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for Drugs and Drug Addiction


Sundhedsstyrelsen
Danish Health and Medicines Authority

**2012 NATIONAL REPORT
(2011 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 Danish "Focal Point". The report was written in the autumn of 2012 to be submitted to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The report is available in Danish as well as in English and was drafted in accordance with EMCDDA guidelines.

The report provides an overview of the drug situation in Denmark. It is based on the most recent statistical and epidemiological data as well as current information on focus areas, projects, activities and strategies within drug prevention, harm reduction and treatment of drug users. In addition, the report provides an outline of applicable Danish law and politics within the drugs area.

Ms Kari Grasaasen, specialist drug consultant, has had the coordinating responsibility for the preparation of the report as well as the chapters on epidemiology. Academic assistant, Ms Marie Sung Lee Asserhøj, the Danish Health and Medicines Authority, prepared the chapter on prevention. On behalf of Copenhagen Municipality, Mr Peter Ege prepared the theme chapter on drugs policy in Copenhagen, and Mr Mads Uffe Petersen, Centre for Drug and Alcohol Research, prepared the theme chapter on inpatient treatment. Other parts of the report were drafted via contributions from various units of the Danish Health and Medicines Authority and the State Serum Institute, especially from Claudia Ranneries, expert consultant. Furthermore, the report contains contributions from the Ministry of Health, the Ministry of Social Affairs and Integration, the Ministry of Justice as well as other authorities and collaboration partners.

The Danish Health and Medicines Authority has appointed a reading panel which has contributed with comments and constructive criticism. The reading panel consisted of Henrik Sælan, medical consultant, Helle Petersen, expert consultant to the Danish Health and Medicines Agency within drug abuse treatment, former social consultant in Copenhagen, Peter Ege, senior lecturer Mads Uffe Petersen, and Steen Møller Bach, head of the SSP and Prevention in Esbjerg Municipality.

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Else Smith
Director General

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Summary

The current drug situation in Denmark

The number of drug users in Denmark is estimated at 33,000, out of which 11,000 are estimated to be cannabis abusers only. This estimate was made by the Danish Health and Medicines Authority in 2010 (former National Board of Health). Compared to previous years, this is an increase in the number of drug users in Denmark. In 2006, the number of drug abusers were estimated to be 27,000, of which more than 7000 were drug users. This increase in the estimated number of drug users is thus dominated by an increase in the estimated number of cannabis users from a little over 7000 in 2006 to 11,000 in 2010. Statistics do not include experimental drug consumption, but estimates the number of individuals with a more constant use of drugs leading to physical, mental and/or social injuries. Actual drug addicts are therefore included in the estimate, as well as stabilised drug addicts (e.g. those being treated with methadone). At present, it is estimated that 13,000 drug users inject the drugs. Injecting drug users are particularly at risk of developing serious injuries and diseases and of dying.

The most recent population survey from 2010 shows a decreasing tendency towards experimental use of illicit drugs - particularly among those under the age of 25 years. In 2008, 8% of those aged under 25 years reported having used one or several illicit drugs other than cannabis within the past year. This figure had gone down to 4 % in 2010. When viewing the drugs individually, the use of cocaine appears to be falling, which is particularly positive since the use of cocaine - as the only drug - was increasing up through the first years of 2000. Cannabis continues to be the most prevalent drug. Much fewer report taking amphetamine and cocaine and even fewer report using psilocybine mushrooms and ecstasy (SUSY 2010).

This positive falling trend in experimental use of illicit drugs is also seen among the very young. Results from the recent ESPAD-survey carried out in 2011 among the 15-16-year-olds in grade 9 shows a dramatic drop in the use of all illicit drugs from 2007 and until today (ESPAD 2011).

In spite of the drop in the experimental use of drugs, there appears to be an increase in poisoning cases arriving at the emergency wards in Denmark. The number of recorded poisonings resulting from illicit drugs reached its peak in 2011 with 1880 cases, and it is assumed that this is a conservative estimate. The increase in poisonings over the past years is particularly seen among those over 30 years. Among the younger population, poisonings are typically caused by cannabis and stimulants, whereas poisonings caused by opioids and a mixture of several drugs are most frequently seen among the older population.

Also psychiatric admissions resulting from drug diagnoses among patients are more frequently seen these years. In 2011, 5,687 persons were admitted with dual diagnoses, which is an increase compared to 2010. Polydrug use is a dominant factor in the dual diagnosis complexity. When considering the various drugs individually, cannabis is the most dominant drug on the market. The number of people admitted to psychiatric treatment with a drug-related secondary diagnosis, including cannabis abuse, total more than 1,500 in 2011, and the number has almost tripled over the past 10 years. Admissions involving cocaine abuse as a drug-related secondary diagnosis (209 persons in 2011) are significantly fewer in numbers, but also here we have seen an increase in recent years. The increase in the admissions recorded with a drug diagnosis might indicate an actual increase, but could also reflect improved registration proce-

dures.

Among the health consequences of drug use, increased mortality should be mentioned. Generally, drug abusers have extremely high mortality rates caused by poisonings and illnesses, including HIV and hepatitis. According to the statistics from the National Commissioner's Office on drug-related deaths, 285 drug-related deaths were recorded in 2011, which is the highest number since registration started. Most of the drug-related deaths are caused by poisoning, with others being caused by violence, suicide and diseases. Annual analyses show that on average, between 3 and 4 different drugs are detected in the blood of a person, whose death is drug-related, which documents a prevalent polydrug use among the drug users who die.

Finally, the consequences of drug use have also become apparent in the statistics on drug users admitted to treatment. In 2011, slightly less than 16,000 individuals were admitted to drug use treatment in Denmark, which is the highest number of recorded drug users since registration started. Data from all the years show that especially the young people are the ones being admitted as newcomers to treatment, typically with cannabis and/or stimulants as their abuse problem. In 2011, almost 4/5 (79.5 %) of the young population aged between 18 and 24 years was admitted to treatment for cannabis use as their primary drug, whereas 9 % and 4 % of the young population was admitted to treatment for use of amphetamine and cocaine, respectively, as their primary drug. Apart from the increasing use of the illicit drugs up through the 1990s, it is likely that the increased treatment capacity, treatment guarantee, and the improved and more targeted treatment programmes have contributed to the documented increase in individuals seeking treatment for their drug use.

As a result of the many and increasing numbers of poisonings caused by illicit drugs, the Danish Health and Medicines Authority prepared a set of guidelines for healthcare professionals on the handling of poisonings at the emergency wards in Denmark.

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 local drug prevention work is often carried in cross-sectoral collaboration between school, social administration and the police (the so-called SSP collaboration). Each municipality may initiate universal, selective and indicated prevention in, among others, schools through local leisure time programmes in collaboration with associations, restaurants, bars, and discoteques and in marginalised residential areas. The know-how centre "Unges Misbrug" (Young People's Abuse) under the National Board of Social Services provide a number of initiatives which are supposed to support the selective/indicated preventive intervention through upgrading of local professionals who meet the young people in their daily work.

In the wake of the social reserve funds agreement, the Danish Health and Medicines Authority has reserved EUR 2.3 million for 6 model municipalities, the task of which is to focus on the presence of alcohol and drugs in youth education environments. Model municipalities have to enter into a committing collaboration, under which they dedicate their work to drug and alcohol policies and early detection of young problem drug and alcohol users within the educational system. Also, social reserve funds have been reserved for projects involving outreach interventions targeted at young people with drug

and alcohol problems within the educational system. These funds are administered by the National Board of Social Services.

In recent years, the Danish Health and Medicines Authority's drug preventive interventions have focused on party settings as a risk arena. Examples of this are projects such as "Ansvarlig Udsækning" [Responsible Serving of Alcohol], media campaigns, where the social organisation Dansk Live works with the attitude against drugs in the *Against Drugs* campaign and the *Unge og Alkohol* campaigns at festivals and in music halls.

In connection with the social reserve fund agreements in recent years, a number of treatment and harm reducing initiatives have been launched. One of the initiatives involves the reservation of funds for quality assurance of the medical cocaine treatment, a project with prescribed heroin, and a number of social initiatives funded by the Ministry of Social Affairs and Integration. Also, legislation has started to provide for the establishment and running of local drug user rooms.

New drugs and new legislation

The Danish Health and Medicines Authority and the National Commissioner's Office's together with the three Danish forensic institutes continue to monitor drugs abused on the illicit market. In the process, a number of new drugs emerge in Denmark and are placed on the list of drugs banned by the Danish Health and Medicines Authority.

Since the publication of last year's drug report, the following drugs have been made subject to control by the Danish Health and Medicines Authority. In executive order no. 997 of 12 October 2011 on the amendment of order on psychoactive substances, it was provided that the drugs 4-MEC, MPPP, and N-ethylbuphedron shall only be used for medicinal and scientific purposes. The order became effective on 27 October 2011. Also in the executive order no. 506 of 30 May 2012 on the amendment of executive order on psychoactive substances it was provided that the drugs metoxetamine and fenazepam shall only be used for medicinal and scientific purposes. The order became effective on 02 June 2012. Finally, the executive order no. 971 of 28 September 2012 on the amendment of executive order on psychoactive substances provided that the drug 5-IT shall only be used for medicinal and scientific purposes. The order became effective on 30 September 2012.

In Denmark, the existing system of individual bans against psychoactive substances has been supplied with a system of bans against entire groups of the same drug. The intention is to make it difficult for the manufacturers to create new drugs which do not fall within the ban, just by changing the molecule combination of already banned drugs. In executive order no. 778 of 4 July 2012 on the amendment of psychoactive substances, it was then provided that the following substance groups shall only be used for medicinal and scientific purposes: benzoylindols, cathinons, cyclohexylphenols, naphthylmethylindens, naphthylmethylindols, phenethylamins, phenylacetylindols, and tryptamins.

Also, an amendment has been made to the law allowing the establishment and running of drug consumption rooms in Denmark. In act no. 606 of 18 June 2012, the law on psychoactive substances was changed creating a basis for the Ministry of Health to authorise the establishment and running of local drug consumption rooms as well as drug consumption rooms run by private institutions with an administrative agreement with local authorities. The act implies that the minister of health may grant a municipality permission to establish and run drug consumption rooms for persons aged 18 and

above with a strong addiction following from long-term and persistent abuse of psychoactive substances.

Selected issues

In this year's report, there are two theme chapters. The theme chapter on *inpatient treatment in Denmark* describes, among others, the historical development, availability, types of treatment, treatment methods and the political context in relation to drug abusers in Denmark. The other theme chapter deals with *drugs policy in Copenhagen*. This chapter describes the framework and tasks facing the Copenhagen Municipality as a result of the magnitude and severity of drug problems in the city, as well as the policy, initiatives and interventions carried out by the Municipality to combat drugs.

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 kept outside. 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 ongoing marginalisation, extinction 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.

Drug use is 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 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 medicinal 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 the hands-on 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 ongoing 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 medicinal 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 and Integration has the central responsibility for the tasks concerning the social drug abuse treatment and the remaining social support within ar-

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 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 2012, the following laws have been adopted within the drugs area:

- Act no. 163 of 28 February 2012 on the amendment of act on psychoactive substances (grouped bans against psychoactive substances). This act renders it possible to supply the existing system of individual bans against psychoactive substances with a system of bans against entire groups of the same drugs. The law implies that the Minister of Health is entitled to introduce bans against entire groups of the same drugs if this is recommended by the Danish Health and Medicines Authority or an international resolution has been made to this effect.
- Executive order no. 606 of 18 June 2012 on the amendment of order on psychoactive substances (drug consumption rooms). This law sets out a basis for the Minister of Health to grant permission to establish and run local drug user rooms as well as drug user rooms run by private institutions with an operating agreement with the municipality. The law provides that, having received an application from a Municipality, the Minister of Health may grant permission to establish and run drug consumption rooms for persons aged 18 and above with a strong addiction following from long-term and persistent abuse of psychoactive substances. The Minister of Health may also stipulate more detailed rules on drug user rooms.

Since the publication of last year's report, the following drugs have been subjected to control:

- In executive order no. 997 of 12 October 2011 on the amendment of executive order on psychoactive substances, it was set out that the drugs 4-MEC (all isomers 2-, 3- and 4-methyl-*N*-ethylcathinone), MPPP (all isomers 2-, 3- and 4-methyl- α -pyrrolidinopropiophenone) and *N*-ethylbuphedrone (2-ethylamino-1-phenylbutan-1-one) shall only be used for medicinal and scientific purposes. The order became effective on 27 October 2011.
- In executive order no. 506 of 30 May 2012 on the amendment of order on psychoactive substances, it was provided that metoxetamine (2-(ethylamino)-2(3-methoxyphenyl) cyclohexan-1-on) and fenazepam (7-brom-5-(2-chlorphenyl)-2,3-dihydro-1*H*-1,4-benzodiazepine-2on) shall only be used for medicinal and scientific purposes. The order became effective on 02 June 2012.
- In executive order no. 778 of 4 July 2012 on the amendment of order on psychoactive substances, it was provided that the following drugs shall only be used for medicinal and scientific purposes:
 - Benzoylindoles
 - Cathinons
 - Cyclohexylphenols
 - Naphthoylindoles
 - Naphthoylpyrroles
 - Naphthylmethylindenes
 - Naphthylmethylindoles
 - Phenethylamines
 - Phenylacetylindoles
 - Tryptamines

The order became effective on 7 July 2012.

- In executive order no. 971 of 28 September 2012 on the amendment of order on psychoactive substances, it was provided that 5-IT (1-(1*H*-indol-5-yl)propan-2-amine) shall only be used for medicinal and scientific purposes. The order became effective on 30 September 2012.

Budget and funding schemes

In order to strengthen interventions within the drug abuse area, a broad majority of the Danish parliament adopted the social reserve grant agreement for 2004. In the agreement, a total of EUR 19.4 million were set aside for 2004-2007 for specific initiatives to combat drugs. To boost this intervention, a majority of the parliament adopted the social reserve grant agreement for 2006. In the agreement, EUR 33.5 million were set aside for the years 2006-2009 for additional dedicated initiatives to combat drugs. And this agreement was strengthened even further for 2008 and 2009 when EUR 16.4 million were set aside for new specific initiatives. In addition to this, another EUR 9.6 million was set aside in the social reserve grants for 2011. Financing of most of the initiatives in the two agreements is permanent, which means that the initiatives stretch beyond the agreement period.

Other information on government grants and social reserve grants allocated over the years has been provided in the annual reports of previous years.

In the social reserve funds for 2012, EUR 3.2 million have been set aside for the years 2012-2015 for a model project involving acute crisis shelters for socially marginalised

drug abusers.

In the Drug Funds allocated by the Ministry of Social Affairs and Integration, a total of EUR 5.2 million have been set aside for initiatives within the social area.

It has not been possible to state a separate amount for drug control interventions.

In recent years, the treatment of drug users in prisons has been upgraded significantly in the budget. The budget figure for 2001 was EUR 0.8 million, whereas the similar budget figures in 2011 were EUR 12.7 million.

As regards municipal expenditure, the accounts and budgets show a heavy increase since 1995 in the funds set aside for socially oriented drug use treatment. The figures for 2011 were thus EUR 114.2 million. (2012 price and salary level), whereas the same figures for 1995 were EUR 37.9 million (2012 price and salary level). The trend from 2010 to 2011 shows a minor decrease of 7 per cent from EUR 122.8 million in 2010 (2012 price and salary level) to EUR 114.2 million in 2011 (2012 price and salary level). The municipalities' expenditure for the prevention of drug use and the medical treatment of drug users cannot be retrieved separately from the municipal accounts and budgets.

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 co-variation 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 at a historically high level, however with a falling tendency. The most recent population survey from 2010 shows that slightly less than half (45%) of the young adults under the age of 35 years has experimented with cannabis ever, and that 14% in the same age group has tried ever illicit drugs other than cannabis. Among the adolescents under the age of 25 years, 38% have ever experimented with cannabis, and 11% have ever tried illicit drugs other than cannabis. When considering the prevalence of the drugs individually, there appears to be a falling trend in 2010 compared to 2008 in the current use of cocaine and in the use of the other stimulants such as amphetamine and ecstasy. 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 ¹(Järvinen 2010). The night club survey is part of a research project referred to as YODA. 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 and 2010. All the surveys were carried out by the State Institute for Public Health, the University of Southern Denmark. The analyses on the prevalence of drugs are based on a population aged between 16 and

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 night club environment specifically.

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

Results from the population surveys among the 16-44-year-olds made in 1994, 2000, 2005, 2008, and 2010 show increases in the experimental use of cannabis up until 2000, and from then on remain on a fairly stable level up until 2010, cf. table 2.2.1. Among both men and women, the current use of cannabis is highest among the young population (16 – 24 years) and then tapers off by increasing age (cf. table 2.2.2 of the annex).

Table 2.2.1 Percentage of 16-44 year-olds who have taken cannabis during the last month, last year and ever in 1994, 2000, 2005, 2008 and 2010

Cannabis used	1994 (n=2,521)	2000 (n=6,878)	2005 (n=4,440)	2008 (n=2,219)	2010 (n=5,748)
Last month	2.4	4.3	4.0	3.5	3.5
Last year (Last month included)	7.4	9.8	8.4	9.1	8.9
Ever (last year included)	37.2	42.4	46.1	45.1	41.5

Source: Unpublished figures from the National Board of Health based on SUSY 1994, SUSY 2000, SUSY 2005 and AiD in 2008 and SUSY 2010

As the above table indicates, the current use of cannabis stagnated from 2000 to 2010 (cannabis used within the last year). Although there seems to be a drop from 2005-2010 in the proportion of those who have tried cannabis ever, the figures indicate that the trend has stabilized, as the "current use" is considered the most reliable target for the prevalence.

Prevalence of other illicit drugs

As regards the other illicit drugs combined, a similar development is seen; an increase in experimental use among the 16-44-year-olds from 1994 to 2000 followed by stagnation from 2000 until today. 2 % of the 16-44-year-olds report in 2010 having a current use of illicit drugs other than cannabis (used within the past year).

Table 2.2.3 Percentage of 16-44 year-olds who have taken cannabis during the last month, last year and ever in 1994, 2000, 2005, 2008 and 2010.

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)
Last month	0.2	1.2	1.1	1.1	0.9
Last year (Last month included)	0.5	3.4	2.7	3.6	2.4
Ever	4.4	11.3	13.5	13.4	12.5

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

The prevalence of the different drugs among the 16-44 year-olds appear from table 2.2.3.1 of the Annex.

Prevalence of illicit drugs among the young adults

The table below focuses on the prevalence of the illicit drugs among the "young adults" under 35 years. This is the age group with the highest prevalence of drugs (and especially the young under 25 years of age).

Table 2.2.4 Percentage of 16-34 year-olds who have taken cannabis during the last month, last year and ever in 1994, 2000, 2005, 2008 and 2010

	1994 (n=1,639)	2000 (n=4,098)	2005 (n=2,502)	2008 (n=1,718)	2010 (n=3,323)
Last month	2.7	5.7	5.9	4.8	5.1
Last year (Last month included)	9.3	13.3	12.5	13.3	13.5
Ever (last year included)	38.0	45.1	49.5	48.0	44.5

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

Table 2.2.5 Percentage of 16-34 year-olds who have taken cannabis during the last month, last year and ever in 1994, 2000, 2005, 2008 and 2010.

Used one or several of the 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)
Last month	0.1	1.8	1.5	1.4	1.3
Last year (Last month included)	0.6	5.0	4.0	4.9	3.4
Ever	4.2	13.3	16.4	16.0	14.4

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

As table 2.2.4 shows, half (45%) of the young adults under the age of 35 in 2010 has tried cannabis ever, and 14% are current users - ie they state having used cannabis within the past years. As far as prevalence of illicit drugs other than cannabis is concerned, 14 % of the young adults under the age of 35 years in 2010 have tried such drugs, and 3 % are current users thereof (table 2.2.5). There is a small, however significant decrease in the current use of drugs other than cannabis among the 16-34-year-olds from 2008 to 2010.

The current use of drugs among the 16-24-year-olds (cf. table 2.2.6 and 2.2.7 below) is higher than among the 25-34-year-olds. However, it is also among this age group that the use of illicit drugs from 2008 to 2010 is the highest. In 2010, 19% of the young people under the age of 25 years report having a current use of cannabis (report having used cannabis within the past year), which is more or less the same level as in 2008. However, 4% of the young people under the age of 25 years report in 2010 having a current use of illicit drugs other than cannabis, which is almost a 50% decrease and significantly fewer than in 2008, when 8% reported a current use.

Table 2.2.6 Percentage of 16-24 year-olds who have taken cannabis during the last month, last year and ever in 1994, 2000, 2005, 2008 and 2010

Cannabis used	1994 (n=735)	2000 (n=1,728)	2005 (n=919)	2008 (n=862)	2010 (n=1,643)
Last month	3.7	7.8	8.2	8.1	7.1
Last year (Last month included)	12.9	20.1	20.5	21.3	18.9
Ever	34.7	41.5	44.2	41.1	38.0

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

Table 2.2.7 Percentage of 16-24 year-olds who have taken cannabis during the last month, last year and have used illicit drugs other than cannabis ever in 1994, 2000, 2005, 2008 and 2010

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)
Last month	0.0	3.0	2.0	2.3	1.7
Last year (Last month included)	0.7	8.0	5.3	8.0	4.3
Ever	3.0	14.5	14.2	15.2	10.6

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

When considering the drugs individually, amphetamine, cocaine and ecstasy are the most prevalent drugs after cannabis. Table 2.2.8 and 2.2.9 below indicate that the proportion of the current use (drugs used within the past year) of amphetamine and ecstasy among the "young adults" is relatively stable from 2000 to 2008, whereas the current use of cocaine somewhat rises during the period. From 2008 to 2010, however, there is a drop in the current use of all three drugs, amphetamine, cocaine, and ecstasy. The decrease in the use of amphetamine is significant for the 16-34-year-olds, whereas the decrease in the use of cocaine and ecstasy is only significant among the 16-24-year-olds. The falling trend in the current use of amphetamine, cocaine and ecstasy during these years is thus particularly seen among the young people under the age of 25 years (re table 2.2.10 of the annex). It also appears from the tables that a significantly higher number of young men than women have a current use of amphetamine, cocaine and ecstasy.

Table 2.2.8 Percentage of the 16-34-year-olds who have a current use of amphetamine, cocaine and ecstasy in 2000, 2005, 2008 and 2010

16-34 years	2000 (n=3,980)			2005 (n=2,456)			2008 (n=1,709)			2010 (n=3,260)		
	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
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
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

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

Table 2.2.9 Percentage of the 16-24-year-olds who have a current use of amphetamine, cocaine and ecstasy in 2000, 2005, 2008 and 2010

16-24 years	2000 (n=1,684)			2005 (n=894)			2008 (n=857)			2010 (n=1,612)		
	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
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
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

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

Overall, there appears to be a falling trend in the use of illicit drugs from 2008 up until today. This falling trend these past few years is particularly observed in the current use of amphetamine, cocaine and ecstasy and particularly among the under 25-year-olds, where the decrease is significant. The prevalence of the different illegal drugs in 2010 (last month, last year, ever) appears from 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 7 % among the 16-24 year-olds who had used cannabis during the previous month. Almost 59 % of these used the drug 1-3 times. The remainder took drugs more frequently (17 % used drugs 4-9 times and 24 % 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 2010, 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. However, it should be mentioned that the prevalence of drugs other than cannabis among the young people under the age of 25 years peaks in the regions of Northern Jutland, Zealand and in the Copenhagen region.

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 MULDD 2008 survey (MULDD 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

Ongoing 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 has tried cannabis ever, and approximately 6% has tried cannabis within the past 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 percentage among the 15-16-year-olds who have tried illicit drugs in 1995, 1999, 2002, 2003, 2007, and 2011

	ESPAD	ESPAD	HBSC	ESPAD	ESPAD	ESPAD
	1995	1999	2002	2003	2007	2011
	(n=2234)	(n=1548)	(n=1418)	(n=2519)	(n=881)	(n=2190)
Cannabis tried ever	18.0	24.4	23.3	22.6	25.5	18,1***
Cannabis last 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); ESPAD 2003 (2004); ESPAD 2007 (2009), HBSC 2002, unpublished figures from ESPAD 2011 (unpublished)

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

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

**The drop from 2007 to 2011 is significant

Compared to 2007, the random sampling made in 2011 is rather extensive. However, almost half of the selected schools did not wish to participate. Class participating rates, however, reached last year's level of 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 night clubs

For the first time, a night life survey was conducted in 2010 (Järvinen 2010). The survey was initiated by scientists from the Centre for Drug and Alcohol 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 experience 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 these drugs, which again confirms a riskier party culture among these young people than among the other young people

Polydrug use prevails in the night life. 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 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 promoting".

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 compari-

son, "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.

Prevalence of khat among Somalis in Denmark

In 2008, the first Danish study on the prevalence of khat was conducted (Sundhedsstyrelsen 2009a). The survey tried to draw a picture of the prevalence of and attitudes towards khat among the Danish-Somali population. The study attempted to involve the many groups within the Somali environment, and 848 subjects, corresponding to 15% of the 15-50-year-old Danish-Somalis, participated in the study.

The study showed that khat is established in the Danish-Somali environment, with 16% of the women and 48% of the men having chewed khat within the past month. In the study, 6% of the women and 29% of the men were categorized as heavy consumers (chew khat more than twice a week). The difference between the genders was thus significant. However, the study also showed that 65% of the Danish-Somalis in Denmark did *not* chew khat. 51% had *never* chewed khat, whereas 14% had *previously* chewed khat, but had stopped. A very positive aspect of the survey was that the prevalence of khat is minimal in the young Danish-Somalis, and that almost none of the 20-year-olds have tried to chew khat which suggests that a new attitude towards khat is gaining ground among the young generation. The starting age for most khat users is between 20 to 24 years. Not only gender, but also education and marital status have an impact on the use of khat.

The attitudes towards khat among the Somalis are divided. Although two-thirds of the Danish-Somalis consider khat to be part of the Somali culture, a large share of the population finds that khat should be prohibited, which in fact it also is today. Khat use is also considered by the Danish-Somalis to be an addictive substance (in 64% of those asked) and up to 75% believed that khat is the cause of health, family and financial problems. As many as 37% of the respondents had experienced such problems resulting from khat.

3 Prevention

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 knowledge sharing, also addresses the young people's norms and behaviour.

The municipalities have the primary responsibility for preventive intervention in Denmark. The municipality is close to its citizens, and on a local level it is possible to plan universal, selective and indicated prevention in schools and through leisure activities in collaboration with associations, restaurants, bars and discotheques as well as in particularly vulnerable residential areas. The local drug prevention work is often carried in cross-sectoral collaboration between school, social administration and the police (the so-called SSP collaboration).

On a state level, one of the Danish Health and Medicines Authority's tasks is to support the municipalities' preventive intervention activities with informative material and communication of knowledge, methodology projects and through specific counselling of the municipalities and other stakeholders. Furthermore, the Danish Health and Medicines Authority also monitors and provides the overall guidelines.

In 2012, the Danish Health and Medicines Authority published a number of prevention packages for the municipalities - including a prevention package on alcohol (Sundhedsstyrelsen 2012a). The prevention packages provide, among others, specific recommendations for the type of interventions to be prioritized by the municipalities within various risk factor categories. The prevention package on alcohol includes recommendations on alcohol as well as drugs used by the young people, since often in this group, there tends to be a correlation between the use of alcohol and illicit drugs.

The prevention package provides the municipalities with a tool to incorporate health into their services, preferably across the various administrative units, as the package is expected to contribute to reducing social inequality in health. The Danish Health and Medicines Authority thus applies the prevention packages to maintain its focus on inequality in health.

In order to substantiate its work with inequality in health, the Authority issues the report "Ulighed i sundhed - årsager og indsatser" [Inequality in health - causes and interventions] (Sundhedsstyrelsen 2011a). The report lists a number of special focus areas which are likely to narrow the inequality gap and a number of underlying factors, such as alcohol and drug consumption as well as smoking are accounted for. The report also stresses that it is important to coordinate different policies in order to reduce the social inequality in health.

Health and inequality of health are thus indeed influenced by elements other than the health care system, for instance employment, social issues, etc. and it is therefore important to involve the different sectors. The same principle applies to the preventive interventions associated with alcohol and drugs. 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. Based on the report "Ulighed i sundhed - årsager og indsatser", the Danish Health and Medicines Authority published another report "Social ulighed i Sundhed - hvad kan kommunen gøre" [Social inequality in Health - how can the municipality intervene]

(Sundhedsstyrelsen 2011b) This report describes the possibilities for the municipality to reduce social inequality in health. The necessity of intervening across sectors in terms of responsibilities and tasks within the municipality is described, and it is recognized that the factors mentioned exist across the administrative entities in the municipality. For instance, surveys made by nurses or doctors on the young people in the 6th-10th grades are used to trace bad drug and alcohol habits. This way of dealing with inequality in health is in alignment with the Danish Health and Medicines Authority's publication "Sundhed på tværs" [Health across administrative sectors] which was published in December 2010 (Sundhedsstyrelsen 2010a). The publication focuses on the collaboration across various administrative entities in the municipality as regards health and prevention.

3.1 Structural issues

In Denmark, the use of illicit drugs is regulated in the executive order on psychoactive substances. The ban against drugs 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.

3.2 Universal prevention

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

Elementary school as an arena

Elementary school is an important intervention arena for universal prevention, as it holds the possibility of getting into contact with almost all children and young people as well as their parents. The elementary school has a general obligation to teach its pupils about prevention and health in the subject "Health, sex and family". Intervention in elementary school carries on as in the previous years. In the autumn of 2011, the Danish Health and Medicines Authority published two pamphlets: "Dit barns festkultur" [Your child's party culture] targeted at parents (Sundhedsstyrelsen 2011h) and "Sæt rammer for alkohol, tobak og stoffer" [Make guidelines for alcohol, tobacco, and drugs] targeted at teachers and headmasters of the Danish elementary school (Sundhedsstyrelsen 2011c). Both publications contain facts about drugs and alcohol and the effect of them and remove prevailing myths on young people and their use of drugs, alcohol and tobacco. Furthermore, the school system focuses on parent agreements in order to procrastinate young people's starting age of drinking and to avoid that they start using drugs. Finally, the most important elements of drugs, alcohol and smoking are listed.

It is recommended that the schools teach according to evidence-based principles, including the use of methods involving each individual pupil. A means to work with the young people's health perceptions is the research-based teaching material "Tackling". (Sundhedsstyrelsen 2009b). The teaching material originates from the US, but the Danish Health and Medicines Authority and the editing house Alinea have together developed and tested the material in a Danish version. In the Danish Health and Medicine Authority's publication "Forebyggelse og sundhedsfremme i skolen" (Prevention and health promotion in schools") (Sundhedsstyrelsen 2009c), other pupil-involving methods are described. They can be used both as drugs prevention and in other preventive areas. The methods are called "Aktive vurderinger" (Active Assessments) and "Du bestemmer" (You Decide), and may be used to work with improvement of family relations, a crucial aspect of drug prevention.

The Danish Health and Medicines Authority regularly updates and reprints the drug facts pamphlet "Stoffer - hvordan virker de, og hvordan ser de ud" (Drugs - how they affect me, and how they look) which is the overall informative material on the most common illicit drugs. The drug facts pamphlet 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 national and local media campaigns).

Youth education as an arena

In 2012, the debate continued on the role of the youth education institutions in the preventive work. In the autumn of 2011, the Danish Health and Medicines Authority published two pamphlets as a contribution to this work. One aimed at the parents, "Hjælp din teenager" [Help your teenager] (Sundhedsstyrelsen 2011d) and one at teachers and school management in the youth education institutions, "Politik for rusmidler og rygning" [Policies governing drugs, alcohol and smoking] (Sundhedsstyrelsen 2011e). These pamphlets were published alongside the Danish national radio's broadcasting of Danish young people's alcohol culture.

The Danish Health and Medicines Agency is also responsible for the administration of the social reserve funds allocated to young people, alcohol and drugs, under which 6 model municipality projects received grants in December 2011. The model municipality projects will test if a committing collaboration with municipalities and youth educations may have a positive effect on the prevalence of drugs and alcohol among young people. All the model municipality projects have two interacting focus areas, of which one has a universal goal of implementing drug and alcohol policies in the participating youth education institutions. In order to facilitate implementation of these policies, the participating model municipalities will participate in a course on competence development, which will primarily enable project coordinators to develop and implement drug and alcohol policies in the youth education institutions. Furthermore, the course will provide the course attendees knowledge on drugs and alcohol within the educational system.

The building focus on alcohol and drug prevention in youth education institutions also means that in other municipalities, this combination of universal intervention and interventions aiming at young people at risk is being launched, e.g. through implementation of alcohol and drug policies and counselling of young people in colleges, business colleges, technical colleges and production colleges. In Skive Municipality, the minimum age of persons to which alcohol can be sold has been raised from 16 to 18 years at all the youth education institutions in the municipality. Holstebro Municipality continues the intervention known as "Åben mobil rådgivning" (Open mobile counselling) in youth educational institutions, with 2 employees in contact with teachers, pupils or student counsellors reaching out to young people who seem to be out of balance and at risk of developing some kind of abuse. From October 2012, this programme will also offer group therapy to young people who are at risk of developing some kind of abuse.

3.3 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. Interventions can be intensified through closer collaboration between players within a specific area.

"Young and healthy" - initiatives for vulnerable young people

The social reserve grants for young people and their health have been allocated to 10 municipal projects, the aim of which, from 2008 to 2011, was to test and develop ways to work with health among young people. The projects have focused on numerous lifestyle factors such as well-being, food, exercise, smoking, alcohol, sex, drugs, sleep. The majority of the projects have focused on drugs and alcohol as a risk factor.

The evaluation from these projects has shown that the production schools, business colleges, and the student counselling sectors are important arenas for health care promotion, as these places are where we find the marginalised young people. The evaluation also shows the importance of defining a clear policy on health and well-being and to include this policy consistently when launching activities and that competence development of teachers and other professionals may contribute to inspiring the young people.

Odense is a prime example where focus has been made on the concept of competence within drugs and alcohol - the ability to manage drugs and alcohol in a proper manner. The intervention has included presentations at the municipality's schools and high schools, the preparation of drug and alcohol policies and anonymous counselling of young people with a drug abuse problem. Experience from this project has shown that the young people need to discuss the use of alcohol and drugs with adults, and that they yearn for respect and clarity from the adults. When the approach to the young people involves dialogue as well as recognition and respect, the project in Odense shows that this yields good results.

Young people's use of alcohol and drugs

"Unges Misbrug" (Young people's use of alcohol and drugs) is a national knowledge centre providing re-qualification to local authorities and their specialist staff involved in working with young people's drug and alcohol problems. The knowledge centre is part of the National Board of Social Services and focuses on finding young people with problem drug use as well as on interventions targeted at the young people's drug use problems through overall intervention. "Unges Misbrug" provides information to professionals on a website with state-of-the-art knowledge within the area. (www.unges-misbrug.dk), consultancy services and day workshops for the municipalities as well as conducts an annual national conference on young people and abuse targeted at professionals.

U-turn

U-turn is Copenhagen Municipality's service to young people under the age of 25 years, and 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 ongoing 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 ran a group treatment project with young people in production schools in the Copenhagen Municipality. The target group was young people using cannabis. Evaluation of the project in 2011 indicated that the cannabis group concept was successful, both in relation to making the young people stop smoking cannabis and to smoking less. For instance, the proportion of daily smokers in the group was reduced by 87%, and 6 of the 18 youngsters stopped smoking entirely. Furthermore, a large portion of the group of young people succeeded in continuing their education or work.

Interventions targeted at young people with drug and alcohol problems

In 2010, the National Board of Social Services granted funds for a variant of U-turn's cannabis group model, including group programs for young people with drug and alcohol problems in commercial and production schools in 6 selected municipalities. The aim of the funds is to help a group of young marginalised people's chances of finishing an education. The program consists of short-term group training supplemented with individual talks at the commercial or production school. The target group includes young people attending commercial schools and production schools and with drug use problems or with drug use problems primarily related to cannabis, but not requiring treatment

The rationale behind the funds is that a large group of young unadjusted people at the commercial and production school are so heavy cannabis users that it is difficult for them to function in a personal, social and educational context. Many of these young people find that they do not get any help at the education institutions, given that cannabis and intoxicants in general are tabooed and it is therefore difficult for them to ask for help, which in many cases leads to the young people dropping out of school.

Social reserve fund: "Young people, alcohol and drugs"

At the end of 2011, the Danish Health and Medicines Authority earmarked EUR 2.3 million from the reserve fund "Young people, alcohol and drugs" for 6 model municipality projects. The aim of the model municipality projects is to test whether increased and committing collaboration between the municipality and the youth educations might contribute to reducing the prevalence of drugs and alcohol among the young generation. The model municipalities' work is supposed to strengthen preventive intervention in alcohol and drugs and contribute to developing methods to further an environment preventing against drug and alcohol abuse in the youth education system through the establishment of drug and alcohol policies.

The part of the project dealing with prevention is early counselling and guidance provided to the young people who are on the brink of problem drug and alcohol use. In this connection, all model municipality projects must take part in a course, where local front personnel in contact with the young people and part of the counselling personnel at the youth educational institutions are trained in talking with the young people about drugs and alcohol in a recognizing and motivating manner. The project will run until 2014 and is overseen by a cross-sectoral evaluator who will be gathering input from the local projects.

Internet-based information and counselling services to young people

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 May 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 themselves see that they have 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 and Integration for the development and redesign of netstof.dk, and as of October 2012, the primary target group will be the young 15-24-year-olds who are at risk of developing abuse patterns requiring treatment. Netstof.dk will continue to provide debate fora, brevkasser and information and will also include a chat function.

Project responsible alcohol serving

In 2009, the Danish Health Medicines Authority (then the National Board of Health) launched the project "Ansvarlig udskænkning" [Responsible alcohol serving], which was a sub-project under the model municipality project "Alkoholforebyggelse i kommunen" [Alcohol prevention in the municipality], where the aim was to strengthen local alcohol preventive intervention through development and implementation of intoxicants policies in 20 model municipalities.

The project was based on the Danish experience gained from projects such as Safe Night Life and Drugs out of Town as well as experience from the Swedish STAD-project "Ansvarsfuld alkoholservering i kromiljøer"². The project was finalised in December 2011 with a conference and with the publication of an evaluation and an inspiration catalogue. The evaluation of the project showed that there was a large interest and a will to take responsibility and contribute actively to a safer night life far beyond the boundaries of the municipality and the health care system. Also it showed that it is possible to implement "responsible alcohol serving" in the Danish municipalities within a period of two years. All municipalities have established collaboration fora and most of them have established license boards. Apart from one, all municipalities had either planned or adopted restaurant plans and plans for occasional licenses. Half of the municipalities had prepared and held courses for the waiters and waitresses. The evaluation also showed that it is a good idea to enter into collaboration with neighbour municipalities in the of responsible alcohol serving, particularly in the areas where the young people commute to party sites in the neighbour municipality.

3.4 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

² www.fhi.se

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.

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, since the use of drugs is often carried out in this environment. 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, they would like to have a good and positive influence, to which the target group of young people can relate.

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 festivals³. 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".

At the Roskilde Festival, which is by far the largest of the festivals, the campaign is evaluated through surveys among the audience. In 2011, the evaluation showed that 75% had seen the campaign, which is a small decrease compared to the last couple of years. However, as in 2010, 29% had discussed the slogans with their friends, and 89% of the audience liked the idea of the festival having an attitude towards drugs (Sundhedsstyrelsen 2011f). Since 2009, the evaluation of the campaign has also included a number of surveys among the audience at three other festivals (in 2011 Vig, Samsø, Bork).

The three festivals address various target groups and may therefore give a more nuanced image of the campaign's reception on a national basis. The campaign material and the evaluation results therefore varied at the three festivals, but more than half of the audience had seen the campaign in 2011, where less than 1/4 had discussed the slogan at the three festivals. This is less than in 2010. On the other hand, almost everybody thought it was a good idea that the festivals voiced their attitude towards drugs. The Against Drugs campaign was launched during the summer of 2012 at 15 festivals. The evaluation of the 2012 campaign is expected to be finalised in the autumn of 2012 and will again be based on a representative section of the festivals involved.

³ www.dansklive.dk

Young people and alcohol

In 2011, 15 festivals participated in the Danish Health and Medicines Authority's and Festival danmark's campaign "Young people and Alcohol with the slogan: "Less drinking - More party" in a new campaign version. The aim of the campaign is to encourage to the enforcement of age limits when serving alcohol to young people. The primary target group of the campaign is the young people's parents and employees at the festivals, but the campaign also addresses the young people under the age of 16 years. The campaign elements are placed at the centre of the tent sites and in the bar areas and primarily consist of printed media, but also have a web section.

The 2011 evaluation which was also based on the festivals in Vig, Samsø, Bork and the Roskilde Festival, described a positive reception of the slogan and the campaign elements among young people, parents and co-workers. 63% of Bork's and 79% of Jelling's festival guests had noticed the campaign, whereas only 38% had noticed it at the Vig festival. While in Borg and Samsø almost 1/3 of the festival guests had discussed the slogan, only 15% had discussed it at the Vig festival. Among the co-workers/parents at the festivals, the knowledge of the campaign was good (Vig with the lowest rate of 66% and Samsø with the highest of 92%), and the campaign was generally favoured.

All in all, the Young and Alcohol campaign has sent the strongest message on fence banners, festival programs, bar posters and badges. At Roskilde, almost the same proportion of the audience in 2011 as in 2010 had noticed the campaign, with 44% having seen it. And almost the same proportion, ie 66% of the staff, had seen the campaign in 2011. By and large all members of the staff supported the campaign. In 2012, 15 festivals again joined the "Unge og Alkohol" campaign, which has the same slogan and almost the same layout as in 2011. Evaluation of the 2012 campaign is expected to be completed in October 2012.

Music against drugs

Supplementary to the festivals' "Against Drugs" campaign, the Danish Health and Medicines Authority started collaboration in 2009 with the music halls on a similar campaign against drugs. 48 music halls participated in the campaign "Music Against Drugs" which was launched in the autumn of 2011. The campaign included elements for the audience as well as the employees. The primary target group of the audience was young people between 16 and 25 years, whereas the employees part was targeted at all the employees at the music halls. The campaign consisted of printed and electronic elements such as large screen spots leading up to the concerts, website, web banners, t-shirts, posters, stickers, etc. Feedback from the audience and the employees from the 2011 campaign showed that they find it worthwhile that the music halls have an attitude towards drugs. However, the feedback still maintains that it is more difficult to establish the campaign in the music halls than at the festivals. In 2012, the campaign will run in 45 music halls during the period from September to November with a new layout and a slogan, but with the same as what is shown at the festivals "SPEAK YOUR MIND - NOT SOMEONE ELSE'S".

4 Drug abuse in numbers

4.1 Introduction

The most recent estimate on drug users in Denmark dates back to 2009 (compiled in 2010). 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 users 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 model⁴. 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 diagnosis⁵. An analysis is then carried out of how many of these people are also listed in the SIB.

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.

⁴ 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.

⁵ The extract 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 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. Estimated number of drug users in Denmark, 1996-2009

	1996	1998	2001	2003	2005	2009
Estimate of drug users 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. In 2005 the number of cannabis abusers was 7,900.

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 then National Board of Health 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 were 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 an abuse problem.

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 in 1996 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 most likely is 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.

At present, there are 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". In connection with the launch of the new reporting portal, all drug abuse reports collected from 2007 and onwards were compiled and harmonised in one database. This has caused changes in relation to previously published reports, for which reason it is not possible to perform any kind of benchmarking.

A number of new treatment projects have been launched in 2011/2012. 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 psycho-social treatment are provided either with or without supportive medicament 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.

The social treatment of drug addicts requires in-depth examination of their situation leading to an individually planned treatment course on an everyday, outpatient or inpatient treatment basis. It is a prerequisite that the drug user's own wishes for treatment are heard and taken seriously. 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. The drug abuser may thus 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 medicament treatment, the drug user cannot formally require treatment within a fortnight after contact to the local authority, but normally medicament treatment, where needed, will be initiated alongside the initiation of the psychosocial treatment.

The aim 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 are changed on an ongoing 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 are the cognitive, socio-educational, solution-focused ones. 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 psycho-social 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 (then the National Board of Health) published in 2008 a guideline on the medical treatment of drug abusers in substitution treatment (Sundhedsstyrelsen 2008a)⁶. The purpose of the guidelines is to reduce morbidity and mortality among drug users, qualify the medical treatment of drug abusers and support overall intervention procedures.

5.3 Drug users 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, among others, information about treatment facilities, ie outpatient and inpatient treatment, as well as the type of treatment (methadone, drug-free, etc.) provided to the receiver.

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 VBGS⁷ and the SIB were mi-

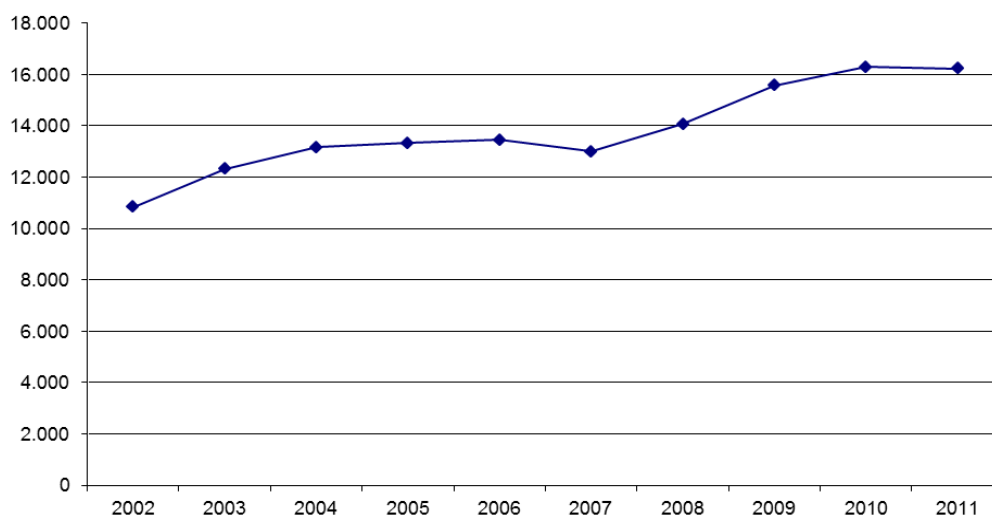
⁶ Guideline. 42 of 1 July 2008 on the medical treatment of drug abusers in substitution treatment.

⁷ VBGS: Waiting time for treatment guarantee to drug abusers.

grated 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 benchmarked with previously publicised reports.

The total number of drug users 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.

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 use treatment with admission date in 2011

Number of clients admitted to treatment in 2011	5,686
Number not treated previously (%)	32
Share of men/women (%)	78/22
Average age men/women (%)	31/31
Opioids as primary drug (%)*	17
Cannabis as primary drug (%)*	63
Stimulants as primary drug (%)*	10
Cocaine as primary drug (%)*	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 yrs	1,017
Number of children not at home, under the age of 18 yrs	290
Foreign citizenship (%)	6

Source: Register on drug abusers in treatment (SIB)

*Rate of 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 stimulants which are particularly in focus of the young people's experimental use of drugs appears 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 ecstasy⁸ as their primary drug⁹. 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.

⁸ Here recorded as MDMA or similar drug.

⁹ The percentages have been calculated on the basis of the part of the treatment population who has 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 elementary school (primary and secondary school), and 8 % left elementary 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 for treatment during the year and who have not been treated for their drug abuse earlier, 2005-2011

	2005	2006	2008	2009	2010	2011
Clients that have not been treated earlier	1,578 out of 5,228	1,329 out of 5,426	2,072 out of 6,243	2,481 out of 6,866	2,352 out of 6,654	1,847 out of 5,686
	(30 %)	(24 %)	(33 %)	(36 %)	(35 %)	(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
Stimulants 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.

*Percentage of 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 method of administration for heroin among the two "client groups", there is also a difference, in that 27% of those not admitted to treatment earlier report having injected cocaine, whereas

43% of those previously receiving treatment have injected heroin. The different administration methods within the two client groups may be explained by a "shorter course of abuse" and that many of the new abusers of opioids are heroin smokers.

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 (Sundhedsstyrelsen 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 substance for clients admitted in 2003 and 2011 with a known primary drug (percentage)

	2003		2011	
	18 – 24-year-olds	All receiving treatment	18 – 24-year-olds	All receiving 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).

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 problems 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 users in substitution treatment

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 (Sundhedsstyrelsen 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 method¹⁰ and the data basis¹¹ vary

¹⁰ 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.

¹¹ 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).

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 were 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.

5.4 Other interventions concerning drug use treatment

Below follows an outline of new treatment oriented initiatives and status. Overall, the initiatives address four main groups of users: the socially less marginalised, the socially very marginalised, the dually marginalised drug abusers and the young people.

The socially less marginalised

Two initiatives - *initiatives involving anonymous outpatient treatment* and *treatment of cannabis and cocaine abuse* are targeted at especially the new drug abusers entering the treatment system and where especially cannabis, cocaine and other speedy drugs are dominant in their abuse. Compared to other drug abusers in treatment, the socially less marginalised users are those who often have a steady contact with their family, they have a 10th grade diploma, they are often salaried workers, and only a few have housing problems and are hardly ever engaged in criminal activity. The activities targeting this group will be testing how treatment can match their needs.

- **Initiatives involving anonymous outpatient drug abuse treatment**

This initiative is targeted at citizens with a drug abuse problem requiring treatment and with a close affiliation to the labour market or the educational system. Today, this group will normally not approach the drug abuse treatment system. The aim of the projects is to find out who and how many can be reached and have them choose treatment via an anonymous program. Through this project, it should be determined whether there is a group of persons with drug abuse problems who do not wish to start treatment due to privacy issues. The program on anonymous outpatient drug abuse treatment is provided in Copenhagen and Odense and has been available from January 2010 up to and including 2012. The social reserve fund for 2010 has set aside EUR 2.2 million for the initiative.

The preliminary results show that it is possible to attract the target group. During the first years of the initiative, there have been 195 admitted to treatment, which is twice as many as estimated at the opening of the initiative. It is a target group, to which anonymity is key. The persons admitted would thus not have chosen to start a treatment program if they had not been offered anonymity. This is primarily due to a wish of not being registered as they fear for the consequences it would have in relation to their job (present and future) and their family.

The preliminary figures also show that 80% of the persons have a job or are following some kind of educational program, 86% live in their own home, 70% have short-term, medium-term or long-term education, 64% are single and 50% always or often have the possibility of getting help from their family. There is a pattern in the drug abuse pattern of this group of people. 70% report cannabis as their primary drug, 16% cocaine and 14% "other". One third has previously received treatment, and 70% have used intoxicants at the age of 14-16 years for the first time.

- **Treatment of cannabis and cocaine abuse**

This initiative includes developing treatment methods that combine treatment of problem cannabis and cocaine use. The models must be made available to the municipalities in order to give them inspiration. Experience from the Copenhagen Municipality shows that cannabis and cocaine users work well together in groups and the gender distribution in the groups is more balanced. EUR 1.1 million have been set aside in 2012-2015 for the initiative. The initiative is under preparation.

The socially very marginalised

Two ongoing initiatives are targeted at the socially most marginalised drug abusers. This group of users do not use the existing treatment system, cannot be retained in the treatment system, and do not fit into the existing programs. These users are characterized by a very high degree of problem complexity on almost all parameters of a social, mental, health, residential and financial nature.

- **Study of the chaotic polydrug users**

A study is being conducted on the prevalence of cocaine abuse among the socially marginalised persons with chaotic polydrug use. The type of intervention problems arising in connection with this group are under investigation. The purpose of the study is to unravel whether or not within this group there are special risk groups, such as immigrants and mentally ill, whose problems complicate intervention further. Such a study will provide a deeper insight into the area and thereby provide a better platform for learning whether or not the development initiatives are sufficiently focused on the complexities of cocaine abuse. Data collection has started and a final report is expected at the beginning of 2013. A total of EUR 0.1 million has been set aside for this study.

- **Emergency crisis centre for socially marginalised drug abusers**

An emergency crisis centre will be established for chaotic drug abusers who have very little contact with the drug abuse treatment system. The purpose of this model project is to establish a low threshold program, under which socially marginalised drug abusers who are in an acute and sometimes life-threatening crisis are given the opportunity to stay in a protected inpatient environment for a

period. The aim is to create some calmness around the individual's chaotic and crisis-ridden situation. A safe environment should be created where deviating behaviour and abuse are not reasons for exclusion, and it should be possible to meet fundamental physical needs for food, clothes, shelter and psychological needs for contact. Using methods such as bridging and social reintegration to the individual's home municipality are needed in order for the individual to revert to a better and more stable situation than the one in which he or she is currently living. There are two aspects to this: First of all, the users must be made ready to accept an aid program, and secondly, the local municipality must be ready to receive the person in question. In the social reserve fund agreement for 2012, EUR 3.2 million have been set aside for this initiative for the period 2012-2015.

The dually marginalised drug abusers in treatment

Several initiatives are targeted at the group of - and their professional counselling - dually marginalised drug abusers with mental illnesses. This target group accounts for a major percentage of the users in drug abuse treatment and for many years, they have been the subjects of a number of different interventions and programs within the psychiatric, socio-psychiatric and abuse treatment programs. In spite of several initiatives launched and increased focus on this target group, there still seems to be challenges in relation to coordination and responsibility and role distribution between the sectors.

- **Development of model projects with a focus on screening and examination of drug abusers with mental illnesses**

The projects are targeted at the dually marginalised drug abusers who are included in drug abuse treatment. Five municipalities, Esbjerg, Horsens, Ålborg, Slagelse and Esbjerg will be trying two screening and collaboration models drawn up on the basis of experience from Århus and Fredericia Municipalities. The aim of the model projects is to develop and test two screening and collaboration models which will contribute to qualifying treatment of dually marginalised drug abusers receiving treatment. The five project municipalities started their work in March 2012 and during the development period, they will be working with further developing the collaboration model, developing employee competencies and systematizing screening practice. A total of EUR 1.9 million have been set aside for the period 2011-2014.

- **Young mentally ill with abuse problems**

The project is targeted at young newcomers in three municipalities in the screening and review project mentioned above. These young people have been considered to have psycho-social problems when screened and they suffer from self-perceived psychological difficulties. The aim of the project is for the young people to reduce their abuse and obtain more control of the mental problems. A model has been developed for support and collaboration optimizing the overall intervention in relation to this group. The model will run under the auspices of social psychiatry. The project has been initiated in three municipalities - Aalborg, Horsens and Gladsaxe - in March 2012 and will run up to and including 2015. A total of EUR 2.4 million have been set aside for the initiative, which is part of the agreement referred to as Psykiatrafonden [the Psychiatry Agreement] 2011-2014.

- **Increased information about citizens with dual diagnoses**

The National Board of Social Services and the Social Development Centre (SUS) are developing a website to be publicized in the autumn of 2012, includ-

ing information material on citizens with dual diagnoses. The purpose of the website is, among other things, to increase the knowledge on and insight into distribution of responsibilities between the various sectors working with dually marginalized citizens and to provide examples of good stories and good collaboration between the sectors. The website will contain a description of the organisational and legislative framework for interventions offered to dually marginalized citizens, a target group description (severely mentally disabled individuals with drug and/or alcohol abuse), and examples of different types of intervention - including a presentation of/reference to evidence-based methods, user involvement and literature.

- **Integrated intervention for psychiatric patients with an abuse problem**
As part of Psykiatraftalen 2011-2014, EUR 2.4 million have been set aside for a model project integrating intervention in socio-psychiatry, abuse treatment and psychiatry. Four project municipalities have been selected (Ballerup, Egedal, Hedensted and Syddjurs), which, in collaboration with the regions, each establish an integrated program for psychiatric patients with abuse problems. The project organisation is expected to be established in August/September 2012, where change workshops will be held in the four project municipalities in order to concretize the target group, purpose, expected results and planned activities of the projects.
- **Strengthened psychiatric intervention offered to psychiatric patients with abuse problems**
As part of the social reserve agreement within the health care area for 2012-2015, EUR 7.2 million were set aside to strengthen the regional treatment programs offered to persons with psychiatric disorders and abuse problems, including a quantitative as well as qualitative expansion of the services. The funds were allocated to the regions in July 2012. The projects receiving grants from the funds focus particularly on the promotion of regional treatment intervention, motivation of the patients and improvement of the collaboration between regions and municipalities to help psychiatric patients with co-morbidities such as drug and/or alcohol abuse.

Special initiatives for the young people

Two initiatives are targeted at the young people in need of treatment for their abuse. During recent years, there has been quite some focus on the very young people with drug and alcohol problems (cf. chapter 3 on prevention), and that abuse in young people rarely is an isolated problem. More often it is a combination of a number of problematic issues, where the abuse is part of the problem, but not necessarily the primary problem. Quite a few young people abstain from seeking help, as they do not perceive themselves as abusers, and they have not necessarily accepted that their drug and alcohol abuse is a part of their problems

- **Pre-treatment program "Project Andre Valg" (PAV)**
Based on experience from studies on the use of pre-treatment programmes in Danish jail houses, young people with abuse problems staying in secured institutions should be offered a pre-treatment program against abuse. The pre-treatment program offered to them includes very much the same elements as the pre-treatment method known from the "Projekt Over Muren" [Project Over the Wall] in the Copenhagen Prisons. The purpose of the initiative is to motivate the young people to talk about their use of drugs and alcohol. The aim is to motivate the young people with abuse problems to receive treatment after their

stay at the secured institution.

A working group and a professional network of project managers have been appointed to develop the pre-treatment programme, the aim of which is to take into account the target group's age and particularly vulnerable situation. All the 7 secured institutions in Denmark are participating in the development and testing of the project. The final program is expected to be ready at the end of 2012. A total of EUR 0.4 million annually have been set aside under the social reserve grants agreement for 2012 and is one of the 17 initiatives on prevention against juvenile crime ("Forebyggelse af ungdomskriminalitet") during the period 2010-2013.

- **Project "Misbrugsbehandling" - treatment program for young people 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 ongoing 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 2 Danish and 1 foreign method:

- U-turn - based on Copenhagen Municipality's existing programs.
- Århus Municipality Model (ÅKM) - based on Århus 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 enroll 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 EUR 8 million have been set aside for the initiative.

5.5 Other initiatives

Educational programs for drug abusers

In 2011, a new competence building supplementary training program for therapists was launched for the first time in four profession high schools. The aim is to qualify the therapists on a broad scale in relation to the social treatment intervention. The supplementary training consists of two modules that can be taken independently or be included in the existing social diploma training scheme. The two modules convey the most recent knowledge on social drug abuse treatment within methods, theory, evidence-based treatment, interdisciplinary and overall intervention, user involvement, legal safety, collaboration with and around the users, social sequelae and problem drug use. In order to support participation in this supplementary training programme, attendance

fees are free of charge for therapists during the period mid-2011-mid-2013. A total of EUR 0.8 million have been set aside for 2010-2013 for this initiative.

5.6 Research into the treatment of drug abusers

The focus areas in connection with research into the treatment of drug abusers are changed on an ongoing basis. At the Centre for Alcohol and Drug Research, focus is made on five areas in particular:

1. **Treatment of special groups of clients using specific methods such as personality disturbances, ADHD and trauma etc.** In a number of current projects it is being investigated, how specific methods affect specific psychiatric conditions such as anxiety, depression and anti-social personality disturbance (ASPD). Especially, focus is made on ASPD. Also, two PhD projects have just started with a special focus on ADHD and PTSD, etc. Finally, under this category, a study has been initiated to examine the effect of Client-Directed-Outcome-Informed, which is a type of treatment of young people between the age of 18-30 who have developed a problematic use of cannabis. These studies are all randomised experiments.
2. **Treatment of young people with a problematic use of drugs.** Both now and before, focus has to a high degree been directed to the treatment of young people under the age of 18 years who have developed a problematic use of drugs. A major study is presently being conducted, involving so far 739 young people under the age of 18 admitted to treatment for their abuse. In continuation of this study, a follow-up study is also currently in force. Furthermore, a survey has quite recently been conducted, under which 2,950 young people at the age of 15-18 have been interviewed about their use of drugs and alcohol, the relationship with parents, leisure activities, mental health, etc. Finally, two PhD projects have been running since 2010 with a special focus on the young problem drug users' lives and the treatment they are being offered. The two PhD projects are qualitative studies.
3. **Treatment in relation to organisation and the total target group.** On a national as well as an international scale very little research is being made on the connection of the entire target group with organisation and treatment results. The current project includes a major survey in four Danish municipalities, where a total of 13,200 randomly selected persons have been contacted. Furthermore, national treatment registers (social, health psychiatry), social registers and crime registers are being pooled for all municipalities. The pooling includes an analysis of more than 30,000 drug abusers' migration through different aid systems before and after a defined treatment episode through a 10-year-period. Further surveys are being made on the municipal organisation of drug abuser treatment and on the political decisions behind the organisation. For instance, it is being investigated how many from the target group are receiving treatment, who reach out to most of the young people in the target group, and the outcome of the treatment (based on pooling of registers).
4. A PhD project with a focus on **psycho-social interventions in outpatient drug abuse treatment, particularly with a focus on the heaviest drug abusers of ethnic origin** shows that also when the social workers meet clients with an ethnic minority background, there is a focus on the clients' individual problems. Focus of these meetings is the clients' housing situation, basis for providing for him/herself, drug craving and withdrawal symptoms. With this group, outpatient

work typically has a harm-reducing aim, where efforts are made to stabilise the client via assistance to his/her social situation and via substitution medication as pharmacological stabilisation. In other words, ideas about inter-cultural differences as a possible barrier do not fill the scene, as the problems of minorities are much more similar to those of the ethnical Danish clients than they differ. The title of the PhD thesis is: *Agents in Social Work: Meetings between social workers and clients with and without ethnic minority background in outpatient drug abuser treatment.*

5. Finally the project "**Prison-based drug treatment in the Nordic countries**" should be mentioned. Control and rehabilitation in Welfare State institutions", which is a major sociological/anthropological survey on the prison-based drug abuser treatment in the four Nordic countries. In Denmark, the project includes a survey on the treatment in three prisons and a PhD project. The purpose of the PhD project is, on the one hand, to investigate how inmates in the Danish prisons react to the drug abuser treatments offered to them during their imprisonment and on the other, to analyse how drug use and the wish for a life without drugs becomes meaningful to the inmates in view of their situation during and after having served their sentence.

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 Commissioner of the 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.

From 2005 to 2008, the number of drug-related deaths had gone down in the National Commissioner's register. From 2008 to 2009 there was a drastic increase, and the number of deaths in 2009 and 2010 were stable at a high level. In 2011, the number is 285, which again is a small increase and the number is the highest since registration started. Analyses of these deaths throughout the years show that poisoning is the predominant cause of death as a result of poly drug use.

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 wards 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 an even 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. HIV testing is voluntary and people who are HIV-infected are reported anonymously. The HIV reporting system includes age, gender, information about any earlier HIV test and risk behaviour, as well as the presumed method of infection. Cases of AIDS are reported by name and 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 years¹². 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 where the source of infection is considered to be intravenous drug use is relatively stable around 10%. In 2011, 9 % of those diagnosed with AIDS were intravenous drug users, which were 5 out of a total of 58 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, reported cases are most likely underestimated.

Studies into the proliferation 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 investigated¹³. 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.

Analysis 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%.

¹² 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.

¹³ The initiative for the study was taken in the national key indicator group for infectious diseases.

6.3 Other drug-related health problems

Non-fatal poisonings caused by illicit drugs

Data from the National Patient Register (LPR) comprise hospital contacts with poisoning as an action diagnosis recorded at the Danish public or private somatic or psychiatric hospitals. The contact includes visits to the emergency room and hospitalisation where the patient was not transferred from the emergency room.

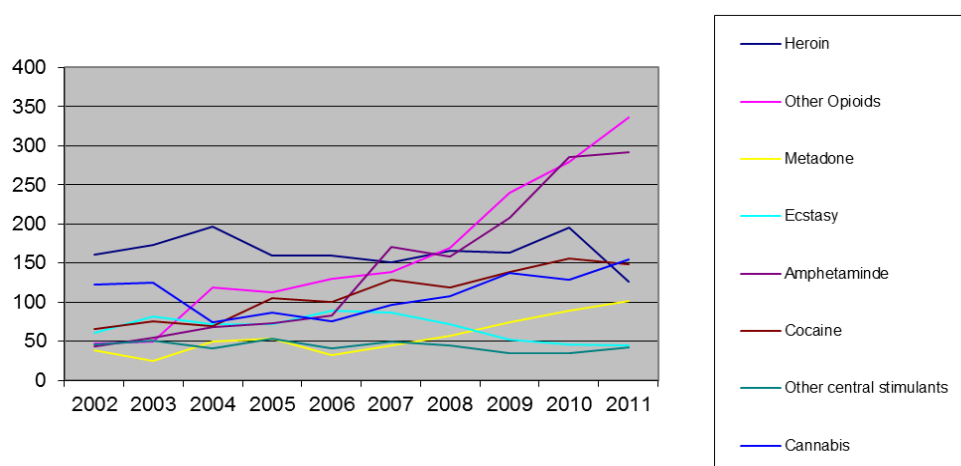
Table 6.3.1 of the annex shows the number and development of the recorded poisonings with the various illicit drugs from 2002 to 2011. From 2010, a data retrieval criterion different from previous ones has been applied. The compilation methods before and after 2010 are thus not identical. It is assumed that the poisonings are under-reported throughout the years, which means that these are minimum figures.

Annually, poisonings have been recorded at 1163-1880 cases caused by illicit drugs from 2002 to 2011. From 2004, there is an increasing tendency from 1163 poisonings in 2004 to 1880 poisonings in 2011, which corresponds to an increase of 61% during the period. The number of poisonings in 2010 and 2011 are, however, stable. The increase throughout the years is due to poisoning with heroin or other opioids or stimulants - especially amphetamine and cocaine. As mentioned, the figures are unconfirmed and should be interpreted with some reservation due to diagnostic uncertainty and other sources of error.

A total of 14,544 cases of poisoning were recorded during the first 10 study years. A vast majority of these cases, almost 90%, were treated in somatic emergency rooms/hospitals, and the remaining 10% in psychiatric emergency rooms/hospitals. As regards the distribution of gender, 2/3 are men (66%) and 1/3 are women (34%).

The figure below shows the developments of poisonings caused by the various drugs from 2002 to 2011 (figures shown in table 6.3.1 of the annex).

Figure 6.3.1. Developments in hospitals contacts resulting from poisoning and intoxication with illicit drugs from 2002-2011



Source: The Danish Health and Medicines Authority's National Patient Register, data from August 2012.

The poisonings in 2011 are shown in table 6.3.2 below. More than half (995 out of 1880) of all poisonings in 2011 occurred among persons over the age of 30, whereas slightly under half of the poisonings (885 out of 1880) occurred among persons under the age of 30. Young people under the age of 24 accounted for 36% (669 out of 1880).

Not surprisingly, most of the poisonings caused by opioids were most frequently seen among persons over the age of 30. Poisonings caused by stimulants were most frequently seen among young people, followed by either polydrug use or drugs that could not be specified.

Table 6.3.2. Contacts to hospital after intoxication and poisoning caused by the various illicit drugs in 2011 broken down by different age groups

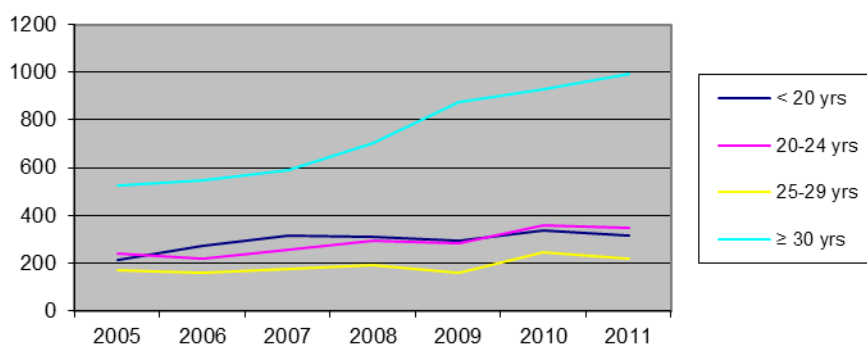
	< 20 years	20-24 years	25-29 years	≥ 30 years
Opioids	34	44	37	541
Stimulants	149	187	99	156
Mushrooms and hallucinogens	9	10	7	6
Cannabis	66	39	17	33
Polydrug use and unspecified	59	68	60	259
Total	317	348	220	995

Source: The Danish Health and Medicines Authority, data collected in August 2012

Among the stimulants, cocaine appears as an exception, also among the poisonings in the slightly older population. Persons at the age of 30 or older accounted for 35% (52% out of a total of 148) of the poisonings caused by cocaine in 2011 (not shown).

The development in the number of poisonings caused by the various drugs throughout the years in the different age groups appears in table 6.3.3 of the annex and appears in figure 6.3.3. below.

Figure 6.3.3. Hospital contacts following intoxications and poisonings broken down by age groups, 2005-2011



Source: The Danish Health and Medicines Authority, data collected in August 2012

As previously mentioned, the number of poisonings has increased since 2005. The increase is primarily seen among persons over 30 years.

Mental illness

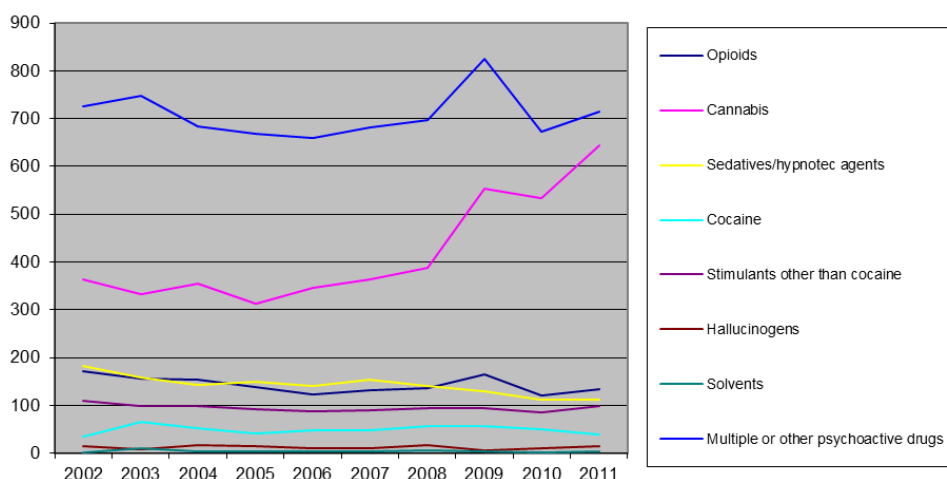
Mental disorders in drug abusers is a well-known phenomenon, given that drug use often occurs with actual mental illness or mental problems in the form of panic reactions, anxiety attacks, depressions and personality disturbances, etc.

In 2011, a total of 5,687 persons were admitted to psychiatric hospitals with a drug-related primary or secondary diagnosis (dual diagnosis). This is more than in 2010, where the number was 5010 persons. During recent years, there has been a steady increase in the number of persons admitted to the psychiatric hospitals with a drug-related diagnosis, however with annual fluctuations (see table 6.3.4 and 6.3.5 of the annex).

In 2011, the number of persons with drug-related secondary diagnosis was 3927 (3445 in 2010), and the number of persons with a drug-related main diagnosis was 1760 (1586 in 2010). The number of persons and hospitalisations involving secondary or primary diagnoses are shown in the tables of the annex and illustrated in figures below.

Over the past 10 years, persons with *primary diagnoses* in relation to "polydrug use" (multiple or other psychoactive drugs) have made up the largest group. The second most frequent group includes persons with a cannabis-related primary diagnosis which in 2011 included 37 % of persons in psychiatric treatment with a drug-related primary diagnoses. The number of persons with primary diagnoses related to cannabis has gone up drastically the past few years. During the same period, the number of persons with an opioid-related primary diagnosis has been moderately declining up until 2006, when it started to increase slowly until 2009. After this, the numbers have been fluctuating.

Figure 6.3.3. Persons registered with drug-related primary diagnoses in psychiatric hospitals, 2002-2011

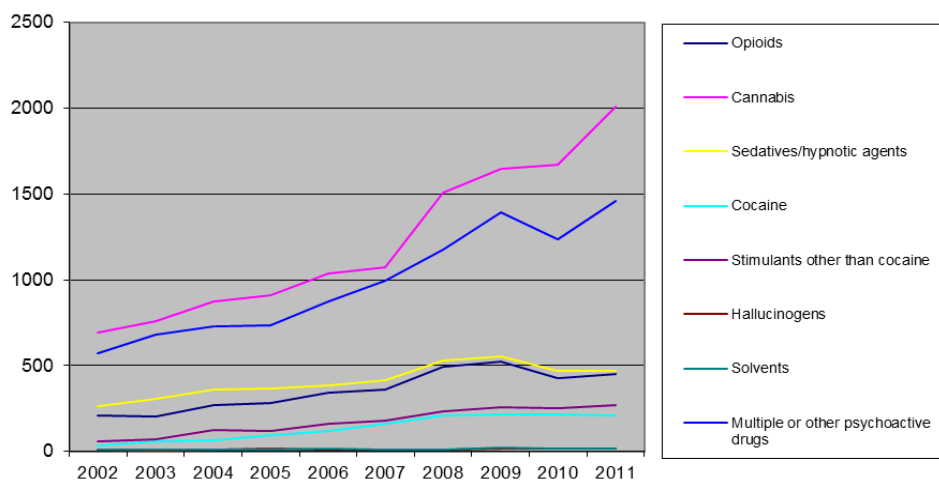


Source: Unpublished figures from the Psychiatric Central Register at the Dept of Psychiatric Demography at Institut for Psykiatrisk Grundforskning, Psychiatric Hospital, Århus

The number of persons with a cannabis *secondary diagnosis* has tripled during the past 10 years. The group comprised 691 persons in 2002 and 2011 persons in 2011. During the same period, there is also an increase in the number of persons hospitalised with secondary diagnoses related to cocaine and other stimulants, however a

moderate decline in the number of cocaine-related hospitalisations is seen from 2008 and up until today. The number of hospitalisations caused by stimulants are, however, considerably lower than the hospitalisations involving cannabis secondary diagnoses.

Figure 6.3.4. Persons registered with drug-related secondary diagnoses in psychiatric hospitals, 2002-2011



Source: Unpublished figures from the Psychiatric Central Register at the Dept of Psychiatric Demography at Institut for Psykiatrisk Grundforskning, Psychiatric Hospital, Århus

The number of hospitalisations with a "polydrug use" secondary diagnosis is high and accounts for 1/3 of all hospitalisations involving a drug-related secondary diagnosis.

6.4 Drug-related deaths and mortality rates among drug abusers

The National Commissioner of 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 Commissioner's Office.

Parallely with the National Commissioner's 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.

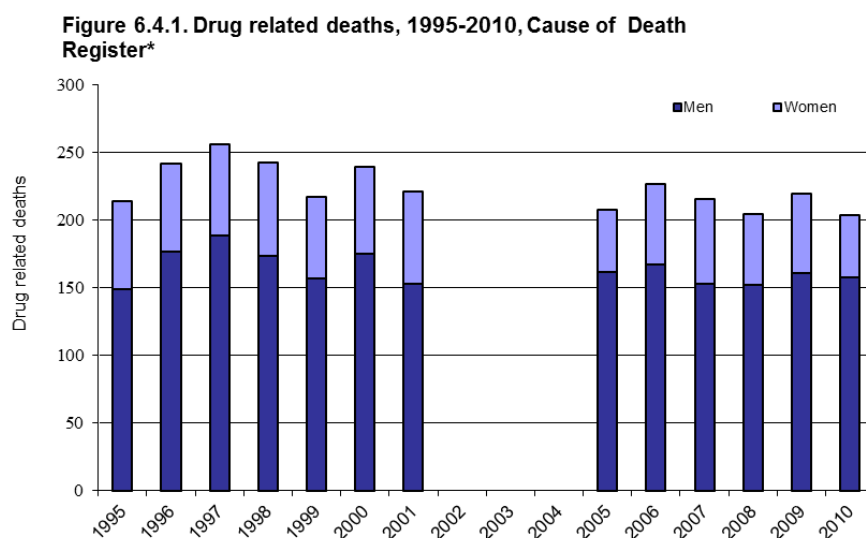
The differences between the figures in the register of the National Commissioner's Office on drug-related deaths and the State Serum Institute's Cause of Death register stem from the differences in populations died and from the differences in definitions of a drug-related death. For instance, the register of the National Commissioner's Office 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 Commissioner's 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 dependence 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 Commissioner's Office.

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 1995-2010¹⁴.



Source: State Serum Institute's Cause of Death Register

* The data for the years 2008 to 2010 from the Cause of Death Register are not complete. Since the actual number of deaths are known from the CPR Register, the data for 2008, 2009, and 2010 have been increased by 2.0; 2.4; and 4.5 per cent in order to benchmark with previous years.

In 2010, the number of recorded drug-related deaths was 204. When considering the whole period, 1995-2010, the number of deaths fluctuate between 200-250. The number of deaths reached a rock bottom low in 2010 with 204 recorded deaths. In 2010,

¹⁴ Valid figures on drug-related deaths recorded for 2002-2004 are not available. Furthermore, the 2011 figures have not yet been compiled.

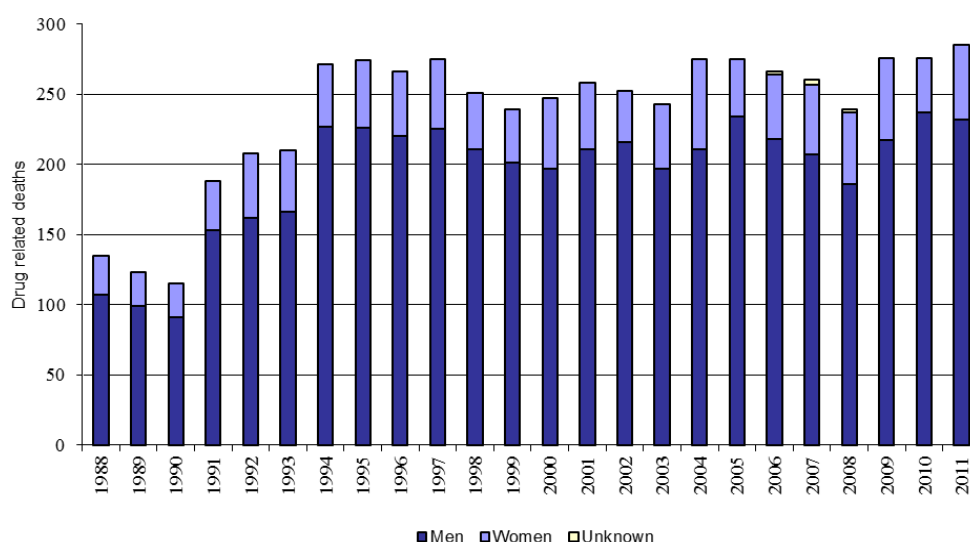
men accounted for 77 % (158) of all drug-related deaths. During the other years, their share of drug-related deaths is between 69% and 74%.

Statistics based on the National Commissioner of Police's register

From the mid-1990s (figure 6.4.2), the number of deaths recorded in the register of the National Commissioner's has been more or less constant, however with annual fluctuations (see table 6.4.1 of the annex). In 2011, 285 drug-related deaths were recorded, and this is the highest number ever. Out of the 285 deaths, 81% were men (232) and 19% were women (53).

The average age at death has gone up for many years. In 1993, the average age was 33 years, whereas in 2011, it was 40.4 years, ie 39.6 years for men and 43.9 years for women, respectively. The proportion of young people under the age of 30 years accounted for 19 per cent of all drug-related deaths in 2011 (the rate was 22% in 2010).

Figure 6.4.2 Drug-related deaths 1988-2011, National Commissioner of Police



Source: National Commissioner of Police 2012

Out of the 285 deaths in 2011, 76% (218) was caused by poisonings after the intake of one or several drugs, whereas 24% (67) was due to another type of drug-related death - for instance violence, accident other than poisoning, illness or an unknown cause of death.

As it appears in Table 6.4.3 below, 24 % of all poisonings (53 out of 218) were caused by heroin/morphine or heroin/morphine in combination with another drug, whereas 52% of the poisonings (114 out of 218) were caused by methadone or methadone in combination with another drug. 23% of the poisonings (51 out of 218) are caused by other drugs.

Table 6.4.3. Poisoning deaths among drug users in the year in question grouped by the assumed main cause of death. The numbers in parenthesis are percentages

	1991	1997	2004	2005	2006	2007	2008	2009	2010	2011
Heroin /morphine	94 (57)	153(71)	81 (38)	77 (37)	83 (37)	69 (34)	70(36)	75(36)	66(32)	53(24)
Methadone	51 (31)	46 (21)	95 (44)	89 (43)	92 (42)	84 (41)	82(42)	96(47)	89(44)	114(52)
Other	9 (12)	17 (8)	38 (18)	40 (20)	46 (21)	52 (25)	43(22)	35(17)	48(24)	51(23)
Poisonings total	154 (100)	216 (100)	214 (100)	206 (100)	221 (100)	205 (100)	195 (100)	206 (100)	203 (100)	218 (100)

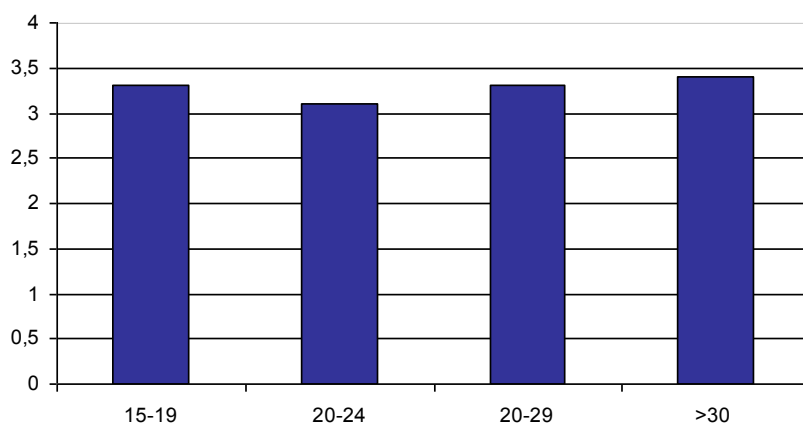
Source: National Commissioner of Police, 2012

Table 6.4.3 shows the development within the various poisoning deaths in the years 1991, 1997, and from 2004 and up to 2011. Overall, the poisonings caused by opioids (heroin/morphine and methadone) account the majority of the deaths.

However, from the 1990s and until today, there appears to be a drastic change in the pattern of poisonings, as within the group of poisonings caused by opioids, there is a decline in the proportion where poisoning caused by heroin/morphine is reported as the primary cause, whereas there is a corresponding increase in the proportion of deaths, where poisoning caused by methadone is reported as the primary cause. Finally, since 1997, there has been an increase in the proportion of deaths with poisoning under the “other” category being 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 other (strong) opioids. In 2011, the category "other" included the following poisoning deaths; other opioids (strong) (5), amphetamine (4), cocaine (4), ecstasy and ecstasy-resembling drugs (2), dextropropoxylene (1), other for instance GHB or ketamine (1).

It should be mentioned 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-leathal 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 2011 in different age groups



Source: National Commissioner of Police, 2012

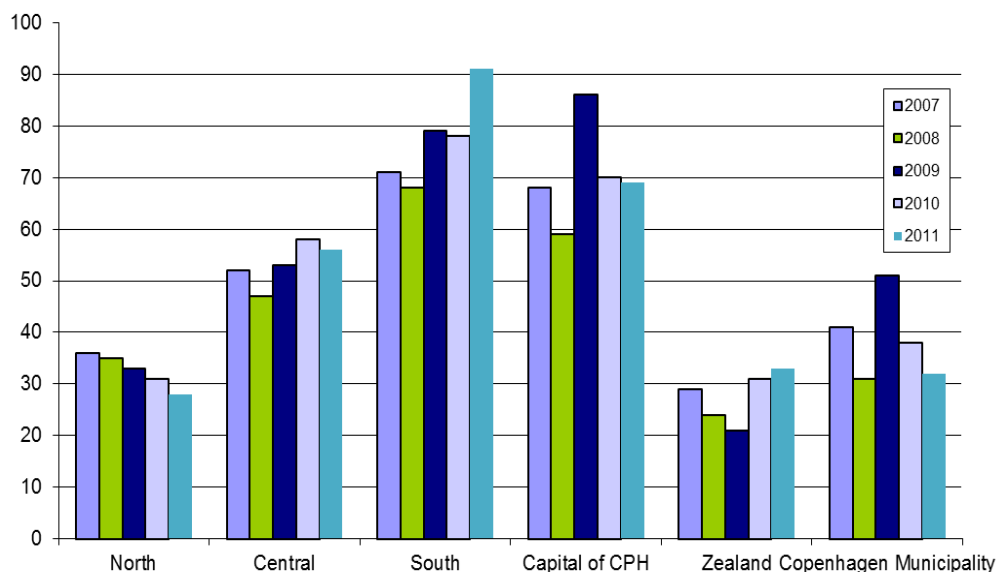
As the figure shows, an average of more than 3 different drugs is found in all deaths, which documents extensive polydrug use among those who die. This also applies to the very young people. The most frequently detected drug in all drug-related deaths is benzodiazepines (64%), followed by methadone (58%) and cannabis (36.5%).

Geographical trends

Out of the 285 drug-related deaths in 2011, 114, 107, and 67 were examined and reported from the forensic departments/institutes in Århus, Copenhagen, and Odense, respectively. The geographical distribution has changed in recent years with more drug-related deaths being recorded in Jutland than in Zealand and the lowest number recorded in Funen.

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.

Figure 6.4.4 Drug-related deaths broken down by regions and Copenhagen Municipality (deaths in Copenhagen Municipality are included in the columns for the capital region).



Source: National Commissioner of Police, 2012

Figure 6.4.4 shows that the number of drug-related deaths are broken down by all the regions, with the highest number being in the region of Southern Denmark and the lowest in the region of Northern Jutland in 2011. The development in the number deaths from 2007 to 2011 varies within the five regions, with a decreasing number in the region of Northern Jutland and an increasing number in the region of Southern Denmark. Copenhagen Municipality accounts for a decline from 2010.

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, this situation involves complex conditions and causality.

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. Drug abusers are also more prone to contract diseases such as thrombosis and blood poisoning, heart valve infection and circulatory disorders. 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 their unorthodox way of living, which is often seen in connection with drug abuse.

In many cases, drug abuse is a long-term or chronic condition, and recovery in the form of being drug-free cannot always be expected from the drug abuser with a long track record of abuse. Harm reduction and particularly target 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

Many physicians are not sufficiently updated on sudden drug poisoning cases which particularly occur when polydrug use is involved. As a result, the Danish Health and Medicines Authority will publish guidelines in 2012 on the treatment of acute drug poisoning with a description of the clinical scenarios and principles of treatment. The purpose of the guideline is to assure quality of the healthcare treatment and thus optimise treatment of acute poisonings.

Also, to make sure that physicians are adequately knowledgeable on the effects and harmful effects of cocaine and other stimulants, the Danish Health and Medicines Authority will publish a guideline in 2012 on the medical treatment of cocaine abuse and other stimulants.

Drug consumption rooms

After Act no. 606 of 18 June 2012 was passed on the amendment of act on psychoactive substances, it has become possible for the municipalities to establish drug consumption rooms as part of their overall services to drug abusers. If the municipality wishes to establish a drug consumption room, the local Social Services Administration must apply to the Ministry of Health.

The purpose of this is to render it possible for the municipalities to include the drug consumption rooms in their harm reduction interventions. The drug consumption rooms must thus contribute to reducing mortality rates and improve the health conditions for the drug abusers. Also, it is assumed that introducing drug consumption rooms might contribute to reducing the disturbance which is felt by the people living in the areas affected by drug abuse. The target group of the drug consumption rooms is people at the age of 18 and above and people who are severely addicted as a result of long-term and persistent abuse of psychoactive substances.

The drug consumption rooms are to act as low threshold services and should match local needs. Therefore, the municipalities are responsible for considering access to drug consumption rooms, capacity, staff, control, types of drugs and - modes of administration as well as rules and regulations, etc. Their deliberations should be made in collaboration with the police, the local community and, where needed, the affected drug abusers. In connection with the drug consumption room, access should be given to relevant social and health care programs. The drug consumption rooms must be manned by qualified personnel, which will also be monitoring drug intake. Monitoring of drug consumption, hand-out of equipment for drug use and guidance is not, in a drug consumption room context, considered as treatment comprised by the Health Care Act or as a business comprised by the Authorisation Act (Indenrigs- og Sundhedsministeriet 2011). However, first aid following an OD or as part of health care programs associated with the drug consumption rooms will be comprised by the Health Care Act and the Authorisation Act.

It is assumed that possession for own use close to a local drug consumption room will not be subject to punishment, confiscation or seizure. It is for the police to assess, whether or not the possession of drugs is meant for own use.

Studies with Naloxone

In March 2010, the Health Care Room and the User Association of Active Drug Users launched a project to prevent against deaths caused by an overdose among drug abusers. The aim of the project was to investigate whether dispensing Naloxone to a group of trained drug abusers from the local area could help reduce the number of ODs. The project was launched after inspiration from other major cities in Europe and the US, where the outcome had been positive.

An overdose kit with equipment for resuscitation and three doses of the antidote Naloxone was dispensed to the participating drug abusers that were recorded as the prescribing physician's assistant and instructed in the responsibilities through delegation of treatment competence. Furthermore, the participants attended a course in the administration of Naloxone, life resuscitation, calling an ambulance, etc.

A total of 28 drug abusers attended the drug abuser. As at September 2011, 84 doses of Naloxone were dispensed, and 16 overdose deaths prevented. Naloxone is still being dispensed to the trained drug abusers, but no new participants are currently being trained.

The project was closed at the end of 2011 with an overall debriefing.

7.3 Prevention and treatment of infectious diseases

All persons suffering from drug abuse are offered injection against hepatitis A and B.

In 2007, the Danish Health and Medicines Authority prepared an action plan for the prevention against hepatitis C. The implementation of the plan was financed by the social reserve fund agreement in 2006. The action plan recommends that the municipalities must ensure that the target group receives systematic preventive interventions, screening for hepatitis A, B, C, and HIV and are offered vaccination against hepatitis A and B as required. The target group includes all intravenous drug users admitted to treatment and drug abusers that have only injected a drug once and therefore do not perceive themselves as intravenous drug users. Drug abusers who have displayed risk behaviour may also fall under the target group.

The intended effect 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 drug abusers aware of the infection risk in general. Also, treatment of the infected drug abusers will eliminate the risk of transferring virus to the non-infected drug abuser group. If they are not immunized, all drug abusers should be offered vaccination against hepatitis A and B. Protection against hepatitis A and B reduces further the risk of deterioration of the condition in those infected with hepatitis C.

In continuation of the action plan, the Danish Health and Medicines Authority has established a reporting system as of 1 January 2011 (www.stofmisbrugsdatabasen.dk) for the monitoring of the municipalities' interventions and services.

Syringe dispense schemes

In 2009, as a result of a request from the Ministry of Health, 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 hand-out 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.

The hand-out 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.

The municipalities are not legally bound to dispense syringes and needles to drug abusers. However, most of the municipalities have a practice for doing so. Expenses for handing out clean tools are financed by the municipalities. Via the social reserve fund agreement for 2004, the municipalities are compensated with EUR 107,000 per year for the hand-out of water ampoules together with the syringe kit which is already being dispensed.

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.

Health programs to the most severely affected drug abusers

The social reserve parties have set aside a total of EUR 3.8 million over four years (2006-2009) for the establishment of particularly targeted health programs to the most severely affected drug abusers. Not all the projects under this fund have been completed within the time frame, and the current projects have therefore been extended up to and including 2011.

The aim of the projects is to improve the health condition among drug abusers generally by increasing access to relevant health programs and by improving the health condition of the homeless drug abusers. The means from the fund have been awarded to Copenhagen, Odense, Esbjerg, Århus, and Guldborgsund municipalities. Experience from the projects has shown that drug abusers have availed themselves of the programs, although to begin with, they are often suspicious of the health care system and the health care professionals. Through the projects, a connection has been established between the socio-professional street plan intervention and health intervention to the general health care system, where the most severely affected drug users are in need of treatment on an ongoing basis.

For the same target group, a health and socio-professional clinic has been established (Sundhedsrummet [the Health Room]) in the Copenhagen Municipality, where treatment is provided for acute injuries, contact is made to the health care system and more general health preventive and health promoting activities are offered.

Health promotion and prevention in drop-in centres

In the social reserve fund agreement of 2006, EUR 3 million were set aside over a three-year-period (2007-2010) to strengthen health promotion and prevention for the most marginalised alcohol and drug abusers and the homeless. The overall purpose of the fund was to ensure necessary medical treatment to the most marginalised and to test and develop methods to find them and retain them in the public programs.

Fredericia, Herlev, Langeland, Nakskov, Odense, Randers, Silkeborg and Aalborg municipalities were awarded grants from the fund. The projects were based on collaboration between municipalities and drop-in centres, and direct health promotion activities have been the focus of the work.

The projects were closed in 2011. During the 3-year-project period, the projects succeeded in integrating health as a natural part of everyday life at the drop-in centres and the abuse centres.

The majority of the users had a physical exam and a follow-up exam or a health interview. Demand for these services and other services such as food scheme, workout and smoke cessation activities was high.

Evaluations show that the presence of health care professionals in drop-in centres contributes to qualify the social work. Furthermore, the health care professional has been the users' primary gateway to the established health care system. Finally, the health care professional has been a resource for the social workers. Results show that almost 90% of all users have been in contact with a general practitioner during the project period, which is an increase of approximately 20% from baseline. Also, results show a general increase in the faith in the health care system and a decline in interrupted patient courses.

The final evaluation of model projects for the groups of the socially marginalised drug and alcohol abusers as well as the homeless appears on www.sst.dk.

National family outpatient clinics

In the Finance Bill for 2008, a total of EUR 16.9 million were set aside over a period of 4 years (2010-2013) for the establishment of family outpatient clinics in hospitals in all five regions. After this period, EUR 3.8 million are 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 finance Act for 2008, means 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 is responsible for the secretariat function for a cross-regional coordination group whose task is to ensure the preparation of joint professional guidelines, etc. The Center also works with the establishment of a joint clinical database for family outpatient clinics and with a project aiming at re-qualifying the health visitors.

An evaluation of the five regional family outpatient clinics will be made together with an evaluation of the counselling function/Center

The entire guideline for the family outpatient clinics 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 a 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 dual diagnoses 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 a problematic and interrupted hospitalisation course. The staff do 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. Results from the mid-term evaluation 2011 show that:

- Cooperation between the target group and the staff in the hospitals is perceived as being much better.
- The social nurse has been connected to 450 patients in somatic care and 226 patients in the psychiatric care.
- The social nurse's expert skills on medication contribute to improving the hospitalisation course.
- The social nurse's knowledge of institutions and services has increased the quality of the discharge process.
- In 370 cases, contact has been established to different municipal institutions after discharge. 20 patients have been discharged without follow-up contact
- The staff reports having gained more knowledge of the target group, related problems and conflict handling.

8 Social correlates and social reintegration

8.1 Introduction

Drug abusers in treatment often have other problems than the abuse of drugs itself. This could for instance be problems with housing, family, job or financial issues. There, a number of social activities are often initiated before, parallel 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.

Given the complexity of the problems facing drug abusers, interventions dealing with one problem will often positively 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 is the local authority's 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 in such a way that supports citizen involvement in case handling. In all cases involving the provision of long-term services, such as drug abuse treatment ongoing follow-up of the social intervention is required.

8.2 Social exclusion and drug use

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 4.3 on the homeless count in 2011 show that 67% 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).

Far from all drug abusers in Denmark receive treatment for their abuse. There are drug abusers that *do not profit from the treatment system*. These could, for instance, be mentally ill persons with extensive and chaotic polydrug use, who are more marginalised than the drug abusers in treatment. The current study of the socially marginalised drug abusers with chaotic polydrug use described in chapter 5.4 will look into the problematic issues and the need for support to this group. In addition, there are drug abusers *who do not want to avail themselves of the treatment system*, because they do not

define themselves as abusers/and or do not wish to be registered. The purpose of the current research project offering anonymous treatment for cannabis and cocaine abuse described in chapter 5.4. is to describe whether it is possible to make this group of abusers seek treatment if anonymity is an option. Finally, there are abusers *who stop taking drugs without help from treatment programs*. Within drug abuse, there is not much knowledge about this group, neither in relation to size or factors leading to cessation. However, research shows that persons recovering from abuse without treatment in general have a more stable network, work, etc. than persons who seek treatment for their abuse problems (Hecksher 2007).

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. The reporting obligation includes different 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 (Ankestyrelsen 2011).

In 2010, decisions were made on the placement of 2,805 children and young people. 65% of these young people were between 12 and 17 years, whereas 13% were children under the age of 3 years. At the end of 2010, a total of 12,565 children and young people between 0-17 years of age 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 2010 were a triggering cause for the out-of-home placement in 18% 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 2010 were the cause of 10% of the cases. These figures are not much different from the ones in 2009.

8.3 Social reintegration

There are a wide range of interventions that can be launched in relation to socially marginalised individuals with drug abuse problems. Interventions targeting at improvement of housing conditions, education, job, social relations, and finances are important measures in terms of social integration- as a means as well as an end itself.

Stable housing situation

In 2011, a count was made and it turned out that in week 6 in 2011, there were approximately 5,290 homeless people in Denmark. They were particularly concentrated in the larger cities and especially in the capital city and its suburban municipalities. Mapping showed that 67% of the homeless were abusers of *drugs, alcohol or medicine*. In addition, 44% of the homeless report themselves that they are suffering from mental illness, and 29% of the homeless report suffering from both mental illness and abuse. For quite a few of the homeless, abuse and mental disorder 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 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 2007, a homeless strategy was launched. The homeless strategy has been extended until the summer of 2013 and will be finalised with a cross-sectoral evaluation of interventions. The strategy is based on the Housing First principle¹⁵. The overall goal of this strategy is to contribute to reducing homelessness in Denmark. The strategy has four long-term goals:

- **No citizen should live a life in the street** Here is a focus on strengthening the outreach and track-down work with a view to giving the group of "street sleepers" alternatives to sleeping out in the open. In addition, it is important to ensure a better flow through the temporary nursing homes so that the "street sleepers" can get a place to stay if they want.
- **Basically, young people should not stay in temporary nursing home but should be offered other alternatives under the Danish Non-Profit Housing Act.** Young people should not be referred to a place in a temporary nursing home or a shelter, where they risk being caught in a long-term marginalisation and expulsion process. It should be made possible for these young people to get a good start in adulthood, including a home, education and work. This requires coordinated intervention, including all the elements of the young person's life.
- **Stay in a temporary nursing home or shelter should not last more than 3-4 months for citizens who are ready to move into a home with the requisite support** The principle behind this is that these housing services should not last more than three to four months for the citizens who are ready to move into a home with the requisite support. In order to ensure speedy social reintegration it is important that support is provided and that alternative homes, reintegration

¹⁵ 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.

homes, temporary local housing services and community homes are increased in numbers.

- **Release from prison and discharge from hospital or treatment services should be made conditional upon a housing alternative** Focus here is made on these transitions in life and a better coordination between the authorities involved in terms of action plans.

Education and activation programmes

Many drug users' background includes poor performance at school and only a very basic educational background when leaving school. Opportunities for catching up on lost schooling 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 Children and Education will be relevant. In this connection, it is worth mentioning General Adult Education (AVU) and Preparatory Adult Education (FVU), which are both educational programs compensating for lacking elementary schooling.

Institutions under the Ministry of Employment offer a number of educational and activation programmes to improve the possibilities for the citizens to provide for themselves through guidance and re-qualification, traineeships in businesses, employment with subsidized wages and rehabilitation. Unemployed drug abusers who are not able to take part in employment programs are eligible for activity and social programs in accordance with the Danish Consolidation Act on Social Services. The aim is to assist in maintaining or improving personal skills or life conditions. The activity and social programs are often provided at the drop-in centres as described below.

Employment

The educational and activation programs as described above are all intended to bring unemployed citizens closer to the labour market in order for them (in the long run) to provide for themselves. Previous drug users are typically offered the same employment promoting programmes as other cash benefit recipients or unemployed. This also applies to active drug abusers, as this is a chance to combine employment intervention with drug abuse treatment. Drug abusers in long-term substitution treatment are, however, primarily offered programmes involving activities and social programs, often in relation to a treatment institution or a drop-in centre.

Citizens who are impaired by a physical or mental handicap or have social problems and therefore cannot keep a job on normal terms, and who cannot use any programs under other legislation should be offered protected employment by the municipalities. "Protected employment" was previously a term for employment activities that were organised in protected workshops, but today "protected employment" is also employment that can be arranged in another organisational framework. This could be in connection with types of housing, temporary nursing homes, drop-in centres, social cafés, etc. Protected employment can also be organised in private companies - on an individual level as well as for a group of citizens.

The local Social Services Administration may also offer targeted employment programs to persons with special social problems. The programs should be planned in such a manner that the individual citizen may gain closer affiliation with the labour market in the long term. For instance, it may be determined whether a person in protected em-

ployment may solve working tasks through training and education in a business facility with the necessary support.

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.

Debt counselling

Voluntary debt counselling is a service to marginalised citizens on how to handle their debts and thus starting living a more stable 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, EUR 5.4 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 EUR 2.2 million were set aside for the establishment of voluntary debt counselling for socially vulnerable citizens with debt problems. During the period 2008-2012, 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.

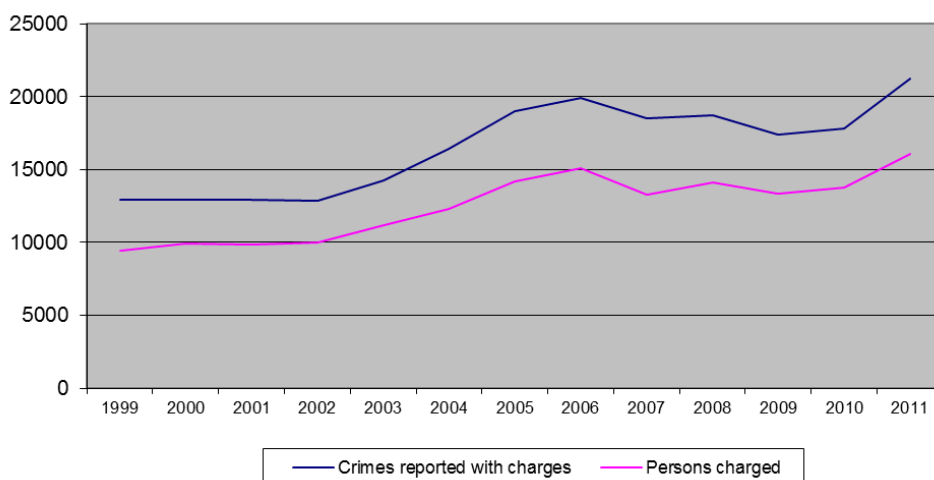
Section 191 of the Danish Criminal Code provides for stricter punishment on qualified violations of the Act on Psychoactive Substances. This means that if the transfer of psychoactive substances is made to a large number of people against considerable remuneration or under other particularly incriminating 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 resulting from violation of drug legislation

In 2011, the National Commissioner of Police registered a total of 21,211 reports filed for the violation of the Drugs Act. In the same year, 16,065 persons were charged for the violation of the Drugs Act. Some persons were thus charged of 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 1999-2011.

Figure 9.2.1. Drug crime from 1999-2011. Crimes reported with charges and the number of persons charged



Source: National Commissioner of Police, 2012

Driving under the influence of psychoactive substances

Until 1 July 2007, driving under the influence of pschoactive 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 need 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 for 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 and 2,477 charges in 2011.

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 tightening 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/prison units, 8 pensions (half-way houses) and 14 departments of the Prison and Probation Service in Freedom. In 2011, 13,946 people were incarcerated in prisons and local prisons. 1,161 were women and 12,785 were men.

A total of 10,671 unconditional prison sentences were reported to the Danish Prison and Probation Service. The sentences represented a total of 72,287 months of all sentences. 62% of the sentences were 3 months or lower and accounted for 13% of all sentences. 7% 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 serve their sentence in a local prison. 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 2011, this happened in 204 cases.

In 2011, the Danish Prison and Probation Service had an average capacity of 4,134 places. On average, the occupancy rate was 97.7%, which equals 4,037 inmates per day. Out of this figure, 160 of the prisoners were females. The average daily occupancy of young people under the age of 18 was 10.5 inmates per day. The inmates were broken down into 908 in closed prisons, 1,335 in open prisons and 1,794, including Copenhagen Prisons. The majority of all inmates in the local prisons and Copenhagen Prisons were remanded in custody.

On a certain date - 13 December 2011 - 66% of the convicted were between the age of 20 and 39 years. 10% were sentenced to 3 months and less. 46% were serving sentences of between 1 year and 5 years. 23% were convicted of drug crimes, 20% of violence, 15% of robbery and 13% of theft.

Drug treatment

Since 2007, a treatment guarantee was introduced and implemented for imprisoned drug users who were found eligible and motivated for treatment and who at the time when treatment is sought have a minimum of 3 months left in prison. The guarantee provides that those prisoners who apply for treatment must, where possible, receive such treatment within a fortnight. In June 2011, the treatment guarantee 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. However, 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 01 September 2012, 12 out of 15 primary treatment programmes have been awarded accreditation, whereas three treatment programmes await assessment by the expert panel.

Strategy and the individual programmes

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.

However, there are relatively few cases that end in placement in a treatment institution as a result of a drug abuse even though such a placement is the basis of referral to all kinds of treatment. Since 2005, the number has even dropped from 160 to 100. The person's local municipality is responsible for paying all expenses in connection with the stay in an institution.

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 programmes in the prisons

There are several types of treatment programmes in the prisons. There are the **motivation and pre-treatment projects** in the local prisons 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 psycho-social **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 takes place, 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

The tables below show the use of intoxicants prior to imprisonment (The Danish Prison and Probation Service 2012). 60% of the convicts in the prisons and local prisons stated that they had been using drugs 30 days prior to their imprisonment. 38% reported that they had not been taking drugs, and 2% did not wish to inform about their drug intake. In the open prisons, the proportion of inmates stating that they had taken drugs 30 days prior to imprisonment 68% compared to 61% in the closed prisons.

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

	Open prisons		Closed prisons		Local prisons		Pensions		2011 13 December		2010 18 December	
	n	%	n	%	n	%	n	%	n	%	n	%
Inmates have used drugs												
Yes	1135	68.4	566	60.9	646	48.8	8	33.3	2355	59.8	2441	60.6
No	509	30.7	348	37.5	613	46.3	15	62.5	1485	37.7	1468	36.4
No wish to disclose	14	0.8	15	1.6	66	5.0	1.0	4.2	96	2.4	122	3
Total	1658	100	929	100	1325	100	24	100	3936	100	4031	100

Source: The Prison and Probation Service 2012

Note: The records are based on the inmates' own information

Note: The records include remand prisoners and convicted prisoners

Note: As regards 2.1% of the inmates, no registration has been made 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 Number and proportion of inmates using drugs

	2009 18 December		2010 18 December		2011 13 December	
	n	%	n	%	n	%
Inmates have used drugs						
Opioids	484	23.2	572	23.4	468	19.2
Stimulants	1295	62.1	1533	62.8	1525	62.5
Cannabis	1458	70.0	1681	68.9	1685	69.0
Alcohol	705	33.8	862	35.3	742	30.4
Benzodiazepines	252	12.1	340	13.9	310	12.7
Hallucinogens	61	2.9	71	2.9	72	2.9
Other	138	6.6	159	6.5	153	6.3

Source: The Prison and Probation Service 2012

Note: An inmate may report use of more than one drug, which is the reason why the share of inmates who report having used the drugs mentioned exceeds 100%.

9.5 Treatment and prevention in prison

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. In comparison, 2,419 treatments were initiated in 2011, of which 2,163 were comprised by the treatment guarantee, cf Table 9.5.1. The cases were related to a total of 2211 different persons.

Type of treatment	Persons	Treatment initiated	Comprised by the guarantee
Detoxification	1	1	1
Treatment of alcoholics	195	210	210
Treatment of cannabis abuse	536	565	535
Treatment of cocaine abuse	25	25	25
Pre-treatment	899	1004	791
Drug-free treatment	447	500	492
Substitution treatment	108	114	109
Total	2211	2419	2163

Source: The Prison and Probation Service 2012

The distribution of treatment types also appears from the table. The most frequently initiated treatment is the pre-treatment (more than 4 out of 10 cases), whereas the treatment of cannabis abuse and drug-free treatment (intensive treatment in a special treatment unit) accounted for one-fourth and one-fifth of all the cases. The detox and cocaine abuse treatment programs were established during 2011 and have not been recorded at the correct name throughout the period, which explains the very low proportion.

Prevention of diseases

With a view to preventing against drug-related diseases, withdrawal symptoms and cravings, the Danish Prison and Probation Service offers medicament 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 users 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 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 the Interior and Social Affairs, 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 are 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. Thus, the first step is to sign a number of specific collaboration agreements with all municipalities in Denmark. The rationale behind this is that not all municipalities are organised in the same way. It is a time-consuming process, and up to and including 2011, 20 agreements had been signed, and in the years to come it is expected that similar agreements will be signed with all the municipalities in Denmark.

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 to a high degree they are a mirror of policy activity.

Illicit drugs have no content declaration, and there are many different drugs hidden in the tablets and powders sold as, among others, "ecstasy". The relatively new drug mCPP with both stimulating and hallucinating effect has been seen more frequently in recent years in the ecstasy tablets and is contained in 49% of the tablets in 2011. The same applies to the hallucinogenic substance 2C-B, which in 2011 appears in 10% of the tablets, which, however, is less compared to in 2010, when 2C-B was contained in 34% of the tablets analysed. Only a few tablets these years contain MDMA (ecstasy), which is somewhat unusual compared to earlier years, when up to 80% of the tablets contained MDMA. There is a drastic change in the contents of the ecstasy pills from MDMA to especially mCPP. MDMA no occurs most often in powder/crystal form instead of in tablets.

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 market¹⁶, 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 Commissioner's Office 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

¹⁶ Results from the special forensic analyses are based on random samples from the "Street Level Project" and from the project on monitoring of prevalence of ecstasy pills mentioned later in this chapter.

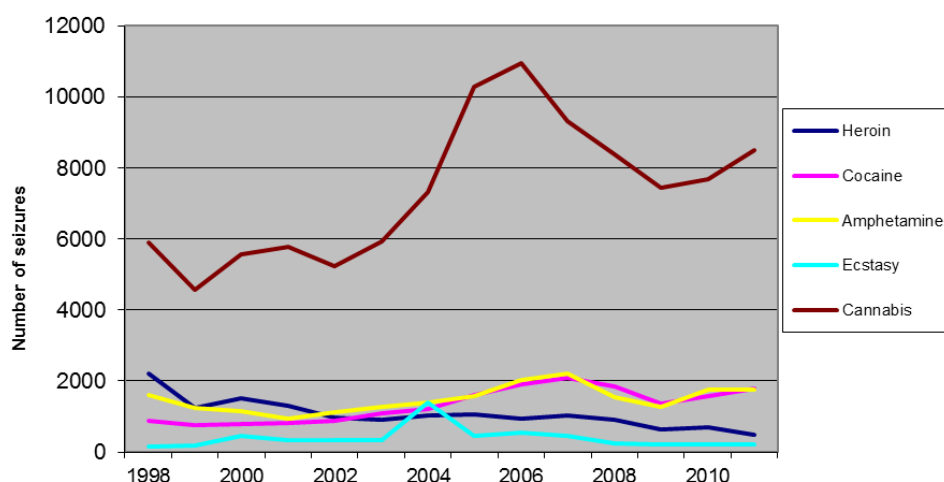
produced in Poland and in the Baltic region. By far the largest part of the seized ecstasy is produced in the Netherlands and Belgium. Cocaine is primarily produced in South America and distributed typically via Spain and the Netherlands. Large quantities of cocaine are also distributed to Europe via 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 ongoing 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 Commissioner's Drug Statistics).

Figure 10.3.1. Drug seizures, 1998-2011



Source: Source: National Commissioner's Drug Statistics 2012

As regards the quantity seized, major fluctuations are seen in most drug types from one year to the other. In spite of the apparent increase in the number of cocaine seizures the past three years, the quantity of the seized cocaine dropped from 72 kilos in 2009 to 54 kilos in 2010 and to 43 kilos in 2011. The quantity of the seized amphetamine, on the other hand, went up drastically during the same period from 104 kilos in 2009 to 194 kilos in 2010, and 240 kilos in 2011. Also the seized quantity of cannabis rose drastically from 1,220 kilos in 2009 to 2,318 kilos in 2010. In 2011, 2,325 kilos were seized, which, however, is still an increase, although the increase is lower than in the two previous years. As in previous years, individual seizures consisted of the different drugs in large quantities. (cf. table 10.3.1 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 Level project" (traditional drugs such as heroin, amphetamine and cocaine) and the "Ecstasy project" (tablets and powder) are described below.

Drug dealing in the streets

The data material of the Street Level Project consists of small random sampling based seizures from 5 police districts in Denmark (Copenhagen, Århus, Odense, Aalborg and Esbjerg) which are submitted for analysis with the forensic departments¹⁷. Table 10.4.1 of the annex shows the distribution of types of drugs seized in Denmark from 2001 to 2011.

Out of the 204 samples analysed in 2011, 70% consisted of stimulants, cocaine and amphetamine, which is the same rate as in 2010. During recent years, the presence of stimulants - especially cocaine - in the project has been increasing, whereas heroin has been decreasing. 21% of all samples in 2011 on a national scale included heroin. By comparison, 44% of the samples analysed at the start of the project in 2000 were heroin. Another 7% of the samples in 2011 contained other psychoactive substances and drug mixtures such as metamphetamine, MDMA and ketamine, and 1% did not contain any psychoactive substances.

In Copenhagen, Århus and Aalborg, cocaine is the most prevalent drug in 2011 (71%, 54%, and 38%, respectively, of all samples); amphetamine is the most prevalent drug in Esbjerg (58% of all samples), whereas Odense has an equal distribution of heroin and amphetamine (38% of heroin and 38% of amphetamine in all samples).

Table 10.4.2 of the annex shows the balance between heroin base ("smokeable heroin") and heroin chloride (white heroin to injection) from 2001-2008. Heroin base continues to be the dominant drug among the heroin samples on national scale. In 2011, the balance between heroin base and heroin chloride was 58 % and 42 %, respectively.

In all the years, there has been a tendency toward Odense distinguishing itself from the other parts of Denmark by being dominated by white heroin. In 2011, 83% of the heroin samples from Odense consisted of the white heroin for injection. By comparison, all the heroin samples in Copenhagen as well as in Århus consisted of the brown heroin for smoking. In Esbjerg, the balance between heroin chloride and heroin base is 40% and 60%, respectively.

Purity of drugs

Table 10.4.3 shows the contents of the various drugs from 2001 to 2008 in the samples analysed from the Street Level Project.

¹⁷ 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 Level Project does not include cannabis or other cannabis products. In addition, ecstasy was excluded from the Street Level Project and is now monitored on its own.

Table 10.4.3. Purity of illicit drugs on a user level in 2001-2011 (median value of active drug)¹⁸

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Heroin chloride	52%	50%	64%	63%	67%	53%	29%	52%	41%	46%	40%
Heroin base	48%	25%	25%	22%	28%	18%	21%	16%	14%	20%	11%
Amphetamine sulphate	9%	13%	9%	9%	10%	7%	6%	8%	6%	6%	5%
Cocaine chloride	43%	36%	37%	24%	25%	18%	16%	19%	17%	21%	20%

Source: 2008; Lindholst et al 2012

The general 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 40% in 2011, whereas the concentration of the brown heroin during the same period dropped from 28% to 11%. Also the concentration of cocaine has been decreasing and in 2005 it was 25%, whereas in 2011, it was 20%.

Over the years, there have been no fundamental differences observed in the concentration of the individual illicit drugs seized in the various parts of Denmark, and everywhere, there has been a large range of variation seen. In every police district, drugs of low as well as high concentration have been found on the market at the same time. It was not possible to pinpoint periods of the year when the concentration was particularly high or low for any of the drugs.

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=25)	Heroin chloride (n=18)	Cocaine (n=87)	Amphetamine (n=56)
Coffeine	96	94	33	91
Kreatine	-	22	42	64
Dextromethorphan	-	17	-	-
Diltiazem	-	-	3	-
Hydroxyain	-	-	3	-
Levamisol	-	-	84	-
Lidocaine	-	22	26	-
Paracetamol	96	22	7	13
Fenacetine	-	-	76	-
Procaine	-	-	6	-

Source: Lindholst et al 2012

¹⁸ 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.

Among other things, almost all heroin base analysed in 2011 also contains caffeine and paracetamol (96% of all samples). Cocaine is the type of drug mixed into most additives. All cocaine samples analysed in 2011 contain additives - on average 3 different types per cocaine sample, most frequently, the additives levamisol (in 84% of all samples in 2011) and fenacetine (in 76% of all samples in 2011). Levamisol is a drug for the treatment of parasitic worm infections and it affects the immune system in humans, whereas fenacetine is a pain relieving drug in the same category as paracetamol.

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 appearance¹⁹. 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 2011, a total of 41 samples of tablets and 300 powder samples from 278 seizures were sent from the police districts to the forensic chemistry departments for analysis.

As regards the tablets in the ecstasy project in 2011, it can be summarized that out of the 41 samples analysed, the stimulant mCPP is the most prevalent drug in tablets on the market. Thus, mCPP was contained in 59% of the tablets analysed - either alone or together with (primarily) amphetamine or metamphetamine and MDMA (ecstasy). MDMA was contained in 12% of the tablets, and 10% contained 2C-B. In as many as 20% of the tablets, there were no active drugs.

In the samples of the ecstasy project, MDMA is now found - as opposed to previous years - primarily in powder. Among the 278 powder samples analysed in 2011, MDMA was contained in 46% of the cases. Metamphetamine was contained in 15% of the drug samples, ketamine was contained in 13% of the powder samples, and GHB in 5% of the drug samples found in liquids. In addition, the powder samples in 2011 contained drugs in the group of the stimulating cathinons (9 different), the stimulating and some times hallucinating phenethylamins (7 different), the cannabis-resembling synthetic cannabinoids (6 different), and a single tryptamine drug. The list of ingredients in powders and liquids in 2011 appears in the Annual Report on Illicit Drugs in Denmark, 2011.

New ingredients and their regulation

New and dangerous substances appear regularly in ecstasy pills – in Denmark and in the rest of Europe. As mentioned in chapter 1 of this report, Denmark has introduced group bans on potential abuse drugs as of 1 July 2012. This means that a number of the new drugs entering the country are now subjected to control prior to being launched

¹⁹ 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.

on the market. Thereby, legislation within this area is more proactive on potential abuse drugs surfacing and entering the country.

High and low drug concentration

The concentration of the different types of active substances in the pills varies a great deal, which poses a major risk of poisoning. Since 2011, the quantity of MDMA in the drug samples varied from 1 to 226 mg. Further information about the drug concentration is provided in the Annual Report on Illicit Drugs in Denmark, 2011.

The systematic ecstasy monitoring in Denmark is believed to give a good overview of the type of ecstasy pills available on the market. The monitoring process also provides quick information about the new synthetic drugs on the illicit market, allowing for the authorities to recommend and control the drugs on a current basis.

However, it should be mentioned that not all narcotics available on the Danish drug market are examined. In 2007, The Department of Forensic Chemistry in Aarhus carried out a study, in which it was estimated that only 5% of the tablets available on the Danish market are seized and thus sent to possible forensic analysis.

Prices

The National Commissioner of Police estimates that the street price for cannabis is around EUR 6.7-9.3 per gram. The price for cannabis is no longer fixed as it once was. Police districts report about prices between EUR 4.0-10.7 for one gram of cannabis. The price per gram for selling heroin on the streets is estimated to be between EUR 134 and 201 for white heroin and between EUR 67 and 134 for brown heroin. The price for cocaine traded in the street is estimated to be between EUR 53.6-80.4 per gram. As regards amphetamine, the price in the streets is estimated to be between EUR 13.4 to 26.8 per gram, whereas the price for an ecstasy pill is estimated to be between EUR 4-10.7.

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 Inpatient treatment of drug abusers

Inpatient treatment of drug abuse has always been a crucial element in the treatment of drug abusers in Denmark. As an introduction, this chapter provides a historical overview with a special focus on the organisational changes and socio-political events of significance to the Danish inpatient treatment. This is followed by a description of the availability and special characteristics of Danish inpatient treatment, and the chapter ends with a discussion and perspectives on the Danish inpatient treatment of drug abuse.

11.1 Historical overview from an organisational perspective

The predecessor of the kind of drug abuse treatment that we know today has existed since the end of the 1960s. In those days, the treatment of young drug abusers was removed from the psychiatric treatment system. Instead, a special treatment system for young people was established, which first and foremost was based on a sociological and socio-psychological understanding of the drug abuse problem (Houborg 2008). In the 1970s and the 1980s, this system consisted of 20 institutions spread all over Denmark. The majority of these institutions were youth centres based in either the municipalities or the counties. For these 20 institutions, there were approximately 400 inpatient places (Alkohol & Narkotikarådet 1983, Winsløv 1986). These inpatient places, however, were not only reserved for drug abusers, and inpatient treatment of drug abuse was undistinguishable from other social interventions offered to young people with problems.

Inpatient treatment of drug abuse, as it is today, started in the last half of the 1980s. At this time, the first private and proprietary inpatient treatment programs were established, and today, they still make up 80-90% of the available inpatient places for drug abusers. The remaining 10-20% of the inpatient treatment programs are publicly owned. The initiators of the establishment of the first inpatient programs were typically persons who had undergone treatment themselves for their drug abuse, and at this time, most of the therapists were also former alcohol and drug abusers without any socio-professional education. This has changed drastically since then.

To some extent, the change in inpatient treatment since the 1980s may be attributable to the drug abusers becoming older and therefore did not really belong anywhere in the social and health care system. From the late 1980s and until the mid 1990s, there were, however, still relatively few inpatient treatment programs for persons who had developed drug abuse symptoms, and often the drug addicts and alcoholics were treated under the same roof. This changed in 1996.

Crucial organisational and socio-political markers

In 1996, drug abuse treatment turned into a speciality under the then county system. The treatment that had previously been given in different places, with nobody really having the full picture, was not merged. This centralisation of drug abuse treatment therefore meant a much higher volume of abuse treatment with more visibility and clearer referral procedures. At the same time, the first national register on all persons admitted to drug abuse treatment (the Danish Health and Medicines Agency's register on drugs abusers in treatment /SIB) was established. This was the first time that a systematic and national CPR-based register was made, which, apart from holding person-

al data, provided information on social and financial markers as well as information on the actual drug abuse problem among those admitted to drug abuse treatment. From 1996, the number of admissions to outpatient treatment rose drastically, and the number of drug abusers referred to inpatient treatment rose accordingly. The number of inpatient treatment programs more than tripled within a period of 5 years. The increase in the number of admissions in outpatient as well as inpatient treatment from 1996 as well as the establishment of more and better organised treatment courses, should also be seen as a result of an increasing need for treatment following drastic increases in the consumption of illicit drugs up through the 1990s (Sundhedsstyrelsen 2011g).

In 2003, the treatment guarantee was introduced for social drug abuse treatment. A person requesting for a treatment program must then be offered such a program within 14 days (Section 101, of the Danish Social Services Act). The guarantee only applies to outpatient psycho-social treatment - in other words not medical treatment, and the person is not at liberty to ask for inpatient treatment, as the referral authorities are the ones to assess whether or not inpatient treatment is relevant for the individual client. Nevertheless, the number of referrals to inpatient treatment have gone up drastically the first two years after the introduction of the treatment guarantee.

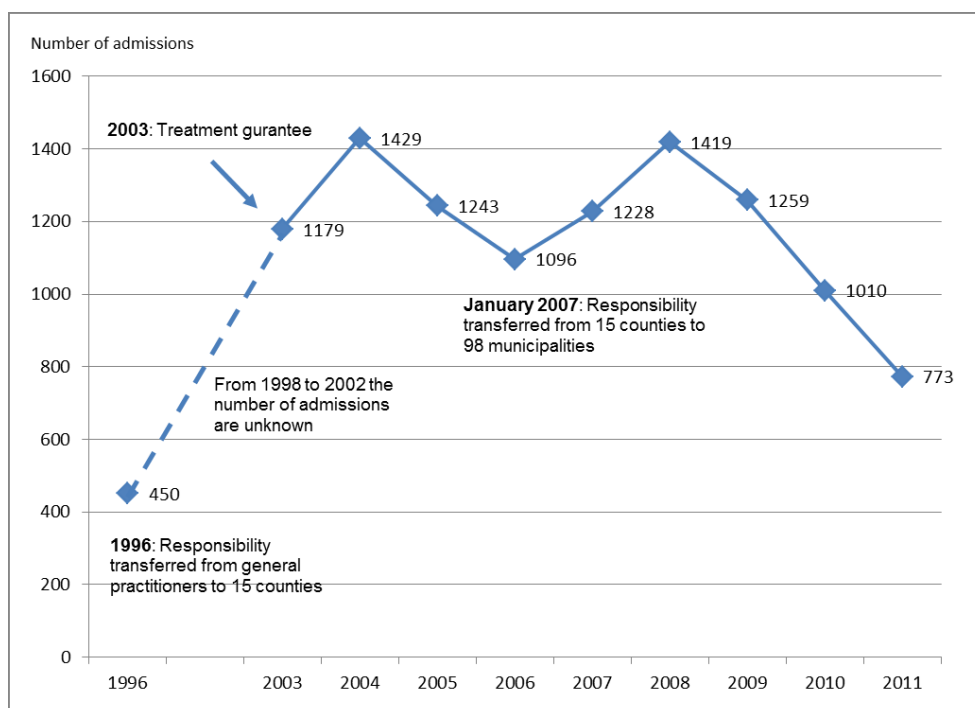
In 2003, it was also compulsory for all inpatient programs treating drug abusers to report about all admissions financed by the public sector to the registration system DanRIS (Dansk Registrerings- og Informations-System). From 2003, full data are provided on all the admissions to inpatient treatment paid by the public sector as regards the inpatient clients' occupancy rates (European Addiction Severity Index), the duration of admission, the cause of discharge etc. Furthermore, DanRIS contains organisational information on treatment methods, employee education and training, etc.

From January 2007, responsibility for the treatment of drug abusers was transferred from the then counties to the 98 newly established municipalities. In other words, drug abuse treatment has been decentralised, with an ensuing establishment of minor treatment units - not the least in the small municipalities.

During the first two years after the introduction of the treatment guarantee, an increase in the number of admissions was observed. However, following this, a drop in the number of admissions appeared until the municipalities take over the tasks of the counties, effective January 2007. The decrease in the admissions up until 2007 cannot be explained directly, but the primary assumption is financial uncertainty in the municipalities up until the closing of the county system, but it is most likely not the whole reason.

The development in the number of referrals to inpatient treatment during the period from 1996 to 2011 can be illustrated in the figure below.

Figure 11.1. Other referrals to specialised inpatient treatment of drug abuse, 1996-2011



Financing

Inpatient treatment is financed almost exclusively by public sector means (today the municipalities), and there are hardly any citizens paying for treatment out of their own pockets. Financing is different than, for instance, financing of inpatient treatment for alcoholics, where several inpatient programs almost primarily admit alcoholics who pay for the treatment themselves.

During the years from 2006 to 2010, the average price per month for inpatient treatment went up from EUR 4.8 to EUR 5.8. It is estimated that in 2006, the public sector used approximately EUR 30.8 million on inpatient treatment, which in 2011 had dropped to approximately EUR 20.1 million. This estimate, however, does not take into account the special agreements between paying authorities and specific inpatient programs.

For the past 10-12 years, by far the majority of the inpatient programs have been run by private institutions.

Since the mid-1990s, between 1 and 7 institutions have been owned by the public sector and thus financed by municipalities or counties. In 2011, there were two publicly owned inpatient programs which had specialised in drug abuse treatment.

11.2 Availability and characteristics

Although the number of referrals to inpatient treatment as described earlier in the chapter have dropped drastically within recent years, the number of inpatient treatment programs have remained on a stable level. In 2011, there were thus 40 inpatient programs in Denmark, which is the same number as in 2006. Out of the 40 inpatient treatment programs in 2011, 6 are pure detox institutions or so-called halfway houses, whereas 3

institutions describe themselves as interim nursing homes. The remaining 31 inpatient programs are all treatment institutions, the aim of which is to achieve permanent addiction recovery (only the latter 31 inpatient programs make up the data basis for figure 11.1).

In 2011, the 31 inpatient programs aiming at complete addiction recovery had a total of 483 beds. By comparison, there were 602 beds associated with the service in 2006. In conclusion, there are thus the same number of inpatient programs today as in 2006, but the number of beds have been reduced by approximately 20% during the period.

Different types of inpatient treatment

Overall, the Danish inpatient programs can be divided into four different inpatient treatment types; the therapeutic society, the Minnesota institutions, the socio-educational inpatient programs, and the religious institutions.

The *therapeutic society* covers the so-called *democratic* therapeutic society and the *hierarchical* therapeutical society. The *democratic therapeutic society* also comprises the socio-psychological model, as drug abuse is not considered to be a disease, but a symptom of psycho-social troubles. These institutions base their work on a philosophy of "living-learning", where each situation in everyday life is used as a tool to live in and understand the world. The basic idea is an organised environment according to an "everybody is equal principle, partially without power and expert structures. The working tools are, among others, long group sessions every day. Especially the early Danish therapeutic society was indeed influenced by this concept²⁰. In these institutions, an equal share of men and women are admitted, which is normally not seen in other Danish inpatient programs. The therapeutic society of today is much more structured and hierarchical than when it was established many years ago.

The *hierarchic concept-based therapeutic society* is heavily structured and uses, to a large extent, junior therapists who are clients admitted to treatment for typically 3-6 months. In this type of treatment, a higher degree of responsibility is delegated to the therapist who thereby gains an increasing number of privileges. The hierarchic concept-based therapeutic society is founded on an American model which is a treatment method used very much in the US today. This is a model which is based on reward principles and "operant conditioning" and therefore also on a model more focused on behaviour. Similar to the democratic-based therapeutic society, the hierarchic concept-based therapeutic societies apply psycho-therapeutic methods and long group sessions as their working tools and view abuse/addiction as a socio-psychological phenomenon (Mølholm 1999, Pedersen 2009, Vanvelde et al 2004). In Denmark, there have only been two institutions throughout the years working under the hierarchic concept-based therapeutic society, of which one institution closed in 2005, whereas the other still exists. Today, 14 institutions define themselves as therapeutic societies.

The philosophy behind the *Minnesota treatment* is much different from the philosophy behind the therapeutic society. From the outset, the Minnesota movement thus perceives addiction as a biogenetic-based disease which can be compared to a kind of allergic reaction. The disease therefore also exists before the first drink has been taken (Anonymous Alcoholics 1994). Addiction to intoxicants is therefore considered as a chronic disease, which, however can be controlled through lifelong abstinence. The

²⁰ Hjulsgård og Projekt Menneske.

means to this is to recognize that something is bigger than oneself and to be confronted with this reality throughout life by participation in AA/NA meetings. The Minnesota treatment is based on 12 steps, through which the addict systematically moves. Typically, the addict works his/her way through the first 4 steps during the inpatient treatment stay and it is then expected that the individual in question goes through the next 8 steps with his/her "sponsor" and through participation in NA meetings (Narcotic Anonymous)

In the 1990s, there was a large gap between the Danish therapeutic society and the Minnesota inpatient programs. Today, this gap has to some extent been eliminated. Today, several inpatient programs that call themselves therapeutic societies apply elements from the 12-step treatment methods, however without necessarily having adopted the philosophy of the Minnesota treatment. Quite a few of the therapeutic societies recommend their client to take part in NA meetings after the end of treatment and might even help them establish contact to NA. Also, several Minnesota institutions use the motivating conversation and different cognitive methods and recognize the social element as a co-player in the explanation to addiction.

The *socio-educational inpatient programs* cover a wide variety of institutions that neither defines themselves as Minnesota or therapeutic societies - nor as religious (below). On a list of 12 different orientations, they have all, however, checked the field of "socio-educational". Most of the publicly owned inpatient programs have defined themselves as socio-educational, which also applies to inpatient programs that have a strong focus on hand-on work. The socio-educational institutions may, however, also use elements from environmental therapy and 12-step treatment.

Finally, throughout the years, there have been inpatient programs that openly recognized that their treatment is based on a religious platform. One of these institutions has been linked with the Scientology movement. However, no clients have been referred to this institution by the public sector. The other religious institutions profess to various Christian religions. Today, there are 3 religious inpatient programs receiving clients on referral from the public sector.

In summary, it should be mentioned that on the establishment of the inpatient treatments and activities, there were differences in treatment philosophy and treatment methods that have now been more or less eliminated. Today, it can be more difficult to know the difference between the therapeutic society and the socio-educational institutions, and elements from the 12-step treatment are part of the treatment in inpatient programs in a number of institutions.

The proportion of drug abusers admitted to the more "clean" Minnesota treatment programs have decreased drastically within the past 10 years. While around 70-75% of the drug abusers in inpatient treatment in 1997 were treated on Minnesota programs, this had dropped to around 30% in 2008. In 1997, around 20% of the drug abusers received inpatient treatment in therapeutic societies, however this had gone up to 49% in 2008. In 2008, around 20% were treated in socio-educational inpatient programs, whereas in 1997 only a few (if any at all) defined themselves as socio-educational inpatient programs specialising in drug abuse treatment.

Education, training, and special interventions

Between 1997 and 2008, the proportion of therapists with a socio-professional education rose from 26.5 to 50.4%. Also the proportion of therapists that have a diploma²¹ from therapeutic studies more than doubled from 23.5 to 52.5%. For instance, the share of inpatient programs employing therapists trained in cognitive therapy has gone up from 20 to 51%, whereas the proportion of inpatient programs using system-oriented therapy has gone up from 8 to 31%. The proportion of inpatient programs that use therapists trained in the 12-step model have dropped from 25 to 15%. A large share of the therapists are trained within gestalt and psycho-dynamic psychotherapy, and it is very common to be trained in several therapeutic methods. Therapist age as well as years of experience has gone up drastically the past 10 years. Today, the average age of a therapist is 45.8 years, and the average years of experience as an abuse therapist is 8.5 years.

The proportion of programs, where *self-help groups* are part of the treatment, have gone down from 65% to 28%, whereas the proportion using *couples and/or family therapy* has gone up from 23% to 64%. Quite a few inpatient programs offer long-term stabilisation to clients in *substitution treatment*. Also the Minnesota programs offer this kind of treatment. The number of beds available to this group is unknown. However, it is presumably a small share. Most of the inpatient programs apply *relapse prevention* which is an integral part of the treatment as long as the client is admitted. One of the key methods is the so-called *Gorski method* (Gorski 1997, CENAPS, 2007). Follow-up relapse preventive interventions after discharge are rarely seen.

In most of the 31 actual inpatient treatment programs it is possible to start a treatment course with *detoxification*. Some inpatient programs use specific detoxification centres in order to separate the detox clients from the other clients. There are no specific figures indicating how many start their treatment with detoxification in the same institution as the one where they received treatment.

Basically, treatment in inpatient programs are separated from the outpatient social and health care intervention, which means that inpatient programs do, for instance, not offer follow-up treatment, case management nor services such as screening, treatment of HIV/AIDS, hepatitis C or sexually transmitted diseases in general. Work training or education in general schooling skills is normally not seen as well.

Finally it should be mentioned that the average duration of treatment in inpatient programs is much shorter than it was in the 1990s. Planned courses of 1-2 years are no longer seen. Most of the planned courses of treatment typically last less than 6 months and are most often offered for 3 months. Today, the average duration of treatment is 136 days (including those who discontinued treatment) against 211 days in 1997. This also means that a higher number of persons complete a treatment program than before (36% in 1997 against 56% in 2011).

²¹ Defined as at least a 1-year training programme including at least 15 days of training in a defined methods.

11.3 Quality assurance

Private inpatient treatment programs in Denmark must be approved by the municipality, in which they are provided (Pedersen 2007). Without such an approval, they are not entitled to receive clients paid by the public authorities. This approval only deals with the institution's compliance with various legal conditions and obligations, including obligations relating to occupational health and safety, accounts, boards, etc. The approval does not concern the use of a specific treatment method, the education of the therapist group and the composition, guidelines or other professional aspects of the treatment

Many inpatient programs, however, have an education policy, certain methods and an overall treatment philosophy. This, however, is changed on a continuous basis and therefore not necessarily documented for each individual program.

All inpatient programs are monitored on their methods/services, the professional competencies of the therapists, client vulnerability and the individual client's course of treatment. Reportings are made to DanRIS mentioned above. Via this monitoring it is possible for each individual municipality to assess and analyse a number of conditions in relation to the individual inpatient program.

Finally, it should be mentioned that the Ministry of Social Affairs and Integration has set aside funds for the evaluation of the inpatient treatment every three years (Pedersen et al 2011). The effect measured as addiction recovery 1 year after end of treatment has turned out to have stabilised between 20% and 25% for opioid addicts for the past 10 years. However, the effect measured as addiction recovery *the past month* has gone up from between 40% to 50% month-by-month during the years after discharge to between 50% to 60% during the same period. This positive trend could be attributed to the implementation of the treatment guarantee in 2003. Today, when a client suffers from a relapse after discontinuation of inpatient treatment, the person is much more frequently admitted to drug abuse treatment shortly after the relapse than was the case prior to the implementation of the treatment guarantee (Pedersen et al 2011).

11.4 Discussion and future perspectives

Throughout the past 10 years, inpatient treatment seems to start matching the standards for other modern treatment programs. The therapists are much more educated than they were before, and evidence-methods have become implemented (primarily cognitive therapy). However, today it is very difficult to distinguish between the various inpatient treatment programs. For instance, there is no clear-cut line between the Minnesota treatment and the Democratic Therapeutic Society, and not specific category of programs can be referred to as better than the others. Instead, the referring authorities must assess the quality on the basis of the competence profile of the therapists and the municipality's experience with certain inpatient programs.

The traditional target group for inpatient treatment in Denmark (heroin addicts aged 30-40 years) is disappearing, and the inpatient programs are standing at a cross roads, where there might be a need for new and different programs targeted at new drug abuser groups. The heroin abusers have grown older, and among them, there is a large and very vulnerable group, which has not become drug-free in spite of repeated efforts. These people need special programs. The often young abusers of stimulants and cannabis need other programs than the heroin addicts. This requires that the mu-

municipalities plan the right mix of programs that match the needs of the various target groups of drug abusers.

12 Drug strategies and interventions in Copenhagen

Nationally, the drug policy is determined by the Danish parliament (the "Folketing") and the government. A municipality or city - although it may be big - may thus have no drug policy of its own. Copenhagen Municipality is the largest municipality in Denmark, and is also the capital city of 550,000 inhabitants.

The Copenhagen Municipality's Social Services Administration sets out the goals and principles, coordinates, monitors and plans interventions in relation to treatment as well as to injury and problem reduction. This applies in relation to drug abusers, the homeless (who often are heavy users of drugs and alcohol) and - in collaboration with the psychiatric services provided the the Capital Region - also intervention in relation to the mentally ill (who are often homeless and have a problematic use of drugs and alcohol). The Social Services Administration is also responsible for the collaboration with the governmental authorities and boards.

The politicians (town council) define the overall framework, including the economic framework, for the area and determine the goals for interventions. As mentioned above, the Social Services Administration plays a pivotal role, as does the police, whose work will be described in detail later on. Part of the treatment, especially the drug-free treatment, is handled by private institutions as suppliers who have signed agreements with the Social Services Administration. Private organisations with an operating agreement with the Copenhagen Municipality run the institutions for the homeless.

There is a strong user organisation in Copenhagen (the User Organisation of Active Drug Users) that primarily handles the interests of the opioid users. The organisation is financed by member contributions and subsidies from the Copenhagen Municipality and the Ministry of Social Affairs and Integration. The user association runs a large drop-in centre and has a rather significant influence on the governmental as well as local drug policy.

Also, there is the "Gadejuristen" (the Street Lawyer), who works for ensuring legal safety for the drug users in relation to public authorities, treatment institutions, etc.

12.1 Drug strategy in Copenhagen

Due to the magnitude and severity of the drug and alcohol problems in Copenhagen, there are special programs offered to users of illicit drugs, some of them having been developed earlier or being provided on a larger scale than in other parts of the country. For instance, this applies to the outreach health care intervention in relation to homeless people with problem drug use and alcohol use and/or mental illnesses, and the outreach intervention in relation to young people with an ethnic background other than Danish and chaotic use of drugs.

Targets, contents, coordination and the key players

In 2011, the Copenhagen Municipality passed an abuse plan for the period 2011 – 2014 (Københavns Kommune 2011a). The plan primarily describes treatment and harm reduction interventions and thus not preventive intervention and the intervention targeted at recreational use. The plan contains four goals and five focus areas which will be described below. The expenses incurred for this intervention in 2011 amounted to EUR 22.1 million.

The goals determined on a political scale are several. One goal is that *a higher number of the drug abusers in Copenhagen must be offered treatment*. Only approximately 1/3 of the estimated number of persons with drug abuse requiring treatment are currently receiving treatment. This also implies that drug abusers must be subjected to *early intervention* - that they enter the treatment system at an earlier stage. Experience shows us that often, many years may pass before the drug abuser is admitted to treatment, and in the meantime both physical and somatic complications typically evolve as a result of the drug abuse. The person becomes a criminal, and the distance to the labour market and a well-functioning social network is big. This makes it difficult to start treatment and the prognosis in relation to rehabilitation is poor. Another goal is that *a larger share of drug abusers admitted to treatment are relieved of their abuse* - either through drug-free treatment or substitution treatment. In relation to those drug abusers who cannot or do not wish to stop their abuse, it is important *to prevent against and reduce the injuries* they inflict on themselves and their surroundings as much as possible. A number of specific initiatives must contribute to obtaining these goals:

- **Early intervention**

As mentioned above, much is gained from getting the drug abusers to accept treatment as early as possible. However, the drug users often have an ambivalent approach to seeking treatment. It can be a stigmatising experience, and motivation for giving up drug abuse may be very fluctuating - drug use does not only have its downsides, it also has its upsides. A number of activities have been launched or planned in order to lower the hostility in relation to seeking treatment.

- **Anonymous counselling and treatment**

The fear of registration is present with many drug abusers. Consequently, an anonymous treatment program was launched in 2011, financed by the National Board of Social Services, primarily targeted at people in jobs or under education. The program has been very popular from day one.

- **Short-term interventions**

It has been demonstrated that individual motivating sessions may bring a building abuse problem to a stop. In Copenhagen, projects have already started to include "step-by-step treatment", in which treatment is adjusted in accordance with the user's problem, and this concept needs to be further developed.

- **Citizens on the edge of the labour market**

The Administration of Employment and Integration needs to be qualified through training in spotting, analysing, and subsequently referring people on daily sick benefits to treatment of potential a drug/alcohol problem. Problem drug use of intoxicants may be one of the causes for slipping out of the labour market, and short-term intervention may alleviate a commencing social come-down for persons that are assumed to be motivated to do something about their drug problem.

- **Internet-based intervention**

It is possible to develop platforms on the internet, where the user can get information about the drugs, test him/herself for the magnitude of his/her drug use, receive guidance on how the negative consequences of drug use can be allevi-

ated and on treatment options. This is a program that the Copenhagen Municipality plans to develop further.

- **Expand treatment capacity**

It is a well-known fact that more and more differentiated treatment programs increase the number of drug abusers using the treatment system. The number of programs, however, is a question of economy, and it is not drug treatment, but alcohol treatment that requires an expansion of treatment capacity.

- **Special intervention for young people**

In order to succeed in attracting more people to treatment, it is necessary to provide treatment programs including young people. With the special programs U-turn²² and POM²³, the Copenhagen Municipality has a firmly rooted treatment program for young people and strong collaboration with Copenhagen Prisons on the treatment and motivation for further treatment of young criminals with drug problems. Many of these young people come from a background other than Danish, and they are under-represented in the treatment system. Supplementary to the tracing process inside the prisons, there is a need for an outreach intervention in the environments where these young people move.

Quite a few in the youth educations are problem drug users, particularly using cannabis, and in cooperation with the youth educational institutions, the U-turn project has prepared short-term counselling and treatment programs to young problem drug users. Parallel with this, U-turn has been instrumental in preparing a general drug policy at the educational institutions with the purpose of preventing drug problems among the young population. Naturally, internet-based intervention would be relevant for the young.

- **Long-term abuse of opioids**

There is an ageing population (average age 47 years) of opioid abusers in Copenhagen. A majority of them are receiving substitution treatment with methadone. A large part of them are working or in other ways socially well-integrated, but many of them are marked by somatic and mental sequelae and absence of a well-functioning social network. Treatment in relation to this group primarily has a harm-reducing focus. Similarly to what is known from the psychiatric sector, Copenhagen has recently developed a support-contact-person program to this group with positive results, and it is the plan that this intervention needs to be expanded.

One of the plans is to enhance the psychiatric competencies in order to strengthen analysis and treatment of the mental disorders in this group. A small segment of the elderly drug abusers are not capable of looking after themselves in their own home due to somatic complications, their abuse situation and in some of them development of dementia. Some of these people are eligible for placement in standard nursing homes, whereas others, due to their young age and deviating behaviour need to be placed in special nursing homes. Copenhagen has established an institution with approximately 20 places for active drug

²² www.utum.dk

²³ www.kfkk.dk

abusers who are incapable of looking after themselves in their own home. At present, the capacity meets requirements, but the development will be monitored closely.

- **Families with abuse problems**

Relatives of abusers, and especially their children, feel the direct and unpleasant consequences of the abuse of family members. The Copenhagen Municipality's efforts in relation to such problems is to help the children living in families where one or several of the adults are abusers and to involve the relatives of persons in treatment. These initiatives were launched to support the children and the relatives, but also to increase treatment quality for the individual drug abuser, as there is clear evidence that the involvement of the relatives in treatment increases its effect.

12.2 Special policy areas

The following lines elaborate on the special drug policy areas²⁴. Some of these will be treated from an overall perspective, either because they have been described more specifically in other chapters in this report, or because they do not represent a major problem.

The open drug scenes - harm and problem reduction

Copenhagen has a large open drug scene located close to the Central Station in the area called Vesterbro. The drug scene has existed since the 1970s and has moved a little on Vesterbro, primarily as a result of police intervention, but also as a result of the establishment of drop-in centre programs that accepted drug intake. It is difficult precisely to estimate the number of users visiting the drug scene, but a fair guess is that the drug scene is visited by approximately 1,000 users, out of which almost half are regulars (daily), whereas the others pay more sporadic visits. The majority of users on the drug scene do not live in Copenhagen, even not in Vesterbro, but they come from the nearby municipalities to trade in and use drugs. Part of the drug scene users also come from abroad, first and foremost Sweden.

Residents and shops near the drug scene have always found this extremely cumbersome. The drug scene is the cause of increased pilfering in the area, massive waste problems, the drug users' behaviour may be perceived as threatening and intimidating, and the drug users exclude the general population from part of the city via their behaviour. The problems have increased concurrently with the very successful residential reconstruction of Vesterbro, which to a large extent has transformed Vesterbro from a working class neighbourhood with pubs and bars into a middle-class neighbourhood with cafés and restaurants. The reconstruction has resulted in backyards and stairways being locked, and part of the public space has been reduced considerably.

Via the social reserve funds, the Social Service Administration has offered access to treatment, made outreach work, established drop-in centres, cafés and a special health room for the users in order to alleviate the nuisance and damage which the open drug scene inflicts on the local residents and the drug abusers.

²⁴ These themes have been selected by the EMDCCA and will be described in the other member countries' drug reports 2012.

Collaboration between the police and the social authorities has improved in recent years, and there are now fixed collaboration methods and close, but more ad hoc collaboration between the police and employees from the social sector. However, apart from the improved collaboration, there is no overall coordination and preparation of joint objectives and strategies.

In 2008, heroin treatment programs were launched (and financed) on a national level and were implemented in 2010. In addition, permission was given to establish drug consumption rooms, and the first drug consumption room in Copenhagen opened on 1 October 2012.

There has been an ongoing pressure from the local population, shops and institutions in the area for the reduction of the nuisances linked with the open drug scene. This and the establishment of drug consumption rooms has led the politicians to prepare an overall plan for Vesterbro that can ensure coherence and coordinated efforts to bring down the level of nuisances for the residents and the injuries suffered by the drug users. The plan was prepared by the Social Services Administration after the local institutions, the police, residents and businesses had been involved in a hearing process. The plan was published in 2011 (Københavns Kommune 2011b).

The overall objectives of the plan are to reduce the injuries suffered by the socially vulnerable drug users and to reduce the nuisance suffered by the residents, institutions and businesses in the local district. The plan contains a number of focal points and specific projects, including:

- The establishment of drug consumption rooms
- Law and order
- Cooperation with psychiatrists in relation to the mentally ill.
- Cleaning and more public lavatories
- Conceptualization of city design
- An expanded health care program offered to prostitutes
- Better coordination of intervention
- Dialogue with residents through regular dialogue meetings and involvement of the local district by establishing new programs and measures
- User involvement, particularly in connection with the establishment of the drug consumption room

According to the plan, the extremely important coordination of the intervention must be handled by the *monitoring group for the Vesterbro plan*. The monitoring group has to be an open forum, in which everybody interested or involved in the work the marginalised drug users and reduction of nuisances can take part. The monitoring group is *not* a steering group, and steering must therefore be handled by individual player based on the knowledge provided by the monitoring group.

Interventions in relation to nightlife

It is a well-known fact that drug intake in discoteques, music festivals, techno parties, etc is rather massive. This applies in Copenhagen as well as in the rest of the country. The major drug intake of a number of known and unknown drugs with unknown concentration gives rise to a large and increasing number of accidental poisonings, some of them being lethal. The issues and the measure initiated in Copenhagen are not different from the other part of the country and have been described in other part of this report which is why they are not described any further here.

Low threshold to drug abusers

Since the middle of the 1980s, harm reduction in the form of a number of low threshold programs has been a significant and integral part of the work in Copenhagen with socially marginalised drug users. Among the measures are dispensing of syringes, needles, boiling equipment, distilled water and citric acid, numerous drop-in centres and shelters for various types of client groups, outreach work involving connection to the treatment system, the social and health care system, outreach health care services provided to people with problem drug use and/or alcohol use and/or mental disorders, low threshold methadone treatment, not waiting lists for treatment and, as the most recent project, drug consumption rooms established in 2012 and 2013.

Both the public and private treatment programs are in charge of the work with the Social Services Administration as the coordinating body. The programs are predominantly publicly financed, primarily by the Copenhagen Municipality, but the state contributes with different funds.

12.3 Current problems and challenges in Copenhagen

Copenhagen has a large illicit drug market, on which the municipality estimates the turnover amounts to between EUR 0.14 and 0.27 bn. The Copenhagen Municipality has asked the government for a trial scheme, under which cannabis is legalised. This has been rejected by the government.

Annex

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Socialstyrelsen [National Board of Social Services] www.stofmisbrugsdatabasen.dk

Sundhedsstyrelsen [Danish Health and Medicines Authority] www.sst.dk

Videncenter om unges misbrug [National Board of Social Services, national knowledge centre for young people and abuse] www.unges-misbrug.dk

Videnscenter for Forebyggelse af Rusmiddelskader hos Børn [Center for Prevention of Substance Effects on the Development of Children] www.familieambulatoriet.dk

The surveys applied

”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.

”Brug af khat blandt personer med somalisk baggrund i Danmark – en undersøgelse af omfang og holdninger” [Use of khat among persons with a Somali background in Denmark – prevalence and attitudes] The National Board of Health 2009

ALS research ApS has conducted a survey ordered by the National Board of Health in March 2009 on the prevalence of khat among the Danish-Somali population aged 15-50 years. The survey also provides a description of the awareness of and attitude towards khat among these people, 848 persons, corresponding to 15% of all 15-50-year-old Danish-Somalis living in Denmark, participated in the survey, Nine Danish-Somali key persons were hired as data employees and access facilitators to different groups in the Somali environment and assisted in completing the questionnaires given to the respondents. The questionnaire was bilingual and prepared in Danish as well as Somali. In addition to the questionnaire, a few telephone interviews have been conducted with experts who have been working with Somalis and with representatives from the Danish-Somali environment. The purpose of this has been to dig deeper into some of the problems and themes resulting from the survey.

"Monitorering af unges livsstil og dagligdag 2002" (MULD 2002), Sundhedsstyrelsen og Kræftens Bekæmpelse [Monitoring of young people's lifestyle]

In 2002, 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. 2,041 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%. Table 2.1.3.1.

"Monitorering af unges livsstil og dagligdag 2003" (MULD 2003), Sundhedsstyrelsen og Kræftens Bekæmpelse [Monitoring of young people's lifestyle]

In 2003, 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. 1,768 young people aged between 16 and 20 years were chosen according to systematic selection. Data collection was made via questionnaires mailed to the respondents. The response rate was approximately 60%.

"Monitorering af unges livsstil og dagligdag 2004" (MULD 2004), Sundhedsstyrelsen og Kræftens Bekæmpelse [Monitoring of young people's lifestyle]

In 2004, 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. 1,772 young people aged between 16 and 20 years were chosen according to systematic selection. Data collection was made via questionnaires mailed to the respondents. The response rate was 58%.

"Monitorering af unges livsstil og dagligdag 2006" (MULD 2006), Sundhedsstyrelsen og Kræftens Bekæmpelse [Monitoring of young people's lifestyle]

In 2006, the National Board of Health and the Danish Cancer Society conducted a representative survey on the 16-20-year-olds' lifestyles and daily routines. 1,964 young people aged between 16 and 20 years were chosen according to systematic selection. Data collection was made via questionnaires mailed to the respondents. The response rate was approximately 68%.

"Unge livsstil og dagligdag 2008" (MULD 2008), Sundhedsstyrelsen og Kræftens Bekæmpelse [Young people's lifestyle and daily routines]

In 2008, 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 respondents were recruited via Userneeds Danmarkspanel and included a total of 1,539 individuals. While the former MULD surveys were conducted via questionnaires sent by ordinary mail, the 2008 survey was only internet-based and the questionnaire was completed electronically over the internet. In the new data collection methods, sources of error are not yet known, for which reason the results from 2008 cannot be directly compared to the results of previous years.

"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.

Skolebørnsundersøgelsen 2002. Health Behaviour in school-aged Children (HBSC). (Pernille Due & Bjørn E. Holstein 2003) Health Behaviour in school-aged Children (HBSC). (Pernille Due & Bjørn E. Holstein 2003)

This report describes the Danish part of the WHO study on the health of children and young people. For the first time, it has been included in a study to investigate the question of the use of cannabis and ecstasy among 15-year-olds. The study was conducted as an anonymous questionnaire handed out in the classrooms of the "folkeskoler" (elementary schools). The random sample included 1,418 young people.

"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 con-

tact 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 2.1.2. The proportion of women and men (percentage) in the different age groups who have used cannabis within the past year in 1994, 2000, 2005, and 2010

		1994	2000	2005	2008	2010
		n=2,521	n=6,887	n=4,484	n=2,229	n=5,748
16 -19 year-olds	Men	19	29	23	28	23
	Women	10	20	19	17	15
20 -24 year-olds	Men	14	24	26	23	24
	Women	9	12	16	19	16
25 -29 year-olds	Men	8	16	17	17	14
	Women	5	6	5	7	8
30 -34 year-olds	Men	9	10	10	5	10
	Women	2	3	3	3	4
35 -39 year-olds	Men	6	8	5	9	6
	Women	2	2	2	0	1
40 -44 year-olds	Men	5	4	4	3	4
	Women	2	2	2	0	0
All 16-44 years	Men	10	14	11	12	12
	Women	5	6	6	7	6
	All	7	10	8	9	9

Source: SUSY 1994, SUSY 2000, SUSY 2005, AiK 2008 and SUSY 2010

Table 2.2.3.1. The proportion of the 16-44-year-olds who have tried one or several of the different illicit drugs within the past month, last year or ever in 2010 (n=5,704)

	Last month	Last year (last month included)	Ever
Amphetamine	0.4	1.3	8.8
Cocaine	0.4	1.6	7.1
Psilocybin mushrooms	0.1	0.3	3.9
Ecstasy	0.1	0.5	4.0
LSD	0.1	0.2	1.2
Heroin	0.1	0.2	0.6
Other drugs*	0.3	0.6	3.0
"Hard" drugs, total**	0.9	2.4	12.5

Source: Unpublished figures from SUSY 2010

*The category "Other drugs" covers GBH, different medicines, etc.

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

Table 2.2.10 The proportion of the 16-24-year-olds (percentage) who have a current use of illicit drugs (tried one or several of the different illicit drugs within the last year) in 2000, 2005, 2008 and 2010

	Last year 2000	Last year 2005	Last year 2008	Last year 2010
Cannabis	19.7	20.5	21.3	18.9
Amphetamine	5.7	4.1	5.4	2.8
Cocaine	2.7	3.3	5.6	2.9
Psilocybin mushrooms	2.1	1.0	1.1	0.7
Ecstasy	2.3	1.5	2.3	1.1
LSD	0.6	0.6	0.2	0.4
Heroin	0.2	0.2	0.0	0.3
Other drugs*	1.0	0.7	2.3	1.1
"Illicit drugs other than cannabis" total	7.7	5.3	8.0	4.3

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

*The category "Other drugs" covers GBH, different medicines, etc.

Table 2.2.11 Percentage of the 16-24-year-olds who tried one or several of the various illicit drugs within the past month, last year and ever in 2010

	Last month	Last year (last month included)	Ever
Amphetamine	1.0	2.8	7.5
Cocaine	0.9	2.9	6.4
Psilocybin mushrooms	0.3	0.7	2.8
Ecstasy	0.3	1.1	4.6
LSD	0.1	0.4	1.2
Heroin	0.1	0.3	0.4
Other drugs*	0.4	1.1	3.6

Source: Unpublished figures from the Danish Health and Medicines Authority SUSY 2010

*The category "Other drugs" covers GBH, 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
Newly diagnosed, HIV positive total	261	321	289	270	307	264	244	312	292	242	274	265
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%)
Newly diagnosed AIDS cases	61	71	45	41	61	45	54	50	40	40	47	58
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%)

Source: Unpublished data from the State Serum Institute. For 2011-data the figures have been compiled on 2 July 2012

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
Hepatitis A, total	81	63	84	71	241	48	42	28	44	45	47	
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%)
Hepatitis B, total *	64	49	62	36	44	30	20	25	25	23	28	16
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%)
Hepatitis C, total *	15	6	5	7	8/378**	2/371	7/398	11/408	6/318	4/292	6/315	7/285
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%)

Source: Unpublished data from the State Serum Institute. For 2011 data, the figures have been compiled in June 2012

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

Source: National Patient Register. Figures for the year 2011 have been compiled in June 2012

*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

²⁵ The figures for 2011 are preliminary and with data from the LPR as at August 2011. The final figures for 2011 may therefore change in subsequent statistics.

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

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

Source: The Danish Health and Medicines Authority, data collected in August 2012

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
F11	Opioids	172	156	155	138	123	133	136	166	120	135
F12	Cannabis	364	333	354	312	347	364	388	553	533	643
F13	Sedatives /hypnotic agents	182	159	143	150	140	154	141	130	112	113
F14	Cocaine	36	65	53	42	49	49	56	57	51	39
F15	Stimulants other than cocaine	109	99	98	93	87	91	94	95	86	98
F16	Hallucinogens	14	9	17	16	10	10	18	6	11	14
F18	Solvents	2	10	5	3	3	4	7	3	1	4
F19	Multiple or other psychoactive drugs	726	747	684	668	660	682	696	826	672	714
Persons with primary diagnoses, total		1605	1578	1509	1422	1419	1487	1536	1746	1586	1760

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.

The table shows the number of persons registered as recipients of psychiatric treatment (either full-day, half-day or out-patient 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 til F19.x (primary diagnosis) used as retrieval criteria. Since a patient can have several drug-related secondary diagnoses, the "total" category is not a summation.

Table 6.3.5. Persons registered with drug-related secondary diagnoses in the 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
F11	Opioids	208	201	271	280	341	358	492	522	428	451
F12	Cannabis	691	759	873	908	1040	1072	1507	1646	1668	2011
F13	Sedatives /hypnotic agents	266	307	359	367	385	417	529	554	468	467
F14	Cocaine	34	61	66	97	118	163	210	217	214	209
F15	Central stimulants other than cocaine	56	73	123	120	162	179	235	261	251	270
F16	Hallucinogens	10	2	13	14	8	8	13	14	14	16
F18	Solvents	13	12	11	8	18	13	13	24	17	18
F19	Multiple or other psychoactive drugs	574	679	728	736	874	995	1176	1396	1239	1458
Persons with secondary diagnoses total		1747	1844	2074	2102	2430	2632	3418	3718	3445	3927

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

The table 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 - F16.x and F18.x - 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	2003	-	-	-
1996	242	177	65	2004	-	-	-
1997	256	189	67	2005	208	162	46
1998	243	174	69	2006	227	167	60
1999	217	157	60	2007*	211	148	63
2000	240	175	65	2008*	211	155	53
2001	221	153	68	2009	222	161	61
2002	-	-	-	2010	204	158	46

Source: Cause of death Register, August, 2011

*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 Commissioner of Police's register on drug-related death. 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				

Source: National Commissioner of Police, 2012

*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
Northern Jutland	36	35	33	31	28
Mid-Jutland	52	47	53	58	56
Southern Denmark	71	68	79	78	91
Copenhagen	68	59	86	70	69
Zealand	29	24	21	31	33
Copenhagen Municipality*	41	31	51	38	32

Source: National Commissioner of Police 2012

* 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
Persons charged	12,902	12,851	14,272	16,390	19,037	19,900	18,506	18,692	17,403	17,825	21,211
Source:	9,858	10,021	11,160	12,313	14,204	15,060	13,294	14,093	13,354	13,749	16,065

Source: National Commissioner's Drug Statistics 2012

Table 10.3.1. Drug seizures in the year in question

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Heroin														
Kg	55.1	96.0	32.1	25.1	62.5	16.3	37.5	27.0	28.9	48.1	43.9	22.4	39.4	36.6
No. of seizures	2,199	1,230	1,499	1,304	966	894	1,041	1,064	927	1,016	906	648	699	488
Cocaine														
Kg	44.1	24.2	35.9	25.6	14.2	104.0	32.3	57.0	76.2	91.8	56.1	72.4	54.16	42.9
No. of seizures	885	744	780	815	881	1,095	1,207	1,615	1,901	2,098	1,858	1,365	1,589	1,777
Amphetamine														
Kg	25.2	31.6	57.1	160.6	34.9	65.9	63.0	195.0	79.4	70.4	119.8	103.8	193.9	240.3
No. of seizures	1,609	1,250	1,152	954	1,134	1,264	1,388	1,573	2,022	2,215	1,543	1,260	1,764	1,757
Ecstasy														
Kg	27,039	26,117	21,608	150,080	25,738	62,475	38,096	44,195	22,712	82,390	17,631	53,929	45,360	16,042
No. of seizures	143	197	444	331	340	322	1388	461	540	452	251	200	200	209
LSD														
Kg	105	83	1,108	156	38	22	483	1201	521	47	482	468	159	1,003
No. of seizures	24	15	18	29	8	7	13	12	8	13	21	18	16	20
Cannabis														
Kg	1,572	14,021	2,914	1,763	2,635	3,829	1,758	1,406	1,035	877	2,914	1,220	2,318	2,325.7
No. of seizures	5,904	4,569	5,561	5,788	5,234	5,942	7,313	10,292	10,962	9,301	8,365	7,430	7,689	8,499

Source: National Commissioner's Drug Statistics 2012

Table 10.4.1. Distribution between drug types on a user level in the year in question

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

Source: Kaa et al. 1997-2005; Lindholst et al 2005-2012

** Ecstasy was excluded from the "Street-Level 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. Distribution between heroin base and heroin chloride in the year in question

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
	n=69	n=80	n=73	n=66	n=66	n=66	n=60	n=52	n=54	n=42	n=43
Heroin base	77%	76%	84%	77%	76%	65%	72%	77%	69%	64%	58%
Heroin chloride	23%	24%	16%	23%	24%	35%	28%	23%	31%	36%	42%

Source: Lindholst et al 2012