



European Monitoring Centre
for Drugs and Drug Addiction


Danish Health and Medicines Authority

**2013 National Report (2012 data) to the EMCDDA
by the Reitox National Focal Point**

DENMARK

New development, Trends, and in-depth information on selected issues

Preface

This year's report on the drug situation in Denmark has been prepared by the Danish Health and Medicines Authority – the National Focal Point – for the European Monitoring Center for Drugs and Drug Addiction in Lisbon. The report was prepared during the autumn of 2013 based on common European guidelines and is available in a Danish version as well as an English translation.

The report provides an overview of the drug situation in Denmark. It is based on the most recent statistic and epidemiological data as well as current information on focus areas, projects, activities, and strategies within drug prevention, harm reduction and drug abuse treatment. Furthermore, the report provides an outline of Danish legislation and policies within the drugs area.

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Summary

The current drug situation in Denmark

Compared to 2000, a new population survey made in 2013 confirms a decreasing prevalence of illicit drugs such as amphetamine, cocaine and ecstasy – also among the young people, where prevalence is the highest. While 8% of the young people under the age of 25 in 2000 reported current use of illicit drugs other than cannabis, the rate had gone down to 4% in 2013 – ie a 50% decrease. This favourable trend does not apply to cannabis where prevalence was more or less the same from 2000 to 2010, but then started to rise slowly from 2010 to 2013. 19% of the young people under the age of 25 reported current use of cannabis in 2010, whereas this rate had gone up to 24% in 2013.

When viewing the drugs on an individual basis, the use of cocaine appears to be on the same level as in 2010, which is particularly positive as the use of cocaine – as the only drug – was on the increase during the first decade of 2000. Cannabis is still the most prevalent drug. The number of amphetamine and cocaine users is still much lower as is the number of psilocybin mushroom and ecstasy users (SUSY 2013).

The positive declining trend in the experimental use of illicit drugs is also seen among the very young people. The results from the most recent international school survey, ESPAD conducted among the 15-16-year-olds in the ninth grade, which was made in 2011 shows a drastic decrease in the use of illicit drugs from 2007 to today (ESPAD 2011).

In spite of the documented drop in the experimental use of drugs, an increasing number of poisonings have been recorded in the emergency rooms in Denmark. The number of poisonings recorded as a result of illicit drugs peak in 2012 with 2028 recorded contacts, and it is assumed that this is a conservative estimate. The increase in the poisonings the past few years is especially seen in those aged 30 and above. From 2011 to 2012, however, there appears to be a marked increase of poisonings among the 20-24-year-olds – an increase from 348 to 439 in the years in question. Among the young people, poisonings are typically seen with cannabis and psychostimulants, whereas poisonings with opioids and compounds of several drugs most frequently appear among the older generation.

Also psychiatric admissions resulting from drug-related diagnoses appear more frequently in these years. However, the development in the number of such admissions in 2010 is more or less on the same level as in 2011. In 2012, 5,709 persons were reported admitted to psychiatric hospitals with a drug-related primary or secondary diagnosis. Polydrug use is a dominant factor in the psychiatric admissions with a drug-related secondary diagnosis. When the admission is caused by one single drug, cannabis is the main culprit. The number of persons admitted to psychiatric treatment with a drug-related secondary diagnosis and where cannabis use is involved was 2000 in 2012, and the number has more than tripled over the past 10 years. There are significantly fewer admissions where cocaine abuse appears as a secondary diagnosis (207 persons in 2012), however an increase is also seen here over the years, although the trend declines from 2009 and onwards. The increase in the recorded admissions with drug-related diagnoses may reflect both an actual increase as well as improved registration routines.

Among other health-related consequences of drug abuse, the increased mortality rates should also be mentioned. Drug abusers generally account for very high mortality rates as a result of poisonings and diseases, including HIV and hepatitis. According to statistics from the National Police on drug-related deaths, 210 drug-related deaths were recorded in 2012. This is the lowest number since 1994. The past few years, the number has been significantly higher, and in 2009 as well as in 2012, the number of drug-related deaths was 275 annually with the number reaching a maximum level in 2011 with 285 deaths.

The number of drug-related deaths in Denmark dropped significantly from 2011 to 2012. This decline is particularly caused by a decline in the Region of Southern Denmark and is noteworthy, because the death rates in this region were high in the years from 2009-2011. It is assumed that the decline is real and not just due to procedural changes or changes in registration practice on drug-related deaths during the period.

There are no bullet proof explanations as to why the drug-related deaths drop so dramatically from 2011 to 2012 in the Region of Southern Denmark. There are most likely a number of factors involved. An overall decline in recent years in the number of drug abusers receiving treatment for the first time with opioids as their main abuse problem could be one of the reasons – also in the Region of Southern Denmark. However, changes in the drug market in the years in question could also be an explanation. Finally, one might assume that the new initiatives and interventions provided by the municipalities to the most vulnerable, such as focusing on general interventions, establishment of health rooms / drug consumption rooms, heroin clinics, prevention of infectious diseases and quality in substitution treatment have had an impact on the trends.

Apart from the drastic decline in the Region of Southern Denmark, there seems to be a decline in all the other regions. The general decline was expected, because the new drug abusers admitted to treatment with opioids as their main abuse problem has been on the decline over the past few years. All other things being equal, opioid abuse is what most often leads to premature death. The interventions mentioned above should thus be assumed to have an impact nationally. Developments in the years to come will show whether or not the positive trend continues.

Most of the drug-related deaths are caused by poisonings, whereas the other deaths occur as a result of violence, accidents, suicide and diseases. Annual analyses show that on average, between 3 and 4 different substances are found in the deceased's blood on each drug-related death, which documents a prevalent polydrug use among those who die.

Finally, the consequences of drug abuse are also detected in the statistics on drug abusers admitted to treatment. The most recent figures from 2011 show that almost 16,000 are being treated for drug abuse in Denmark. This is the highest figure recorded since registration started. Data from all the years show that the young generation in particular accounts for those receiving treatment, and their drug use problem is typically cannabis and/or psychostimulants. In 2011, almost 4 out of 5 (79.5%) of the young population between the age of 18 and 24 in treatment took cannabis as their primary drug, whereas 9% and 4% of the young people in treatment used amphetamine and cocaine, respectively, as their primary drug. In addition to the increasing use of the illicit drugs up through the 90s, it must be assumed that the increased treatment capacity, treatment guarantees and the improved and more targeted treatment programs have contributed to the documented increase in drug abuse treatment.

The number of drug abusers in Denmark is currently estimated to be 33,000, out of which figure 11,000 are estimated to be cannabis abusers. This estimate has been made by the Danish Health and Medicines Authority in 2010. This is an increase in the number of drug abusers in Denmark compared to previous years. In 2006, the number of drug abusers was estimated to 27,000, out of which 7,000 were cannabis users only. The increase in the estimated number of drug abusers is thus characterized by an increase in the number of cannabis abusers from 7000 in 2006 to 11,000 in 2010. These figures do not include experimental drug use, but estimates the number of persons who are more permanent users of drugs leading to physical, mental and/or social injuries. Drug addicts are thus included in the estimate, including drug addicts receiving drug substitution therapy. At present, 13000 drug abusers are estimated to inject the drugs. Injecting drug users are particularly at risk of developing severe injuries and diseases and eventually of dying.

The Danish Health and Medicines Authority is currently preparing new estimates on the number of drug abusers in Denmark. This new estimate is planned to be completed in the autumn of 2013 and will be published separately.

New developments within prevention, treatment and harm reducing initiatives

In recent years, several prevention, treatment-related and harm reducing initiatives have been launched in Denmark, on a local as well as a governmental level. The purpose of these initiatives is to curb the developments within drug use and limit the ensuing damage.

The Danish Health and Medicines Authority has had a survey made on the municipalities' work with prevention of alcohol and drug use. It shows that all municipalities are engaged in activities and that this work is carried out together with the schools and police (known as the SSP collaboration). Furthermore, many municipalities work together with institutions within youth education and party settings where the young people move. The primary target group for the local work is children and young people in Primary school; the secondary target group is children and young people with a risky attitude.

The Danish Health and Medicines Authority administers the social reserve fund project known as "Unge, alkohol og stoffer" (Young people, alcohol and drugs), including selective and universal prevention interventions within youth education. The project is running in 6 model municipalities. The model municipalities and the youth education institutions, with which they have entered into collaboration, are in the process of preparing drug and alcohol policies for the schools and are developing and implementing methods for early detection of young people with problem drug use in the youth education institutions.

Furthermore, the National Board of Social Services is heading a project of outreach interventions to young people with drug and alcohol problems at the business colleges and production schools in 6 selected municipalities. The aim is, among others, to enhance the target group's possibilities for acquiring an education.

The National Board of Social Services has also developed the net-based programs for young 15-24-year-olds at risk of developing treatment-requiring abuse. This has been done on the basis of 2 evaluations of previous programs (netstof.dk and SMASH). The evaluations showed that the net-based programs reached a group of young people who were experimenting with cannabis and other drugs and who traditionally are diffi-

cult to reach.

The Danish Health and Medicines Authority's preventive work still includes focus on party settings as a risk arena. Examples of such projects include "Ansvarlig udskænkning" (Serving drinks responsibly), media campaigns where the organisation Dansk Live takes a stance on the attitude towards drugs, the so-called *Against Drugs* campaigns and *Unge og Alkohol* campaigns at festivals and music halls.

The social reserve fund agreements over recent years have substituted a number of treatment and harm reducing programs. In order to qualify drug treatment, the Danish Health and Medicines Authority prepared at the end of 2012 guidelines to medical professionals on the treatment of acute drug and alcohol poisonings as well as guidelines for the treatment of abuse of cocaine and other psychostimulants. In addition to this, separate funds have been reserved for Naloxone to be accessible as a user-administered antidote in Copenhagen, Aarhus, Odense and Glostrup and a legal base has been made for establishing and running local drug consumption rooms which have been up and running in Copenhagen since the autumn of 2012, in Odense since the spring of 2013, and now underway in Aarhus.

New drugs and new legislation

The Danish Health and Medicines Authority and the National Police monitor abuse drugs on the illicit market together with the three institutes of forensic chemistry in Denmark. This monitoring process results in the detection of a number of new abuse drugs in Denmark which either as part of the group prohibition or recommendation from the Danish Health and Medicines Authority already are or will be subject to control in accordance with the act on psychoactive substances.

Since the publication of last year's report on the drug situation in Denmark, the following drugs have been made subject to control on the recommendation of the Danish Health and Medicines Authority: As of 1 February 2013, the drugs *AM-2233* and *ethylphenidate* shall only be used for medical and scientific purposes. As of 16 February 2013, the drug *etizolam* shall only be used for medical and scientific purposes. As of 9 March 2013, the drugs *6-APB* and the isomers *4-* and *5-APB* as well as *UR-14* shall only be used for medical and scientific purposes. Finally, as of 5 April 2013, the drugs *apinaca* and *5FUR* shall only be used for medical and scientific purposes.

As of 1 July 2012, Denmark added prohibition of whole groups of generic drugs (generic system) to the ban on individual drugs. This resulted in the emergence of a number of new drugs in Denmark that have already been included in the ban. As of 1 July 2013 and until 1 September 2013, the following drugs appeared on the list; *2C-C*, *α-PVP*, *MDPBP*, *Pentdrone*, *Methedrone*, *JWH-081*, *MAM-2201* and *4-chloramfetamine*.

1 Drug policy; legislation strategies and economic analysis

The government's policy is that all citizens should be an active part of society. Nobody should be excluded. According to the government, the most vulnerable groups deserve special attention, and the individual must be met with respect, demands, and care. The government wishes to put an end to the on-going marginalisation, expulsion and unworthy conditions of life, and it is its ambition to bring down the high mortality rates among drug abusers in Copenhagen as well as to reduce the injuries, problems and nuisance resulting from drug abuse in the streets.

Within the drug abuse area, the government has a dedicated goal that in 2020, significant changes must have been made within drug abuse treatment and drug-related deaths. In 2012, at least half of the drug abusers terminating the treatment program for their drug abuse must either be clean or experience having reduced their abuse, and by 2020, the number of drug-related deaths must be reduced and maintained at a level of no more than 200.

Drug use is a complex issue. Drug use programmes thus involve many different institutions across professional and sectoral boundaries. It is a task that needs to be solved in collaboration with the local and regional authorities, the governmental authorities within health care, social services, and the judiciary as well as the governmental customs authorities.

The Ministry of Health and Prevention coordinates government intervention and is responsible for the primary legal basis, ie legislation on psychoactive substances, including the ban against new synthetic drugs. The Ministry is also responsible for controlling the legal use of drugs for medical and scientific purposes. In addition, it oversees the government's tasks associated with preventive intervention, including medical treatment of drug users.

Within prevention, the government core tasks are handled by the Danish Health and Medicines Authority, which also monitors and makes sure that the new trends and drug problems are identified and communicated widely. The municipalities are responsible for preventive intervention, whereas the Danish Health and Medicines Authority is responsible for contributing to the development of new methods which are communicated locally in combination with counselling and guidance.

The Danish Health and Medicines Authority is also responsible for the government tasks in relation to the medical focus on treatment of drug users. The Authority is responsible for setting out the professional guidelines for medical treatment to be implemented by the municipalities. The Authority should also monitor treatment intervention as well as follow up on the municipalities in this respect.

Also, the Danish Health and Medicines Authority is responsible for the overall drug monitoring, for the preparation of surveys and analyses of drug use in the population and the drug market, for collecting data and qualifying the data on an on-going basis, and ultimately to act as the national focal point for the European Monitoring Center for Drugs and Drug Addiction (EMCDDA).

Finally, the Danish Health and Medicines Authority administers the rules on the legal use of psychoactive substances. The Authority issues authorisations to companies asking to handle psychoactive substances for scientific or medical purposes and performs

control on these drugs through inspections. The Authority issues certificates for the transport of psychoactive substances across borders and is responsible for reporting to the International Narcotics Control Board (INCB) in accordance with the conventions of 1961 and 1971 on narcotic and psychotropic substances.

The Ministry of Social Affairs, Children, and Integration has the central responsibility for the tasks concerning the social drug abuse treatment and the remaining social support within areas such as housing, education, jobs, residential assistance, etc.

The Ministry of Justice is responsible for the overall justice system, including the police, and for the prosecution of the persons committing drug-related crime as well as dealing with the imprisoned drug users.

The Ministry of Tax is responsible for customs control and for the control with precursors, ie chemicals used for the production of drugs.

The Ministry of Foreign Affairs is responsible for the overall policy associated with foreign affairs, safety and aid, including the policy aiming at assisting the drug-producing countries and transit countries in their efforts to reduce supply and demand of drugs.

The municipalities are responsible for the actual preventive intervention, for the medical and social treatment of drug abusers and for the social support. The municipalities, which also play a crucial role within the drugs area, are assisted by the central authorities in such matters as monitoring, overall guidelines, documentation, knowledge sharing, etc.

The distribution of responsibility on a central level requires coordination. In its role as coordinator, the Ministry of Health and Prevention has a special obligation towards the intervention made across the ministerial areas of responsibility. This Ministry regularly assesses the overall drugs policy, including the need for adjustment. This also includes the need for interdisciplinary initiatives as a response to current and future challenges. The Ministry also oversees the necessary follow-up on the implementation of cross-sectoral initiatives.

New legal framework, including new drugs under control

In 2013, no new laws have been passed within drug control.

Since the completion of last year's report on the drug situation in Denmark, the following substances have been made subject to control:

In executive order no. 99 of 30 January 2013 on the amendment of executive order on psychoactive substances it was set out that the drugs *AM-2233* ((2-iodophenyl)[1-((1-methylpiperidine-2-yl)methyl)-1H-indol-3-yl]methanone) og *ethylphenidate* (ethyl[[2-phenyl-2-(piperidine-2-yl)]acetate]) shall only be used for medical and scientific purposes. The executive order came into effect on 1 February 2013.

In executive order no. 146 of 13 February 2013 on the amendment of executive order on psychoactive substances, it was set out that the drugs *etizolam* (4-(2-chlorophenyl)-2-ethyl-9-methyl-6H-thieno[3,2-f][1,2,4]triazolo[4,3-a][1,4]diazepine) shall only be used for medical and scientific purposes. The executive order came into effect on 16 February 2013.

In executive order no. 230 of 6 March 2013 on the amendment of executive order on psychoactive substances it was set out that the drugs *6-APB* and isomers *4-* and *5-*

APB (1-(1-benzofurane-6-yl)propane-2-amine and "4-yl" and "5-yl" isomers) and UR-144 ((1-pentyl-1H-indol-3-yl)(2,2,3,3-tetramethylcyclopropyl)methanone) shall only be used for medicinal and scientific purposes. The executive order came into force on 9 March 2013.

In executive order no. 348 of 3 April 2013 on the amendment of executive order on psychoactive substances it was set out that the drugs *apinaca* (N-(1-adamantyl)-1-pentyl-1H-indazol-3-carboxamide) and 5FUR-144 ([1-(5-fluoropentyl)-1H-indol-3-yl](2,2,3,3-tetramethylcyclopropyl)methanone) shall only be used for medical and scientific purposes. The executive order came into force on 5 April 2013.

1.1 Budget and funding schemes

In order to enhance drug abuse interventions, a broad majority in the Danish Parliament (Folketinget) signed the social reserve fund agreement for 2004. This agreement included the reservation of DKK145million over the years from 2004 to 2007 for named initiatives to combat drug abuse. In order to qualify interventions even further, a majority of the parties in the Folketinget signed the social reserve fund agreement of 2006. This agreement included the reservation of DKK 250bn for specific drug combat projects to run during the years from 2006 to 2009. In order to enhance treatment intervention even further, the social reserve fund agreements for 2008 and 2009 set aside DKK122million for the initiation of new dedicated initiatives with another DKK71.9million being reserved in the social funds for 2011. Financing of most of the initiatives included in the agreements is permanent, meaning that the initiatives stretch beyond the agreement period.

Further information on the Budget over the years and the social reserve funds have been described in detail in previous years' reports.

The Ministry of Social Affairs, Children & Integration's Drug Reserve has set aside DKK103million from 2013-2018 to a drug abuse package containing 10 specific initiatives targeted at social treatment of drug abuse. The overall aim of the package is to contribute to enhance the quality of the social treatment of drug abuse via use of know-how and methods that have a documented effect on the citizens. The aim is also to ensure focus on comprehensive social efforts and follow-up on the individual citizen.

The municipalities' expenses on prevention of drug abuse and the medical drug abuse treatment cannot be retrieved specifically from the municipal accounts and budgets.

As for local government expenditure, the accounts and budgets show a heavy increase since 1995 in the funds reserved for social treatment of drug abusers. Thus the 2012 accounts showed an amount of DKK877million (2013 price and wage level), whereas the same accounts for 1995 were DKK277million (2013 price and wage level). The trend from 2011 to 2012 shows a minor increase of 1 per cent from DKK865million in 2011 (2013 price and wage level) to DKK877million in 2012 (2013 price and wage level).

As for treatment of drug abusers in the prisons, there has been a significant upward trend. Budgets for 2001 were thus DKK6.2million, whereas the same budget figures in 2012 were DK98.9million.

It has not been possible to indicate a separate amount for control intervention within the drug abuse area.

2 Drug use in special environments and among special groups

2.1 Introduction

The phenomenon of trying drugs is typically one associated with young people, and most of them stop at some point. Population surveys show that the experimental use of drugs reaches its peak among the 16-19-year-olds, and very few people try drugs for the first time after the age of 20. Among those at the age of 40 years and above, only a small percentage has tried any kind of drugs within the past year. By and large, it is the same group of young people who expose themselves to different kinds of risky behaviour. Studies document that often the same young people make up the group of heavy drinkers, daily users of tobacco and cannabis users. Also, there appears to be a significant correlation between having used cannabis and having used one or several illicit drugs.

Results of the surveys of recent years indicate that the experimental use of cannabis and other illicit drugs in Denmark is high. From 2000 and until today, however, there appears to be a drop in the prevalence of the illicit drugs, except from cannabis. The prevalence of cannabis was stable from 2000 to 2010, when it starts to rise. Results from a new population survey made in 2013 show that less than half (46%) of the young adults under 35 years of age have experimented with cannabis ever, and 14% within the same age group have tried illicit drugs other than cannabis ever. Among the adolescents under the age of 25 years, 42% have experimented with cannabis ever, and 9% have tried illicit drugs other than cannabis ever. When considering the prevalence of the drugs individually, there appears to be a falling trend in the current use of the psychostimulants amphetamine and ecstasy, whereas the use of cocaine has stabilized. This positive trend is particularly seen in the group of young people under the age of 25 years.

In 2011, a follow-up of the ESPAD-survey from previous years was made. It describes the development in the experimental use of drugs and alcohol - including the illicit drugs among the 15-16-year-olds. The results from the survey in 2011 show the same trend as that of the population survey among adults - a positive falling trend these years in the experimental use of illicit drugs.

In 2010, the first night club survey was made in Denmark (Järvinen 2010). The night club survey is part of a research project referred to as YODA¹. The main results from the survey on drugs in the night life are described later in this chapter.

The surveys mentioned above, including specific data, are listed at the end of this report.

2.2 Use of illicit drugs in the population

The results provided here are based on national population surveys of the self-reported use of illicit drugs from 1994, 2000, 2005, 2008, 2010, and 2013. All the surveys were carried out by the State Institute for Public Health, the University of Southern Denmark.

¹ YODA is the acronym for Youth, Drugs and Alcohol and is a survey of attitudes towards and experience with illicit drugs among the youth population and young adults in the population in general and in the nightclub environment specifically.

The analyses on the prevalence of drugs are based on a population aged between 16 and 44 years. In persons more than 44 years of age, use of illicit drugs is limited, and the 44-year-olds are therefore not included.

Prevalence of cannabis

The results from the population surveys show increases in the experimental use of cannabis up until 2000, following which it is relatively stable up until 2010. From 2010 and until 2013, there is a small, however statistically significant increase in the proportion of individuals reporting having used cannabis within the past year, cf. table 2.2.1.

The proportion of the 16-44-year-olds reported having used cannabis within the previous month is more or less constant during the period from 2000 to 2013. However, also in this case there is a slightly increasing trend from 2010 to 2013. The current use of cannabis is highest in the young age groups, both in men and women, (16-24 years) and then gradually tapers off by increasing age (cf table 2.2.2 of the annex).

Table 2.2.1. Percentage of the 16-44-year-olds who have used cannabis during the previous month, last year and ever in the year in question

Cannabis used	1994 (n=2.521)	2000 (n=6.878)	2005 (n=4.440)	2008 (n=2.219)	2010 (n=5.748)	2013 (n=5.013)
Previous month	2.4	4.3	4.0	3.5	3.5	4.6
Last year (including last month)	7.4	9.8	8.4	9.1	8.9	12.2
Ever (including last year)	37.2	42.4	46.1	45.1	41.5	44.2

Source: Unpublished figures from the Danish Health and Medicines Authority based on SUSY 1994, SUSY 2000, SUSY 2005, AiD in 2008 and SUSY 2010 and 2013

Prevalence of other illicit drugs

When considering the other illicit drugs as a whole, there appears to be an increasing experimental use among the 16-44-year-olds from 1994 to 2000. This trend is then replaced by stagnation from 2000 until today. More than 2% of the 16-44-year-olds report in 2013 being current users of illicit drugs other than cannabis (used within the past year).

Table 2.2.3. Percentage of the 16-44-year-olds who have used one of several illicit drugs other than cannabis the previous month, the past year and ever in the year in question.

Used one or several of the illicit drugs other than cannabis	1994 (n=2.521)	2000 (n=6.878)	2005 (n=4.440)	2008 (n=2.219)	2010 (n=5.704)	2013 (n=4.905)
Previous month	0.2	1.2	1.1	1.1	0.9	1.0
Last year (including last month)	0.5	3.4	2.7	3.6	2.4	2.6
Ever	4.4	11.3	13.5	13.4	12.5	13.6

Unpublished figures from the Danish Health and Medicines Authority based on SUSY 1994, SUSY 2000, SUSY 2005, AiD 2008, SUSY 2010 and SUSY 2013

The prevalence of the various drugs used among the 16-44-year-olds in 2013 appears in Table 2.2.3.1 of the annex.

Prevalence of illicit drugs among young adults

The tables below show the prevalence of the illicit drugs among the "young adults" (adults under the age of 35 years). This age group accounts for the highest prevalence of illicit drugs, especially among the young people under 25 years.

Table 2.2.4. Percentage of the 16-34-year-olds have used cannabis the previous month, last year and ever in the year in question.

Cannabis used	1994 (n=1.639)	2000 (n=4.098)	2005 (n=2.502)	2008 (n=1.718)	2010 (n=3.323)	2013 (n=3.073)
Previous month	2.7	5.7	5.9	4.8	5.1	6.4
Last year (including last month)	9.3	13.3	12.5	13.3	13.5	17.6
Ever (including last year)	38.0	45.1	49.5	48.0	44.5	45.9

Source: Unpublished figures from the Danish Health and Medicines Authority based on SUSY 1994, SUSY 2000, SUSY 2005, AiD 2008, SUSY 2010 and SUSY 2013

Table 2.2.5. Percentage of the 16-34-year-olds who have used one or several illicit drugs other than cannabis the previous month, the last year, and ever in the year in question.

Used one or several illicit drugs other than cannabis	1994 (n=1.648)	2000 (n=4.019)	2005 (n=2.470)	2008 (n=1.710)	2010 (n=3.287)	2013 (n=3.011)
Previous month	0.1	1.8	1.5	1.4	1.3	1.3
Last year (including last month)	0.6	5.0	4.0	4.9	3.4	3.6
Ever	4.2	13.3	16.4	16.0	14.4	14.4

Source: Unpublished figures from the Danish Health and Medicines Authority based on SUSY 1994, SUSY 2000, SUSY 2005, AiD 2008, SUSY 2010 and SUSY 2013

As table 2.2.4 shows, almost half (46%) of the young adults in 2013 have tried cannabis ever, and 18% are current users – ie report having used cannabis within the past year. This is an increase in the prevalence of cannabis compared to 2010, when 14% reported current use of cannabis. As for prevalence of illicit drugs other than cannabis, this is on the same level in 2010 and in 2013, with 14% of the young adults having used these types of drugs and 4% being current users (table 2.2.5).

The current use of drugs among the 16-24-year-olds (table 2.2.6 and 2.2.7 below) is higher than among the 25-34-year-olds. The trend towards an increase in the prevalence of cannabis and the stagnation in the use of other illicit drugs is also seen among the young people under the age of 25. In 2013, 24% of the young population under 25 years report being current users of cannabis (report having used cannabis within the past year), which is an increase compared to 2010, when 19% reported being current users. A total of 4% of the young people under 25 years report in 2013 being current users of illicit drugs other than cannabis, which is the same level as in 2010.

Table 2.2.6. Percentage of the 16-24-year-olds who have used cannabis the previous month, last year and ever in the year in question.

Cannabis used	1994 (n=735)	2000 (n=1.728)	2005 (n= 919)	2008 (n=862)	2010 (n=1.643)	2013 (n=1.652)
Previous month	3.7	7.8	8.2	8.1	7.1	8.5
Last year (including last month)	12.9	20.1	20.5	21.3	18.9	23.9
Ever	34.7	41.5	44.2	41.1	38.0	41.5

Source: Unpublished figures from the Danish Health and Medicines Authority based on SUSY 1994, SUSY 2000, SUSY 2005, AiD 2008, SUSY 2010 and SUSY 2013

Table 2.2.7. Percentage of the 16-24-year-olds who have used illicit drugs other than cannabis previous month, last year and ever in the year in question.

Used one or several of the illicit drugs other than cannabis	1994 (n=740)	2000 (n=1.690)	2005 (n=900)	2008 (n=858)	2010 (n=1.619)	2013 (n=1.619)
Previous month	0.0	3.0	2.0	2.3	1.7	1.6
Last year (including last month)	0.7	8.0	5.3	8.0	4.3	3.9
Ever	3.0	14.5	14.2	15.2	10.6	9.1

Source: Unpublished figures from the Danish Health and Medicines Authority based on SUSY 1994, SUSY 2000, SUSY 2005, AiD 2008, SUSY 2010 and SUSY 2013

When considering the drugs individually, amphetamine, cocaine and ecstasy are the second most prevalent drugs after cannabis. As it appears in table 2.2.8 and 2.2.9 below, the proportion of the current use (drug used within the past year) of amphetamine as well as ecstasy among the "young adults" dropped from 2000 to 2013, whereas the current use of cocaine is stable throughout the period. The drop in current use of amphetamine is statistically significant among the 16-24-year-olds only. The young men account for a much larger share than the young women when it comes to current use of amphetamine, cocaine and ecstasy.

As something new in the survey from 2013, questions on the prevalence of ketamine and GHB have been included. In former surveys, the results on the prevalence of these drugs fell under the joint category "other". As it appears in table 2.2.10 of the annex, 0.5% of the young people under 25 years report being current users of ketamine (used within the past year), whereas the rate for GHB is as low as 0.1% and hardly measurable.

Table 2.2.8. The proportion in percentage of the 16-34-year-olds with a current use of amphetamine, cocaine and ecstasy in the year in question.

16 – 34 yrs	SUSY 2000 (n=3.980)			SUSY 2005 (n=2.456)			AiD 2008 (n=1.709)			SUSY 2010 (n=3.260)			SUSY 2013 (n=2.982)		
	men	women	Total	men	women	Total	men	women	Total	men	women	Total	men	women	Total
Amphetamine tried within the past year	5.3	1.4	3.2	3.4	1.2	2.2	5.3	1.4	3.1	3.6	0.9	2.0	2.2	0.8	1.4
Cocaine tried within the past year	3.4	1.0	2.1	5.4	1.0	2.9	5.8	1.5	3.4	4.7	0.8	2.5	3.6	1.3	2.4
Ecstasy tried within the past year	1.7	0.8	1.2	1.8	0.2	0.9	1.9	0.6	1.1	1.3	0.4	0.8	1.2	0.3	0.7

Source: Unpublished figures from the Danish Health and Medicines Authority based on SUSY 2000, SUSY 2005, AiD 2008, SUSY 2010 and SUSY 2013

Table 2.2.9. The proportion in percentage of the 16-24-year-olds with a current use of amphetamine, cocaine and ecstasy in the year in question.

16-24 yrs	SUSY 2000 (n=1.684)			SUSY 2005 (n=894)			AiD 2008 (n=857)			SUSY 2010 (n=1.612)			SUSY 2013 (n=1.608)		
	men	women	Total	men	women	Total	men	women	Total	men	women	Total	men	women	Total
Amphetamine tried within the past year	9.0	3.1	5.9	6.5	2.4	4.1	9.8	2.1	5.4	4.9	1.2	2.8	2.4	0.9	1.6
Cocaine tried within the past year	4.6	1.3	2.8	5.4	1.9	3.3	9.8	2.4	5.6	5.3	1.1	2.9	3.6	1.3	2.3
Ecstasy tried within the past year	3.3	1.5	2.3	3.1	0.4	1.5	4.0	1.0	2.3	1.7	0.6	1.1	1.6	0.6	1.0

Source: Unpublished figures from the Danish Health and Medicines Authority based on SUSY 2000, SUSY 2005, AiD 2008, SUSY 2010 and SUSY 2013.

All in all, there appears to be a tendency towards a decline in the use of the illicit drugs from 2000 and up until today. The most significant percentage drop among the 16-24-year-olds is seen in the current use of amphetamine (cf table 2.2.10 of the annex). Also, there is a significant drop in the current use of ecstasy and psilocybin mushrooms during this period. The proportion of the 16-24-year-olds reporting current use of cocaine is more or less constant throughout the period from 2000 to 2013. The prevalence of the various illicit drugs (previous month, last year and ever) appears in table 2.2.11 of the annex.

Frequency in the use of illicit drugs

In the SUSY survey in 2010, those who were currently using cannabis or other illicit drugs within the previous month were asked how many times they had taken drugs. There was a total of 8.5% among the 16-24 year-olds who had used cannabis during

the previous month. A total of 82% of these used the drug 1-3 times. The remainder took drugs more frequently (9% used drugs 4-9 times and 9% more than 10 times during the previous month). When it comes to indications of how frequently drugs are used, the figures are very small, for which reason the accuracy of these results is uncertain.

Regional differences in the use of illicit drugs

In SUSY 2013, regional benchmarking has been made on the prevalence of the illicit drugs. The results indicate that the use of cannabis is the highest in the Copenhagen region. Among the young people under the age of 25 years in the Copenhagen region, it turns out that 10 - 15 percentage points more of these young people have tried cannabis ever compared those within the same age group in the other regions. As regards drugs other than cannabis, prevalence is more even from a geographical perspective.

Starting age

Analyses of the experimental use of illicit drugs confirm that almost everybody using illicit drugs have started their drug use before the age of 20 (SUSY 2005). The so-called MULD 2008 survey (MULD 2009) indicated that around 50% of the boys and girls who have tried cannabis have tried the drug when they were 15-16 years. The starting age related to psychoactive substances other than cannabis is typically slightly later in life, but still when the young people are in their teens.

2.3 Drug use in the school and youth population

On-going surveys have been made on the experimental use of illicit drugs among the very young. The ESPAD surveys conducted in 1995, 1999, 2003, 2007 and in 2011 show an increase in the experimental use of cannabis and other illicit drugs among the 15-16-year-olds from 1995 to 1999. From this period, the experimental use stabilizes from 2007, however with minor, but significant increases in the experimental use of cannabis, ecstasy and cocaine from 2003 and onwards. From 2007 to 2011 there is a significant drop in the experimental use of the illicit drugs among the young people aged 15-16 years. For most of these drugs, this decrease is significant.

As shown in table 2.3.1 below, a little less than 1/5 of the 15-16-year-olds have tried cannabis ever, and approximately 6% has tried cannabis within the previous month. This reflects a decrease in the experimental use of cannabis among the very young Danish school children from 2007 until today, however the level is still high. As regards amphetamine, the drug has been tried by slightly less than 3%, whereas cocaine and ecstasy have been tried by approximately 2% of the young school children in 2011. This is a 50% decrease in the experimental use of these drugs from 2007 to 2011, and this drop is significant.

The gender differences still apply in the experimental use of illicit drugs among the 15-16-year-olds and in general, more boys than girls have tried the different drugs. Only LSD, ecstasy, and sniffing have been tried by almost as many girls as boys.

Table 2.3.1. The proportion in percentage among the 15-16-year-olds who have tried illicit drugs in 1995, 1999, 2002, 2003, 2007 and 2011

	ESPAD 1995 (n=2234)	ESPAD 1999 (n=1548)	HBSC 2002 (n=1418)	ESPAD 2003 (n=2519)	ESPAD 2007 (n=881)	ESPAD 2011 (n=2.190)
Cannabis tried ever	18.0	24.4	23.3	22.6	25.5	18.1***
Cannabis tried previous month	6.1	8.1	-	7.6	10.6*	6.2***
Amphetamine tried ever	1.6	4.0	-	4.0	5.0	2.5***
Cocaine tried ever	0.3	1.1	-	1.8	3.2*	1.9***
Heroin (injection) tried ever	0.2	0.1	-	0.7	0.5	.
Smokeable heroin tried ever	1.5	1.3	-	1.0	-	.
Ecstasy tried ever	0.5	3.1	2.4	2.5	5.2*	1.5***
LSD tried ever	0.2	1.0	-	1.1	1.1	0.7
Psilocybin mushrooms tried ever	0.5	1.8	-	1.5	1.1	0.7
Sniffing tried	6.3	7.5	-	8.3	6.1**	3.9***

Sources: ESPAD 1995 (1997); ESPAD 1999 (2000); HBSC 2002; ESPAD 2003 (2004); ESPAD 2007 (2009); ESPAD 2011 (2012)

*The increase from 2003 to 2007 is small, however significant

**The decrease from 2003 to 2007 is small, however significant

*** The drop from 2007 to 2011 is statistically significant

Compared to 2007, the figures from 2011 originate from a major random sampling. However, approximately half of the selected schools declined participation. The response rate in the participating classes, however, matched that of previous years of approximately 90%.

2.4 Drug use in special environments and among special groups

This section outlines the results from a new survey on the use of illicit drugs in the nightclub environment in Denmark, a study in risk behaviour, and the use of khat among the Somali population in Denmark.

Experience with illicit drugs in nightclubs

For the first time, a nightlife survey was conducted in 2010 (Järvinen 2010). The survey was initiated by scientists from the Centre for Alcohol and Drug Research at the Aarhus University and the SFI - the National Research Centre for Welfare, and is based on qualitative as well as quantitative survey methodology. The focus of the survey was to produce knowledge on the young people's experience with, attitudes towards and risk assessment of the drugs.

The nightclub survey showed that 40% of the young club guests (at an average age of 21 years) reported that at some point in their lives, they had tried an illicit drug other than cannabis (typically cocaine, amphetamine and/or ecstasy). 58% of the guests have at some time in their life tried cannabis. The survey points out that a key cause of the higher prevalence of drugs among club guests than among the population in general - particularly in relation to the use of drugs other than cannabis - is that this category of young people are particularly oriented towards a lifestyle which includes frequent parties and an inherently high intake of drugs.

The survey also shows that in addition to the most prevalent drugs - amphetamine, cocaine and to some extent ecstasy - a large part of the night club guests also have ex-

perience in the use of the less prevalent and less known illicit drugs, such as ketamine, GBH (fantasy), mushrooms and/or LSD. Approximately 10% of the club guests have all tried this drug, which again confirms a riskier party culture among these young people than among the other young people.

Polydrug use prevails in the nightlife. The survey states that 91% of the young people who had tried cocaine had also tried other illicit drugs. The general idea that cocaine is a drug used in higher circles and associated with high status is overthrown in the survey which points out that the "exclusive" cocaine user - ie, one who uses cocaine exclusively and who does not experiment with other drugs - is almost non-existing. The survey also maintains that cocaine use is often combined with a very large intake of alcohol. According to the young people, cocaine is often used to prolong and intensify the alcohol rush and the "cocktail" of alcohol-cocaine represent the ultimate party rush in the clubs.

Attitudes and risk assessment among the young people in Denmark

Another focus point of "drugs and night life" was the Danish young people's knowledge of drugs and their risk assessment of various types of drugs. The results are not based on the actual night life survey, but on focus group interviews among the pupils in business colleges and high schools, of which some have tried cannabis, whereas the majority of them have limited experience in drug use. This reflects the situation among young people in Denmark. Due to their lacking experience in drugs, they build their knowledge and perceptions of various drugs on the experience and perceptions of their friends. These perceptions - known as discourse - are interesting, as often they are crucial to the young people's willingness to experiment with a drug. The survey demonstrated that cannabis to a large extent is perceived as a harmless drug, because it is associated with normality and because smoking a joint is not as deterring as injecting or sniffing a drug. Ecstasy, on the other hand, is a drug considered to be very dangerous, because according to the young people, nobody knows what a pill contains, and because the use of ecstasy is associated with abnormality and uncertainty. Finally, cocaine is described later in the survey as a drug placed in a mid-position between dangerous and harmless. On the one hand, the young people perceive it is harmless, one of the reasons being that it is typically sniffed, and because it is associated with addiction. On the other, the drug is perceived as one without any impact on one's life as a whole and that it may even be "performance enhancing".

These risk perceptions are crucial to the inexperienced young people's willingness to experiment with drugs, and the duality of the attitude towards cocaine means that an increasing number of young people might just be willing to experiment with it.

Alcohol and the party culture's influence on drug use

The "Drugs and Night Life" project also included a survey based on a representative selection of 3000 Danish young people aged between 17 and 19 years. The results of this survey showed - as in other surveys - that there is a strong link between high alcohol consumption and experience with cannabis and other illicit drugs. 63% of the young people who are binge drinkers every weekend (drinking more than 5 glasses per event within the past 30 days) have also tried to smoke cannabis. In comparison, 20% of the young people who have drunk less than 5 drinks per event within the past 30 days had tried cannabis. When it comes to drugs other than cannabis, 27% of the young binge drinkers report that they have tried one or several of the other illicit drugs. In comparison, "only" 7% of those who have not been on a binge-drinking spree have tried an illicit drug other than cannabis. In summary: the so-called *drug and alcohol focused young*

people have, to a large extent, experience in illicit drugs.

Various socio-economic factors, such as the parents' educational background, the parents' drinking habits and the young people's educational level influence the extent of their consumption of alcohol and their experience with illicit drugs. For instance, the parents' weekend alcohol consumption has an influence on the young people's alcohol consumption and their experience with illicit drugs. The parents of young people using drugs have lower educations, whereas the parents of young people with high alcohol consumption have a higher educational level.

3 Prevention

3.1 Introduction

Targeted and persistent intervention is one of the basic elements in Danish drug policy when it comes to preventing and acting quickly on emerging abuse. Young people and their parents are the key target groups, and it is important that intervention is focused and, apart from sharing knowledge, also addresses the young people's norms and behaviour.

The Danish approach to prevention against drug abuse is based on the principle that health is influenced by a variety of factors, such as employment, education, social conditions, etc. Therefore, it is necessary to work across the various sectors when addressing drug prevention intervention. For instance, interventions involving the retention of young people in an educational program could be instrumental in preventing young people's risk behaviour in connection with drugs - and vice versa. Well-being and mental health are thus important themes of Danish prevention intervention.

One of the focus points in Danish health care policy is to reduce inequality in health care. In 2011, the Health and Medicines Authority published the report "Ulighed i sundhed – årsager og indsatser" [Inequality in health – causes and interventions] (The Health and Medicines Authority 2011a). The report provides special focus areas, which will reduce the differences in the Danes' life expectancy and health. It describes the different factors that are the underlying cause of inequality, for instance the use of alcohol, tobacco and drugs. The report also emphasizes the importance of coordinated and cross sectoral policies to reduce social inequality of health.

In continuation of the report mentioned above, the Health and Medicines Authority published another report in 2011 under the title "Social ulighed i Sundhed – hvad kan kommunen gøre" [Social inequality in Health Care – how the municipality overcomes it] (The Danish Health and Medicines Authority 2011b). It describes what the municipality can do in order to reduce social inequality in health. It also describes the necessity of the municipality acting across responsibilities and tasks. For instance, surveys of the 7th to 9th grade population made by school nurses or doctors can be used to identify imminent detrimental drug and alcohol habits. This way of dealing with inequality in health is consistent with the Health and Medicines Authority's publication titled "Sundhed på tværs" [Health across sectors] from December 2010 (Sundhedsstyrelsen 2010a). It focuses on the collaboration within local governments in terms of health and prevention.

In 2012 and 2013, the Danish Health and Medicines Authority has published a number of *prevention packages* for the municipalities. These packages provide, among others, specific recommendations to which interventions the municipalities should prioritise within various risk factors. For instance, prevention packages have been made on alcohol (The Danish Health and Medicines Authority 2012a), mental health (Sundhedsstyrelsen 2012b), and tobacco (The Danish Health and Medicines Authority 2012c). These prevention packages are a tool for the municipalities to include health into their services, preferably across administrative boundaries as it is expected to contribute to social inequality of health. With the prevention packages and other activities, the Health and Medicines Authority maintains strong focus on inequality of health in society.

The prevention package contains – apart from the focus on prevention of alcoholism - also a number of recommendations related to drugs. The reason is that there is a close correlation between the use of alcohol and (an experimental) use of illicit drugs by young people. As a supplement to this, a prevention package on drugs is expected to be publicized in December 2013.

In addition, the Danish Health and Medicines Authority has earmarked social reserve funds for projects that indirectly may contribute to preventing against drug abuse. For instance, as part of the health care social reserve funds for 2009 and 2010, DKK30million have been set aside for a 4th earmarking of funds, the purpose of which is to boost health care intervention for socially marginalised and vulnerable groups. Out of these funds, 5 municipalities have received means for projects focusing on mental health and well-being among school children. Mental well-being and health enhances learning, increases the chances of completing an education and protects against risk behaviour in the form of abuse, smoking and physical inactivity.

In the spring of 2013, the Government introduced a health program titled "More citizen, less patient". The program focuses on counteracting the growing inequality in the Danes' health condition. It is set out in the government program that the health care system needs a health check in order to identify focus areas and thereby put a stop to inequality.

Distribution of tasks in drug and alcohol prevention

On a state level, the Health and Medicines Authority's mission is, among others, to support the municipalities' prevention intervention by providing informative material of all kinds, by initiating projects with a methodological aim as well as give specific counselling to the municipalities and other stakeholders. The prevention packages mentioned above are an example of such counselling. Furthermore, the Health and Medicines Authority is also committed to overseeing and communicating overall guidelines to the municipalities and their intervention work.

The municipalities have the main responsibility for prevention intervention. The municipalities are in close contact with their citizens, and locally it is possible to organize universal, selective and indicated prevention in schools and through local leisure programs in collaboration with unions, restaurants, bars and discotheques as well as with particularly exposed residential areas.

Study of local prevention intervention within drug abuse

In order to identify local intervention within the area, the Danish Health and Medicines Authority carried out in 2013 a study of the municipalities' prevention intervention within drug abuse (KORA 2013). The study was conducted as an interview survey based on a structured questionnaire submitted to all the municipalities in Denmark. The response rate was 92%.

The study covers a wide range of areas, including how each municipality has organised intervention activities, who they cooperate with, their primary target group the competencies they have, and the competencies they do not have, the municipalities' specific programs and framework as well as the challenges facing them within the themes mentioned above.

The study shows, among other things, that local drug prevention is often carried out across sectors, involving the schools, local social authorities and police (known as the SSP cooperation). Furthermore, many municipalities work closely together with treat-

ment institutions in their preventive work and almost half of the municipalities also cooperate with the party settings.

The primary target group for local prevention intervention is the pupils in Primary school and then children and young people showing risky behaviour. Most activities are carried out in the environments where the young people move, ie Primary schools, youth education institutions and party settings.

The study has also showed that the prevention staff's most frequently applied methods involve "majority misunderstandings", parent involvement, "the talk of worry", and the motivating talk. These sessions often take place with the young person, his/her parents or in connection with teaching in Primary school or in the youth education institutions. Some municipalities state in the questionnaire that they offer programs on open counselling for pupils and, in some cases, also parents in youth education institutions

3.2 Structural issues

In Denmark, the use of illicit drugs is regulated in the executive order on psychoactive substances. The ban against drugs used for purposes other than medical and scientific contributes significantly to drug prevention, as it reduces availability and it sends a strong signal to the young people and other potential users that drugs are dangerous and may cause injury. Also, Denmark has signed the FN conventions that have laid down international regulations on drugs.

All municipalities in Denmark have drug intervention programs. 73% of the municipalities include them as part of the action plans for prevention, either as a separate document or as part of the municipality's children and young persons policy or health care policy. A large majority of the municipalities focus interventions on groups or arenas. 87% of the municipalities provide interventions focusing on Primary schools, and 2/3 of the municipalities collaborate with youth education institutions and/or nightlife settings (KORA 2013).

3.3 Universal prevention

Universal prevention includes interventions targeted at the entire population or segments of it irrespective of risk factors and risk behaviour.

Primary school as an arena

Primary school is an important arena for universal prevention as it provides an opportunity for contact with mostly all children, young people and their parents. The Danish Primary schools Act commits primary schools to teach children a number of subjects, including health, sexual behaviour and living in a family. Under these subjects lay teaching in drugs and alcohol. It is up to each local government or school to decide the details of the subjects taught.

The study of the municipalities' prevention intervention in relation to drug abuse has shown that 1 out of 3 municipalities has a mandatory "package" of prevention activities that all pupils in certain grades should be subjected to. The rest – 2/3 of the municipalities – have one or two programs (eg a prevention counsellor going through a brief or extended course), between which the schools can choose.

Furthermore, the municipalities' prevention workers most places have a formalised and extended collaboration with the teachers in primary school, including annual theme days or drug and alcohol seminars where:

- The teachers' knowledge about drugs and alcohol as well as signs of concern are enhanced
- The teachers are trained in conducting the "worry talks" with the pupils.

The Danish Health and Medicines Authority recommends that the schools teach according to evidence-based principles including methods involving the pupils. For instance, the Health and Medicines Authority recommends the method known as "Tackling" (The Danish Health and Medicines Authority 2009a). This is a method which originated in the US, but which the Authority developed in collaboration with the printing house Alinea and tested in a Danish version. Moreover, other methods involving pupils are described in the Authority's publication "Forebyggelse og sundhedsfremme i skolen" [Prevention and health promotion in school] (Sundhedsstyrelsen 2009b), and "Aktive vurderinger" [Active assessment], and "De bestemmer" [You decide]. The methods can be included in working with the improvement of family relations which is a crucial aspect of prevention against drugs. They can also be used in other preventive areas

In the autumn of 2011, the Danish Health and Medicines Authority issued two pamphlets: "Dit barns festkultur" [Your child's party culture] aiming at parents (The Danish Health and Medicines Authority 2011f) and "Sæt rammer for alkohol, tobak og stoffer" [Determine limits for alcohol, tobacco and drugs] aiming at teachers and management in elementary schools (The Danish Health and Medicines Authority 2011c). Both publications contain facts about drugs and alcohol as well as their effect. They also demythed stories about young people, drugs, alcohol and smoking. The first pamphlet focuses on entering into parent agreements on postponing the drinking age among the young people and avoiding the use of drugs, the second pamphlet provides an outline of the most important elements in substance and smoking policy.

Finally, the Danish Health and Medicines Authority will update and reprint the drug facts pamphlet "Stoffer - hvordan virker de, og hvordan ser de ud" [Drugs - how they affect me, and how they look] at the end of 2013 (The Danish Health and Medicines Authority 2007a). The pamphlet is the overall informative material on the most common illicit drugs. It can also be used by personnel working with drug and alcohol prevention in youth education institutions and in a local prevention context. The drug facts pamphlet is also used as supplementary material to the party setting campaigns ((see chapter 3.4).

Youth education as an arena

The study of the municipalities' prevention intervention in relation to drug abuse shows that 68% of the municipalities cooperate or are in dialogue with youth education institutions in terms of drug prevention.

In some parts of Denmark, collaboration is in a start-up phase, in others it is more firmly rooted with programs such as annual theme days, monthly meetings with contact teachers etc., counselling and ideas for the development of drug and alcohol policies in schools. Also, there are programs involving competence development and consultation with teachers and student counsellors (eg methods for early detection, how to manage the difficult conversation, etc).

In a number of municipalities, intervention at the youth education institutions does not have a narrow focus on drugs and alcohol and the inherent problems, but a wider focus on retention and well-being of pupils. For instance, this applies to Roskilde municipality, where focus on drugs and alcohol and health are part of the youth education strategy to retain the young people in the educational system. The project has four branches: dialogue with the young people, programs involving counselling at the institution, competency training for teachers and student counsellors as well as programs offered to the individual school on inspiration and help to the initiatives that may lead to a health lift for everybody.

The study has shown that the work with drug prevention in youth education institutions is an area in progress. The youth education institutions are typically privately owned institutions, and according to Danish law, they are not obliged to teach in subjects related to health or prevention against abuse. Intervention in the youth education institutions is thus conditional upon mutual interest and willingness. The municipalities state that similar challenges apply in terms of interventions within party settings.

Approximately 30% of the municipalities offer the youth education institutions permanent programs for universal prevention. This may either be in the form of introductory programs or permanent collaboration with the SSP counsellors or abuse counsellors being present at the institutions with open programs for counselling and guidance of the students.

Healthy business colleges

In the summer 2012, the Danish Health and Medicines Authority published an inspiration catalogue to the business colleges and their teachers on how to contribute to setting up a healthy framework in the schools and introduce health in the curricula, including use and abuse of drugs (Danish Health and Medicines Authority 2012d). The inspiration catalogue contains specific examples of how to convey knowledge about drugs to the young people and how to enter into dialogue with them. This kind of action might contribute to tearing down the myths that exist on drugs. One method is a dilemma game where the young people are asked to discuss the various forms of dilemma related to drugs. Also, a rather large number of municipalities offer external teaching where drug abuse counsellors visit the schools and give presentations.

The social reserve fund project: "Young people, alcohol and drugs"

The Danish Health and Medicines Authority is responsible for the administration of the social reserve fund project dedicated to young people, alcohol and drugs, where in December 2011, 6 model municipalities received grants. A total of DKK17million was reserved for the project, which runs until 2014. The aim of the model municipality projects is to test whether enhanced and binding collaboration between the municipality and the youth education institutions can contribute to limiting the prevalence of drugs and alcohol among young people. The model municipalities' intervention is intended to strengthen prevention against alcohol and drugs and contribute to developing methods to promote a drug and alcohol prevention environment at the youth education institutions through the formulation of drug and alcohol policies. All projects are divided into two types of intervention: a universal and a selective one (described in section 3.4)

The universal intervention consists of planning and implementation of drug and alcohol policies at the youth education institutions involved in the projects. The participating model municipalities have been instructed in how to develop and implement such policies at courses offered by the Health and Medicines Authority.

Project status in the autumn of 2013 is that some projects have chosen to draft a joint policy which applies to all the education institutions involved, whereas other projects have chosen for each institution to draft its own policy. The policies vary between having a strict focus on drug and alcohol, whereas others have a more broad focus on well-being and retention of the pupils, with drug and alcohol problems having high priority, but not the only subjects.

A mid-term evaluation of the projects is expected to be completed during the autumn of 2013. The final evaluation is planned to be made at the end of 2014.

Separate publications

In the autumn of 2012, the Danish Health and Medicines Authority published two new pamphlets: 1) "Hjælp din teenager" [Help your teenager] which addresses parents (Danish Health and Medicines Authority 2011d) and 2) "Politik for rusmidler og rygning" [Policies related to drugs, alcohol and smoking] targeted at teachers and leaders of youth education institutions (Danish Health and Medicines Authority 2011e).

3.4 Selective and indicated prevention

As opposed to universal prevention, selective and indicated prevention is targeted at individual persons or groups, in whom the risk of developing a problematic attitude towards alcohol and drugs is high. Selective prevention may also include interventions in special risk situations or special arenas.

Social reserve fund project: "Unge people, alcohol and drugs"

The selective part of the social reserve fund project "Young people, alcohol and drugs" (described in section 3.3 above) consists of early intervention in the form of counselling and guidance to young people heading for problem drug and alcohol use. Staff in all 6 model municipality projects have been trained to deal with the young people and talk to them about drugs and alcohol in an acknowledging and motivating manner. The various programs under the projects are under development. Some of the projects include programs that solely focus on young people with abuse problems, whereas other projects have a more diverse approach on, for instance, well-being, with abuse problems being only a part of the curricula.

Internet-based information and counselling programs for young people

www.netstof.dk is a nationally based service provided to young people seeking information and advice on alcohol, cannabis and other drugs. Netstof.dk has existed since 1998 and from being a small website for the 14-18-year-olds, netstof.dk has now expanded into a comprehensive and interactive youth portal with a problem page and young-young contact. In 2005, the text-based prevention initiative titled SMASH (SMS + HASH) was launched as an anonymous support and counselling project for young cannabis users with the purpose of providing harm reduction, information and support in relation to stopping cannabis smoking. In 2009, SMASH launched a new website and expanded its activities with counselling and support in relation to "faster" drugs such as amphetamine, ecstasy and cocaine as well as an alcohol package.

The SMASH project as well as netstof.dk have been evaluated. Evaluations show, among others, that the two portals reach out to a group of young people who experiment with cannabis and other drugs, but who traditionally are difficult to reach, because they do not see themselves as having a drug problem. Based on the two evaluations, it was decided in 2012 to merge the positive feedback on netstof.dk in one single site. Social reserve funds have been allocated by the Ministry of Social Affairs, Children and

Integration for the retention and further development of a national program on internet-based counselling to young people using Netstof.dk. The primary target group is young people aged from 15-24-years and at risk of developing abuse patterns requiring treatment. The funds have been given for the period 2012-2015. Netstof.dk will

continue to provide debate fora, correspondence columns and information and will also include a chat function.

www.Stofinfo.sst.dk is the Danish Health and Medicines Authority's website providing information about drugs. The site is especially dedicated to young people, but also to teachers who wish to introduce the subject in classes and with the parents who wish to discuss the problem of drugs with their children. In stofinfo.sst.dk it is possible to read facts about different drugs and how they affect the body, statistics on drug abuse in Denmark, case stories told by young people who have been abusers and a link to recommended material addressing parents and schools.

U-turn

U-turn is Copenhagen Municipality's service to young people under the age of 25 years, and it offers a combination of prevention and early detection. This project concentrates on open anonymous counselling and long-term programmes, under which young people can get help for their use of cannabis and other intoxicants. This project provides group as well as individual counselling. Also, counselling is provided to families, friends and boy/girlfriends of young people who wish to cut down on their use of intoxicants as well as to consultants working in schools, social centres and institutions. Experience from the work with the young people is collected on an on-going basis and major efforts are made to convey the findings. This is done via the new website www.ungrus.dk which was launched in 2012. Professionals working with prevention and treatment of drug abuse among young people may seek new information and inspiration from this website. The site also provides information about new courses and projects concerning young people and intoxicants.

During the period 2009-2010, U-turn conducted a study on group therapy of young people in production schools in Copenhagen Municipality. The target group consisted of young people who used cannabis. Evaluation of the project in 2011 showed that the cannabis groups had a positive effect in terms of making the young people stop smoking cannabis and smoking less tobacco. The proportion of young people who were daily smokers was reduced by 87%, and 6 of the 18 young individuals stopped smoking altogether. Furthermore, a large part of the group succeeded in maintaining their education or their job.

Project "Outreach interventions to young people with alcohol and drug problems"

This project tests an adapted version of U-turn's cannabis group model with group programs offered to young people with alcohol and drug problems in business colleges and production schools in 6 selected municipalities. U-turn is a program offered by Copenhagen Municipality to young people under 25 years who smoke cannabis or use drugs. The aim of the project is to help vulnerable young people to finalise their education. The intervention includes short-term group sessions supplemented with individual sessions at the business college or the production school. The target group is young people attending business colleges or production schools and who have shown problem drug use or non-treatment requiring cannabis abuse.

The project is based on the somewhat sad fact that to a large group of young people who are unadjusted in business colleges or production schools, their use of cannabis is so heavy that they encounter problems in functioning on a personal, social and a professional level, which eventually may lead to them dropping out of school prematurely.

In mid-2013 the project municipalities are running the first group sessions. The model will be finally determined at the end of 2013, following which it will be tested in the municipalities until the end of 2015. The effect of the tested model will be documented.

Responsible serving of alcohol

In 2009, the Danish Health and Medicines Authority issued the pamphlet "Ansvarlig udskænkning" [Serving Alcohol Responsibly] (Sundhedsstyrelsen2009c). This pamphlet has a drug as well as an alcohol preventive aim and provides methods to set up a decent framework for serving alcohol responsibly. Focus is particularly directed at nightlife settings, where young people are frequent guests. The aim is a safe nightlife in which the young people are not afraid to move. The means are cooperation, dialogue, common goals and agreements, training and control. The municipality and the police are responsible for issuing licenses and temporary licences, respectively, to serve alcohol in the local community. "Serving alcohol responsibly" is a method to assume this task in cooperation with the various bars and restaurants. This means that alcohol is served responsibly and in line with the other preventive interventions carried out by the municipalities on drugs and alcohol.

The study of the municipalities' work with prevention against drug abuse shows that the municipalities use the experience obtained from "serving alcohol responsibly". Two out of three municipalities work together with night life settings on the basis of the experience gained from the project, including:

- courses for door men and other staff in alcohol and drugs, first aid, conflict management, etc. and
- establishment of a forum for dialogue between the municipality (for instance, license board, SSP), licence holders, police, education institutions and other relevant stakeholders.

The contents of "Ansvarlig udskænkning" were based on experience from projects such as "Trygt natteliv" [Safe night life] and the model municipality project "Narkoen ud af byen" [Drugs out of town] as well as research results from the Swedish STAD-project dealing with responsible serving of alcohol at inns².

3.5 National and local media campaigns

Media campaigns in the form of mass media communication aiming at the entire population or the broad target group are not used in the drugs prevention in Denmark. The reason is that when all is said and done, the use of illicit drugs only exists in a fraction of young people, however receives much attention in the media. Therefore, it is assessed that it is neither necessary nor appropriate to flash the problem further through widespread campaigning, which may lead to creating unintentional "advertising" for drugs and contribute to "majority misunderstandings" among the Danish population.

² www.fhi.se

However, since 2003, the Danish Health and Medicines Authority has been cooperating with the trade organisation Festival danmark (which has now merged with the site spillesteder.dk and become the professional organisation of live music, also known as Dansk Live) on an annual campaign against drugs on the festivals in Denmark running over several days. Since 2009, this cooperation was followed up by a campaign aiming at young people and their use of alcohol. In 2009, this collaboration was expanded to include a similar anti-drug campaign in these musical settings. The party settings have been selected as the central arena, as the studies show that it is in these venues that the risk of the young people experimenting with drugs is high. As an important part of the campaigns, the festivals and music venues have been the organizers of the campaigns. The idea is that as trendsetting players in the young people's party environment, the various organizers would like to have a good and positive message to send to the target group of young people.

Dansk Live Against Drugs

The Danish Health and Medicines Authority cooperates with the organisation of live music, Dansk Live, on a drug preventive "Against Drugs" campaign. In 2012, the campaign was launched at 15 festivals. Primary target group of this collaboration is the young festival participants and in particular the 16-25-year-olds. The festivals have good experience in using the material, which consists of printed and electronic elements. The festivals also have statements on their websites and in their festival newspapers. All elements contribute to signalling a common stance on drugs. In 2011, focus was once again made on the words THINK and CHOOSE, however, with a new campaign layout. In 2012, the campaign changed its slogan and layout to "SPEAK YOUR MIND - NOT SOMEONE ELSE'S". In 2013, the slogan sounds: "DON'T LET OTHERS SPEAK YOUR MIND".

The evaluation of the 2012 (The Danish Health and Medicines Authority 2012e) campaign is based on audience surveys carried out at the Roskilde Festival – which is by far the largest of the 15 festivals – and at three minor festivals, which have been randomly selected among the other festivals. These are the festivals held at Vig, Skive, and Samsø. The four festivals address different target groups and give a varied picture of how the campaign has been received.

At the Roskilde Festival, the evaluation for 2012 showed that 70% had seen the campaign, which is slightly lower than the previous years. On the other hand, more festivalgoers had discussed the message of the campaign with others in 2012 (33%) than in 2011 (29%). 93% of the audience think it is good that the festival has an attitude toward drugs.

The 2012 evaluation from the three smaller festivals showed that only approximately 1/3 of the audience in two out of the three festivals had seen the campaign. This is almost half the number compared to 2011. On the 3rd festival, 65% of the audience had seen the campaign, which was a small increase compared to the year before. At 2 of the festivals, approximately 20% had discussed the message of the campaign with each other, whereas almost 40% had discussed it at the 3rd festival. Between 83% and 90% of the audience thought that it was a good idea that the festivals had an attitude towards drugs.

Dansk Live – Young people and alcohol

In 2012, 13 festivals and all the Grøn Koncert-events participated in the Danish Health and Medicines Authority's and Dansk Live's campaign Young People and Alcohol with the slogan "Less Alcohol – More Party". The focus of the campaign is teenage drinking,

and it focuses on the age limits for serving and selling alcohol. The aim of the campaign is, among others, to urge to compliance with age limits for serving alcohol. The primary target group for the campaign is thus the young people's parents and employees at the festivals, but the campaign also addresses the young people under 16 years of age. The campaign elements are located at the tent sites and around the bars and primarily consists of printed media, but there is also a website. The contact to the parents is made via PR slogans, where useful advice is communicated to parents of teenagers.

Young People and Alcohol was – similarly to Against Drugs – evaluated both at the Roskilde Festival and at the three small festivals in Vig, Skive, and Samsø (The Danish Health and Medicines Authority 2012f). The overall result of the evaluations were that there appeared to be less awareness of the campaigns in 2012 than in 2011.

At the Roskilde Festival, 15% of the staff had noticed the campaign compared to 66% in 2011. The result from 2012 also showed that 82% of the employees could answer the question of the legal minimum age for buying alcohol at a festival. The evaluation also showed that there had been some problems in implementing the physical elements. This could be one of the explanations to the poor response from the staff. However, the evaluation from 2012 showed – as in 2011 – that 92% of the staff thinks the campaign is a good idea.

The 2012 evaluation from the festivals in Vig, Skive, and Samsø showed that the staff support the message of the campaign and think that it is important that the festivals take a clear stance on teenagers and alcohol. All the staff at the Vig festival concurred to that, as did the staff at the Skive and Samsø festivals by 77% and 81%, respectively. 98% of the staff participating in the evaluation knew the rules on serving alcohol.

The evaluation also showed that last year there had been some implementation problems. For instance, there were problems in hanging up the posters near the bars, etc. The result was that the campaign was less visible to the audience than the previous years. In Samsø, it dropped from 79% to 68%, in Vig it dropped from 38% to 28%, and in Skive it reached a rock-bottom low of 24%. The experience from the implementation of the campaign has been used in a constructive manner for the campaign in 2013.

Music against drugs

In 2012, the campaign Music Against Drugs ran in 45 music halls during the period from September to November with the same slogan as the one used at the festivals ie: "DON'T LET OTHERS SPEAK YOUR MIND". The campaign addresses both the audience and the staff at the music halls. The primary target group within the audience is the young people between 16 and 25 years of age, whereas the staff target group is made up of all staff working in the music halls. In 2012, the campaign included printed as well as electronic elements, such as web banners, t-shirts for the staff, posters, stickers, badges, etc. Feedback from the audience and the staff again was positive towards the music halls voicing their attitude towards drugs. The feedback, however, also shows that it is more difficult to get the message through to the music halls than at the festivals, and that it is difficult to plan a campaign matching all music halls. The fact is that they all differ significantly in terms of target group and size.

4 Drug abuse in numbers

4.1 Introduction

On the publication of this report, the Danish Health and Medicines Authority is preparing new estimates on the number of drug abusers in Denmark. The estimates are planned to be made in the autumn of 2013 and will be published separately. The most recent estimate on the number of drug abusers in Denmark, which will be outlined below, was made in 2010 and is based on figures from 2009. This chapter thus contains the results from 2010 – and therefore the only available estimate at present.

The number of drug users in Denmark is estimated to be 33,000. Out of this figure, approximately 11,000 are estimated to be cannabis users. Comparable figures from 2001, 2003 and 2005 suggest that the estimated number of drug users in Denmark during the period is increasing.

The estimate is made using the capture-recapture method and is in accordance with the guidelines set out by the European Monitoring Centre for Drugs and Drug use (EMCDDA). The calculations thus adhere to European standards for such estimates. As it appears in Chapter 5, changes have been made to the Danish Board of Health's register on drug abuser admitted to treatment. This has meant that data from 2006-2008 were inadequate, for which reason a new estimate was made in 2010 based on data from 2009. The admission register for treatment is a crucial source to compile the number of drug abusers in Denmark.

In 2009, an estimate was made for the first time in Denmark on the number of injecting drug users. The number of injecting drug users in Denmark is estimated to be 13,000, of which half the number is estimated to live east of the Great Belt.

Apart from these estimates on the number of drug abusers and intravenous drug users, no estimates have been made on the number of drug abusers more specifically, nor have they been made in special groups in the population.

4.2 Estimated number of drug abusers in Denmark

The estimate on the number of drug abusers is associated with some uncertainty. The estimate is dependent, in one respect, on the definition of a drug abuser, and in another, on which methods and data material the estimate is based.

As in previous years, the estimate made in 2010 was made using the capture-recapture model³. The estimate is carried out based on the National Patient Register (LPR) and the national register of drug abusers who are receiving or have received treatment (SIB). The approach has been to investigate how many persons are registered in the LPR with a drug-related diagnosis⁴. An analysis is then carried out of how many of these people are also listed in the SIB.

³ This method is recommended by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) in order to be able to carry out comparisons across countries.

⁴ The codes F11.1, F11.2, F11.9, F12.1, F12.2, F12.9, F14.1, F14.2, F14.9, F15.1, F15.2, F15.9, F19.1, F19.2, F19.9 are used in this case.

The estimate on the number of drug abusers from 1996 to 2009 appears in table 4.2.1. Since the calculations of the estimates throughout the years are based on the "live" registers, an adjustment in the estimates from previous years has also been made in connection with the preparation of the 2010 estimate.

The estimate does not include experimental drug use, but estimates the number of people who have a more constant use of drugs, as a result of which they suffer harmful physical, mental and/or social effects. Drug abusers in substitution treatment have been included in the estimate.

Table 4.2.1. Estimate on the number of drug abusers in Denmark, 1996-2009

	1996	1998	2001	2003	2005	2009
Estimate on drug abusers in DK	20,284	24,394	25,514	26,468	27,896	33,074
95 % confidence interval	± 1,592	± 1,937	± 1,789	± 1,590	± 1,628	± 1,923

Source: The Danish Health and Medicines Authority 2010b

The estimate is statistically uncertain (confidence interval). However, even when including this uncertainty, there is a clear increase in the number of drug abusers from 2001 to 2009. The number of drug abusers in 2009 is estimated to be 33,000, of which 10,900 are estimated to be cannabis abusers, and the number of the group of abusers has increased from 7,900 in 2005.

In recent years, the "population" of drug users receiving treatment, which is one of figures used for calculating the estimate, has changed (the treatment population is described in the next section). There seems to be an actual, relative decrease in the number of drug users seeking treatment for opioids/heroin addiction, while there are an increasing number of users seeking treatment for addiction to cannabis and stimulants. The change is particularly seen among the "new" individuals in drug treatment and is assumed to reflect the similar changes in the population of drug abusers.

4.3 Scope of intravenous drug use

During the period 2004-2008, the Danish Health and Medicines Authority supported the DEADHEP project, under which, as part of the study on HIV and hepatitis prevalence among drug-related deaths in Denmark, also by means of autopsies, it was examined whether or not the deceased suffered from hepatitis as a sign of intravenous drug abuse (Christensen et al 2006) (read more in chapter 6). Based on this, the Danish Health and Medicines Authority started to estimate the number of intravenous drug abusers by comparing DEADHEP with the Danish Health and Medicines Authority's register on drug users enrolled in treatment (SIB = Stofmisbrugere Indskrevet i Behandling) (Christensen et al 2009). The estimate is based on a capture-recapture estimate made on newly admitted patients in the treatment registry in each of the years 2003 and 2005 and those registered in DEADHEP in 2006 (a total of 5,126 subjects). The estimate was stratified by age, gender and geographic region and calculated by means of a log-linear model.

Based on these calculations, the estimate is that at present, there are 13,000 active intravenous drug users in Denmark (safety interval of 10,066-16,821). Half of them live east of the Great Belt. Between half and 2/3 are unknown to the treatment system.

As shown previously in this chapter, the Danish Health and Medicines Authority's overall estimate of the number of drug abusers is 33,000, of which 11,000 are cannabis abusers. As it is estimated that there are 13,000 intravenous drug abusers in Denmark, it is assumed that around 60% of the drug abusers (not including cannabis abusers) are intravenous drug users (primarily users of opioids).

The 13,000 intravenous drug users equal 3.6/1000 inhabitants between 15 and 64 years in Denmark (95%, safety interval of 2.8-4.6). The proportion of intravenous drug users in the Danish population equals the share of drug abusers in the other European countries of 1-5/1000 of the 15-64-year-olds (EMCDDA 2010).

Number of intravenous drug users calculated by mortality

As a supplement to the above calculations, an estimate was made on the number of intravenous drug users in Denmark from a multiplicative model based on the mortality observed among intravenous drug users in treatment during the period 2004-2006. The mortality observed among intravenous drug users in treatment was 2.0/100 person years and the calculated number of deaths was an average of 225/year. This equals a one-year prevalence of 11,186 (95%, safety interval of 9,670-15,634). The estimate is slightly lower than the 13,000 observed when using the capture-recapture method.

4.4 The number of homeless people with abuse problems

In 2011, the special "homeless count" was made showing that 67% of the homeless who were included in the count either had a problem with alcohol, medicine or drugs. The rate is highest among those sleeping in the streets and among the persons who have been spending the night in night shelters, where 77% and 80%, respectively, in these groups were abusers of some kind. The proportion of abusers who spent the night with family and friends is 63% and the proportion of abusers using drop-in centres is 72%. The homeless count is a follow up on the one made in 2009. The results in 2011 equal those of 2009.

5 Drug treatment – demand and availability

5.1 Introduction

The municipalities are responsible for all kinds of drug abuse treatment, whether it be outpatient, day or inpatient treatment (except from the treatment provided in prisons and local prisons). By far the majority of all drug-related treatment is targeted at drug abuse and the ensuing social and health problems. The municipality must ensure the requisite coherence between medical treatment and social treatment as well as any other social support.

Most drug abusers in treatment receive outpatient treatment. They are also offered supplementary day or inpatient treatment if more intensive care is required. When a drug abuser is given medical treatment, he/she will also be entitled to social treatment as required. A treatment plan must always be drawn up.

The number of drug users in treatment has increased steadily since 1996, when the Danish Health and Medicines Authority (then National Board of Health) started recording drug users admitted to treatment. From 1996 to 2006, the number of persons admitted to treatment almost tripled. The reason for this is primarily assumed to be the introduction of the treatment guarantee and improved treatment capacity. From 2006 to 2008, there was a drop in the number of drug abusers in treatment, which is most likely due to the changes in registration practice and the transition to the new SEI - the registration that changed the admission and discharge procedures. Another thing is that in these "transition years", registration was affected by the fact that the municipalities took over responsibility from the counties at the turn of the year 2006/2007. From 2008 to 2010, the number of people admitted to treatment started to go up again.

The most recent figures from 2011 show that there are almost 16,000 drug users registered in the register on drug abusers in treatment (SIB). More than 7,600 of these drug users receive substitution treatment – either with methadone or buprenorphine.

Today, the National Board of Social Services collects the data on treatment and enters it into the drug abuser database, which was launched in June 2011. The drug abuse database is thus the joint reporting portal for all relevant authorities, including the State Serum Institute's register on drug abusers in treatment (SIB), the National Board of Social Service's VBGS registry and DanRIS-"ambulant" outpatient as well as the Centre for Alcohol and Drug Research's register DanRIS-"døgn". The merger of the registers contained in the drug abuse database have required major technical changes – both on the establishment of the drug abuse database itself, but also in the technical solutions between the municipalities' reporting system and the new common reporting platform. Because of the changed conditions, reporting of data for 2012 has not yet been completed, and some of the figures listed in this chapter are therefore based on last year's statistics with data for 2011.

A number of new treatment initiatives have been launched in 2012/2013. These are described together with other treatment-oriented initiatives under section 5.4.

5.2 The treatment system – strategy, politics and organisation

In Denmark, access to treatment is easy. Treatment is publicly financed and, depending on the scope and nature of the problem, various types of psychosocial treatment are provided either with or without supportive medicinal treatment, as outpatient or inpatient treatment. Treatment is predominantly accepted on a voluntary basis. The law holds limited opportunities for compulsory treatment, particularly in relation to pregnant problem drug users. However, these options have only been used in very few instances since the new legislation came into force in 2008.

The local authority is responsible for the medical and social treatment of drug abuse, and for preparing a treatment plan for the following course of treatment. This treatment plan must be combined with the action plan under Section 141 of the Danish Consolidation Act on Social Services.

Treatment is based on in-depth examination leading to an individually planned treatment program on either an everyday, outpatient or inpatient treatment basis. It is a prerequisite that the drug user's own wishes for treatment is crucial. In Denmark, treatment of drug abusers is guaranteed to persons above the age of 18 years, and in special cases to young people under the age of 18. Under this guarantee, the drug abuser may demand that a program for social treatment be initiated no later than 14 days after a request for treatment has been submitted to the local authority.

Persons who have been referred to treatment are entitled to choose between public treatment programs and approved private treatment programs of a type similar to the one, to which they were referred, ie within the framework of the described treatment plan. As regards the medicinal treatment, the drug user cannot formally require treatment within a fortnight after contact to the local authority, but normally medicinal treatment, where needed, will be initiated alongside the initiation of the psychosocial treatment.

The purpose of the action plan prepared for the individual drug user is to secure correlation between the medical and the social aspects of drug use treatment as well as the other social problems resulting from drug use.

The treatment plans must support the overall action plan focusing on medical and social conditions and providing the framework for the whole cooperation process with the drug user. The social treatment plan must include targets for the process on a short-term as well as a long-term basis, and the agreements made in relation to it. The treatment addresses the drug abuser's general life situation. Therefore, intervention comprises health as well as social issues, including any problems in relation to housing, crime, work and network.

Social treatment addressing drug abuse must be general as well as specific and follow a program involving the individual abuser's needs. In practice, this may include a number of different types of services. It could, for instance, be individual sessions, group sessions, couple sessions, family treatment, social counselling, detox, health care programs and social skills training. Moreover, some treatment institutions offer specialised programs for special target groups. These could be to young people under the age of 25, to pregnant women, drug abusers with children, and mentally ill drug abusers, etc. The range of services is changed on an on-going basis concurrently with the emergence of new types of treatment and focus on new target groups.

Normally educational coaches and social workers will be in charge of the social treatment. In addition, a large variety of professional groups such as psychologists and psychiatrists are included in the treatment work.

The four most prevalent approaches to treatment in Denmark include cognitive, socio-educational, solution-focused, and systematic methods. Out of these four types, the cognitive approach is the most prevalent. Most often, the individual treatment institutions apply more than one approach.

The social abuse treatment may have therapeutic elements as well as socio-professional, medical and caring elements. The mix of treatment provided to the individual user depends on the goals set out for the treatment.

The local Social Services Administration is under an obligation to provide free medical treatment with addictive substances for persons abusing opioids (substitution treatment). This obligation is set out in Section 142, subsection 1 of the Danish Health Care Act. The local Social Services Administration is also responsible for ensuring the requisite correlation between the medical treatment and the ensuing psychosocial intervention as well as the efforts to deal with the social problems also facing the drug user. The medical treatment plan is part of the social action plan and is assumed to be an integral part of the individual municipality's overall treatment and care services provided to the drug user.

The medical treatment of drug abuse primarily comprises examination and treatment of the nature and scope of the drug abuse. Furthermore, the medical treatment of drug users comprises an investigation and assurance of treatment of the physical and mental problems related to the drug use. The indication for initiating substitution treatment with opioids is always based on a medical assessment.

Quality assurance of substitution treatment

During recent years, efforts have been made to perform quality assurance and development of substitution treatment in Denmark. As part of this work, the Danish Health and Medicines Authority published in 2008 a guideline on the medical treatment of drug abusers in substitution treatment (Danish Health and Medicines Authority 2008a). The guideline should contribute to reducing morbidity and mortality among drug abusers, qualify medical drug abuse treatment and support interventions overall.

A registration and reporting system have been set up as a follow-up to the Guideline.

5.3 Drug abusers in treatment

Drug abusers admitted to treatment

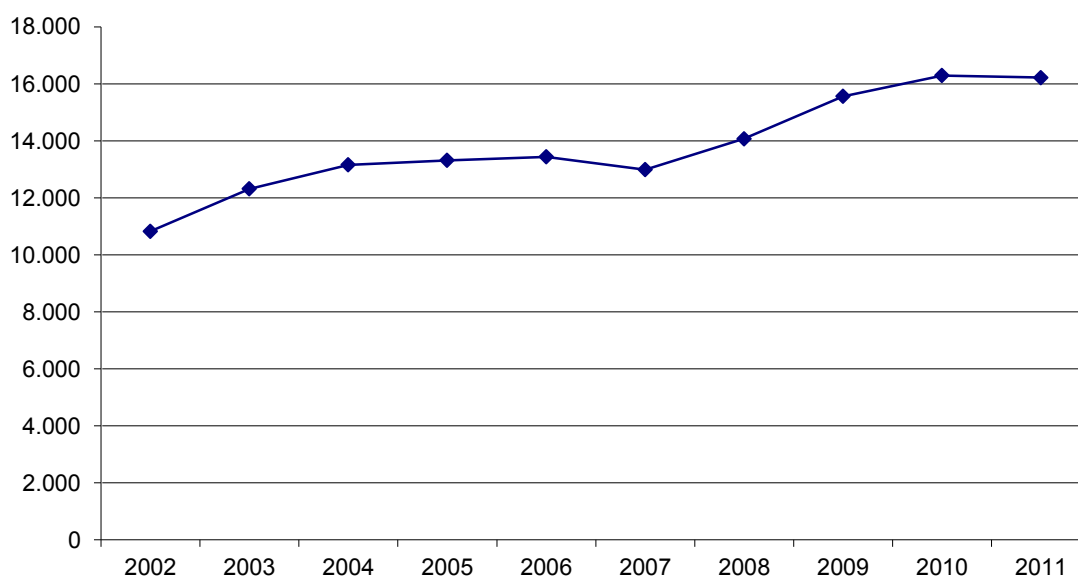
As of 1996, the Danish Health and Medicines Authority has registered all drug users admitted to treatment. Based on information collected from the "Register of drug abusers in treatment" (SIB) it is possible to obtain a description of those persons seeking help for their problem drug use. The register contains, for instance, information about treatment facilities, ie outpatient and inpatient treatment, as well as the type of treatment (methadone, drug-free, etc.) provided to the receiver.

As mentioned above, the reporting for 2012 is not complete. The figures and statistics below are therefore based on data from 2011 and are identical to the figures and statistics contained in last year's publication.

Since 2011, reporting to the SIB has been made via the new joint reporting portal, the database on drug abusers (SMDB) under the auspices of the National Board of Social Services. In connection with the establishment of a joint reporting portal, the existing data sources within the drug abuser field, including the VBGS⁵ and the SIB were migrated and merged. Also, the merging variables that were previously reported to different registers were consolidated and updated. The transition to the joint reporting solution SMDB has caused data breakdown and the results from the report should therefore be interpreted with caution. The reports in this chapter are based on migrated SIB data (from 2007 and onwards) from the new drug abuser database and cannot be directly compared to the reports from the previous years.

The total number of drug abusers admitted to treatment during 2011, is slightly under 16,200, which is the second highest number registered drug abusers since the opening of the register. The development in the number of drug abusers receiving treatment has been increasing over recent years, cf figure 5.3.1.

Figure 5.3.1. Number of drug abusers receiving treatment, 2002-2011



Source: Register on drug abusers in treatment (SIB). Data from 2002-2006 are based on reports to the Danish Health and Medicines Authority, data from 2007-2011 are based on migrated SIB data from the drug abuser database (SMDB).

In 2011, 5,686 persons were admitted to treatment in Denmark. This figure includes people admitted for the first time and those who are readmitted for treatment. The rate of persons who have not previously been admitted to treatment is 32% in 2011, which is the same level as in previous years. Separate figures and description of the “new” treatment will be provided later in this chapter.

⁵ VBGS: Waiting time for treatment guarantee to drug abusers.

Table 5.3.1 provides a few selected characteristics of the clients who were admitted in 2011.

Table 5.3.1. Clients admitted to drug abuse treatment with admission date in 2011	
Number of clients admitted to treatment in 2011	5,686
Number not treated previously (%)	32
Men/women (%)	78/22
Average age men/women (%)	31/31
Opioids as primary drug (%)*	17
Cannabis as primary drug (%)*	63
Psychostimulants as primary drug (%)*	10
Cocaine (%)*	5
Injection previously treated heroin users (%)	43
Injection, non-previously treated heroin users (%)	27
On payroll (%)	10
Daily cash benefits (%)	3
Cash benefits (%)	44
Early retirement pension (%)	11
Other income and uninformed income (%)**	31
Own dwelling (%)	53
Single men/women (%)	67/62
Number of children living at home, under the age of 18	1,017
Number of children not living at home, under the age of 18	290
Foreign citizenship (%)	6

Source: Register on drug abusers in treatment (SIB) (SIB)

*Those who report a primary drug

** including 15 % unreported, 5 % student grants and 5 % daily sick benefits

Primary drug in drug abuse

In 2011, 63% of the drug users reported cannabis as their primary drug when admitted to treatment for drug abuse. The opioids as a primary drug were reported by 17%, stimulants and cocaine by 15% and 6% reported "other drugs" as the primary drug on admission. Quite a few drug abusers seeking treatment use several drugs, where 45% of the drug users reported having used more than one drug prior to admission in 2011.

The psychostimulants that are particularly in focus of the young people's experimental use of drugs appear to a lesser degree as the primary drug for abusers admitted to treatment in 2011. 9% report amphetamine, 5% report cocaine, and 0.3% report ecstasy⁶ as their primary drug⁷. These drugs are thus mainly used as a supplement. Cannabis was the primary drug for 63% of those admitted to treatment and is also used as a secondary drug among 14% of those admitted to treatment in 2011.

Age and gender distribution

In 2011, 78 % men and 22 % women were receiving treatment for drug abuse. The share of women is thus the same as in previous years. The average age of admission in 2011 was 31 years for men and women and thus almost unchanged compared to last year.

⁶ Here recorded as MDMA or similar drug

⁷ The percentages are based on the treatment population having reported a primary drug

Social background variables

The information on social background variables reflects a marginalised group in terms of labour market affiliation, education, housing and social life.

A large part of the drug abusers receiving transfer income with only 10% being employed. Almost half of them either receive unemployment benefits or cash benefits. In all, 26% have completed an education beyond Primary school (primary and secondary school), and 8 % left Primary school before the 9th grade. The low level of education should be viewed in the light of the fact that most of the drug abusers start taking drugs at a very young age. The housing situation of drug abusers is also very bad. Only 53 % have their own home – as many as 3 % are actually homeless. A majority of the male as well as the female drug abusers are singles.

A total of 1,017 children lived together with a drug abuser admitted for treatment in 2011, whereas 209 children under the age of 18 were placed outside home.

Foreign citizens

A minor proportion of the drug users receiving treatment are foreign citizens, amounting to a little over 6% in 2011. The proportion of clients of foreign nationality receiving treatment almost corresponds to the proportion of foreign nationals in the population as a whole.

New recipients of treatment

The national register of drug addicts receiving treatment provides information as to whether or not the clients have previously been admitted for treatment. Information about newly admitted users is particularly interesting since this group reflects recent trends in the type of drugs used, methods of administration prevailing in which age groups, etc. In other words, it is possible to follow new trends over time in terms of drug use and the recruitment of new drug users. Table 5.3.2 below provides information about the newcomers.

Table 5.3.2. Clients admitted to treatment during the year without having been treated for their drug abuse earlier, 2005-2011*

	2005	2006	2008	2009	2010	2011
Clients who have not been treated earlier	1,578 out of 5,228 (30 %)	1,329 out of 5,426 (24 %)	2,072 out of 6,243 (33 %)	2,481 out of 6,866 (36 %)	2,352 out of 6,654 (35 %)	1,847 out of 5,686 (32 %)
M/W (%)	75/25	76/24	76/24	79/21	78/22	76/24
Average age M/W	27/28	27/27	28/27	27/27	28/27	27/27
Opioids as primary drug (%)**	17	14	12	8	7	5
Cannabis as primary drug (%)*	53	50	55	65	68	73
Psychostimulants as primary drug (%)*	13	17	16	12	11	11
Cocaine as primary drug (%)*	9	10	10	7	7	6
Injecting heroin abusers (%)	19	18	24	21	16	27

Source: The Danish Health and Medicines Authority's register on drug users admitted for treatment in 2005-2011

* Data for the period 2008 to 2011 have been updated against previous publications based on migrated SIB data from the drug abuser database.

**Those reporting primary drug.

As it appears from table 5.3.2, 32% of the admitted clients in 2011 had not been treated earlier. Not surprisingly, the average age was lower among the newcomers than the average age of the treatment population as a whole. Among the newcomers are slightly more women compared to gender distribution of the treatment population as a whole.

Primary drug and mode of administration

A higher share of the newcomers report cannabis as their primary drug compared to those who have been receiving treatment earlier - 73% compared to 63%. Among the 1,847 newcomers with reported primary drug, only 5% use opioids as their primary drug, 11% report having used a stimulant (in this case amphetamine or ecstasy), and 6% report using cocaine as the primary drug.

As regards mode of heroin administration among the two "client groups", there is also a difference, as 27% of those not treated previously report having injected the drug, whereas 43% of those treated previously report having injected heroin. The difference in the mode of administration between the two client groups may be explained by a "shorter abuse career" and by the new opioid abusers for a large part smoking their heroin.

Young people receiving drug treatment

Young drug users are accounting for an ever-increasing share of all drug users receiving treatment. Updated figures are given below, as part of an extension to the special survey carried out by the Danish Health and Medicines Authority in the autumn 2005, based on an extract from the Danish Health and Medicines Authority's register of drug users receiving treatment (Danish Health and Medicines Authority 2005).

In 2011, less than 3,950 young people between the age of 18 and 24 were receiving treatment. When comparing the youth population receiving drug abuse treatment and the total number of Danish youngsters in the same age group, a figure of 3,950 means that 8 out of every 1,000 young people aged between 18 and 24 years were receiving treatment in 2011, which is the same level as last year.

Table 5.3.3. Distribution of primary drug for clients admitted in 2003 and 2011 with a known primary drug (in percentage)

	2003		2011	
	18 – 24-years	All in treatment	18 – 24 years	All in treatment
Cannabis	46.0	25.6	79.5	63.4
Heroin	15.3	30.2	2.5	11.1
Amphetamine	12.7	5.8	9.4	9.5
Cocaine	5.8	4.4	3.5	5.1
Ecstasy	4.0	1.2	0.5	0.3
Other opioids	4.8	20.1	0.6	3.7
Benzodiazepines	1.7	2.1	1.7	1.8
LSD	0.0	0.0	0.0	0.0
Other	9.8	10.5	2.3	3.9

Source: Register on drug abusers in treatment (SIB). Persons admitted to treatment in 2011

As it appears from table 5.3.3, what is characteristic of the youth population is that, to an increasing extent, cannabis is the main problem of their addiction. In 2003 and 2011, the number of young people seeking treatment for cannabis addiction exceeded those seeking treatment for heroin addiction.

Drug abusers in substitution treatment

As mentioned earlier in this chapter, the technical problems resulting from the merger of the registers in the drug abuse database have also affected the data on drug abusers in substitution treatment. The data are therefore based on data from 2011 and are thus unchanged compared to the data provided in last year's report.

Previously, the Danish Health and Medicines Authority recorded the number of persons in long-term methadone treatment based on data from the prescription register. The most recent records show that 5,700 persons in 2004 were admitted to substitution treatment with methadone. The records provided information about the number of persons admitted to methadone treatment under the Danish Prison and Probation Service and number of persons without a civil registration number (The Danish Health and Medicines Authority 2008a).

From 2008, the figures are based on the number of drug abusers in substitution treatment with either methadone or buprenorphine on data reported to the register on drug abusers in treatment (SIB). Since the compilation method⁸ and the data basis⁹ vary

⁸ In previous statistical records, long-term substitution treatment was defined as receiving substitution treatment for 5 months. In this one, the number of persons receiving substitution treatment are calculated on the basis of the most recently started course of treatment with substitution medication for persons in treatment in 2011.

from 2008 and onwards compared to the years before 2004, the results from the various periods are not directly comparable.

The most recent figures from the register on drug abusers in treatment shows that among all those receiving drug abuse treatment, around 7,050 persons were in substitution treatment in 2011. When including data from the Danish Prison and Probation Service, the total number of persons in substitution treatment arrives at barely 7,600 in 2011. This is lower than the updated figures for 2010 based on the SIB data retrieved from the new joint reporting portal (SIB), which showed that less than 7,850 persons received substitution treatment.

Buprenorphine and methadone are used in substitution treatment. The Danish Health and Medicines Authority's revised guidelines on the prescription of addictive medicines from 2008 emphasizes that buprenorphine should be used as a first-line preparation for opioid dependent drug users which had not previously been treated and that this drug in any event should be used to the greatest extent possible in substitution treatment.

The number of persons in substitution treatment with buprenorphine was approximately 1,400 persons in 2011, which is slightly lower than in 2010, which could be due to the transition to the new drug abuser reporting portal, SIB.

Treatment with heroin

As of March 2009, treatment with medically prescribed heroin for injection has been allowed in Denmark. The first clinics opened in April 2010. Five clinics have been established all over Denmark in Copenhagen, Hvidovre, Odense, Aarhus and Esbjerg.

Basically, the aim of the treatment is to prevent against a deterioration of the patients' health condition and in the long run to achieve an improvement of their quality of life in terms of health and social integration.

The patients inject heroin under the guidance of health care personnel at the clinics and do this up to twice daily every day. This is a highly specialised area of treatment, and the health care personnel must comply with special requirements for training and experience set out by the Danish Health and Medicines Authority.

The patients belong to the group of "hard to treat" patients, ie patients who are interested in receiving help for their abuse problems, but which are difficult to provide adequate help in traditional substitution treatment. It is a group who has been through numerous long-term treatment programs with methadone prior to initiating treatment with medically prescribed heroin.

During the period from April 2009 to the end of December 2012, 252 patients have been admitted to treatment. 70 of those admitted were discharged again. The ones admitted are followed beginning with an interview at treatment start-up and subsequently every six months. Their answers are recorded in a database.

In the spring of 2013, the Danish Health and Medicines Agency evaluated the scheme on the bases of recorded data. The evaluation shows that the scheme has been suc-

⁹ Former statistical recordings were based on figures provided by the prescription register, whereas this material is based on the register on drug users receiving treatment (SIB).

cessful in terms of improving the drug abuser's social situation, limiting abuse of illicit drugs, reducing criminal activity, and reducing risky behaviour. Their mental well being appears to improve, however several are diagnosed with physical illnesses in their daily contact with health care personnel and regular sessions with a doctor, physical examination and treatment. This appears to affect the self-assessed physical health adversely. Their level of energy is much lower than in the population in general and does not change during treatment. A relatively large proportion is discharged again, especially from some of the clinics, and data indicate that the more critical abusers account for the majority of those who are discharged again. Some of those who are discharged return to the traditional substitution treatment, either permanently or for a given period. The drop-out rate concurs with that of the similar Swiss scheme and that of the traditional substitution treatment.

There are some heroin abusers that do not fit into the current scheme. It has therefore been decided that the scheme should be extended to include administration of heroin as a tablet. Tablets can be used if injection is not possible due to the patient's damaged veins, if transfer of the patient to methadone treatment is insufficient, or if the patient does not wish to continue in heroin treatment, but wants to stop injection. The tablet may also be used for chronic heroin addicts who are not injecting drug users, but for instance smoke heroin instead. Treatment with tablets is expected to come into force at the end of 2013.

Drug abusers admitted to inpatient treatment

Special data on inpatient treatment are collected from the Drug Abuse Database (SMDM), which came into use in the middle of 2011. All inpatient institutions treating individuals with drug abuse problems are committed to sending data to SMDM. There were 40 inpatient institutions registered in SMDM in 2012. Out of this number, 31 were actual inpatient institutions, and out of this number, three did not submit any data in 2012, out of which two had closed down. The table below shows the development in admissions every year from 2005-2012.

Time	N	Age	Women	Men
2005	1244	32.8	26 %	74 %
2006	1096	33.1	26 %	74 %
2007	1228	33.2	25 %	75 %
2008	1419	33.8	25 %	75 %
2009	1259	33.0	24 %	76 %
2010	1010	32.6	23 %	77 %
2011	773	32,0	22 %	78 %
2012	710	31,1	23 %	77 %

Source: Center for Rusmiddelforskning (Center for Alcohol and Drug Research), Dansk Registrerings- og Informationssystem, DanRIS 2012.

As it appears from table 5.3.4, there is a significant drop in the number of individual admitted to inpatient treatment from 2009 and onwards.

The average age for drug abusers admitted to inpatient treatment has not changed significantly over the years, and was 31 years in 2012. The proportion of women also

appears to be relatively stable throughout the period, although there appears to a declining tendency in the proportion of women from 2008 and onwards. One person may be admitted several times per year, but at least 30 days will have to pass before a return to the institution is considered a new admission.

The 710 admissions that were recorded in 2012 are distributed on a total of 675 persons. There are significant changes in the clients' average EuropASI drug composite score from 2011 to 2012 (0.43 in 2011 to 0.40 in 2012). Composite scores for crime, conflicts with family and network as well as mental problems are lower in 2012 than in 2011, whereas the alcohol score is a bit higher – however without being statistically significant. The proportion of clients using heroin up to the initiation of treatment has dropped from 41% in 2008 to 25% in 2012. In general, the number of opioid users admitted to inpatient treatment is on the decline.

Completion and severity rates

The number of clients who complete their inpatient treatment as planned has dropped from 56% in 2011 to 50% in 2012. The average number of admission days in 2012 is 144, which is an increase of 8 days compared to the 136 days in 2011.

In 2011 and 2012, the inpatient institutions completed the EuropASI form for 73% and 65%, respectively of their clients who were admitted in those years. The ASI form provides the basis for calculating the level of social severity, including housing conditions and provision. In this context, 2012 appears to have a higher severity rates than 2011 in terms of the clients' housing and income. The number of individuals admitted without a home rose from 9% in 2011 to 11% in 2012. The number of clients with a reported primary income resulting from illegal activities went up from 4% in 2010 to 9% in 2012.

The total of 710 admissions in 2012 comes from 86 out of the 98 Danish municipalities

5.4 Initiatives concerning treatment of drug abuse

The clear mission of the government's drug abuse policy is for treatment of drug abusers to have changed significantly in 2012. The proportion of citizens who terminate their treatment program as either clean or with reduced drug abuse has been approximately one third since 2008. In 2020, at least half of the drug abusers terminating a treatment program for their abuse must either be clean or perceive their abuse as being reduced.

As previously mentioned, the Ministry of Social Affairs, Children and Integration launched its work with a comprehensive drug abuse package in 2013. A total of DKK103million have been reserve for the package, which contains 10 specific initiatives. The package should contribute to raising the quality of social treatment of drug abuse. One of its focus areas is to enhance treatment intervention by applying useful methods and having the citizen experience a more systematic follow-up on treatment as well as care being taken of problems other than those of drug abuse.

The target group of the overall intervention is differentiated and ranges from citizens with a need for relatively short and focused help to citizens with complex problems, which may be in need of a number of interventions across local administrations and sectors. The drug abuse package thus also includes initiatives focusing on drug abuse treatment in general and its framework, whereas other initiatives reach out to a more limited target group such as young drug abusers.

On the implementation of the Drug Abuse Package, existing knowledge and experience will be included, with a particular focus on methods with documented effect.

In addition to the Drug Abuse Package, the Ministry of Social Affairs, Children and Integration are working with a number of initiatives related to social treatment of drug abuse. One of them is described below, an initiative aiming at alcohol and drug users who are not, or only to a limited extent, are socially marginalised by their abuse, and who are either working or under education (anonymous outpatient drug abuse treatment). Other initiatives are targeted at the most socially marginalised people with drug abuse problems (Acute crisis centre for the socially marginalised with drug abuse problems and Study of socially marginalised citizens with chaotic polydrug use). Furthermore, two other projects are described where the focus is on young people with problematic drug use (PAV – pre-treatment in the secured institutions and Project abuse treatment to young people). Finally, three initiatives focusing on double marginalised young people are described, ie citizens who both have abuse problems and who are mentally ill (Model project with a focus on screening and examination. Young mentally ill with an abuse problem and Integrated intervention) and finally a training course for drug abuse therapists.

Study of anonymous outpatient treatment of drug abusers

The study of anonymous outpatient treatment of drug abusers is targeted at citizens who require treatment for their drug abuse and who have close ties to the labour market or the educational system without wanting to be associated with being treated for their abuse. The aim of the projects is to gain knowledge on who and how many it is possible to reach and persuade to choose treatment via an anonymous program. This project of anonymous outpatient treatment for drug abuse is available in Copenhagen and Odense and has been running since January 2011. In the social reserve funds for 2012, DKK 16.5million have been set aside for the initiative. The social reserve funds for 2012 have reserved an additional DKK 5million for the projects, which means that they will be running until the end of 2013.

Project evaluations show that 430 persons have been admitted to treatment in 2011 and 2012. Evaluations also show that the projects have in particular recruited among the most resourceful group of citizens in the educational system or on the labour market. They do not see themselves as users of abuse treatment programs, for which reason the possibility of receiving treatment anonymously is crucial to their decision of contacting the authorities. The consideration for their work (including future job opportunities) is the most prominent reason for their wish of being anonymous. It is worth mentioning that substitution treatment for opioid abuse cannot be received anonymously, and the primary target group for the projects are thus cannabis and cocaine abusers and users of other psychoactive stimulants.

The evaluation also shows that 72% of those admitted are men, their average age is 31 years, 72% of them use cannabis as their primary drug, 50% have an ASI score of max 0.15 and 86% of them have an ASI score of max 0.3. Furthermore, 47% of those admitted have a medium-long or long supplementary education, 61% have an income and 20% receive student grants. It has thus been possible to recruit a relatively resourceful group to drug abuse treatment via an anonymous group-based treatment program.

Study of socially marginalised people with chaotic polydrug use

The report "Study of socially marginalized citizens with chaotic polydrug use" was prepared by Rambøll for the National Board of Social Services. The report includes the results of a study conducted in Copenhagen, Aarhus, and Odense. The study describes new findings about some of the most marginalised drug abusers, including observations as to who these citizens are, what characterises them, their needs for interventions from the official system and the special challenges associated with giving them the right help and support.

The study shows that around 450-500 marginalized citizens with chaotic polydrug use live in Copenhagen, Aarhus and Odense. Although they only make up less than two per cent of the total number of people with drug abuse problems in Denmark, they are much more visible in the community, and they have a number of complex problems that make it difficult for them to receive relevant programs and interventions. Their lifestyle and behaviour make them particularly vulnerable, because not only do they have risky attitudes towards use of drugs and alcohol, which they use without consideration for contents or toxicity, they also take the drugs under often unhygienic conditions.

The drug abuse environments and the abuse patterns in the three cities differ in a number of ways. In Copenhagen, cocaine constitutes a significant part of the chaotic polydrug users' consumption, which is not quite as dominant in Aarhus and Odense. On the other hand, abuse of Ritalin (ADHD medication) is much more prevalent in Aarhus and Odense than in Copenhagen. The study also showed that some from the target group have started abusing drugs at an early age, sometimes as early as at 8-10 years of age, following which their abuse intensifies during their early teens.

Compared to the other marginalised groups – including the homeless or the overall group of people receiving drug abuse treatment – the study's results show that socially marginalised citizens with polydrug use have more mental and health problems and some of them are also cocaine addicts. The study also points out that there are challenges in offering this target group the right programs on support and treatment, given that two out of three citizens in the target group are under abuse treatment programs, slightly fewer than half of them use the city's drop-in centres or other low threshold programs, and also less than half of them have a local support contact person or are under a home support program. All in all, the study indicates that a relatively large proportion of these citizens are not offered programs that match their needs. Also, the complexity of their situation constitutes a challenge when it comes to overall interventions for this target group, as it is perceived as difficult to plan and coordinate the interdisciplinary interventions required to secure comprehensive intervention.

The report can be downloaded at the National Board of Social Services' website www.socialstyrelsen.dk

Acute crisis centre for socially marginalised citizens with drug abuse problems

An acute crisis centre has been established for socially marginalised citizens who have drug abuse problems and find themselves in an acute and critical situation. The purpose of the program is to give this group of citizens an acute offer for a protected stay in an institution where they are given support to find stability in a crisis situation and to maintain stability after their stay. During the stay, the citizen is provided social and medical help to stabilise the crisis situation, is supported in defining needs for help after the stay, and an integration plan is prepared together with the citizen his/her local social services and the centre.

The acute crisis centre is a model project where collaboration agreements have been signed with 10 municipalities. A key element of the model is the collaboration between the acute crisis centre, the drop-in centres and the local social services on admission, the stay, and discharge from the program. To the citizen, admission to the program goes through the drop-in centre or through outreach workers from the municipality, and the drop-in centre also takes care of the citizen after discharge. The local social services are involved in administration of the admission and during the stay in formulating the social action plan and plan for discharge and integration into society. The acute crisis centre lies in Munkerup in the northern part of Zealand, and is so far a study project running for the period 2013-2015. The centre can accommodate 20 citizens at a time and basically, it is possible to stay at the centre for a period of up to three months.

In the social reserve funds for 2012, DKK 24million have been reserved for the period 2012-2015. In the social reserve fund for 2013 another DKK 8million have been set aside for capacity expansion of the program. The program will be evaluated with a view to strengthening the knowledge base for future interventions of this nature to the target group.

The pre-treatment program "Projekt Andre Valg" (PAV), Project other Choices

Based on the experiences from studies on the use of pre-treatment programs in Danish jails, young people with abuse problems staying in young offender institutions must be offered a pre-treatment program

to prevent against abuse. The pre-treatment program offered to the young people resembles the pre-treatment method known from "Project Over Muren" (POM) [Project Over the Wall], which runs in the Copenhagen Prisons. The purpose of the initiative is to motivate the young people to talk about their use of alcohol and drugs. The intention is to motivate young people with abuse problems to accept drug abuse treatment after their stay at the institution.

Today, all the 8 young offenders institutions in Denmark offer PAV to the young people. Empirical data show that a majority of the young people gladly accept participation in PAV during their stay. The connection to another treatment program, where necessary, after their stay is, however a major challenge to both the local case handler and the professional staff at the institution. DKK3.3million have been reserved every year in the social reserve funds agreements for 2010 under the headline "Prevention of juvenile crime". The young offenders institutions will be receiving social reserve funds for the establishment of PAV programs up until the end of 2015.

Project Abuse Treatment – Treatment program for youngsters under the age of 18

Three systematic models for treatment provided to young people under the age of 18 are being tested in 2011-2014 in 6 selected municipalities. The effects of the three models need to be documented on an on-going basis and evaluated with a view to gaining more insight into the type of abuse interventions that have a positive effect on the young people's abuse problems and, if possible, the type of intervention that matches a given target group the best.

There are two Danish and one foreign method:

- U-turn - based on Copenhagen Municipality's existing programs.
- Aarhus Municipality Model (ÅKM) - based on Aarhus Municipality's existing programs.
- Multisystemic Therapy - Contingency management (MST-CM) - based on a US program

The municipalities have spent the first year of the project period with being established and starting to enrol the young people into treatment programs. Parallel with this, a teaching and practice program has been developed for introduction to the methods, which also contains supervision and consultations. The aim is that in the summer 2015, elaborate descriptions of the three models will be available, and the other municipalities in DK will be able to benefit from this valuable information and, where required, initiate similar local treatment programs. The project is part of a strategy referred to as Lige Muligheder [Equal Opportunities] from the social reserve fund agreement for 2008, and DKK60 million have been set aside for the initiative. The first results from the effect evaluation made by SFI are expected to be publicized in the spring of 2014.

Development of model projects with a focus on screening and examination of drug abusers with mental problems

The projects are targeted at drug abusers with mental illnesses who are included in drug abuse treatment. Four municipalities, Esbjerg, Horsens, Aalborg and Slagelse, are testing a work process and method description prepared and further developed on the basis of two screening and collaboration models from Aarhus and Fredericia municipalities. The work process description provides for the screening procedure for all citizens participating in the project. The aim is to systematise and qualify:

- Screening and the subsequent adapted drug abuse treatment.
- Coordination with regional psychiatric institutions and social psychiatric institutions on the citizens who need treatment concurrently with drug abuse treatment.

The four municipalities started by testing the models at the beginning of 2013. The staff receives on-going training in relation to implementation of the new screening practice and the adapted abuse treatment. The project municipalities are still working on more formalised collaboration agreements with the regional psychiatric institutions in particular. DKK14million have been reserved, and the projects will be running up to and including February 2015.

Young mentally ill citizens with abuse problems

This project is targeted at young newcomers in three municipalities in the screening and examination project mentioned above. It includes citizens who, when screened in connection with their abuse problems, are considered to have psychosocial problems and/or have self-assessed mental difficulties. The aim of the project is for the young people to reduce their abuse and to achieve higher control over their mental problems. Three models are being developed for support and collaboration to optimise the overall intervention. The support includes group-based as well as individual psychosocial programs. The model is administered by the social psychiatric departments in the three municipalities. The project was launched in Aalborg, Horsens and Gladsaxe, and these three municipalities will be testing their model description from the beginning of 2013. The project will be running through February 2015. A total of DKK18million have been reserved for the initiative which is part of the Danish Psychiatry Agreement 2011-2014.

Integrated intervention for mentally ill citizens with abuse problems

As part of the Danish Psychiatry Agreement 2011-2014, DKK18million have been reserved for a project integrating psychosocial interventions, drug abuse treatment and psychiatric treatment of citizens with severe mental illnesses and abuse problems. The towns of Ballerup, Egedal, Hedensted, and Syddjurs cooperate with the the Capital Region of Denmark and Central Region Denmark in these integrated programs. The project organisation has been established, and the first competence training days have been held.

A common methodology has been developed, including a handbook, on which the two projects (4 municipalities and 2 regions) are based. This integrated intervention initiative is defined by support and treatment across sectors and is carried out through coordination and physical presence, meaning that professionals carry out activities with different angles (treatment, support), while being physically present at the same time with the organisations working on an integrated basis.

The project operates on a cross sectoral basis, and activities are performed on an outpatient basis. The testing of methods started in the spring of 2013. Further competence training activities are planned for the autumn of 2013.

Educational programs for the treatment drug abusers

During the summer of 2013, a two-year project where drug abuse therapists were offered subsidized supplementary training was completed. This supplementary treatment consisted of two modules on theory and methods for treatment of drug abusers. The courses could be followed individually or as part of the social diploma certificate program. The modules were available in four university colleges in Denmark.

At the closing of the project, almost 200 students had completed the program. Admission to bachelor profession programmes requires at least two years' relevant business experience. In practice, the students in the program were those with only few years' experience and those with long-term experience within the drug abuse field. The three groups of teachers, social workers and nurses were almost equally represented in the teams.

The oral as well as the written evaluations of this project reflect a high degree of satisfaction among the participants throughout Denmark. This satisfaction is related to the professional contents and level of the modules, selected themes and literature as well as the participants' assessment of whether the content of the modules could be transferred to a real life scenario.

5.5 Research in the treatment of drug abusers

The focus areas associated with research in the treatment of drug abusers are constantly changing. At the Centre of Alcohol and Drug Research there is currently much focus on the following areas/projects:

Treatment of special groups of clients with specific illnesses, such as personality disorders, ADHD, and trauma, etc

In a number of on-going projects it is being studied how specific methods affect specific target groups, including psychiatric conditions such as angst, depression and anti-social personality disorders (ASPD). The project "Short-term treatment of individuals with abuse problems and criminal behaviour (ILC)" is a randomised multicentre efficacy study on manual-based short-term treatment of individuals with anti-social personality

disorders in abuse treatment. There is a need for developing methods that can be used in outpatient treatment programs that are in contact with and potentially exclude this target group, ie abuse treatment, social programs and programs for the homeless. In addition to testing of methodology and efficacy analysis, the study also focuses on un-biasing the knowledge on anti-social behaviour.

Another project looking into personality disorders is Clinical Interview to Assess Levels of Functioning (CALF). Inspired by the future diagnostic system (DSM-5) where focus is intensified on the individual functional level, the Centre for Alcohol and Drug Research has embarked on a pilot study of a clinical interview which can be conducted by psychiatrists and psychologists treating people with personality disorders and other mental illnesses. The purpose of the interview is to unravel the functional level through the assessment of four life areas. Under this category, a randomised study of Client-Directed-Outcome-Informed treatment of 16-30-year-olds in treatment for cannabis abuse will be completed during the summer of 2013.

Treatment of young problem drug users

Currently as well as during recent years, focus has particularly been directed towards the treatment of young people under the age of 18 who have become problem drug users. A survey of 2,950 young people's needs for help, help-seeking behaviour and the result of this help were published in 2012. At present, data collection continues in cooperation with, among others, SFI (The Danish National Research Centre for Social Welfare), and in the coming years, books and articles will be published on young people's abuse of alcohol and drugs, and the help they are offered to reduce this abuse.

Register-based treatment research (DATLoC)

During recent years, the Centre for Alcohol and Drug Research established a program, the purpose of which is to follow clients in drug and alcohol treatment in the period up to and after one or several treatment episodes. The studies will be conducted on the basis of comprehensive surveys and merger of registers. Currently, the database consists of more than 60,000 different subjects who have been treated for drug and/or alcohol abuse, including young people under 18 years. Information from this database have been merged with data from all the large national registers, and on-going projects follow the clients from 5 years before and 5 years after a given treatment episode. At present, control groups are being established making it possible to compare client progress with the progress of other groups over a 10-year period. In the DATLoC program it will also be possible to study cost efficiency and regional/municipal variances in client processes, which again can be correlated with organisation of interventions in the different regions/municipalities. The first articles from DATLoC will be published in 2013.

Mention should finally be made of the project, "**Prison-based drug treatment in the Nordic countries - Control and rehabilitation in Welfare State institutions**". Drug treatment in Nordic prisons is supported by NOS-HS. This research project, which compares drug treatment in Denmark, Sweden, Norway, and Finland has now been running for two years. The project is headed by the Danish Centre for Alcohol and Drug Research at Aarhus University. The first results describe how the various countries have debated drug treatment in prisons, with zero tolerance and health rights being some of the arguments. The project's two other focus areas are how drug treatment is implemented differently in practice in 12 selected prisons and how the inmates perceive the increasing use of treatment. The project will end in the spring of 2014, but research results will be provided on an on-going basis. The project also includes a PhD project with the purpose of studying how inmates in Danish prisons relate to the drug

treatment programs offered to them during imprisonment and to study how the inmates find meaning in drug use and the wish to be clean in the light of their life situation during and after imprisonment.

PhD projects on treatment: Two PhD projects have been running since 2010 with a particular focus on young problem drug users' life and the treatment offered to them. Another PhD project includes cannabis drug users in and outside treatment. All three PhD projects are qualitative studies.

6 Health correlates and consequences

6.1 Introduction

Drug abuse has a number of health-related consequences, and drug abusers are prone to very high risks of mortality due to poisoning and diseases, including HIV and hepatitis.

The number of drug-related deaths are recorded in two registers - the register of the National Police and the Cause of Death Register under the State Serum Institute. The latter is used for benchmarking with countries in the EU and is based on a joint European definition. In 2012, the National Police recorded 210 drug-related deaths, and this is absolutely the lowest number seen in years and significantly fewer than in 2011, when the number was 285. Analyses of these deaths throughout the years show that poisoning is the primary cause of death as a result of polydrug use.

There are no bullet proof explanations as to why the drug-related deaths drop so dramatically from 2011 to 2012 in the Region of Southern Denmark. There are most likely a number of factors involved. An overall decline in recent years in the number of drug abusers receiving treatment for the first time with opioids as their main abuse problem could be one of the reasons – also in the Region of Southern Denmark. However, changes in the drug market in the years in question could also be an explanation. Finally, one might assume that the new initiatives and interventions provided by the municipalities to the most vulnerable, such as focusing on general interventions, establishment of health rooms / drug consumption rooms, heroin clinics, prevention of infectious diseases and quality in substitution treatment have had an impact on the trends.

Drug users are often infected with blood-borne infectious diseases caused by intravenous drug use and sexual activity without condom. Based on the various studies it is estimated that up to 75% of the drug users are infected with Hepatitis C, whereas approximately 35% are infected with Hepatitis B. Less than 5% are infected with HIV.

Mental disorders in drug users is a frequent phenomenon, given that drug use often appears together with actual mental illness or mental problems in the form of panic reactions, anxiety attacks, depressions and personality disturbances, etc. Statistics on psychiatric admissions show that there has been an increase throughout the years in patients admitted for psychiatric treatment, and where drug abuse is a contributory factor on the admissions (dual diagnoses).

To study the scope of contacts at the Danish emergency rooms resulting from poisoning after intake of illicit drugs, special statistics have been compiled on the poisonings recorded at the somatic and psychiatric emergency wards. The fact that far from all poisoning cases are reported means that these statistics provide minimum figures only. The statistics, however, document that there has been a steady increase in the number of persons annually admitted to the emergency rooms in Denmark with poisoning symptoms resulting from intake of illicit drugs. The drugs causing poisoning are normally stimulants among the very young, whereas opioids, including heroin and methadone, are the main causes of poisoning among slightly older drug users.

6.2 Drug-related infectious diseases

HIV/AIDS

Action taken in Denmark against HIV is based on the principle of voluntarism, anonymity and openness, providing direct and honest information and security for individuals in their contact with the health authorities. The HIV reporting system includes the civil registration number (CPR no.), information about previous HIV test and risky behaviour and assumed manner of infection. AIDS is also reported with personal data. Table 6.2.1 of the annex shows the number of reported newly diagnosed HIV positive and out of them, the number of intravenous drug users the past 10 years¹⁰. The number of persons newly diagnosed as HIV positive has varied from year to year, as has the number of infected persons where the source of infection is assumed to be intravenous drug use. In 2011, 4% (10 persons) of those newly diagnosed as HIV positive were registered as intravenous drug users. This percentage has remained more or less the same between 4% and 11% the past 10 years.

The proportion of newly diagnosed AIDS cases with the source of infection being considered to result from intravenous drug use has been relatively stable around 10%. In 2012, 10% of those diagnosed with AIDS were intravenous drug users, which constituted four out of a total of 41 persons.

Hepatitis A, B, and C

Despite minor fluctuations, there seems to have been a decline in the number of registered acute hepatitis cases in the Danish population as a whole over recent years (Table 6.2.2 of the Annex). During the period, the share of acute hepatitis cases, where the infected person has been an intravenous drug abuser, has been under our around 1% for hepatitis A, varied between 0 and 32% for acute hepatitis B and between 0 to 85% for acute hepatitis C. However, the proportion of persons reported with chronic hepatitis C resulting from intravenous drug abuse is relatively stable at 67-75%. The number of reported cases of acute hepatitis B and C is low in Denmark. Therefore, the major fluctuations in the proportion attributable to intravenous drug abuse should be read with caution. Since hepatitis C is often asymptomatic in the acute phase, the reported cases are most likely underestimated.

Studies on the prevalence of infectious diseases

As part of the qualification, harmonisation and mapping of the prevalence of infectious diseases among drug abusers in the EU, the Danish Health and Medicines Authority supported a research project from 2004-2008, during which period the prevalence of infectious diseases among drug abusers (Christensen 2006) was investigated¹¹. Studies have been made on the prevalence of HIV and hepatitis B and C among the drug-related deaths (approximately 250 a year), which were recorded in the National Commissioner's register.

¹⁰ The figures from previous years have been adjusted and updated, which is the reason why they differ slightly from the figures provided in preceding annual reports. The State Serum Institute

¹¹ The initiative for the study was taken in the *national key indicator group for infectious diseases* and a member of the group, special consultant PhD Peer Brehm Christensen is the project leader for the study.

Results from the 5-year-study show that the prevalence of hepatitis B and C among drug abusers over recent years is more or less constant and perhaps falling and the prevalence of HIV among drug abusers is unchanged and a relatively rare phenomenon. Depending on the study year, approximately half of those examined had positive antibodies against hepatitis C, whereas approximately 1/4 hepatitis B (anti-HBc) positive and 1/4 were protected against hepatitis B (anti-HBs positive). HIV infection in the study population was almost unchanged during the period and less than 4%.

6.3 Other drug-related health problems

Non-fatal poisonings caused by illicit drugs

Hospital contacts with drug poisoning as the action diagnosis are recorded in the National Patient Register (LPR). The data retrieved below include such action diagnoses after visits to the emergency room and admissions to somatic and psychiatric hospitals where the patient was not transferred from an emergency room.

Table 6.3.1 of the annex shows the number and development of the recorded poisonings with the various illicit drugs from 2003 to 2012. From 2010, a data retrieval criterion different from previous ones has been applied. The compilation methods before and after 2010 are thus not identical. It is assumed that the poisonings are under-reported throughout the years, which means that these are minimum figures.

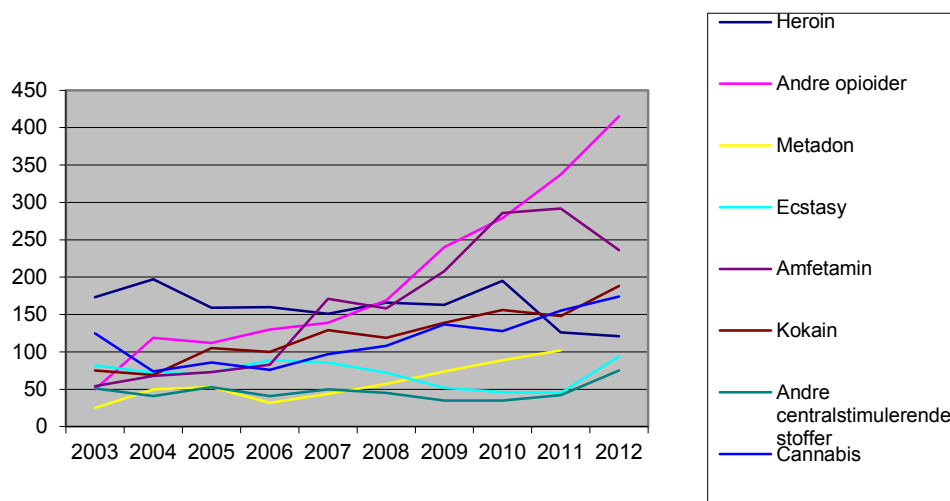
Each year, between 1163 and 2028 poisonings have been recorded with illicit drugs from 2003 to 2012. As of 2004, an increasing trend appears from 1163 poisonings in 2004 to 2028 poisonings in 2012, which equals an increase of 74% during the period. In spite of a general increase in the total number of poisonings from 2004 and until today, there is a drop in the number of poisonings caused by heroin from 2010 to 2012 (from 195 to 121 during the period).

The increase throughout the years is primary caused by poisoning with "other" opioids (not heroin) or psychostimulants – particularly amphetamine and cocaine. From 2011 to 2012, a significant increase is seen for the first time in the number of poisonings with ecstasy (from 45 to 94), although the number in 2012 is still significantly lower than the number of poisonings caused by amphetamine (236) and cocaine (188) in the same year. As mentioned, the figures are unconfirmed and should be read with some reservation due to diagnostic uncertainty and other sources of error.

A total of 15,257 cases of poisoning have been recorded during the past 10 study years. A vast majority of them, almost 90%, were treated in the somatic hospitals and the remaining almost 10% in psychiatric hospitals. As for distribution of gender, the men account for 2/3 (66%) and the women for 1/3 (34%).

The figure below shows the developments of poisonings caused by the various drugs from 2003 to 2012 (numbers shown in table 6.3.1 of the annex).

Figure 6.3.1 Development in hospital contacts due to poisoning and intoxication from illicit drugs from 2002-2012



Source: The National Patient Register, State Serum Institute, data from May 2013

The poisonings in 2012 are shown in table 6.3.2 below. More than half of them (1054 out of 2028) of all poisonings in 2012 occurred in persons over the age of 30 years, whereas a little less than half of the poisonings (974 out of 2028) occurred in persons over the age of 30. Young people under the age of 24 accounted for 38% (765 out of 2028) of the cases.

Most of the poisonings caused by opioids were most frequently seen in persons above the age of 30. Poisonings caused by psychostimulants were most frequently seen in young people followed by polydrug use or drugs that could not be specified.

Table 6.3.2. Hospital contacts due to intoxication or poisoning caused by the various illicit drugs in 2012 broken down by different age groups

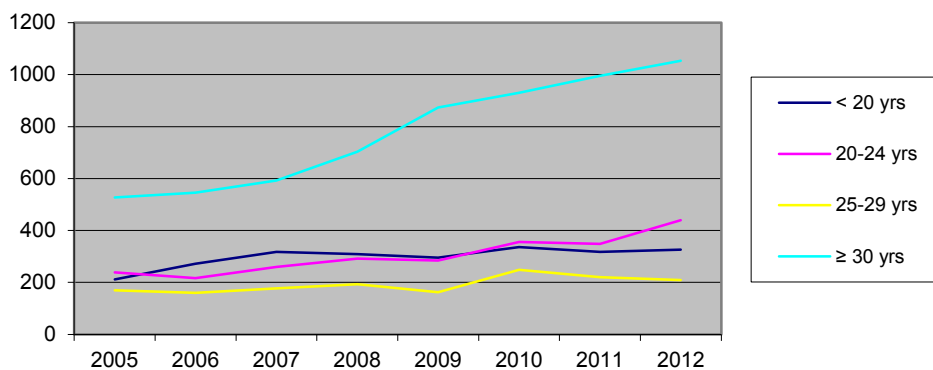
	< 20 yrs	20-24 yrs	25-29 yrs	≥ 30 yrs
Opioids	37	60	46	585
Psychostimulants	165	231	102	155
Mushrooms and hallucinogens	12	13		11
Cannabis	63	44	17	50
Polydrug use and unspecified	49	91	44	253
Total	326	439	209	1054

Source: The National Patient Register, State Serum Institute, data from May 2013

Among the psychostimulants, cocaine also appears, rather exceptionally, among the poisonings in the slightly older population. Persons at the age of 20 or older accounted for 33% (62 out of a total of 188) of the poisonings caused by cocaine in 2012 (not shown).

The trend in the number of poisonings caused by the various illicit drugs throughout the years in the various age groups is shown in table 6.3.3 of the annex and is illustrated in 6.3.2 below.

Figure 6.3.2 Hospital contacts following intoxication and poisoning broken down by age groups from 2005-2012



Source: The National Patient Register, the State Serum Institute, data from May 2013

As previously mentioned, the number of poisonings caused by illicit drugs has gone up in recent years. The increase is particularly seen in persons above the age of 30. However, it should be noted that a marked increase is seen in the number of poisonings of young people aged between 20 and 24 years from 2011 to 2012 (from 347 to 439).

Mental illness

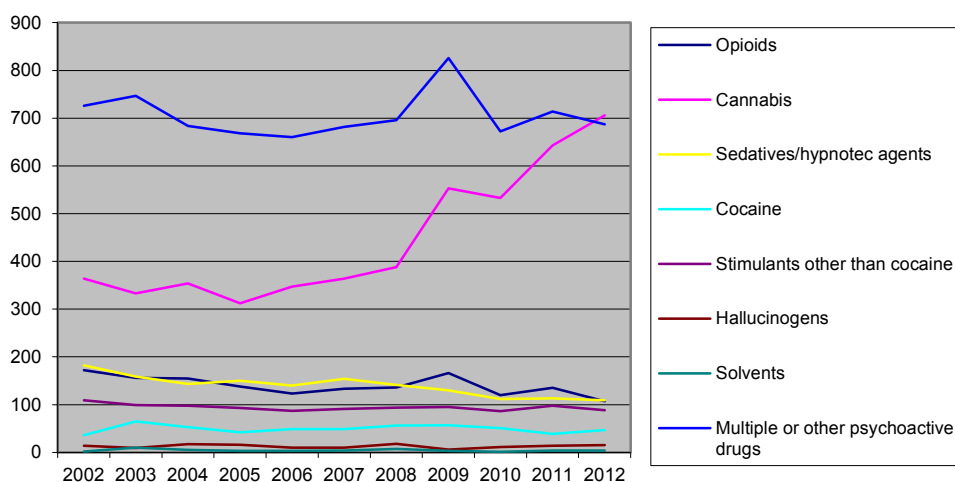
Mental disorders in drug abusers is a well-known phenomenon, given that drug abuse often walks hand in hand with mental illness or mental problems such as panic reactions, anxiety attacks, depressions, personality disturbances, etc.

In 2012, a total of 5,709 persons were admitted to psychiatric hospitals with a drug-related primary or secondary diagnosis. This is almost the same level as in 2011, when the number was 5,687. During recent years, there has been a steady increase in the number of persons admitted to psychiatric hospitals with a drug-related diagnosis, however with annual fluctuations (see table 6.3.4 and 6.3.5 of the annex)

In 2012, the number of persons with drug-related diagnoses was 3,946 (3,927 in 2011), and the number of persons with a drug-related primary diagnosis was 1,763 (1,760 in 2011). The number of persons and admissions with primary or secondary diagnoses are shown in tables of the annex and illustrated in the figures below.

Over the past 10 years, persons with *primary diagnoses* in relation to polydrug use (multiple or other psychoactive substances) have made up the most prominent group. However, in 2012, the number of persons with cannabis-related primary diagnoses was for the first time superseded by the number of polydrug use diagnoses. Persons with cannabis-related primary diagnoses accounted for 40% of all persons admitted to psychiatric treatment with a drug-related diagnosis in 2012. During the same period, the number of persons with an opioid-related primary diagnosis was slightly falling, however with annual fluctuations.

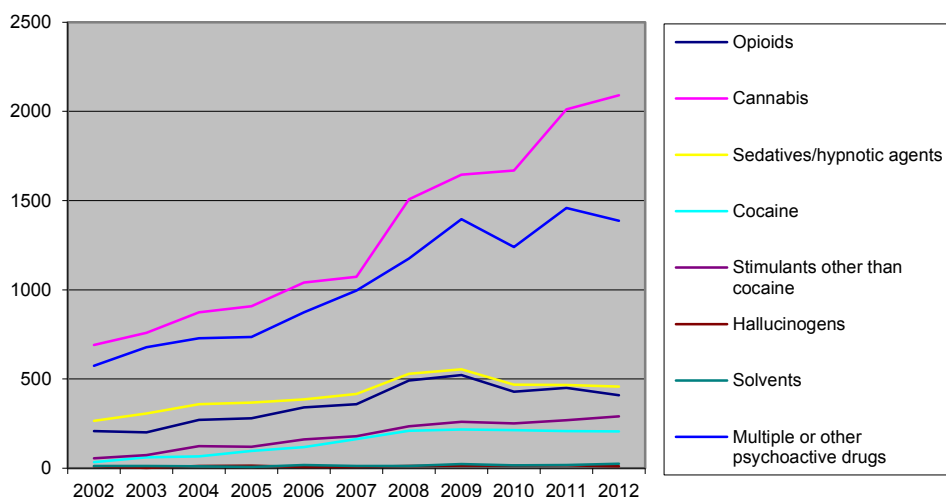
Figure 6.3.3. Persons registered with drug-related primary diagnoses in psychiatric hospitals, 2002-2012



Source: Specific data from the Psychiatric Central Register under the Dept of Psychiatric Demography at the Institute of Psychiatric Basic Research, Psychiatric Hospital, Aarhus

The number of persons with a cannabis-related *secondary diagnosis* have almost tripled during the past 10 years. The group included 759 persons in 2003 and 2091 persons in 2012. During the same period, there is also an increase in the number of persons admitted with secondary diagnoses related to cocaine and other psychostimulants, although the number of cocaine-related admissions from 2008 and up until today have stabilised. The number of admissions with cocaine and other psychostimulants, however, is significantly lower than admissions with cannabis secondary diagnoses.

Figure 6.3.4. Persons registered with drug-related secondary diagnoses in psychiatric hospitals, 2002-2012



Source: Specific data from the Psychiatric Central Register under the Dept of Psychiatric Demography at the Institute of Psychiatric Basic Research, Psychiatric Hospital, Aarhus

The number of admissions involving polydrug use as a secondary diagnosis is considerable and accounts for more than 1/3 of the total number of admissions with a secondary diagnoses related to drugs.

6.4 Drug-related deaths and mortality among drug abusers

The National Police has recorded all drug-related deaths since 1970. The register includes deaths involving reporting to the police for the purpose of post-mortem and where information of problem drug use is available. This could, for instance, be in the case of individuals found dead, sudden unexpected death, accidents – including poisoning, homicide and suicide. Deaths caused by poisoning or other type of accident where the individual in question had taken drugs will thus also be registered in the register of the National Police.

Parallely with the National Police register, the Danish Health and Medicines Authority (which has now handed over the task to the State Serum Institute) has publicized a sequence of statistics on drug-related deaths since 1995. The statistics are based on data retrieved from the Cause of Death Register and comprises the deaths that are drug-related in accordance with the EU definition.

The differences between the figures in the register of the National Police on drug-related deaths and the State Serum Institute's Cause of Death register stem from the differences in death populations and from the differences in definitions of a drug-related death. For instance, the register of the National Police only states deaths that have been subject to post-mortem, whereas all deaths in Denmark are registered in the State Serum Institute's Cause of Death register.

The figures that are annually publicized by the EMCDDA on drug-related deaths in the ET are mainly collected from the national cause of death registers (as they are from Denmark) and are referred to as the "national definition". Therefore, any comparison with other European countries should be based on data from the State Serum Institute's Cause of Death Register. In a Danish context, the National Police register on drug-related deaths, however, is an important source for the analysis of developments over time and contains, among others, specific information about poisonings, which cannot be collected from the Cause of Death Register.

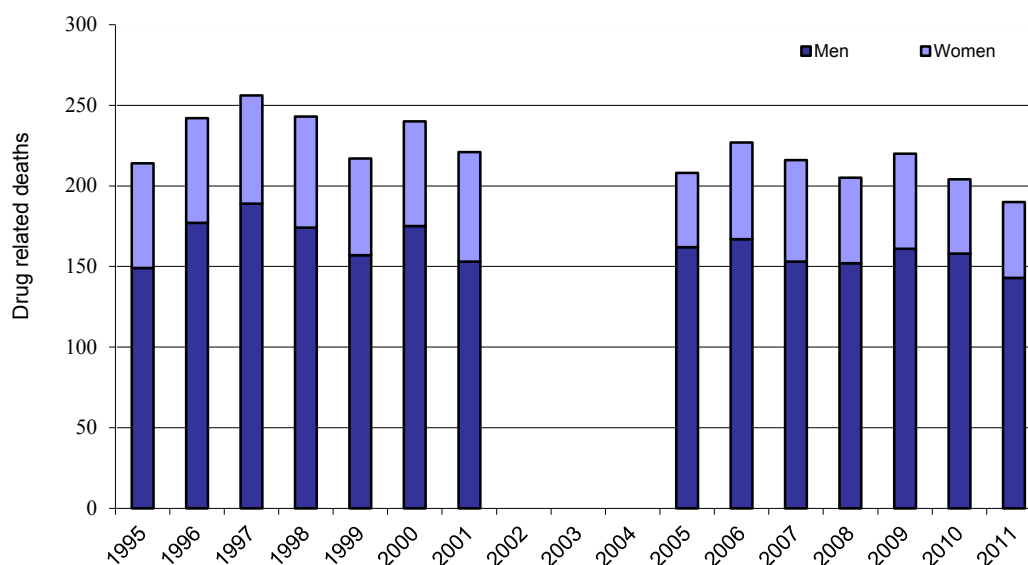
Statistics based on the Cause of Death Register

In the figures from the Cause of Death register, the European definition is used on the drug-related deaths (EMCDDA, 2005). This register includes deaths coded as deaths resulting from detrimental use of drugs or addiction and drug psychoses as well as deaths caused by poisoning (intentional or unintentional poisoning). Deaths caused by traffic accidents or other accidents, where illicit drugs were involved have not been included in this register, but in the register of the National Police.

Figure 6.4.1 shows the development of drug-related deaths recorded in the State Serum Institute's Cause of Death Register for the period 1995-2011¹².

¹² Valid figures on drug-related deaths recorded for 2002-2004 are not available. Furthermore, the 2011 figures have not yet been compiled.

Figure 6.4.1. Drug related deaths, 1995-2011, Cause of Death Register*



Source: State Serum Institute, Cause of Death Register, 2013

* The data for the years from 2007 to 2011 from the Cause of Death Register are not complete. As the actual number of deaths are known from the CPR register, the data for 2007-2011 have been raised by 1.7; 1.9; 2.2; 3.0; and 4.1 per cent, respectively in order to compare with previous years.

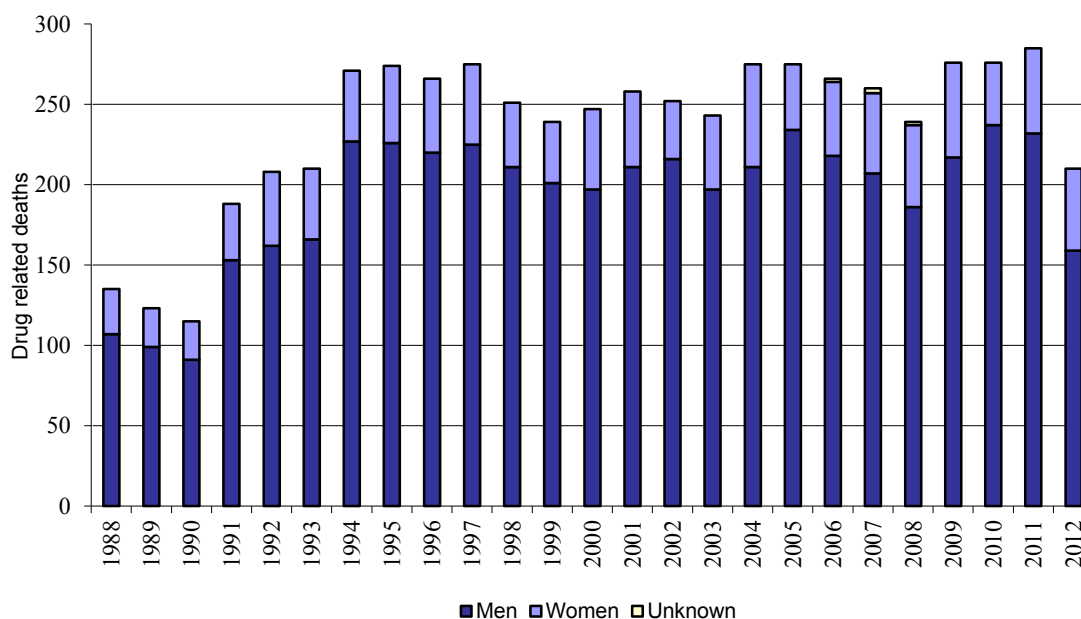
In 2011, the number of recorded drug-related deaths was 190. When considering the whole period from 1995 to 2011, the number of deaths fluctuates between 190-250. The number is at its lowest in 2011 when a mere 190 deaths were recorded. In 2011, men accounted for 75% (143) of all drug-related deaths.

Statistics based on the National Police register

From the mid-1990s (figure 6.4.2), the number of deaths recorded in the National Police register has been almost constant, however with annual fluctuations (see table 6.4.1 of the annex). In 2012, 210 drug-related deaths were recorded, which is the lowest number since 1994. Out of the 210 deaths, men accounted for 76% (159), and women for 24% (51).

The average age at death has been rising for many years. In 1993, the average age was 33 years, whereas in 2012 it was 41.9 years, with 41.8% years for men and 42.3 years for women. The rate of young people under the age of 30 was 13% of all drug-related deaths in 2012 (the rate was 19% in 2011).

Figure 6.4.2. Drug-related deaths 1988-2012, National Police



Source: National Police 2013

Out of the 210 deaths in 2012, 79% (166) were caused by poisonings with one or several drugs, whereas 21% (44) were caused by another type of drug-related death – for instance, injury other than poisoning, disease or unknown cause of death.

As table 6.4.3 shows, 24% of all poisonings (40 out of 166) are caused by heroin/morphine or heroin/morphine in combination with another substance, whereas 60% of the poisonings (100 out of 166) were caused by methadone or methadone in combination with another drug. 17% of the poisonings (28 out of 166) were caused by other drugs.

Table 6.4.3. Poisoning deaths among drug abusers in the year in question grouped by the assumed most significant cause of death. Numbers in parenthesis are percentages

	1997	2004	2005	2006	2007	2008	2009	2010	2011	2012
Heroin/morphine	153(71)	81 (38)	77 (37)	83 (37)	69 (34)	70(36)	75(36)	67(33)	53(24)	40(24)
Methadone	46 (21)	95 (44)	89 (43)	92 (42)	84 (41)	82(42)	96(47)	89(44)	114(52)	100(60)
Other	17 (8)	38 (18)	40 (20)	46 (21)	52 (25)	43(22)	35(17)	48(24)	51(23)	28(17)
Poisonings total	216 (100)	214 (100)	206 (100)	221 (100)	205 (100)	195 (100)	206 (100)	204 (100)	218 (100)	166 (100)

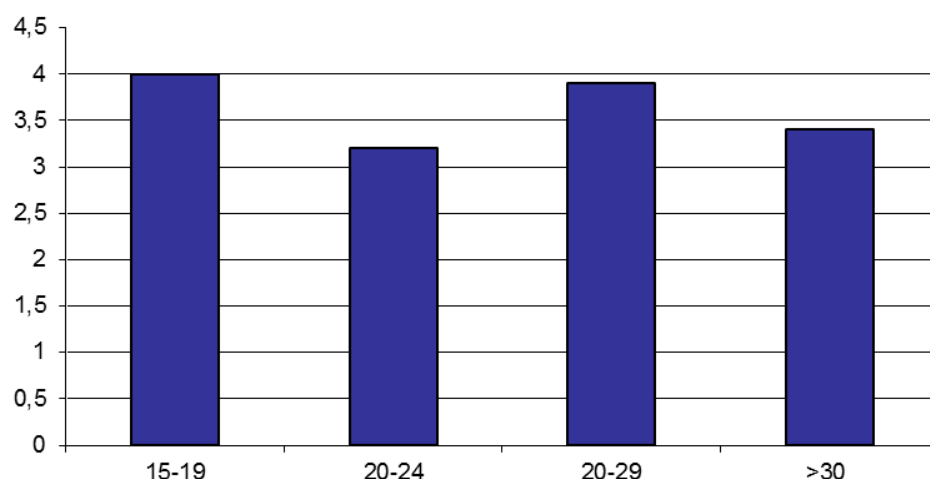
Source: National Police, 2013

Table 6.4.3 shows the developments in the various poisoning deaths for the years 1997 and from 2004 and onwards. Overall, poisonings caused by opioids (heroin/morphine and methadone) account for the majority of deaths over the years. The poisoning deaths include accidents and suicide.

However, from the 1990s and until today, there appears to be a drastic change in the pattern of poisonings. The fact is that within the group of poisonings caused by opioids, there is a decline in the number of deaths, where heroin/morphine poisoning is reported as the primary cause. Conversely, there is a corresponding increase in the proportion of deaths, where methadone poisoning is reported as the primary cause. Finally, since 1997, there has been an increase in the proportion of deaths, where poisoning under the “other” category is stated as the primary cause. The rate, however, has been steady over recent years. The group of “other” contains drugs such as amphetamine, cocaine and ketobemidone. In 2012, the “other” category included the following poisoning deaths: cocaine (4), ketobemidone (2), amphetamine (1), ecstasy and ecstasy-resembling substances (1).

It should be emphasized that the drug mentioned in the left column of table 6.4.3 is the drug classified by the forensic experts as the *main cause* of the poisoning. In a majority of the deaths, a number of drugs contribute to the poisoning – ie more than one drug was found in a deadly dose. Other drugs which could also be found in the blood of the deceased such as benzodiazepines, alcohol, etc. are also recorded. Figure 6.4.3 below shows the number of drugs - the lethal ones as well as the non-lethal ones - that are found in the blood of the deceased, broken down by different age groups.

Figure 6.4.3. The average number of drugs found among poisoning deaths in 2012 broken down by different age groups



Source: National Police, 2013

As the figure shows, an average of more than 3 different drugs were found among all deaths, which documents widespread polydrug use among those who die from poisoning. This also applies to the very young. The most frequently found drug among all drug-related deaths is benzodiazepines (65%) and methadone (65%) followed by cannabis (39%) and heroin (28%).

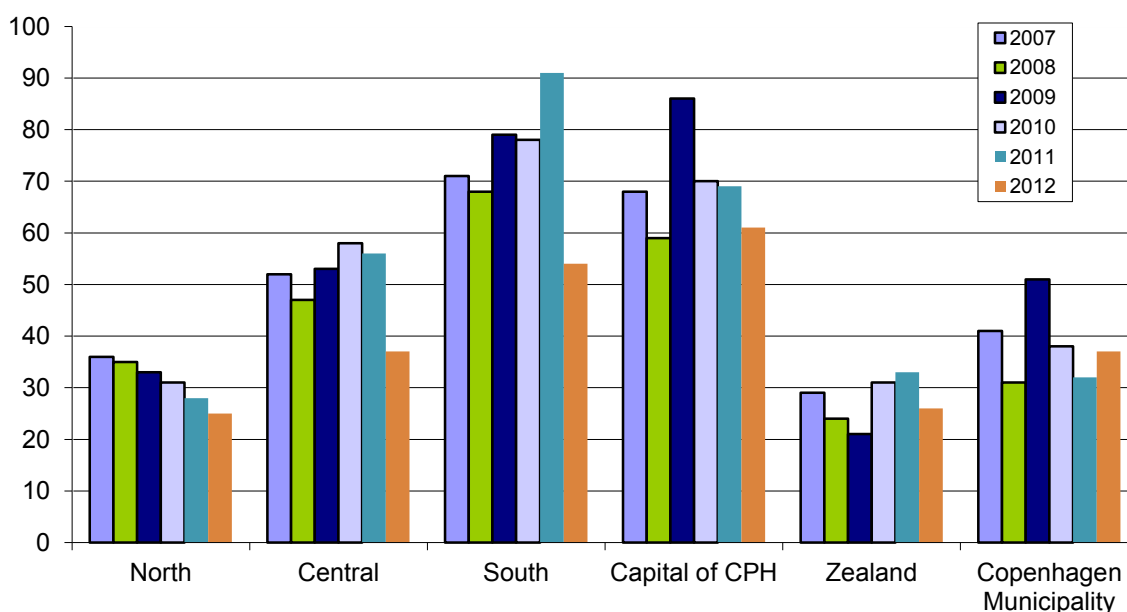
Geographical trends

Out of the 210 drug-related deaths in 2012, 94, 76, and 40 were examined and reported from the forensic departments/institutes in Copenhagen, Aarhus, and Odense, respectively. During recent years, a higher number of drug-related deaths have been

seen in Jutland than on Zealand. In 2012, more drug-related deaths were seen on Zealand than in Jutland. Funen still accounts for the lowest number of drug-related deaths.

The development in the total number of drug-related deaths for the period 2007-2011 broken down by regions and the Copenhagen Municipality appears in figure 6.4.4 below. The figures are provided by the municipality, in which the drug abuser lived at the time of death, and not where death occurred. In the cases where a person has been recorded with a substitution number, it will not be possible to name a municipality of residence.

Figure 6.4.4 Drug-related deaths broken down by regions and the Copenhagen Municipality (deaths in Copenhagen Municipality are included in the columns for the Capital Region of Denmark).



Source: National Police, 2013

Figure 6.4.4 shows that the number of drug-related deaths are distributed on all the regions with the highest number in the Capital Region of Denmark, and the lowest number in the North Denmark Region. The development in the number of deaths from 2007 to 2012 varies within the five regions. However, there is a decline in all regions from 2011 to 2012. The decline is most significant in the South Denmark Region. In spite of a decline in the number of deaths in the Capital Region of Denmark, there is an increase in the number of deaths in the Copenhagen Municipality compared to 2011. Copenhagen Municipality is the municipality with the highest number of drug-related deaths (37) followed by Aarhus (13), Aalborg (12), and Odense municipality (10).

As mentioned in the introduction to the chapter there are no bullet proof explanations as to why the drug-related deaths drop so dramatically from 2011 to 2012 in the Region of Southern Denmark. There are most likely a number of factors involved. An overall decline in recent years in the number of drug abusers receiving treatment for the first time with opioids as their main abuse problem could be one of the reasons – also in the Region of Southern Denmark. However, changes in the drug market in the years in question could also be an explanation. Finally, one might assume that the new initia-

tives and interventions provided by the municipalities to the most vulnerable, such as focusing on general interventions, establishment of health rooms / drug consumption rooms, heroin clinics, prevention of infectious diseases and quality in substitution treatment have had an impact on the trends.

Apart from the drastic decline in the Region of Southern Denmark, there seems to be a decline in all the other regions. The general decline was expected, because the new drug abusers admitted to treatment with opioids as their main abuse problem has been on the decline over the past few years. All other things being equal, opioid abuse is what most often leads to premature death. The interventions mentioned above should thus be assumed to have an impact nationally. Developments in the years to come will show whether or not the positive trend continues.

7 Health interventions

7.1 Introduction

Often, drug and alcohol abuse has far-reaching consequences to an individual's health. Apart from the physical and mental injuries to the person's health, the abuse may be life threatening.

Drug abusers account for a heavy prevalence of mental disorders and mentally ill patients are heavy users of intoxicants. A mental disorder may make it difficult to go through treatment for drug problems, and drug abuse may maintain and worsen an underlying mental illness. Often, the situation is highly complex.

Drug abusers are indeed prone to increased somatic morbidity and account for much higher mortality rates than the background population. Many illnesses contracted by the drug users occur as a result of non-sterile and harming intravenous administration, involving infectious liver diseases and HIV. Other diseases that occur as a direct consequence of injecting drug use may be boils, thrombosis and blood poisoning, and heart valve infection. Other disorders such as illnesses of the teeth, trauma, lung diseases, TB and abdominal diseases are also seen in the abusers. These disorders are caused by the special living conditions and the lifestyle, which is often seen in connection with drug abuse.

In many cases, drug abuse is a long-term chronic condition, and recovery in the form of being drug-free cannot always be expected from drug abusers with a long track record of abuse. Harm reduction and particularly targeted health programs are therefore indeed an integral part of the treatment.

During recent years, the social reserve funds have set aside means to initiate a number of different healthcare programs and harm-reducing interventions for the drug abusers within and outside the established treatment system.

7.2 Prevention of poisonings and drug-related deaths

The government's clear statement for the drug abuse area is that in 2020, a significant change has been made in terms of drug-related deaths. The number of drug-related deaths has fluctuated between approximately 240 and 285 the past few years, and the number has been increasing since 2008. Before 2020, the number should be reduced and maintained at a maximum level of 200. This equals a reduction of 30%.

In December 2012, the government granted an application from Odense, Aarhus and Copenhagen Municipalities for the completion of a study into the drug-related deaths in these three municipalities. The study was conducted by the Norwegian Centre for Drugs and Addiction Research (Senter for rus- og ahengighedsforskning - SERAF), and is expected to be completed in the summer of 2014. The study will look into all drug-related deaths in the three municipalities from 2008-2011 and will consist of a quantitative as well as a qualitative part based on both merged registers as well as interview with staff in the treatment system and relative to the deceased. The deaths will be reviewed in order to gain more knowledge about the factors leading to and reasons for the deaths. The study is part of a number of new initiatives taken in recent years to prevent against deaths among drug abusers in Denmark. The various initiatives are described below.

Guideline on the medical treatment of acute drug poisonings

Many doctors have insufficient knowledge of acute drug poisonings, which particularly occur in polydrug use. As a result, the Danish Health and Medicines Authority published in 2012 a guideline on the treatment of acute drug poisoning (The Danish Health and Medicines Authority 2012g) with a description of the clinical picture and treatment principles. The guideline is intended to ensure the quality of the medical treatment so that treatment of acute poisoning is optimised. The guideline can be downloaded from the Health and Medicines Authority's website www.sst.dk.

Guideline on the treatment of cocaine abuse and abuse of other psychostimulants

In order to secure physicians' knowledge of effects and detrimental effects of cocaine and other psychostimulants, the Danish Health and Medicines Authority published a guideline in 2012 (The Danish Health and Medicines Authority 2012h) on the medical treatment of cocaine abuse and abuse of other psychostimulants. The guideline can be downloaded from the Health and Medicines Authority's website www.sst.dk.

Drug consumption rooms

In the Act no. 606 of June 2012 on the amendment of Act on Psychoactive Substances (Drug Consumption Rooms), the legal framework as authorised by the minister of health and prevention was set out for the establishment and running of local drug consumption rooms run by private institutions that had signed an agreement with the municipality.

At present, there are drug consumption rooms in Copenhagen and Odense, and it is expected that such rooms will be established in Aarhus by the end of 2013.

Drug consumption rooms may be part of the harm reducing part of the municipality's overall programs offered to drug abusers. Experience from abroad seems to confirm that drug consumption rooms may contribute to reducing mortality among the drug abusers and improve their health as well as limit the inconveniences for the surrounding community. The target group is persons at the age of 18 and above with strong addiction as a result of long-term and persistent abuse of drugs.

Being responsible for the social welfare and the health programs aiming at reducing the harm inflicted on drug abusers and their surroundings, each municipality is responsible for deciding whether or not interventions should include drug consumption rooms as part of the programs offered to drug abusers. Such rooms should only be included in the plans if the municipality already has a large variety of treatment and harm reducing schemes, and it should be recognized that drug consumption rooms cannot replace such schemes, but merely supplement them. The individual municipality should discuss their plans with the police, as the establishment of drug consumption rooms is also a police matter. Furthermore, the local community and, to a certain extent, the drug abusers involved should also have their say. In order to achieve the required benefits of reducing mortality among the drug abusers and improving their lives as well as bringing down the inconveniences for the surroundings, the drug consumption rooms should be offered as low threshold programs.

Once it has been decided that drug consumption rooms should be offered as a harm reduction program to drug abusers in the municipality, it is crucial that the municipality fully understands the problem in order to plan the social and health-related interventions aiming at harm reduction. The same understanding and insight is required when

the local programs are to be considered in terms of access, capacity, staff, drug types, modes of intake, rules of order, and supervision. All this should be planned in cooperation with the police, the local community, and, where possible, with the drug abusers involved. Access should also be made to relevant social and health-related programs. The drug consumption rooms must be manned by qualified personnel who most supervise drug consumption.

The ban against prohibition of psychoactive substances for purposes other than medical and scientific still applies. However, it is assumed that possession of psychoactive substances for own consumption inside or close to a public drug consumption room or a drug consumption room run by a private institution that has signed an agreement with the municipality will not be pursued by the police if the person in question is 18 years and as a result of a long-term and persistent abuse of psychoactive substances is heavily addicted to the drug in question.

Experience with drug consumption rooms in Copenhagen

In October 2012, the first stationary, however interim drug consumption room was opened in Denmark close to the Health Room at Halmtorvet in Copenhagen. The Health Room is open on all weekdays from 8.30 a.m. to 11.30 p.m. and is staffed with 6 nurses, 4 educational therapists, a project leader, a group of temps, and a social handyman. The healthcare leader of the Mændenes Hjem is the nursing coordinator and there is also a doctor.

During the first six months of opening, there have been 43,340 drug consumptions in the rooms, distributed on 841 users. Some of the users show up many times a day, whereas others only visit the room once. Around 80% of the users are men, and 20% are women, which equals the distribution among drug abusers in general. Around every fifth user is of foreign nationality. Users with Danish citizenship come from the municipalities of the Capital Region of Denmark.

The group of foreigners account for approximately every fifth of all users. Copenhagen Municipality is aware that the drug consumption rooms in themselves attract foreign citizens to Vesterbro's open street scene. However, as long as movement across the borders is free and there are different social programs in the different countries, it is highly likely that marginalised foreigners will walk the streets of Copenhagen and take advantage of the drug consumption rooms. The homeless unit in Copenhagen Municipality has a program that is particularly targeted at the marginalised foreigners, and over time, fruitful collaboration has evolved with the authorities of other countries, where citizens are also receiving help to return.

The drug consumption rooms have also appealed to the female drug users, but it appears as if some of the women prefer to take their drugs in the so-called "fixelances" where the atmosphere is calmer. "Fixelances" are rebuilt ambulances with staff, where they can take their drugs in the same way as in the stationary drug consumption rooms.

It is primarily psychostimulants such as cocaine and amphetamine that are used in the drug consumption room. Cocaine and amphetamine thus make up 2/3 of the drugs consumed. Approximately 10% of the drugs used are the combination of heroin/cocaine. 10% of the drugs consumed are heroin alone, whereas approximately 6% is methadone.

During the first six months, 32 ODs have been handled, where all the persons survived. Clean syringes are handed out and collected when used. Users of the drug consumption rooms are referred to social welfare and health programs as well as to drug abuse treatment.

In August 2013, a drug consumption room called "Skyen" [the Cloud] opened in Mændenes Hjem in Lille Istedgade. In addition to injecting drugs in "Skyen", it is also possible for the user to smoke drugs. The Social Services Committee in Copenhagen Municipality has decided that the interim drug consumption room on Halmtorvet will be open until the turn of the year 2013/2014 in order to service the high number of users with a need for taking their drugs in safe surroundings. Copenhagen Municipality finds it positive that different rooms in different locations provide a variety of options so that everybody – also the women – have access to taking their drugs in safe settings.

Prevention deaths through the use of Naloxone

As described in Chapter 6 of this report, around 80% of all the recorded poisoning deaths in Denmark occur after the intake of opioids (heroin, morphine, methadone, etc). The drug naloxone is an opioid antagonist that counteracts the adverse effects of opioids on the respiratory system.

Countries outside Denmark and Copenhagen Municipality have had good experience with user-administered use of Naloxone for the prevention of poisoning deaths caused by opioids and harmful injury resulting from opioid poisoning. Based on the positive experience from a pilot project in Copenhagen Municipality, a new government financed project has been launched involving other major municipalities in Denmark, where drug abuse in the streets exists.

The purpose of the project is to reduce the number of deaths and other injuries resulting from overdose in persons with opioid abuse by user-administered naloxone combined with training.

The intervention is locally implemented in four municipalities (Copenhagen, Aarhus, Odense, and Glostrup. Persons with a drug abuse problem, their family and relatives, and professionals working with drug abusers are trained in resuscitation and the use of naloxone. Copenhagen Municipality is the coordinating municipality with responsibility for training the other municipalities' local teachers and for collecting project data.

The project terminates with an evaluation in mid-2015.

7.3 Prevention and treatment of drug-related infectious diseases

The most important way to avoid drug-related infectious diseases such as hepatitis B (HBV), C (HCV) and HIV is to reduce the sharing of injection tools. The ways to implement this is to replace intravenous drug use with drugs taken orally, or by smoking and by dispensing clean syringes and needles to the drug abusers.

Furthermore, all current and former drug abusers should be offered testing for HBV, HCV, and HIV when they are in contact with the health care system and offered vaccination against HBV if they have not been infected. Intravenous drug users, cohabitants and family under the age of 18 and persons who have been infected with HBV and HCV are offered free of charge a combination vaccine against both hepatitis A and B to further reduce the risk of deterioration of the chronic HCV infection. Cohabitants, fami-

ly aged 18 and above and permanent sex partners of persons with HBV are only offered a free vaccination against HBV.

All patients who are diagnosed to be infected with HBV or HCV should be instructed thoroughly in how to avoid infecting other people. This information must be given by the physician who gives the diagnosis or treats the patient.

Referral of patients with HIV, HBV and HCV

A newly diagnosed HIV infected person should immediately be referred to a special unit of infectious medicine for further examination, counselling, and treatment, where necessary. HIV-infected people should be offered regular check-ups every 3-6 months. The check-up includes further guidance, clinical examination, on-going assessment of the immune system and the quantity of HIV-RNA in the blood with an assessment of needs for treatment.

Patients with HBV and HCV infection should be referred to a special unit carrying out further diagnostics, counselling, and assessment with a view to on-going control and/or medical treatment. The referral may be supplemented with support and follow-up schemes in order to secure completion. The work must be planned and ensure that agreements have been made on the collaboration between special units and drug abuse treatment institutions.

Treatment of chronic HBV and HCV

Today, the treatments available cannot cure the patient completely, but may slow down cell division and duplication and thereby reduce inflammation. As a result, the patient's disease may be brought to the inactive stage of the disease, whereby the risk of developing cirrhosis of the liver and liver cancer is reduced.

In the case of acute hepatitis C, everybody who is not spontaneously cured within 21 weeks should be offered treatment. Treatment cures more than 90% of the patients with acute infection. Approximately 50-80% of the patients with chronic HCV who are treated can be cured with the treatment programs currently available. Patients with cirrhosis of the liver do not always respond favourably to treatment and have more side effects than patients who do not suffer from cirrhosis of the liver. It is therefore important to identify patients with chronic HCV who are at risk of developing fibrosis (replacement of liver cells with connective tissue) and complete treatment before the disease develops into cirrhosis of the liver.

In 2007, the Danish Health and Medicines Authority prepared a national action plan for the prevention of hepatitis C among drug abusers, in which it is pointed out that the municipalities must ensure that the target group is systematically offered preventive measures, screening for hepatitis A, B, C and HIV, as well as offered vaccination against hepatitis A and B when required. The target group includes all intravenous drug users who are admitted to treatment and drug abusers who have injected themselves only once and thereby perhaps do not see themselves as intravenous drug users. The aim of the action plan is primary as well as secondary prevention, since screening and counselling are supposed to make the infected as well as the non-infected persons aware of the infection risk in general. Furthermore, treatment of infected people will eliminate the risk of them transmitting the virus to non-infected people.

In continuation of this action plan, the Danish Health and Medicines Authority established a reporting system as of 1 January 2011 for the monitoring of the municipalities' interventions and services.

Syringe dispense schemes

The municipalities are not legally bound to dispense syringes and needles to drug abusers. The handout of syringes and needles typically takes place via treatment institutions, the local pharmacies, drop-in centres or shelters. In some places, vending machines have been installed.

Expenses for dispensing clean tools are paid by the municipality. Via the social reserve fund agreement for 2004, the municipalities receive compensation in the amount of DKK800,000 annually for the hand-out of water ampoules together with the syringe kit, which is already being dispensed.

In 2009, as a result of a request from the Ministry of Health and Prevention, Local Government Denmark looked into the prevalence of syringe exchange schemes in the various municipalities in Denmark. In its report, Local Government Denmark concluded that the number of drug abusers who have access to clean syringes and needles is high. The reason is that all the large municipalities that have a relatively large number of drug abusers handout clean tools. The survey has not been broken down on a local level, but Local Government Denmark has found that it provides a useful picture of local practice.

7.4 Other interventions to reduce morbidity among drug abusers

In recent years, the social reserve fund agreements have set aside means for several interventions that provide health care counselling and treatment to drug abusers in the streets or in drop-in centres. Also special regional family outpatient clinics have been established for pregnant drug abusers and their children. Some of these interventions are described in detail below.

National family outpatient clinics

The Budget for 2008 provided for a total of DKK126.3million being reserved over four years (2010-2013) for the establishment of regional family outpatient clinics in hospitals in all five regions. The establishment phase has been extended by another year until the end of 2014. Following this, DKK28.5million will be carried forward as a permanent grant.

The aim of the family outpatient centres is to ensure an interdisciplinary and comprehensive solution to the mother, the child, a possible partner and siblings. The aim of this kind of intervention is to prevent against congenital defects and diseases as well as growth-dependent development problems and failure of care in children born of women with drug problems.

In the Budget for 2008, funds were also set aside for the establishment of a counselling function for the new family outpatient clinics. The counselling function was established in April 2009 as a Center for Prevention of Substance Effects on the Development of Children.

The Center assumes the secretariat function for a cross-regional coordination group. This ensures common professional guidelines, common diagnosis lists, etc for the work in the five regional family outpatient clinics. The Center is also in charge of the imple-

mentation and continued development of the family outpatient clinics' joint clinical quality database, which was established on 1 January 2013. The Center is also working on a project involving requalification of health visitors for early detection and support to pregnant women with foetus-threatening alcohol and drug use and to children who have been exposed to drugs and alcohol during their mothers' pregnancy.

By the end of 2014, an evaluation report will have been prepared on the implementation and the function of the five regional family outpatient clinics and their counselling functions etc at the Center.

The entire guideline for the family outpatient clinics (The Danish Health and Medicines Authority 2009d) can be read on the website of the Danish Health and Medicines Authority www.sst.dk. The Center's website is www.familieambulatoriet.dk.

Project Social Nursing – the good patient course

The project is financed by the social reserve funds and established under KABS VIDEN. The project started on 1 February 2010 and stretches over a three-year-period. Four hospitals/centres are involved in the Projekt Socialsygepleje [Project Social Nursing]: Hvidovre Hospital, Bispebjerg Hospital, Psykiatrisk Center Glostrup and Psykiatrisk Center Nordsjælland.

The aim of the project is to ensure counselling, knowledge conveying and bridging in relation to a group of the socially most vulnerable patients admitted to somatic hospitals or to a psychiatric centre for the purpose of strengthening a good patient course. The project thus comprises persons with problem drug use and/or alcohol use, homeless people, persons with comorbidities and prostitutes and focuses on better coherence in the treatment from admission and until the municipality takes over.

The rationale behind the project is that persons who are drug abusers often have problematic and interrupted hospitalisation periods. The staff does not have the requisite tools to handle the problematic issues associated with patients with drug abuse, and the patients are considered a nuisance.

A social nurse is employed in each of the four places. The social nurse is the patient's advocate in dealings with the staff. This work involves making plans for the good discharge and establishing contact to treatment institutions, nursing clinics or shelters. In dealings with the staff, the social nurse provides sparring on patient course, trains and works with attitudes.

The results from the mid-term evaluation in 2011 show, among others, that the staff in the hospitals have gained better knowledge about the target group's problems and that conflict management and the collaboration with the target group is perceived as significantly better. Furthermore, the social nurse's expert skills on medication and the knowledge of institutions and programs have given a quality lift to admissions as well as discharges.

8 Social correlates and social reintegration

8.1 Introduction

Drug abusers in treatment often have other problems than the abuse of drugs itself. Therefore, a number of social activities are often initiated before, parallelly with and after a treatment program. Overall orientation and coordination across local administration, interventions and sectors are thus key to the help given to socially marginalised citizens with complex problems.

The purpose of social interventions in relation to the target group is that the local authority must offer special interventions which can contribute to preventing against a worsening of the problems for each individual and improve the individual's social and personal function, chances of development and ways of living life as well as planning the overall interventions adapted to the individual's needs.

Given the complexity of the problems facing drug abusers, interventions dealing with one problem will often have an impact another. For instance, helping a drug abuser to find a home will often make it easier for the person to reduce the use of intoxicants. Also, it may be necessary to initiate several interventions at the same time if something has to succeed. For instance, that the person who has received help to find a home only can stay there if focus is made on his/her consumption of intoxicants.

The social action plan, cf Section 41 of the Danish Consolidation Act on Social Services, is the local authorities' tool to ensure that the social intervention is coherent and takes into account the whole perspective for the individual. The local case handler is responsible for coordination and continuity in each case. The social action plan may be used to define clearly the obligations of the involved persons, institutions and branches of local administration. The work with the social action plan is organised with the aim of citizen involvement in case handling. In all cases involving the provision of long-term services, such as drug abuse treatment on-going follow-up of the social intervention is required.

8.2 Social exclusion and drug abuse

As shown in chapter 5.3, drug abusers in treatment are characterized by being a socially vulnerable group when it comes to their labour market affiliation, education, housing situation and social life. In addition, they suffer from physical and mental problems that lead to further exclusion. Also the homeless and the inmates in the prison system show clear signs of drug abuse. The figures from chapter 4 on the number of homeless in 2013 show that 65% of the citizens living in homeless institutions are users of one or several drugs. As regards the inmates in the Danish prisons, statistics show that approximately 60% of the inmates were users of intoxicants prior to their imprisonment (chapter 9). Finally, as shown in Chapter 5.3, there appears to be a dramatic increase in the number of young people receiving drug abuse treatment.

Children and young people in out-of-home placement

As part of the Danish placement reform of 1 January 2006, the National Social Appeals Board was given the responsibility of keeping statistics on the decisions made concerning children and young people that are placed out-of-home. Statistics are based on the municipalities' reporting of all decisions on placement of children and young people. Reporting is required to contain different types of basic information about the

child/young person and the triggering cause of the placement such as abuse (drug and alcohol abuse) with the parents, or with the children/the young people (National Social Appeals Board 2012).

In 2011, decisions were made on the placement of 2,634 children and young people. 44% of these were aged between 15 and 17 years 22% were aged between 12 and 14 years, whereas 14% were between 0 and 3 years. By the end of 2011, a total of 12,364 children and young people between the age of 0 and 17 years were placed outside home. As mentioned above, the municipalities have reported the triggering causes of the placement, and often there are reasons for an out-of-home placement. Statistics show that drug/alcohol problems at home/in parents in 2011 were a triggering cause for the out-of-home placement in 17% of the cases. When considering the triggering causes of out-home-placement in the child/the young person it is seen that the drug/alcohol problems in 2011 were the cause of 11% of the cases. These figures are not much different from the ones in 2010.

8.3 Social integration

Drug abusers are a diverse group of people with different needs for intervention and support. The municipalities should be able to provide treatment programs for types of drug abusers, but today, not all drug abusers receive steady treatment for their abuse.

Therefore, there is a need for on-going development of programs for drug abusers based on knowledge currently available within the area in order for the programs to match the individual citizen's needs and special challenges.

The Ministry of Social Affairs, Children and Integration has therefore started to work on a drug abuse package which contains 10 specific initiatives, the purpose of which is to raise the quality in the social treatment of drug abusers. The drug abuse package focuses on strengthening treatment interventions and is based on methods that work and on the citizen feeling more systematic follow-up on the treatment. The citizen should also get the impression that care is taken of other problems than just the abuse itself.

The drug abuse package contains, among others, a methodology program with a special focus on strengthening treatment of the young person with a drug abuse problem and the follow-up treatment. Furthermore, the package includes an initiative focusing on treatment that reaches out to and embraces the most marginalised drug abusers.

There are a wide variety of interventions that can be initiated for the socially marginalised drug abusers. Interventions that are targeted at improving their housing situation, their education, employment social relations and economy are important elements to ensure social integration – as a means as well as the end goal itself.

Steady housing situation

In 2013, a count was made that showed that in week 6, there were a total of 5,800 homeless people in Denmark. They were particularly concentrated in the larger communities and especially in the capital city and its suburban municipalities. The study showed that 65% of the homeless were abusers of drugs, alcohol and medicine. Furthermore, 47% of the homeless are reported suffering from a mental illness, and 31% of them suffer from mental illness as well as drug abuse. For quite a few homeless, abuse and mental illness were recorded as primary causes of homelessness (Lauritsen et al 2011).

A number of services have been established of a temporary as well as a permanent nature, the purpose of which is to help drug users establish a stable housing situation. Temporary nursing homes are interim housing programs for homeless people with special social problems. Apart from being a housing service, these homes provide services that prepare and support the user in being able to function in his/her own home after "discharge" from the temporary nursing home. Furthermore, the municipalities are able to enter into agreements with council housing organisations on renting idle flats to individuals trying to become re-integrated into society. These flats can be offered to the drug user who has been living in a temporary nursing home, inpatient treatment facilities or in some other kind of residential setting. Citizens who do not fit into or who do not feel comfortable in traditional housing arrangements in spite of the social support are offered to live in established special settings referred to as "alternative homes". In addition, there are "alternative nursing homes" which are housing programs including long-term accommodation to, among others, drug users, who do not fit into traditional nursing homes for the elderly due to abuse, dementia or other problematic behaviour. The "alternative nursing homes" are often established in the same settings as the temporary nursing home.

In 2008, the parties behind the social reserve fund agreement launched a major comprehensive strategic program for reducing homelessness in Denmark. Approximately DKK500million were reserved for the program which would be running from 2009 to 2013 with a focus on testing methods to get the citizens out of their homelessness.¹⁷ 17 municipalities have joined the work with the homeless strategy. The strategy has been based on the Housing First principle¹³. The overall principle of the strategy is to reduce the number of homeless people in Denmark.

The key element of the Homeless Strategy is the work in implementing "Housing First" and three housing support methods with documented effect abroad into a Danish context. Evaluation of the Homeless Strategy shows that the three home support methods combined with a housing solution provides a very good chance that the homeless citizen is brought out of his/her homelessness. Evaluation of the Homeless Strategy shows that only a very small proportion of the citizens who have been offered this program have lost their home again. Only approximately 5-10% have lost their home at the end of the observation period. In other words, it is documented that the citizens manage to keep their home when given the necessary support. Therefore, in August 2013, the parties behind the social reserve fund adopted a plan for how the results from the Homeless Strategy could be implemented in the municipalities that have joined forces in the work with the Homeless Strategy and be implemented in other municipalities who wish to enhance interventions in the area.

Education and activation programs

Many drug users have performed poorly at school and only have a very basic educational background when leaving school. Opportunities for catching up on lost schooling

¹³ In the Housing First strategy, early stabilisation of the homeless person's housing situation is applied in combination with individual social support as an important element in a recovery process. The individual support is sought achieved through a number of supportive measures, eg practical housing support, help to handle contact to the public authorities, stabilisation of finances, treatment programs, etc. In this connection, it is important that interventions have an overall approach and are coherently targeted at the individual's specific needs.

after leaving school are good in Denmark. The responsibility for the ordinary educational system is distributed among several ministries, depending on educational level and type. Since a large share of the abusers have a lower educational level than the average, the various programs for adult education under the Ministry of Education will be relevant. In this connection, General Adult Education (AVU) and Preparatory Adult Education (FVU) are worth mentioning. They are both educational programs compensating for lack of Primary schooling. In addition, there are the labour market training programs (AMU), which are short-term programs meant to meet the low skilled and skilled workers' new or uncovered needs for business oriented vocational and supplementary training. The labour market training programs are accepted as competence-giving throughout Denmark and may be included in educational structures and may also give credit transfer to mainstream business-oriented education programs.

Institutions under the Ministry of Employment provide a number of activation programs for unemployed people in order to enable this group to provide for themselves. The programs are generally offered according to the individual's qualifications and must aim at the individual going back to work.

The programs are divided into 1) guidance and requalification 2) traineeship and 3) employment with wages being subsidized by the municipality. Guidance and requalification involve training and courses, as specially organised curricula that are supposed to develop or uncover the unemployed citizen's professional, social or language skills with a view to requalify the person to the labour market.

Also, a vocational rehabilitation program is a possibility for individuals with limited work capacity who cannot get a job through other support schemes (for instance vocational training on normal student grants or mainstream activation programs). Unemployed drug abusers will often have complex problems involving employment, education, health and social relations and would therefore also be the target group for a resource program. Persons under a resource program often have one coordinating case handler and the program is organised as an overall intervention with the purpose of bringing the person closer to a job or education in the long run.

Unemployed drug abusers who are not able to take part in vocational training programs may, according to the Danish Act on Social Services, be offered an activity and social program. The purpose of this type of program is to provide assistance in self-maintenance or improvement of personal skills or of life conditions. The activity and social programs are often provided at the drop-in centres described below.

Employment

The activation programs laid down in the Danish employment legislation must be planned individually in order to bring the unemployed persons closer to the labour market so that they are able to provide for themselves in the long run in a non-subsidized job. Here, there is a possibility of employment intervention being carried out concurrently with drug abuse treatment.

Citizens who cannot get a job or stay in one on normal terms due to significantly impaired physical or mental capacity or special social problems, and citizens who cannot avail themselves of other vocational programs should be offered protected employment by their local municipality. Protected employment can be employment activities organised in protected workshops and employment can be organised in other organisational settings. It can be in other types of housing, temporary nursing homes, drop-in centres, shelters and social cafés. Protected employment can also be organised in private com-

panies –on an individual level as well as for a group of citizens. Protected employment can be given to citizens receiving early retirement benefits or cash benefits, etc.

Steady social relations

A large part of the social work with drug users is carried out at drop-in centres. The drop-in centres are activity and social programs provided for in the Danish Consolidation Act on Social Services. More than 100 of the many drop-in centres in Denmark are organised in the Association of Drop-in Centres in Denmark. There are particularly 3 different types of drop-in centres targeting at drug abusers. There are drop-in centres aiming at a mixed group of active drug abusers, drug abusers in substitution treatment and previous drug abusers (approximately half of the drop-in centres). Then there are drop-in centres that solely address drug abusers in substitution treatment, and that primarily are established as a supplement to abuse centres. Finally, there are drop-in centres that only address former drug abusers.

The drop-in centres may have programs that are only of a caring nature, but where the work also includes activating and developing programs. Many drop-in centres perform outreach work. Quite a few of the drop-in centres for active drug abusers provide nursing care and the possibility of counselling provided by social workers or other professionals. For previous abusers, the drop-in centre creates the possibility of social gathering and activities with equals. In other words, this is a caring programme, the aim of which is to increase the individual user's quality of life every day. The social reserve funds for 2013 have reserved funds for the period 2013-2016 in order to boost interventions at the drop-in centres by developing local strategies with this area and by improving collaboration between the municipalities and the drop-in centres.

Debt counselling

Voluntary debt counselling is a service to marginalised citizens on how to handle their debts and thus starting living a more steady life. The aim of the counselling services is to help marginalized citizens gain an overview of their finances, make a budget and a realistic plan for paying instalments. In connection with the social reserves for 2012, DKK40 million have been set aside over 4 years for voluntary debt counselling targeted at the socially vulnerable citizens with debt problems. The initiative is based on experience from a similar initiative from the social reserve funds in 2008, when DKK16 million were set aside for the establishment of voluntary debt counselling for socially vulnerable citizens with debt problems. At the middle of 2011, 4,000 citizens received debt counselling.

Other social programs

There are other social programs that the target group may benefit from, including the possibility for a support and contact person, socio-educational help and personal and practical aid. The municipalities are in charge of a support and contact person to persons with mental illnesses, persons with drug or alcohol abuse and persons with special social problems who do not have or cannot stay in their own home. The overall purpose of the programs is to enhance the citizen's ability to build and maintain contact to the surrounding world based on own wishes and needs. Thus, the citizens get to use the opportunities available from the local community and the other established programs. Also the municipalities must provide help, nursing or support as well as training and assistance in developing the skills of persons with considerably reduced physical or mental functionality or special social problems.

Drug abusers may also need home nursing. The municipalities are under an obligation to help persons who need personal help/nursing and practical assistance with tasks at home as a result of temporary or permanently reduced physical or mental functionality or special social problems.

9 Drug-related crime, prevention of drug-related crime and prison

9.1 Introduction

The control on illicit drug trafficking, including prosecution of people committing drug offences, falls under the jurisdiction of the Danish Ministry of Justice. This chapter describes control measures on drug-related crime and the handling of drug users in the Danish prisons.

9.2 Drug-related crime

Drug crime is punishable under the Act on Psychoactive Substances and under section 191 of the Danish Criminal Code. Any violations of the Act on Psychoactive Substance are punishable by a fine or imprisonment for a period of up to 2 years. In connection with sentencing, it is considered whether or not the drug is intended for own use, or if the drug has been sold or intended for selling. Also, the type and quantity of the drug is considered. Where the possession of the drug is caused by heavy addiction following long-term and persistent use of psychoactive substances, the alternative sentence may be a warning supported by social conditions.

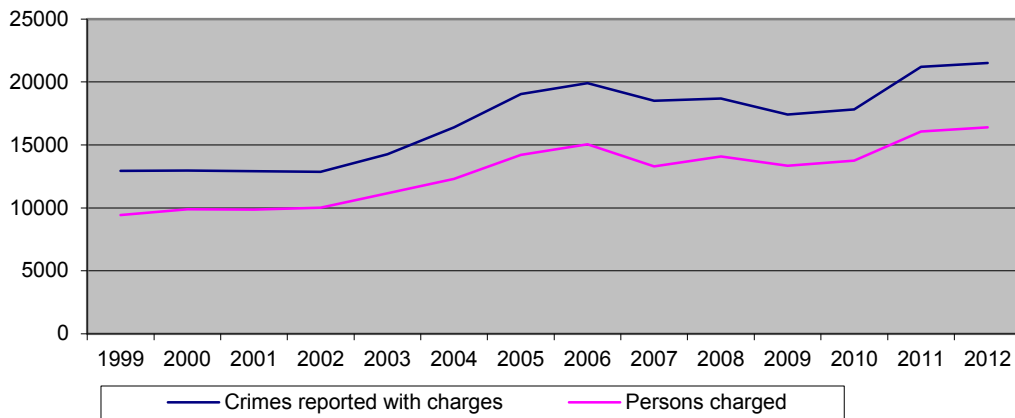
Section 191 of the Danish Criminal Code provides for stricter punishment on qualified violations of the Act on Psychoactive Substances. This means that if psychoactive substances are sold to a large number of people against considerable remuneration or under other particularly incriminating conditions, the punishment for violation of the Act on Psychoactive Substances may be extended to prison for a period of up to 10 years. When selling particularly dangerous or injurious substances, the offender may be further punished with a sentence of prison for a period of up to 16 years.

Charges with violation of drug legislation

In 2012, the National Police registered a total of 21,498 reports filed for the violation of the Drugs Act. In the same year, 16,401 persons were charged with the violation of the Drugs Act. Some persons were thus charged with several counts as regards violation of the Drugs Act.

The figure below shows the trends in the number of crimes reported on one or several charges in accordance with the Drugs Act and the number of persons charged under the Drugs Act during the period 2000-2012.

Figure 9.2.1. Drug-related crime in the year in question. Crimes reported with charges and the number of persons charged



Source: National Police, 2013

Driving under the influence of psychoactive drugs

Until 1 July 2007, driving under the influence of psychoactive substances was only punishable if the person was in such a condition that he/she was unfit for safe driving of the motor vehicle (the driver's ability criterion). In practice, this meant that punishment only became relevant in cases where it could be proved that the person in question had taken drugs and for that reason had been in the condition mentioned above. In order to lift the burden of proof it had become necessary to perform a clinical exam of the suspect. Conviction was thus based on the fulfilment of strict requirements for police investigation and proof from the prosecution.

On 1 July 2007, the Danish Road Traffic Act was amended, according to which a zero limit was introduced for driving under the influence of certain psychoactive substances which the driver had not taken in accordance with a legal prescription or which the driver had taken in accordance with, but not in compliance with a legal prescription. According to the new rules, cf Section 54 (s1) of the Danish Road Traffic Act, the prosecution shall only prove that the person's blood – during or after driving – contained psychoactive substances, which under rules stipulated by the minister of justice are classified as being hazardous to traffic safety. In order to improve the possibilities for the police to identify drivers under the influence of drugs, the amendment furthermore gave the police the necessary powers to perform eye examinations as well as sweat and saliva testing.

This amendment led to a significant increase in the number of charges with violation of the Danish Traffic Act, Section 54 (ss1). Thus, the number of charges went up from 282 in 2007, to 1,101 in 2008, 1,502 in 2009 and 1,622 charges in 2010 2,477 charges in 2011, and 3,269 in 2012.

Violations of section 54, (ss 1) of the Danish Traffic Act are punishable by fine. However, in particularly aggravating instances, punishment may increase to prison for a period of up to 1 year and 6 months.

As of 1 January 2012, section 54 (ss1) was also amended in terms of tightening sanctions as regards the cases of violation of the zero limit, where the person in question has taken the drug without a legal prescription (however there is no intention of tighten-

ing the rules in those cases where the person has a legal prescription, but has exceeded the prescribed dose).

9.3 Treatment in prisons

In Denmark, there are 13 prisons, 43 local prisons/lock-up units, 8 pensions (half-way houses) and 14 departments of the Prison and Probation Service in Freedom. In 2012, 13,903 people were incarcerated in prisons and lock-up facilities. 1,144 were women and 12,759 were men.

A total of 10,589 unconditional prison sentences were reported to the Danish Prison and Probation Service in 2012. The sentences represented a total of 70,576 months of all sentences. 63% of the sentences were 4 months or lower and accounted for 14% of all sentences. 6% of the sentences were more than 2 years and accounted for 46% of all sentences.

By far the majority of the convicted persons do time in the open and the closed state prisons, whereas a minor share serves their sentence in a lock-up facility. Furthermore, imprisonment in special cases may be made either fully or partially in the Danish Prison and Probation Service pensions or institutions outside the Danish Prison and Probation Service. This may occur in pursuance of section 78 of the Danish Corrections Act if the convicted person is deemed to have a need for special treatment or care. In 2012, this happened in 189 cases.

In 2012, the Danish Prison and Probation Service had an average capacity of 4,123 places. On average, the occupancy rate was 96.6%, which equals 3,984 inmates per day. Out of this figure, 159 of the prisoners were women. The average daily occupancy of young people under the age of 18 was 10.9 inmates per day. The inmates were placed in 884 in closed prisons, 1,309 in open prisons and 1,792 in lock-up facilities. The majority of all inmates in the local prisons and Copenhagen Prisons were remanded in custody.

On a specific date – 11 December 2012 - 66% of the convicted were between the age of 20 and 39 years. 12% were sentenced to 4 months and less. 43% were serving sentences of between 1 year and 5 years. 23% were convicted of drug crimes, 20% of violence, 13% of robbery and 14% of theft. 72% of the prisoners were Danish citizens

Strategy and the individual programs

The national strategy governing drug treatment of individuals under the Danish Prison and Probation Service is based on one of the main principles for the Danish Prison and Probation Service: the normalisation principle, which says that the conditions in the prisons must copy those of the rest of the society in all cases, and that the prisoners to a high degree must have access to the same programs as society in general.

In practice, this means that the Prison and Probation Service's clients must be able to use society's drug abuse treatment schemes. The clients who have been released or those with a conditional sentence must have the same opportunities as those who have no criminal record and seek treatment via their local municipality. For those who are still incarcerated it means that to the widest extent possible, they should be transferred from the prison to a suitable treatment institution. In order to be transferred, the inmate should not be prone to escape, should not be considered dangerous or otherwise insult the general feeling of justice through such a placement. Placement in a treatment institution may also be planned and started already before or on start-up of imprisonment.

Since 1997, there has been a gradual introduction of social treatment programmes in the prisons for those who cannot be transferred to treatment outside the prison. The national strategy is primarily based on the so-called import model, ie a model where private and public treatment institutions outside the Prison and Probation Service auspices offer drug treatment in the prisons in close collaboration with the Prison and Probation Service's own personnel. The target group of the import model is thus the group of inmates who cannot use the services of society.

In order to secure treatment of this group, the normalisation principle is in focus here. As a reflection of the treatment programmes provided to the society in general, a selected number of treatment institutions representing different methods within drug abuse treatment have established treatment in most of the prisons in Denmark.

The treatment institutions are thus under a contractual obligation to provide specific treatment (in cooperation with the Prison and Probation Service's staff), typically for a four-year-period, following which the treatment is offered again.

The various treatment programs in the prisons

There are several types of treatment programmes in the prisons. There are the **motivation and pre-treatment projects** in the lock-up facilities all over Denmark that are primarily based in the abuse centres of the local municipality, and the aim is to prepare the remand prisoners for the treatment provided to them in the prisons when serving their sentence or after release from remand custody. Then there are the **treatment departments**, which are completely isolated from the ordinary prison environment and are thus defined as inpatient treatment units, given that the inmates move about in a therapeutic treatment environment.

Furthermore, there are **follow-up treatment units** in selected prisons for inmate who have long-term sentences and who have completed primary treatment. The follow-up treatment has a major focus on education /employment and re-integration and is carried out according to the import model. In this connection, there are programmes for psychosocial **support in connection with substitution treatment** (medical treatment with methadone/Subutex) across the existing department in all prisons. Quite a few inmates are in substitution treatment and are followed-up by supportive sessions.

Similarly, there are programmes for cocaine abuse treatment for inmates in open prisons and programmes for **cannabis abusers** in all the prisons. The cocaine, cannabis and substitution programmes have been planned as day treatment (outpatient treatment), during which the inmates are referred to common departments where they participate in treatment for a short-term or long-term period as a supplement to or instead of training/other type of employment.

Finally, there are the **special so-called contract departments**, where no treatment is provided, but where inmates who do not wish to serve their sentence with drug abusers can be sure of serving their sentence in a completely drug-free environment. The Danish Prison and Probation Service also has 8 social re-integration pensions.

9.4 Drug abuse among the prison population

Table 9.4.1 below shows the use of intoxicants prior to imprisonment (The Danish Prison and Probation Service 2013). Almost 60% of the prisoners in prisons and lock-up facilities report in 2011 and in 2012 having used intoxicants 30 days prior to their imprisonment. Approximately 38% in both years maintained that they had not taken any

intoxicants and 3% did not wish to inform about their drug use. In the open prisons, the proportion of prisoners who reported in **2012** having taken drugs 30 days prior to their imprisonment was 69% compared to 60% in the closed prisons.

Table 9.4.1. Inmates' use of drugs 30 days prior to imprisonment

	Open prisons		Closed prisons		Lock-ups		Pensions		2011 13 December		2012 11 December	
	n	%	n	%	n	%	n	%	n	%	n	%
Inmates taking drugs												
Yes	1135	68.4	566	60.9	646	48.8	8	33.3	2355	59.8	2201	58.8
No	509	30.7	348	37.5	613	46.3	15	62.5	1485	37.7	1426	38.1
No wish to disclose	14	0.8	15	1.6	66	5.0	1.0	4.2	96	2.4	115	3.1
I alt	1658	100	929	100	1325	100	24	100	3936	100	3742	100

Source: Danish Prison and Probation Service 2013, unpublished

Note: The records are based on the inmates' own information. The figures include prisoners remanded in custody and convicted. For 2.1% of the inmates, no records have been stated on the intake of drugs prior to imprisonment. This group has been excluded from the table.

Table 9.4.2. Drugs taken 30 days prior to imprisonment. The number and proportion of inmates using drugs

	2010 18 December		2011 13 December		2012 11 December	
	n	%	N	%	N	%
Inmates taking drugs						
Opioids	572	23.4	468	19.2	417	18.9
Psychostimulants	1533	62.8	1525	62.5	1306	59.3
Cannabis	1681	68.9	1685	69.0	1579	71.7
Alcohol	862	35.3	742	30.4	716	32.5
Benzodiazepines	340	13.9	310	12.7	269	12.2
Hallucinogens	71	2.9	72	2.9	48	2.1
Other	159	6.5	153	6.3	136	6.2

Source: Danish Prison and Probation Service 2013, unpublished

Note: Where the columns add up to more than 100%, this is most likely because an inmate has stated more than one drug

It appears from table 9.4.2 that almost every fifth of those who in 2012 confirmed having used drugs the past 30 days prior to imprisonment had used opioids, whereas it was every fourth a few years ago. As in 2011, the most preferred drug is still cannabis (almost 3 out of 4 cases) which in 2012 is even increasing compared to the year before, whereas psychostimulants are still at a high level, although a moderate drop was seen compared to 2011 to a little less than 60% in 2012.

9.5 Treatment and prevention in prison

Since 2007, a treatment guarantee in the prisons has been given to the imprisoned drug abusers which are believed to qualify and be motivated for treatment and who, at the time when treatment is applied for, are expected to have at least 3 months left of their sentence. According to the guarantee, all inmates of the target group requesting for treatment should have started treatment within a fortnight. On 1 June 2011, the treatment was expanded to apply to prisoners in custody and prisoners with short-term sentences, which means that all prisoners in the institutions under the Danish Prison and Probation Service are now comprised by the guarantee. Moreover, the deadline of starting treatment within a fortnight still applies.

The treatment includes day treatment where the inmate serves his sentence in the so-called common department with other inmates who are not in treatment, and includes treatment in special wards where all inmates follow the same treatment, isolated from the rest of the inmates.

The treatment guarantee has been observed within the time limit in 82% of the recorded cases in 2011, which is a decrease of 6% compared to the year before. In almost 3 out of 4 cases, where treatment had not been initiated within the limit of 14 days, it was initiated within one month.

All primary drug treatment programmes under the Prison and Probation Service must follow an accreditation procedure, in which an expert panel assesses whether or not the treatment programme complies with the standards for good treatment. As at 1 January 2013, 12 out of 15 primary treatment programs have been awarded accreditation, whereas 3 programs still await the expert panel's judgement.

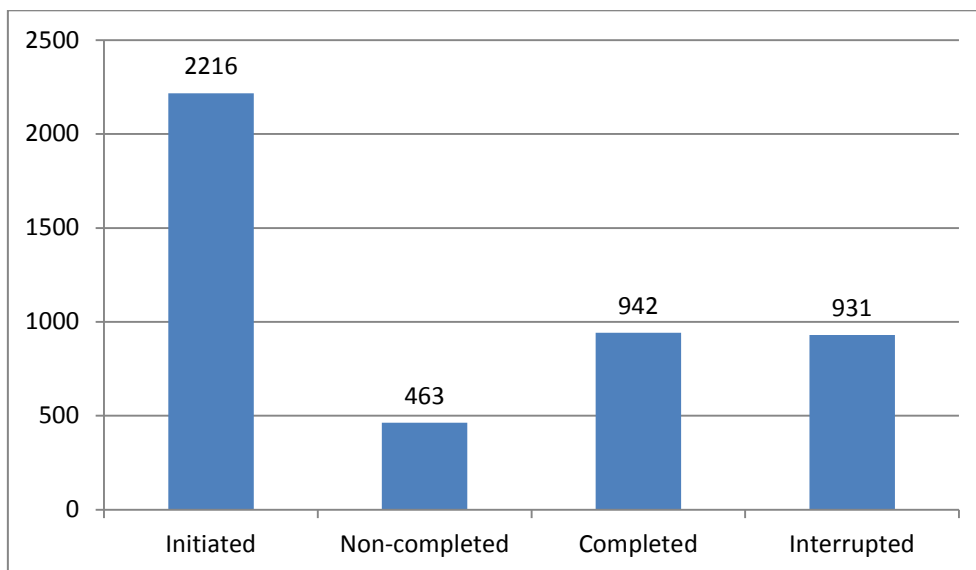
Prisoners in drug treatment

Overall from 1997 and until today, capacity has been expanded from 18 to approximately 290 places in actual treatment units. In addition, there are the contract department places and a varying number of inmates who receive day treatment. The table below shows the number of treatments and individuals who have been enrolled in treatment in 2011, categorized by type of treatment.

No consistent statistics have been prepared on the development in the number of annual treatment courses until in recent years. The Danish Prison and Probation Service believes that in 1998 and in 1999, a total of approximately 40 treatment courses were initiated, of which 25 were finalised according to plan. By comparison, 2216 treatment programs were initiated in 2012, cf figure 9.5.1 below (added to these, 1208 pre-treatment programs in lock-up facilities, which is a total of 3424 initiated treatment programs). In 2011, 2419 treatment programs were initiated. This somewhat lower figure should be viewed in the light of the fact that the data in 2011 were solely based on records at the Danish Prison and Probation Service's Client System, whereas the data from 2012 are retrieved from the treatment institutions, with which the Prison and Probation Service cooperate.

As figure 9.5.1 below indicates, the number of completed programs is relatively low (more than half of the ones initiated), but a large share of these interruptions are found among the pre-treatment programs where the inmate has been transferred directly from remanded custody to serving his/her sentence, whilst receiving pre-treatment.

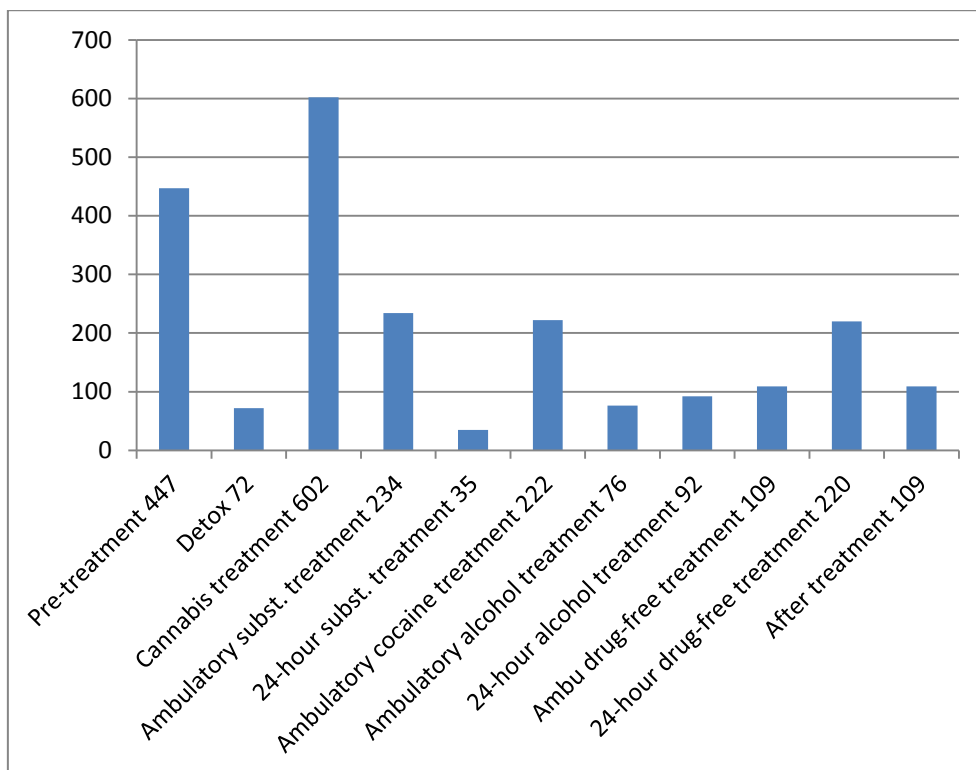
Figure 9.5.1. The number of initiated, non-completed, completed and interrupted programs in the prisons according to figures provided by treatment institutions



Source: Danish Prison and Probation Service 2013, unpublished

A large group of interruptions occur on the transfer from one prison to the other and on release. The relatively high number of interruptions are therefore not because the inmates have declined treatment or have been rejected.

Figure 9.5.2 Number of drug treatments initiated in prisons in 2012 broken down by type (n=2216)



Source: Danish Prison and Probation Service, 2013, unpublished

The distribution of treatment categories appears in figure 9.5.2. The most frequently initiated treatment is the pre-treatment (more than 4 out of 10 cases), whereas pre-treatment account for almost one-sixth of all programs. In addition, there are a large number of pre-treatment programs in the lock-up facilities, which have not been included. Detox, drug-free treatment in inpatient and outpatient clinics and the cocaine treatment programs together make up the largest group and are all focused on a life without drugs. The same principles applies for after-treatment programs

Prevention of diseases

With a view to preventing against drug-related diseases, withdrawal symptoms and cravings, the Danish Prison and Probation Service offers medicamental treatment for withdrawal symptoms. This treatment may extend over weeks or months. This temporary treatment is very often followed by substitution treatment that may last up to several years when deemed necessary by an interdisciplinary panel of people. This service is normally received and communicated to the institution expected to take over treatment after the prisoner's release.

For the purpose of preventing against infectious diseases, including in particular abscesses, sepsis, hepatitis, HIV and AIDS, the Danish Prison and Probation Service dispenses condoms, chlorine rinse fluid for cleaning of needles and syringes, vaccination against hepatitis B and A and general physical exams, including information about the above diseases and general physicals on an equal footing with the rest of the population. Inmates, however, do not have access to free syringes and needles.

9.6 Reintegration of drug abusers after their release

When drug-users are in treatment during their imprisonment and then released, the municipal treatment centre will receive a report in advance with a description of the type of treatment provided, a status of the treatment and an assessment of further treatment required.

If treatment terminates during imprisonment, there might be a need for supplementary treatment and in this case, the prison will contact the local treatment centre with a view to determining a strategy for after-care.

In order to improve the transition between imprisonment and the subsequent release, the Ministry of Social affairs published in 1998 a set of guidelines for the cooperation between the social authorities and the institutions and departments of the Danish Prison and Probation Service. This cooperation has, however, not always functioned satisfactorily although the need for coordination is high. Launched interventions, including treatment programmes, often fall to the ground if no follow-up is carried out on release (Ramsbøl, H. 2003). In February 2006, the Ministry of Social Affairs issued an executive order no. 81 on the municipalities' obligation to coordinate action plans with the Danish Prison and Probation Service for certain groups of individuals. This executive order provides that four weeks prior to the release of a prisoner, the Danish Prison and Probation Service must contact the municipality with a view to coordinating action plans and the municipality is under an obligation to follow up on the contact.

It has turned out to be difficult to establish cooperation with the municipalities. Therefore, the Danish Prison and Probation Service has a focus on the coordination of action plans in order to improve quality.

In order to support implementation of both the new and the older legislation, the Ministry of Social Affairs, Children and Integration, the Ministry of Employment and the Directorate of the Danish Prison and Probation Service jointly launched a project in 2006, the aim of which was to develop, test and describe methods for good case handling on the release of a prisoner. Participants in the project were three prisons, a number of municipalities, the Danish Prison and Probation Service in Freedom (KIF) and treatment centres, which are important players when it comes to generating coherence in intervention.

The project was completed in the middle of 2009 and pointed to a number of barriers for good cooperation and recommended a specific approach for the cooperation - a so-called "timetable for the good release". The recommendations of the project are currently being implemented and a number of specific collaboration agreements are being signed with all municipalities in Denmark. So far, agreements have been signed with 75 municipalities, with the remaining ones being signed very soon. The agreements can be viewed on the Prison and Probation Service's website.

10 Drug markets

10.1 Introduction

The police seizure statistics provide no entirely clear picture of trends in the quantities available of the various drugs over time. Major fluctuations exist in the quantity of drugs seized over the years, but often such statistical fluctuations reflect that bulk seizures have been made in each of the years. Seizure statistics are a very rough indicator of the supply of drugs on the illicit market, because they are indeed affected by police interventions.

Illicit drugs have no content declaration, and there are many different drugs hidden in the tablets and powders sold as, among others, "ecstasy". While the relatively new active substance, mCPP, which has stimulating and hallucinating effects, is dominant in the ecstasy tablets in recent years, the tide has turned, and MDMA (ecstasy) is again the dominant active substance and was contained in 59% of the tables examined. MDMA is also found to a large extent in powder samples and was contained in 46% of the powder samples examined in 2012 – either alone or in combination with ketamine (in 10% of the powder samples), GHB (in 6% of the powder samples) or metamphetamine (in 5% of the powder samples).

Results from the forensic analyses of the drugs in recent years also show that there is a large variation in purity and in drug concentration of the illicit drugs on the market¹⁴, and the illicit drugs contain additives to a large extent. In, for instance, all cocaine samples examined in Denmark, an average of 3 different additives were detected - typically medicines, which in themselves affect the user of the drugs. As the concentration and contents of the drugs therefore are often unknown, this implies a special risk upon intake.

The systematic monitoring of "new" drugs in Denmark was adjusted from 2011. Before 2011, "ecstasy" pills were solely submitted and analysed systematically for monitoring. Today, as of 2011, powders and fluids have also been included in the process. This change has been made in recognition of the fact that the many new drugs emerging on the market are also introduced in these types of administration. The results from the last six months of monitoring are described later in this chapter.

10.2 Drug supply and demand

The National Police collects information about the countries, which produce and distribute the illicit drugs seized in Denmark. As in previous years, Morocco is still the key country where cannabis is produced for the Danish market, with Spain, Portugal and the Netherlands being the key distribution countries. As regards heroin, the vast majority comes to Denmark from Afghanistan and Pakistan, whereas amphetamine seized in Denmark has primarily been produced in Holland and Belgium. A minor, however not insignificant part of the amphetamine available in Denmark is also produced in Poland and in the Baltic region. By far the largest part of the seized ecstasy is produced in the Netherlands and Belgium. Cocaine is primarily produced in South America and distrib-

¹⁴ Results from the special forensic analyses are based on random samples from the "Street Project" and from the project on monitoring of prevalence of ecstasy pills mentioned later in this chapter.

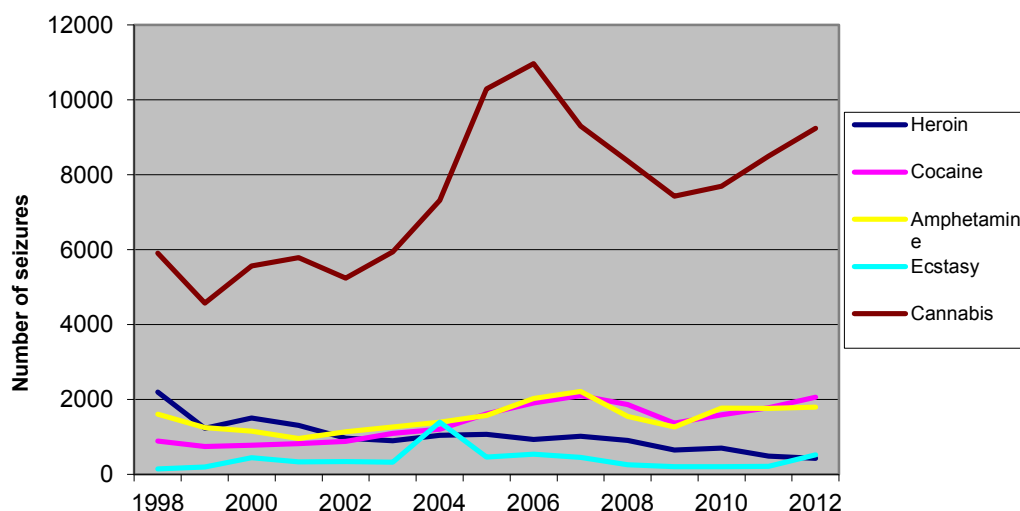
uted typically via Spain and the Netherlands. Large quantities of cocaine are also distributed to Europe via countries in West Africa and countries in the Baltic region.

As far as drug supply is concerned, seizure statistics show that the various illicit drugs are spread all over Denmark. In almost all police districts, seizure of the various drugs is seen.

10.3 Seizures

Police and customs keep on-going records of the quantity and the number of seizures of illicit drugs made at borders, airports and ports in connection with major investigations, as well as street-level confiscations. The data on seizures is regularly reported to the National Centre of Investigation (NCI), which compiles and publishes annual statistics based on this data (National Police Drug Statistics).

Figure 10.3.1. Drug seizures in the year in question



Source: National Police, 2013

As for the quantity seized, major fluctuations are seen in most drug types from one year to the other. In spite of an increase in the number cocaine seizures the past three years, the quantity of cocaine seized dropped from 72 kilos in 2009 to 54 kilos in 2010, 43 kilos in 2011, and 42 kilos in 2012. The quantity of amphetamine seized, however, rose significantly during the same period from 104 kilos in 2009 to 194 kilos in 2010, 240 kilos in 2011, and 302 kilos in 2012. The seized quantity of cannabis in 2012 was 1,334 kilos, which is significantly less than in 2011 and 2010, when more than 2,300 kilos were seized in each of these years. The number of ecstasy pills seized increase significantly from 16,042 pills in 2011 to 72,654 pills in 2012. However, it is worth noting that two single seizures of ecstasy in Copenhagen accounted for around 86% of the total quantity. This follows the pattern of previous years, when single seizures of the various substances are made in large quantities. The number of seizures and the quantity seized appears in table 10.2.1 of the annex.

10.4 Purity, drug concentration and prices

In Denmark, drugs seized are analysed with a view to monitoring developments within drug purity and concentration and to follow the introduction of new drugs abused on the market. The results from the "Street project" (traditional drugs such as heroin, amphetamine and cocaine) and the "Ecstasy project" (tablets, powders and fluids) are described below.

Drug trafficking in the streets

The data material of the Street Project consists of small random sampling based seizures from 5 police districts in Denmark (Copenhagen, Aarhus, Odense, Aalborg and Esbjerg), which are submitted for analysis with the forensic departments¹⁵. Table 10.4.1 of the annex shows the distribution of types of drugs seized in Denmark from 2002 to 2012.

Out of the 207 samples analysed in 2012, 71% contained the psychostimulants cocaine and amphetamine, which is the same rate as in 2011. In recent years, the prevalence of the psychostimulants in the project – especially cocaine has, however, been increasing, whereas the prevalence of heroin has been declining. 15% of all samples in 2012 in Denmark were heroin. By comparison, 40% of the samples in 2002 were heroin. Furthermore, 11% of the samples in 2012 contained other psychoactive substances and drug compositions such as methamphetamine, MDMA and ketamine, and 4% contained non-psychoactive substances.

In Copenhagen, Aarhus and Aalborg, cocaine is the most prevalent drug in 2012 (78%, 60%, and 42%, respectively, of all samples). Heroin is the most prevalent drug in Esbjerg (38% of all samples), whereas amphetamine is the most prevalent in Odense (31% of all samples). Table 10.4.2 of the annex shows the prevalence ratios of heroin base ("smokeable" heroin) and heroin chloride (white heroin for injection) from 2002 to 2012. For the first time in many years, the white heroin chloride for injection is the most prevalent drug in the heroin samples in Denmark. In 2012, the heroin chloride and heroin base ratios were 58% and 42%, respectively.

In all the years, there has been a tendency toward Odense standing out from the other parts of Denmark by having the highest prevalence rate for white heroin. In 2012, all heroin samples from Odense were white heroin for injection. By comparison all the heroin samples in Copenhagen, Aarhus and Aalborg were the brown heroin for smoking. In Esbjerg, the heroin chloride and heroin base ratio is 70% and 30%, respectively.

Purity of drugs

Table 10.4.3 shows the contents of the various drugs from 2002 to 2012 in the samples analysed from the Street Project.

¹⁵ During the forensic analysis, the identity of the illegal drug and additives, if any, are registered. Furthermore, the purity and weight of the test are determined. The Street Project does not include cannabis or other cannabis products. In addition, ecstasy was excluded from the Street Project. This is consistent with the fact that the project from 2003 and up until today is monitored on its own.

Table 10.4.3 Purity of illicit drugs on a user level (median value of active drug)¹⁶

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Heroin chloride	50%	64%	63%	67%	53%	29%	52%	41%	46%	40%	32%
Heroin base	25%	25%	22%	28%	18%	21%	16%	14%	20%	11%	11%
Amphetamine sulphate	13%	9%	9%	10%	7%	6%	8%	6%	6%	5%	5%
Cocaine chloride	36%	37%	24%	25%	18%	16%	19%	17%	21%	20%	23%

Source: Lindholst et al 2013

The trend is that the concentration of the various drugs has dropped, however with annual fluctuations. For instance, the concentration of the white heroin chloride dropped from 67% in 2005 to 32% in 2012, whereas the concentration of the brown heroin during the same period dropped from 28% to 11%. Also, the concentration of cocaine has been decreasing. However, purity appears to have been relatively stable for the past three years, and in 2012, it was 23%. Purity of amphetamine is generally low and was 5% in 2012.

Through the years, no significant variances have been observed in the concentration of the individual illicit drugs seized in different parts of Denmark, and overall, we see a large variation interval. In all police districts, drugs have been found of a low as well as a high concentration in the markets simultaneously. It has not been possible to pinpoint periods during the year when concentrations were particularly high or low.

Additives and fillers

As shown in table 10.4.4, illicit drugs sold in the streets also contain different "fillers" or additives. Most of the fillers are active medicines that can also have an effect on the use after intake.

Table 10.4.4. The presence of additives in heroin base, heroin chloride, cocaine and amphetamine in 2011 (the result as a percentage of the total number of samples of each drug type)

Number	Heroin base (n=13)	Heroin chloride (n=18)	Cocaine (n=99)	Amphetamine (n=47)
Caffeine	92	100	28	85
Kreatine	8	6	54	70
Dextromethorphan	8	100	-	-
Diltiazem	-	-	1	-
Hydroxyain	-	-	1	-
Levamisol	-	-	75	-
Lidocaine	-	-	22	-
Paracetamol	92	78	5	21
Fenacetine	-	-	22	-
Procaine	-	-	1	-

Source: Lindholst et al 2013

¹⁶ Since the purity in most drugs is not evenly distributed, these percentages show the median value of purity rather than the average value. This is consistent with the practice in the institutes of forensic chemistry.

The fact is that almost all heroin base analysed in 2012 also contains caffeine and paracetamol (92% of all samples). Cocaine is the type of drug with the highest number of additives. All cocaine samples analysed in 2012 contain additives – on average 2 different substances per cocaine sample. Most frequently seen are the additives levamisol (in 75% of all samples in 2012) and creatine (in 54% of all samples in 2012). Levamisol is a drug for the treatment of parasitic worm infections and it affects the immune system in humans, whereas creatine is a substance that transports energy to the muscles.

Ingredients in tablets and powder

Since 2001, the Danish Health and Medicines Authority, in collaboration with the National Commissioner of the Police and the three institutes of forensic chemistry, have been monitoring the prevalence of ecstasy pills in Denmark. In 2011, this collaboration was expanded to include liquids and powder as well. Samples analysed from seizures of tablets, liquids, and powder sent from the police districts to one of the three institutes of forensic chemistry are collected, examined and described in relation to drug concentration, drug composition and appearance¹⁷. Every six months, the results of these analyses and a major annual report is posted on the website of the Danish Health and Medicines Authority www.sst.dk.

In 2012, a total of 580 samples of powder and fluid and 881 tablets were examined at the forensic institutes in order to determine ingredients and concentration. These cases were based on 541 seizures submitted by the police districts to the forensic departments for analysis.

As regards the tablets in the ecstasy project 2012, it can be summarized that MDMA (ecstasy) was contained in 59% of the tablets, which is an increase compared to the past years. 12% of the tablets in 2011 contained MDMA. Also, there is a decrease in tablets containing mCPP, with mCCP being contained in 19% of the tablets in 2012. In 2011, 59% of the tables contained mCPP and were thus the most prevalent tablets on the market. The hallucinogen 2C-B was contained in 7% of the tablets examined in 2012, which a slightly lower than in 2010 as well as in 2011. In 4% of the tablets, no active ingredients were found.

MDMA is not only found in tablets, it also appears in powder form. Out of all 541 powder samples examined in 2012, 52% of these contained MDMA. Furthermore, a large number of the powder samples containing MDMA also contained ketamine in various ratios. Methamphetamine was contained in 4% of the drug samples, ketamine was contained in 8% of the powder samples, and GHB in 6% of the drug samples found in fluids. Furthermore, 2% of the powder samples analysed in 2012 contained drugs in the category of euphoric cathinones, 5% the euphoric and sometimes hallucinating phenethylamines, whereas the cannabis-resembling synthetic cannabinoids were contained in 3% of the cases. Finally, 2% of the powder samples contained hallucinogenic tryptamine substances. The list of ingredients in powders and liquids in 2012 appears in the Annual Report on Illicit Drugs in Denmark, 2012 (Aarhus University 2013).

¹⁷ The database is not restricted to pills with MDMA (ecstasy), but all pills seized with a non-professional appearance, assessed according to logo, colour and pressing. The database also contains pills, where subsequent chemical analyses show the presence of synthetic substances or other psychoactive substances not normally present in medicines.

New ingredients and their regulation

New and dangerous drugs appear regularly in tablets and powders – in Denmark as well as the rest of Europe. As of 1 July 2012, Denmark introduced group bans on illicit drugs. This means that a number of the new drugs brought to Denmark are now subject to control prior to being launched on the market. In this way, legislation has become more proactive when it comes to defining potential abuse drugs that surface and enter the country

High and low drug concentration

Concentration of the various active drugs in the tablets varies a great deal, which poses a major risk of poisoning on intake. For instance, since 2001, the quantity of MDMA varied in the drug samples from between 1 and 199 mg. The highest MDMA concentration, however, was found in a capsule and contained 226 mg of MDMA. Further information about drug concentration is provided in the Annual Report on illicit Drugs in Denmark, 2012 (Aarhus University 2013).

The systematic monitoring of powders, fluids and tablets in Denmark is believed to give a good overview of which ingredients are available on the market. The monitoring process also gives speedy information about new synthetic drugs on the illicit market, which enables the authorities to recommend and control drugs on an ongoing basis.

However, it should be mentioned that not all drugs that flourish on the Danish drug market are subjected to control. In 2007, the Department of Forensic Chemistry carried out a study, which estimated that merely 5% of the tablets available on the Danish market are seized and thus submitted for forensic analysis.

Prices

The National Police estimates that the price for cannabis in the streets amounts to around DKK50-70 per gram. The police districts state prices of between DKK30 and 100 for one gram of cannabis. The price per gram for heroin sold in the streets is estimated to amount to between DKK1,000 and 1,500 for the white heroin and between DKK500 and 1,000 for the brown heroin. The price for cocaine sold in the streets is estimated to be between DKK400 and 600 per gram. For amphetamine, the price in the streets is estimated to be between DKK100 and 200 per gram, whereas the price for an ecstasy pill is estimated to be between DKK30 and 80.

The prices for the different drugs vary a great deal in the different parts of Denmark, and it is noted that the price for trading drugs in the streets follows standard market forces and therefore may vary on the basis of supply, demand and quality.

11 Annex

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The National Board of Social Services:

www.socialstyrelsen.dk

The Danish Health and Medicines Agency:

www.sst.dk

Center for Prevention of Substance Effects on the Development of Children:

www.familieambulatoriet.dk

De anvendte befolkningsundersøgelser

”Sundhed- og sygelighedsundersøgelsen 2013, Statens Institut for Folkesundhed, Syddansk Universitet [Health and morbidity in DK]

The Health and Morbidity Survey 2013 (SUSY 2013) is based a random sampling of 25,000 Danes at the age of 16 years and above. All the persons invited received an invitation letter and a questionnaire. Also, it was possible to respond to an identical web questionnaire. A total of 14,265 persons (57.1%) have completed the questionnaire. Questions on a number of psychoactive substances were given to all respondents. The respondents were asked to indicate whether they have ever used the drug in question, and if this was the case whether it was within the previous month, the recent year or earlier, and how old the respondent was when he/she tried the drug for the first time. Also, the respondents were asked about the number of days they had been taking cannabis for the past month.

”Sundhed og sygelighed i Danmark 2010, Statens Institut for Folkesundhed, Syddansk Universitet [Health and morbidity in DK]

The Health and Morbidity Survey 2010 (SUSY-2010) is based on random sampling of 25,000 Danes at the age of 16 years and above. Data collection was made by mailed questionnaires and an internet version. The printed questionnaire was sent to the sample population and in the accompanying letter, they were asked to answer the questionnaire on the internet. A total of 15,165 persons (60.7%) submitted responses. All respondents were asked to answer questions about a number of psychoactive substances. The respondents were requested to indicate whether they had ever taken the drug in question and if so, whether this had taken place within the past month, the past year or earlier, and how old the respondent was when he/she had tried the drug for the first time. Also, the respondents were asked about the number of days they had been taking cannabis for the past month.

”Alkohol i Danmark - Voksnes alkoholvaner og holdninger til alkoholpolitik” (AiD 2008), Sundhedsstyrelsen, Statens Institut for Folkesundhed og Syddansk Universitet [Alcohol in Denmark – Adults’ alcohol habits and attitudes towards an alcohol policy]”

A national study conducted in the spring of 2008 based on a regional and age stratified random sample of 7,000 Danes aged 16 years and above. Data collection was made by sending questionnaires by mail and receiving answers on the internet. The printed questionnaire was sent to the sample population and in the accompanying letter, they were asked to answer the questionnaire on the internet. The response rate was 57%.. All age groups were asked questions about a number of psychoactive substances. The respondents were requested to indicate whether they had ever taken the drug in question and if so, whether this had taken place within the past month, the past year or earlier, and how old the respondent was when he/she had tried the drug for the first time. The same questions were asked in the Danish morbidity and mortality survey (SUSY). Furthermore, the respondents were asked, whether they knew anybody who took any of the drugs in question and how many days during the past month they had been using cannabis.

”Rusmiddelforbruget – i folkeskolens afgangsklasse og udviklingen fra 1995-1999” Institut for Epidemiologi og Socialmedicin, Aarhus Universitet (Sabroe & Fonager 2002) [Use of intoxicants in school]

This report was based on the Danish ESPAD 1999 study (see above). The random

sampling of the report was expanded compared to ESPAD 1999 and included pupils from the 9th grade. Therefore, in addition to the 15-16 year-olds, pupils aged 14-17 were also included, since they attend the 9th grade as well. Thereby, the number participating pupils went up to 1750.

”Sundhed og sygelighed i Danmark 1994 og udviklingen siden 1987” Dansk Institut for Klinisk Epidemiologi 1994 (nu SIF) (Kjøller et al. 1995) [Health and morbidity in Denmark] 1995)

A national survey conducted in 1994 among a representative segment of the population aged 16 and above. The survey included questions on a variety of health issues. A sample population of 6,000 individuals were selected at random from the central personal registry. The question on use of psychoactive drugs was put to the 16-44 age group, which included a total of 2,521 people. Data collection was carried out as **personal interviews at home. The response rate was a total of 78%.**

”Sundhed og Sygelighed i Danmark 2000 – og udviklingen siden 1987” Statens Institut for Folkesundhed (SIF) 2000 (Kjøller & Rasmussen 2002) [Health and morbidity in Denmark]

A national survey was conducted in three data collection rounds in February, May and September 2000 among a representative segment of the Danish population aged 16 and above. The survey included, as in 1994, questions on a variety of health issues. The sample population of a total of 22,486 persons was selected in three random sampling rounds. The data was collected based on personal interviews conducted in the respondents' homes. In addition, the respondents were provided with a questionnaire, which they themselves were requested to fill in and submit. Questions on psychoactive substances were asked in the self-assessment questionnaire to all age groups. Interviews were carried out with 16,690 persons – a total response rate of 74.2 %. The self-assessment questionnaire was completed by 63.4% of the selected respondents.

”Sundhed og Sygelighed i Danmark 2006 – og udviklingen siden 1987” Statens Institut for Folkesundhed (SIF) 2006 (Notat af Niels Kr. Rasmussen og Ola Ekholm, sept 2006) [Health and morbidity in Denmark]

A national survey conducted from May 2005 to March 2006 among a representative segment of the population aged 16 and above. The survey included, as in 1994 and 2000, questions on a variety of health issues. The sample population of a total of 21,832 persons was selected at random. The data was collected based on personal interviews conducted in the respondents' homes. In addition, the respondents were provided with a questionnaire, which they themselves were requested to fill in and submit. Questions on psychoactive substances were asked in the self-assessment questionnaire to all age groups. Interviews were carried out with 14,566 persons – a total response rate of 66.7 %. Data collection was performed by handing out the questionnaires to the interviewees in the classrooms.

”The 1995 ESPAD report – Alcohol and Other Drug Use Among Students in 26 European Countries” CAN og Pompidou Group (Hibell et al. 1997)

As part of a joint European study (The European School Study Project on Alcohol and Other Drugs), a national school survey was conducted in 1995 on young people and their relationship with drugs. The survey was carried out in Denmark among a representative segment of 15-16 year-olds in 9th grade at randomly selected “folkeskoler”, private schools and continuation schools. Data collection was performed by handing out the questionnaires to the interviewees in the classrooms. A total of 2,234 pupils participated in Denmark, which equals a response rate of approximately 90%.

“The 1999 ESPAD report – Alcohol and Other Drug Use Among Students in 30 European Countries” CAN og Pompidou Group (Hibell et al. 2000)

In 1999, the survey from 1995 was repeated among a representative segment of 15-16 year-olds in 9th grade at randomly selected “folkeskoler”, private schools and continuation schools. Data collection was performed by handing out the questionnaires to the interviewees in the classrooms. A total of 1548 Danish pupils participated, which equals a response rate of 91.7%.

“The 2003 ESPAD report – Alcohol and Other Drug Use Among Students in 30 European Countries” CAN og Pompidou Group

In 2003, the surveys from 1995 and 1999 were repeated among a representative segment of 15-16 year-olds in 9th grade at randomly selected “folke-skoler”, private schools and continuation schools. Data collection was performed by handing out the questionnaires to the interviewees in the classrooms. A total of 2519 Danish pupils participated, which equals a response rate of 89.2 %.

The 2007 ESPAD report – Alcohol and Other Drug Use Among Students in 36 European Countries” CAN og Pompidou Group (unpublished)

In 2007, the surveys from 1995, 1999 and 2003 were once again conducted in a representative selection of 15-16-year-old pupils in 9th grades at public, private and continuation schools (efterskoler) selected at random. Data collection was performed by handing out the questionnaires to the interviewees in the classrooms. A total of 1,087 Danish pupils from the 9th grade participated in the survey. In the school classes included in the survey, practically all the pupils that were in school that day participated. On average, approximately 90% of the pupils are in school on that particular day. There were quite a few of schools (approximately 50%), where the school board and the school inspectors were not interested in the school participating in the survey. Their reasons were often that the 9th grade pupils had already spent a great deal of class time on other surveys, one of them being the PISA-survey.

The 2011 ESPAD report – Alcohol and Other Drug Use Among Students in 36 European Countries” CAN og Pompidou Group (unpublished)

In 2011, the surveys from 1995, 1999, 2003, and 2007 were repeated among a representative selection of 15-16-year-old pupils in the 9th grade at randomly selected public schools, private schools and continuation schools. Data collection was performed by handing out the questionnaires to the interviewees in the classrooms. A total of 2772 ninth grade pupils took part in Denmark. Practically all the ninth grade students who were in school on that particular day took part in the survey. On average, approximately 90% of the pupils are in school on a random day. There were quite a few schools (approximately 50%) where either the school board or the principal were not interested in taking part in the survey. The number of participating pupils thus increased to 2,545. Their reasons were often that the 9th grade pupils had already spent a great deal of class time on other surveys, one of them being the PISA-survey.

“Unge og Rusmidler – En undersøgelse af 9. klasses elever” Institut for Epidemiologi og Socialmedicin, Aarhus Universitet (Sabroe & Fonager 1996) [Young people and intoxicants – survey of pupils in the 9th grade]

This report was based on the Danish input to the ESPAD 1995 study (see above). The random sampling of the report was expanded compared to ESPAD 1995 and included pupils from the 9th grade. Therefore, in addition to the 15-16 year-olds, pupils aged 14-17 were also included, since they attend the 9th grade as well. Thereby, the number participating pupils went up to 2545.

Unge erfaringer med rusmidler – i 2003 og udviklingen siden 1995. Institut for Epidemiologi og Socialmedicin, Aarhus Universitet (Sabroe & Fonager 2004) [Young people and intoxicants – in 2003 and development since 1995] Institut for Epidemiologi og Socialmedicin, Aarhus Universitet (Sabroe & Fonager 2004) [Young people and intoxicants – in 2003 and development since 1995]

This report is based on the Danish ESPAD 2003 study. The random sampling of the report was expanded compared to ESPAD 2003 and included pupils from the 9th grade. Therefore, in addition to the 15-16 year-olds, pupils aged 14-17 were also included, since they attend the 9th grade as well. Thereby, the number of participating pupils went up to 2978.

”Unge Livsstil og Dagligdag 2000 – forbrug af tobak, alkohol og stoffer” (MULD 2000), Sundhedsstyrelsen og Kræftens Bekæmpelse 2000 (Sundhedsstyrelsen & Kræftens Bekæmpelse 2002) [Young people’s lifestyle and daily routine]

In 2000, the National Board of Health and the Danish Cancer Society conducted a representative internet-based survey on the 16-20-year-olds’ lifestyles and daily routines. The survey included questions on young people’s use of drugs, including their experiences with illicit drugs. 3,048 young people aged between 16 and 20 were chosen according to systematic selection. Data collection was made via questionnaires mailed to the respondents. The response rate was approximately 70 %.

”Unge Livsstil og Dagligdag 2001 – geografiske forskelle og ligheder” (MULD 2001), Sundhedsstyrelsen og Kræftens Bekæmpelse, (Sundhedsstyrelsen & Kræftens Bekæmpelse 2003) [Young people’s lifestyle and daily routines]

In 2001, the National Board of Health and the Danish Cancer Society conducted a representative survey on the lifestyles and daily routines of 16-20 year-olds. 3,048 young people aged between 16 and 20 were chosen according to systematic selection. Data collection was made via questionnaires mailed to the respondents. The response rate was approximately 70 %.

”Youth, Drugs and Alcohol (YODA)” (Center for Rusmiddelforskning, Aarhus Universitet og SFI – Det Nationale Forskningscenter for Velfærd)

The YODA project (”Stoffer i nattelivet” [Drugs in the Night Life]), cover a number of data sources, which are qualitative as well as quantitative:

- A large quantitative survey conducted in 2008. This survey is partly a cross-section survey (a questionnaire survey among 3000 Danish young people aged 17-19 years, selected from the CPR register) and partly a panel survey (a questionnaire survey among 2000 young people born in 1989, also selected from the CPR register). In 2005, the young people from the panel survey have, at the age of 15-16 years, completed a large questionnaire on alcohol and parties (see Gundelach & Järvinen 2006) and their responses from 2008 thus make it possible to monitor them over time.
- A focus group survey among typical Danish young people conducted during the spring and summer, 2008. The purpose of this survey was to analyse these young people’s attitudes towards and knowledge about drugs.

A nightclub survey conducted in the autumn and winter 2008-2009. The purpose of this survey was to analyse the prevalence of drugs in the night life and make contact with young people with broader drug experience than the typical Danish young people in the focus group survey mentioned above. The nightclub survey consists of a brief questionnaire survey conducted in the night clubs, an internet-based questionnaire

survey, ethnographic observations from the night clubs and finally qualitative interviews (focus group interviews and individual interviews) with nightclub guests regularly using drugs. The YODA project has been financed by the Rockwool Foundation and the results are described in the book "Stoffer og natteliv" [Drugs and Night Life) (Järvinen) 2010.

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Table 2.2.2. Percentage of women and men in the various age groups who used cannabis within the previous year in 1994, 2000, 2005, 2008, 2010, and 2013

		1994	2000	2005	2008	2010	2013
		n=2.521	n=6.887	n=4.484	n=2.229	n=5.748	n=5.013
16-19-yrs	Men	19	29	23	28	23	27
	Women	10	20	19	17	15	19
20-24- yrs	Men	14	24	26	23	24	30
	Women	9	12	16	19	16	21
25-29- yrs	Men	8	16	17	17	14	20
	Women	5	6	5	7	8	8
30-34- yrs	Men	9	10	10	5	10	12
	Women	2	3	3	3	4	4
35-39- yrs	Men	6	8	5	9	6	8
	Women	2	2	2	0	1	3
40-44- yrs	Men	5	4	4	3	4	4
	Women	2	2	2	0	0	1
All 16-44 yrs	Men	10	14	11	12	12	16
	Women	5	6	6	7	6	9
	All	7	10	8	9	9	12

Source: SUSY 1994, SUSY 2000, SUSY 2005, AiD 2008, SUSY 2010 and SUSY 2013

Table 2.2.3.1. Percentage of the 16-44-year-olds who tried one or several of the various illicit drugs within the previous month, last year, and ever in 2013 (n=4.905).

	Previous month	Last year (previous month included)	Ever
Amphetamine	0.4	1.0	9.3
Cocaine	0.5	1.7	8.5
Psilocybin mushrooms	0.1	0.3	3.8
Ecstasy	0.2	0.5	4.2
LSD	0.1	0.2	1.4
Heroin	0.1	0.1	0.7
Ketamine	0.1	0.2	1.1
GHB	0.0	0.1	0.7
Other drugs*	0.3	0.8	2.6
"Illicit drug other than cannabis **"	1.0	2.6	13.6

Source: Unpublished figures from 2013

*The category "Other drugs" covers various medicines, etc.

** A combined category including "used an illicit drug other than cannabis"

Table 2.2.10. Percentage of the 16-24-year-olds who are current users of illicit drugs (tried one or several of the various illicit drugs within the past year) in 2000, 2005, 2008, 2010 and 2013

	Last year 2000	Last year 2005	Last year 2008	Last year 2010	Last year 2013
Cannabis	20,1	20,5	21,3	18,9	23,9
Amphetamine	5,9	4,1	5,4	2,8	1,6
Cocaine	2,8	3,3	5,6	2,9	2,3
Psilocybin mushrooms	2,2	1,0	1,1	0,7	0,8
Ecstasy	2,3	1,5	2,3	1,1	1,0
LSD	0,6	0,6	0,2	0,4	0,3
Heroin	0,2	0,2	0,0	0,3	0,1
Ketamine**	-	-	-	-	0,5
GHB**	-	-	-	-	0,1
Other drugs*	1,1	0,7	2,3	1,1	1,5
" Illicit drug other than cannabis "	8,0	5,3	8,0	4,3	3,9

Source: Unpublished figures from the National Board of Health on SUSY 2000, SUSY 2005, AiD 2008, SUSY 2010 and SUSY 2013

*The category "Other drugs", covers GHB, Ketamine, various medicines, etc.

** For the first time, questions have been asked on Ketamine and GHB "alone" as has been done with amphetamine, cocaine, ecstasy, etc. In previous years, the answers on ketamine and GHB under the category of "Other drugs".

Table 2.2.11. Percentage of the 16-24-year-olds who tried one or several of the various illicit drugs within the previous month, last year and ever in 2013

	Last month	Last year (last month included)	Ever
Amfetamine	0,6	1,6	5,7
Cocaine	0,8	2,3	5,7
Psilocybin mushrooms	0,1	0,8	2,4
Ecstasy	0,4	1,0	3,2
LSD	0,1	0,3	1,0
Heroin	0,1	0,1	0,4
Ketamine	0,2	0,5	1,6
GHB	0,0	0,1	0,9
Other drugs*	0,5	1,5	3,4

Source: Unpublished figures from the Danish Health and Medicines Authority SUSY 2013

*The category "other drugs" covers different medicines etc..

Table 6.2.1. Number of newly diagnosed HIV positive and AIDS diagnosed in the entire population, including the proportion of intravenous drug users, in the year in question

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Newly diagnosed, HIV positive total	261	321	289	270	307	264	244	312	292	242	274	265	198
Newly diagnosed HIV positive with intravenous drug use (percentage of all newly diagnosed)	20 (8%)	31 (10%)	31 (11%)	24 (9%)	13 (4%)	17 (6%)	10 (4%)	21 (7%)	15 (5%)	14 (6%)	14 (5%)	10 (4%)	13
Newly diagnosed AIDS cases	61	71	45	41	61	45	54	50	40	40	47	58	41
Newly diagnosed AIDS cases with intravenous drug use (percentage of all newly diagnosed)	7 (11%)	10 (14%)	4 (9%)	11 (27%)	4 (7%)	4 (9%)	3 (6%)	4 (8%)	7 (18%)	4 (10%)	5 (11%)	5 (9%)	4

Source: Unpublished data from the State Serum Institute. For 2012-data the figures have been compiled on 2nd July 2013

Table 6.2.2. Registered number of acute cases of hepatitis A, B, and C in the entire population, including intravenous drug users, in the year in question

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Hepatitis A, total	81	63	84	71	241	48	42	28	44	45	47	13	53
Hepatitis A with intravenous drug use (% of all diagnosed)	0	0	0	0	1 (0.4%)	1 (2%)	0	0	0	0	0	1 (8%)	0
Hepatitis B, total *	64	49	62	36	44	30	20	25	25	23	28	16	24
Hepatitis B with intravenous drug use (% of all diagnosed)	20 (32%)	12 (24%)	12 (19%)	7 (19%)	9 (21%)	3 (10%)	1 (5%)	2 (8%)	5 (19%)	3 (13%)	1 (4%)	1 (6%)	5 (21%)
Hepatitis C, total *	15	6	5	7	8/378**	2/371	7/398	11/408	6/318	4/292	6/315	7/285	12/239
Hepatitis C with intravenous drug use (% of all diagnosed)	9 (60%)	3 (38%)	1 (50%)	2 (29%)	3/285 (37%/75%)	0/253 (0%/68%)	6/279 (86%/70%)	5/292(45%/72%)	1/216(16%/68%)	0/211 (0%/72%)	3/230(50%/73%)	2/195 (29%/68%)	5/169 (42%/71%)

Source: Unpublished data from the State Serum Institute. For 2012 data, the figures have been compiled in June 2013

* Cases with acute hepatitis B and C include a certain generic volume

** acute/chronic hepatitis C cases

Table 6.3.1 Developments of hospital contacts after intoxications and poisonings caused by illicit drugs in the year in question

	Code*	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012 ¹⁸
Heroin	T40.1	161	173	197	159	160	151	166	163	195	126	121
Other opioids	T40.2 +T40.2A +T40.2B	47	50	119	112	130	139	169	240	279	336	415
Methadone	T40.3	38	25	50	53	32	44	57	74	89	102	116
Opioids	F11.0	52	60	49	65	48	60	72	63	73	92	76
Opioids total		298	308	415	389	370	394	464	540	636	656	728
Designer drugs (excl. ecstasy)	T40.6A + T43.8A	21	12	15	3	6	10	40	37	61	64	60
Ecstasy	T40.6B +T43.6B	60	82	72	72	89	86	72	52	46	45	94
Amphetamine	T43.0A +T43.6A	43	54	68	73	83	171	158	208	286	292	236
Cocaine	T40.5 +F14.0	65	75	69	105	100	129	119	139	156	148	188
Other stimulants	F15.0	46	51	41	53	41	50	45	35	35	42	75
Stimulants total		235	274	265	306	319	446	434	471	584	591	653
Psychoactive mushrooms	T40.6C +T40.9A	8	3	10	6	13	13	7	12	5	13	22
LSD	T40.8	2	1	2	7	11	16	27	7	8	14	7
Hallucinogens	F16.0	5	4	6	11	5	12	8	2	12	5	7
Hallucinogens total		15	8	18	24	29	41	42	21	25	32	36
Cannabis	T40.7 +F12.0	122	125	74	86	76	97	108	137	128	155	174
Polydrug use and unspecified**	T40.4 +T40.6 +T40.6V +40.6X +T40.9 +F19.0	645	694	391	400	449	367	449	447	497	446	437
Intoxications and poiso- nings, total		1315	1409	1163	1205	1243	1345	1497	1616	1870	1880	2028

Source: National Patient Register. Figures for the year 2012 have been compiled in May 2013

*New codes have been introduced in 2004 and 2010. **From 2004, a number of new sub-codes for polydrug use and unspecified poisonings have been included. These are as follows: T404A, T409A, T409B, T409C, T409D, T409X, T409Z

¹⁸ The figures for 2012 are preliminary (data from The National Patient Register as of May 2013). The final figures for 2012 may therefore change in subsequent statistics.

Table 6.3.3. Hospital contacts after intoxication and poisonings broken down by age groups in the year in question

Age group	2005	2006	2007	2008	2009	2010	2011	2012
< 20 years	212	272	317	309	295	336	317	326
20-24 years	238	216	259	292	284	356	348	439
25-29 years	170	160	177	193	162	248	220	209
≥ 30 yrs	527	545	592	703	874	930	995	1054
Total	1147	1193	1345	1497	1615	1870	1880	2028

Source: The Danish Health and Medicines Authority, National Patient Register, data collected in May 2013

Table 6.3.4. Persons registered with drug-related primary diagnoses in psychiatric hospitals in the year in question

Diagnosis code	Mental illnesses or disorders caused by the use of:	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
F11	Opioids	172	156	155	138	123	133	136	166	120	135	107
F12	Cannabis	364	333	354	312	347	364	388	553	533	643	706
F13	Sedatives /hypnotic agents	182	159	143	150	140	154	141	130	112	113	109
F14	Cocaine	36	65	53	42	49	49	56	57	51	39	47
F15	Stimulants other than cocaine	109	99	98	93	87	91	94	95	86	98	88
F16	Hallucinogens	14	9	17	16	10	10	18	6	11	14	15
F18	Solvents	2	10	5	3	3	4	7	3	1	4	4
F19	Multiple or other psychoactive drugs	726	747	684	668	660	682	696	826	672	714	687
Persons with primary diagnoses, total		1605	1578	1509	1422	1419	1487	1536	1746	1586	1760	1763

Source: Specially retrieved figures from the psychiatric central register at the department of psychiatric demography of the Institute for Psychiatric Basic Research, Psychiatric Hospital, Aarhus.

Table 6.3.4 shows the number of persons registered as recipients of psychiatric treatment (either full-day, half-day or outpatient treatment) as a result of drug use or volatile solvents. ICD-10 codes have been used, and the diagnoses F11.x til F16.x og F18.x to F19.x (primary diagnosis) used as retrieval criteria. Since a patient can have several drug-related primary diagnoses, the "total" category is not a summation.

Table 6.3.5. Persons registered with drug-related secondary diagnoses in psychiatric hospitals in the year in question

Diagnosis code	Mental illnesses or disorders caused by use of:	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
F11	Opioids	201	271	280	341	358	492	522	428	451	409
F12	Cannabis	759	873	908	1040	1072	1507	1646	1668	2011	2091
F13	Sedatives / hypnotics	307	359	367	385	417	529	554	468	467	458

F14	Cocain	61	66	97	118	163	210	217	214	209	207
F15	Other psychoactive stimulants	73	123	120	162	179	235	261	251	270	291
F16	Hallucinogens	2	13	14	8	8	13	14	14	16	10
F18	Solvents	12	11	8	18	13	13	24	17	18	26
F19	Multiple or other psychoactive drugs	679	728	736	874	995	1176	1396	1239	1458	1386
Persons with secondary diagnoses total		1844	2074	2102	2430	2632	3418	3718	3445	3927	3946

Source: Specially retrieved figures from the psychiatric central register at the department of psychiatric demography of the Institute for Psychiatric Basic Research, Psychiatric Hospital, Aarhus. Table 6.3.5 shows the number of persons registered as recipients of psychiatric treatment (either full-day, half-day or outpatient treatment) as a result of drug use or volatile solvents. ICD-10 codes have been used, and the diagnoses F11.x til F16.x og F18.x to F19.x (secondary diagnosis) used as retrieval criteria. Since a patient can have several drug-related secondary diagnoses, the "total" category is not a summation

Table 6.4.1. Drug-related deaths in the year in question. Distribution by gender

Year	Total	Men	Women	Year	Total	Men	Women
1995	214	149	65	2004	-	-	-
1996	242	177	65	2005	208	162	46
1997	256	189	67	2006	227	167	60
1998	243	174	69	2007*	211	148	63
1999	217	157	60	2008*	211	155	53
2000	240	175	65	2009	222	161	61
2001	221	153	68	2010	204	158	46
2002	-	-	-	2011	190	143	47
2003	-	-	-				

Source: Cause of death Register, August, 2013

*The figures for 2007, 2008, and 2009 have been increased by 2.4%, 2.8%, and 3.4% , respectively, in relation to the reported number of death certificates for comparison reasons.

Table 6.4.2. Drug-related deaths in the year in question based on the National Police's register on drug-related deaths. Distribution by gender

Year	Total	Men	Women	Year	Total	Men	Women
1981	148	113	35	1997	275	225	50
1982	134	107	27	1998	250	210	40
1983	139	110	29	1999	239	201	38
1984	158	125	33	2000	247	197	50
1985	150	116	34	2001	258	211	47
1986	109	88	21	2002	252	216	36
1987	140	116	24	2003	245	197	48
1988	135	107	28	2004	275	211	63
1989	123	99	24	2005	275	234	41
1990	115	91	24	2006	266*	218	46
1991	188	153	35	2007	260**	207	50
1992	208	162	46	2008	239*	186	51
1993	210	166	44	2009	276	217	59
1994	271	227	44	2010***	276	237	39
1995	274	226	48	2011	285	232	53
1996	266	220	46	2012	210	159	51

Source: National Police, 2013

*Gender not informed for 2 persons

** Gender not informed for 3 persons

*** Adjusted for the total number of deaths

Table 6.4.4. Drug-related deaths broken down by regions in the year in question

	2007	2008	2009	2010	2011	2012
Northern Jutland	36	35	33	31	28	25
Mid-Jutland	52	47	53	58	56	37
Southern Denmark	71	68	79	78	91	54
Copenhagen	68	59	86	70	69	61
Zealand	29	24	21	31	33	26
Copenhagen Municipality*	41	31	51	38	32	37

Source: National Police, 2013

* The number included in the Copenhagen Municipality is also included in the Capital Region

Table 9.2.1. Drug crime in the year in question. Reported offences with charges and number of persons charged

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Persons charged	12,902	12,851	14,272	16,390	19,037	19,900	18,506	18,692	17,403	17,825	21,211	21,498
Source:	9,858	10,021	11,160	12,313	14,204	15,060	13,294	14,093	13,354	13,749	16,065	16,401

Source: National Police, 2013

Table 10.2.1. Drug seizures in the year in question

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Heroin													
Kg	32.1	25.1	62.5	16.3	37.5	27.0	28.9	48.1	43.9	22.4	39.4	36.6	40.6
Seizures	1,499	1,304	966	894	1041	1064	927	1,016	906	648	699	488	430
Cocaine													
Kg	35.9	25.6	14.2	104.0	32.3	57.0	76.2	91.8	56.1	72.4	54.16	42.9	42.1
Seizures	780	815	881	1,095	1,207	1,615	1,901	2,098	1,858	1,365	1,589	1,777	2,056
Amphetamine													
Kg	57.1	160.6	34.9	65.9	63.0	195.0	79.4	70.4	119.8	103.8	193.9	240.3	301.5
Seizures	1,152	954	1,134	1,264	1,388	1,573	2,022	2,215	1,543	1,260	1,764	1,757	1,793
Ecstasy													
Pcs.	21,608	150,080	25,738	62,475	38,096	44,195	22,712	82,390	17,631	53,929	45,360	16,042	72,654
Seizures	444	331	340	322	1388	461	540	452	251	200	200	209	523
LSD													
Doses	1,108	156	38	22	483	1201	521	47	482	468	159	1,003	
Seizures	18	29	8	7	13	12	8	13	21	18	16	20	18
Cannabis													
Kg	2,914	1,763	2,635	3,829	1,758	1,406	1,035	877	2,914	1,220	2,318	2,326	1,334
Seizures	5,561	5,788	5,234	5,942	7,313	10,292	10,962	9,301	8,365	7,430	7,689	8,499	9,239

Source: National Police, 2013

Table 10.4.1. Ratio of drug types on a user level in the year in question

Year	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
	n=152	n=198	n=188	n=200	n=196	n=203	n=200	n=195	n=195	n=204	n=204	n=207
Heroin	45%	40%	39%	33%	34%	33%	30%	27%	28%	21%	21%	15%
Amphetamine	22%	24%	20%	29%	23%	34%	30%	31%	29%	33%	27%	23%
Cocaine	22%	30%	32%	34%	36%	30%	34%	35%	37%	37%	43%	48%
Ecstasy**	9%	2%	-	-	-	-	-	-	-	-	-	-
Metamphetamine***	-	-	4%	1%	5%	1%	2%	3%	3%	1%	2%	3%
Other psychoactive substances/drug combinations	1%	3%	4%	3%	1%	2%	2%	3%	3%	5%	5%	4%
Non-psychoactive substances	1%	2%	1%	-	2%	1%	2%	2%	1%	3%	1%	4%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Source: Kaa et al. 2002-2005; Lindholst et al 2005-2013

** Ecstasy was excluded from the "Street Project" from 2003 and is now monitored independently.

***The number of samples containing pure methamphetamine has increased dramatically from 2002, which is why the drug is listed in its own category in the table. In previous years, methamphetamine has been a rare and sporadic drug and is contained in the category "other psychoactive substances/drug compositions until 2003. In the latter category for the entire period, the samples, in which methamphetamine appears in combination with other drugs, are also included.

Table 10.4.2. Heroin base and heroin chloride ratio in the year in question

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
	n=80	n=73	n=66	n=66	n=66	n=60	n=52	n=54	n=42	n=43	
Heroin base	76%	84%	77%	76%	65%	72%	77%	69%	64%	58%	42%
Heroin chlo- ride	24%	16%	23%	24%	35%	28%	23%	31%	36%	42%	58%

Source: Lindholst et al 2013