Governmental conceptions of the drug problem: A review of Norwegian governmental papers 1965–2012

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ABSTRACT

BACKGROUND – It is almost 50 years since the “new” drug problem appeared in Norway. How have central authorities conceived of the drug problem during these 50 years? On what have relevant policymaking and action been based? How has the government’s conceptions of the drug problem been expressed over the years? DATA – White papers, action plans, bills etc. RESULTS – A review of the main policy documents shows how Norway adopted strict penal measures from the outset, while recognizing at the same time the need to apply an interdisciplinary approach to drug abuse and initiate various support measures for drug users alongside the penal measures. In recent years, there has been an increasing emphasis on seeing drug abuse as a health-related problem rather than one of control. Substance abuse is today perceived more in terms of dependency or as a disease, and harm reduction is increasingly seen as a pivotal aspect of policy. People with drug problems were known until recently as substance abusers, though the preferred term today is “drug dependents”. CONCLUSIONS – As such, one could say, Norway seems to have developed a “schizophrenic” view of the drug problem. On the one hand, the health aspects of drug abuse are increasingly central to thinking, while on the other penalties for drug offenses remain high. This health/penalty loop in turn seems to prevent the government from softening its stance on penalties – even if such a move were considered appropriate.

KEYWORDS – Drug policy, governmental documents, Norway

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Introduction

In Norway, as in most western countries, the drug policy climate underwent radical change in the mid-1960s. Up until that point, drugs as a social problem had been discussed mostly by a relatively small group of health and legal professionals because misuse was confined to health personnel and patients with access to morphine. Legislators remained passive, the press showed little interest and drug problems were hardly noted in the population in general (Bergersen Lind, 1973). Interest
exploded when the “new” drugs – cannabis, LSD and amphetamines – emerged on the scene, threatening traditions and ideology. These new substances had little or no medical use and had to be obtained via illicit channels. The government quickly decided to act, however, because the people most likely to use and abuse these substances were young (ibid.).

In an effort to nip the problem in the bud, the government moved quickly to introduce strict penalties for drug-related offenses. Indeed, between 1968 and 1984, penalties grew ever harsher, with the maximum sentence for the worst offences reaching 21 years, the most severe penal reaction in Norway for any crime. Spurring this escalation in sanctions were the ideas of the Swedish psychiatrist, Niels Bejerot, who had likened the spread of drug abuse among young people to an infectious epidemic (Justis- og politidepartementet, 1967).

Norwegian drug policy cannot, however, be understood in light of the criminal provisions alone. The aim of the legislators has always been to prevent the illegal sale and smuggling of drugs. From a general deterrence point of view, however, banning the use of drugs was also seen as a necessary adjunct. At the same time, the authorities have been concerned with the basic causes underlying the use/abuse of narcotic drugs. What is the best response to this and to wider drug-related problems? Should drug use/abuse be seen as a symptom of underlying pressures, social, economic or personal? Is the abuse of narcotic drugs (and other substances) a disease in itself? Opinions have differed over the years, as much among the general public, as experts, politicians and government authorities. While what are often called the symptom theories were the main source of causal explanations for many years, a disease perspective has been gaining ground in recent time. While people with drug problems were previously referred to as substance abusers, it is increasingly common to use the term “substance dependents” to denote persons whose use of drugs causes problems.

Most people would probably say the criminal aspect has overshadowed other attempts in Norway to understand why some people choose to use drugs. Viewing the drug problem primarily as an issue of crime and punishment with law enforcement as the main response, has obscured – or hindered – a focus on help and treatment. The view of law enforcement as the most important means of combating the new drug problem of the 1960s is discussed by Bergersen Lind (1974), Christie and Brun (1985) and Hauge (1989). Nevertheless, it might be fruitful to look more closely at how narcotic drugs and drug problems were perceived in government documents over the years. What can we say about the conceptions of narcotic drugs and the measures taken to address the problem of politicians and policymakers? To what extent have changes in these conceptions been expressed and to what extent have such changes affected government action?

What about the fact that when it comes to law enforcement, all available measures were being applied as early as 1984 with the adoption of statutory punishment, while in the area of health care and social services, the authorities have been more or less free over the years to assess and undertake whatever measures they deemed adequate?
Data and method
The data for this article were sourced from government documents, i.e. bills, white papers, reports, action plans and reports dealing with drugs and drug-related issues, from the mid-1960s to recently.

How the government and governmental agencies have conceived of drug problems/drug use/drug abuse and drug users/abusers over a nearly 50-year period is studied by examining the words and terms used in relevant documents.

The necessity of a strict legislation
The first Norwegian laws on drugs, the Opium Act of 1913 and Opium Act of 1928, came in response to the Hague Convention (1912) and Geneva Convention (1925), not because Norway was perceived to have a drug problem.

The same can be said on the whole of the 1964 Medicinal Products Act, a response to the 1961 UN Convention on Narcotic Drugs (Single Convention on narcotic drugs). This may seem somewhat strange given that Norway was one of the first countries in Europe to establish a clinic for drug abusers – in 1961. The clinic was, however, set up to treat so-called classic drug abusers, i.e. patients and healthcare professionals where easy access to morphine was one of the factors in their drug abuse.

However, in the mid-1960s the situation changed completely. The appearance of cannabis took everyone by surprise and resulted in a kind of panic. As already said, the 1964 Medicinal Products Act was a response to the 1961 Single Convention, thus pre-dating the “new” drug problem in Norway. In line with the UN Convention, the law targeted illegal possession and sale of drugs and had no explicit provision on use. All the same, the government introduced a ban on use in a 1965 regulation, empowering the courts to hand down penalties for drug use, which they did when the first drug cases came up for trial that year (Bergersen Lind, 1974). Thus, an important aspect of Norwegian drug policy is that the use of narcotic drugs was criminalized as early as the mid-1960s, when in Sweden, which in many ways has influenced Norwegian drug policy, the use of drugs was not criminalized until 1984. In Norway, criminalizing use was seen from the very beginning as an important preventive measure, persuading young people not to give in to temptation (Justis- og politidepartementet, 1967). In the EU, only Finland, France and Sweden still criminalize actual use (EMCDDA, 2014).

Bergersen Lind (1974) suggests dividing the evolution of Norwegian drug legislation between 1913 and the 1970s into three stages. The first stage, covering the years between 1913 (the first Opium Act) and 1928, she describes as the stage of readiness (beredskapsfase); the second, from 1928 (the second Opium Act) to 1965, as a stage dominated by health concerns and thinking (den helsedominerte fase); the final phase starts with the 1964 Medicinal Products Act and is dominated by the criminalization approach (den strafferettsdominerte fase) (ibid.). As the rather dramatic rise in penalties for drug crimes between 1965 and 1984 continues to characterize the situation, most people will be of the opinion that criminalization even today dominates Norwegian drug policy.

In 1966, the Penal Code Council was asked by the Ministry of Justice and Police
to consider the pros and cons of raising the penalties for dealing in illicit drugs. The four permanent members of the Council were all highly respected senior legal practitioners: Supreme Court Judge Rolv Rysdal; professor in criminal law Johs. Andenæs; Director General of Public Prosecution Andreas Auli; and Country Court Judge Ole Harbeck. Two additional members were added as experts, the psychiatrists Nils Retterstøl and Arnfinn Teigen (Justis- og politidepartementet, 1967).

The Council’s 1967 report refers to the epidemic-like spread of drug use in many countries among young people and serious social problems associated with it. References are made to the Swedish psychiatrist Nils Bejerot and his analyses of the potential for a drug-use epidemic. There is no doubt, the Council emphasized, that narcotic drugs are a problem society has to combat with all the means at its disposal, and that response must be active and coordinated. Young people should be given sober and objective information about the hazards of drug abuse in terms of the user’s physical and mental health, and indeed of the well-being of society. The Council also calls attention to the need to stop the illegal supply of drugs and to control the prescription of narcotic medicines. Prevention efforts must be complemented by expanding treatment capacity in order to help current abusers and people at risk. It is stressed by the Council that prevention and treatment need to be more effective; there is a need to know more about what leads to the use and abuse of drugs. To learn about these factors, more research is needed (ibid.).

However, the Council had been asked for its opinion on whether the penalties for illegal possession of drugs should be increased. Although the Council stressed the need for prevention and treatment, it stated with all possible clarity that harsh measures in the form of punishment were also needed to prevent the drug problem gaining a foothold in Norway. Illegal possession as well as illegal use of drugs should therefore be punished.

“In society’s fight against the abuse of drugs (misbruk av narkotika) there is an indispensable need for effective sanctions. Strict regulations against the illegal supply and sale of drugs are undoubtedly necessary. But it is also necessary, according to the Penal Code Council, to penalize the illegal possession and use of narcotic drugs as part of the fight against abuse. This applies even if prohibition and punishment in themselves are insufficient to resolve the personal and social problems of the individual, and even though many users primarily will be in need of help and support measures. (ibid.)

The 1964 Medicinal Products Act set the maximum sentence for what were considered serious drug crimes, i.e., illegal possession and sale of substantial quantities, at two years. Some people, the Penal Code Council pointed out, will do everything they can to take advantage of the demand for narcotic drugs; a maximum penalty of two years imprisonment was too lenient.
Illegal supply and sale of drugs should be met with severe penalties. In many countries, large-scale smuggling and sale of drugs, one has found, are perpetrated by persons who exploit without mercy the need of certain people to obtain these substances. It may be assumed that efforts will be made also in this country to create a market for drugs, where smugglers and dealers will seek to use the demand for these drugs for profit – without regard to the harm caused to others. Many of the circumstances surrounding the trafficking and dealing [of illicit drugs] can be so grave and serious that the maximum penalty of two years must be considered to be too lenient. There are strong reasons therefore to raise the currently applicable statutory maximum penalty. (ibid.)

However, criminal provisions for drug users and people seeking material gain from smuggling and dealing drugs were not the only topics addressed by the Council. They also wanted legislation on drugs to have a general deterrent effect, to prevent potential users from trying drugs.

Penal provisions prohibiting the illegal possession and use of narcotic drugs could help form public attitudes towards such toxins and influence the public’s behaviour in this matter. These moral and habit-forming effects (vanedannende virkning) must be considered to be of particular importance at a time when the use of such substances is becoming more widely known and appeals to the curiosity and interest especially of young people. The fact that unauthorized use is punishable by law, must also be assumed to deter some of those who would otherwise want to start misusing drugs. It is therefore assumed that the threat of punishment would, to some extent, limit unauthorized possession and abuse of drugs. (ibid.)

The authorities consulted on the matter all supported the recommendations of the Council. As stated by the Ministry of Social Affairs, “society has to combat the dealing and use of such substances with every means at its disposal” (Ot. prp. nr. 46, 1967–1968). Thus in the parliamentary handling of the report, a new section (Section 162) was added to the Penal Code in 1968 to address what were described as serious drug crimes. While the Penal Code Council and the Ministry of Justice and Police suggested a maximum sentence of five years, Parliament raised it to six. The maximum penalty for less serious drug offenses under the Medicinal Products Act remained unchanged at two years imprisonment. At the same time, an amendment to the Medicinal Products Act prohibited the use of drugs (ibid.).

Some members of Parliament wanted an even higher maximum sentence and others too called for stricter sentences. Thus the maximum penalty for serious drug offenses (Penal Code § 162) was raised to ten years in 1972 (Ot. prp. nr. 5, 1971–1972). In the Bill, the Ministry of Justice and Police recalled a newspaper article by a well-known professor in criminal law, Anders Bratholm, who agreed with raising the maximum sentence to ten years. The fear of severe punishment, he suggested, would help dissuade foreign actors from...
entering the Norwegian drug market. Raising the maximum penalty would unquestionably have a general deterrent effect on drug offenses, even if it is doubtful whether it will apply to other areas, Bratholm added (ibid.). The Director General of Public Prosecution and Ministry of Justice and Police both saw deterrence as the most important reason to raise the maximum penalty for drug crimes (ibid.). “Drug crimes carried out by professionals have to be seen as some of the most serious crimes in our society”, said the Ministry of Justice and Police. The purpose, however, of increasing the maximum sentence, Ministry of Justice and Police added, is to make it less attractive for professional drug dealers to come and ply their trade and seek to develop a market in Norway. According to the Ministry, raising the maximum penalty was not meant to affect penalties for people who only use drugs, who have to be regarded more as victims than as perpetrators. The offenses conducted by these people are not under the Penal Code § 162, but the milder provisions of the Medicinal Products Act (ibid.).

Even if the use of drugs provides a reason for punishment, we can see the penalties were designed above all to target the dealers and smugglers.

The maximum penalty for serious drug crimes was raised again, this time to 15 years, effective from 1981 (Ot. prp. nr. 62, 1980–1981). It was justified by reference to the moral responsibility of suppliers of illicit drugs. As the Ministry of Justice and Police put it: “Drug use has gradually developed into a serious social and personal problem. Those ensuring the supply of drugs undertake a serious moral responsibility. This should be reflected in the system of moral assessment the criminal law represents” (ibid.).

The maximum sentence was raised yet again to 21 years, effective from 1984 – the maximum sentence in Norway for any crime. Serious drug crimes, the government said once again, were among the most serious crimes in society (Ot. prp. nr. 23, 1983–1984). Table 1 shows the changes in the Norwegian drug-related legislation.

### Table 1. Norwegian drug-related legislation.

| Year | Legislation |
|------|-------------|
| 1913 | The Opium Law (Hague Convention) |
| 1928 | The new Opium Law (Geneva Convention) |
| 1964 | The Medicinal Products Act (Single Convention) Less severe drug crime: fines, possibly three months imprisonment More severe drug crimes: 2 years imprisonment |
| 1968 | Ban on use in the Medicinal Products Act Penal Code § 162: maximum penalty six years imprisonment |
| 1972 | Penal Code § 162: maximum penalty 10 years imprisonment |
| 1981 | Penal Code § 162: maximum penalty of 15 years imprisonment |
| 1984 | Penal Code § 162: maximum penalty of 21 years imprisonment The Medicinal Products Act: for use of drugs, fines possibly six months in prison The provision of more severe (2 years in prison) was moved to the Penal Code |

### Symptom or disease?

The panic caused by the arrival of “new” narcotic drugs in the mid-1960s led the government to take radical steps to combat the problem. However, at the same time, it...
was necessary to find out why some people developed drug use problems. This was evident already in the 1967 Penal Code Council report in which it is suggested that drug use is usually connected to personal and social problems; many users will therefore need help and support, and the government should introduce measures to that effect (Justis- og politidepartementet, 1967).

We will therefore leave the law enforcement issue for a while to look more closely at how governmental authorities tried to comprehend the causes of drug use/abuse. Whether abuse of narcotic drugs should mainly be conceived as a symptom of underlying problems or more in terms of an illness came to be of importance.

In 1976, the government presented the first white paper on drugs to Parliament where it states:

> The abuse of addictive substances is a symptom and not a delimited disease”, and “It is the belief of The Ministry (of Social Affairs) that abuse of addictive substances, in both younger as older age groups, should be seen principally as a symptom of personal, family and social problems and consequent dissatisfaction and maladjustment.... If the work is to be successful, by achieving a gradual reduction of the scope of the problem and its consequences, it will be necessary to explore the needs and problems of these clients in a systematic way. (St. meld. nr. 66, 1975–1976)

Thus, the so-called symptom theory was put forward as the “official” explanation of drug abuse.

The following years saw the public sector grow increasingly involved in the drug field. In 1979, for example, the government laid out an action plan. What were assessed to be the three key players in the fight against drugs would receive increased funding: the social welfare system; the customs; and the police (St. prp. nr. 138, 1978–1979). The action plan sets out the government’s current conception of the drug problem. “[It] is a complex problem. It is the result of a complicated interplay between the individual human being, the substance and the environment. An overall action plan should therefore contain measures that target all the three main parties.” The action plan emphasized the need to synchronize restrictive control measures with other forms of prevention, treatment and aftercare. If special measures to combat drug problems are going to have lasting impact, a qualitative improvement of society through the strengthening of family and community capacity and children’s upbringing will have to take place (ibid.).

As can be seen, the government gives great importance to social and structural factors in explaining the drug problem and highlights them as important priority areas. Once again we find that drug use is seen as a symptom of underlying conditions and problems.

Norway was for years reluctant to use substitution treatment for opioid abusers. As an example, in the action plan of 1979 the government says a clear no to methadone treatment by referring to the negative experiences in other Nordic countries. It is known “from experience that the possibility of getting prescribed drugs undermines the motivation for treatment.” Thus, the
action plan concludes, “there is reason to maintain a restrictive policy in this area” (ibid.).

In 1985 a new white paper on drug policy was presented (St. meld. nr. 13, 1985–1986). Narcotic substances and their effects, the government states, can be seen from different angles. The fact that pharmacologists, psychologists, lawyers and sociologists have emphasized different aspects is one of the reasons for the lack of terminological consistency with regard to narcotic drugs, the government argues. The ability of narcotic substances to affect the nervous system, the government adds, explains the general physiological changes. At the same time, however, it is important to gain a social understanding of intoxication and behavioural changes related to intoxication. According to the white paper, it is necessary to explore behavioural as well as physiological changes. This is because behavioural changes can also be learned. The consequence of all this has been to muddy the notion of “abuse” (misbruk). Indeed, as the white paper points out, abuse can be defined in legal, medical, pharmacological, moral and social terms, producing a multitude of different definitions (ibid.).

The 1985 white paper speaks of two main groups in connection with the problem of drug abuse that came to Norway in the mid-1960s. It spread initially among younger members of upper middle class families. They experimented with drugs as a part of the hippie culture and in opposition to the authorities. Thereafter, drug use spread to young people from less advantaged families. They soon became the main source of recruitment to drug abuse. But even if advantaged young people are likely to use drugs as a pleasure-seeking activity, the 1985 white paper continues, drug abuse usually takes the form of self-medication. Drugs are used as an escape from painful feelings and defence against a troubled reality. As in earlier governmental documents, the misuse of drugs is seen as a symptom of various underlying problems (ibid.).

It can also be worth noting that in the 1985 white paper the government failed to mention substitution treatment altogether. Substitution treatment still had no relevance to Norway, the government believed, even though the HIV epidemic was spread among injecting drug users.

The emergence of a harm reduction philosophy

In the following years, however, attitudes to relief measures to drug abusers changed rather dramatically. As in other countries, there was fear that the HIV/AIDS epidemic would spread among injecting drug users. By the 1990s, the health of the heaviest drug abusers had deteriorated significantly, and the overdose death rate was rising. Norway responded by taking steps in stark contrast to the country’s otherwise restrictive drug policy. Beginning in 1988, a large scale programme was initiated to distribute syringes and needles to injecting drug users.

1997 saw another white paper on drugs (St. meld. nr. 16, 1996–1997). The government here describes the causes of the drug problem as complex and without a simple solution. On the one hand, there is a major illegal production and international trafficking of narcotic drugs; on the other, the desire to get high on legal or illegal substances is related to individual and social
factors. Norway, the white paper goes on, has had a restrictive drug policy since drug abuse became a social problem in the mid-1960s. The law prohibits dealing, possession as well as use of the substances. The government maintains a restrictive line on drug policy and continues to ban the dealing, possession and use of drugs. Serious drug offenses will be met with serious penalties. It is vital, however, to balance restrictive control measures with other preventive efforts and treatment, the government underlines (ibid.).

The government thus continues its dual approach to the drug problem with strict control measures to prevent drug trafficking, and providing people with drug abuse problems with the necessary help and treatment. Although the government confirms its adherence to a restrictive drug policy, changes are evident. Indeed, they were arguably quite dramatic insofar as Norway upheld measures which in many ways stand in contrast to what was otherwise said about maintaining a restrictive drug policy. Substitution treatment can be seen as an example. In 1994, after much back and forth, a pilot methadone treatment programme started. It was discussed in the 1997 white paper: methadone treatment can be used as a regular supplement to other treatment; about 2-300 patients nationwide would likely benefit (ibid.). However, by the end of 2013, more than 7,000 patients were undergoing substitution treatment in Norway.

The notion of harm reduction which began to emerge at the time was one some found difficult to accept. Nevertheless, measures aimed at reducing the harm caused by substance abuse were far from new. By discussing what harm reduction means in terms of substance abuse, the 1997 white paper helped give the concept legitimacy. Scepticism to the approach, the white paper points out, can be put down to the fact that the people who advocate harm reduction measures, also tend to advocate the liberalization of drug policy. This taint by association is unfavourable, the government states, and does little to promote the development of strategies and measures in the fight against drug abuse. Easy access to clean needles is mentioned as an example of such a strategy, by limiting the transmission of HIV (ibid.).

In the following years, harm reduction increasingly informed health-related action. For example, as a part of the effort to slow the growing number of overdoses, the then minister of social affairs, invited relevant municipalities to apply in 1999 for state grants for what became known as “low-threshold health services for substance abusers”. “A significant reduction in the harm to communities and public health from substance use” will be the main goal of the government’s alcohol and drug policy, the government’s substance abuse action plan for the years 2003-2005 declares, along with “easier access to effective advice, help and treatment as well as a significant reduction in the incidence of drug-related harm and mortality” (Socialdepartementet, 2002). Although the government disagrees with calls to liberalize and legalize narcotic drugs, it emphasizes nevertheless the need to facilitate the work of the health and social sectors.

By 2004, harm reduction was receiving even greater emphasis. After some back and forth, Parliament passed a temporary law that gave municipalities the opportunity to establish injecting room facilities.
The fact that the Injection Rooms Act exempted the use of drugs within the framework of a drug injection scheme from prosecution, serves to illustrate how the health of abusers is increasingly being seen as more important than prohibiting the use/possession of narcotic drugs. Ensuring the dignity of heavy drug users was stated as one of the main reasons for the drug injection scheme. The Injection Rooms Act was made permanent in 2009.

It is also worth mentioning that by the early 2000s, government papers distinguish less and less between alcohol and drug related problems. The terms alcohol abuse(r) and drug abuse(r) are gradually replaced by substance abuse(r). Although alcohol and narcotic drugs have different legal status and thus are treated differently in legislation, they are seen as part of the same problem when it comes to help and treatment (Meld. st. nr. 30, 2011–2012).

Abuse – Dependence
Up until recently, the term drug/substance abuse (narkotika-/rusmiddelmisbruk) has been used in reference to drug/substance problems. Thus persons with problems related to drug/substance abuse (narkotika-/rusmiddelmisbruk) have normally been referred to as drug/substance abusers (narkotika-/rusmiddelmisbrukere). This goes for governmental papers, too. However, the government’s action plan of 2008 changed all this. Substance abuse became substance dependence (rusmiddelavhengighet) and substance abusers substance dependents (rusmiddelavhengige) without explanation (Helse- og omsorgsdepartementet, 2008). We should probably see this as a consequence of the 2002–2004 reorganization in the national health service. Until 2004 treatment for substance abuse (alcohol as well as narcotic drugs) was the responsibility of county authorities, and provided by the social services. However, in 2004, substance abuse treatment became a responsibility of the state specialist health services (Ot. prp. nr 3 & 54, 2002–2003). This is largely a consequence of the 2002 reorganization of the health service which relieved county authorities of their responsibility for the specialist somatic and mental health services, and handed that over to the state. Although the new responsibility of the specialist health services to provide substance abuse treatment is supposed to be interdisciplinary in nature, the transfer of responsibilities nevertheless sends a clear signal that people with problems related to substance abuse will primarily be seen as the responsibility of the national health service. Thus the term “drug/substance abuser” is gradually being replaced by “drug/substance dependent” by governmental authorities as well as by people in general.

A report from a committee appointed by the government to look at how best to address the many needs of substance abusers takes a step further by talking about the disease of dependence (Helse- og omsorgsdepartementet, 2010). The chair of the committee was a now retired senior politician of foreign affairs, Thorvald Stoltenberg. Only one of the members of the committee came from the substance abuse field.

Moreover, in the most recent white paper on drug policy of 2012, the government generally uses the term substance dependent (Meld. st. nr. 30, 2011–2012). Nevertheless the prevailing concepts of
substance abuse problems are discussed. The white paper notes that some countries consider substance abuse problems, dependence and disease as equal. The government underlines that it is obvious that heavy use of alcohol and drugs may cause dependence and illnesses that have to be treated as a disease. However, at the same time, the government warns, the disease perspective can be too narrow. One needs to apply both social and societal perspectives to the prevention, harm reduction and treatment of substance abuse.

So the 2012 white paper also expresses the government’s view of drug abuse as not simply a disease; various socio-economic and personal factors come into play as well. There is no doubt, however, that the government’s conception of narcotic drugs and the understanding of problems related to the use/abuse of narcotic substances have undergone a major revision. While substance abuse as a symptom of underlying conditions, the so-called symptom theory, previously dominated and structural measures were regarded as important, substance abuse as a medical condition has more or less taken over. An important consequence is that the health services are increasingly seen as the first port of call for treatment.

Norway – A drug free society?
The government’s conception of the drug problem can also be studied from the point of view of what has been said over the years about the political objectives of drug policy. Right from the start in the mid-1960s, it was government policy to combat drug problems. It was not, however, until the 1985 white paper that Norway as a drug-free society became the declared objective (St. meld. nr. 13, 1985–1986). The wording derived from a decision made at the Nordic ministerial meeting in Stockholm in 1982 (Alcoh och narkotika, 1982), though only Norway and Sweden established this as the national policy goal. In the 1985 white paper, the goal of a drug-free society is described as strongly rooted in the public opinion, the political parties and NGOs. It is widely understood, the white paper says, that Norway as a society cannot accept drug use/abuse in any form. Given the policy to achieve a drug-free society in Norway, there is no reason to differentiate between so-called “light” and “heavy” narcotic substances. And while there is indeed a difference between substances with regard to medical and other types of problem, this is no reason to take a more liberal approach to some substances than others (St. meld. nr. 13, 1985–1986).

A drug-free society has been seen as a naive and not very appropriate policy since the drug problem, by all accounts, is here to stay (Andenæs, 1996; Åsheim, 2012)). Whether the government in 1985 actually thought it was a realistic proposition to eliminate the drug problem or whether it primarily was intended as a strategic and ideal target, is hard to say. Nonetheless, the notion of Norway as a drug free society is something governmental authorities have had to deal with over the years, although mention of it has declined somewhat.

In the 1997 white paper, a comprehensive solution to the drug problem in the foreseeable future is seen as un realistic (St. meld. nr. 16, 1996–1997). It is pointed out that some people claim that the drugs policy has had no effect so far, and that Norway’s restrictive drug policy has to be
questioned. In response, the government argues, liberalizing drug policy will be taken as a sign that society no longer considers drugs as a serious problem. In all likelihood, liberalization will increase the availability and abuse of drugs. It is therefore essential to maintain the long-term political goal: a society free of drug abuse (ibid.). As may be observed, the government’s formulation is somewhat less powerful than previously, in that it is the long-term perspective that now is emphasized.

As already mentioned, Norway has gradually adopted an increasingly integrated or coherent substance policy. As far as possible no distinction is made between drug-related problems and problems related to other substances. This is reflected in action plans and the like that appeared after the mid-1990s. They all deal with substance problems regardless of source, alcohol or other drugs. This can, for instance, be noted in the title of the 2012 white paper, “See me! A Coherent Substance Policy” (Se meg! En enhetlig rusmiddelpolitikk). It looks as if the integration of different substances into “a single cohesive” policy has altered the perceptions of the possibility of achieving a drug free society in some ways. In the 2012 white paper the 1997 goal of Norway as a society free of drug abuse is once again reformulated to a goal including abuse of all substances, narcotic drugs, alcohol or other substances. “The goal is to reduce the negative consequences of substance abuse for individuals, third parties and society and give the population more years in good health” (Meld. st. nr. 30, 2011–2012). Instead of proceeding with an unrealistic goal of Norway becoming a drug-free society (or free of drug misuse) the government seems to go for more pragmatism. The goal has been moderated to reducing problems associated with substance abuse in general, be it alcohol, narcotics or other substances.

**Decriminalization?**

Looking at Norway one could argue that the conception of the drug problem as expressed in government documents is no longer in harmony with the criminal provisions. This is especially true of the Medicinal Products Act, which proscribes the use and possession of narcotic drugs. It may seem unreasonable that a behaviour said to have its roots in underlying psychosocial factors or illness, should lead to prosecution. It is also claimed that criminalization in itself harms the persons concerned (Pedersen, 2010). A criminal record of drug use/possession can for instance, harm a person’s career prospects. For these reasons, some kind of decriminalization of drug use/possession has been advocated over the years. For example, a majority of the Criminal Law Council, in 2002 proposed to decriminalize the use and possession of narcotic drugs for personal use (NOU, 2002:4). The government inquiry into the needs of substance abusers and how they can be met (the Stoltenberg Committee) referred to experiences from Portugal. As an alternative to criminal sanctions, the Stoltenberg Committee proposed the establishment of multidisciplinary committees where people arrested by the police for using drugs could get information and support from professional health and social workers (Helse- og omsorgsdepartementet, 2010). Thus, when in 2012 the government submitted its white paper on substance policy, they could not avoid the issue. The government reviews...
in the white paper the various arguments for decriminalization, but is not satisfied “... that decriminalization and/or legalization will reduce the drug problem” (St. meld. nr. 30, 2011–2012). General deterrence is the most important reason for the government maintaining the ban on the use of drugs. And again, decriminalization/legalization of narcotic drugs would make them more available and socially acceptable, lead to increased use and more widespread problems. The government underlines, moreover, the obligation to the UN conventions (ibid.).

Summary and conclusions
There is no doubt that the “new” narcotic drugs were seen as a major threat from the start in the mid-1960s, with the Penal Code Council calling for strict penalties. At the same time, however, the use and abuse of drugs also needed to be conceived as a personal and social problem.

Karl Evang, the long-serving, highly influential Norwegian director of public health in the years 1938 to 1972, was probably the most important source of Norwegian drug policy terminology in these early years. Evang refers to drug abuse as an interdisciplinary problem (Evang, 1969) and an epidemic. All steps have to be taken to halt the epidemic. He blamed sociologists to examine whether these narcotic substances were more dangerous than alcohol, since they were primarily concerned with the substances pharmacological effects and biochemical properties. Evang saw sociological factors as the most important when it comes to causality as well as effects. “It may sometimes seem surprising that some sociologists do not seem to be aware that the degree of social acceptance of narcotic drugs – the sociological factor – is the strongest factor in deciding whether a drug will spread or not.” If drugs become as socially acceptable as drinking, Evang stated, the use of narcotic drugs will spread rapidly. There is therefore an urgent need to ban the use of these substances (ibid.).

Norwegian drug policy-making in these early years was based on the fear that narcotic drugs could become socially accepted and widespread. Strict sanctions were needed as a deterrent, primarily to stop the illegal supply of drugs, but also their use. Nevertheless, the need for specialized services and treatment was also acknowledged. Penalties escalated fast in Norway, however, and by 1984 the statutory punishment had been raised to 21 years for serious drug crimes.

Little by little, however, the strict penalties became the subject of sometimes hard criticism. One vocal critic was professor Johs. Andenæs, the Grand Old Man of criminal law and member of the Penal Code Council, whose work between 1967 and 1984 formed the basis of the prohibition of the use of drugs in the Medicinal Products Act and the Penal Code § 162 for serious drug crimes. In the mid-1990s he launched a vehement attack against prevailing drug policy (Andenæs, 1996), calling for a significant reduction in the penalties and arguing that the use and possession of small quantities for personal use should be decriminalized altogether. It was logical, he said, to use punishment to stop the evil of drug abuse (narkotikaon-det) when it appeared in the 1960’s. Moreover, he argued, since one has learned from experience that strict penalties obviously do not solve the drugs problem, it...
Table 2. Governmental perception of and responses to the drug problem over time.

| Description of the problem | Mid-1960s–1970s | 1980s | 1990s | 2000– 
|---------------------------|-----------------|-------|-------|-------|
| **Youth problem**         | Drug abuse/drug abuser | Substance dependency/substance dependent |
| **Epidemic**               | Interplay between the individual human being, the substance and the environment | Disease mixed with a social and societal perspective |
| **Symptom of underlying factors.** | Imprisonment for severe drug crimes set to 2 years, 6 years and then to 10 years. Penalty for use and possession: fines, possibly or 3 months imprisonment. | Imprisonment for severe drug crimes rose to 15 years, then to 21 years. Penalty for use and possession: fines, possibly 6 months imprisonment. | Imprisonment for severe drug crimes rose to 15 years, then to 21 years. Penalty for use and possession: fines, possibly 6 months imprisonment. | Decriminalization of use would make drugs more available and socially acceptable. |
| **Needle programmes, substitution treatment** | A drug free society | A society free of drug abuse | To reduce the negative consequences of substance abuse to individuals, third parties and society |
| **Low threshold health services** | The Drug Injection Rooms Act |

made no sense to increase them. Thus, a 50 per cent decrease in penalties would not affect the supply and use of narcotic drugs, he maintained (ibid.).

Penalties for dealing with drugs were from the very beginning motivated by prevention. As shown in the statements taken from the Penal Code Council report from 1967, the purpose of prohibiting the use was to persuade people tempted to use drugs not to do so. Although the initial conception of drug use/abuse was a symptom of underlying social/psychological problems, there may be reason to question whether actual use was prohibited and punished.

How legislators of today would have acted given a new opportunity is impossible to know. However, they would probably not have found it very useful to prohibit the use and possession of small quantities. It may also be that the provisions in Section 162 of the Penal Code on serious drug offenses would have looked somewhat different. One could say that Norway in many ways has managed to manoeuvre itself into a corner when it comes to drug legislation. As the consequences of liberalization are not known, politicians are unwilling to take the risk of lowering penalties. The fear of creating a negative signal is probably the main reason. The aspiration of Norway as a drug free society has, however, been watered down over the years, and become more «sober».

Table 2 summarizes the findings of this review. Even if the sentencing frameworks for drug offenses have remained the same for 30 years, government papers show how the conception of drug misuse changed in that period. While underlying problems used to be cited as the main explanation of drug abuse, it is increasingly seen as an illness. At the same time, people with...
a problematic drug habit are more likely to be called substance dependents today, rather than “substance abuser”. Although the change in terminology might make substance abuse seem less shameful, we can question whether it is always appropriate. To denote people who abuse drugs as drug dependents might be perceived by the people themselves and their immediate circle as indicating that it is more or less impossible to get out of substance abuse. Since a primary goal of treatment should be to prevent drug abuse developing into drug dependency, such signals are arguably not in the best interest of either the abusers themselves or society in general.

Harm reduction measures are now a central part of Norwegian drug policy. Syringes are handed out in large numbers all over the country. Low-threshold health services are established in many municipalities and local authorities are given the opportunity to establish drug consumption facilities. More than 7,000 patients are in substitution treatment with methadone and buprenorphine. The Stoltenberg Committee was asked to consider whether heroin should be included in substitution treatment. A majority of the Committee was in favor of setting up a pilot project with heroin treatment. The government did not, however, support of the idea. “After an overall assessment, the government has not found the evidence satisfactory to introduce a pilot scheme at the present time” (Meld. st. nr. 30, 2011–2012). In February 2014 the government also said no to allow the smoking of heroin within the framework of the injection room scheme (Helse- og omsorgsdepartementet, 2014).

In other words, although a range of harm reduction measures has been adopted, it appears that Norway for now has come to a limit to what is considered appropriate. If the condition of heaviest drug abusers fails to improve, this may change in the coming years.

Declaration of interest None.

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