European Monitoring Centre for Drugs and Drug Addiction

Norway

Norway Drug Report 2018

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 2016 (or most recent year) and are provided to the EMCDDA by the national focal point, unless stated otherwise.

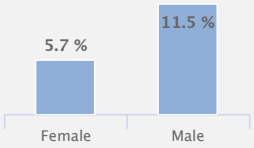
THE DRUG PROBLEM IN NORWAY AT A GLANCE

Drug use

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

Cannabis

8.6 %



Other drugs

MDMA	**1.6 %**
Amphetamines	**0.5 %**
Cocaine	**1.3 %**

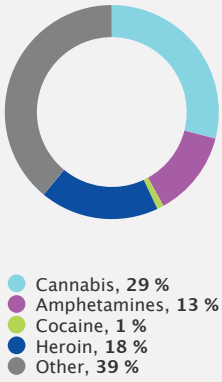
High-risk opioid users

9 015

(6 708 - 13 977)

Treatment entrants

by primary drug



Opioid substitution treatment clients

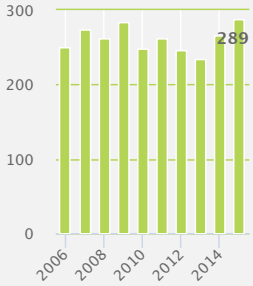
7 554

Syringes distributed

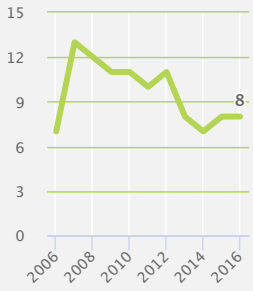
through specialised programmes

2 919 344

Overdose deaths



HIV diagnoses attributed to injecting



Source: ECDC

Drug law offences

36 184

Top 5 drugs seized

ranked according to quantities measured in kilograms

1. Cannabis resin
2. Herbal cannabis
3. Amphetamines
4. Cocaine
5. Methamphetamines

Population

(15-64 years)

3 422 208

Source: EUROSTAT Extracted on: 18/03/2018

NB: Data presented here are either national estimates (prevalence of use, opioid drug users) or reported numbers through the EMCDDA indicators (treatment clients, syringes, deaths and HIV diagnosis, drug law o?ences 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 in Treatment entrants graph include clients entering treatment due to poly-drug use, which accounts for 27% of treatment entrants.

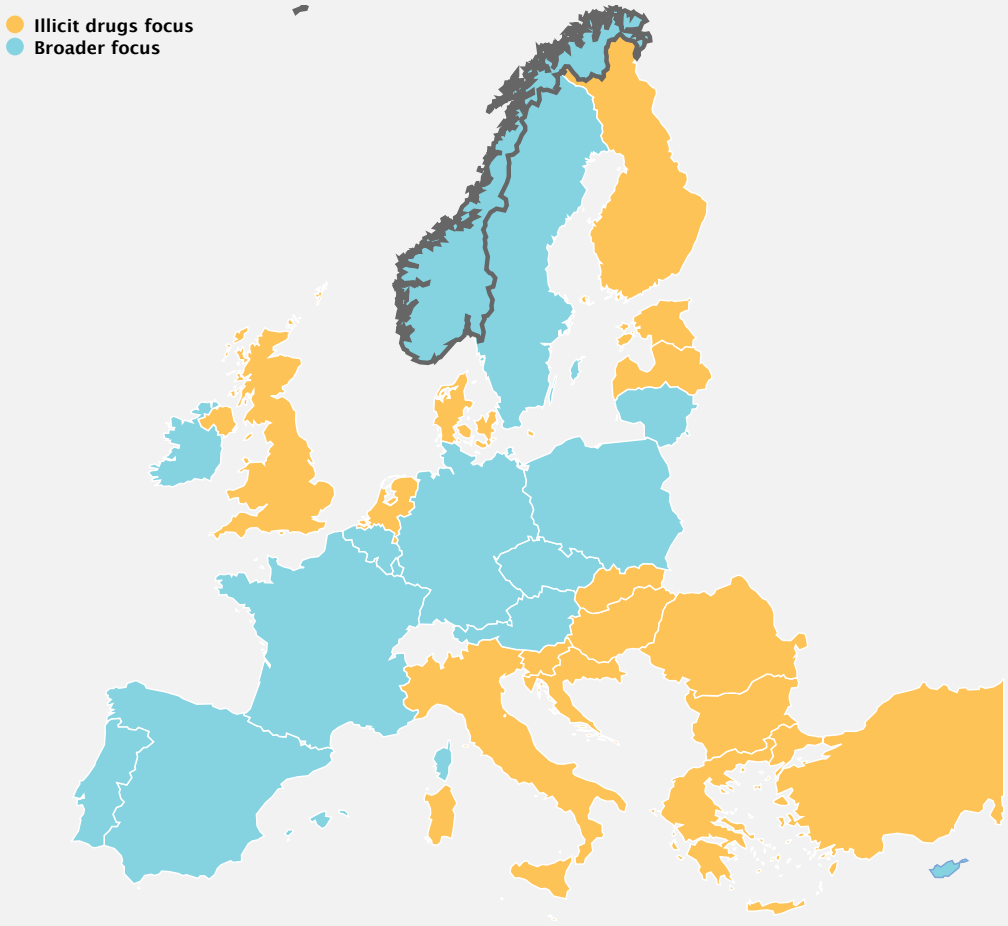
National drug strategy and coordination

National drug strategy

In 2015, the Norwegian government presented a new action plan addressing substance use and addiction: 'Prop. 15 S: The action plan for the alcohol and drugs field (2016-2020)'. This plan, which succeeded the white paper to the Storting (parliament) 'Meld. St. 30 (2011-2012): See me! A comprehensive drug policy: alcohol — drugs — doping', serves as the current national drugs strategy document. However, the fundamental principles in white paper no 30 (2011-2012), which promoted a comprehensive alcohol and drug policy covering alcohol, illicit drugs, addictive medications and doping, can still be traced in existing policy. The integrated action plan comprises and prioritises activities for prevention, early intervention, treatment and aftercare for individuals with substance abuse problems. The aim is to help individuals to cope with their lives, or achieve the best possible control over the most important aspects of them, with the following 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 the inclusive society. Health promotion and prevention principles are embedded in all areas of society and priority is given to early interventions. This policy manifests as restrictions on alcohol consumption, combatting 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 Action Plan for the Drugs and Alcohol Field (2007-12) was completed in 2012. It found that nearly all of the 147 measures outlined in the plan had been undertaken. A programme evaluating the effects of the implementation of the Action Plan for the Alcohol and Drugs Field (2016-20) was set up in 2016.

Focus of national drug strategy documents: illicit drugs or broader



NB: Year of data 2016. Strategies with broader focus may include, for example, licit drugs 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 care 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. There were no associated comprehensive budgets for the Norwegian National Action Plan on Alcohol and Drugs (2007-12); however, the authorities 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 266.7 million (NOK 2.4 billion) was allocated to the drugs and alcohol field. In 2016 and 2017, the grant was increased by NOK 541 million for drugs and NOK 446 million for alcohol. Additional funding of about EUR 16 million (NOK 150 million) has been budgeted for interdisciplinary specialised treatment for illicit drugs and alcohol use in 2017, complementing the EUR 564.13 million (NOK 5.340 billion) spent in 2016.

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; therefore, the total size of and trends in drug-related public expenditure cannot be estimated.

Drug laws and drug law offences

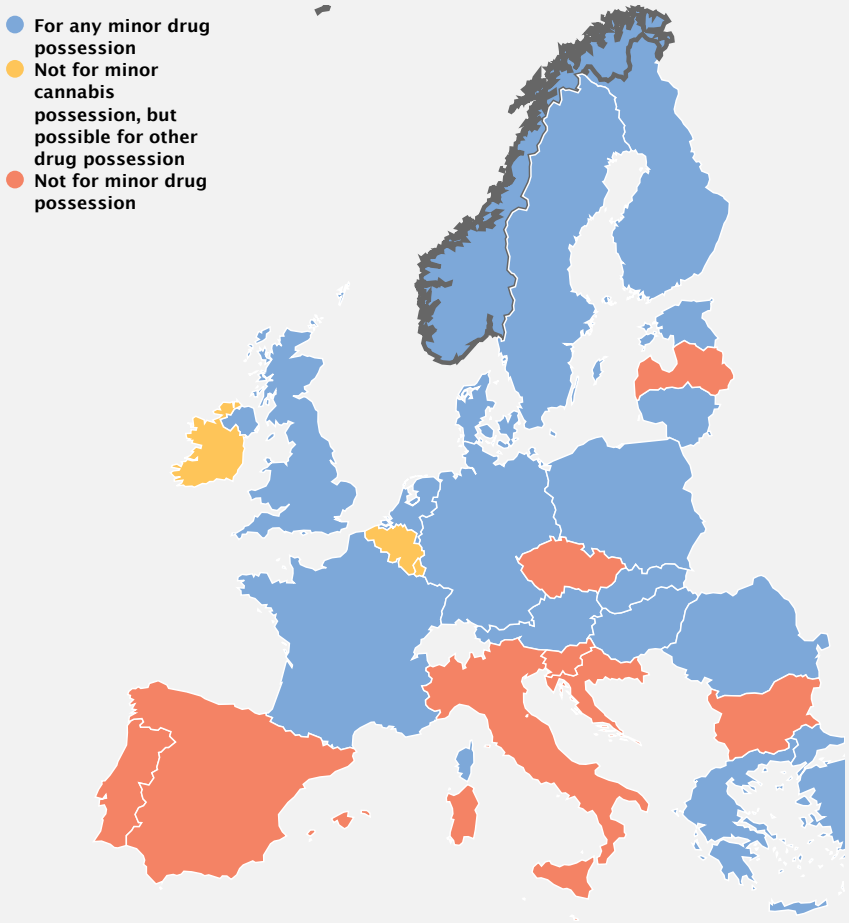
National drug laws

In Norway, there are no separate laws that relate only to illicit drugs. The use and possession of minor quantities of drugs falls under the provision of the Act on Medicinal Products. Penalties comprise fines or imprisonment for up to six 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 two years. An offence may also be deemed by a special evaluation to be aggravated by taking into consideration the type of substance involved, its quantity and purity, and the nature of the offence. Pursuant to 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. Nevertheless, in Norway, 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 started in 2006 as a trial, and in 2016 the government accepted it as a permanent and nationwide programme.

In 2013, a new regulation relating to narcotics came into force, which allows scheduling of substances by 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)

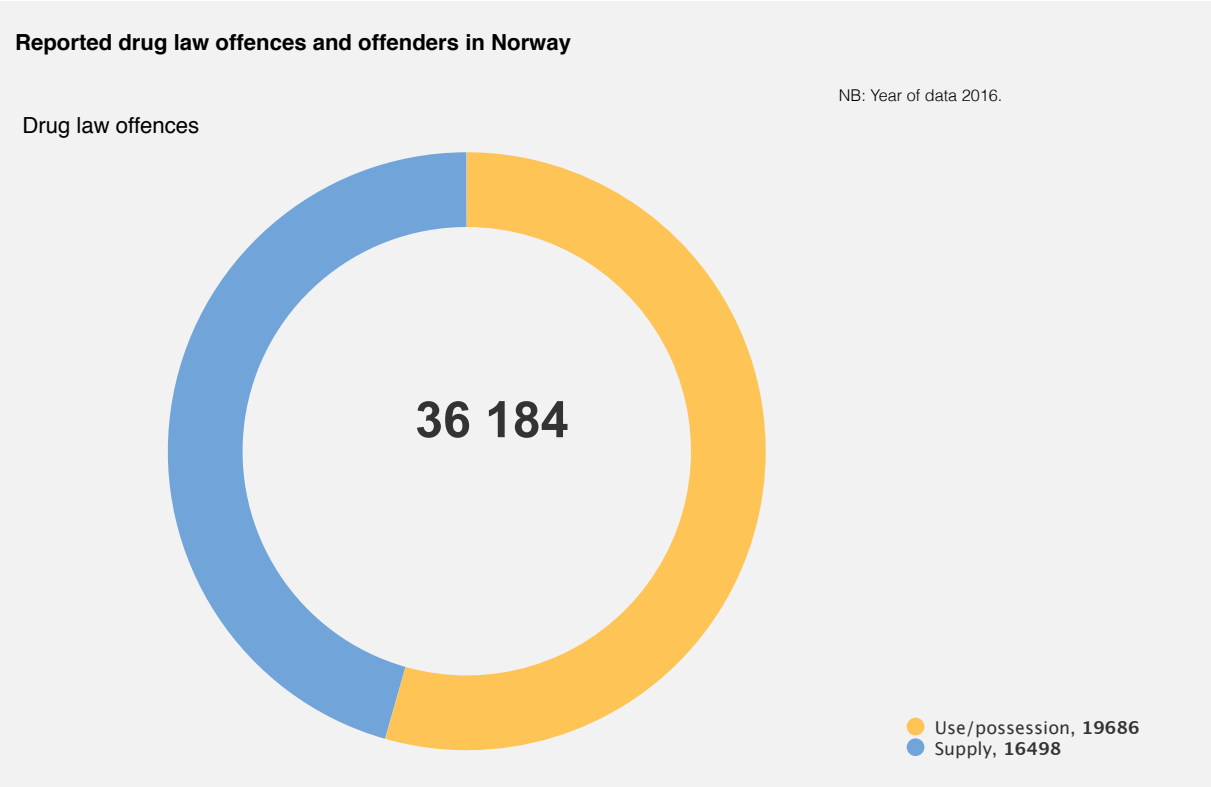


NB: Year of data 2016

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 a total of 48 152 DLOs were reported. In 2015 and 2016 the number of reported DLO has reduced. The available data indicate that use- and possession-related offences constitute the largest group.



Drug use

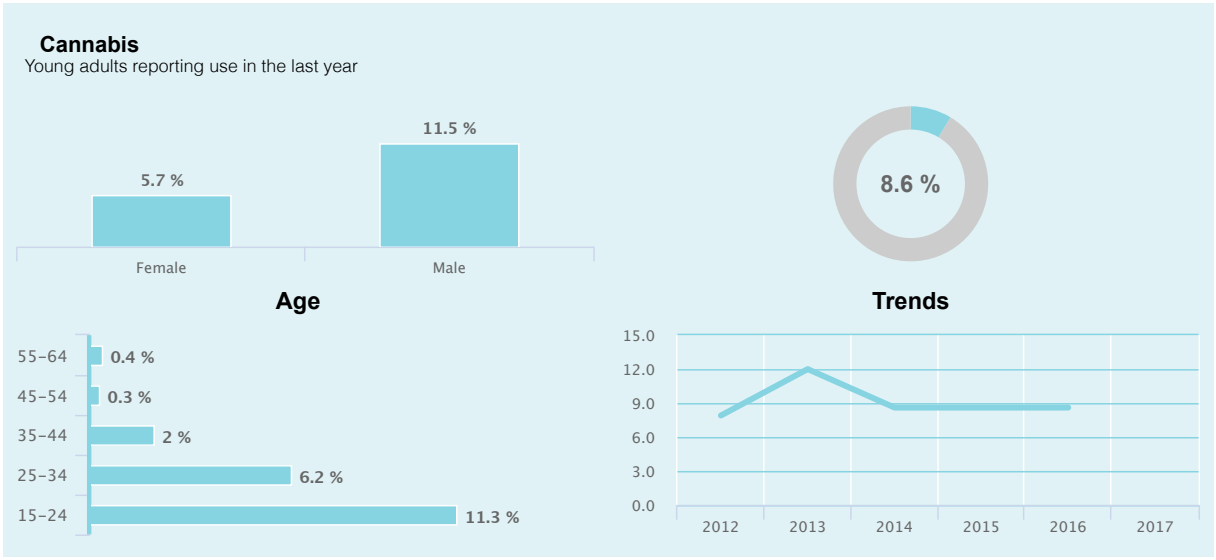
Prevalence and trends

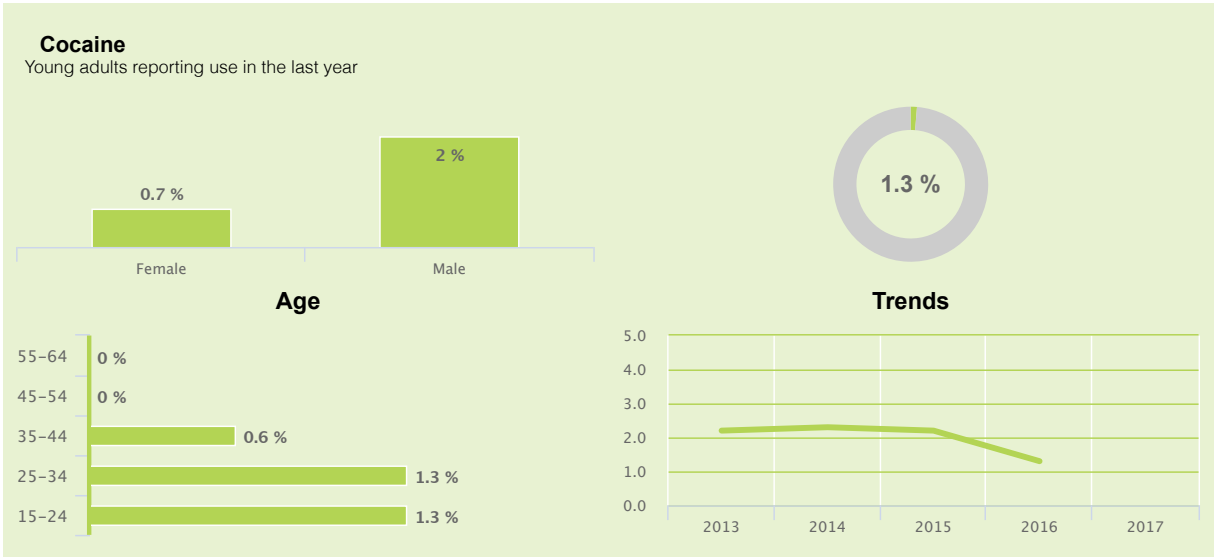
Data from the annual general population surveys carried out since 2012 indicate that cannabis is the most commonly used illicit drug among the general population in Norway, and its level of use has been relatively stable in recent years. In 2016, about 1 in 10 of young adults reported having used cannabis in the last 12 months. Use of all other substances is reported to be lower, with cocaine being the most prevalent illicit stimulant drug used. The use of illicit drugs is concentrated mostly among young adults, and males generally report higher prevalence rates than females.

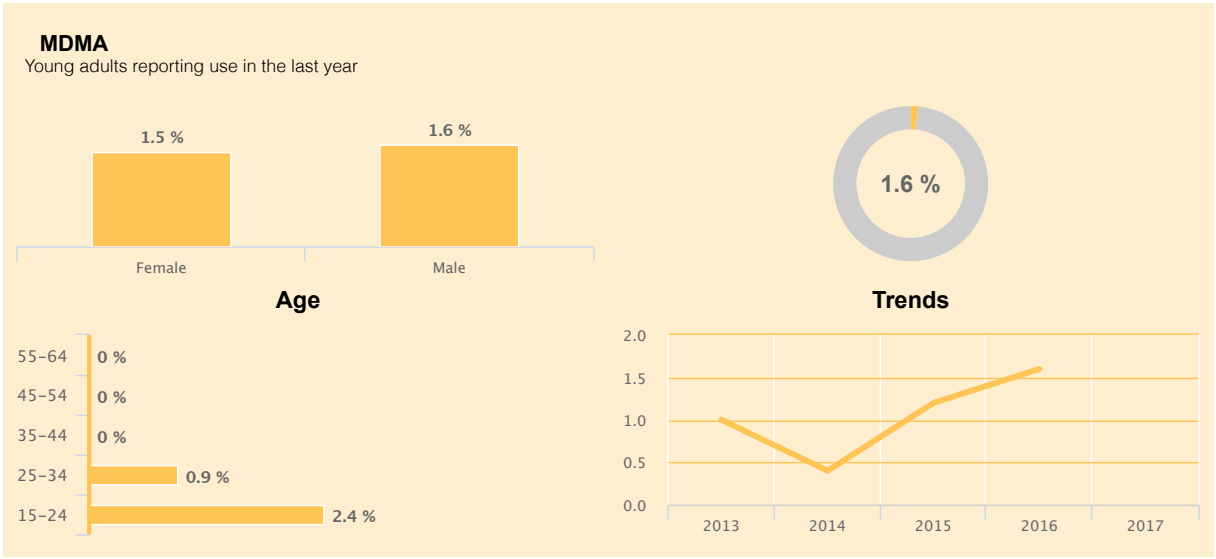
The prevalence of use of new psychoactive substances (NPS) is very low among the adult general population, and studies indicate that experimentation with these substances may be more common among young people in nightlife settings.

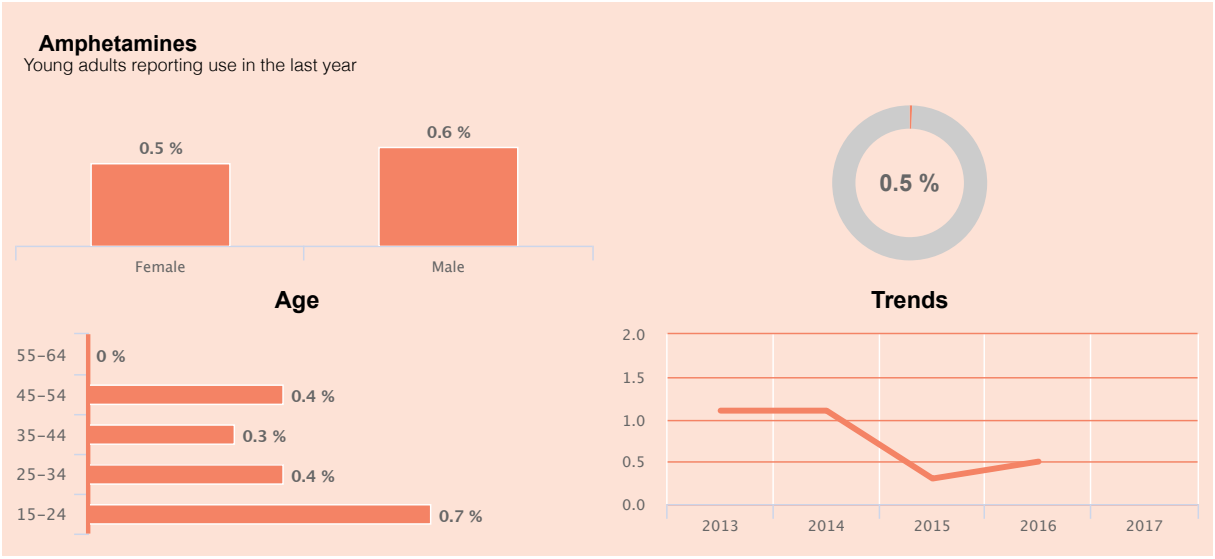
The city of Oslo participates in the Europe-wide annual wastewater campaigns undertaken by the Sewage Analysis Core Group Europe (SCORE). This study provides data on drug use at a municipal level, based on the levels of illicit drugs and their metabolites found in wastewater. The increase in levels of the stimulant MDMA/ecstasy reported in 2016 was followed by a sharp decrease in 2017. Oslo is 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 metabolites found was reported in 2017, although at lower levels than in 2011-14.

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





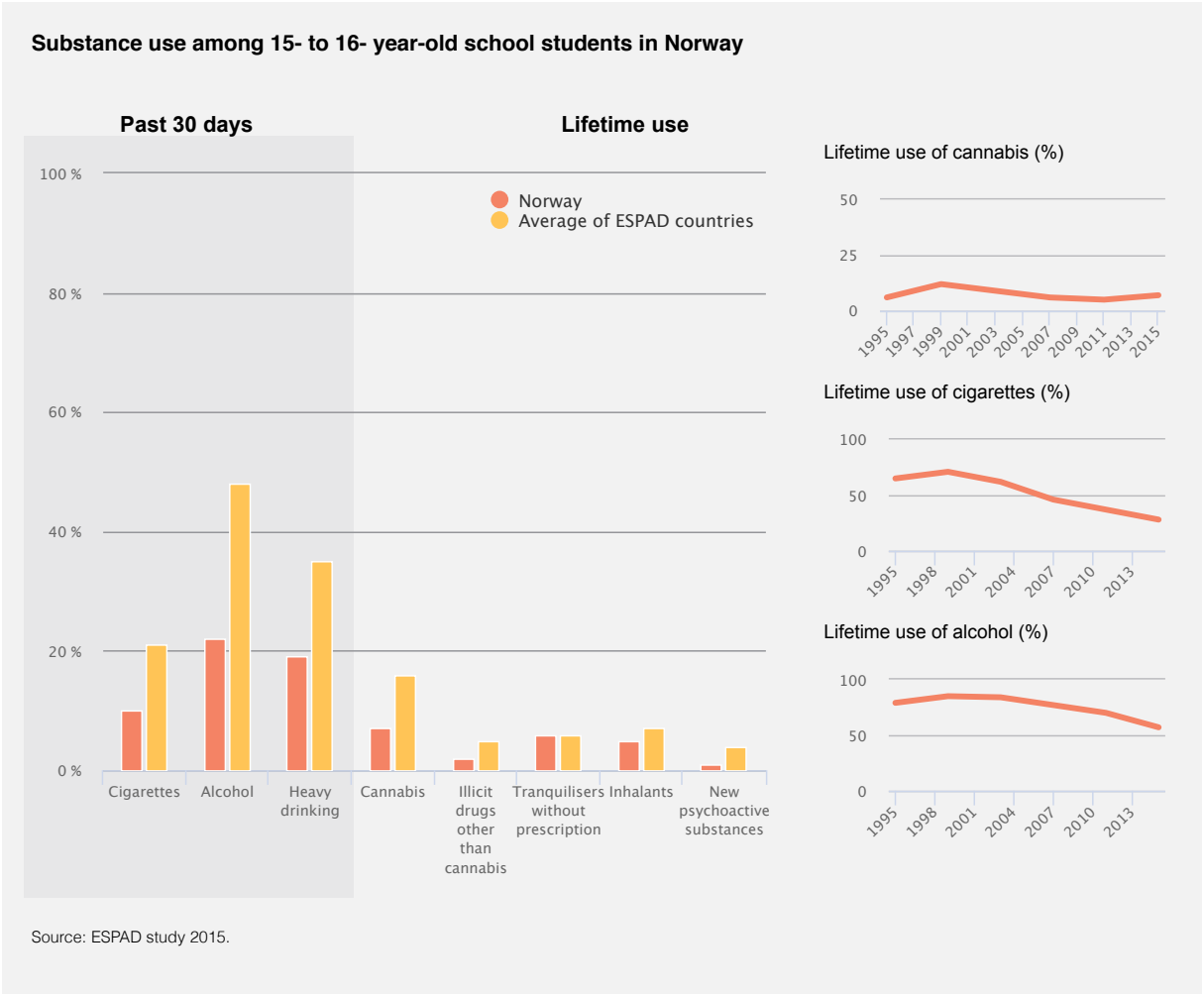




NB: Estimated last-year prevalence of drug use in 2016.

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 (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 each less than half the ESPAD average.



Source: ESPAD study 2015.

High-risk drug use and trends

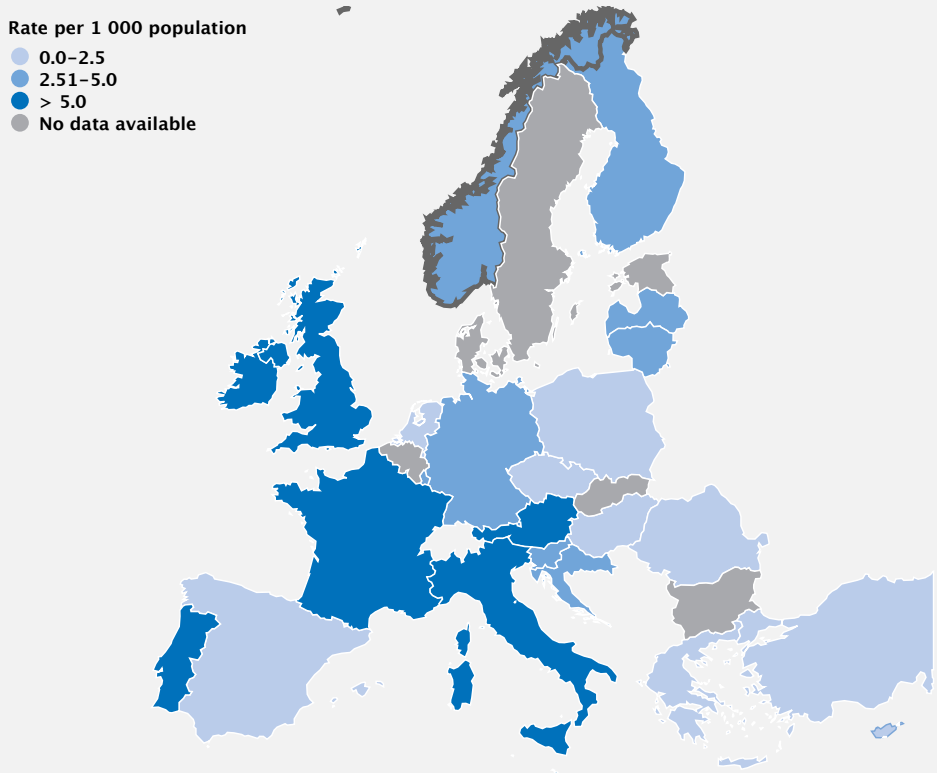
Studies reporting estimates of high-risk drug use can help to identify the extent of the more entrenched drug use problems, while data on first-time entrants to specialised drug treatment centres, when considered alongside other indicators, can inform an understanding of the nature of and trends in high-risk 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. It was estimated that the population of PWID was around 8 900 people in 2015 (2.6 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.

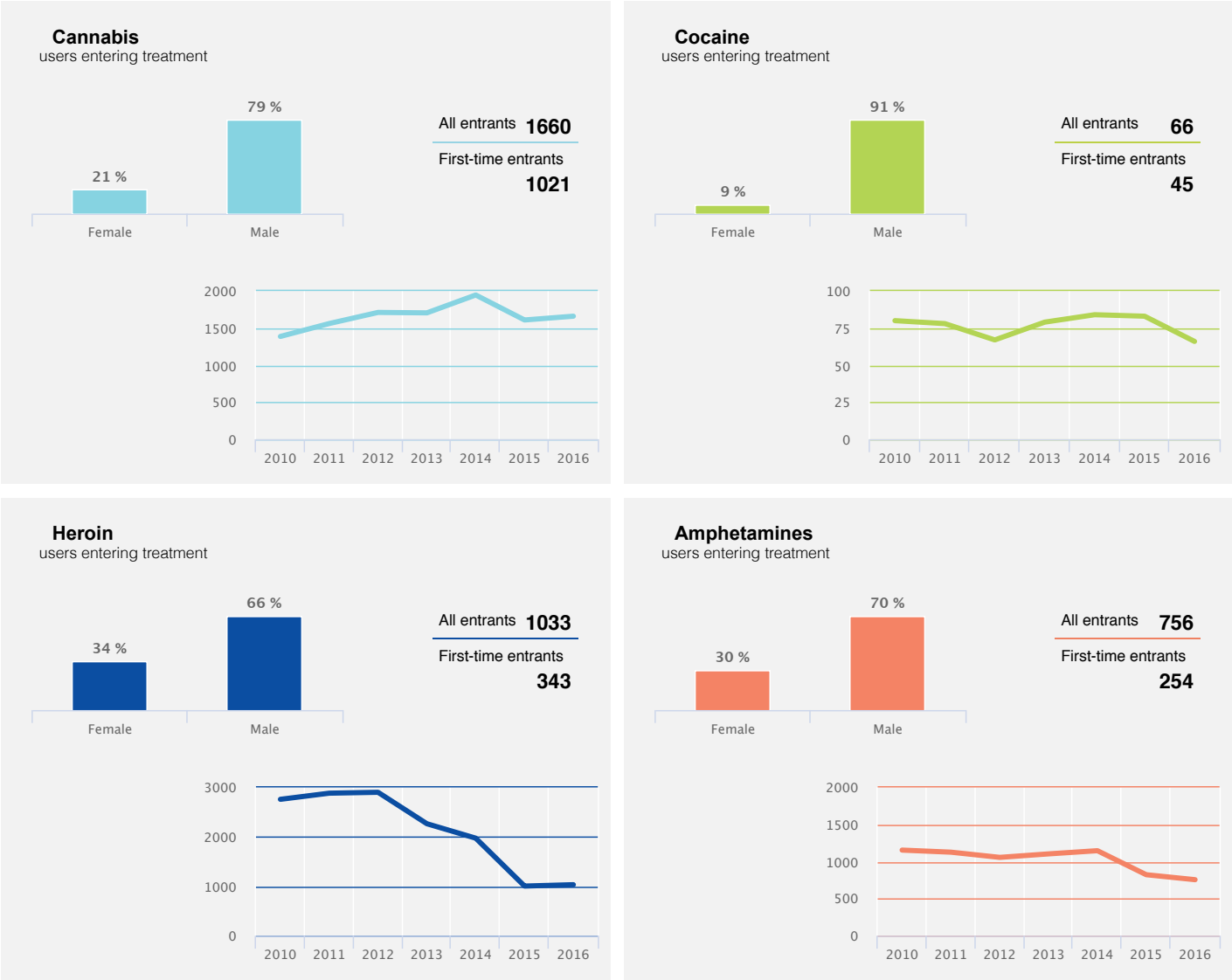
Data from specialised treatment centres in Norway indicate that polydrug users are the main group entering drug treatment; the other main groups are users of cannabis and opioids. The long-term analysis indicates that there has been a decrease in the number of clients seeking treatment as a result of heroin (and opioid) use over recent years. 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 in treatment varies by primary drug and type of programme.

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



NB: Year of data 2016, or latest available year

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



Drug harms

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) hepatitis C virus (HCV) infection cases has been in decline since 2008; however, the available data suggest that around 8 out of 10 HCV cases 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 infection remains high.

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

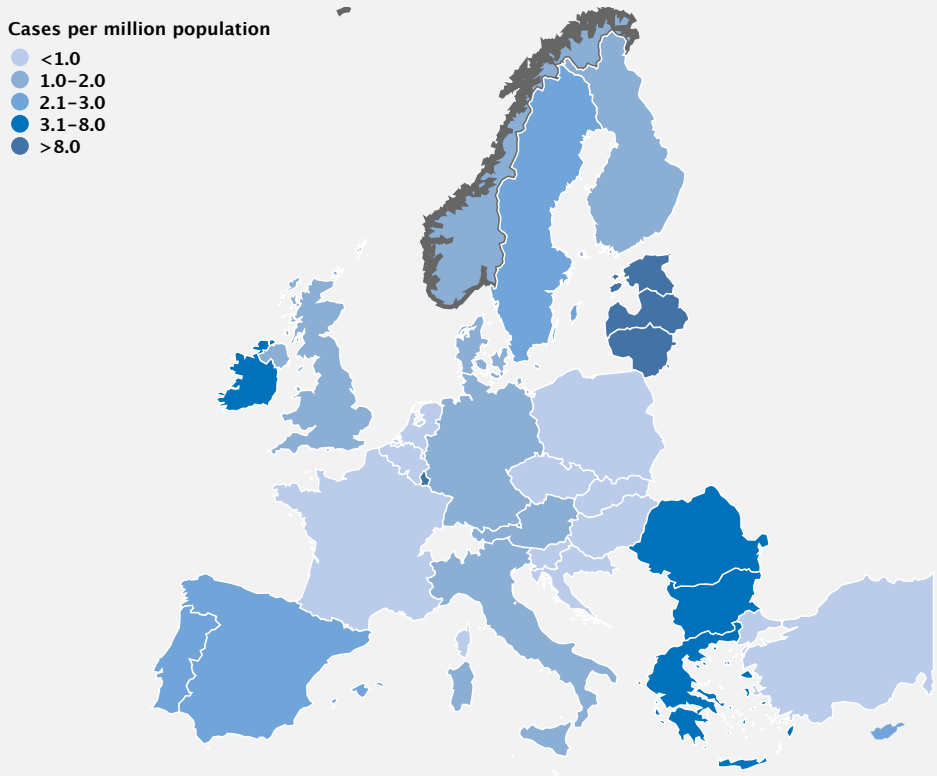
region	HCV	HIV
National	56.99	1.52
Sub-national	:	:

Year of data: 2016
Source: national opioid substitution treatment programme

It has been reported that the prevalence of hepatitis B virus (HBV) infections among PWID increased considerably between 1995 and 2008, but has remained relatively stable since then. Free of charge HBV vaccination has been offered to PWID since the mid-1980s.

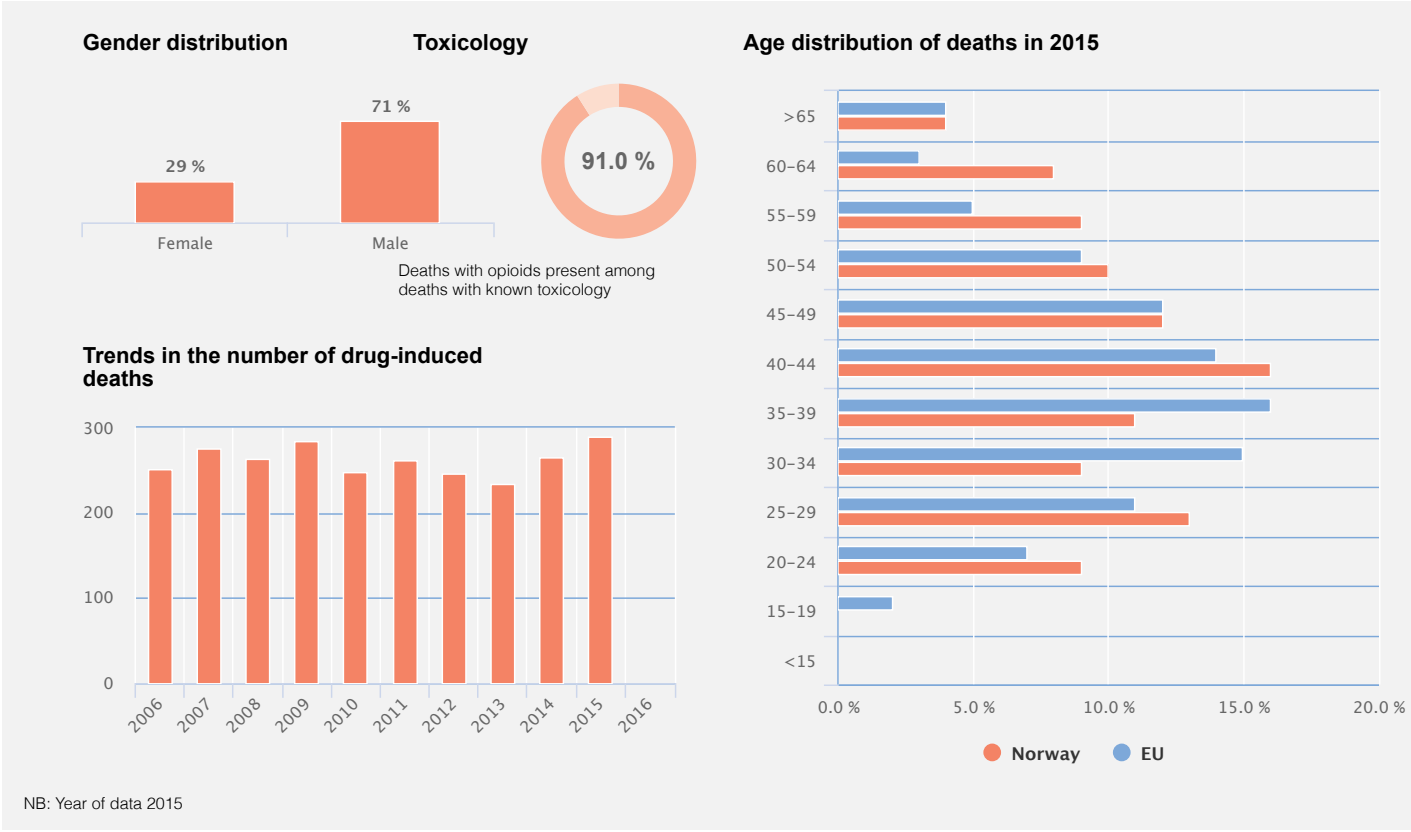
Injecting remains the most common route of administration among high-risk drug users, who as a result are more susceptible not only to viral, but also to bacterial, infections, such as botulism. Between 1997 and 2015, a total of 27 cases of wound botulism were reported, including sporadic cases and minor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

Newly diagnosed HIV cases attributed to injecting drug use



NB: Year of data 2016, or latest available year. Source: ECDC.

Characteristics of and trends in drug-induced deaths in Norway



NB: Year of data 2015

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. In this framework, a review of recreational drug toxicity showed that new psychoactive substances (NPS) were found in around 8 % of the cases, although they were not clinically suspected. Still, the majority of patients treated for recreational drug toxicity had consumed traditional drugs (amphetamines, heroin, benzodiazepines, etc.).

Another source of information is the number of emergency calls resulting in ambulances being dispatched to the Oslo drug consumption room, which decreased slightly in 2016 compared with 2015 (294 and 333 times respectively).

Bergen is the location of another source of information, and provides a biannual report on the number of drug- related emergency calls in the city. More than a third of the drug-related call-outs registered by the Section for Acute Medicine in Bergen between October 2015 and September 2016 were related to opioids, and a quarter to gamma-hydroxybutyrate (GHB)/gamma-butyrolactone (GBL).

In general, injectable opioids (such as heroin) are believed to be the main reason for non-fatal overdoses in Norway. Nevertheless GHB/GBL is also the cause of a significant number of drug-related emergencies.

Drug-induced deaths and mortality

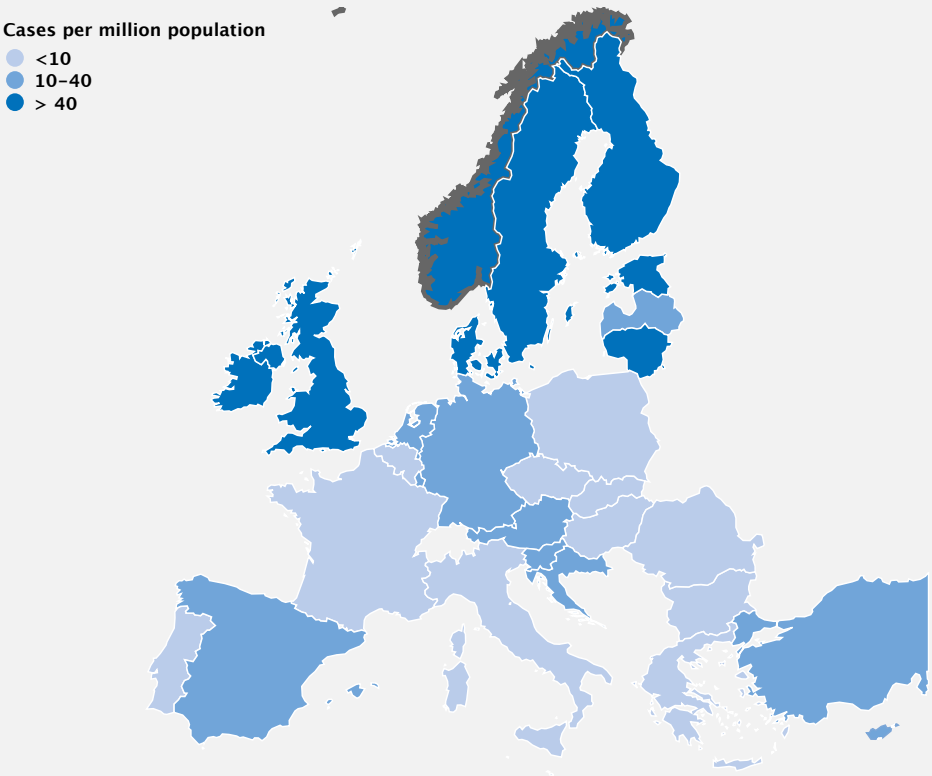
Drug-induced deaths are deaths that can be attributed directly to the use of illicit drugs (i.e. poisonings and overdoses).

In 2015, the Cause of Death Register reported an increase in the number of drug-induced deaths compared with 2014 and 2013. Oslo and Bergen reported the highest numbers of deaths; however, drug-induced deaths were detected in all counties. The majority of victims were male. In recent years, there has been an increase in the age of those dying as a result of overdoses in Norway, and in 2015 the victims were on average almost 47 years old. According to toxicological reports, opioids, mainly heroin, but also morphine/codeine, methadone and other synthetic opioids, were found to be the drug most commonly involved in drug-induced deaths.

The annual opioid substitution treatment (OST) survey from 2016 showed a mortality rate (all causes) of 1.2 % (corrected rate) per year for patients in OST (similar to the level in 2015), and that these deaths were dominated by somatic causes. Overall, the situation in Norway is stable in terms of the characteristics and contexts of those who died.

The latest European average of drug-induced mortality rate among adults (aged 15-64 years) was 21.8 deaths per million. In Norway, this rate was 81.23 deaths per million in 2015. Comparison between countries should be undertaken with caution. Reasons include different reporting systems and case definition and registration processes, as well as under-reporting in some countries.

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



"NB: Year of data 2016, or latest available year. Comparison between countries should be undertaken with caution. Reasons include systematic under-reporting in some countries, different reporting systems and case definition and registration processes."

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 Drug 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, and gives priority to early interventions. The municipal sector and the Ministry of Health and Care Services have agreed to establish a programme for public health work in the municipalities called the Public Health Programme (2017-2027) , with the aim of integrating mental health and drug prevention as a part of public health work.

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 a regional level. Seven regional competence centres are key partners in coordinating and improving local prevention in the municipalities. Prevention is funded by public funds, which are allocated to policies at a local level through various grant schemes.

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.

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 focus primarily on regulating access to alcohol and medicines, with the municipalities having a key role in the area of controlling access to psychoactive substances, predominantly alcohol, at a local level. Collaboration between agencies, including the police and municipalities, to prevent crime in the licensed trade has strengthened.

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.

Programmes to integrate parents into prevention activities are also supported. The 'Love and limits' programme, which is an adaptation of the 'Strengthening families' programme, is one of the most common in Norway and aims to enhance cooperation between school and home and to strengthen the social skills of adolescents. New target groups for universal prevention include students, employees and elderly people.

Selective prevention targets mainly young people outside the school environment, specifically, those who drop out of school early, through outreach work, 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 the staff 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. Programmes for disruptive children and their families, and children from families with problems resulting from drug dependence, are available.

Provision of interventions in schools in Norway

NB: Year of data 2016

Harm reduction

The harm reduction goals within Norway's alcohol and drug policy have been 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 called for the scaling-up of activities to prevent overdose risks and promotes emergency assistance and treatment for drug users. In June 2016, the government presented a national strategy on hepatitis which 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. 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, 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 more than 3 million syringes were distributed through low-threshold facilities in 2016, the majority being given out in Oslo, Bergen and Trondheim.

A total of 14 municipalities participated in the implementation of the national overdose strategy 2014-17, and overdose prevention programmes are funded by dedicated grants from the Directorate of Health. The strategy has been extended to 2018 and the number of participating municipalities is expected to increase. Several municipalities have also adopted local action plans and measures. By the end of 2016, more than 3 800 naloxone kits had been distributed in the participating municipalities.

Two supervised injection rooms were operational in Norway by the end of 2016, in Oslo and Bergen. Since the one in Oslo was established, about 300 000 injections have been supervised there, with no fatality occurring.

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	No	No
Bulgaria	Yes	No	No	No
Croatia	Yes	No	No	No
Cyprus	Yes	No	No	No
Czech Republic	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 an 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 drugs policy reform of 2004 stipulates that 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.

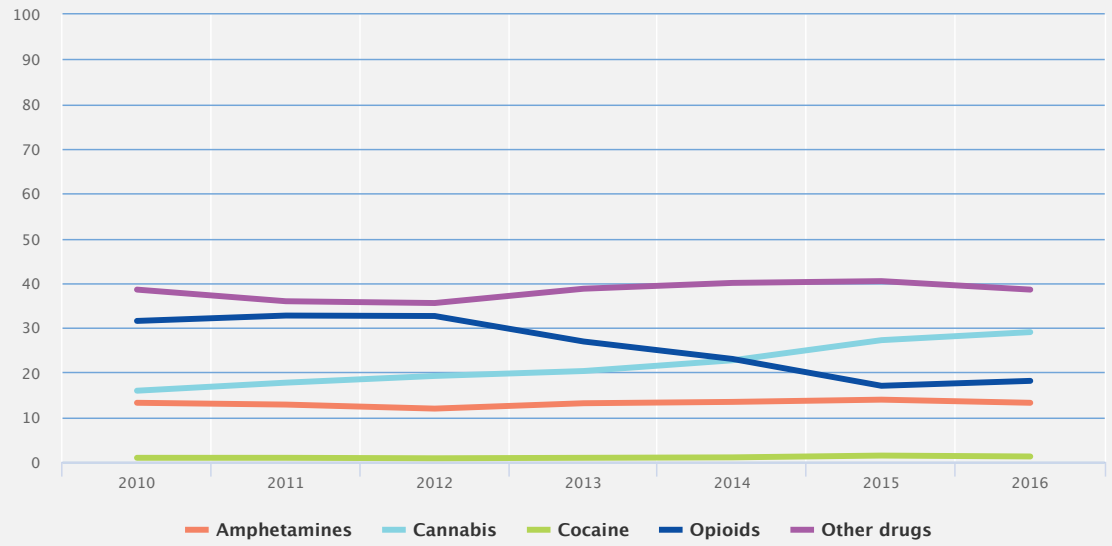
Treatment provision

In 2016, a total of 17 925 clients were treated in Norway, the majority of whom were treated in outpatient settings.

The largest group had opioid dependence or problem use as their primary diagnosis, followed by those who received treatment because of cannabis dependence or problem use and those who received treatment because of polydrug use.

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 2016, 7 554 clients received OST. Approximately 6 out of 10 clients were treated with buprenorphine-based medications, while the remaining clients were treated with methadone, and slow-release morphine was prescribed to a small proportion of clients. The long-term analysis indicates some reduction in new OST admissions since 2011. 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.

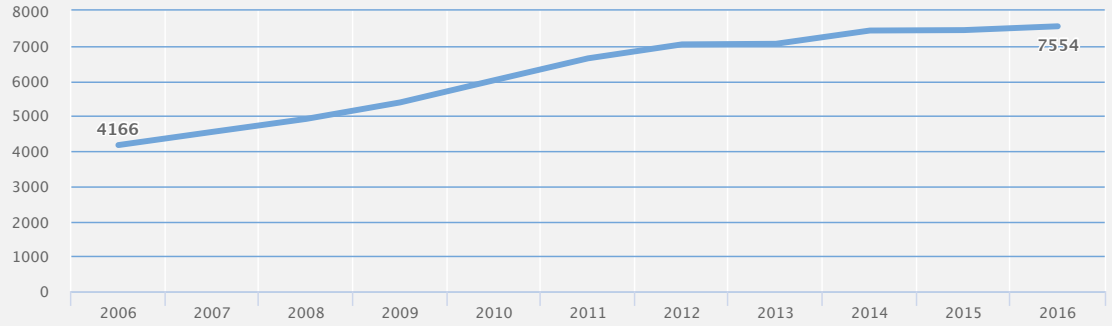
Trends in percentage of clients entering specialised drug treatment, by primary drug, in Norway



NB: Year of data 2016. Other substances include clients entering treatment due to poly-drug use. In 2016 clients entering treatment due to poly-drug use accounted for 27% of all clients entering treatment.

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: Year of data 2016.

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. An increase in the number of prisoners has been observed in recent years.

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. A recent study indicated that just over one third of inmates had used illicit substances while they were in prison, with cannabis, opioid substitution treatment (OST) medication, benzodiazepines, amphetamines and heroin being the most commonly reported. Around 1 in 10 prisoners have hepatitis C virus infection. A recent study documented a particularly high overdose mortality rate in the first days and the first weeks following release. Overdose deaths accounted for 85 % (*n* = 123) of all deaths during the first week following release.

A distinctive feature of the provision of interventions within the Norwegian correctional service is the 'import' model, 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.

More than half of the healthcare staff in prisons has 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. The drug treatment available in Norwegian prisons includes counselling, motivational interviewing, OST, testing and counselling for infectious diseases, education and training, and preparation for release. With regards to infectious diseases, testing, risk assessment, treatment, counselling and information are provided.

The correctional service has 13 units for addressing drug and alcohol problems. Several prisons organise drug and alcohol programmes, for example the National Substance Abuse Programme, or motivational interviews to motivate inmates to seek treatment. OST is offered by the prison health and care services. Available data indicate that 271 prisoners received OST in 2016.

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. Most prisons have a reintegration coordinator, and a reintegration guarantee was introduced in 2007-08, which ensures that binding collaborative structures are established between the correctional service and public agencies when an inmate is released from prison.

Quality assurance

The current 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 the 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.

There is no specific education system to prepare professionals for working in the area of drug demand reduction, but 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 action plan for the alcohol and drug 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. Additionally, the government has launched diverse 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 in websites and through scientific and non-scientific (national and international) journals.

Drug markets

Cannabis is the most commonly seized drug in Norway. While the Netherlands, Denmark and Spain are important in the cannabis resin distribution to Norway, in 2016 Poland emerged as a transit country for this drug, with customs reporting large (≥ 100 kg) quantities arriving in lorries from Poland via Sweden. Herbal cannabis reportedly enters via Sweden or by sea from Germany or other EU countries. 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 is brought to Norway 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 2016 in Norway came via Poland, Sweden and Germany. The MDMA/ecstasy that is available on the Norwegian market comes mainly from the Netherlands and Poland.

The long-term trend in drug seizures reported from the National Crime Investigation Service indicates an increase in the total number of seizures between 2007 and 2014, whereas in 2015 and 2016 the total number of seizures reported decreased. As a consequence, the numbers of seizures of individual substances reported in 2016 were either stable or below the levels of 2015. This may be explained by the priorities of the police and customs activities. However, in 2016, record amounts of cannabis resin and herbal cannabis were reported, while the quantity of cocaine seized remained stable, and cannabis plants, amphetamines (including methamphetamine) and MDMA were seized in lower amounts than in previous years. In 2016, the quantity of heroin seized was a quarter of that in 2015, and among the lowest for the period 2007-16.

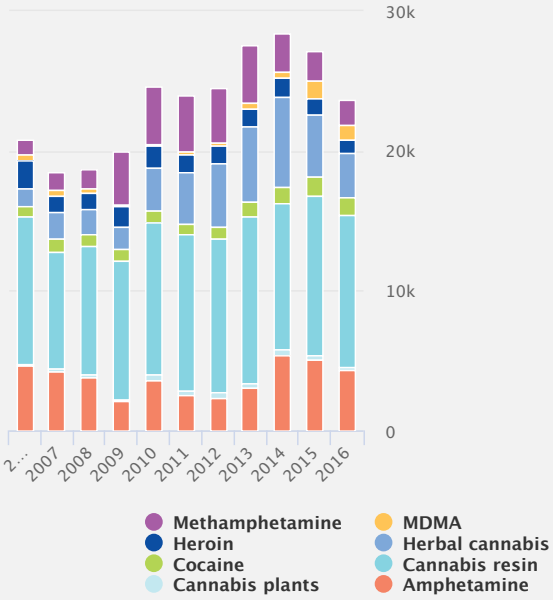
There has been an increase in the number of new psychoactive substances (NPS) seizures in Norway since 2009; however, since 2012, numbers have levelled off, and the number of reported seizures almost halved between 2015 and 2016 (860 and 460 seizures respectively). The NPS are mainly smuggled into Norway via postal shipments, mainly from the United Kingdom, Netherlands and Spain. The most recent data indicate that synthetic cannabinoids and benzodiazepine-like substances are the most frequently seized NPS.

According to national law enforcement authorities, online drug transactions have increased in recent years for NPS as well as established illicit drugs.

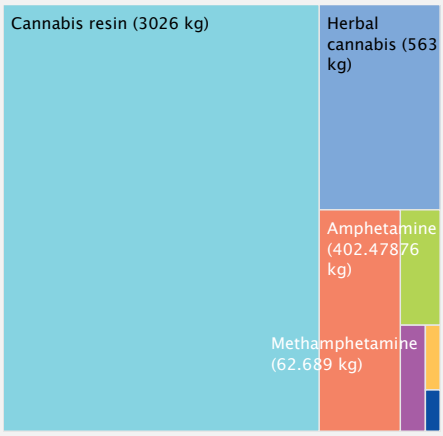
With regard to law enforcement activities, priority is increasingly being given to strengthening technology-based intelligence to tackle the challenges posed by the use of the internet and postal services for smuggling drugs into the country.

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

Number of seizures



Quantities seized



NB: Year of data 2016

Key statistics

Most recent estimates and data reported

	Year	Country data	EU range Min.	EU range Max.
Cannabis				
Lifetime prevalence of use - schools (% , Source: ESPAD)	2015	6.51	6.5	36.8
Last year prevalence of use - young adults (%)	2016	8.6	0.4	21.5
Last year prevalence of drug use - all adults (%)	2016	3.9	0.3	11.1
All treatment entrants (%)	2016	29.04	1.0	69.6
First-time treatment entrants (%)	2016	37.6	2.3	77.9
Quantity of herbal cannabis seized (kg)	2016	563	12	110855
Number of herbal cannabis seizures	2016	3190	62	158810
Quantity of cannabis resin seized (kg)	2016	3026	0	324379
Number of cannabis resin seizures	2016	10912	8	169538
Potency - herbal (% THC) (minimum and maximum values registered)	2016	n.a.	0	59.90
Potency - resin (% THC) (minimum and maximum values registered)	2016	n.a.	0	70.00
Price per gram - herbal (EUR) (minimum and maximum values registered)	2016	n.a.	0.60	111.10
Price per gram - resin (EUR) (minimum and maximum values registered)	2016	n.a.	0.20	38.00
Cocaine				
Lifetime prevalence of use - schools (% , Source: ESPAD)	2015	0.8	0.9	4.9
Last year prevalence of use - young adults (%)	2016	1.3	0.2	4.0
Last year prevalence of drug use - all adults (%)	2016	0.6	0.1	2.3
All treatment entrants (%)	2016	1.2	0.0	36.6
First-time treatment entrants (%)	2016	1.7	0.0	35.5
Quantity of cocaine seized (kg)	2016	104.1	1.00	30295
Number of cocaine seizures	2016	1233	19	41531
Purity (%) (minimum and maximum values registered)	2016	n.a.	0	99.00
Price per gram (EUR) (minimum and maximum values registered)	2016	n.a.	3.00	303.00
Amphetamines				
Lifetime prevalence of use - schools (% , Source: ESPAD)	2015	0.9	0.8	6.5
Last year prevalence of use - young adults (%)	2016	0.5	0.0	3.6
Last year prevalence of drug use - all adults (%)	2016	0.3	0.0	1.7
All treatment entrants (%)	2016	13.2	0.2	69.7
First-time treatment entrants (%)	2016	9.4	0.3	75.1
Quantity of amphetamine seized (kg)	2016	402.4	0	3380
Number of amphetamine seizures	2016	4288	3	10388
Purity - amphetamine (%) (minimum and maximum values registered)	2016	n.a.	0	100.00
Price per gram - amphetamine (EUR) (minimum and maximum values registered)	2016	n.a.	2.50	76.00
MDMA				
Lifetime prevalence of use - schools (% , Source: ESPAD)	2015	0.9	0.5	5.2
Last year prevalence of use - young adults (%)	2016	1.6	0.1	7.4
Last year prevalence of drug use - all adults (%)	2016	0.6	0.1	3.6
All treatment entrants (%)	2016	n.a.	0.0	1.8
First-time treatment entrants (%)	2016	n.a.	0.0	1.8
Quantity of MDMA seized (tablets)	2016	38353	0	3783737
Number of MDMA seizures	2016	1030	16	5259
Purity (MDMA mg per tablet) (minimum and maximum values registered)	2016	n.a.	1.90	462.00
Purity (MDMA % per tablet) (minimum and maximum values registered)	2016	n.a.	0	88.30
Price per tablet (EUR) (minimum and maximum values registered)	2016	n.a.	1.00	26.00
Opioids				
High-risk opioid use (rate/1 000)	2013.00	2.6	0.3	8.1
All treatment entrants (%)	2016	18.1	4.8	93.4
First-time treatment entrants (%)	2016	12.6	1.6	87.4
Quantity of heroin seized (kg)	2016	13.4	0	5585

Number of heroin seizures	2016	998	2	10620
Purity - heroin (%) (minimum and maximum values registered)	2016	n.a.	0	92.00
Price per gram - heroin (EUR) (minimum and maximum values registered)	2016	n.a.	4.00	296.00
Drug-related infectious diseases/injecting/death				
Newly diagnosed HIV cases related to Injecting drug use -- aged 15-64 (cases/million population, Source: ECDC)	2016	1.5	0.0	33.0
HIV prevalence among PWID* (%)	2016	1.52	0.0	31.5
HCV prevalence among PWID* (%)	2016	56.99	14.6	82.2
Injecting drug use -- aged 15-64 (cases rate/1 000 population)	2015	2.6	0.1	9.2
Drug-induced deaths -- aged 15-64 (cases/million population)	2015	81.23	1.4	132.3
Health and social responses				
Syringes distributed through specialised programmes	2016	2919344	22	6469441
Clients in substitution treatment	2016	7554	229	169750
Treatment demand				
All entrants	2016	5716	265	119973
First-time entrants	2016	2716	47	39059
All clients in treatment	2016	17925	1286	243000
Drug law offences				
Number of reports of offences	2016	36184	775	405348
Offences for use/possession	2016	19686	354	392900

* PWID — People who inject drugs.

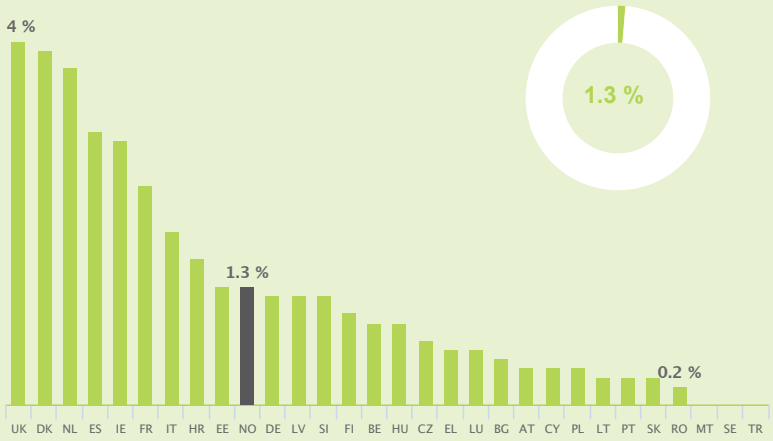
The percentage of clients in treatment for opioids is a minimum value, not accounting for opioid clients registered as polydrug users.

EU Dashboard

EU Dashboard

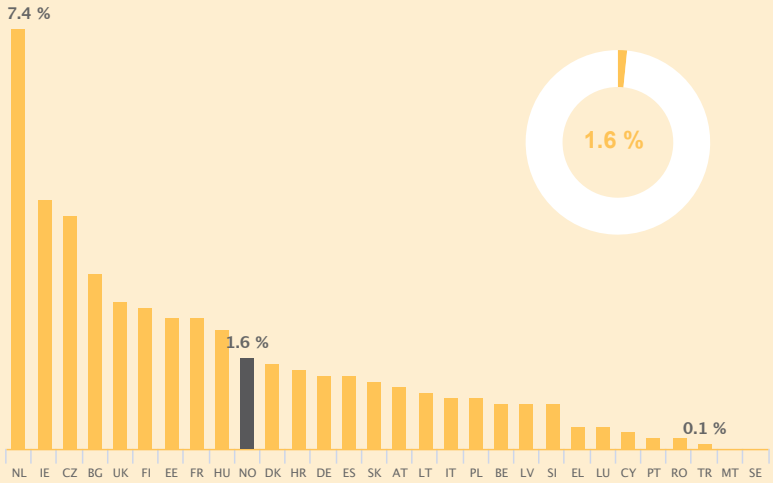
Cocaine

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



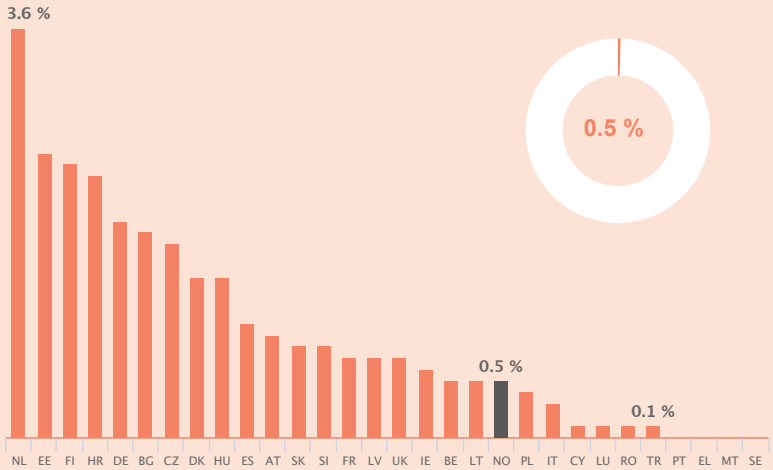
MDMA

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



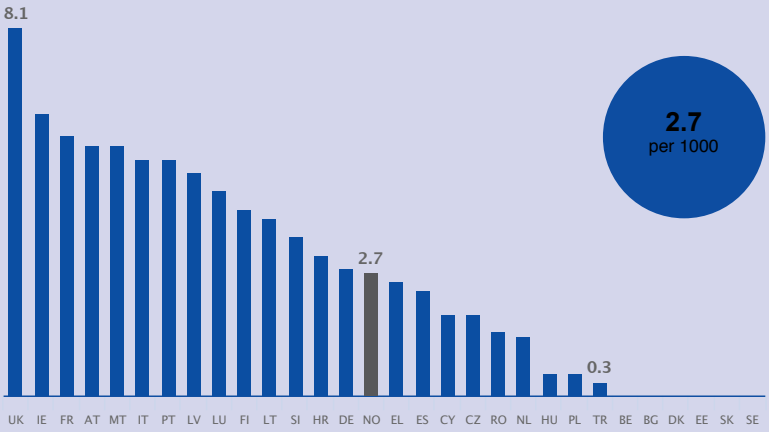
Amphetamines

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



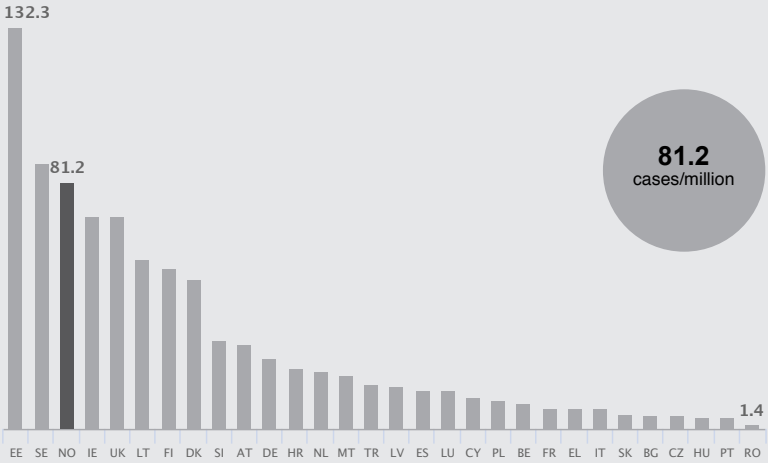
Opioids

High-risk opioid use (rate/1 000)



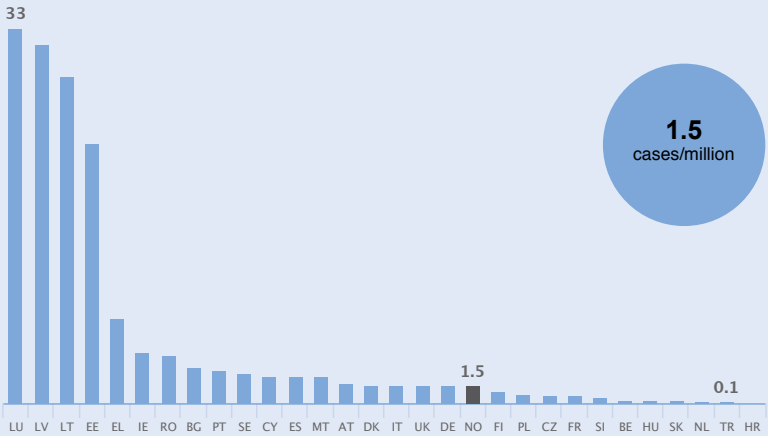
Drug-induced mortality rates

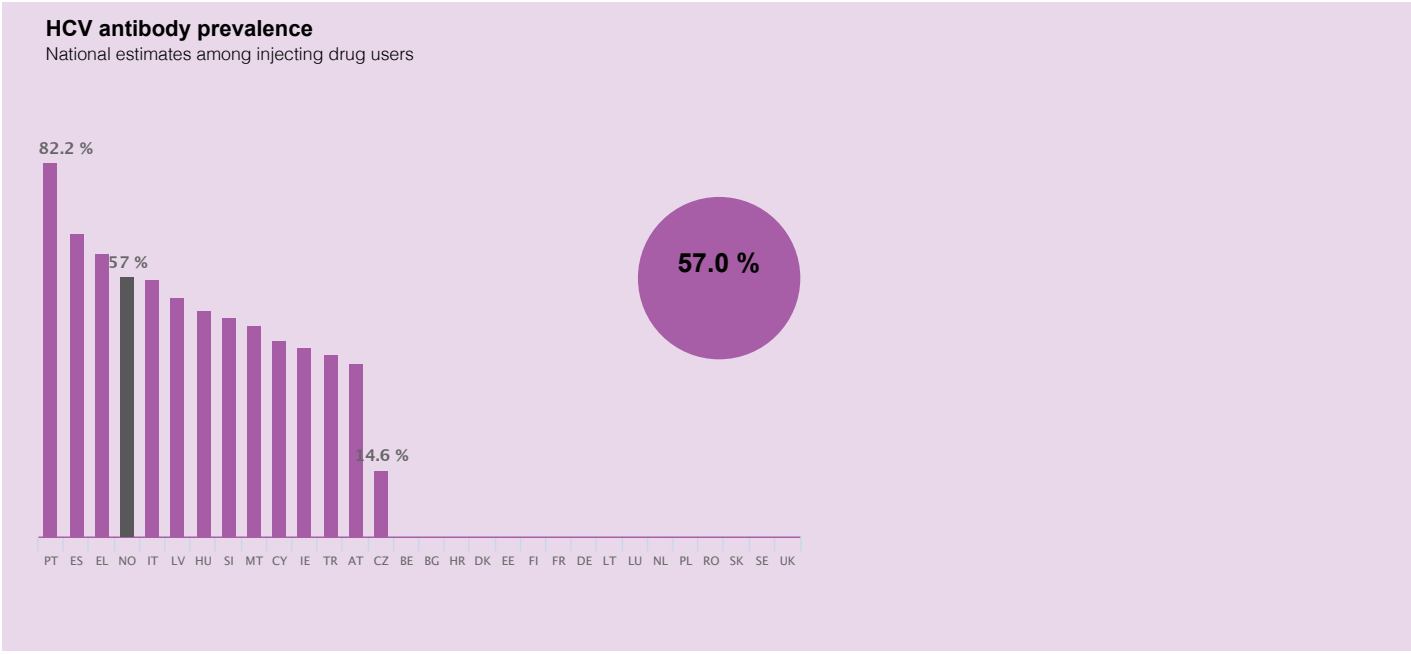
National estimates among adults (15-64 years)



HIV infections

Newly diagnosed cases attributed to injecting drug use





"NB: Caution is required in interpreting data when countries are compared using any single measure, as, for example, di?erences 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. Countries with no data available are marked in white. The age range for last year prevalence among young adults is 16 -34."

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 forensic science, physical and mental health, the prevention of communicable diseases and the prevention of harmful environmental influences. It is placed directly under the Ministry of Health and Care Services.

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