drug-induced mortality rates

National estimates among adults (15-64 years)



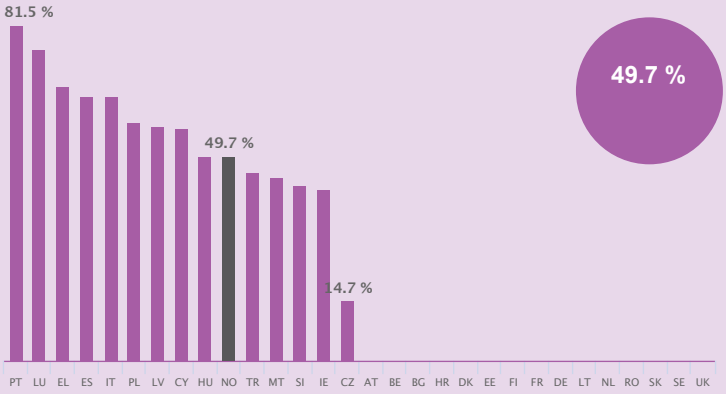
HIV infections

Newly diagnosed cases attributed to injecting drug use



HCV antibody prevalence

National estimates among injecting drug users



NB: Caution is required in interpreting data when countries are compared using any single measure, as, for example, differences may be due to reporting practices. Detailed information on methodology, qualifcations on analysis and comments on the limitations of the information available can be found in the EMCDDA Statistical Bulletin. Last year prevalence estimated among young adults aged 16-34 years in Denmark, Norway and the United Kingdom; 17-34 in Sweden; and 18-34 in France, Germany, Greece and Hungary. Drug-induced mortality rate for Greece are for all ages.

About our partner in Norway

Since 2016 the Norwegian focal point has been located in the Norwegian Institute of Public Health (FHI). FHI acts as a national competence institution for governmental authorities, the health service, the judiciary, prosecuting authorities, politicians, the media and the general public on issues related to physical and mental health, prevention of communicable diseases and prevention of harmful environmental influences. It is placed directly under the Ministry of Health and Care Services.

Click here to learn more about our partner in Norway .

Norwegian national focal point

Norwegian Institute of Public Health

Department of Substance Use

P.O. Box 222 Skøyen

NO-0213 Oslo

Norway

Tel. +47 40627424

Fax. +47 22 34 04 01

Head of national focal point: Mr Thomas Anton Sandøy

Methodological note: Analysis of trends is based only on those countries providing sufficient data to describe changes over the period specified. The reader should also be aware that monitoring patterns and trends in a hidden and stigmatised behaviour like drug use is both practically and methodologically challenging. For this reason, multiple sources of data are used for the purposes of analysis in this report. Caution is therefore required in interpretation, in particular when countries are compared on any single measure. Detailed information on methodology and caveats and comments on the limitations in the information set available can be found in the EMCDDA Statistical Bulletin .