

# **Document no. 3:12**

(2004–2005)

***The Office of the Auditor General's  
investigation of the management and  
supervision of measures aimed at substance  
abusers***

## **To the Storting (Norway's parliament)**

The Office of the Auditor General hereby submits Document no. 3:12 (2004–2005),  
*The Office of the Auditor General's investigation of the management and supervision of  
measures aimed at substance abusers.*

The Office of the Auditor General, 15 June 2005.

For the Board of Auditors General  
*Bjarne Mørk-Eidem*  
Auditor General

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# The Ministry of Health and Care Services

## The Office of the Auditor General's investigation of the management and supervision of measures aimed at substance abusers

### 1 INTRODUCTION

In its recommendation to the Storting on the Act relating to Social Services, Recommendation no.9 (1991–92) to the Odelsting, the Standing Committee on Social Affairs underlined that substance abuse is one of Norway's greatest social problems. This applies to the individual users and their families as well as to society as a whole which bears the burden of considerable costs and use of resources. During the last ten to 15 years there has been a significant increase in the use of intoxicants and in the number of deaths related to heavily dependent substance abusers. Total municipal net expenditure on social services in 2003 amounted to NOK 7.2 billion. The Norwegian Institute for Alcohol and Drug Research (SIRUS)<sup>1</sup> carried out an investigation commissioned by the Ministry of Local Government and Regional Development in which it was estimated that the total expenditure in 2001 with regard to substance abusers was approximately NOK 2.2 billion.

Pursuant to the Act relating to Social Services substance abusers must receive help to break away from the abuse of alcohol and other intoxicants through counselling, guidance and other support measures. The Ministry of Health and Care Services has the overall national responsibility for support measures, rehabilitation and aftercare for substance abusers. The implementation of national drug and alcohol policies has been delegated to bodies at various administrative levels, for example the Directorate for Health and Social Affairs, the Norwegian Board of Health, the county governors' offices, the state health enterprises, resource centres for questions related to intoxicants, and the local authorities. The municipal authorities have the main responsibility for the monitoring of the individual drug abuser. Monitoring may include a wide range of measures such as identification, mapping, assessment, advice and counselling, treatment and aftercare.

The purpose of the investigation of the Office of the Auditor General (OAG) was to shed light on the degree to which the Ministry ensures that the monitoring of substance abusers is in line with the decisions and intentions of the Storting. The investigation has mapped:

- how the Ministry fulfils its overall national responsibility for the municipalities' monitoring of substance abusers

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<sup>1</sup> SIRUS Report no. 3/2003: *Rus og Psykiatri i inntektssystemet for kommunene* (Substance abuse and psychiatry in the municipal revenues system) by Hans Olav Melberg and Øyvind Omholt Alver

- to what extent the management and case-processing system in the municipalities is appropriate and adequate
- to what extent the municipalities provide follow-up in the form of advice, counselling and support measures for clients with substance abuse problems
- to what extent the municipalities exercise their responsibility for the monitoring of clients undergoing medication-assisted rehabilitation, compulsory placement and treatment in institutions.

The OAG's report on the investigation is appended. A draft of the report was submitted to the Ministry of Health and Care Services in a letter of 28 January 2005. The audit criteria were submitted to the Ministry of Social Affairs at an earlier stage. In a letter of 11 March 2005, the Ministry commented on the matters addressed in the report and its remarks on the factual part of the report have largely been taken into account and included in the report. The Ministry's comments on the assessments in the report are given in Section 3.

## **2 SUMMARY OF THE INVESTIGATION**

The audit questions in the investigation are explored by means of interviews, examination of the case files, questionnaire surveys and document analysis.

In order to shed light on how local authorities supervise substance abusers before, during and after support measures, interviews were conducted and case files were reviewed at 24 social service offices in 17 municipalities and three districts in Oslo. The municipalities included in the investigation are large and medium-sized urban and rural municipalities in various parts of the country. The sample is limited to municipalities with more than 10,000 inhabitants to ensure that the range of services was examined in places where there were a relatively large number of substance abusers. The case files of 219 clients were reviewed, providing information about the specific follow-up in individual cases by social services. Emphasis was put on mapping the practices of the social services in the period from 1998 until spring 2004. In order to acquire information about management and the case-processing systems in the municipalities, interviews were conducted with the social service, and documents such as organization charts, case-processing routines, planning documents, annual reports and other reports from the municipal and social services were obtained and examined.

With regard to work carried out at national level on the monitoring of substance abusers, interviews were conducted with the Ministry of Social Affairs, the Ministry of Health, the Directorate for Health and Social Affairs and the county governors in Oslo and Akershus. In addition a questionnaire was sent to county governor's offices throughout Norway. A meeting was also held with the Norwegian Board of Health. A number of Reports to the Storting, Propositions to the Odelsting, official reports and research reports linked to this area have been examined. Data on the social services from Municipality-State-Reporting (KOSTRA) /Statistics Norway have also been studied.

### **2.1 The Ministry's overall and national responsibility for the monitoring of substance abusers**

The investigation shows that at the start of 2005 there is no systematic form of reporting from municipalities to the central authorities with regard to the monitoring of substance abusers. Furthermore the investigation reveals that there are no available statistics on the number of substance abusers who are clients of the social services, nor is there other relevant countrywide information about the work of municipal social services with substance abusers. From 1994 the Research Council of Norway carried out an evaluation of the Act relating to Social Services, funded by the Ministry of Health and Social Affairs. However, none of the projects in the evaluation dealt explicitly with substance abuse care. In 2004 an evaluation of the social services' follow-up of substance abusers was conducted, and the first inspection of the follow-up was carried out in the same year. Apart from this, no evaluation of the Act relating to Social Services in its entirety or of those parts containing provisions specifically targeted at the monitoring of substance abusers has been conducted. Inadequate reporting, evaluation and statistics entail the risk of the Ministry not acquiring sufficient knowledge of whether substance abusers receive the supervision to which they are entitled pursuant to the Act relating to Social Services. Therefore the question arises as to whether the Ministry has the necessary governance information in this area.

The investigation shows that the central authorities have not been proactive in the development of guidelines, tools and models which might lead to a greater degree of systemisation in the work of the local authorities in their monitoring of substance abusers.

In connection with the action plan *Kunnskap og brubygging* (Knowledge and bridge-building) (1998–2001), specialist forums addressing social and substance-related issues were established. Following the completion of the action plan a key priority area for the Ministry has been the establishment and continuation of such forums. The investigation has shown that the county governor's offices have done little to maintain and develop these forums.

Furthermore the investigation reveals that resource centres addressing substance abuse questions, whose remit includes providing advice and introducing measures to enhance the competence of social services in the municipalities, have not been proactive towards social services in this area. The investigation makes it evident that the social services have little or no contact with the resource centres when monitoring substance abusers.

In 2004 altogether 16 per cent of 457 municipalities and urban districts in Norway received grants linked to the municipalities' follow-up of substance abusers. The grants have an impact on the whole area of social welfare and substance abuse, with substance abusers as one of several target groups. The Directorate for Health and Social Affairs has stated that it is not necessarily the municipalities with the greatest needs who receive grant funding but rather the municipalities with the financial means to co-finance projects, the competence to draw up the project application and the resources to monitor and implement projects.

## **2.2 The municipalities' monitoring of substance abusers**

*Management and case-processing systems in the municipalities*

A third of the municipalities and urban districts investigated do not have a comprehensive action plan dealing with the follow-up of substance abusers. The investigation further reveals that in eight out of 20 municipalities the annual report does not include information about the monitoring of substance abusers by the social services. In addition there are indications of inadequate planning and lack of focus on the key priority areas with regard to such follow-up.

Another finding is that the case-processing tools in the social services are primarily made for financial reporting in the social services area and are not adapted for reporting on the follow-up of substance abusers or other clientele. As a result, several of the social services keep manual registers that are not part of the case-processing tools in order to report on the monitoring of substance abusers, for example in respect of the number of clients receiving treatment at substance abuse institutions.

A review of documents from the municipal social services shows that one-third of the social services in the investigation do not have case-processing routines for their work and that three-quarters of the social services do not have written case-processing routines for the monitoring of substance abusers. The lack of written case-processing routines may lead to varying practices among case officers at the same social service office and a lack of predictability for the clients.

Furthermore the examination of case files shows that there is insufficient documentation in the case notes and the case files in municipal social services. The lack of documentation poses the risk of losing continuity in the social service's monitoring of substance abusers and may entail the protection afforded to the client by law not being safeguarded. Verifiability in the case of complaints, supervision and audits may also be reduced.

The investigation reveals that the social services have limited knowledge of the regulations concerning internal control in the health and social services, and that the work on the establishment of internal control systems in the social services has barely started. The lack of internal control systems constitutes the risk of errors and deficiencies in case processing not being detected and corrected.

#### *The monitoring of substance abusers by the municipal social service*

Studies of case files show that in 56 out of 219 cases substance abuse is mentioned one year or more after the first contact with the social service. In a large number of cases – 166 out of 219 cases (76 per cent) – the client had a substance abuse problem prior to the first contact with the social services. In addition it emerges that that in 81 out of 219 cases the client was assessed one year or more after the first contact with the social service. Late identification and mapping of substance abuse may delay the social services' application of targeted support measures aimed at substance abuse. The deficiencies in mapping may also mean that the social services do not have an adequate basis to provide targeted assistance. One of the reasons for late identification and mapping may be that the municipalities do not have sufficient competence and methodology in this area.

The investigation by the OAG and investigations carried out by other government bodies show that general services pursuant to Chapter 4 of the Act relating to Social Services are only to a very limited extent provided to substance abusers even though the Act prescribes this. The investigation also reveals that there is a lack of housing and that

case processing with regard to the allocation of housing for substance abusers is a very lengthy procedure. This is supported by other research and studies. There is reason to question whether clients with a substance abuse habit are sufficiently given the help that they need and to which they are entitled.

The investigation indicates that the social services experience difficulty in finding a treatment programme for substance abusers who have a dual diagnosis of both substance abuse and mental health problems. One-third of the municipalities lack a range of support measures for such clients. Seven social services mention problems linked to the refusal of psychiatric institutions to treat clients who are substance dependent or under the influence of drugs and who clearly have serious mental health problems.

The review of case files shows that 11 per cent of substance abusers have received a minimum of counselling and guidance before and during community-based help. There are also wide variations in the number of counselling and guidance sessions devoted to the individual client. The investigation further reveals that several social services apparently lack the necessary routines and systems for providing counselling and guidance to substance abusers.

In respect of monitoring before, during and following institutional placement, the investigation shows that a care plan has been prepared for only five out of 55 clients in connection with institutional treatment. In the case of 23 out of 55 clients there is no documentation to show that the social service has carried out any form of assessment of applications for institutional treatment. Furthermore, a number of the clients have had no contact with the social services during and following institutional placement, and in some cases no post-institutional follow-up treatment had been planned. The lack of contact between the client and the social service in the post-institutional follow-up phase involves a breakdown in the provision of an integrated care plan and indicates that the social service is unable to carry out an assessment of the client's situation.

The review of case files shows that in the case of nine clients on medication-assisted rehabilitation programmes (MAR) it had taken the social service over a year to evaluate and submit the application after the first mention of a request for medication-assisted rehabilitation. In two cases the application was made four years after the programme had been mentioned. The investigation further reveals that there are differing practices among social services as to whether applications are submitted as they are received or as and when the municipality has the capacity to deal with more clients on this programme. This finding is backed up by the evaluation of the MAR programme undertaken by the Directorate for Health and Social Affairs which raises the question as to whether applicants receive equal treatment. The investigation of the OAG also shows that in a quarter of the cases no documentation has been found that the client has received community-based support measures under this programme. It is debatable whether MAR clients are afforded adequate social rehabilitation.

Studies of case files indicate that although required by law there is no care plan in just over half the cases involving compulsory measures. Furthermore, in the case of five out of 13 substance abusers, it took over 90 days from the initial mention of compulsory measures as an alternative for the social services to institute proceedings. For three of 11 pregnant substance abusers it took over 60 days for proceedings to be instituted. Lengthy processing times for clients under assessment for compulsory placement

constitute a risk both to the client's life and health and to the children of pregnant substance abusers.

On several occasions the Standing Committee on Social Affairs has expressed the opinion that provisions for compulsory measures are not applied sufficiently often. In 1998 amendments to the Act relating to Social Services were adopted with the intention of achieving a more effective application of the regulatory framework linked to compulsory placement of substance abusers. The investigation indicates that only to a very limited extent do the social services take the initiative with regard to compulsory placement. A total of 53 substance abusers underwent compulsory placement in 2003 following decisions by the County Committee for Social Affairs.

### **3 THE MINISTRY OF HEALTH AND CARE SERVICES' COMMENTS**

The Ministry of Health and Care Services made a statement in reply to the report of the OAG in a letter of 11 March 2005. In addition, on the same date the Ministry of Labour and Social Affairs submitted a statement on the report to the Ministry of Health and Care Services. This was attached to the letter from the Ministry of Health and Care Services to the OAG.

The Ministry of Health and Social Services states that the OAG's report constitutes an important basis for the Ministry's future work to improve the situation of substance abusers.

In the opinion of the Ministry the report puts insufficient focus on the fact that substance abuse care does not constitute a separate care service. In Recommendation no.121 to the Storting (1992–93) the Standing Committee agreed with the Ministry's wish to integrate the treatment of substance abusers into the ordinary health and social welfare system.

The Ministry refers in its statement to the fact that there is no clear definition of "substance abuser" that would facilitate the collection of systematic information and statistics.

The Ministry expresses the view that the work of the Storting is based on the strengthening of local self-government with the aim of decentralising authority and tasks to municipal level to the highest degree possible. Reference is made to Recommendation no. 307 (2000–2001) to the Storting from the Standing Committee on Local Government and Public Administration where the committee concurs that the goal must be that authority and tasks must be decentralised to the municipal level where possible. The Committee states that the responsibility for decisions and task-solving must be placed as closely as possible to the clients involved.

The Ministry points out that in recent years the Ministry of Health and Social Affairs and subsequently the Ministry of Labour and Social Affairs and the Ministry of Health and Care Services have had responsibility or shared responsibility for a range of action plans, including *Kunnskap og brubygging* (Knowledge and Bridge Building), *Tiltaksplan mot fattigdom* (Planned Measures to Combat Poverty), *Rusmiddel politisk handlingsplan* (Action Plan for Policies on Alcohol and Drugs), *Opptappingsplanen for psykisk helse* (Escalation Plan for Mental Health) and *Boligsosialt arbeid – bistand til å mestre et*

*boforhold* (Work with Social Housing – help in mastering living conditions). The Ministry is of the opinion that these action plans have been directed towards the social services both at present and in the past. The measures in these action plans have been targeted at disadvantaged groups in society, of which substance abusers form a considerable proportion.

The Ministry also points out that in recent years a considerable amount of work has been devoted to improving work with substance abusers and their conditions. This is exemplified by a significant increase in the provision of medication-assisted rehabilitation and by the establishment of low-threshold health and social services. The Ministry further mentions “drug reforms” where the central authorities through the regional health enterprises have taken over responsibility for second tier services from the county authorities, including responsibility for providing inter-disciplinary specialist services for substance abusers. The Ministry’s view is that the analysis is not complete since the investigation by the OAG does not take into account the widespread changes that have taken place recently.

#### **4 THE OFFICE OF THE AUDITOR GENERAL’S REMARKS**

The purpose of the OAG’s investigation has been to evaluate the extent to which the Ministry discharges its overall national responsibility to ensure that the monitoring of substance abusers is conducted in line with the decisions and intentions of the Storting. In order to do this, the OAG has gathered data from the municipalities. The investigation is delimited so as to exclude assessments of measures that have been put into effect fairly recently since it is unlikely that they have been implemented and are operative.

The Ministry of Health and Care Services has the overall national responsibility for legislation on social services that covers monitoring and support measures for substance abusers. This involves among other things the responsibility for providing an integrated range of services and system of support measures as laid down in the Act relating to Social Services. A prerequisite for enabling the central authorities to exercise their overall national responsibility when the responsibility for task-solving has been delegated to the local authorities is the provision of regular management information, for example by means of reporting, evaluation and statistics.

The OAG’s investigation has shown that the municipalities do not report systematically to the central authorities on the monitoring of substance abusers, that evaluations are infrequent and that there are no relevant statistics on the work of the municipal social service with substance abusers. The OAG considers the strengthening of supervision in line with the Act relating to Social Services positive but is of the opinion that this does not compensate for weaknesses inherent in the reporting system, evaluation and statistics.

The OAG notes that substance abuse care is not a separate area. Nevertheless it is felt that relevant information about important social policy groups should be available at government level. The Ministry of Health and Care Services indicates that problems in formulating a clear definition of “substance abuser” make it impossible to collect data and statistics at the national level. The OAG appreciates that there are challenges in establishing a reporting scheme that is fully adequate. However, it is possible to prepare indicators for follow-up and support measures for acknowledged substance abusers who

are in contact with the social services. The investigation reveals that individual municipalities have case-processing systems where it is possible both to distinguish substance abuse clients from other clients and to prepare overviews of clients who have an acknowledged substance abuse problem.

In recent years the Ministry has had responsibility or partial responsibility for a number of action plans and grant schemes targeted towards weaker social groups, including substance abusers. The OAG's investigation shows that it has been difficult to put in place measures that are retained over time through these action plans.

The Ministry of Health and Care Services has prepared a circular describing the application of the Social Welfare Act in general terms and also guidelines on provisions involving compulsion. Nevertheless the investigation reveals that there are considerable deficiencies in the municipal follow-up of substance abusers, for instance that the identification and mapping of the problem of substance abuse is carried out very late. The investigation indicates that the social service does not have adequate and appropriate methods, routines and systems to provide a satisfactory monitoring of substance abusers. The OAG questions whether the Ministry of Health and Care Services (the former Ministry of Social Affairs) has been sufficiently active in ensuring that guidelines, tools and models are developed to achieve a greater degree of systemisation in this work.

Many municipalities do not have case-processing routines, and their documentation in case notes and case files is deficient. A lack of written case-processing routines may lead to differing practices among case officers at the same social service, resulting in inefficiency. There is also a risk that it will not be possible to achieve continuity in the follow-up and that the client's right to the protection of the law will not be safeguarded. Lack of documentation reduces verifiability with regard to complaints, supervision and audits.

The investigation further shows that it takes a long time for the social service to proceed with cases involving compulsory measures and applications for medication-assisted rehabilitation. There are indications that not everyone who applies for medication-assisted rehabilitation receives equal treatment. The time spent on case processing before compulsory measures are implemented is regarded as lengthy in relation to the serious nature of such cases. Lengthy case processing for clients who are being assessed for compulsory placement constitutes a risk to life and health both for the clients and for the children of pregnant substance abusers.

Moreover little consideration is given to the provision of general services under the Act relating to Social Services in relation to the follow-up of substance abusers. There is also a lack of housing for such clients. A quarter of those on medication-assisted rehabilitation who are entitled to social rehabilitation have not had the benefit of community-based support measures during the rehabilitation. Additionally there is a lack of follow-up and contact between the social service and clients during institutional treatment as well as at the post-institutional phase. The OAG's investigation shows that the provision of assistance, monitoring and support measures that drug abuse clients need and to which they are entitled is inadequate.

## **5 THE MINISTRY OF HEALTH AND CARE SERVICES' RESPONSE**

The matter has been submitted to the Ministry of Health and Care Services, and the Minister replied as follows in a letter of 2 May 2005:

*"We refer to earlier correspondence and to our recent letter dated 11.03.05, and to the Office of the Auditor General's letter with attachment dated 13.04.05.*

*The Ministry has no further comments on the Office of the Auditor General's remarks."*

## **6 THE OFFICE OF THE AUDITOR GENERAL'S STATEMENT**

The investigation shows that the Ministry of Health and Care Services does not have adequate information about the municipal follow-up of substance abusers and that the Ministry has only to a limited extent conducted evaluations of the monitoring of substance abusers by the municipal social service. In the opinion of the OAG the Ministry should be provided with regular information about the work of the municipalities in order to fulfil its overall national responsibility in this area.

The OAG underlines that many substance abusers are not given the follow-up to which they are entitled by the municipal social service. In many cases the time spent by the social services in mapping and identifying the substance abuse problem and in implementing compulsory measures or requesting medication-assisted rehabilitation is very lengthy. Only to a very limited extent do substance abusers obtain general services pursuant to the Act relating to Social Services, and those on medication-assisted rehabilitation programmes do not always receive the necessary specialist social rehabilitation. Additionally in a number of cases substance abusers are not monitored by the social service during institutional treatment and in the post-institutional follow-up phase.

It is the view of the OAG that the Ministry should take the initiative to develop guidelines, tools and models that ensure greater systemisation and knowledge in the work of the municipalities and that also provide substance abusers with improved follow-up from the social service in the municipalities.

The matter is to be submitted to the Storting.

Adopted at the meeting of the Office of the Auditor General, 25 May 2005.

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**Appendix**

# **Report**

## **Management and monitoring of measures for substance abusers**

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**Appendix 1** .....

## 1 Introduction

### 1.1 BACKGROUND FOR THE INVESTIGATION

In its recommendation to the Storting on the Act relating to Social Services, Recommendation no.9 to the Odelsting (1991–92), the Standing Committee on Social Affairs underlined that substance abuse is one of our greatest social problems. This applies both to the individual users and their families as well as to society which bears the burden of considerable costs and use of resources.

During the last ten to fifteen years there has been a significant increase in the use of intoxicants and in deaths related to the number of heavily-dependent substance abusers. New groups of substance abusers and new patterns of substance abuse have emerged. In 1989 the number of injecting substance abusers was estimated at between 4,000 and 5,000 whereas in 2001 the estimate increased to between 10,500 and 14,000. The number of drug-related deaths also rose during the 1990s, especially in the last half of the decade. In 1990 there were altogether 90 drug-related deaths as against 405 in 2001.<sup>2</sup> There was also an increase in alcohol consumption generally in the population during the 1990s.<sup>3</sup>

The Standing Committee stated in its Recommendation no. 184 (1996–1997) to the Storting to Report no. 16 (1996–1997) to the Storting on drug policies that the treatment measures adopted and the results achieved should receive critical scrutiny. The Standing Committee expressed the opinion that too many substance abusers go from one treatment plan to another and that this is costly for society in respect of financial and human resources. The Committee added that there is an inadequate range of post-institutional care and that the municipalities are not doing a good enough job in this area. In addition the local authorities and treatment institutions must not only ensure that the drug abuser finds employment or begins a course of education but that housing is offered and help given to establish a new social network.

Substance abusers in Norway must be provided with services by the central authorities in the same way as other inhabitants. This applies for instance to services and support for personal economy, housing, education and work. Substance abusers must also receive services targeted at their substance abuse, in other words they should receive help to break away from their addiction or to limit their intake of drugs in addition to services that will ensure a satisfactory state of health.

In 2003 the total municipal net expenditure on social services amounted to NOK 7.2 billion. Some NOK 4.4 billion was associated with net operating expenses for social benefits and NOK 2.1 billion was allocated to advice, guidance and preventive efforts by the social services.<sup>4</sup> Net operating expenses under function 243 concerning facilities for people with substance-related problems amounted to NOK 635.4 million. The municipalities recorded expenditure incurred for institutional stays, treatment and post-institutional care under this function up to 2004 when the responsibility for substance

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<sup>2</sup> Report on the drug situation in Norway, 2002 (The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The Norwegian Institute for Alcohol and Drug Research (SIRUS).

<sup>3</sup> In 1991 the alcohol consumption per inhabitant aged 15 and over amounted to 4.90 litres of pure alcohol. In 2003 alcohol consumption had risen to 6.03 litres of pure alcohol per inhabitant aged 15 and over. (SIRUS 2003/SIRUS website).

<sup>4</sup> Municipality-State-Reporting (KOSTRA).

abuse institutions was transferred to regional health enterprises. Other municipal expenses for support measures and monitoring of substance abusers are not specified in KOSTRA (Municipal-State-Reporting).

SIRUS (the Norwegian Institute for Alcohol and Drug Research) has estimated that the total expenditure for substance abusers amounted to approximately NOK 2.2 billion or NOK 479 per inhabitant in 2001.<sup>5</sup> SIRUS is of the opinion that this is a conservative estimate because many expenses are excluded (e.g. employment measures) and because the estimate is based on the assumption that substance abusers receive the same amount of social benefits as other recipients. However, SIRUS believes that many substance abusers receive more financial support than other users of the social services and that this is paid over a longer period of time. They conclude that it is likely that substance abusers receive a larger proportion of social assistance than the amount on which these calculations are based.<sup>6</sup>

SIRUS estimates that approximately 23 per cent of the recipients of social welfare have drug-related problems<sup>7</sup> while SINTEF (the Foundation for Scientific and Industrial Research at the Norwegian Institute of Technology) puts the number at 38 per cent.<sup>8</sup> Based on these estimates the number of substance abusers who are in contact with the social service is between 33,000 and 55,000 countrywide.<sup>9</sup>

The Ministry of Health and Care Services was given the overall national responsibility for ensuring that assistance, rehabilitation and aftercare of substance abusers were implemented in line with the decisions and intentions of the Storting from 1 October 2004. The Ministry has the overall and national responsibility for the Act relating to Social Services. This entails responsibility for the provision of services and a range of measures as described in the Act relating to Social Services and the Act relating to Municipal Health Services.<sup>10</sup> The Ministry of Labour and Social Affairs was given the overall national responsibility for policies on substance abuse in Norway as well as the responsibility for the coordination of efforts to mitigate substance abuse problems from 1 October 2004.<sup>11</sup>

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<sup>5</sup> The estimate from SIRUS is based on the fact that all expenditure in the function "Provisions for people with drug problems" in KOSTRA can be attributed to substance abusers. This is also the case for 23% of expenses for financial social assistance, advice and counselling provided by the social service. In addition 11.6 per cent of expenditure on child welfare can be attributed to expenses related to substance abusers.

<sup>6</sup> SIRUS Report no. 3/2003: *Rus og Psykiatri i inntektssystemet for kommunene* (Intoxicants and Psychiatry in the municipal revenue system) by Hans Olav Melberg and Øyvind Omholt Alver, Pages 37 and 38.

<sup>7</sup> SIRUS Report no. 3/2003: *Rus og Psykiatri i inntektssystemet for kommunene* (Intoxicants and Psychiatry in the municipal revenue system) by Hans Olav Melberg and Øyvind Omholt Alver.

<sup>8</sup> SINTEF Report (2004): *Rusklienter og tjenester før "rusreformen"* (A cross-sectional study of substance abusers and services provided to substance abusers prior to the drug reform programme) by Tonje Gundersen, Lisbet Grut, Mitch Loeb, Torleif Ruud, Tone Eikeland, Sverre Nesvåg, og Esben Olsen.

<sup>9</sup> The estimates are based on the number of recipients of financial social assistance reported in KOSTRA. In SINTEF's investigation the number of substance abusers is estimated on the basis of all clients of the social services so that the estimate may be too high.

<sup>10</sup> Letter of 03.11.2004 from the Ministry of Health and Care Services to the Office of the Auditor General.

<sup>11</sup> Proposition no.1 (2004–2005) to the Storting.

Bodies at several administrative levels are charged with providing a range of services for substance abusers. As a result coordination between the participants presents a challenge for the flow of information and interaction. Similarly it is difficult to acquire an overview of whether the policy instruments in the area of substance abuse function as they are intended to.

## 1.2 PURPOSE AND ISSUES

The purpose of the investigation is to shed light on the degree to which the Ministry ensures that the monitoring of substance abusers in the municipalities is implemented in accordance with the decisions and intentions of the Storting.

The investigation is to examine the following audit questions:

1. How does the Ministry fulfil its overall national responsibility for the municipal follow-up of substance abusers?
2. To what extent are the management and case-processing systems in the municipalities adequate and appropriate for fulfilling current requirements for monitoring substance abusers?
3. To what extent do the municipalities provide follow-up for substance abuse clients in the form of advice, counselling and assistance?
4. To what extent do the municipalities exercise their responsibilities in the monitoring of clients undergoing medication-assisted rehabilitation, compulsory placements and institutional treatment?

The term substance abuser refers to clients who in the opinion of the municipal social service have an acknowledged or concealed problem related to the abuse of alcohol and/or other intoxicants. It is essential to gather data at the municipal level in order to give opinions on how the Ministry ensures that the monitoring of substance abusers in the municipalities is implemented in accordance with the decisions and intentions of the Storting. Audit questions 2, 3 and 4 focus on the municipalities. The investigation is restricted to covering the monitoring of substance abusers in the municipalities pursuant to the Act relating to Social Services. This may include a wide range of measures such as identification, mapping, assessment, counselling, community-based measures, care plans and treatment programmes. The investigation will present a more detailed mapping of the work of the social service with a number of these measures. This applies to the monitoring of clients on medication-assisted rehabilitation, compulsory placement and institutional treatment but does not cover the follow-up of substance abusers' families.

"Municipal social service" means the social service or other bodies in the municipality who supervise substance abusers pursuant to Chapter 6 of the Act relating to Social Services, and is hereafter referred to as "the social service" unless otherwise specified.

The investigation is delimited so as to exclude evaluations of measures that have been adopted relatively recently, and which consequently cannot be expected to be implemented and operative. This applies to:

- substance abuse institutions that were transferred to the central authorities represented by the regional health enterprises with effect from 1 January 2004
- the right to individual care plans for clients who receive long-term coordinated services in accordance with an amendment to the Act relating to Social Services with effect from 1 January 2004
  - the overall professional supervision of the municipal social service, including supervision of the monitoring of substance abusers that was transferred to the Norwegian Board of Health with effect from 1 January 2003

## **2 Methodological approach and implementation**

The audit questions in the investigation are focused on by means of interviews, examination of case files, questionnaire surveys and analysis of documents. In addition data from official reports, research reports and Statistics Norway are utilised.

### **2.1 DATA COLLECTION AT NATIONAL LEVEL**

An interview with the former Ministry of Health and Ministry of Social Affairs was conducted on 21 September 2004 in order to obtain information about the work of the ministries on the monitoring of substance abusers. Also participating were units that were transferred to either the Ministry of Health and Care Services or to the Ministry of Labour and Social Services in the reorganisation of 1 October 2004. The minutes of the meeting were verified by the Ministry of Health and Care Services on 3 November 2004.

Furthermore on 10 September 2004 an interview was conducted with the Directorate for Health and Social Affairs in order to obtain information about the work of the Directorate on the monitoring of substance abusers. A meeting was also held with the Norwegian Board of Health with the aim of acquiring information about the Board's general countrywide supervision of the range of services offered to substance abusers. Summaries were prepared for both meetings and these have been verified by the respective agencies.

All county governors are included in a questionnaire survey of tasks linked to the municipal follow-up of substance abusers. The investigation has been conducted in order to obtain a comprehensive picture of the tasks of the county governor, for example support such as competence upgrading, counselling and supervision of the social service's activities

### **2.2 DATA COLLECTION IN THE MUNICIPALITIES**

In order to shed light on the audit questions in the investigation at municipal level, interviews and case file reviews have been carried out. The Office of the Auditor General (OAG) has chosen to examine case files so as to obtain precise information about the monitoring of substance abusers by the social service, and the interviews supplement this information. In addition documentation such as planning documents and reports has been procured together with statistics of various kinds linked to the social service's follow-up of substance abusers.

#### **2.2.1 Selection of municipalities**

The criteria for the selection of municipalities are based on the requirement that the sample must consist of both urban and rural municipalities – large and medium-sized in population density and geographical extent. Small municipalities are excluded from the selection because it was intended to focus on the range of services in places with a large number of substance abusers.

Twenty municipalities have been selected on the basis of the above criteria. There is reason to believe that the findings of the investigation will apply to other urban and rural municipalities of a similar size. Altogether 24 social services are included in the investigation: in addition to the 20 «ordinary» social services, four external enterprises with responsibility for the follow-up of substance abusers pursuant to Chapter 6 of the Act on Social Services are included.

The social services in the following municipalities are included in the data selection:

- Three social services in three districts in Oslo (Nordstrand, St. Hanshaugen and Sagene Districts)
- Seven social services in four cities with a population of over 50,000 (Bergen, Drammen, Stavanger and Tromsø)
- Six social services in five medium-sized towns with a population of between 30,000 and 50,000 (Arendal, Bodø, Sarpsborg, Tønsberg and Ålesund municipalities)
- Three social services in three small towns with less than 30,000 inhabitants (Horten, Lillehammer and Molde municipalities)
- Five social services in five large and medium-sized rural municipalities with a population of more than 10,000 (Asker, Elverum, Karmøy, Lørenskog og Stjørdal municipalities)

### **2.2.2 Interview**

The interview with the social services concerns information about the management and case-processing systems in the municipalities. The routines and work of the social service in monitoring substance abuse clients in community-based measures and institutions as well as the use of coercion and medication-assisted rehabilitation (MAR) are also covered. Interviews were conducted with the head of section and the case officers who deal with drug-related problems. The main focus of the interview was on the situation at the social service at the time of the interview and on the current practice immediately prior to the interview. The summaries of all the interviews have been approved by the social service.

### **2.2.3 Review of case files**

The review of case files was conducted in order to obtain information on how targeted the follow-up of substance abusers by the municipal social service is. The social service's provision of advice and counselling, support measures and follow-up before, during and after these measures was mapped.

The cases are chosen at random and they are representative of all the cases in the municipalities visited. Prior to the audit visits the social service had compiled an overview of clients with an acknowledged or concealed drugs problem. The basis for the selection is the social service's awareness of a drugs problem. Appendix 1 gives a more detailed description of the selection of case files and distribution according to gender, age and substance abuse.

The selection of cases has been restricted to cases that were first registered with the social service on 1 January 1998 or later. The reason for this is that it is most relevant to map the practices of the social service in recent years. In order to limit the review of

case files, the mapping of institutional treatment, compulsory placement and medication-assisted rehabilitation has been restricted to the last registered relevant treatment. Cases involving medication-assisted rehabilitation or compulsory placement were registered prior to 1 January 1998 but the measure itself, i.e. the medication-assisted rehabilitation or compulsory placement, is recorded in the period from 1 January 1998 or later. The reason for this was that there are few clients who qualify for medication-assisted rehabilitation who were also registered for the first time on 1 January 1998 or later. When it comes to compulsory placement there would be too few cases if the selection was limited to cases registered for the first time on 1 January 1998 or later.

In the 24 social services the sample includes seven or eight cases involving institutional treatment or community-based measures, four or five cases involving medication-assisted rehabilitation, and two or three cases involving compulsory measures. Data from the case files of 219 substance abusers have been recorded. Some 55 cases involve institutional treatment, 26 cases compulsory placement, 67 cases medication-assisted rehabilitation and 71 cases community-based measures only.

#### **2.2.4 Review of documentation**

A review of the organisation chart, planning documents, annual reports and if appropriate other reports has been conducted in order to map to what extent the social service sets out objectives and prepares plans, treatment routines and status reports on substance abusers.

The social services were requested to document existing case-processing routines for work in the social service generally and the monitoring of substance abusers in particular. Documentation of standardised registration or assessment forms used in follow-up and internal control systems was also requested.

The social services have furnished details of the number of clients, substance abuse clients, substance abuse clients undergoing institutional treatment, clients under medication-assisted rehabilitation and clients undergoing compulsory measures. Furthermore data regarding the total number of man-years in the social service, the number of man-years for case officers/social welfare counsellors and the number of man-years for drugs abuse counsellors have been procured. All figures are as per 31 December 2003.

### **2.3 DATA FROM OTHER SOURCES**

A variety of Reports to the Storting, Propositions to the Odelsting, official reports and research reports linked to this field have been studied.

In the description of the facts, reference is made to data from several investigations conducted by or commissioned by other government bodies:

- SINTEF, Rogaland Research and SIRUS have conducted an investigation commissioned by the Directorate for Health and Social Affairs that describes the range of services available to substance abusers and also their needs according to the evaluation of the service providers. The investigation includes information

- from a sample of 159 representative social services, 407 list patient doctors and 109 substance abuse institutions and substance abuse programmes.
- AIM ResearchBasedConsulting has conducted an evaluation of Medication Assisted Rehabilitation (MAR) commissioned by the Directorate for Health and Social Affairs. The evaluation includes countrywide statistical data on MAR and data from interviews with MAR centres, county authorities, municipalities and users in all four MAR regions.<sup>12</sup>
  - The Norwegian Building Research Institute was commissioned by the Directorate for Health and Social Affairs to carry out a countrywide mapping of the homeless.<sup>13</sup>
  - The FAFO Research Foundation was commissioned by the Directorate for Health and Social Services to map services offered to people who were previously homeless. The investigation includes data from questionnaires from 147 municipalities and city districts. Large municipalities are over-represented in the survey. In addition the investigation includes interviews with 28 municipal employees as well as employees in voluntary institutions and eight users of the range of services provided.<sup>14</sup>
  - The Norwegian Board of Health conducted a countrywide survey of people with a dual diagnosis of substance abuse and mental health problems in 1999.<sup>15</sup>
  - In 2004 the Norwegian Board of Health carried out a countrywide inspection of the range of services offered to substance abusers pursuant to the Social Services Act, Chapter 4. Three municipalities under each county governor's office were inspected.<sup>16</sup>

Information about the number of recipients of social benefits, expenditure in the social services and net expenditure related to social benefits is derived from Statistics Norway/Municipality-State-Reporting (KOSTRA).

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<sup>12</sup> The Directorate for Health and Social Affairs/AIM 2004: *Evaluering av legemiddelassistert rehabilitering* (Evaluation of Medication-assisted Rehabilitation), SKR Report no. 7/2004: *Bidrag til evaluering av legemiddelassistert rehabilitering i Norge* (Contribution to the evaluation of medication-assisted rehabilitation in Norway) – Report to the Ministry of Health and Social Welfare) by Mona Baadstøe Hansen, Hege Kornør and Helge Waal.

<sup>13</sup> The Norwegian Building Research Institute: *Bostedsløse i Norge – en kartlegging* (A survey of the homeless in Norway) by Thorbjørn Hamen, Arne Holm and Steinar Østerby.

<sup>14</sup> FAFO Research Foundation: *Den vanskelige fortsettelsen – En kartlegging av tjenester til tidligere bostedsløse 2004* (The difficult transition. A study of services for previously homeless people) by Siri Ytrehus and Jon Anders Drøpping.

<sup>15</sup> The Norwegian Board of Health, report series 10/2000.

<sup>16</sup> Norwegian Board of Health Report no. 4/2005: *Oppsummering av landsomfattende tilsyn i 2004 med kommunale sosialtjenester for rusmiddelmissbrukere* (Summary report of countrywide supervision of municipal social services for substance abusers in 2004).

### 3 Audit criteria

## 3.1 THE OVERALL NATIONAL RESPONSIBILITY FOR MONITORING OF SUBSTANCE ABUSERS

The Ministry of Labour and Social Affairs has the overall national responsibility for policies related to substance abuse. The Ministry has therefore a special responsibility to coordinate efforts targeted at substance abuse and also to take the initiative to discuss substance abuse policy issues with the ministries concerned when necessary.<sup>17</sup> The Ministry must ensure reporting activities that describe developments in this area.

The Ministry of Health and Care Services has the overall national responsibility both for ensuring that support measures, rehabilitation and aftercare for substance abusers are implemented in line with the resolutions and intentions of the Storting and for contributing to the treatment and care of substance abusers.<sup>18</sup>

The Ministry of Health and Care Services has the overall national responsibility for the Act relating to Social Services, including supervision and measures for substance abusers. Among other things this entails the responsibility for the range of services offered and the provision of a joint programme of measures as described in the Act relating to Social Services and the Act relating to Municipal Health Services.<sup>19</sup>

The Ministry is to provide the guidelines and instructions that are necessary to fulfil the purpose of the Act.

The Ministry is also responsible for promoting the initiation of research that may be of significance for performing tasks in accordance with the Act. Furthermore, the Ministry must ensure that there is a sound training programme for staff and that those who apply the Act receive proper guidance. The Ministry also addresses the preparation of information material for the use of the social service.<sup>20</sup>

The Ministry must exercise supervision to ensure that the Act relating to Social Services, regulations and other provisions applicable to services and measures pursuant to the Act are applied correctly and in a manner that promotes the purpose of the Act in an expedient and appropriate way. The Ministry must also ensure that experience acquired in the application of the Act is assessed and that necessary amendments are made to the regulatory framework.

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<sup>17</sup> The Norwegian Government's Action Plan to Combat Drug- and Alcohol-related Problems 2003 – 2005.

<sup>18</sup> The responsibility for second-tier services for substance abusers was transferred to the Ministry of Health from 01.01.2004.

<sup>19</sup> Letter from the Ministry of Health and Care Services dated 03.11.2004 to the Office of the Auditor General.

<sup>20</sup> Pursuant to the Act relating to Social Services § 2 – 5.

### 3.2 THE DIVISION OF RESPONSIBILITY AND TASKS BETWEEN STATE AND MUNICIPALITIES

The purpose of the Act relating to Social Services is to promote financial and social security, to improve living conditions for those in difficult circumstances, to contribute to increased equality of opportunity and status, to prevent social problems and to be instrumental in ensuring that the individual is given the opportunity to lead an independent life and to enjoy an active and meaningful existence together with others. The national objectives are that the entire population, regardless of age, gender, sexual affiliation, residence, income and resources shall be assured good access to national health and social services of a high quality.<sup>21</sup>

Main goals for the follow-up of substance abusers are to improve access to effective counselling, and to provide help and treatment for people with substance-related problems and their families. One objective is to increase the percentage of people with substance abuse problems who are helped by medication-assisted rehabilitation and medication-free treatment to break away from substance abuse or to attain a considerable improvement in their quality of life. A main objective in drug and alcohol policy is to reduce the incidence of drug and alcohol-related harm to health as well as the number of substance-related deaths<sup>22</sup> The Storting has expressed the opinion that all-out efforts must be made to improve housing conditions for substance abusers, while at the same time network building through education, work and leisure activities is important for the achievement of general social rehabilitation.<sup>23</sup>

The follow-up of the individual substance abuser mainly rests with the municipalities. In Report no. 23 (1992-93) to the Storting concerning the relationship between the state and the municipalities, it was stated that management by objectives and results is to be the basic standpoint in the relationship between state and municipalities. This is a management tool where targets are clarified, performance requirements determined and routines for performance reporting are systematised. For management by objectives and results to function satisfactorily the following requirements must be fulfilled:

- defined objectives and performance requirements
- documented correlation between results and policy instruments
- reporting of goal achievement and effects

One prerequisite to enable the central authorities to fulfil their overall national responsibility when the local authorities have the responsibility for tasks is that continuous feedback is given on the development of services and the results achieved in relation to the national goals set. There is a need for governance information, for example by means of regular reporting, evaluations and statistics, partly in order to evaluate the correlation between resource input and the result, and partly to evaluate the use of policy instruments and to establish whether the goals set for the municipal enterprise have been achieved.

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<sup>21</sup> Circular IS-1/2004: *Nasjonale mål, hovedprioriteringer og tilskudd for 2004* (National objectives, main priorities and grants for 2004).

<sup>22</sup> The Norwegian Government's Action Plan to Combat Drug- and Alcohol-related Problems (2003–2005)

<sup>23</sup> Proposition no. 1 (2003–2004) to the Storting.

### 3.3 THE MUNICIPALITIES' ORGANISATION, MANAGEMENT AND CASE-PROCESSING SYSTEM FOR THE MONITORING OF SUBSTANCE ABUSERS

The municipalities have considerable leeway to organise services as they find appropriate and to shape the range of support measures that is provided. In the preliminary work on the Act relating to Social Services it was pointed out that the Act is intended to give the municipalities the freedom to develop a range of support measures while at the same time it is to be formulated in such a way that it lays the foundation for the achievement of overall national goals on social policies. An overriding national goal is to ensure security and reasonable living conditions for all members of society. It was underlined in the preparatory work for the legislation that the local framing of a range of services must not be at variance with the right to human dignity and equality of treatment.<sup>24</sup>

Section 1-7 d of the Act on the Sale of Alcoholic Beverages instructs the municipality to prepare an action plan for alcohol policies. The Ministry's template for a municipal action plan for drug and alcohol policies stresses that municipalities must deal with such issues in a comprehensive manner.<sup>25</sup> An assessment of whether the municipality has achieved the defined performance goals through the existing measures must be carried out.

The Local Government Act requires the municipalities to draw up a finance plan that covers at least the next four budget years and an annual budget covering the whole of the activity of the municipality.<sup>26</sup> The Planning and Building Act stipulates that the local authorities must prepare a municipal plan with a view to coordinating physical, social, aesthetic and cultural developments.<sup>27</sup>

There should be written procedures, instructions and routines for case processing and monitoring of substance abusers in order to ensure equality of treatment and predictability in the follow-up. Descriptions of routines may serve to expose shortcomings and deficiencies and enhance awareness of the need for a holistic approach and an improved exploitation of resources.<sup>28</sup> Case-processing routines for the social service should include requirements for documentation in case files and case records. The documentation is of importance in ensuring uniform and targeted monitoring of clients and continuity, for example if a case officer is replaced. This also applies to the client's right of access and verifiability in the case of complaints, supervision and audits.

In accordance with best practices in public administration, the social service's work with substance abusers should be conducted in a systematic manner. The regulations

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<sup>24</sup> Proposition no. 29 (1990 – 1991) to the Odelsting.

<sup>25</sup> Template for the municipal action plan on drug and alcohol policies.

<sup>26</sup> §§ 44 no. 3 and § 46 no. 2.

<sup>27</sup> § 20–1.

<sup>28</sup> The National Directorate for the Prevention of Alcohol and Drug Problems: *Gravide rusmiddelmisbrukere og misbrukere med små barn – temahefte/veileder for social- og barneverntjenesten i kommunen* (Pregnant substance abusers and substance abusers with small children – a guide for the municipal social and child welfare service) 1999. Regulation on internal control of the social and health service 20.12.2002 no. 1731.

concerning internal control in the Health and Social Services state that the municipality has responsibility for developing, implementing, monitoring, evaluating and improving necessary procedures, instructions and routines etc.<sup>29</sup>

### 3.4 THE MUNICIPALITIES' MONITORING OF SUBSTANCE ABUSERS

Monitoring of substance abusers may include a wide range of measures such as identification, mapping, counselling, treatment and care. In accordance with Report no. 16 (1996 – 97) to the Storting the aim of these measures is to control or stop drug and alcohol abuse and prevent the further development of medical, psychological and social problems.

Early identification of people with drug and alcohol problems is important in order to provide targeted help to substance abusers.<sup>30</sup> Recommendation no. 184 (1996 – 97) to the Storting and Report no. 69 (1991–92) to the Storting state that early identification is crucial in order to permit speedy intervention and to provide a better opportunity of monitoring the substance abuser over a continuous period of time in his/her own environment. The question of drug and alcohol problems should be brought up as a matter of standard procedure by the social service at the registration stage or during one of the first conversations with the client.

Pursuant to the Act relating to Social Services the social service has a duty to establish what kind of care and treatment plan the substance abuser needs.<sup>31</sup> This entails the mapping of both the client's need for assistance and the reasons leading to the current situation. This information should form the basis for an overall evaluation of the client's situation prior to making a decision on the assistance to be provided.<sup>32</sup> The purpose of thorough mapping is to ensure that support measures are individually adapted.<sup>33</sup> Mapping should take place at an early stage in order to reveal the client's needs, problems and opportunities. In addition thorough mapping is essential when framing measures, for example the choice of institutional treatment.

The social service has a general responsibility for providing information, advice and guidance that can help solve or prevent social problems.<sup>34</sup> Another responsibility is to help the individual abuser to break away from using alcohol and intoxicants.<sup>35</sup> When the social service has formed a clear picture of the client's situation, attempts must be made

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<sup>29</sup> Regulation on internal control in the health and social services of 20.12.2002, § 4 g).

<sup>30</sup> The Government's Action Plan to Combat Drug- and Alcohol-related Problems (2003–2005).

<sup>31</sup> (Proposition no. 78 to the Odelsting on the Act to amend the Act relating to Social Services (1997–98): 18)). Circular I-1/93, *Act relating to Social Services*.

<sup>32</sup> The National Directorate for the Prevention of Alcohol and Drug Problems (1998): *Småbyundersøkelsen – alkoholvaner blant mottaksklienter på et sosialkontor – en utprøving av kort intervensjon* (Small town survey – alcohol habits of clients at a social welfare office – testing of short interventions).

<sup>33</sup> The National Directorate for the Prevention of Alcohol and Drug Problems /Ministry of Health and Social Affairs (1995): *Effekter av behandlingen – Behandling av rusmiddelproblemer, en utredning om effekten av ulike behandlingsformer* (The effects of treatment – Treatment of alcohol and drug problems – a report on the effect of various forms of treatment).

<sup>34</sup> Act relating to Social Services §§ 4–1 and 4–2.

<sup>35</sup> Act relating to Social Services § 6–1.

to assist the client so as to solve the problem or prevent the emergence of a social problem. The duty to give advice and guidance covers both questions of a personal nature and advice on official support schemes.<sup>36</sup> If the social service itself cannot provide such help, it must ensure that help is provided by others if at all possible.<sup>37</sup>

The social service must cooperate with other sectors and administrative levels when this promotes the fulfilment of tasks decreed by law.<sup>38</sup> Recommendation no. 9 (1991–92) to the Odelsting and Proposition no. 29 (1990–91) to the Storting state that cooperation between the social service and other areas of public administration should cover the general exchange of experience, planning and coordination as well as concrete cooperation in individual cases.

When a client has complex needs and/or measures are implemented by several bodies, responsibility groups should be established if appropriate with representatives of the bodies concerned. The work of responsibility groups is systematic and binding, and extends over a period of time with a joint programme of meetings, minutes etc.<sup>39</sup>

### 3.4.1 Community-based measures

The social service must primarily attempt to assist the substance abuser by providing advice, guidance and support measures outside institutions. Proposition no. 29 (1990–91) to the Odelsting and comments on the Act relating to Social Services, §6-1, state that the social service must evaluate whether general services under the Act should be provided to the individual substance abuser. This applies to measures such as the provision of temporary accommodation or housing to people in difficulties, practical assistance and training, relief measures, finding a place in an institution or home with round-the-clock care services or arranging measures in the case of pressing care responsibilities.<sup>40</sup> The social service can give financial support for living expenses,<sup>41</sup> and in special cases financial assistance to cope with a difficult life situation (emergency assistance).

The abuse of drugs and alcohol is a problem which may also require support measures that are designed to help individuals to break the abuse habit. Special measures may include the appointment of a support person, the establishment of a support network at work, and contact with the primary health service or specialist health services.<sup>42</sup> In the Government's Action Plan to Combat Drug and Alcohol-related Problems (2003–2005) and Proposition no. 1 to the Storting (2002–2003) from the Ministry of Health, it is emphasised that human dignity and enhanced quality of life depend on the provision of basic needs such as housing, work and/or activities and a social network. According to comments on the Act, the provision of housing where aid and protection facilities are

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<sup>36</sup>The National Directorate for the Prevention of Alcohol and Drug Problems: *Småbyundersøkelsen* (Small town survey).

<sup>37</sup> Act relating to Social Services § 4–1.

<sup>38</sup> Act relating to Social Services § 3–2.

<sup>39</sup> Oslo Municipality (1999): *Kvalitetshåndbok for sosialtjenesten* (Quality manual for the social service) and *Administrativ terminologi for pleie og omsorgstjenesten* (Administrative terminology for the nursing and care service).

<sup>40</sup> Act relating to Social Services, Chapters 3 and 4.

<sup>41</sup> Act relating to Social Services, Chapter 5.

<sup>42</sup> Act relating to Social Services § 6–1. According to Proposition no. 29 (1990–91), to the Odelsting the list of measures in the Act is not exhaustive.

available will often be necessary in order to provide abusers with help in the community.  
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### 3.4.2 Monitoring during institutional treatment

When community-based help is inadequate, the social service must draw up a treatment plan to be implemented in a suitable treatment or care institution.<sup>44</sup> It is not a pre-requisite that the client brings up this issue.<sup>45</sup> Pending placement in an institution, the social service must arrange for temporary measures if necessary.<sup>46</sup>

In Recommendation no. 184 to the Storting (1996–97) the Standing Committee on Social Affairs expresses the opinion that it is vital that there is a treatment plan available when the substance abuser is motivated. The social service should attempt to procure a place in an institution as swiftly as possible when this is deemed appropriate and in accordance with the wishes of the client. In cases of detoxification outside an institution, it must be ensured that an institutional stay commences immediately after the detoxification has been completed.

In Recommendation no. 10 (1998–1999) to the Odelsting the Standing Committee on Social Affairs points out that the municipalities should draw up provisions for substance abusers who are resident in institutions on a voluntary basis. The social service must monitor clients on a course of treatment through conversations and home visits if necessary, and by making arrangements for the measures required on the termination of a stay at an institution.<sup>47</sup> This means that the social service should visit the client during institutional stays.<sup>48</sup>

In accordance with Proposition no. 3 to the Odelsting (2002–2003)<sup>49</sup> the social service shall primarily attempt to establish treatment measures that are voluntary. If voluntary measures are not successful, the social service must consider institutionalising the client if he/she consents.<sup>50</sup> This involves the client giving consent on admission to being kept there for up to three weeks.

### 3.4.3 Monitoring of compulsory placement

A substance abuser may be referred without giving consent to an institution for examination and treatment planning if physical or mental health is endangered and if voluntary support measures are not adequate. The client may be kept there for up to three months.<sup>51</sup>

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<sup>43</sup> Circular I-1/93.

<sup>44</sup> Act relating to Social Services § 6–1.

<sup>45</sup> Circular I-1/93: *Lov om sosiale tjenester* (Act relating to Social Services).

<sup>46</sup> Act relating to Social Services § 6–1.

<sup>47</sup> Act relating to Social Services § 6–1.

<sup>48</sup> Circular I-1/93: *Lov om sosiale tjenester* (Act relating to Social Services).

<sup>49</sup> *Om lov om endringer i lov 13.12.1991 nr. 18 om sosiale tjenester mv. og i enkelte andre lover (statlig overtakelse av deler av fylkeskommunens ansvar for tiltak for rusmiddelmissbrukere* (On the Act on amendments to the Act 13.12.1991 on social services etc. and in several other Acts (State takeover of part of the county authority's responsibility for measures for substance abusers).

<sup>50</sup> Act relating to Social Services § 6–3.

<sup>51</sup> Act relating to Social Services § 6–2.

The social service must take the initiative to assess whether the substance abuser's situation is such that the conditions for the use of coercion are fulfilled and whether compulsory admission is necessary. The social service shall monitor the client during and after admission.

The social service also has a duty to assess the use of coercion should they be informed by the client's immediate family of extensive drug abuse.<sup>52</sup> In the case of pregnant substance abusers, speedy case processing and short time limits are required.<sup>53</sup>

A pregnant substance abuser may be institutionalised without giving consent and may be kept in the institution throughout the entire pregnancy if the abuse is such that it is most probable that the baby will be born with birth defects.<sup>54</sup> During her stay the mother must be offered satisfactory assistance for her drug abuse as well as help to enable her to care for her child.<sup>55</sup> The social service must carry out an assessment every third month to establish whether the retention is still necessary.

A care plan must be prepared for substance abusers who are in institutions following a decision on the use of coercion.<sup>56</sup>

#### **3.4.4 Monitoring at the post-institutional stage**

The social service must make arrangements for the provisions that are required at the termination of a stay in an institution.<sup>57</sup> In addition relevant measures for the post-institutional period must be planned and, if appropriate, commenced during the institutional stay in order to ensure continuity in the chain of measures.

A cohesive treatment strategy must incorporate the provision of a long-term programme for clients after their discharge from the institution. This will encompass a social network, emergency assistance, care services and support persons as well as housing and work.<sup>58</sup> The social service is responsible for establishing such follow-up and integration measures and must monitor the client in the post-institutional period.

#### **3.4.5 Monitoring during medication-assisted rehabilitation**

During the deliberations on Report no. 16 (1996–97), to the Storting the Storting passed a resolution that offered medication-assisted rehabilitation as a countrywide and permanent service for heavily-dependent substance abusers.<sup>59</sup>

When a client applies for medication-assisted rehabilitation, the social service is required to assess whether this is the most appropriate measure. The assessment must include

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<sup>52</sup> The Act relating to Social Services § 6–1a.

<sup>53</sup> Proposition to the Odelsting no. 48 (1994–95).

<sup>54</sup> Act relating to Social Services § 6–2a.

<sup>55</sup> The National Directorate for the prevention of Alcohol and Drug problems: *Gravide rusmiddelmisbrukere* (Pregnant substance abusers (1999).

<sup>56</sup> Act relating to Social Services § 6–1.

<sup>57</sup> Act relating to Social Services § 6–1.

<sup>58</sup> The Norwegian Government's Action Plan to Combat Drug- and Alcohol-related Problems (2003 – 2005).

<sup>59</sup> Recommendation no. 184 (1996–1997) to the Storting.

whether the social service has the necessary capacity to monitor the client. The social service may reject the application in the first instance.<sup>60</sup>

If the client's application is approved, the social service must coordinate the preparation of the application and this will include compiling and coordinating comprehensive provisions for the rehabilitation programme.<sup>61</sup> The provisions must describe what improvements the applicant hopes to achieve in his/her quality of life and own situation through medication-assisted rehabilitation.

The goal of the rehabilitation programme is for the substance abuser to break away from hard-core substance abuse environments and resort to treatment, rehabilitation and care measures. Other goals are to reduce harm resulting from substance abuse and the danger of overdose deaths, to improve the substance abuser's physical condition and ability to function in society, to achieve a substance-free state and a better quality of life, and to experience rehabilitation both socially and occupationally to the extent possible.<sup>62</sup> Proposition to the Storting no. 1 (2002–2003) from the Ministry of Health and the Government's Action Plan to Combat Drug- and Alcohol-related Problems (2003–2005) state that a range of measures targeted at the substance abuser must be put into effect in order to achieve the objectives set, and that both psychosocial and medical follow-up are essential. The social service must monitor the client during rehabilitation.

The social service, the health service and specialist services as well as other bodies involved should enter into a binding cooperation with focus on the individual participant in medication-assisted rehabilitation, including participation in responsibility groups.<sup>63</sup>

Once the application for medication-assisted rehabilitation has been granted, waiting time for inclusion in the programme should be as short as possible.<sup>64</sup>

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<sup>60</sup> MARIO, The Alcohol and Drug Addiction Service, Oslo Municipality: *Veileder i medikamentassistert rehabilitering* (Guide to medication-assisted rehabilitation).

<sup>61</sup> Circular I-33/2000 and Circular I-33/2001.

<sup>62</sup> Circular I-33/2000.

<sup>63</sup> Circular I-33/2001.

<sup>64</sup> The Norwegian Government's Action Plan to Combat Drug- and Alcohol-related Problems (2003–2005): 28.

## 4 The facts

### 4.1 The ministry's implementation of the overall national responsibility

The Ministry of Labour and Social Affairs has the overall national responsibility for drug and alcohol policy in Norway as well as the responsibility for coordinating efforts to counter drug and alcohol problems. In addition the Ministry is responsible for SIRUS and Vinmonopolet (the Norwegian Retail Monopoly).<sup>65</sup>

The Ministry of Health and Care Services has the overall responsibility for the implementation of the Act relating to Social Services and is also responsible for the range of services and unified provisions as set out both in this Act and in the Municipal Health Services Act. The Ministry of Health and Care Services has the overall national responsibility for monitoring substance abusers both in the municipalities and in the regional health enterprises.

The implementation of national policies on intoxicants has been delegated to bodies at different administrative levels.

The Directorate for Health and Social Affairs allocates grant funding and monitors action plans. Together with county governors, resource centres for substance-related issues and university colleges, the Directorate monitors measures aimed at enhancing knowledge and competence in the municipalities in the field of substance abuse.

SIRUS is a specialist research institution whose remit is to contribute to greater knowledge of both use and abuse of intoxicants as well as assuming responsibility for the annual mapping of the drug and alcohol situation in the municipalities among other things.

The seven regional resource centres provide advice on substance-related questions and upgrade the competence of the municipalities in the field of intoxicants. They also work with preventive measures and develop competence both locally and nationally by providing expertise in this area. Together with SIRUS the resource centres document the drug and alcohol situation locally thereby providing input for the development of drug and alcohol policies. Since their establishment they have been allocated funds by the host county authority. In addition the organisation of the majority of resource centres has been linked to clinics that have either been owned by the county authorities or have had an operational agreement with them.<sup>66</sup> The Directorate for Health and Social Affairs has had responsibility for the regional resource centres since 1 January 2002, and entered into agreements with them from 1 January 2004.

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<sup>65</sup> Letter dated 03.11.2004 from the Ministry of Health and Care Services to the OAG.

<sup>66</sup> The Ministry of Labour and Social Affairs states in a letter of 11.03.2005 to the Ministry of Health and Care Services that one of the resource centres was transferred to the central authorities as of 01.01.2002. Furthermore two of the resource centres were owned by the county authorities while the remaining three were private institutions who had agreements with the county authorities. As of 01.01.2004 the Directorate for Health and Social Affairs entered into agreements with the resource centres. The resource centre in Oslo is as an office of the municipal Alcohol and Drug Addiction Service in the municipality of Oslo.

The Norwegian Board of Health carries out specialist supervision of the municipal social service, including supervision of the monitoring of work concerning intoxicants.

The county governor is responsible for monitoring the municipalities, thus contributing to the realisation of the national goals in the drug and alcohol area – for instance by providing guidance and upgrading competence in the municipalities. The county governor also deals with complaints about individual decisions under the Act relating to Social Services, including decisions related to substance abusers. In addition the county governor must carry out supervision of municipal service provision, including follow-up and measures for substance abusers commissioned by the Norwegian Board of Health.

The central authorities are responsible through the regional health enterprises for institutional treatment of substance abusers and also medication-assisted rehabilitation. The regional health enterprises have chosen different forms of organisation when fulfilling these tasks. Many of the round-the-clock services are run by voluntary organisations or private foundations with or without agreements with the regional health enterprises. In the case of medication-assisted rehabilitation, regional specialist centres have been established in all health regions. The centres have responsibility for the specialist aspect of rehabilitation while monitoring of social welfare aspects takes place under the supervision of the municipal social service.

The municipalities are responsible for the implementation of a considerable part of the drug and alcohol policy. The municipal social service must assist the substance abuser to break away from the abuse of alcohol and other intoxicants by providing advice, guidance and support measures. When necessary the social service must help draw up a treatment programme for clients with a substance abuse problem and also monitor the client during and after treatment.

#### **4.1.1 The Ministry's policy instruments**

The Ministry's policy instruments directed at the municipalities are for the most part Acts and regulations, grants, guidance and information as well as action plans. In Report no. 23 (1992 – 93) to the Storting on the relationship between the central and local authorities it is a basic assumption that a reporting system which gives the central authorities the necessary governance information will be established.

##### **Reporting**

Reporting in KOSTRA covers the social welfare area generally. Services linked to the monitoring of substance abusers in the municipality cannot be distinguished.<sup>67</sup> The Ministry has no knowledge of whether an assessment has been carried out of an expansion or change in KOSTRA's reporting which would make it possible to discern the follow-up of substance abusers.<sup>68</sup>

Nor do statistical publications that are prepared in connection with the annual publication of municipal social and health data shed light on the statistics or on comparative figures related to substance abusers.<sup>69</sup> The Ministry stated in Report no. 69 (1991–1992) to the

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<sup>67</sup> Summary of the interview with the Directorate for Health and Social Affairs, 10.09.2004.

<sup>68</sup> Summary of the interview with the Ministry of Social Affairs and the Ministry of Health, 21.09.2004.

<sup>69</sup> Summary of the interview with the Directorate for Health and Social Affairs 10.09.2004.

Storting that this publication may provide a solution for the lack of statistics on the municipalities' situation in this respect. The unofficial translation of this statement is as follows:

*At present there are no reliable statistics in the substance abuse area. As a result it is difficult for the municipalities to assess their own situation and, for example, to establish the correlations in development trends in the municipality. The Ministry wishes to strengthen work on statistical development and research in this area and has as its aim that the publication of municipal social and health data will also provide information about the situation of the municipalities in the field of substance abuse in the near future.*<sup>70</sup>

In light of the Norwegian Government's Action Plan to combat Drug- and Alcohol-related Problems (2003–2005), the Ministry of Labour and Social Affairs presented in 2004 the first yearly report of the drug and alcohol situation in Norway. It describes the status in this field as well as priority tasks in 2003–2004 and the government's overall efforts. The report covers the contribution of the central government but does not give an account of the efforts of the municipal authorities.<sup>71</sup>

SIRUS gathers information about the drug and alcohol situation in the municipalities,<sup>72</sup> for example how the work is organised, what provisions are offered and the number of employees and clients. In addition SIRUS maps the municipal administration of the Act on the Sale of Alcoholic Beverages, including information about the number of licences granted and conditions relating to sales in the municipalities. The follow-up of substance abusers is not covered.<sup>73</sup>

The Directorate for Health and Social Affairs expresses the opinion in the interview with the OAG that municipal reporting is regarded as inadequate and that it is felt that there is a need for more current and updated information not only about the extent of substance abuse but also about follow-up and measures provided for substance abusers in the municipalities.<sup>74</sup>

#### *Research, reports and evaluations*

An evaluation commissioned by the Ministry and the Directorate for Health and Social Affairs has been conducted. This is a cross-sectional study of substance abusers and services provided to substance abusers prior to the drug reform programme and deals with the social service's monitoring of substance abusers.<sup>75</sup> The survey was carried out in 2003 and published in December 2004.

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<sup>70</sup> Report no. 69 (1991–92) to the Storting: *Tiltak for rusmiddelmisbrukere*: 8 (Measures for substance abusers: 8).

<sup>71</sup> Report (July 2004): *Rusmiddelsituasjonen i Norge – Årlig redegjørelse om rusmiddelsituasjonen* (The substance abuse situation in Norway – a yearly report).

<sup>72</sup> Up to 2002 the selection consisted of a mapping of 60 municipalities. In 2003 this was expanded to include all municipalities countrywide. Figures have not yet been published but preliminary figures are available.

<sup>73</sup> Summary of the interview with the Directorate for Health and Social Affairs 10.09.2004.

<sup>74</sup> Summary of the interview with the Ministry of Social Affairs and the Ministry of Health, 21.09.2004.

<sup>75</sup> SINTEF Report (2004): *Rusklienter og tjenester før "rusreformen. En tverrsnittundersøkelse* (A cross-sectional study of substance abusers and services provided to substance abusers prior to the drug reform programme) by Tonje Gundersen, Lisbet Grut, Mitch Loeb, Torleif Ruud, Tone Eikeland, Sverre Nesvåg, og Esben Olsen.

Apart from this, the Ministry and the Directorate for Health and Social Affairs commissioned two reports about the health services<sup>76</sup> and the health of heavily-dependent substance abusers.<sup>77</sup> In addition an evaluation of the monitoring of clients on medication-assisted rehabilitation has been conducted.<sup>78</sup> In the area of social welfare, the Ministry and the Directorate for Health and Social Affairs commissioned a mapping of services for those who had previously been homeless<sup>79</sup> as well as two evaluations of *Tiltaksforsøket* (Trial programme of measures)<sup>80</sup> and the action plan *Kunnskap og brubygging* (Knowledge and bridge-building) (1998–2002). In both the mapping and the two evaluations, substance abusers are one of several target groups.<sup>81</sup>

### Information and guidance

The Ministry has delegated contact with the municipalities to the Directorate for Health and Social Affairs, and the Directorate is mainly responsible for circulating information and circulars to the municipalities.<sup>82</sup> Together with the Ministry, the Directorate has the responsibility for preparing the publication (named *Hjulet*) that presents municipal social and health data and the central goals, main priorities and information about grants to the municipal health and social services.<sup>83</sup> In the interview with the OAG the Directorate states that it stresses the importance of dialogue with the municipal sector with particular focus on information and the upgrading of competence. The contact and provision of information takes place mainly through the municipalities which have been allocated grants for projects and support measures.<sup>84</sup>

In the interview the Directorate explains that it views the county governors as the main instrument for communication with the municipalities. The county governors' offices state in the investigation that they often advise the social services on general legal questions as well as questions on the legal aspects of specific cases. In addition they provide

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<sup>76</sup> SINTEF Report: *Helsetjenester for tunge rusmiddelmissbrukere* (2003) 75 (Health services for heavily-dependent substance abusers).

<sup>77</sup> SINTEF Report: *Helsetjenester for tunge rusmiddelmissbrukere*(2003) 76 (Health services for heavily-dependent substance abusers).

<sup>78</sup> AIMResearchedBasedConsulting: *Evaluering av legemiddel assistert rehabilitering* (An evaluation of medication-assisted rehabilitation) and SKR Report no. 7/2004: *Bidrag til evaluering av legemiddelassistert rehabilitering i Norge* (The evaluation of medication-assisted rehabilitation in Norway).

<sup>79</sup> FAFO's mapping of services to those who were previously homeless and the Norwegian Building Research Institute's mapping of the extent and characteristics of the homeless.

<sup>80</sup> *Nytter det? Erfaringer fra Tiltaksforsøket 2000–2004 – Evaluering av Forsøket med kommunalt ansvar for aktive, arbeidsretta tiltak for langtidsmottakere av sosialhjelp* (Is it of use? Experience from a trial programme of measures 2000–2004 – Evaluation of municipal responsibility for active, work-targeted measures for long-term recipients of social help) by Ivar Lødemel, Asbjørn Johannessen, Eva Buschmann, Kristine Lier and Gry Velvin of Oslo University College.

<sup>81</sup> Rogaland Research: *Statlig handlingsplan i møte med mange kommunale virkeligheter – Delrapport i evalueringen av Kunnskap og brubygging (2001)* (Government action plan confronted with municipal realities – Interim report on the evaluation of “Knowledge and bridge-building”) and *Kompetanseheving i et lukket fagfelt? – Sluttrapport i evalueringen av Kunnskap og brubygging (2002)* (Competency upgrading in a closed specialist field? – Final report in the evaluation of “Knowledge and bridge-building”).

<sup>82</sup> Summary of the interview with the Ministry of Social Affairs and the Ministry of Health, 21.09.2004.

<sup>83</sup> Circular IS-1/2004: *Nasjonale mål, hovedprioriteringer og tilskudd for 2004 – Styrings- og informasjonshjulet for helse- og sosialtjenesten i kommunene* (National goals, main priorities and grants for 2004 –Social and health data in the municipalities).

<sup>84</sup> Summary of the interview with the Directorate for Health and Social Affairs, 10.09.2004.

guidance on central government priority areas, as well as on specialist social welfare guidance and on the processing of complaints. Only seldom do they advise the social services on planning in areas such as the preparation of the drug and alcohol policy action plan or finance planning (in cases related to drugs and alcohol) or the preparation of case-processing routines for the social welfare and substance abuse areas. The investigation reveals that their guidance of the municipal social services is grounded on applications from the municipalities as well as on priority areas and subjects decided by the county governors' offices and/or the Ministry and the Directorate for Health and Social Affairs. Specific cases involving substance abusers or municipal reporting seldom form the context for guidance provided by the county governors' offices to the social services.

The Ministry states in the interview that the regional resource centres are well informed about the competence of the municipalities in this respect and that these centres must organise support measures directed at the needs of the municipalities.<sup>85</sup> The Directorate expresses the opinion that the resource centres play an active role vis-à-vis the municipalities, but that this varies in content and scope from centre to centre. Moreover at present the activities of the different resource centres are insufficiently coordinated. The Directorate adds that it is working to strengthen coordination and to clarify tasks and result requirements.<sup>86</sup> Fourteen of the social services who answered this question<sup>87</sup> say in the interview that they have little or no contact with the resource centres on substance abuse questions. Three social services mention that their contact with the resource centres is linked to the prevention of drug and alcohol problems.

### **Statutes and regulations**

The Act relating to Social Services is general and is applicable to all involved parties. The Storting has resolved that additional provisions for the follow-up of substance abusers are to be presented in a separate chapter – Chapter Six: Special measures for drug and alcohol abusers. Circular I-1/93 gives comments and observations on the Act and its provisions, and this is supplemented by Circulars I-1/94 and I-45/98.

Medication-assisted rehabilitation is neither mentioned nor sanctioned by statute. It is sanctioned in Circulars I-5/2003 and I-33/2001. These Circulars are relatively specific and set their own goals as well as providing descriptions of how those undergoing medication-assisted rehabilitation shall be monitored by the municipalities.

Two amendments to Chapter 6 of the Act relating to Social Services relating to the use of coercion in the case of substance abusers were adopted in the 1990s. The first amendment, which was adopted in 1994, dealt with compulsory placement of pregnant substance abusers. The Storting had requested the government to submit a proposal for an amendment to the Act, thus permitting the use of compulsory placement for pregnant substance abusers.<sup>88</sup> The second amendment, which was adopted in 1998, concerned clarifying compulsory placement for other substance abusers. For example more precise formulations were adopted regarding the preparation of provisions and the duty to assess coercion when there is a request from a close relative. This amendment was

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<sup>85</sup> Summary of the interview with the Ministry of Social Affairs and the Ministry of Health, 21.09.2004.

<sup>86</sup> The Directorate for Health and Social Affairs: Report on the future functions and organisation of the resource centres (June 2004).

<sup>87</sup> Fourteen social services from different resource centre regions.

<sup>88</sup> Resolution of the Storting of 10.11.1994.

adopted after the Storting had requested the government in Report no. 35 (1994–95) to the Storting to be instrumental in ensuring that the provision on compulsory placement of substance abusers was implemented in accordance with the intentions of the Storting. On several occasions the Storting had voiced the opinion that the provisions for coercion were underused in the case of qualified substance abusers. On 1 January 1999 amendments to the rules on the retention of substance abusers without consent having been given came into force. These amendments were followed up in a circular and a guide was prepared on the use of coercion vis-à-vis substance abusers pursuant to the Act relating to Social Services §§ 6–2, 6–2a and 6–3.

In 1998 the Storting requested the government to examine the range of assistance and treatment for substance abusers. In the light of this the Ministry of Health and Social Affairs appointed a working group whose tasks included presenting recommendations on the Act relating to Social Services with regard to support measures and the preparation of individual care plans for substance abusers.<sup>89</sup> A number of these recommendations have been implemented as part of the drug reform and the Storting has adopted an amendment to the Act relating to Social Services so that those who need long-term coordinated services now have the right to an individually prepared care plan.<sup>90</sup> The Directorate for Health and Social Affairs says in the interview that the implementation of the statutory provision on individual care plans has been an important assignment for the Directorate.<sup>91</sup>

In 1994 the Research Council of Norway conducted an evaluation of the Act, financed by the Ministry of Health and Social Affairs. However, none of the projects in this evaluation dealt explicitly with substance abuse care. The Ministry views supervision in this area as a form of evaluation of the application of the statute in the municipalities.<sup>92</sup>

### *Supervision*

The Ministry stated in the interview that there had been little supervision of the municipal follow-up of substance abusers prior to the Norwegian Board of Health being charged with the supervision of the Social Services Act in 2001.<sup>93</sup> In 2004 the Norwegian Board of Health and the county governors carried out a countrywide supervision of the municipal follow-up of substance abusers.<sup>94</sup>

### **Action plans**

In the interview the Directorate for Health and Social Affairs expressed the opinion that an action plan may be a useful instrument to achieve national goals if the plan is well-formed and provision has been made for funding.<sup>95</sup>

No specific action plans have been prepared for the social service's monitoring of substance abusers. However, substance abusers are one of several target groups for

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<sup>89</sup> Interim report 3 submitted to the Ministry of Health and Social Affairs, 23.06.1999.

<sup>90</sup> Act relating to Social Services § 4–3a.

<sup>91</sup> Summary of the interview with the Directorate for Health and Social Affairs, 10.09.2004.

<sup>92</sup> Summary of the interview with the Ministry of Social Affairs and the Ministry of Health, 21.09.2004.

<sup>93</sup> Summary of the interview with the Ministry of Social Affairs and the Ministry of Health, 21.09.2004.

<sup>94</sup> Norwegian Board of Health, Report no. 4/2005: *Oppsummering av landsomfattende tilsyn i 2004 med kommunale sosialtjenester for rusmiddelmissbrukere* (Summary of countrywide supervision of Municipal Social Services for Alcohol and Drug Abusers in 2004).

<sup>95</sup> Summary of the interview with the Directorate for Health and Social Affairs, 10.09.2004.

various action plans in the field of social welfare, for example *Kunnskap og brubygging* (1998–2001) (Knowledge and bridge-building) and “A Plan of Action for combating Poverty” (1998–2001). The Norwegian Government’s Action Plan to Combat Drug- and Alcohol-related Problems (2003–2005) covers the entire area of substance abuse including the municipal follow-up. The two last-mentioned action plans are ongoing and have not been evaluated. It is too early to say what results, if any, have been achieved.

In the evaluation of the action plan – Knowledge and bridge-building – it was pointed out that the action plan had not prompted substantial state funding compared with other action plans such as the plan of action for the elderly and the plan of action for mental health services. In contrast to these plans, the action plan – Knowledge and bridge-building – did not include funds earmarked for the enhancement or development of the range of services.<sup>96</sup> The evaluation of the action plan reveals that competence in the municipal health service has increased but it cannot be concluded that there has been any qualitative improvements in the level of service provision in the municipalities as a result of the action plan.<sup>97</sup>

In connection with the action plan, the Ministry took the initiative to establishing specialist forums in all counties so that case officers in the social service could meet to exchange experiences and reflect on work-related issues.<sup>98</sup> Specialist substance forums were also set up.

In the Directorate’s commission specifications for the county governors’ offices in 2004, it was underlined that the latter were responsible for maintaining and developing specialist forums. Some 13 out of 18 county governors’ offices report that they have established such forums or networks. In two of these, there are only five municipalities that participate. Three state that they do not have separate specialist drug and alcohol forums but that substance abuse is a subject that is brought up in the specialist social welfare forums. Ten of the 24 social services under the auspices of seven county governors’ offices do not participate in specialist social welfare forums while a total of 17 do not participate in specialist drug and alcohol forums. Two of the remaining seven who do participate say that they only meet once a year and in their opinion the drug and alcohol forums play therefore only a limited role in enhancing competence.

Four of the social services point out that through the action plan – Knowledge and bridge-building (1998-2001) – the offices of the county governor provided a range of measures to upgrade competence vis-à-vis the social service. Five social services report that they have not participated in such initiatives following the termination of the action plan. Two social services state that the commitment of the county governors’ offices and

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<sup>96</sup> Rogaland Research, Report RF – 2002/097: *Kompetanseheving i et lukket fagfelt? Sluttrapport i evalueringen av Kunnskap og brubygging* (Competency upgrading in a closed specialist field – final report in the evaluation of “Knowledge and bridge-building”) by Jorunn-Elise Skaftun, Sverre Nesvåg and Tor Bjarne Olsson.

<sup>97</sup> Rogaland Research, Report RF – 2002/097: *Kompetanseheving i et lukket fagfelt? Sluttrapport i evalueringen av Kunnskap og brubygging* (Competency upgrading in a closed specialist field – final report in the evaluation of “Knowledge and bridge-building”) by Jorunn-Elise Skaftun, Sverre Nesvåg and Tor Bjarne Olsson.

<sup>98</sup> Action plan I-0910 N: *Kunnskap og brubygging – sosialtjeneste si førstelinje* (6) (Knowledge and bridge-building – the front line of the social service).

their focus on competence upgrading in the social service decreased after the action plan was concluded.<sup>99</sup>

The Directorate for Health and Social Affairs states in the interview that its impression is that a considerable proportion of the structures and measures that were established in the action plan – Knowledge and bridge-building – were either weakened or disappeared after the conclusion of the action plan.

### **Central government grants**

Municipal monitoring of substance abusers is by and large financed by block grants. In addition, individual municipalities receive grants for priority areas, action plans and projects.

The fiscal budget<sup>100</sup> includes an item – Grants for substance abusers etc.<sup>101</sup> Provisions under this item have a wide impact area and affect the entire social welfare and drug- and alcohol-related field. Substance abusers are one of several target groups. Grants for low-threshold health provisions and medication-assisted rehabilitation are also provided under this item.<sup>102</sup>

In the main the grant schemes are based on a system whereby municipalities apply for grant funding. The grants are then distributed among individual municipalities. The Directorate explains that it is not necessarily the municipalities with the greatest needs who receive grant funding but rather the municipalities who have the financial means to provide co-funding and competence to draw up the project applications in addition to having resources to follow up and implement projects.<sup>103</sup>

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<sup>99</sup> Summary of the interview with the Directorate for Health and Social Affairs, 10.09.2004.

<sup>100</sup> Proposition no. 1 (2004–2005) The Ministry of Health and Care Services, and Proposition no. 1 (2004–2005) The Ministry of Labour and Social Affairs.

<sup>101</sup> Chapter 621, Item 63 *Grants for substance abusers etc.* Transferred from the Ministry of Social Affairs to Chapter 761, Item 63 on the budget of the Ministry of Health and Care Services.

<sup>102</sup> Proposition no. 1 (2004–2005) to the Storting), Chapter 761, Item 63.

<sup>103</sup> Summary of the interview with the Directorate for Health and Social Affairs, 10.09.2004.

**Overview of the number of municipalities who received grants in 2004 under items “Grants for substance abusers”, “Low-threshold health provisions”, and “Medication-assisted rehabilitation”.<sup>104</sup>**

- 41 municipalities and urban districts have received NOK 27.5 million in grants for provisions for the homeless.
- 16 municipalities and urban districts have received grants totalling NOK 16 million under pilot schemes aimed at providing financial social assistance and follow-up for clients with long-term problems.
- 17 municipalities and urban districts have received grants totalling NOK 16 million for coordination between the Directorate of Labour (Aetat), the National Insurance Service and the social welfare service.<sup>105</sup>
- 38 municipalities have received grants totalling NOK 43.4 million for low-threshold health measures.
- 26 municipalities have received grants totalling NOK 13 million for medication-assisted rehabilitation.

Altogether 137 grants have been given to 75 municipalities and urban districts. This means that 16 per cent of the 457 municipalities and urban districts in Norway have been awarded such grants.

Under the item “Grants for substance abusers”, funding is also given to the county governors’ offices and resource centres for drug- and alcohol-related questions for the upgrading of competence in the social service. The Ministry regards this as important for goal achievement<sup>106</sup> and the action plan “Knowledge and bridge-building” (1998-2001) has been followed up by extraordinary annual appropriations of NOK 16.5 m to strengthen municipal work with substance abusers.<sup>107</sup>

There have been no evaluations of grant schemes in the drug and alcohol area.<sup>108</sup>

## **4.2 The municipalities’ organisation, management and case-processing system**

### **4.2.1 Organisation**

The municipalities have wide latitude to organise services and to shape support measures as they wish. On the other hand they must endeavour to shape support measures that lay the groundwork for the achievement of Norway’s overall goals on social policy. It is a national objective to ensure social security and reasonable living

<sup>104</sup> The Directorate for Health and Social Affairs.

<sup>105</sup> NOK 7 million has been allocated by the Ministry of Modernisation.

<sup>106</sup> Proposition no.1 (2004–2005) to the Storting.

<sup>107</sup> The Ministry of Social Affairs, Report: *Rusmiddelsituasjonen i Norge* (July 2004).

<sup>108</sup> Summary of the interview with the Directorate for Health and Social Affairs, 10.09.2004.

conditions for all social groups as well as preserving human dignity and equality of treatment.<sup>109</sup>

The social services have different organisations. In four of the 20 municipalities investigated, monitoring of substance abusers pursuant to Chapter Six of the Social Services Act is carried out by separate enterprises (drug and alcohol units). These units are not part of the social service organisation.

**Municipalities in the investigation with their own drug and alcohol units are organised in different ways:**

- In one municipality the drug and alcohol unit comes under nursing and care services in the section for mental health, while the social service is organised separately as part of the child welfare and social welfare section
- In one municipality the monitoring of substance abusers is shared between the social welfare office and the drug and alcohol unit's social service section. The social service of the drug and alcohol unit is subordinate to both the social medicine centre and the municipal drug and alcohol unit the social medicine centre is not a municipal organ.
- In one municipality the rehabilitation section is responsible for monitoring substance abusers during and after institutional treatment in the municipality, while the urban district social welfare offices are responsible for follow-up prior to treatment in an institution and for the first three months of institutional treatment. The rehabilitation section then assumes the entire responsibility for the client, including the provision of financial social assistance.
- In one municipality the centre for preventive measures is a separate enterprise on an equal footing with the social service in the municipality's two-step model. Substance abusers can approach the centre directly or they can be referred by the municipal social service.

Totally 24 social services have therefore been investigated – twenty "ordinary" social services and four other enterprises that monitor substance abusers pursuant to Chapter Six of the Act relating to Social Services.

Ten of the 20 "ordinary" social services in the investigation have a separate drug and alcohol section. These form part of the social service and are mainly responsible for case processing pursuant to Chapter Six of the Act relating to Social Services. Their organisation varies.

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<sup>109</sup> Proposition no. 29 (1990-91) to the Odelsting.

**Examples of the organisation of drug and alcohol sections in the investigation:**

- One social service has a mapping and action team consisting of an outreach service, the drug and alcohol section and provisions for housing elderly substance abusers. The social welfare office manages the finances of clients while the department for mapping and support measures monitors the substance abusers. The outreach service monitors substance abusers under 25 while those over 25-26 are transferred to the drug and alcohol section.
- One social service has a social welfare office and an outreach service previously targeted at young people but now directed at adults. The outreach service monitors hard-core substance abusers – those in shelters and on medication-assisted rehabilitation. Child welfare is responsible for outreach activities aimed at young people.
- One social service has an action unit that is split in two. One part has responsibility for the general monitoring of clients (including substance abusers) while the other part is responsible for follow-up of clients on medication-assisted rehabilitation.

The other ten “ordinary” social services that do not have a separate drug and alcohol section are also organised in different ways – from a generalist model where all employees work with all kinds of cases to models with a multi-disciplinary team or monitoring section.

In several of the municipalities, social services pursuant to Chapter 4 of the Act relating to Social Services have been detached from the social service. The social service then commissions social services from other bodies in the municipality, for example the health and care services departments.

The social services investigated find cooperation with other bodies on the monitoring of substance abusers challenging. The following comments from one of the social services illustrate the general impression given by the interviews:

*“...Cooperation with the health and care services is a big challenge. There seems to be a big difference when it comes to accessibility. We have to deal with all the clients who approach us and assess what assistance can be given. The health and care services can refuse clients by referring to a lack of capacity or by saying that the client’s problems are outside their area.”*

Other municipalities in the investigation experience an increasing need to cooperate with the municipal mental health service due to the growing numbers of clients with a dual diagnosis of substance abuse and mental health problems and because the division of responsibility between the mental health service and the social service is not clearly defined. Several municipalities have found a solution by merging the social service and the mental health service.

The Norwegian Board of Health’s countrywide supervision of provisions for substance abusers shows that municipalities have different methods of coordinating services for substance abusers. Furthermore, supervision reveals that there is little cooperation

between nursing and care departments and the social service on measures that might improve the follow-up of substance abusers.<sup>110 111</sup>

#### 4.2.2 Plans

It is stressed in the Ministry's template for a municipal action plan for drug and alcohol policies<sup>112</sup> that policy questions faced by the municipality should be dealt with in a comprehensive manner. Seven of the 20 municipalities in the sample do not have an overall action plan for drug and alcohol policies that deals with the follow-up of substance abusers.

The Local Government Act requires that the municipalities prepare a finance plan for at least four years and an annual budget that covers all the activity of the municipality.<sup>113</sup> There are variations in how specific and comprehensive the plan is when it comes to the description of follow-up for substance abusers. Some municipalities barely mention the follow-up and have no separate goals for this user group while other municipalities describe priority areas and challenges at length, and have set goals for the monitoring of substance abusers.

#### 4.2.3 Reporting

The annual reports of eight of the 20 municipalities do not contain information about the municipal follow-up of drugs and alcohol. They deal mainly with financial aspects and there is less focus on results. Consequently the follow-up of substance abusers is not mentioned. In the annual reports where it is mentioned, the comprehensiveness of the content varies. Some municipalities mention follow-up in one sentence while others present community-based measures, monitoring of medication-assisted rehabilitation, institutional treatment and housing conditions for substance abusers. Only to a limited extent do the social services report whether the objectives of action plans have been achieved.

If case-processing tools in the social service are specially adapted, they may form a basis for reliable reporting from the municipalities to the state, for example in reporting to KOSTRA. The investigation shows that case-processing tools in the social service are primarily adapted to financial reporting on the social welfare area, for example financial social assistance, and are less suited to reporting the follow-up of substance abusers. The social services therefore keep manual lists which are not part of case-processing tools to report on the follow-up of substance abusers, for example on the number of clients undergoing alcohol- and drug-related treatment. Some municipalities have case-processing systems where it is possible to distinguish these clients from other clients so that an overview of clients with an acknowledged drug- or alcohol-related problem can be prepared.

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<sup>110</sup> Summary of the interview with the Norwegian Board of Health, 19.08.2004.

<sup>111</sup> The Norwegian Board of Health, Report no. 4/2005: *Oppsummering av landsomfattende tilsyn i 2004 med kommunale sosialtjenester for rusmiddelmissbrukere* (Summary report of countrywide supervision of municipal social services for substance abusers in 2004).

<sup>112</sup> The Ministry of Health and Social Affairs: Template for the municipal action plan on drug and alcohol policies.

<sup>113</sup> §§ 44 no. 3 and 46 no. 2.

#### 4.2.4 Case-processing routines

Seven of the 20 social services in the investigation do not have written case-processing routines for their work. (The drug and alcohol units are not included in this figure because they have no need for case-processing routines for the entire social service.) Written case-processing routines for the social service deal primarily with routines for financial social assistance. Some 18 of altogether 24 social services have no written case-processing routines for monitoring substance abusers. Seven of these have neither case-processing routines for the social service as a whole nor routines for the follow-up of substance abusers. Figures derived from SINTEF show that over two-thirds of the social services do not have written procedures or a manual providing guidance for dealing with the needs of substance abusers.<sup>114</sup> Sixteen of 24 social services have no routines for cooperating with other bodies on the follow-up of substance abusers.

#### 4.2.5 Documentation in the case records and case-processing systems

Seventeen of 24 social services report in the interviews that documentation in case records are incomplete, especially for guidance and counselling sessions. Conversations are documented if the case officer has time. Case officers have individual practices when it comes to documentation of advice and guidance. The social services attribute incomplete documentation in case records to a lack of capacity and resources.

##### **Examples of deficient documentation from the study of case files:**

- In 24 out of 219 cases (11 per cent) case records for guidance and counselling meetings are not documented.
- In 27 out of 219 cases (12 per cent) the mapping of the client is not documented.
- In 22 out of 55 institutional cases (40 per cent) the application for institutional treatment is not documented.

#### 4.2.6 Internal control

None of the 20 municipalities have an internal control system for the social service as required by the regulation on internal control.<sup>115</sup>

In the interview with the OAG, the Board of Health states that:

*The regulation on internal control has not been the focus of the county governors' supervision of the social service. Nevertheless the county governors have had the opportunity to offer advice and guidance on the regulation. The county governors discern a trend where the municipalities and social services only implement this regulation to a limited degree.*<sup>116</sup>

<sup>114</sup> SINTEF Report (2004): *Rusklinter og tjenester før "rusreformen". En tverrsnittundersøkelse* (A cross-sectional study of substance abusers and services provided to substance abusers prior to the drug reform programme) by Tonje Gundersen, Lisbet Grut, Mitch Loeb, Torleif Ruud, Tone Eikeland, Sverre Nesvåg, and Esben Olsen.

<sup>115</sup> Regulation on internal control in the health and social service of 20.12.2002, § 4 g. The regulation entered into force 01.01.2003.

<sup>116</sup> Summary of the interview with the Norwegian Board of Health, 19.08.2004.

## 4.3 Municipal monitoring of substance abusers

### 4.3.1 Identification of drug and alcohol problems

Early identification of people with drug and alcohol problems is of importance both for swift intervention in the history of abuse and to provide a better opportunity to monitor the substance abuser<sup>117</sup> continuously over time in his or her own environment.<sup>118</sup> The date of the first mention of drugs and/or alcohol is recorded in the case file. This has been used as an indicator of the time taken by the social service to identify the substance abuse problem. The indicator may be a source of error because the abuse may have been identified earlier without this having been documented in the case file.

*Figure 1 Proportion of clients and time of first mention or identification of the substance abuse problem. Per cent*

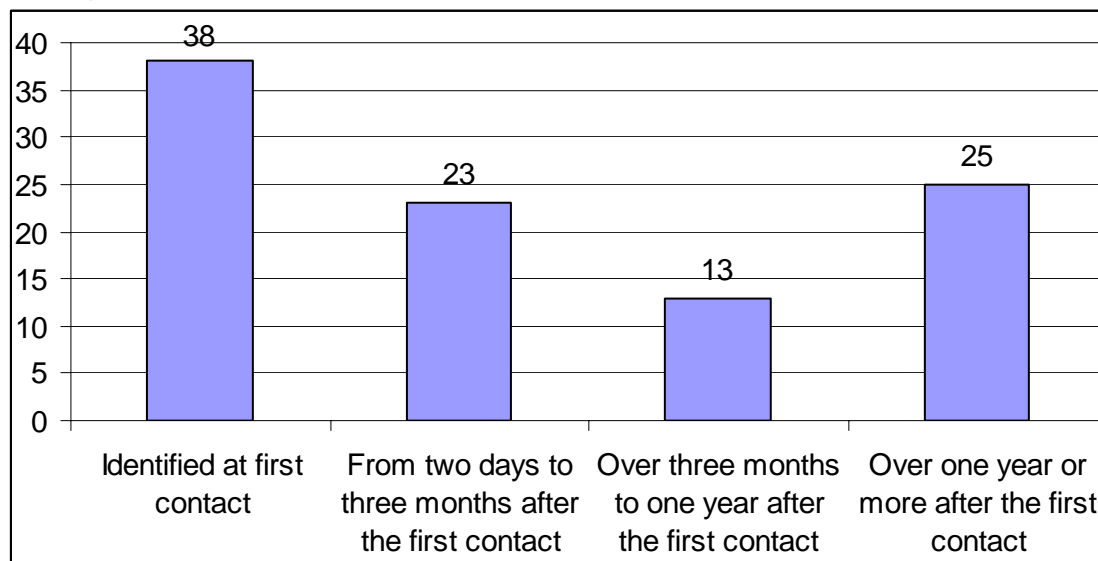


Figure 1 shows that in 56 cases (25 per cent) substance abuse is mentioned one or more years after the first contact with the social service.<sup>119</sup>

Moreover the case file review shows that in 166 of 219 cases (76 per cent) the client had a substance abuse problem prior to the initial contact. In 76 of the 166 cases the problem was identified at the initial contact. In the remaining 90 cases the problem was identified at a later stage.

The review of the case files shows that the proportion of clients whose substance abuse was identified at the first contact varies from 20 to 67 per cent among the various social services. At 12 of the 24 social services, questions are not asked about the use of intoxicants when new clients contact them. Two social services have the view that case

<sup>117</sup> In the OAG's investigation it is the awareness of the municipal social service that that the client has a recognised and/or known drug abuse problem that is the data are based on.

<sup>118</sup> Report no. 69(1991–1992) to the Storting and Recommendation no. 184 (1996–1997) to the Storting.

<sup>119</sup> The first contact with the social service when the case file review is conducted.

officers must be wary of asking questions about drug and alcohol problems during the initial conversation. The case officer should avoid a negative focus during the first conversation and should simply listen to what the client has to say.

Several social services report that the substance abuse is discovered when the client is unable to work or is not present for conversation sessions or does not deliver the required documentation. Alternatively substance abuse may be discovered through purely physical indications. One social service divulges that clients may have been in the system for five years before the substance abuse problem is identified. The social welfare office employs a psychologist who maps the heavily-dependent, long-term clients and from time to time the psychologist has discovered substance abuse problems of which the social welfare office was previously unaware.

Another social service relates in the interview that in connection with a project directed at the Action Plan for Combating Poverty a new practice has been introduced when processing new clients. Questions are now asked about substance-related problems and this has resulted in the exposure of many concealed problems. According to this social service there is a correlation between the fact that case officers now ask directly about such problems and their increased identification.

The Ministry points out that efforts both nationally and internationally to find a satisfactory definition of 'substance abuser' have been unsuccessful. The Ministry is of the opinion that late identification of substance abusers may be due to the fact that 'substance abuse' is not a clearly defined concept.<sup>120</sup> Establishing a distinction between 'normal' use of drugs and alcohol and 'abuse' can be problematic. The Ministry also expresses the view that many people would make the point that substance abuse is illegal.<sup>121</sup> The OAG's investigation has taken as its starting point the realisation by the municipal social service that a client has an acknowledged and/or concealed substance abuse problem.

### **4.3.2 Mapping**

It is vital that the social service maps the client's need for care and treatment measures at an early phase. In the case file review, checks have been carried out to establish whether any form of mapping has taken place and when that occurred. Mapping was defined as an overall assessment of the various aspects of the client's life situation (work, housing etc.) as well as substance abuse and health problems. Information in the form of memos relating to social welfare, notes on transfer and initial registration as well as mapping forms, letters or reports from other bodies requested by the social service were registered as mapping. The application form for financial social assistance was not regarded as mapping.

In 27 of 219 cases (12 per cent) there was no documentation that the client had been screened. This figure is distributed over 14 of 24 social services. This may mean either that no mapping has been undertaken or that it is not documented.

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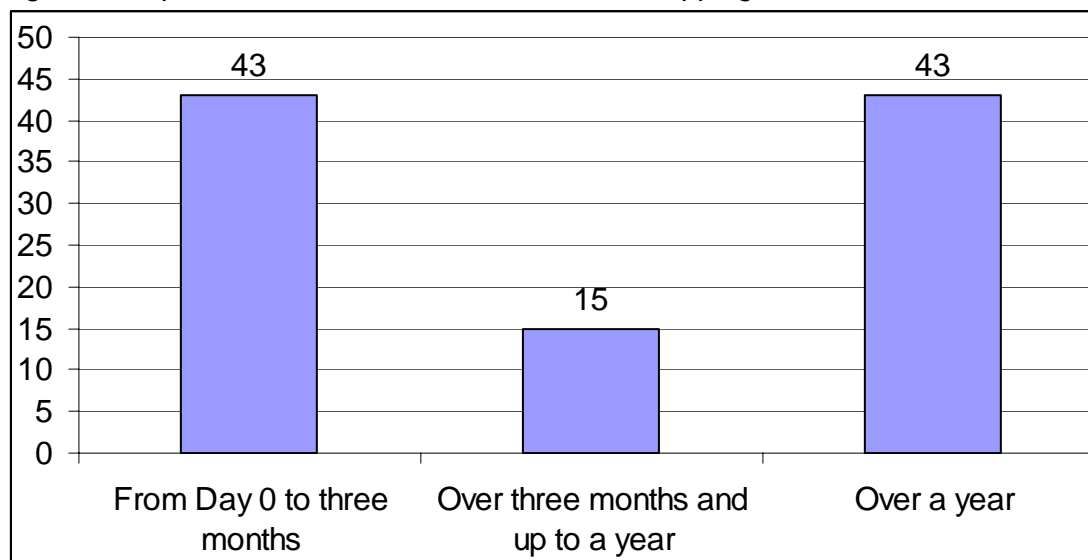
<sup>120</sup> Letter dated 11.03.2005 from the Ministry of Health and Care Services to the OAG.

<sup>121</sup> Letter dated 11.03.2005 from the Ministry of Health and Care Services to the OAG.

Documentation of mapping is lacking in only one MAR case and in none of the cases involving coercion. This may be because mapping of clients is mandatory both for applications for medication-assisted rehabilitation and in cases involving coercion that are submitted to the County Social Welfare Board.

The time from the initial contact with the social service to the first documented mapping is used as an indicator of the time spent on mapping the client and the extent to which this takes place at an early stage.

Figure 2 Proportion of clients and time of the first mapping. Per cent. N=192<sup>122</sup>



In 81 cases (43 per cent) mapping has been carried out one year or more after the social service's first registration of the client. The cases which lack such documentation (12 per cent) have been excluded.

The documents collected have been reviewed to find out whether the social services have a client mapping form directed at substance abuse problems. A total of 14 of 24 have no registration form for use with new clients. In addition 13 of 24 have no registration form for use when measures, such as referral to institutions, are commenced or prepared. Eight of the 13 have neither a registration form for the initial contact nor a monitoring form for substance abusers.

Nineteen of 24 social services have not been offered courses etc. by the county governor or the resource centres on the identification and mapping of substance abusers. Ten of 18 county governors' offices have not implemented competence upgrading measures for mapping and identification of substance abuse problems.

<sup>122</sup> 27 cases (12 per cent) lacked documentation of the mapping and are excluded.

### 4.3.3 Community-based measures

The OAG's investigation surveys community-based measures assigned to substance abusers. Community-based measures may have been arranged but have not been found in the case file review because of a lack of documentation.

Some of the measures are directly linked to the Act relating to Social Services while others, such as work, education and leisure activities, are measures which the social service helps to arrange.

#### Financial social assistance

In 205 of 219 cases, i.e. 94 per cent, financial social assistance has been provided. Those who do not receive social assistance are mainly clients aged 41 or more whose abuse problem is alcohol-related.

#### Services pursuant to Chapter 4 of the Act relating to Social Services

The table provides an overview of all the clients in the documented material who have received services pursuant to Chapter 4 of the Act relating to Social Services.

*Table 1 Proportion of substance abuse clients who have received community-based assistance. Per cent. N = 219*

	Have received	Have not received	Total
Practical assistance	3	97	100
Relief measures in case of pressing care responsibilities	1	99	100
Payment for persons with arduous care duties	0	100	100
Support person	12	88	100

Altogether 186 clients (85 per cent) have not been provided with services such as practical assistance and training, relief measures for those with burdensome care responsibilities, payment to persons with arduous care duties or support persons.

The case file review shows that a total of seven clients out of 219 have been allocated practical assistance and training. Two clients have received relief measures because of burdensome care responsibilities for a substance abuser. There are no cases where payment has been made to persons with arduous care duties.

In addition a support person has been appointed for 26 clients (12 per cent). Six of the 24 social offices report that they use or have used support persons for substance abusers. Fourteen social services also mention that although support persons have been used on occasion, this is not very common for this group of clients. Four social services state that they do not offer this service to substance abusers. One of the social services maintains that the provision of support persons is governed by Chapter 4 of the Act relating to Social Services. Accordingly, substance abusers are not regarded as a target group and they are not given priority for such interventions.

Pursuant to the Act relating to Social Services, the county governor must supervise the municipal provision of services, including monitoring and provisions for substance abusers, in cooperation with the Norwegian Board of Health. The results of the

countrywide supervision conducted in 2004 reveal that only to a limited degree do municipalities offer services to substance abusers under Chapter 4 of the Act.<sup>123</sup> The circular on social housing provisions implies that nursing and care services are only to a lesser extent granted to substance abusers.<sup>124</sup>

### Allocation of housing

Housing offering aid and protection facilities may often be necessary in order to help the substance abuser in the community.<sup>125</sup> In many cases the social service does not administrate such housing but will assist the client to find a place to live.

*Table 2 Proportion of cases where substance abusers have been allocated housing. Per cent. N = 219*

	Have received	Have not received	Total
Housing with care and protection facilities	6	94	100
Permanent housing for the disadvantaged	26	74	100
Temporary accommodation	33	67	100

Altogether 109 clients (50 per cent) have been assigned one or more support measures such as housing offering care and protection, permanent housing for the disadvantaged or temporary accommodation.

Temporary accommodation is the kind of housing most commonly allocated to substance abusers. Decisions to allocate temporary accommodation have been made in the case of 72 clients (33 per cent).

Some 14 clients (6 per cent) have been allocated places in housing with aid and protection facilities. It proved difficult to establish from case file documentation how closely monitored these clients were. Such housing includes both housing with supervision several times a week and housing with a 24-hour care service.

Permanent housing for people in difficult circumstances, i.e. municipal rental property, has been assigned to 56 clients (26 per cent).

Generally speaking, the survey shows that there is a lack of housing for substance abusers in the municipalities. Nine of 11 social services that have provided figures for housing with aid and protection facilities for this group put the figure at between four and seven. Four other social services report that they have a lack of suitable housing for substance abusers in the municipality.

The review of case files reveals that allocating housing is a lengthy process and that some clients are not provided with the housing they need.

<sup>123</sup> The Norwegian Board of Health, Report no. 4/2005: *Oppsummering av landsomfattende tilsyn i 2004 med kommunale sosialtjenester for rusmiddelmissbrukere* (Summary report of countrywide supervision of municipal social services for substance abusers in 2004).

<sup>124</sup> Circular U-10/2002: *Boligsosialt arbeid – bistand til å mestre et boforhold* (Social housing efforts – support to master residential skills).

<sup>125</sup> Circular I-1/93.

**Examples from the case file review:**

- One client needs temporary accommodation at the beginning of December 2000 but there are no vacant rooms. In the last half of January 2001, he puts in another application for temporary accommodation, and this is repeated in the middle of March 2001. At the beginning of June 2001, he asks for accommodation in a block of bedsits. Towards the end of 2001, he is living in a refuge.
- The social service put in a referral at the beginning of November 2002 for housing with care and protection facilities. The social service managed to find housing at the beginning of May 2003.
- The client has had a compulsory placement and the social service says in the middle of October that they will help the client to find housing. At the beginning of February 2003, the client asks about this again. He has still not been provided with housing in the middle of May 2003. Housing is assigned in August 2003.
- A client is assessed as requiring housing with care and protection facilities but the municipality does not have such amenities. The client is offered temporary accommodation.
- The client is registered for the first time in 2002 and a plan that includes housing is prepared at an early stage. In spring 2004 the client has not been assigned housing.

Several countrywide surveys from other state institutions support the OAG's findings on the lack of housing.

The Norwegian Building Research Institute has conducted a survey that shows that there are still some 5,200 people who lack permanent housing. The survey indicates that an increasing number of those who are homeless are substance abusers and/or people with mental health problems.<sup>126</sup>

FAFO has carried out a survey that shows that the municipalities have piecemeal and arbitrary procedures when dealing with the homeless.<sup>127</sup>

An official report on research in the drug and alcohol field states that knowledge about the contents and scope of the various housing and care measures is necessary.<sup>128</sup>

The Board of Health's countrywide supervision of the social service revealed deficiencies in municipal efforts to provide housing for substance abusers. Several municipalities have been criticised for not offering the housing facilities required by substance abuse clients. This applies to those who need daily assistance with the

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<sup>126</sup> The Norwegian Building Research Institute: *Bostedsløse i Norge – en kartlegging* (A survey of the homeless in Norway) by Thorbjørn Hamen, Arne Holm and Steinar Østerby.

<sup>127</sup> FAFO Research Foundation: *Den vanskelige fortsettelsen – En kartlegging av tjenester til tidligere bostedsløse 2004* (The difficult transition. A study of services for previously homeless people) by Siri Ytrehus and Jon Anders Drøpping.

<sup>128</sup> Norwegian Official Report 2003:4: *Forskning på rusmiddelfeltet, En oppsummering av kunnskap om effect av tiltak* (Research in the field of intoxicants. A summary of knowledge of the impact of support measures).

dressing of wounds who are accommodated in a refuge or block of bedsits. The countrywide supervision has also shown that large municipalities do not have sufficient capacity to satisfy the demand for temporary accommodation. It appears that no assessment has been conducted as to whether temporary accommodation offers adequate provisions for substance abusers.<sup>129 130</sup>

SINTEF's report on substance abusers and services prior to the drug and alcohol reform shows that there is a gap between the need for housing and the accommodation offered in the municipalities participating in the survey.<sup>131</sup>

### **Residential skills training**

Documentation shows that 24 clients (11 per cent) have been offered residential skills training by the social service. The review of case files indicates that this is offered by 14 of 20 municipalities. Interview data reveal that 15 of 24 social services state that they provide such training. According to the statements of the social services, this takes place in different ways – not necessarily in connection with permanent housing. Some social services report that they have access to special 'training' dwellings while others have access to blocks of bedsits where clients can be offered these skills. In addition some social services use municipal environment therapists or peripatetic teams for substance abuse clients living in municipal or private housing. One social service provides residential skills training under the auspices of the adult education service.

### **Contact with primary health service and specialist health service**

Contact with the primary health service<sup>132</sup> and the specialist health service<sup>133</sup> is mentioned in the Act relating to Social Services as a separate measure for substance abusers. The investigation reveals that a large proportion of clients are in contact with the primary health service and the specialist health service. Both of these services are engaged in monitoring substance abusers. Referral to the specialist health service must be made by the patient list doctor.

*Table 3 Proportion of cases where substance abuse clients had contact with the primary or specialist health services. Per cent. N = 219*

	Have had contact	Have not had contact	Total
Primary health service	66	34	100
Specialist health service	73	27	100

In 144 of 219 cases (66 per cent) the substance abuser has been in contact with the primary health service for the purpose of follow-up. In the interview, 12 of the social

<sup>129</sup> Letter of 27.08.2004 with minutes of the meeting with the Norwegian Board of Health 19.08.2004.

<sup>130</sup> Norwegian Board of Health, Report no. 4/2005: *Oppsummering av landsomfattende tilsyn i 2004 med kommunale sosialtjenester for rusmiddelmissbrukere* (Summary of countrywide supervision in 2004 of municipal social services for substance abusers).

<sup>131</sup> SINTEF Report (2004): *Rusklienter og tjenester før "rusreformen". En tverrsnittundersøkelse* (A cross-sectional study of substance abusers and services provided to substance abusers prior to the drug reform programme) by Tonje Gundersen, Lisbet Grut, Mitch Loeb, Torleif Ruud, Tone Eikeland, Sverre Nesvåg, and Esben Olsen.

<sup>132</sup> This covers contact with the patient list doctor, mental health nurse, physiotherapist or contact with the dental health service.

<sup>133</sup> Contact with the specialist health service consists of contact or treatment in a psychiatric outpatient clinic, contact with a psychologist or psychiatrist, or the somatic specialist health service.

services state that they use mental health nurses in the municipality for follow-up. The most common form of contact with the primary health service is through the patient list doctor.

In 159 of 219 cases (73 per cent) the substance abuser has been in contact with the specialist health service. The review of qualitative data shows that the most usual form of contact with the specialist health service is with the young persons' mental health team or psychiatric outpatient clinics/hospitals.

It has been impossible to find out through the case file review and on the basis of the documentation available there whether contact between the substance abuser and the primary health service has been a single, sporadic event or if it has lasted some time. Additionally in a number of cases it has not been possible to establish if it is the social service that has referred the client to the primary health service and/or the specialist health service.

A survey conducted by the Board of Health estimates that in 1999 approximately 4,000 people in Norway with serious long-term mental illnesses such as schizophrenia, affective mental disorders, serious anxiety disorders and personality disorders did not receive the treatment and care they needed.<sup>134</sup>

A SINTEF report from 2003 on health services for heavily-dependent substance abusers indicates that little research has been carried out on how substance abusers are looked after when it comes to mental health care.<sup>135</sup>

A SINTEF report from 2004 on substance abusers and services prior to the drug reform shows that mental health care services required by clients are not always supplied.<sup>136</sup>

The investigation mapped the attitude of the social service to the combination of substance abuse and mental illness. Seven social services report in the interview that the municipality lacked provisions for clients with a dual diagnosis of mental health problems and substance abuse. Seven social services refer to problems that arise because mental health institutions will not treat clients who are substance-dependent or under the influence of alcohol or drugs and who are clearly suffering from mental illness.

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<sup>134</sup> The Norwegian Board of Health, Report Series no. 10/2000.

<sup>135</sup> SINTEF Report (2004): *Rusklienter og tjenester før rusreformen* (Health Services for heavy substance abusers) by Torleif Ruud and Deborah Reas.

<sup>136</sup> SINTEF Report (2004): *Rusklienter og tjenester før "rusreformen". En tverrsnittsundersøkelse* (A cross-sectional study of substance abusers and services provided to substance abusers prior to the drug reform programme) by Tonje Gundersen, Lisbet Grut, Mitch Loeb, Torleif Ruud, Tone Eikeland, Sverre Nesvåg, and Esben Olsen.

One social service reports on efforts made to get clients with substance and mental health problems admitted to various mental health institutions, often without success. This social service describes a situation where such attempts were made for one client over a period of 18 months. The drug and alcohol treatment institution responded that the client could not be hospitalised for substance dependence treatment because of the magnitude of the client's mental health problems. The mental health institution responded that the client's mental health problem was not serious enough and that the substance abuse problems were too great for mental health treatment to be offered. Finally the social service succeeded in having the client admitted to a psychiatric institution. This social service feels that second-tier services too often disclaim responsibility for these clients. The social service cannot refuse them and will often be their only point of contact. The social service in question expresses the view that there are many undiagnosed people with this type of problem.

### **Work, education and leisure activities**

To preserve their dignity and enhance their quality of life, substance abusers' basic needs such as housing, work, leisure activities and social network must be covered.

*Table 4 Proportion of clients who have received work placements, support measures at work, education or leisure-time activities. Per cent. N=219.*

	Have received	Have not received	Total
Work placements	33	67	100
Support measures at work	4	96	100
Education	15	84	100
Leisure-time activities	11	89	100

Altogether 103 clients (47 per cent) have received one or more measures such as work placements, support measures at work, education or leisure activities.

Around one-third of all clients have received an offer of work-related measures. Nine clients (four per cent) have received support measures at work. This low percentage may be because people with substance abuse problems who are in employment do not contact the social service. Education and leisure-time activities have been offered to 34 and 25 clients (15 and 11 per cent) respectively.

It is difficult to establish from the documentation in the case files whether the client has taken advantage of such provisions over an extended period of time or has dropped out after a short time. It is also difficult to ascertain whether the need for such provisions was covered.

SINTEF's survey of substance abusers and services prior to the drug reform revealed that the need for education, work and activation measures in the municipalities had not been met.

#### 4.3.4 Contact prior to and during community-based provisions

##### Counselling and guidance meetings

The social service's follow-up of substance abusers prior to and during community-based measures takes place through the provision of advice and guidance etc. The interviews disclose that this normally happens in meetings at the offices of the social service or in telephone conversations.

Moreover advice and guidance may be given on home visits, during activities with the client as well as in written form in the case of decisions. In 25 of 219 cases (11 per cent) it emerged that the social service had paid a home visit to the client.

The number of documented counselling and guidance meetings is an indicator of the social service's monitoring of the client.

Mapping here is limited to periods when the client is not in an institution or on medication-assisted rehabilitation.

In 24 of 219 cases (11 per cent) there are no case notes or any form of documentation to verify that counselling and guidance meetings between the social service and the client have taken place. It is difficult to know whether there have not been any meetings or whether the meetings have not been documented.

*Table 5 Counselling and guidance meetings with the client after the substance abuse problem is revealed – from the first contact up to 2004. Number and per cent.*

	Number	Percent
One meeting	15	8
Two to three meetings	33	17
Four to five meetings	25	13
Six to seven meetings	42	22
11 to 20 meetings	56	29
21 to 30 meetings	10	5
Over 30 meetings	10	5
Total	191*	100

\*In 24 cases there is no documentation and in four cases it has not been regarded as relevant to register advice and guidance because these cases date too far back in time and are therefore excluded.

Table 5 shows that, according to the documentation in the case files, 15 of altogether 191 clients (8 per cent) have had one counselling and guidance meeting with the social service. Nine of these are cases where the clients had their first contact with the social service prior to 2003. According to the documentation in the case files and case records, these clients have had less than one meeting per year.

Some 33 clients (17 per cent) have had two to three meetings with the social service. Twenty-six of these (79 per cent) had their first contact with the social service prior to 2003, and 18 of the 26 (54 per cent) had their first contact before 2002. Twenty-five

clients (13 per cent) have had three to five meetings and 20 of them (80 per cent) had their first contact prior to 2002.

In some cases the number of counselling and guidance meetings will be affected by whether clients have been institutionalised many times, have been in prison, or have started on medication-assisted rehabilitation shortly after the first contact. In cases where the first contact took place a long time in the past, the number of registered meetings may be influenced by the fact that in many cases the social services did not establish an electronic case file system until the middle of the 1990s or later. The number of meetings will also be affected by the number of years the substance abuser has been in contact with the social service.

The number of counselling and guidance meetings clients take part in annually differs. In 2003 the number varied between one and twenty. The average for 2003 was four.

This variation is confirmed by the interviews. All the social services report that the frequency of these meetings varies from several times a week to one meeting every six months. The frequency of contact between the case officer and the client is influenced by the social service's assessment of the need for help and by variables such as age, pattern of abuse and the client's motivation for support measures. For example, meeting frequency may increase when support measures are being planned or when an application for medication-assisted rehabilitation is made. Four social services feel that they have too few resources to carry out the optimal number of meetings with substance abuser clients. Four social services express the view that fewer counselling and guidance meetings are conducted with clients who are not motivated for measures that will assist them to break away from substance abuse.

### **Responsibility group**

Establishing responsibility groups with representatives of the bodies involved is an instrument that may be used to coordinate the follow-up of substance abusers with complex needs who require services from a number of agencies.

According to 16 of 24 social services, responsibility groups are set up for demanding clients who require follow-up from many different agencies. Responsibility groups have been established for 74 of 219 clients (34 per cent) either prior to or during community-based provisions. For four of these clients no contact with the social service other than that in the responsibility group is documented. In the remaining 70 cases the client has had contact both in the responsibility group and through counselling and guidance meetings.

#### **4.3.5 Follow-up of treatment at a substance abuse institution**

When assistance outside the institution is inadequate, a treatment programme in a suitable treatment or care institution may be used as an instrument. Voluntary institutional treatment has been provided to 55 of 219 clients (25 per cent).<sup>137</sup> Some 71 of 219 clients (32 per cent) have not received institutional treatment, only community-based measures. Of these, 58 clients had their first contact with the social service prior

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<sup>137</sup> Voluntary institutional treatment for those who have received compulsory treatment or MAR has not been registered or examined in the case file review.

to 2003 and for eight of them the first contact took place as early as 1998. There can be several reasons why these clients have not received institutional treatment. The Act relating to Social Services states that the social service must primarily employ community-based measures for substance abusers. In some cases the substance abuser may not be motivated for or want institutional treatment. It may also be the case that such treatment was not available when the client was motivated.

In the further assessment of the monitoring of institutional treatment, the investigation is limited to the client's most recent treatments when there have been several such stays.

### Waiting time

In Recommendation no.184 (1996–97) to the Storting the Standing Committee on Social Affairs underlined how important it was that treatment be offered when the substance abuser is motivated. Mapping in the case files evidences the length of time it has taken from the last mention of or reference to institutional treatment until the social service applies for this.

For 40 per cent of the 55 cases of institutional treatment, documentation on the application is lacking. Consequently it is not possible to find out how long the application process has taken. Documentation is provided in 33 cases.

Figure 3 Proportion of clients and point of time for the social service's application for institutional treatment after the first mention. Per cent. N=33

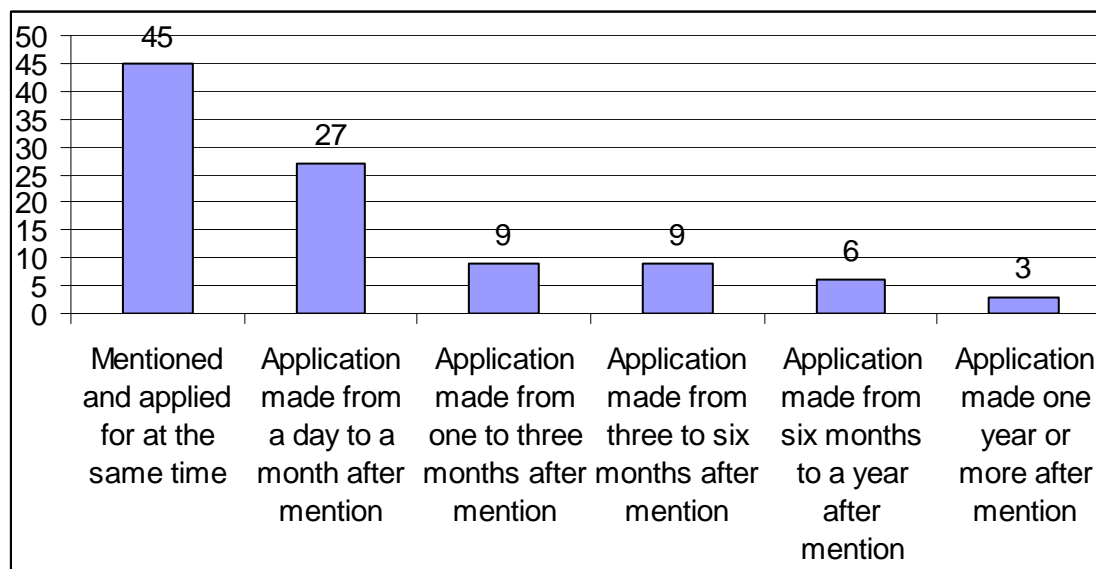


Figure 3 indicates the percentage of clients and the point of time when the social service applies for institutional treatment after the first mention.

In the case of 24 clients (72 per cent) the application was sent at the same time or within a month after the first documented question about institutional treatment. For eight clients (24 per cent) it took over a month and up to a year from the first mention until the application. For one client it took over one year, but in this case it was pointed out that the client has mental problems and is difficult to get in touch with.

In addition the time taken from the social service's most recent application for institutional treatment until the start-up has been mapped.

Figure 4 Proportion of clients and point of time for start-up of institutional treatment after an application by the social service. Per cent. N=33.

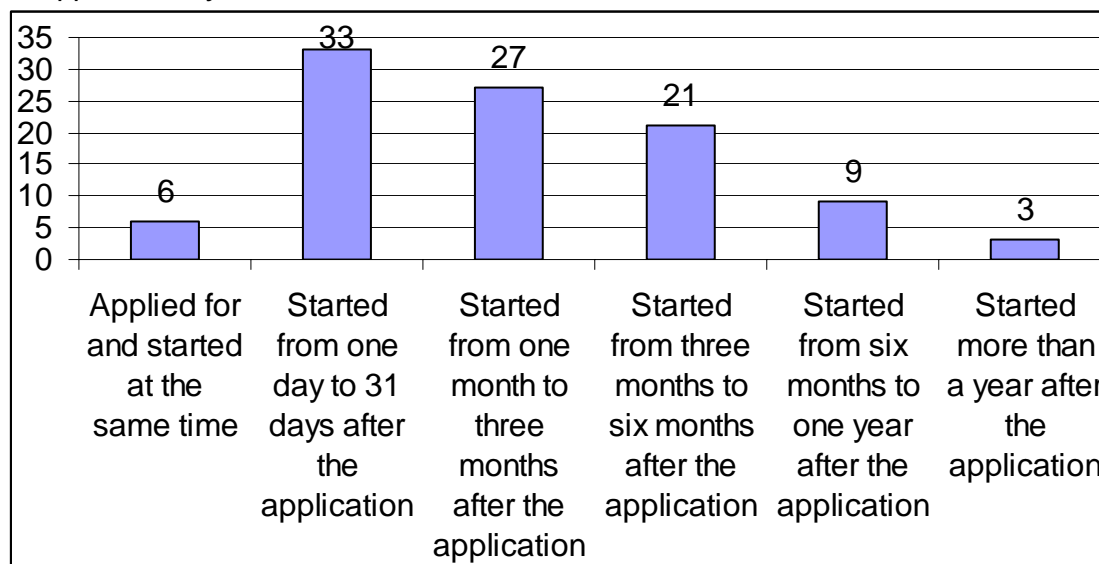


Figure 4 shows that for altogether four clients (12 per cent) it has taken from six months or more from the application until the start-up of treatment.

For 13 clients (39 per cent) the application and start-up of treatment happened at the same time or within a month, while for 16 clients (48 per cent) it had taken from one month to a year. In altogether 22 of 55 cases (40 per cent) there is no documentation of the application or the date of application.

### Mapping

As part of the case file review an investigation has been conducted of whether the social service mapped the client's substance-related problem as well as the physical and mental state of health when an application was made for a place in an institution.

Table 6 The social service's mapping of the substance-related problem in connection with the application for a place in an institution. Per cent

	Yes	No	Total
Is there documented mapping of the application for an institutional place?	58	42	100
Has the social service mapped the substance abuse problem in connection with the application?	56	44	100
Has the social service mapped the client's physical and mental health in connection with the application?	39	61	100

In a total of 23 cases (42 per cent) there is no documentation that the social service has carried out any form of mapping in connection with the application. In 24 cases (44 per

cent) there is no information that the social service has carried out a mapping of the substance-related problem. In 53 cases (60 per cent) there is no information that the social service has conducted a mapping of the client's physical or mental state of health.

All the social services report that they carry out mapping prior to making an application for a place in an institution. However there are variations as to whether this is documented and how it is documented. The social service may also have carried out mapping in connection with a previous institutional placement shortly before the most recent treatment.

### **Preparation of the care plan**

The care plan is an instrument for planning institutional treatment. This has been prepared for five clients (9 per cent of 55 cases) undergoing voluntary institutional placement. For one of these the care plan or action plan has been prepared by the institution. Three of the social services state that care plans are compiled for all clients in connection with institutional treatment. At four social services there are varying practices as to whether care plans are prepared for clients who are to be admitted to treatment institutions for substance abuse problems. Five social services say that care plans are not prepared and eight others explain that the institutions prepare the care plan. One social service states that most, but not all, institutions prepare action plans for substance abuse clients

### **Follow-up during institutional treatment**

The social service's follow-up during a course of treatment takes place in meetings and telephone conversations with the client or through responsibility groups. Such groups have not been established for 12 of 55 clients (22 per cent) nor has there been any contact between the social service and the client during the institutional stay. Thus according to the available documentation, 12 clients have not received any follow-up from the social service during institutional treatment.

Some 43 of 55 clients (78 per cent) have been monitored through a responsibility group, a meeting with the social service or telephone contact. In the case of 30 of 55 clients a responsibility group has been set up during the institutional stay. For 18 clients (33 per cent) a meeting with the social service has been conducted at the institution or elsewhere during their stay while 18 (33 per cent) have had telephone contact.

Twelve social services report that they only monitor substance abuse clients undergoing treatment through the responsibility group and its meetings. The case file review reveals that seven of these have not established responsibility groups for all those who either are undergoing treatment or who have undergone treatment.

All social services state that the frequency of meetings of the responsibility group varies according to the client and what stage of the treatment the client has reached. Several social services say that it also depends on the location of the institution. If an institution is far away, fewer meetings are conducted and the same applies to the responsibility groups.

### 4.3.6 Compulsory placement of substance abusers in an institution

#### Prior to compulsory placement

Substance abusers can be admitted to an institution for examination and planning of treatment without giving consent should their physical or mental health be endangered and if voluntary support measures are not adequate. A pregnant substance abuser can be placed in an institution without consent and kept there throughout the duration of the pregnancy if the abuse is of such a nature that there is a strong likelihood that the baby will be born with a birth defect.

On a countrywide basis, 53 substance abusers were placed in institutions following a final decision on the use of coercion.<sup>138</sup> Fourteen of these cases involved pregnant substance abusers.

In the case file review, altogether 26 cases involving decisions on compulsory admission in the period from 1998 to 2003 have been examined. Twenty-four of these related to women.

*Table 7 Number of cases by type of case*

Cases under § 6-2 without an emergency decision	Cases under § 6-2 with an emergency decision <sup>139</sup>	Cases under § 6-2a with an emergency decision	Cases with only an emergency decision under § 6-2 and 6-2a	Total number of coercion cases
7	6	9	4*	26

\* Three of these cases involve emergency decisions on pregnant substance abusers

Thirteen cases under § 6-2 – retention in an institution without consent – have been examined and in six of the cases the social service made a provisional emergency decision. There are also nine cases under § 6 -2a – coercion for pregnant substance abusers – where emergency decisions were made by the social service in all cases. In addition, there are four cases where only a provisional emergency decision was made. Three of these are governed by § 6.2a and one by § 6.2.

For 20 of 26 clients voluntary institutional treatment was tried out before compulsory admission was requested by the social service and for 19 of 26 clients community-based measures have been attempted first. For 9 of 26 clients retention with consent in an institution was tried out before an application for the use of coercion was made by the social service.

The social service must prepare a care plan for substance abusers who are institutionalised following a decision on compulsory admission.<sup>140</sup> In 14 of 26 cases (54 per cent) no care plan as required by law exists.

<sup>138</sup> The Directorate for Health and Social Affairs.

<sup>139</sup> The social service can make a temporary decision on compulsory placement pending processing of the final decision on the use of coercion by the County Committee on Social Affairs.

<sup>140</sup> Act relating to Social Services § 6–1.

In the case files the time taken from the first mention of compulsory placement until the social service puts forward an application for the use of coercion is mapped. This is an indicator of the length of time used by the social service to assess and put forward such an application.

*Table 8 Time from first mention of compulsory admission until the social service applies for the use of coercion.<sup>141</sup> . Number and per cent*

	§ 6-2 without emergency decision	§ 6-2 with emergency decision	§ 6-2a retention of pregnant substance abusers (all emergencies)	Emergency decision under § 6-2 and §6-2a	Total
0-30 days	2 (29 %)	3 (50 %)	2 (25 %)	2 (50 %)**	9 (36 %)
31-60 days	1 (14 %)	2 (33 %)	4 (50 %)	1 (25 %)	8 (32 %)
61-90 days	1 (14 %)	0 (0 %)	1 (12.5 %)	1 (25 %)**	3 (12 %)
Over 90 days	3 (43 %)	1 (17 %)	1 (12.8 %)	0 (0 %)	5 (20 %)
<b>Total</b>	<b>7 (100 %)</b>	<b>6 (100 %)</b>	<b>8 (100 %)*</b>	<b>4 (100 %)</b>	<b>25 (100 %)</b>

\* In one case there is no date to indicate when the social service brought the case before the County Committee for Social Affairs

\*\* Under §6.2a.

For five clients with a compulsory placement under § 6-2 it took over 60 days for the social service to apply for compulsory admission.

For three pregnant substance abusers with a compulsory placement under § 6.2a, it took over 60 days for the social service to make the application and for one of them it took almost half a year.

In one case there is no documentation of when the case was submitted to the County Committee for Social Affairs.

For one pregnant substance abuser subject to an emergency decision only, it took three months before the application for compulsory admission was made. The social service was aware of the woman's pregnancy two months before coercion was mentioned. The baby was born before the main hearing.

When the social service makes an emergency decision, the substance abuser will be placed in an institution within 48 hours. The social service must submit an application for compulsory admission to the County Committee for Social Affairs within a period of 14 days after the emergency decision has been made. If there is no such decision, the substance abuser will be placed in an institution until the final decision has been made by the County Committee for Social Affairs.

<sup>141</sup> This covers either the period pending an emergency decision on the use of coercion (pending a final decision) or the time until the final decision on the use of coercion (without an emergency decision) is made.

In eight of 12 cases involving coercion, the client had been pregnant for five months or more by the time of placement in an institution following an emergency decision.<sup>142</sup> The case file review has also established the time it takes from the social service's submission of an application for the use of coercion until the County Committee on Social Affairs makes its decision.

*Table 9 Time taken from the submission of the application for the use of coercion to the County Committee for Social Affairs until the final decision of the County Committee. Number and per cent.*

	Type of coercion case	Type of coercion case	Total
	§ 6-2	§ 6-2a retention of pregnant substance abusers	
0-30 days	5 (36 %)	5 (62 %)	9 (43 %)
31-60 days	6 (43 %)	3 (37 %)	9 (43 %)
61-90 days	2 (14 %)	0 (0 %)	2 (9 %)
Over 90 days	1 (7 %)	0 (0 %)	1 (5 %)
Total	14 (100 %)	8 (100 %)*	21 (100 %)

\* In one case there is no date to indicate when the social service brought the case before the County Committee for Social Affairs

For three clients in cases involving coercion governed by § 6-2 it took over 60 days from the time the social service submitted the application until the County Committee for Social Affairs made its final decision. There are no cases under § 6-2a where it has taken a corresponding length of time.

For three clients in coercion cases under § 6-2a it took over a month from the submission of the case till the final decision of the County Committee.

For three clients in cases involving a provisional decision under § 6-2a, the cases were never heard by the County Committee for Social Affairs because the mother gave birth before the cases were brought. Another case involving a provisional decision was rejected by the committee. The grounds for the rejection were that the treatment institution had not prepared a special treatment programme for the client in question and that no account was given of the purpose of the treatment

### **Follow-up during compulsory placement in an institution**

Meetings of the responsibility groups took place in 21 of 26 cases during the compulsory placement. There is no documentation for 12 of 26 clients that there has been contact through meetings or telephone conversations between the social service and the client during this time.

Two of the eleven social services who commented on the monitoring of clients during a compulsory placement report that clients undergoing compulsory treatment receive the same follow-up from the social service as substance abusers in a voluntary treatment

<sup>142</sup> In three cases the mothers gave birth from one to two months after proceedings for compulsory placement had been started. It is assumed that the date of birth is around the due date.

institution. Eight social services state that clients undergoing compulsory placement are monitored more frequently or more closely than clients undergoing voluntary treatment.

#### **The social service's assessment of the use of coercion**

In the interview with the OAG, the social service was asked to give an assessment of why coercion was used only to a limited extent in the case of substance abusers. They report that a great deal of preparation is necessary before a application can be submitted to the County Committee for Social Affairs. The criteria for the use of coercion also make it difficult to successfully bring such a case before the County Committee.

In addition it is difficult to document the need for compulsory admission for a substance abuser. Case-processing is resource-intensive. Another problem is that the client must have a place in an institution that caters for compulsory placements before the case is heard by the County Committee for Social Affairs. Few institutions will admit clients on the basis of a decision on coercion. There is said to be an inadequate range of institutional provisions for the compulsory admission of substance abusers. It emerged in the interviews that in some cases the County Committee for Social Affairs has decided on the use of coercion but that the decision has not been implemented because the health enterprise has been unable to offer a place before the decision became invalid.

Several social services state that they do not believe or have no experience that the use of coercion in the case of substance abusers is a method that will achieve the desired results. Moreover they have also experienced that coercion may lead to overdoses and deaths in the wake of compulsory placement. Two social services maintain that the reason that there are few cases involving the use of coercion is that there is a big demand from substance abusers for voluntary placement and this is given priority over coercive measures.

### **4.3.7 Post-institutional monitoring**

#### **Planning and post-institutional monitoring**

There are altogether 55 cases where clients have undergone voluntary institutional treatment and 26 cases of compulsory placement. In 13 of the 55 cases (24 per cent) the client is still being treated at the time of data collection. In addition one of the cases involving the use of coercion is not relevant because the County Committee for Social Affairs rejected the case. Thus a total of 67 clients are eligible for follow-up after voluntary institutional treatment (42) or compulsory admission (25).

Planning of the follow-up at the end of voluntary or compulsory institutional placement is important for maintaining and continuing any improvement achieved by the client in mastering his/her substance abuse problem or other problems. No such planning has been carried out for altogether 15 of 67 clients (22 per cent).

All the social services state that the planning of the follow-up takes place during the institutional stay. However different times are given as to when during the course of treatment the planning should be carried out. This varies from the start of the institutional stay to immediately prior to discharge. One social service indicates that the time varies according to the requirements of the institution. Some institutions maintain that post-institutional follow-up is planned before the client is admitted while other institutions

initiate planning of the follow-up at the end of the client's stay. Three social services state that planning follow-up after a short stay at a treatment institution for substance abuse is problematic. A short stay is defined as being up to three months.

### Post-institutional measures

After discharge clients must be offered the opportunity to take part in a long-term programme that includes a social network, emergency help, support persons, housing and work.

The investigation includes the case files of 67 clients where the social service has been responsible for follow-up after institutional placement. Some 32 clients completed their course of treatment prior to 2003 while 37 clients completed voluntary institutional treatment or compulsory placement in 2003 or 2004.

*Table 10 Proportion of substance-abuse clients who have received support measures in the post-institutional period (including voluntary and compulsory placement in an institution. Per cent. N = 67.*

	Have received	Have not received	Total
Treatment to maintain a substance-free state/ out-patient treatment for substance abuse	40	60	100
Measures to improve physical or mental health	33	67	100
Housing/ residential skills training	24	76	100
Work/ education	22	78	100
Leisure-time/ social training	18	82	100
Measures supervised by the institution	37	63	100
Other	42	58	100

The measures provided after institutional treatment need not be the social service's own provisions or provisions established with their support. The documentation in the case file indicates whether measures have been allocated to the client on a more general basis.

According to Table 10, the most usual post-institutional follow-up is the maintenance of the client's substance-free state/out-patient treatment for substance abuse, and 'Other'.<sup>143</sup> A total of 27, 25 and 28 clients respectively (40, 37 and 42 per cent) receive such provisions.

Some 12, 15 and 16 clients (18, 22 and 24 per cent) respectively have received follow-up in the form of leisure-time activities and social training, work placements, education and housing measures/residential skills training.

All the social services state that they provide services pursuant to the Act relating to Social Services (for example a support person and milieu therapy) and report on needs for community-based measures such as child welfare and municipal health services at

<sup>143</sup> "Other" includes measures such as conversations with the social service, referral to the child welfare service, the milieu therapy service, aftercare group, contact with Alcoholics Anonymous/ Narcotics Anonymous, support persons and medication-assisted rehabilitation.

the post-institutional stage. In addition they attempt to provide follow-up for housing, work and education courses and if necessary a responsibility group. They also help with referrals for out-patient care or mental health services as well as arranging follow-up conversations.

**Six social services mention specific measures in post-institutional follow-up that are available for the substance abuser in the community:**

- Two social services have a centre for follow-up care where different activities take place.
- One social service provides leisure-time activities through a municipal project.
- One social service uses a private aftercare group consisting of former substance abusers
- One social service mediates contact with a privately-run conversation group
- One social service states that they put particular focus on post-institutional monitoring of substance abusers. The municipality has prepared a support scheme directed at clients who have completed institutional treatment. This is given priority as regards staffing, and the complement of staff has been doubled in 2004. All the participants are provided with sheltered housing shielded from active substance abusers. This offer does not apply to those on medication-assisted rehabilitation.

Four social services say specifically that they have no or very few provisions for post-institutional follow-up.

Three social services mention that housing and related follow-up services are problematic and that there are deficiencies.

**Contact between the social service and the client in the post-institutional period**

The follow-up in the post-institutional period can take place through a responsibility group, meetings with the social service and telephone contact.

Responsibility groups may be appropriate for the follow-up of clients who have undergone voluntary treatment or compulsory placement. The case file review indicates whether a responsibility group has been appointed to monitor the client after treatment on the basis of the available documentation.

*Table 11 Proportion of substance abuse clients who are monitored by a responsibility group in the period after the most recent voluntary institutional treatment and after the most recent compulsory placement. Number and per cent.*

N=67	Number	Per cent
Responsibility group YES	23	34
Responsibility group NO	44	66

A responsibility group has been established at the post-institutional phase for 23 of 67 clients (34 per cent). For nine of these, one meeting of the responsibility group has been held during the entire period following institutional placement. Four of these clients completed their treatment as early as 2000 or 2001 while five completed their treatment in 2003.

It is not appropriate to establish responsibility groups in the follow-up phase of treatment in all cases. A meeting with the social service may be sufficient. In 20 of 44 cases where no responsibility group has been set up or where there has been no meeting of the responsibility group, a meeting with the social service has been conducted.

For 23 of 67 clients (34 per cent) there has been no contact between the social service and the client through a responsibility group, a meeting with the social service or telephone contact in the post-institutional follow-up phase.

### 4.3.8 Medication-assisted rehabilitation

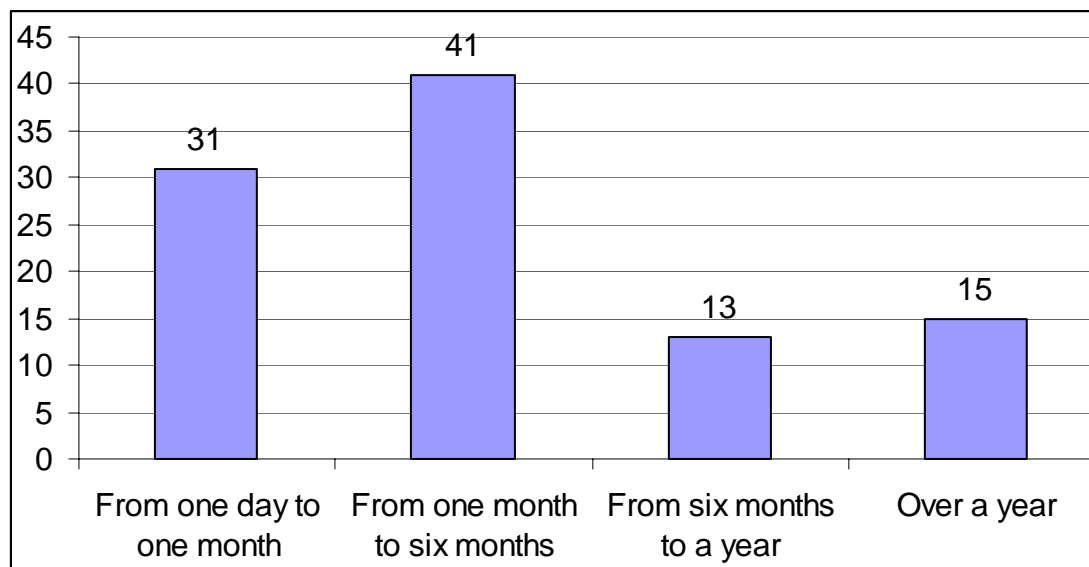
#### Prior to the application for medication-assisted rehabilitation (MAR)

The social service assesses whether MAR is the most appropriate measure for the client in connection with the application. It is important that MAR is available when the substance abuser is motivated for the treatment.

Altogether 443 MAR cases were registered as of 31 December 2003 at the 24 social services in the investigation. A total of 67 MAR cases were examined in the case file review, all of which had commenced after 1 January 1998.

The case file review establishes the time that has passed from the first mention of MAR until the social service prepares the application for the client.

Figure 5 Proportion of clients and point of time when the social service applies for MAR after the first mention. Per cent. N=61\*.



\* There was a lack of documentation in six MAR applications.

For nine clients (15 per cent) it took over a year from the first mention of MAR until the application was prepared. For two of these clients the process took around four years.

The interviews show that there is a variation among social services as to when they start the application process for MAR once the client has expressed a wish for this. One municipality states that all applications are prepared within three months of the client expressing such a wish. Three others report that the client's application is prepared when the social service has the capacity to deal with the application and that there are waiting lists for case processing. The waiting time at one of the three social services is between six and twelve months from the time the application is delivered until the social service is ready to begin processing the case. A fourth social service says that the application process does not start until there is capacity to start MAR treatment.

In the evaluation of MAR by the Directorate for Health and Social Affairs it emerges that there are wide variations in the work of the municipalities on MAR applications. For example it varies whether applications are made on an ongoing basis for those who are eligible or whether the application is made as the municipality or the MAR centre has the capacity to take on more MAR clients. The evaluation report shows that municipalities can have lists of clients who want MAR that date back up to three years but no application has been made. According to the report, the opportunities that clients have to deliver applications for MAR and how long the processing of the applications takes depend on where they live.<sup>144</sup>

When the social service supports an application for MAR it must coordinate the preparation of a comprehensive care plan for the rehabilitation programme.<sup>145</sup> For five of 67 clients (7 per cent) there is no documentation of a care plan in the case file.

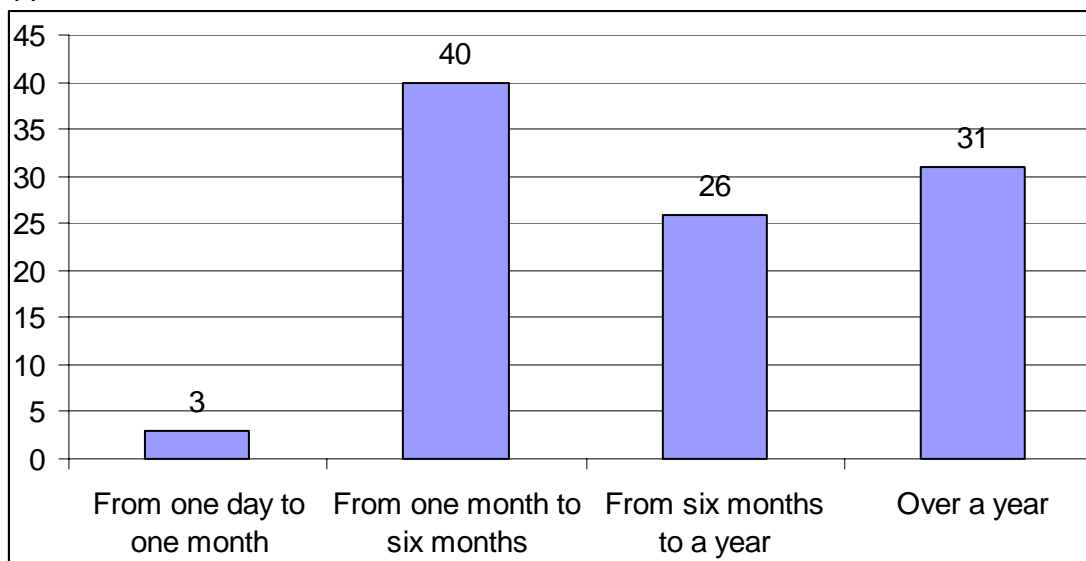
The investigation maps the time that passes from the social service's application for MAR until this is started. This is an indication of how long the regional methadone centres take to process the application, and if it is approved, to give the go-ahead. For altogether 18 clients (31 per cent) it has taken over a year from the time the social service sent the application until the client started MAR. In two of these cases it has taken around three and a half years from the initial application to the start-up.

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<sup>144</sup> The Directorate for Health and Social Affairs/AIM 2004: *Evaluering av legemiddelassistert rehabilitering* (Evaluation of medication-assisted rehabilitation).

<sup>145</sup> Circular I-33/2000 and Circular I-33/2001.

Figure 6 Proportion of clients and start-up time for MAR after the social service's application. Per cent. N=58\*



\*In five cases the client did not start MAR. There was no application in five other cases.

In nine cases there is no documentation of the time taken. Five of these cases lack documentation because MAR had not been commenced at the time of data collection. In one case the application was sent in 2001.

The social services state that waiting times for the start of MAR vary and quote times of from three months to four years. Three social services maintain that they do not experience that there is a long waiting time after the application has been sent to the intake team.

The MAR evaluation carried out by the Directorate for Health and Social Affairs shows that the waiting time from application to intake differs tremendously and that it varies from 0 to 24 months.<sup>146</sup>

### Measures under MAR

Community-based measures for MAR clients can be municipal housing, offers of work and work training, referral to an out-patient section, a psychiatrist or psychologist, offers of education and a support person, institutional treatment etc.

For 16 clients (26 per cent) no documentation has been found that the client has been assigned community-based measures. Five of these clients have been in institutions during MAR.

Half of the clients who have received community-based measures (46 in all) have received several measures, for example a support person and housing in addition to follow-up for housing and out-patient treatment as part of the same MAR monitoring scheme. Some MAR clients live in a residential care institution or have the option of daily

<sup>146</sup> The Directorate for Health and Social Affairs/AIM 2004: *Evaluering av legemiddelassistert rehabilitering* (Evaluation of medication-assisted rehabilitation).

treatment at voluntary treatment institutions. In 27 of 62 MAR cases (43 per cent) treatment has been provided in an institution either in addition to community-based measures or as the sole measure.

In the evaluation of MAR carried out by the Directorate for Health and Social Affairs, the municipalities are quoted as referring to a lack of resources. This means that they are not always able to provide measures such as work or other pursuits, organised social activities and gatherings for MAR clients.<sup>147</sup>

**Examples of MAR measures:**

- One social service offered a daily programme for MAR clients through a project supported by the Ministry of Social Affairs. The project is about to be discontinued because project funding is no longer sufficient to pay staff. The same social service provides housing that is manned during the day and in the evening and that is primarily used for MAR clients.
- One social service receives financial support from the state which enables 25 MAR clients in the municipality to receive individually adapted work measures through the action plan to combat poverty. Another provision is a conversation group for MAR clients run by a drug abuse counsellor at the hospital. The social service has two clients in this group. Apart from this, the social service has no other community-based measures for either MAR clients or other substance abusers.
- One social service provides an activity centre for MAR clients
- One social service purchases MAR programmes from a neighbouring municipality
- One social service has a milieu therapy service that carries out individual monitoring of living-skills training for MAR clients
- One social service has a milieu therapist in a 50 per cent part-time position that carries out outreach work among MAR clients. The municipality has a meeting place where MAR clients can get together once a week. Leisure-time activities are offered to MAR clients only, but not to substance abuse clients as a group.
- One social service offers living-skills training with a milieu therapist for four clients with the support of the Ministry of Social Affairs. In addition, excursions, job placements, support for courses, education and information meetings are offered.
- One social service offers MAR clients upper secondary schooling with courses in cookery, data, training in participation in leisure-time activities and how to structure the day as well as offering the lower secondary school's curriculum. The same municipality has housing arrangements that accommodate four MAR clients who can be monitored individually.
- One social service arranges a get-together for MAR clients once a month.

**Contact during MAR**

The social service's follow-up can take place through the responsibility group, meetings or telephone contact.

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<sup>147</sup>The Directorate for Health and Social Affairs/AIM 2004: *Evaluering av legemiddelassistert rehabilitering* (Evaluation of medication-assisted rehabilitation).

The social services in the investigation express the view that follow-up of MAR is resource-intensive. The social service must undertake to monitor all their clients who have been allocated MAR.

For two clients there is no documentation that there has been any contact with the social service whether through a meeting of the responsibility group, a meeting outside the group or telephone contact.

All social services report that they establish responsibility groups for all MAR clients. For six of 62 clients (10 per cent)<sup>148</sup> no documentation has been found in the case file data that a responsibility group has been set up. However, all of these had started MAR in 2003.

The investigation shows that during the MAR period the number of meetings, either of the responsibility groups or with the social service, varies for each individual client. For example, for two clients who started MAR in the same year the number of meetings of the responsibility group during the entire MAR period varies from three to 26. The MAR evaluation conducted by the Directorate for Health and Social Affairs reveals that the rehabilitation effort and follow-up varies among and within municipalities. The evaluation also indicates that MAR clients' contact with the social service varies from county to county and the contact may vary according to how much contact the client has had with the MAR centre in the region.<sup>149</sup>

It appears that a larger proportion of clients have had contact with the social welfare office during MAR than in the case of other community-based measures or during institutional treatment and the post-institutional follow-up. The MAR evaluation conducted by the Directorate for Health and Social Affairs suggests that the follow-up of MAR clients is more structured than the follow-up for other substance abuse clients. The view is expressed in the report that the care plan and responsibility groups' scheme for all MAR clients leads to greater systematisation and provides a framework for the follow-up.<sup>150</sup>

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<sup>148</sup> There are five cases where MAR has not been started. The number of cases here is therefore 62.

<sup>149</sup>The Directorate for Health and Social Affairs/AIM 2004: *Evaluering av legemiddel assistert rehabilitering* (An evaluation of medication-assisted rehabilitation), SKR Report no. 7/2004: *Bidrag til evaluering av legemiddelassistert rehabilitering i Norge* (The evaluation of medication-assisted rehabilitation in Norway) by Mona Baadstøe Hansen, Hege Kornør and Helge Waal.

<sup>150</sup> The Directorate for Health and Social Affairs/AIM 2004: *Evaluering av legemiddel assistert rehabilitering* (An evaluation of medication-assisted rehabilitation).

## 5 Assessments

The investigation of the Office of the Auditor General shows that only to a limited degree does the Ministry collect systematic information about the municipalities' follow-up of substance abusers, and very few evaluations of the follow-up have been conducted. The central authorities have not played a very active role in developing guidelines, tools and models for the greater systematisation of municipal efforts to monitor substance abusers.

The OAG's investigation of 20 municipalities has detected weaknesses in municipal management and case-processing systems for this work. Over a third of the municipalities have not prepared plans on drug and alcohol policies. Three-quarters of the municipalities do not have written case-processing routines for the follow-up of substance abusers. The investigation has also revealed that there are deficiencies in documentation in the social services' case records and case notes.

The investigation has documented a range of weaknesses in municipal follow-up of substance abusers. Identification and mapping of the substance abuse problem takes place at a late stage and the social service takes a long time to submit both applications for the use of coercion and applications for medication-assisted rehabilitation. The investigation shows that the provision of social services pursuant to Chapter 4 of the Act relating to Social Services is given little consideration in the follow-up of substance abusers, and that there is a lack of housing for this group. Moreover a quarter of MAR clients who are entitled to specialist social rehabilitation are not allocated community-based measures. Deficiencies are also revealed in follow-up and contact between the social service and clients during institutional treatment and in the post-institutional follow-up.

### 5.1 The ministry's overall national responsibility for the monitoring of substance abusers

The Ministry of Health and Care Services requires systematic information on the current situation and developments in municipal work on the follow-up of substance abusers. This is essential for the Ministry's ability to implement their overall national responsibility in a satisfactory manner. As early as the beginning of the 1990s, the Ministry stated that there was insufficient information to shed light on the municipalities' situation in the area of intoxicants.<sup>151</sup>

The investigation shows that at the start of 2005 there is no regular system of reporting from the local to the central authorities on the follow-up of substance abusers. There are no statistics on the number of substance abusers who are clients of the social service or on other relevant countrywide information about municipal work with substance abusers. In addition case-processing systems for substance abusers in the municipalities are not well enough adapted for reporting on the municipal and state level so that relevant

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<sup>151</sup> Report no. 69 (1991-92) to the Storting: *Tiltak for rusmiddelmisbrukere* (Support measures for substance abusers).

information about the social services' follow-up is not available. Only one evaluation of the social service's follow-up of substance abusers has been conducted. Few evaluations have been made of the Act relating to Social Services as a whole as well as those sections that have provisions aimed at the follow-up of substance abusers.

Deficiencies in reporting, evaluation and statistics constitute a risk of the Ministry acquiring insufficient knowledge of whether substance abusers receive the follow-up they have a right to pursuant to the Act relating to Social Services. It may be questioned whether the Ministry has the necessary governance information in this area.

The Ministry has prepared circulars which define more explicitly the application of the Act relating to Social Services as well as guidelines on coercion provisions. The OAG's investigation nevertheless reveals considerable deficiencies in the social service's follow-up of substance abusers. The investigation shows that the social service does not have adequate and appropriate methods, routines and systems to provide a satisfactory follow-up of these clients. There is reason to ask whether the Ministry (and the former Ministry of Social Affairs) has been sufficiently active in ensuring that guidelines, tools and models have been developed to secure a higher degree of systemisation in this work.

The action plan – Knowledge and bridge-building (1998-2001) – brought about a knowledge boost for the social service. The investigation shows that the county governors' offices have not adequately maintained and developed specialist forums on social and substance-related questions in line with the intentions of the Ministry. This suggests that some of the impact of the action plan is gradually waning and may indicate that the Ministry has not been altogether successful in developing measures that were established during the action plan.

The resource centres for drug and alcohol issues are charged with providing advice and competence upgrading measures to the municipal social service. The investigation reveals that the social services have little or no contact with these resource centres in the follow-up of substance abusers. It appears that the resource centres do not play a sufficiently active role.

In recent years the Ministry has been responsible or partly responsible for a number of action plans and grant schemes directed at weaker groups in society, and one of the target groups is substance abusers. The OAG's investigation shows that it has been difficult to achieve a long-term impact from these measures.

## **5.2 Municipal monitoring of substance abusers**

### **5.2.1 Management and case-processing systems in the municipalities**

The investigation shows that over a third of municipalities have not prepared an action plan for uniform policies on drugs and alcohol. This entails a risk of a lack of planning and focuses on the priority areas in the follow-up of substance abusers. In addition the investigation shows that the social services largely fail to report on the goal achievement of action plans on drug and alcohol policies. Deficient reporting may constitute a risk of

weak management information both for the local and central authorities in the work of following up substance abusers in the municipalities.

There should be written procedures, instructions and routines for case processing and monitoring of substance abusers so as to ensure quality and continuity in the follow-up. The investigation shows that a third of the social services investigated do not have case-processing routines for their work and that three-quarters do not have written case-processing routines for the follow-up of substance abusers. This may lead to the development of different practices among case officers at the same social service as well as inefficiency, poor quality and a lack of predictability and continuity.

Good management practices require that administrative case-processing routines be backed by written documentation. The case file review reveals that documentation in the case records and files is deficient. This involves the risk that continuity in the follow-up cannot be ensured, for instance when a case officer is replaced. In addition, the client's right to legal protection is not safeguarded, for example when the client wishes to access case documentation in the event of a complaint. A lack of documentation reduces verifiability in connection with complaints, supervision and audits.

The investigation shows that the social services lacked knowledge of the regulation on internal control in the health and social service and that the work to establish a system of internal control has barely started.<sup>152</sup> The lack of such a system constitutes a risk that errors and deficiencies in case processing will not be detected and corrected.

### **5.2.2 The municipal social service's follow-up of substance abusers**

Early identification and mapping of people with drugs problems are important factors if targeted assistance is to be given to substance abusers.<sup>153</sup> The case file review shows that documentation of the mapping of these clients is deficient and that the identification and mapping of substance abusers by the social services are carried out at a late stage. This may entail the social service intervening too late with targeted measures aimed at the substance abuse problem. A lack of mapping may mean that the social service has an inadequate basis for targeted support measures. One of the reasons for belated mapping and identification may be that the municipalities do not possess adequate competence and methodology in this area.

The OAG's investigation as well as investigations carried out by other public bodies indicates that services pursuant to Chapter 4 of the Act relating to Social Services are not adequately provided for the substance abuser as the Act calls for. The findings also indicate that there is a lack of housing and lengthy case processing for the allocation of housing for substance abusers in the municipality. This is supported by other research and reports. There is reason to question whether substance abuse clients receive the assistance they need and to which they are entitled in sufficient measure.

Before the social service refers a substance abuser for institutional treatment, the client's situation should be thoroughly mapped. A care plan should be drawn up for substance abusers who are in institutions on a voluntary basis. In 23 of 55 cases (43 per cent)

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<sup>152</sup> Regulation on internal control in the health and social service 20.12.2002, § 4 g.

<sup>153</sup> The Norwegian Government's Action Plan to Combat Drug- and Alcohol-related Problems (2003–2005).

there is no documentation that the social service has carried out any mapping in connection with an application for institutional treatment. Only in five cases has a care plan been prepared. Thus there appear to be weaknesses in the social services' planning and organisation of institutional treatment.

In accordance with the Act relating to Social Services, the social service must monitor the clients during and after institutional placements. The social service must also ensure that measures of significance for the post-institutional stage are planned in order to ensure continuity in the chain of provisions. The review of case files shows that a number of clients have not had any contact with the social service during and after institutional placement. Nor have post-institutional follow-up measures been planned. This may mean that the follow-up is random and insufficiently targeted. A lack of contact between the client and the social service at the post-institutional phase involves a breach of the chain of provisions and implies that the social service therefore is unable to assess the client's situation at this time. Seen in light of the fact that less than a quarter of clients are allocated leisure-time activities and social training, work placements and education or a provision of housing/living-skills training, there is reason to question whether the substance abuser is given satisfactory help after an institutional stay.

When a client applies for MAR, the social service has the duty to evaluate whether this is the most appropriate measure. The social service can refuse the application in the first instance.<sup>154</sup> The case file review shows that for nine clients it took over a year for the social service to evaluate and forward the application after the client had expressed a wish for MAR. According to the OAG's investigation, the social services have different practices as to whether the application is submitted on an ongoing basis or as and when the municipality has the capacity to take on more MAR clients. This finding is supported by the MAR evaluation which the Directorate for Health and Social Affairs has conducted. According to the report of the Directorate, the opportunities that clients have to deliver applications for MAR and how long the processing of the applications takes depend on where they live.<sup>155</sup> It may be questioned whether MAR applicants receive equality of treatment.

The investigation reveals that in a quarter of cases no documentation has been found that the client has been allocated community-based measures during MAR. It is debatable whether MAR clients received adequate specialist social rehabilitation.

Substance abusers may be admitted to an institution for examination and preparation of treatment without having given consent if their physical or mental health is endangered and if voluntary measures are insufficient. In the case of coercion towards pregnant substance abusers, there are requirements for speedy case processing with short time limits.<sup>156</sup> The case file review shows that for five of thirteen substance abusers it took the social service over 90 days to submit an application for coercion. For three of eleven pregnant substance abusers it took over 60 days for the social service to submit the application. The social service's case-processing time prior to the submission of the

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<sup>154</sup> MARIO, The Alcohol and Drug Addiction Service, Oslo Municipality: *Veileder i medikamentassistert rehabilitering* (Guide to medication-assisted rehabilitation).

<sup>155</sup> The Directorate for Health and Social Affairs/AIM 2004: *Evaluering av legemiddelasistert rehabilitering* (Evaluation of medication-assisted rehabilitation).

<sup>156</sup> Proposition no. 48 (1994-95) to the Odelsting.

application for the use of coercion is regarded as lengthy taking into consideration the serious nature of the case. For pregnant substance abusers it is vital that the time spent on case processing is as short as possible in order to prevent or limit the probability of harm to the baby and to enable the mother to look after her baby. Lengthy case processing for clients under assessment for compulsory placement constitutes a risk to life and health both for the clients and for the children of pregnant substance abusers.

The social service must prepare a care plan for substance abusers who are admitted to an institution on an involuntary basis.<sup>157</sup> In somewhat over half of all cases involving the use of coercion no care plan has been prepared as required by law. The investigation reveals that there are marked weaknesses in the social service's planning of compulsory placements.

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<sup>157</sup> Act relating to Social Services § 6 – 1.

## Appendix 1

### Method used in the selection of case files

Clients are registered in a general manner in the case-processing system of the social service and there is no selection categories that facilitate the selection of cases related to problematic substance use.

The social services have been asked to prepare a list of all substance abuse clients who are 'active' in the social service prior to the interview with the OAG. If the social service has a complete list of 'active' clients with a substance abuse problem, they were requested to send this to the OAG. The social services that do not have lists of all their 'active' clients have been given the following guidance on the procedure they should follow to acquire an overview of substance abusers in the social service.

- Take a printout of all newly registered clients in the case-processing system in February and October in the period from 1998 to 2003.
- The list of all newly registered clients should be delivered to all the case officers at the social service. The case officers mark the clients who have an acknowledged or concealed substance abuse problem. It is therefore the case officer's awareness of such a problem that provides the basis for the selection.
- In addition the social services must draw up an overview of all clients who have been granted medication-assisted rehabilitation in the period from 1 January 1998 to 31 December 2003, and a list of cases involving compulsory placement pursuant to Chapter 6 of the Act relating to Social Services in the period from 1 January 1998 to 31 December 2003.

### Selection according to gender, age and substance abuse:

The case file data consist of 78 females and 141 males, 36 and 64 per cent respectively of the data material. According to figures on referrals of substance abusers to treatment and care institutions provided by SIRUS, gender distribution has remained at 70 per cent for males and 30 per cent for females for several years.<sup>158</sup> The gender distribution in the case file data may therefore be said to be representative.

*Table 1 Gender distributions in the case file data*

Gender	Number	Per cent
Females	78	36
Males	141	64
Total	219	100

In 17 per cent of cases (37 cases), substance abuse is chiefly abuse of alcohol, while in 79 per cent of the cases (173 cases), the main problem is abuse of drugs. In four per cent of the cases (9 cases) the type of substance abuse is not indicated. There may be some over-representation of drugs cases in the case file material. However this is difficult to determine because there are no other statistics on the number of substance abuse clients of the social services. The investigation is not structured to provide an assessment of the social service's follow-up of different kinds of substance abusers.

<sup>158</sup> Hege Lauritzen and Astrid Skretting 2004. The national documentation system within the programme of measures for substance abusers. SIRUS.

*Table 2 Type of substance abuse problem. Number and per cent*

Type of substance abuse problem	Number	Per cent
Alcohol abuse	37	17
Drugs abuse	173	79
Type of substance abuse problem not indicated	9	4
Total	219	100

The age distribution in the case file material ranges from 18 to 68. Some 75 per cent of the cases involve clients from 18 to 40. Figures for 2002 provided by SIRUS show that 50 per cent of all those who approach treatment and care institutions are from 16 to 40. There appears to be a predominance of cases involving young substance abusers in the case file data. One explanation may be that 126 cases in the investigation are registered for the first time after 1998 and older substance abusers are more likely to have been registered prior to 1998.

*Table 3 Age distribution Number and per cent*

Age	Number	Per cent
18-25	59	27
26-30	44	20
31-35	35	16
36-40	28	13
41-45	28	13
46-55	18	8
56 and over	7	3
Total	219	100