



Norway

Country Drug Report 2017



Contents: At a glance | National drug strategy and coordination (p. 2) | Public expenditure (p. 3) | Drug laws and drug law offences (p. 4) | Drug use (p. 5) | Drug harms (p. 8) | Prevention (p. 10) | Harm reduction (p. 11) | Treatment (p. 12) | Drug use and responses in prison (p. 14) | Quality assurance (p. 15) | Drug-related research (p. 15) | Drug markets (p. 16) | Key drug statistics for Norway (p. 18) | EU Dashboard (p. 20)

THE DRUG PROBLEM IN NORWAY AT A GLANCE

Drug use

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

Cannabis

8.6 %



6.1 % 11 %

Other drugs

Cocaine	2.2 %
MDMA	1.2 %
Amphetamines	0.3 %

High-risk opioid users

9 015
(6 708 - 13 977)

Opioid substitution treatment clients

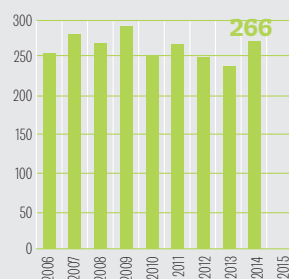
7 498

Syringes distributed

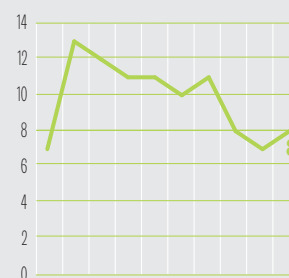
through specialised
programmes

2 500 192

Overdose deaths



HIV diagnoses attributed to injecting



Source: ECDC

Drug law offences

48 152

Top 5 drugs seized

ranked according to quantities
measured in kilograms

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

Population

(15-64 years)

3 399 645

Source: EUROSTAT
Extracted on: 26/03/2017

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 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.

About this report

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 2015 (or most recent year) and are provided to the EMCDDA by the national focal point, unless stated otherwise.

An interactive version of this publication, containing links to online content, is available in PDF, EPUB and HTML format: www.emcdda.europa.eu/countries

National drug strategy and coordination

National drug strategy

Norway's drug policy objectives are set out in the 2012 government white paper 'See me! A comprehensive drugs and alcohol policy', which covers alcohol, illicit drugs, addictive medications and doping (Figure 1). These substances are addressed through five areas: (i) prevention and early intervention; (ii) coordination — services working together; (iii) greater competence and better quality services; (iv) help for those with severe drug dependence — reducing the number of overdose fatalities; and (v) efforts aimed at next of kin and at reducing harm to third parties. 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 priority is given to early interventions. This policy manifests as restrictions on alcohol consumption, combating drugs through prohibition and targeting drug trafficking and organised crime. Further development of access to opioid substitution treatment (OST) and the reduction of open drug scenes are also set out in

the paper. The objectives of the 2012 white paper have been supported and elaborated by subsequent government white papers and strategies, which have a more targeted focus. These include the prevention-focused 2014 public health white paper 'Coping and opportunities', the National Overdose Strategy (2014-17) and the Action Plan for Alcohol and Drug Field (2016-20).

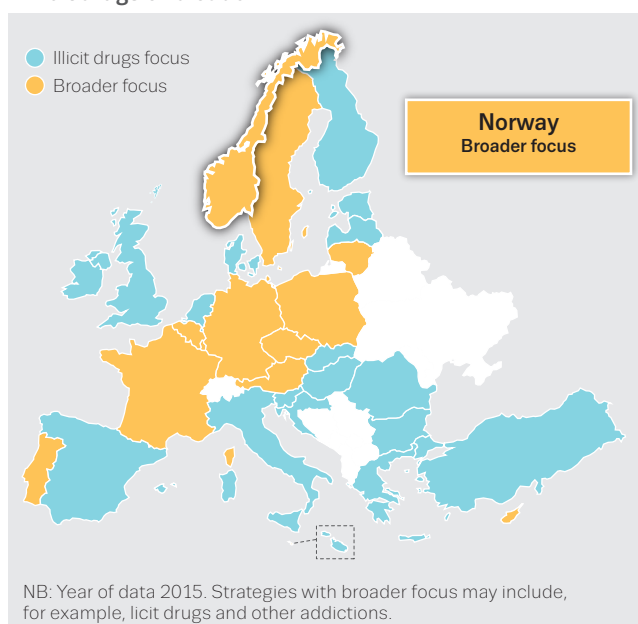
Like other European countries, Norway evaluates its drug policy and strategy through ongoing indicator monitoring and specific research projects. A final internal evaluation of the Action Plan for the Drugs and Alcohol Field (2007-12) was completed in 2012. It found that nearly all of the 147 measures outlined in the plan had been undertaken.

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

FIGURE 1

Focus of national drug strategy documents: illicit drugs or broader



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.

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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, the drug and alcohol fields were allocated a budget of EUR 266.7 million (NOK 2.4 billion). An additional budget of EUR 20.5 million (NOK 185 million) for interdisciplinary specialised treatment for problem drug and alcohol use was foreseen in 2016; and expenses for specialist health services were estimated to be EUR 558.83 million (NOK 5 193 billion) in 2015. In addition, the (partial) financing of various public institutions in the alcohol and drugs field amounted to approximately EUR 30.8 million (NOK 276 million) in 2015.

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 nature of the funding system and the lack of consolidated data mean that reporting on the total size and trends in drug-related public expenditure in Norway is not possible.

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 (Figure 2).

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 is involved, its quantity 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 three-year trial of a drug treatment programme under court control started in 2006. This was subsequently extended until the end of 2014, and was finally accepted as a permanent and nationwide programme by the government in 2016.

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.

FIGURE 2

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

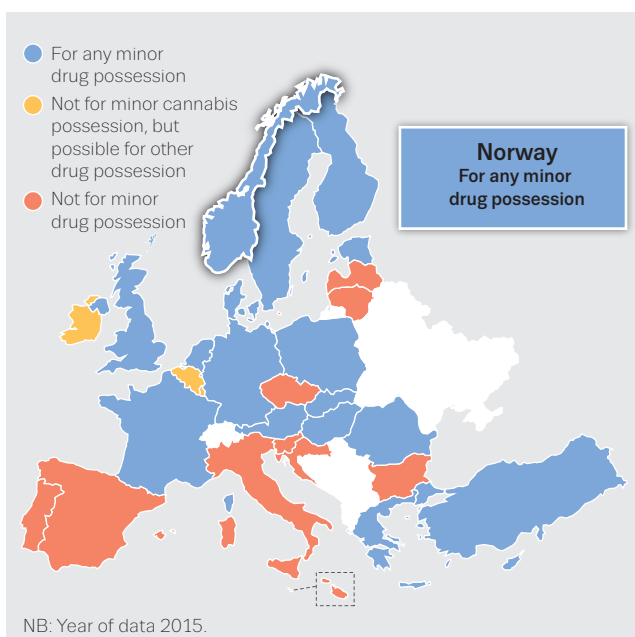
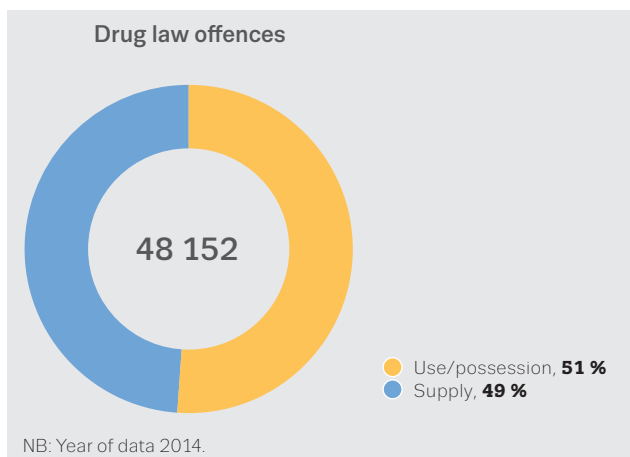


FIGURE 3

Reported drug law offences in Norway



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.

In the last decade, the number of reported DLOs has increased in Norway, and a total of 48 152 DLOs were reported in 2014. The available data indicate that the proportions of use-related and supply-related offences were almost equal among the reported DLOs (Figure 3).

Drug use

Prevalence and trends

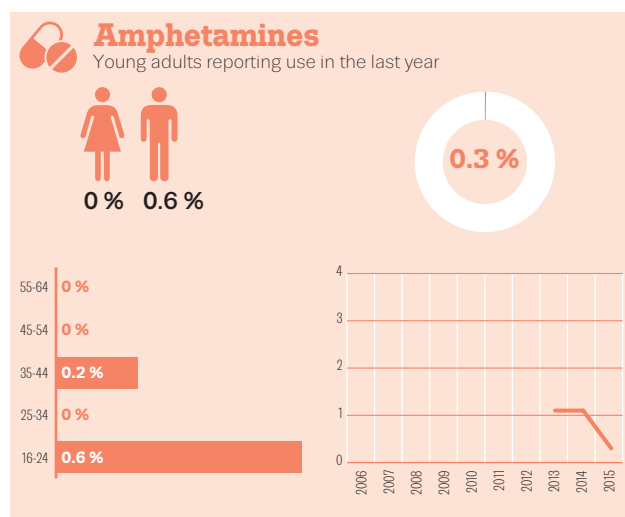
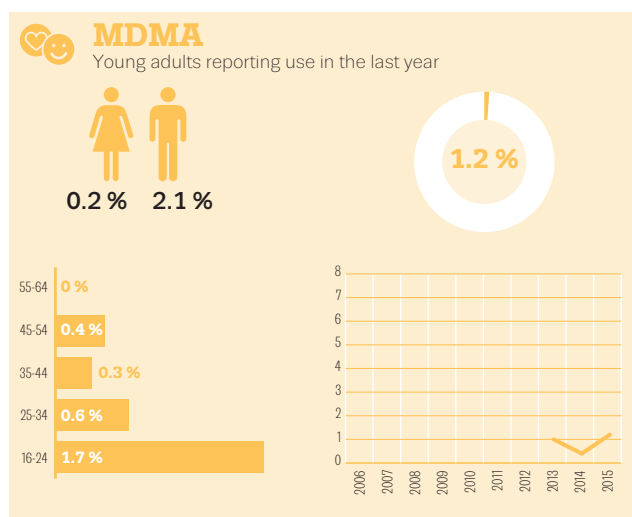
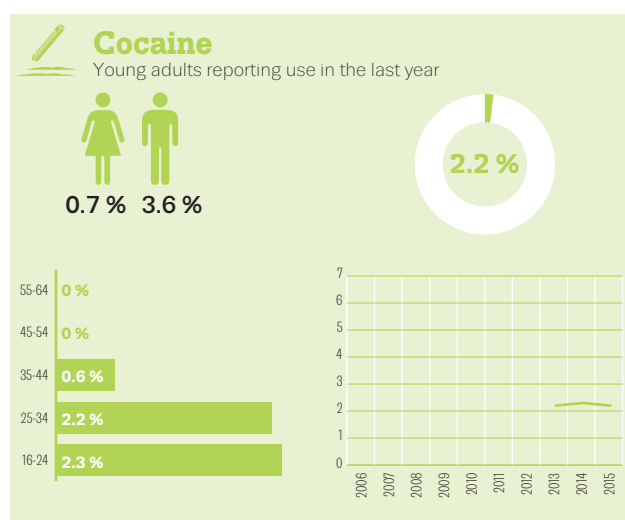
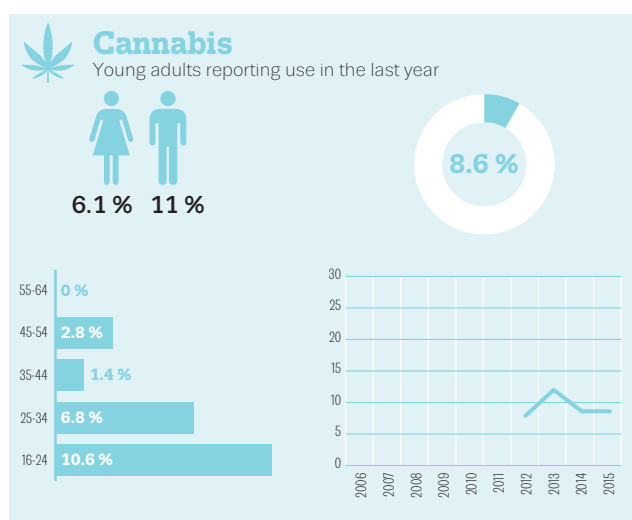
Data from the annual general population surveys carried out since 2012 indicate that cannabis is the most commonly used illicit drug among the general population in Norway, and its level of use has been relatively stable in recent years. Use of all other substances is reported to be lower, with cocaine 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 (Figure 4).

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 community level, based on the levels of different illicit drugs and their metabolites in sources of wastewater. An increase in levels of the stimulant MDMA/ecstasy was reported in 2016, which may be related to the increased purity or increased availability and use of the drug. Oslo is among the European cities with relatively high methamphetamine levels in wastewater, although a decreasing trend has been observed since 2014.

FIGURE 4

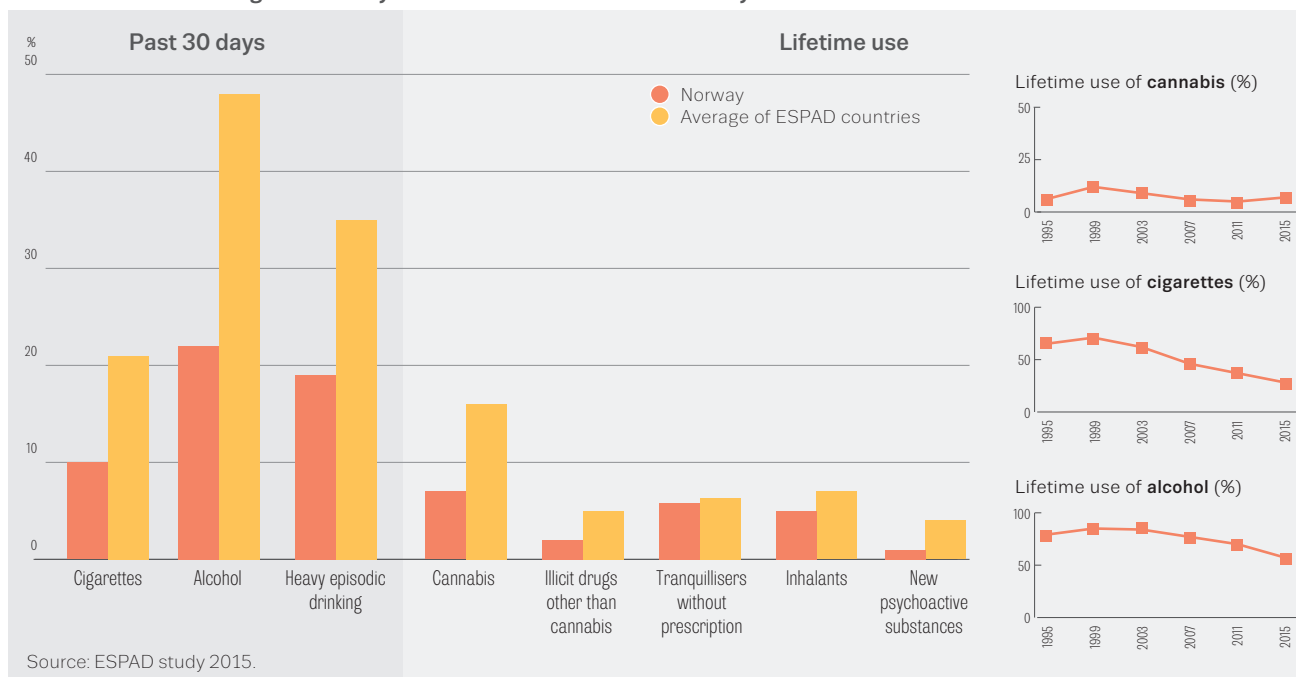
Estimates of last-year drug use among young adults (16-34 years) in Norway



NB: Estimated last-year prevalence of drug use in 2015.

FIGURE 5

Substance use among 15- to 16-year-old school students in Norway



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 appears to have a generally low prevalence of substance use. Norwegian students reported significantly 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 (Figure 5).

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 the first-time entrants to specialised drug treatment centres, when considered alongside other indicators, can inform understanding on the nature and trends in high-risk drug use.

High-risk drug use in Norway is linked mainly to injecting amphetamines and opioids, mainly heroin. The latest available estimate indicates that, following a decline between 2008 and 2012, the number of people who inject drugs (PWID) has stabilised since 2012 (8 400 people in 2014). The estimated number of opioid users who are not participating in OST has also remained relatively stable in recent years (Figure 6).

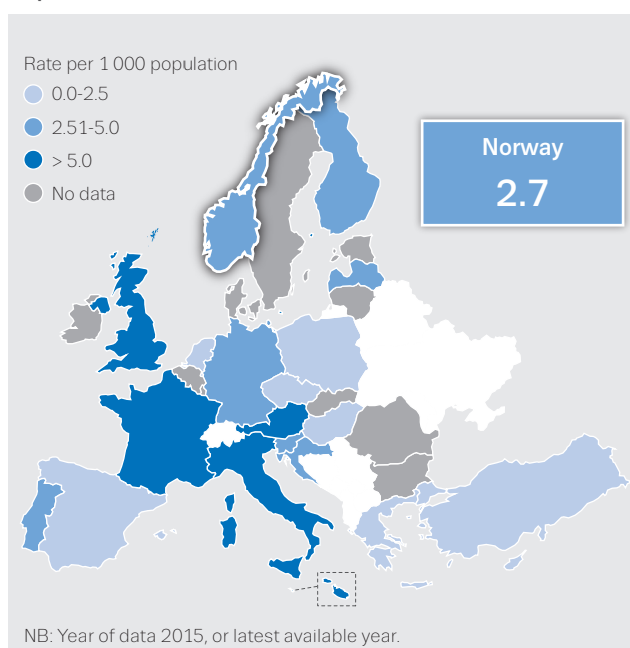
Based on data from the general population surveys, it has been estimated that 0.3 % of 16- to 64-year-olds in Norway use cannabis daily or almost daily, although daily or almost daily cannabis use is far more common among marginalised groups, such as homeless drug users.

High-risk drug use in Norway is linked mainly to injecting amphetamines and opioids

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. However, it is necessary to consider that the Norwegian monitoring system is undergoing reorganisation, which may affect data validity. The long-term analysis indicates that there has been a decrease in the number of clients seeking treatment as a result of 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.

FIGURE 6

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



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 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 (Figure 7) and has remained stable over recent years. However, the available data (on both acute and chronic cases) for hepatitis C virus (HCV) infection show that almost 9 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 is high (Figure 8).

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 of drugs among high-risk 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 botulism were reported, including 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.

Drug-related emergencies

In Norway, information on acute drug-related emergencies is available for Oslo and Bergen. Two hospitals in 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. Another source of information is the number of emergency calls resulting in ambulances being despatched to the Oslo drug consumption rooms, which increased slightly in 2015 compared with 2013-14. Bergen provides a semi-annual report on the number of drug-related emergency calls in the city.

FIGURE 7

Newly diagnosed HIV cases attributed to injecting drug use

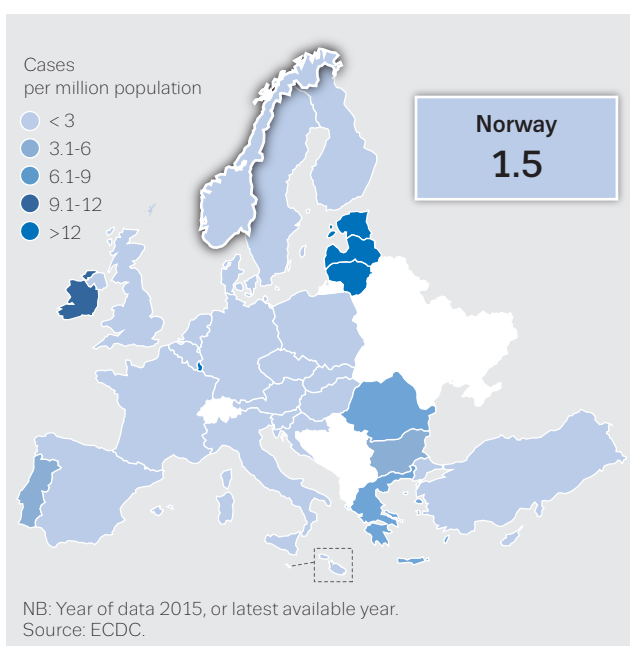
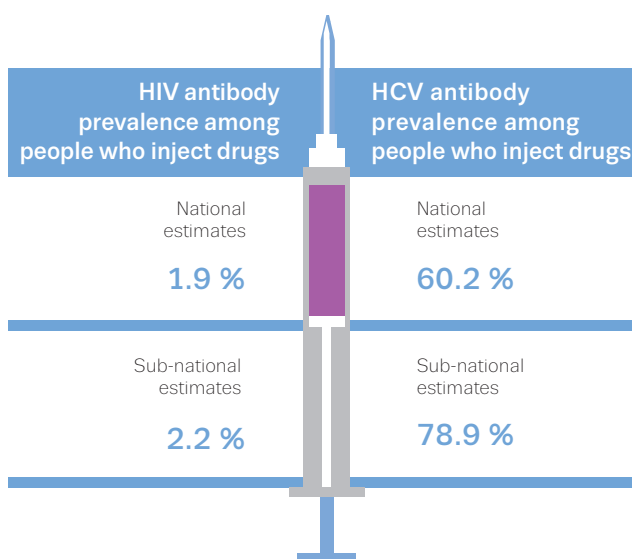


FIGURE 8

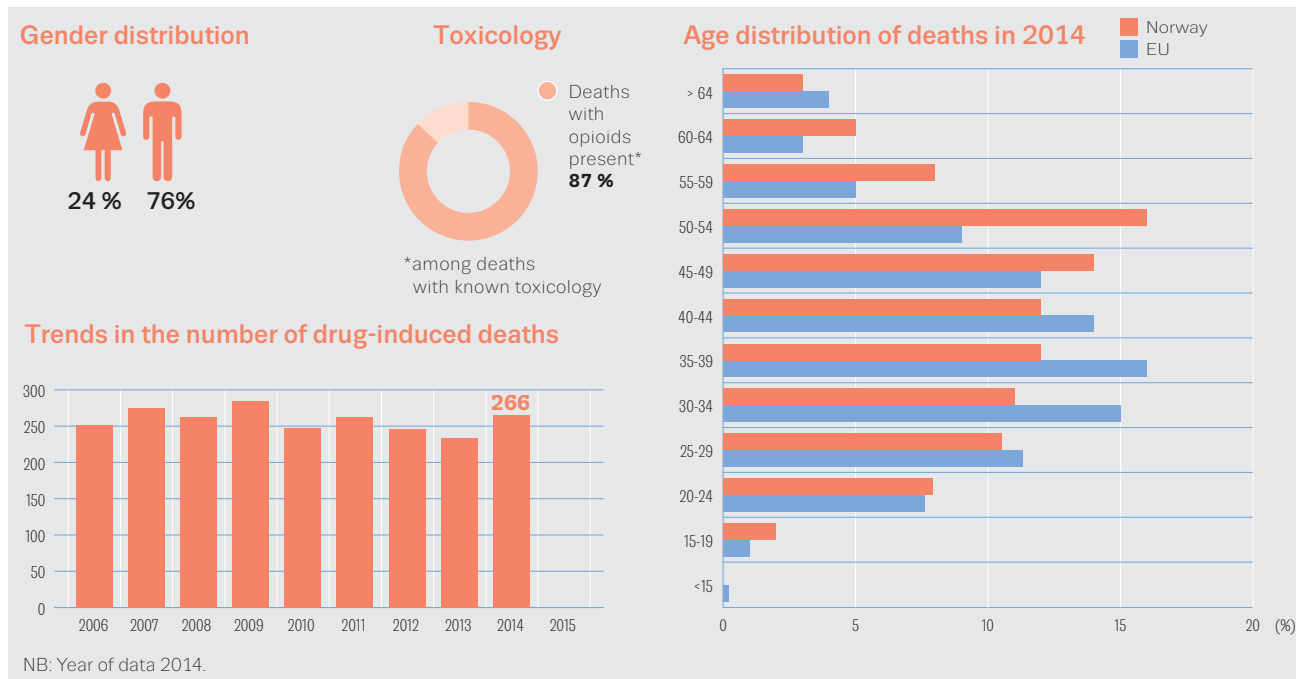
Prevalence of HIV and HCV antibodies among people who inject drugs in Norway



NB: Year of data 2015.

FIGURE 9

Characteristics of and trends in drug-induced deaths in Norway



In general, injectable opioids (such as heroin) are believed to be the main reason for non-fatal overdoses in Norway. Nevertheless, the data available from the Euro-DEN for Oslo and the details of emergency calls for Bergen suggest that gamma-hydroxybutyrate (GHB)/gamma-butyrolactone (GBL) is also the cause of a significant number of drug-related emergencies.

Drug-induced deaths and mortality

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

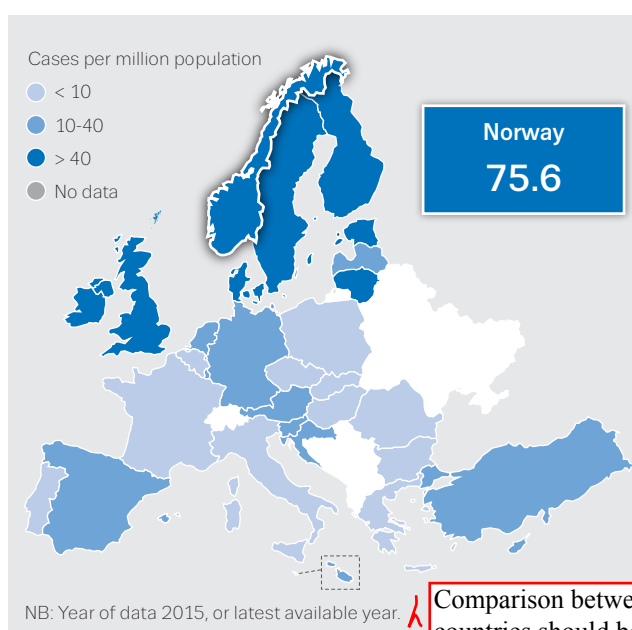
In 2014, the Cause of Death Register reported an increase in the number of drug-induced deaths compared with 2013. According to toxicological reports, opioids were found to be the drug most commonly involved in drug-induced deaths. The majority of victims were male. In recent years, there has been an increase in the age of those dying as a result of overdoses in Norway (Figure 9).

The most recent drug-induced mortality rate among adults (aged 15-64 years) was 75.6 deaths per million (Figure 10), almost four times the European average of 20.3 deaths per million.

The latest European average of drug-induced mortality rate among adults (aged 15-64 years) was 20.3 deaths per million. In Norway, this rate was 75.6 deaths per million in 2014 (Figure 10). 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.

FIGURE 10

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



Comparison between the countries should be undertaken with caution.

Prevention

In Norway, the prevention of drug and alcohol use is an important public health priority that is emphasised in the government's 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 Norwegian Directorate of Health (NDH) 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 monies, which are allocated to policies at a local level through various grant schemes.

An important aspect of the Norwegian prevention culture 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 drug 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.

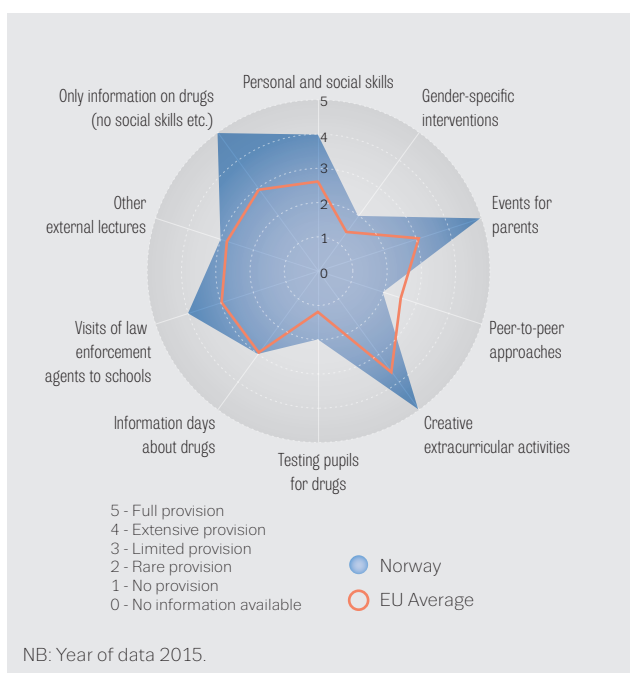
In schools, priority is given to universal prevention activities that are comprehensively integrated into a learning environment, while the implementation of curricular school-based prevention programmes is decreasing. Programmes to integrate parents into prevention activities are also supported. The '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 (Figure 11).

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 and young cannabis smokers. 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, and programmes for disruptive children and their families and children from families with problems resulting from drug dependence are also available.

FIGURE 11

Provision of interventions in schools in Norway (expert ratings)



Harm reduction

Endorsed as integral part of the treatment and health services for people who use drugs in 1996, the harm reduction goals within Norway's comprehensive alcohol and drug policy have been defined more recently in the white paper 'See me! A comprehensive drugs and alcohol policy' and were confirmed in the current national action plan. The aim of harm reduction measures is to improve health and a more dignified life for substance users, including the prevention of overdoses and drug-related infectious diseases, such as HCV infection. Moreover, a national overdose strategy for 2014-17 calls for the scaling-up of activities to prevent overdose risks and promotes emergency assistance and treatment for drug users. In Norway, the municipalities are responsible for the organisation of harm reduction measures on the basis of local needs and challenges. While cooperation between local public health and social services constitutes the backbone of service provision, private non-profit organisations are important partners in the implementation of harm reduction in the municipalities.

Harm reduction interventions

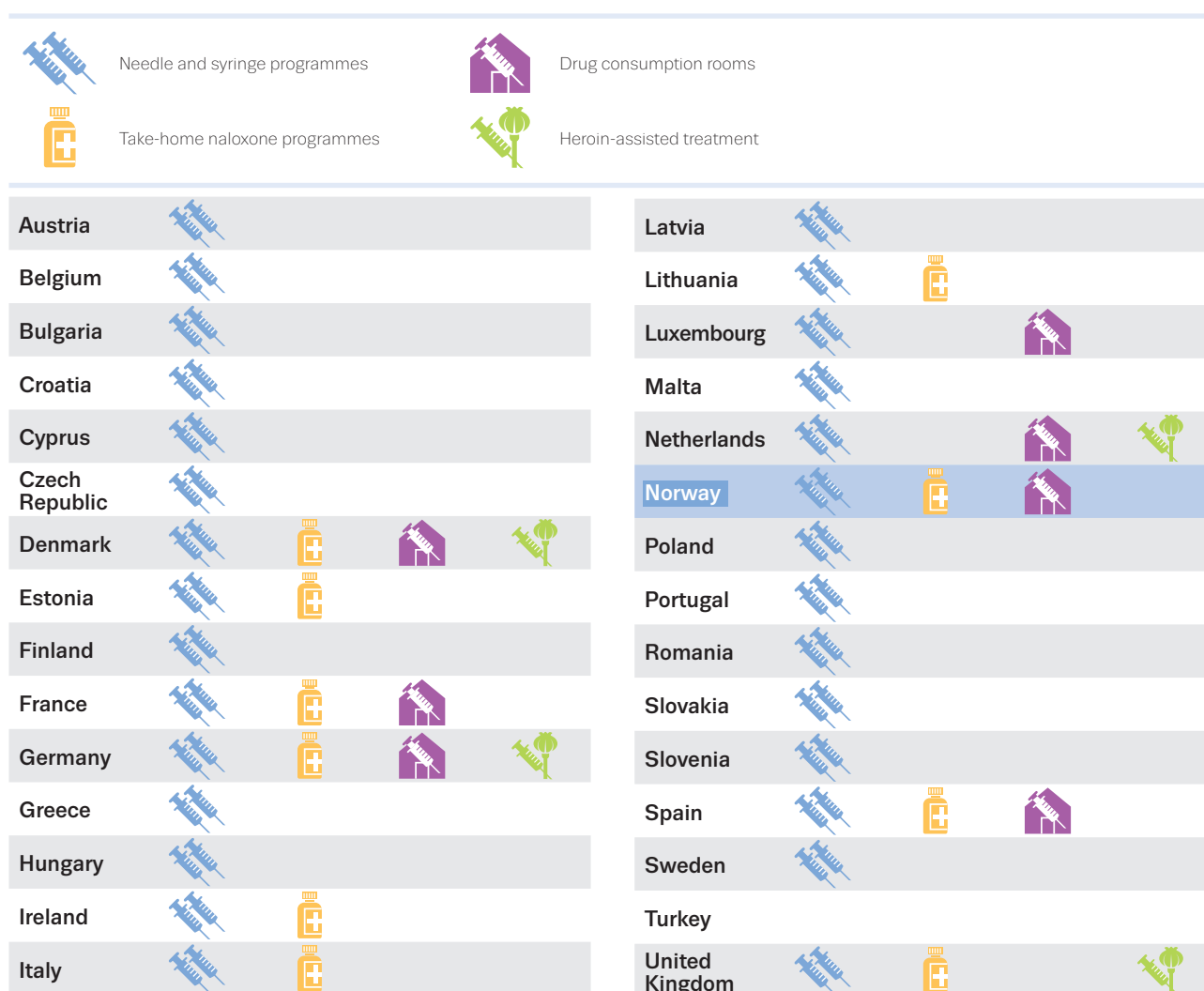
Low-threshold facilities already offer a broad range of services, such as health checks, treatment of sores, vaccinations (including the provision of free hepatitis A and B vaccines), distribution of injecting equipment, nutritional and hygiene guidance, prevention of overdoses, general advice and guidance, and follow-up and referral to other parts of the health service on a long-term basis.

In 2015, an estimated 2.5 million syringes were distributed through low-threshold facilities to PWID; about half of these were provided in Oslo. This estimate does not include all syringe providers in the country and is, therefore, lower than the total number of syringes distributed in 2015.

Prevention of drug-related overdoses is among current national priorities. In this context, several municipalities

FIGURE 12

Availability of selected harm reduction responses



NB: Year of data 2016.

have adopted local action plans and measures, and a trial project combining the provision of training in overdose response with the distribution of naloxone (by nasal applicator) to peers and families of drug users was sponsored by the Ministry of Health and Care Services in Oslo and Bergen. In 2016, this take-home naloxone project was expanded to five other cities.

In 2009, the temporary law on supervised drug consumption facilities was made permanent and municipalities that want to establish those services now have a legal basis for doing so. Two injection rooms were operational in Norway by the end of 2016 (Figure 12).

Take-home naloxone projects are running in seven cities and injection rooms are operational in two cities by the end of 2016

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 the care services are 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 extraordinary funds at their disposal for the development of special high-priority work in the areas of epidemiology, research, prevention and treatment.

FIGURE 13

Drug treatment in Norway: settings and number treated

Outpatient

Specialised treatment centres (12 378)

Inpatient

Residential drug treatment (5 316)

NB: Year of data 2015.

Drug treatment in Norway encompasses a range of available services including assessment, detoxification, stabilisation and short- and long-term residential treatments and medication-assisted treatment, such as 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 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 care arrangements with specialised drug treatment centres.

Treatment provision

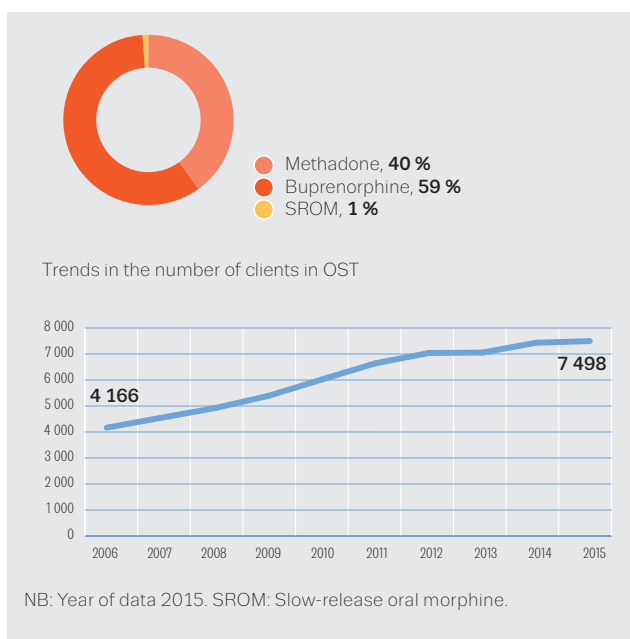
In 2015, a total of approximately 17 700 clients were treated in Norway, the majority of whom were treated in outpatient settings (Figure 13).

The treatment data from Norway are reported based on the 10th revision of the International Statistical Classification of Diseases and Related Health Problems codes. Around 20 % of treatment clients enter specialised treatment as a result of polydrug use and they are usually reported in the category 'other drugs'. The Norwegian treatment monitoring system is undergoing reorganisation following the recent adoption of the Treatment demand indicator 3.0 standard protocol definitions.

OST using methadone has been available through a nationwide programme since 1998, and buprenorphine-based medication has been available since 2001. However, 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 2015, approximately 6 out of 10 clients treated with OST received buprenorphine-based medication, while the remaining clients were treated with methadone, with slow-release morphine prescribed to a small proportion of clients. The long-term analysis indicates that the number of OST clients has been increasing steadily, by about 500 each year, although some reductions in new admissions have been recorded since 2011 (Figure 14).

FIGURE 14

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



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, which consists of 45 prisons and probation centres throughout the country. An increase in the number of prisoners has been observed in recent years, and more than half of the total of approximately 4 000 prisoners are foreign nationals from both European and non-European countries.

Several studies conducted among the Norwegian prison population have shown 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 slightly more than one third of inmates had used illicit substances while they were in prison, with cannabis, OST medication, benzodiazepines, amphetamines and heroin being the most commonly reported. Of those reporting illicit substance use while in prison, the majority reported daily use of one or more drugs during the six months prior to sentencing. Screening of urine samples of prisoners for the presence of illicit substances in 2015 indicated that cannabis was the most used substance, followed by amphetamines and heroin. In a relatively high proportion of samples, the presence of OST medication or benzodiazepines was also reported, although it was not possible to establish whether the results were due to drug abuse or the use of prescribed medication.

Drug-related infectious diseases remain important, as 1 in 10 prisoners is HCV positive. Moreover, many prisoners have comorbid mental health disorder.

A distinctive feature of the provision of interventions within the Norwegian correctional service is the 'import' model, which entails 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 have taken a specialised training course 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 409 prisoners received OST in 2015.

Prisoners should be tested for blood-borne diseases, such as HBV, HCV, HIV and sexually transmitted diseases. Unvaccinated prisoners should be offered vaccination if they are in a high-risk group. 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.

**Screening of prisoners
in 2015 indicated that
cannabis was the most
used substance, followed
by amphetamines
and heroin**

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.

Additionally, there are a number of policies and guidelines that are intended to contribute to quality in services. The Directorate of Health has an ongoing responsibility for deciding on guidelines for healthcare and social services. In recent years, the Health Directorate has published several policies and guidelines for drug treatment. Examples of these are the national guideline for OST, *Together in coping* (2010), the *Guide for local mental healthcare and drug-related work for adults: a tool for municipalities and the specialist healthcare* (2014), *Procedures for drug testing* (2014) and the *National professional guideline for the treatment and rehabilitation of substance abuse and drug dependency* (2016).

Beyond the requirements addressed by laws, policies and guidelines, there is no specific accreditation system for the various service providers, either at a local level or at the national level.

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. 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. Recently, however, a specialised course in drugs and drug dependence medicine for physicians was adopted and will be implemented in 2017.

A specialised course in drugs and drug dependence medicine for physicians will be implemented in 2017

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 one of the priorities of the government's investment in research and falls within the objectives of improving quality and developing skills in the drugs and alcohol field. Within the current national action plan, there is a section devoted to drug-related research. 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.

Recent studies include population-based and clinical epidemiology research, basic biological, neurobiological and behavioural research 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 (SERAF) and the Norwegian Institute of Public Health, as well as some university departments and privately funded research institutes. Research findings are disseminated through several websites and through scientific and non-scientific national and international journals.

Drugs and alcohol research is one of the priorities of the government's investment and falls within the objectives of improving quality and developing skills in the drugs and alcohol field

Drug markets

Cannabis is the most commonly seized drug in Norway. The Netherlands and Spain are typically implicated in cannabis resin distribution to Norway, and herbal cannabis reportedly enters via Sweden or by sea from Germany. In addition, some domestic cultivation of cannabis takes place indoors. Heroin is brought to Norway through Belgium, Germany and the Netherlands. Cocaine also enters Norway through other European countries in vehicles or using 'drug mules'. Most amphetamines (predominantly amphetamine) seized in 2015 in Norway came from illegal laboratories in the Czech Republic, Lithuania, the Netherlands and Poland. The MDMA that is available on the Norwegian market comes mainly from the Netherlands, while postal shipments from Germany and the United Kingdom have also been identified. Postal shipments are the most common way of smuggling NPS into Norway.

Data from the National Crime Investigation Service indicate that the total number of drug seizures has been relatively stable during the last four years, while the long-term trend indicates an increase in the total number of seizures.

This may be explained by the priorities of the police and customs activities. In 2015, a record number of cocaine and MDMA seizures were reported, while, in terms of quantities seized, record amounts of both amphetamines and MDMA were recorded, and the amount of seized cocaine also remained high. In contrast, the quantities of cannabis resin and heroin seizures remained stable, while herbal cannabis and cannabis plants were seized in lower amounts than in previous years (Figure 15). There has been an increase in the number of NPS seizures in Norway since 2009; however, since 2012, numbers have levelled off. The most recent data indicate that benzodiazepine-like substances are most frequently seized, while substances belonging to synthetic cannabinoids group were the second most frequently seized NPS.

The retail price and purity of the main illicit substances seized are shown in Figure 16.

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 in to the country.

FIGURE 15

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

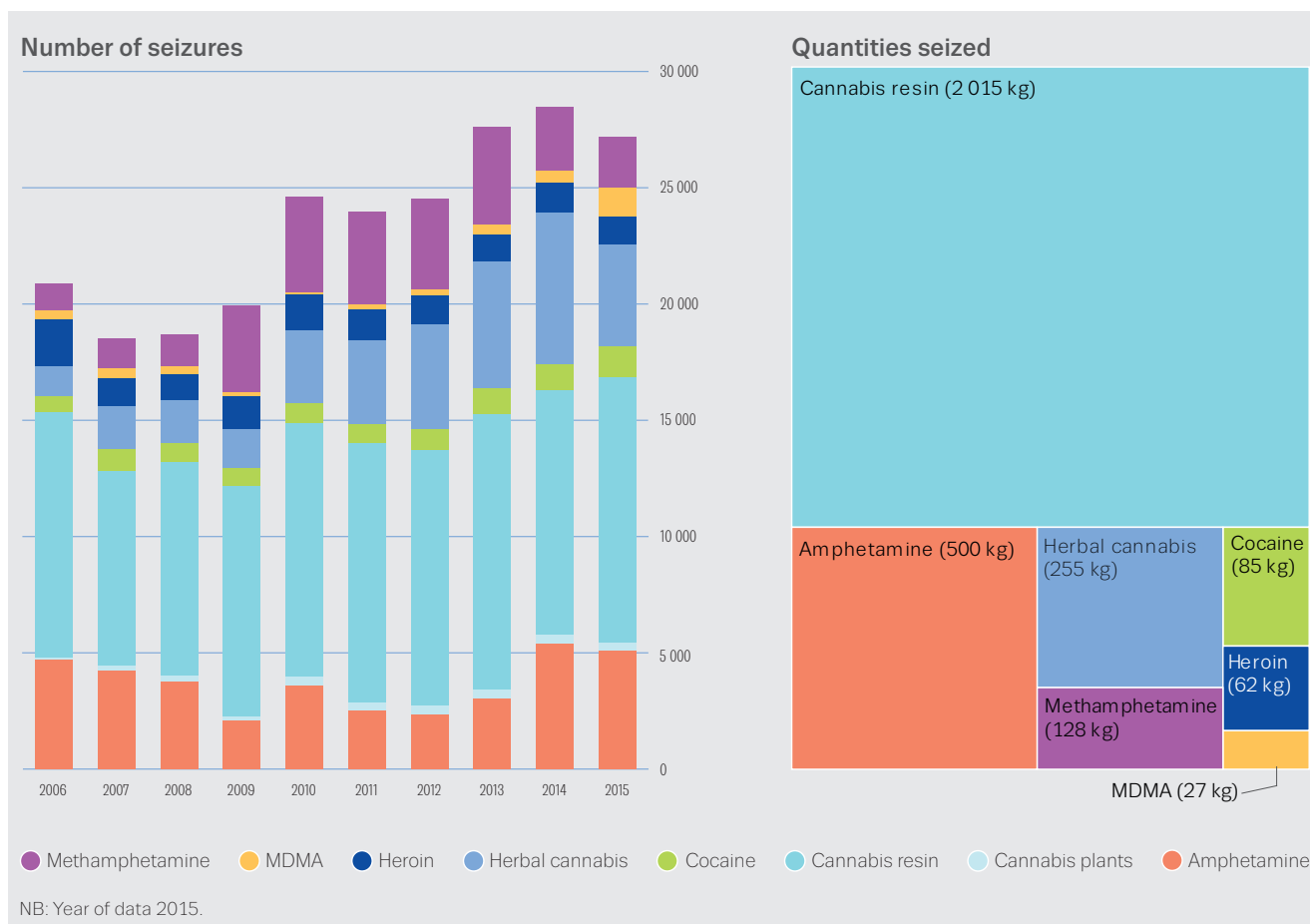
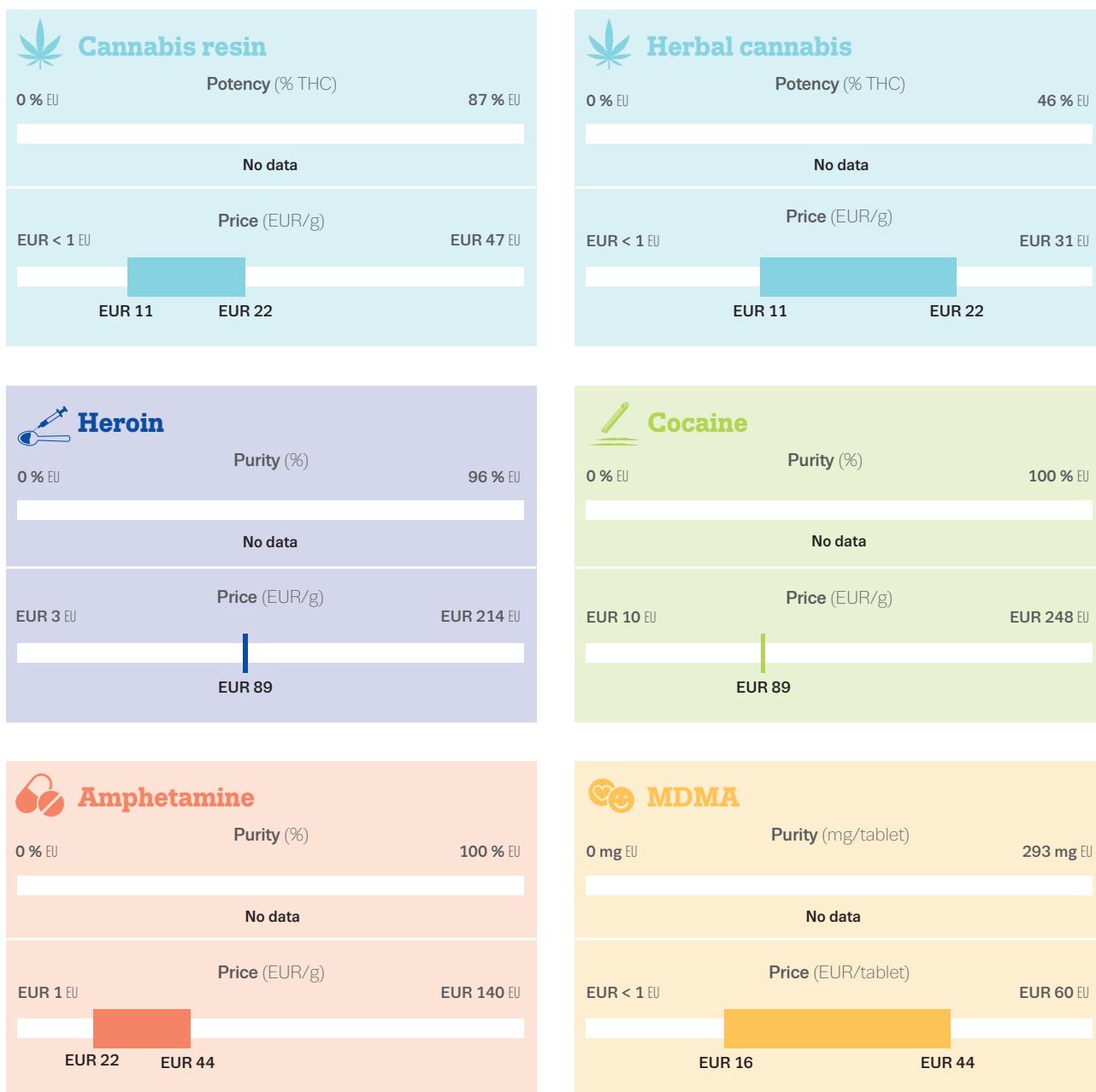


FIGURE 16

Price and potency/purity ranges of illicit drugs reported in Norway



NB: Price and potency/purity ranges: EU and national mean values: minimum and maximum.
Year of data 2015.

KEY DRUG STATISTICS FOR NORWAY

Most recent estimates and data reported

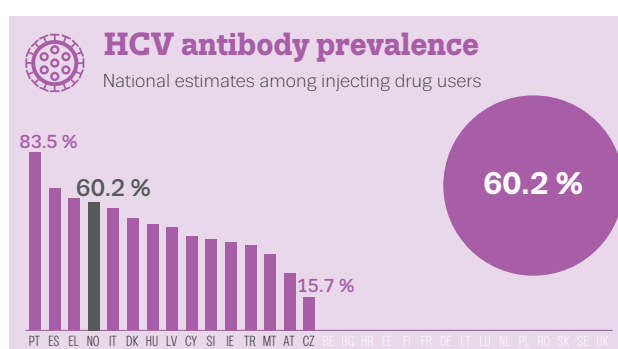
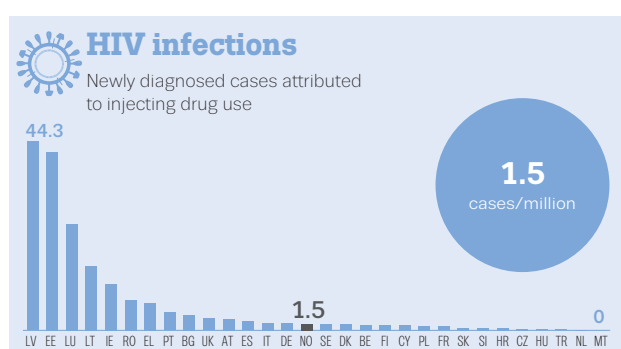
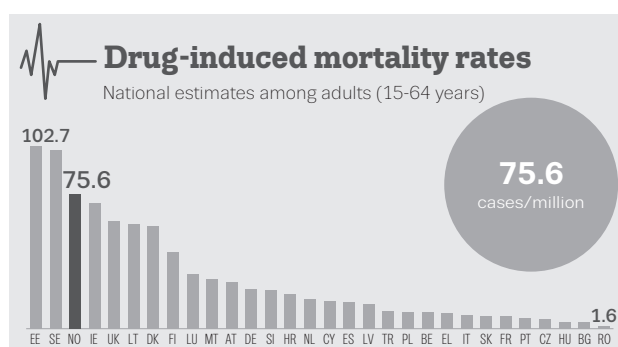
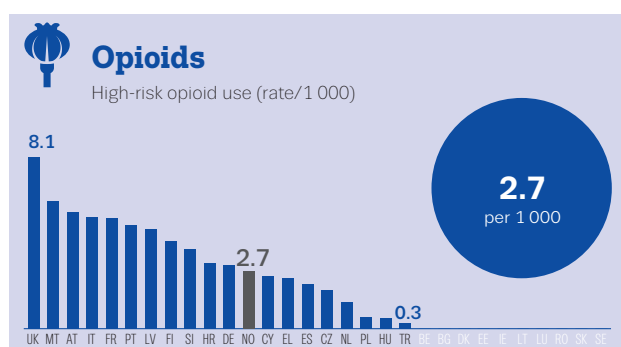
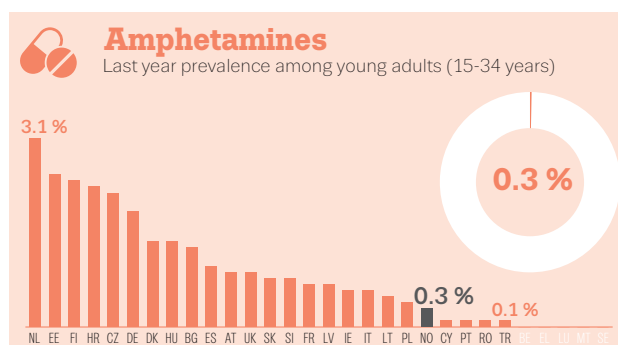
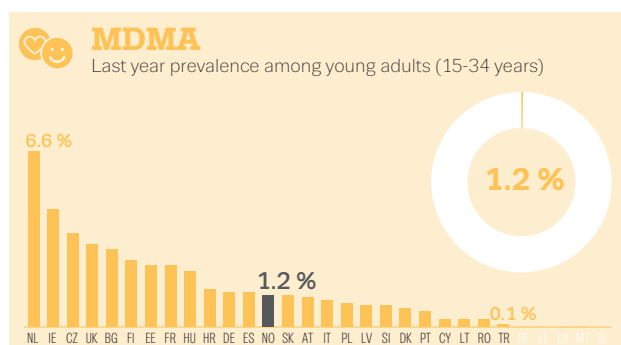
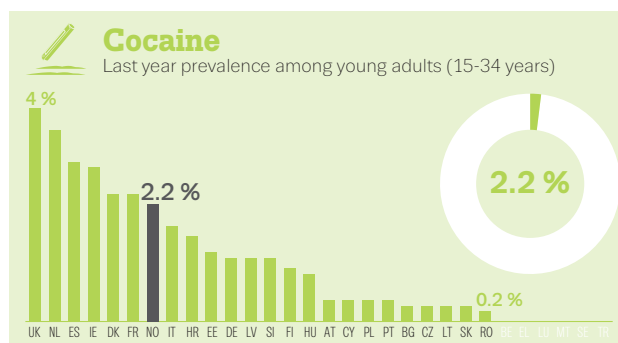
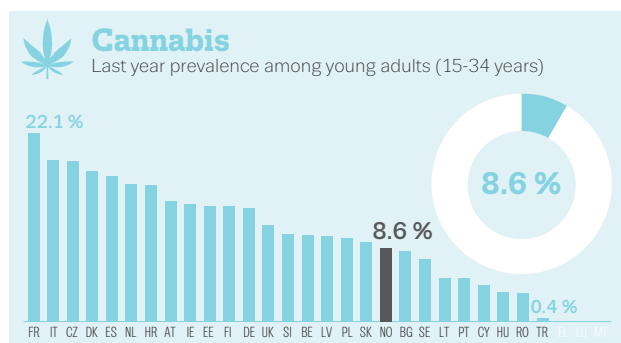
	Year	Country data	EU range	
			Minimum	Maximum
Cannabis				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	6.5	6.5	36.8
Last year prevalence of use — young adults (%)	2015	8.6	0.4	22.1
Last year prevalence of drug use — all adults (%)	2015	4.2	0.3	11.1
All treatment entrants (%)	2015	27	3	71
First-time treatment entrants (%)	No data	No data	8	79
Quantity of herbal cannabis seized (kg)	2015	255	4	45 816
Number of herbal cannabis seizures	2015	4 411	106	156 984
Quantity of cannabis resin seized (kg)	2015	2 015	1	380 361
Number of cannabis resin seizures	2015	11 394	14	164 760
Potency — herbal (% THC) (minimum and maximum values registered)	No data	No data	0	46
Potency — resin (% THC) (minimum and maximum values registered)	No data	No data	0	87.4
Price per gram — herbal (EUR) (minimum and maximum values registered)	2015	11-22	0.6	31.1
Price per gram — resin (EUR) (minimum and maximum values registered)	2015	11-22	0.9	46.6
Cocaine				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	0.9	0.9	4.9
Last year prevalence of use — young adults (%)	2015	2.2	0.2	4
Last year prevalence of drug use — all adults (%)	2015	1	0.1	2.3
All treatment entrants (%)	2015	1	0	37
First-time treatment entrants (%)	No data	No data	0	40
Quantity of cocaine seized (kg)	2015	85.3	2	21 621
Number of cocaine seizures	2015	1 332	16	38 273
Purity (%) (minimum and maximum values registered)	No data	No data	0	100
Price per gram (EUR) (minimum and maximum values registered)	2015	89	10	248.5
Amphetamines				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	0.9	0.8	6.5
Last year prevalence of use — young adults (%)	2015	0.3	0.1	3.1
Last year prevalence of drug use — all adults (%)	2015	0.2	0	1.6
All treatment entrants (%)	2015	14	0	70
First-time treatment entrants (%)	No data	No data	0	75
Quantity of amphetamine seized (kg)	2015	500	0	3 796
Number of amphetamine seizures	2015	5 089	1	10 388
Purity — amphetamine (%) (minimum and maximum values registered)	No data	No data	0	100
Price per gram — amphetamine (EUR) (minimum and maximum values registered)	2015	22-44	1	139.8

	Year	Country data	EU range	
			Minimum	Maximum
MDMA				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	1	0.5	5.2
Last year prevalence of use — young adults (%)	2015	1.2	0.1	6.6
Last year prevalence of drug use — all adults (%)	2015	0.6	0.1	3.4
All treatment entrants (%)	2015	0	0	2
First-time treatment entrants (%)	No data	No data	0	2
Quantity of MDMA seized (tablets)	2015	116 353	54	5 673 901
Number of MDMA seizures	2015	1 241	3	5 012
Purity (mg of MDMA base per unit) (minimum and maximum values registered)	No data	No data	0	293
Price per tablet (EUR) (minimum and maximum values registered)	2015	16-44	0.5	60
Opioids				
High-risk opioid use (rate/1 000)	2013	2.7	0.3	8.1
All treatment entrants** (%)	2015	17	4	93
First-time treatment entrants (%)	No data	No data	2	87
Quantity of heroin seized (kg)	2015	62	0	8 294
Number of heroin seizures	2015	1 178	2	12 271
Purity — heroin (%) (minimum and maximum values registered)	No data	No data	0	96
Price per gram — heroin (EUR) (minimum and maximum values registered)	2015	89	3.1	214
Drug-related infectious diseases/injecting/deaths				
Newly diagnosed HIV cases related to injecting drug use (cases/ million population, Source: ECDC)	2015	1.5	0	44
HIV prevalence among PWID* (%)	2015	1.9	0	30.9
HCV prevalence among PWID* (%)	2015	60.2	15.7	83.5
Injecting drug use (cases rate/1 000 population)	2014	2.5	0.2	9.2
Drug-induced deaths — all adults (cases/million population)	2014	75.6	1.6	102.7
Health and social responses				
Syringes distributed through specialised programmes	2015	2 500 192	164	12 314 781
Clients in substitution treatment	2015	7 498	252	168 840
Treatment demand				
All clients	2015	5 908	282	124 234
First-time clients	No data	No data	24	40 390
Drug law offences				
Number of reports of offences	2014	48 152	472	411 157
Offences for use/possession	2014	24 671	359	390 843

* 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



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, qualifications 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.

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About the EMCDDA

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is the central source and confirmed authority on drug-related issues in Europe. For over 20 years, it has been collecting, analysing and disseminating scientifically sound information on drugs and drug addiction and their consequences, providing its audiences with an evidence-based picture of the drug phenomenon at European level.

The EMCDDA's publications are a prime source of information for a wide range of audiences including: policymakers and their advisors; professionals and researchers working in the drugs field; and, more broadly, the media and general public. Based in Lisbon, the EMCDDA is one of the decentralised agencies of the European Union.



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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