



European Monitoring Centre
for Drugs and Drug Addiction

 **Sundhedsstyrelsen**
National Board of Health

**2010 NATIONAL REPORT
(2009 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 National Board of Health, the Danish "Focal Point". The report was written in the autumn of 2010 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 been principle coordinator on the preparation of the report and has written the chapters on epidemiology. Marie Asserhøj, academic staff member, has prepared the chapter on prevention, and Helle Petersen, head of department, has prepared the chapter on the health care interventions targeted at drug use as well as the theme chapter on guidelines for treatment. Hanna Freya and Iben Nordentoft have prepared the theme chapter on financing of drug treatment. The contents of the remaining parts of the report are contributions from various units under the National Board of Health, especially from the Health Documentation office by Special Advisor Claudia Ranneries, the Ministry of the Interior and Health, the Ministry of Social Affairs, the Ministry of Justice as well as a number of collaborative partners.

The National Board of Health has appointed a reading panel which has contributed with comments and constructive criticism. This panel consists of Henrik Sælan (medical advisor), Peter Ege (social consultant), Mads Uffe Pedersen (associate professor), Steen Møller Bach (head of SSP and prevention) and Anne-Marie Sindballe (Special Advisor). Ms Birgitte Neumann, the National Board of Health, has been responsible for layout and proofreading.

November 2010

Else Smith
Director appointed ad interim

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Summary

The current drug situation in Denmark

In 2010, the National Board of Health made new estimates on the number of drug users in Denmark. This estimate shows that the number of drug users in Denmark is 33,000, of which more than 11,000 are cannabis users alone. Compared to previous years, the number of drug abusers in Denmark has gone up. In 2006, the number of drug users totalled an estimated 28,000, of which almost 8,000 were cannabis users. The increase in the estimated number of drug users is thus characterized by an increase in the estimated number of cannabis users from a little less than 8000 in 2005 to 11.000 in 2009. 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. Drug addicts are thus included in the estimated figures as are drug addicts in substitution treatment. At present, it is estimated that 13,000 drug abusers inject drugs. These individuals are at a particular risk of developing serious injuries and diseases.

Since year 2000, national population surveys have shown a generally stable level for the experimental use of cannabis as well as other illicit drugs. From year 2000, the curve broke after drastic increases in the use of illicit drugs up through the end of the nineties. A new population survey from 2010 now shows a falling trend in the use of drugs - especially in the age group under 25 years. The falling trend appears for all the drugs, also for cocaine, the prevalence of which turned out to increase throughout the first decade of this century. Cannabis continues to be the most prevalent drug. Much fewer drug abusers report taking amphetamine and cocaine and even fewer report using psilocybin mushrooms and ecstasy.

Each year, the emergency wards report 1100-1600 visits, of which poisoning and illicit drugs make up the cause of the contact. This is assumed to be a conservative estimate. The number of poisonings reported as a result of drugs reaches peaks in 2009 with 1,662 visits to the emergency wards. 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.

Data on psychiatric admissions suggest that drug diagnoses among patients admitted are becoming a more and more frequent cause of hospitalization. In 2009, a total of 5,000 persons were recorded to suffer from actual comorbidity, with mental disorders and drug abuse walking hand in hand. Polydrug use makes up the predominant part of comorbidity. When viewing the drugs individually, cannabis appears to be the prevailing drug. The number of people admitted to psychiatric treatment with a drug-related secondary diagnosis, including cannabis abuse, totals more than 1,600 in 2009, and the number has almost tripled over the past 10 years. Stimulants are also increasingly becoming a contributory cause of the psychiatric admissions these years.

Among the health consequences of drug use, increased mortality should be mentioned. Drug users have very high mortality rates, generally because of poisoning and diseases, including HIV and hepatitis, and drug users who are released from prison have particularly high mortality rates shortly after their release due to poisoning. After a few years with a drop in the recorded drug-related deaths, an increase has set in from 2008 to 2009 with drug-related deaths rising from 239 to 276. This increase has led the National Board of Health to initiate a survey, the purpose of which is to map the cause

of death patterns further. Most of the drug-related deaths are caused by poisoning, with others being caused by violence, accidents, suicide and diseases. More detailed analyses of the drug-related deaths document that polydrug use is the main culprit among those who die. On average, between three and four drugs are detected in the deceased's blood in each drug-related death.

Finally, the consequences of drug use have also become apparent in the statistics on drug users admitted to treatment. In recent years, the number of admissions has increased, and in 2009 there were almost 14,000 individuals admitted to drug abuse treatment in Denmark.

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 drug use problem. In 2009, more than 2/3 (70 %) of the young people aged between 18 and 24 years admitted to treatment used cannabis as their primary drug, whereas 12% and 5% of the young people were being treated for using amphetamine and cocaine 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.

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. 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 is entitled to launch universal, selective and indicated prevention in schools through local recreational programmes in collaboration with associations, restaurants, bars and discotheques and in particularly vulnerable residential areas.

The National Board of Health's drug prevention intervention projects have focused on party settings as a risk arena. This has resulted in projects such as "Ansvarlig udsækning" (Responsible Alcohol Serving) and the campaigns "Against Drugs" and "Unge og Alkohol" (Young People and Alcohol). The organisations and Festival danmark and Spillesteder.dk are the formal organizers of the campaigns. In this way, they show their attitude towards drugs. These projects and campaigns are dedicated towards creating a safe night life, reducing violence and injury and promoting the compliance with age limits for serving alcohol.

"Unge Misbrug" (Young People's Drug Use) is a national knowledge centre under the "Udsatte"-unit (Marginalised Persons Unit) of the National Board of Social Services. The centre offers advice to the municipalities and their social services staff in relation to their work with young people with drug problems. The purpose of the knowledge centre is to enable the professional staff to take on an overall approach when working with young drug users. "Unge Misbrug" focuses on finding the young people who have a problematic use of drugs and on interventions targeted at reducing their drug problems through large-scale intervention. The centre primarily addresses the needs of drug use counsellors who meet the young people through their daily work.

In connection with recent years' agreements between the government and the parties behind the annual distribution of certain funds in the social area, a number of initiatives

have been taken within prevention, treatment and harm reduction. Some of the funds have been allocated to the introduction of targeted healthcare services provided to the most vulnerable drug users and funds allocated to initiatives addressing particularly marginalised groups, including homeless drug users in drop-in centres as well as pregnant drug users in regional family outpatient settings.

Today, there is a focus on the quality of medical treatment provided to drug users. One of the initiatives includes ensuring uniform quality in treatment provided. The other is a completely new scheme introduced in Denmark in 2010, with prescribed heroin. The scheme is intended for drug users who, in spite of long-term substitution treatment, already have or face serious health complications. This is expected to meet the needs of approximately 300 drug users.

New drugs and new legislation

The National Board of Health and the National Commissioner's Office's together with the three Danish forensic institutes monitor drugs on the illicit market. The purpose is, among others, to consider whether or not control measures and bans can be implemented when new drugs surface.

From the end of 2009 and until the autumn of 2010, a number of new drugs have surfaced in Denmark, and the National Board of Health has recommended the ban of such drugs. These drugs are 2-aminoindan, AMT, DPT and MDPPP, metamphepamone, flouramphetamine (all isomers o-, m- and p- flouramphetamine), Tapentadol INN and a number of synthetic cannabinoids.

Selected issues

The selected issues chapter on financing drug use treatment describes how the Danish treatment of drug users is financed by the public sector. The Selected Issues chapter on treatment guidelines includes a description of the development of national guidelines for drug use treatment in Denmark.

1 Drug policy; legislation, strategies and economic analysis

Danish drug policy is founded on four principles: prevention, treatment, harm reduction and control. In other words, consistent bans and effective control measures are far from suffice. There is also a need for targeted and persistent interventions to comply with the principles of prevention, early intervention, treatment and harm reduction. There is a need for limiting the supply and demand for drugs.

The existing harm reduction interventions may seem contradictory when it comes to fighting relentlessly against drugs and striving for a society without drug problems. However, they are pragmatic and sensible and initiated in consideration of the weakest drug users and society in general. Harm reduction will therefore continue to be one of the cornerstones of Danish drugs policy.

The Danish drugs policy rests on the ban against any non-medical and non-scientific use of drugs, and the government rejects any proposal on the legalisation of drugs for purposes other than medicine and science.

Therefore, the government is against any proposal on the legalisation of cannabis. The use of cannabis may have severe consequences, and especially children and young people as well as marginalised adults are vulnerable to such.

The Government cannot accept the establishment of public injection rooms in Denmark and is adamant in rejecting the introduction of such rooms. The Government believes that it would take things too far if drug users were allowed to possess and use drugs in certain locations. Injection room fall outside the Government's principle of harm reduction.

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

On a central level, the Ministry of the Interior and Health is responsible for coordinating government initiatives. The ministry is also responsible for controlling the legal use of drugs. Furthermore, it oversees the governmental responsibilities concerning preventive intervention and treatment intervention of the healthcare sector, including medical treatment. The Ministry of Social Affairs is responsible for the government's social treatment programmes. The Ministry of Justice has the main responsibility for supervision and policing, including measures for drug users in prison. The Ministry of Tax Affairs is responsible for custom controls and inspecting precursors.

In 2004, a political agreement was signed and as of 1 January 2007, a local government reform was launched, which basically changed the framework of local and regional responsibilities. The impact of the local government reform on the drugs issue is that the responsibility for prevention as well as for the social and medical drug use treatment has been passed on from the counties to the municipalities. As the municipalities are also responsible for other social tasks, their work of coordinating the social and medical treatment of drug use has thus become easier.

The municipalities are thus assisted by the central authorities in such matters as monitoring, overall guidelines, documentation, knowledge sharing, etc.

1.1 New legal framework, including new drugs under control

In 2010, the following laws have been adopted to combat drugs.

- Act no. 629 of 11 June 2010 on the amendment of the Act on Social Services, the Act on legal safety and administration of social services and the healthcare act as well as the abolishment of the act on preventive home visits for the elderly, etc. This Act which came into effect as of 1 July 2010 simplified the rules pertaining to approval of private botilbud. This means that the local council's approval of certain types of private botilbud to, for instance, drug users and the registration of the same services on the Social Services Gateway (Tilbudsportalen) are merged into one work routing without curbing down on the municipalities' obligations in relation to securing quality and contents of the private botilbud.

In 2010, the following narcotic drugs were subjected to control:

- In executive order no. 190 of 26 February 2010 on the amendment of the executive order on psychoactive substances it was provided that the drugs 2-aminoindan, AMT, DPT, MDPPP and methamphetamine and CP 47, 497-C6; CP 47, 497-C7; CP 47, 497-C8 and CP 47, 497-C9, HU-210, JWH-018, JWH-073, JWH-200, JWH-250 and JWH-398, which are all synthetic cannabinoids shall only be used for medical and scientific purposes. The order became effective on 04 March 2010.
- In executive order no. 610 of 4 June 2010 on the amendment of executive order on psychoactive substances it was provided that the drug flouramphetamine (all the isomers o-, m- and p-flouramphetamine) shall only be used for medical and scientific purposes. The order became effective on 09 June 2010.
- In executive order no. 1033 of 26 August 2010 on the amendment of executive order on psychoactive substances, it was provided that the drug Tapentadol INN shall only be used for medical and scientific purposes. The order became effective on 02 September 2010.

During the parliamentary year 2009-2010, members of the Opposition have moved the following bills:

- Proposal for parliamentary decision no. B 35 on project investigating controlled sales of cannabis. The proposal did not reach the 2nd reading and consequently not a vote, but at the 1st reading, there appeared to be a majority against.
- Proposal for parliamentary decision no. B52 on the establishment of treatment programmes for steroid users. The proposal did not reach the 2nd reading and consequently not a vote, but at the 1st reading, there appeared to be a majority against.
- Proposal for parliamentary decision no. B 210 on stricter punishment for smuggling khat, which means that the punishment will correspond to that of similar violations in Sweden. During the 1st reading of the proposal, it was informed that the Ministry of Justice already prior to the moving of the proposal had asked the Rigsadvokaten and the National Commissioner to investigate

whether there was any basis for providing stricter punishment on the import, selling and possession of khat. The Government rejected the proposal with reference to the fact that any decision on stricter punishment should await the investigation mentioned above. The proposal did not reach the 2nd reading and consequently not a vote, but at the 1st reading, there appeared to be a majority against.

- Proposal for parliamentary decision no. B 71 on the establishment of injection rooms for drug users as part of the harm-reducing and treatment-related work within drugs. The proposal was rejected at the 2nd reading.

1.2 National strategies within the drugs area

In spite of additional and improved initiatives launched for drug users, society is still faced with major challenges to fight drugs. During recent years there has been a decline in the number of drug users seeking treatment due to heroin use and at the same time an increasing number of drug users see treatment for cannabis and cocaine use. This shift is assumed to reflect a change in the drug use pattern in Denmark. Today, there appears to be more cannabis and cocaine users and fewer heroin users. This renders intervention necessary.

Thus, with its new drug action plan "The Fight against Drugs II" from October 2010, the Government has stepped up interventions and launched 19 specific and new initiatives within each of the four cornerstones of Danish drugs policy. Prevention, treatment, harm reduction and control. With this action plan, follow-up is made on a report drafted by an expert panel on cocaine use and submitted to the Minister for the Interior and Health in May 2010.

This action plan also followed up on the signing of the social reserve fund agreement for 2011, under which a total of DKK 71.9 mill (EUR 9.6 million) was set aside for initiatives within prevention, treatment and harm reduction. Furthermore, a number of initiatives mentioned in the action plan are financed by DKK 48.5 mill (EUR 6.5 million) from the drug reserves under the Ministry of Social Affairs.

The action plan "The Fight against Drugs II" is the most recent step in the lengthy process of strengthening drug use interventions. When the new Government signed an agreement in 2001, it was decided to fortify the common responsibilities for the weakest groups in society. This decision was subsequently followed up by general initiatives such as the signing of a number of agreements concerning social reserves, the preparation of action programmes "Our Joint Responsibility I" and "Our Joint Responsibility II [in Danish: Det fælles ansvar I + II] and the appointment of the Council for the Socially Marginalised. In the next governmental agreement signed in 2003, intervention measures were expanded and were expressed in "The Fight Against Drugs" action plan, which was presented by the Government in October 2003. This action plan has since been followed up by social reserve agreements from 2004, 2006, 2008, and 2009 and contain a number of specific initiatives, all aiming at curbing drug use and the injury resulting from it.

"The Fight against Drugs" action plan as well as the specific initiatives launched following the publication hereof are constantly monitored and evaluated in order to make the necessary adjustments of the national drugs policy.

1.3 Budget and funding schemes

In order to strengthen intervention, the government signed the social reserve grants agreement for 2004. In this agreement, DKK 145 million (EUR 19.3 million) was set aside for the period 2004-2007 to cover specific drug initiatives. In order to boost intervention even more, the Government signed the social reserve agreement for 2006. In this agreement, DKK 250 million (EUR 33.8 million) was set aside over the years of 2006-2009 for other dedicated drug initiatives. In order to intensify treatment interventions further, the social reserve agreements for 2008 and 2009 set aside DKK122 mill (EUR 16.3 million) for the launch of new dedicated initiatives. Financing of most of the initiatives in the two agreements are permanent, which means that the initiatives stretch beyond the agreement period.

The information on government grants and social reserve grants allocated over the years has been provided in the annual reports of previous years. The new governmental grants are as follows:

- The social reserve grants for 2010 include an additional 1.4 mill (EUR 0.2 million) annually for the financing of the prescribed heroin scheme.
- The social reserve grants allow for DKK 6.0 mill (EUR 0.8 million) in 2010 and DKK 5.0 mill (EUR 0.7 million) for the period 2011-2011 for the anonymous treatment of drug users.
- The social reserve grants for 2010 allow for DKK 5.0 mill (EUR 0.7 million) for the period 2010-2013 for services provided to drug using prostitutes.
- The social reserve grants for 2010 allow for DKK 16.0 mill (EUR 2.1 million) in 2010 and DKK 10.0 mill (EUR1.3 million) in 2011 and onwards for the strengthening of the treatment guarantee in
- the prisons.

As a follow-up on the "Fight against Drugs II" action plan, the following amounts have been reserved:

- The social reserve grants for 2011 allow for DKK 19.0 mill (EUR 2.5 million) in 2011 for a model municipality project targeted at young people and drug use.
- The social reserve grants for 2011 allow for DKK 1.0 mill (EUR 0.1 million) in 2011 for quality assurance of the medical cocaine treatment
- The social reserve grants for 2011 allow for DKK 25.5 mill (EUR 3.4 million) during the period 2011-2014 to test the advantages and disadvantages of injection rooms.
- The social reserve grants for 2011 allow for DKK 26.4 mill (EUR 3.5 million) to be set aside for the period 2011-2014 for further drug use treatment of prisoners.
- The Drugs Fund of the Danish Ministry of Social Affairs has set aside DKK 48.5 mill (EUR 6.5 million) for initiatives within the social area.

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

As regards treatment of drug use in the prisons, there has been a significant upgrading the past year. The budget figure for 2001 was DKK 6.2 mill (EUR 0.8 million), whereas the similar budget figures in 2009 were DKK 78.4 mill (EUR 10.5 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 budget figure for 2009 was DKK 909.6 million (EUR 121.3 million), whereas the similar budget figures in 1995 were DKK 276.6 mill (EUR 36.9 million). Municipal expenditure on prevention against drug use and the medical drug use treatment cannot be specified on the basis of the local accounts and budgets.

2 Prevalence of illicit drugs

The phenomenon of trying drugs is typically one associated with young people, and most of them stop at some point. The majority of those who try drugs do so on an experimental basis for a short period during their younger years. Surveys among the whole population indicate that the experimental use of drugs is highest among the 16-19-year-olds and that very few try drugs for the first time after the age of 20. In age groups over 40, only a small percentage has used any type of drugs within the last year. By and large, it is the same group of young people who expose themselves to different kinds of risk behaviour. Studies document that often the same young people make up the group of heavy drinkers, smokers 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 from population surveys show that the level of experimental use of cannabis and other illicit drugs in Denmark is historically high, however with a downward trend within the past few years.

A new population survey from 2010 shows that a little less (45%) than half of the young adults under the age of 35 have experimented with cannabis ever, and 14% in the same age group have tried illicit drugs other than cannabis ever. Among the young people under 25 years, 38% have experimented with cannabis ever, and 11% have tried illicit drugs other than cannabis ever.

When viewing the prevalence of drugs individually in 2010, a declining trend is seen in the use of cocaine and in the use of other stimulants such as amphetamine and ecstasy. This declining trend appears particularly in the age group under 25 years.

The various surveys referred to in the following chapters and describing the development of the experimental use of illicit drugs among the adult population (SUSY¹ and AiD²), the young adults (MULD³) and the very young (ESPAD⁴), are described at the end of the report in terms of data and methods.

2.1 Use of illicit drugs in the population

The results provided here are based on national population surveys on the self-reported use of illicit drugs from 1994, 2000, 2005, 2008, and in 2010. All surveys have been conducted by the National Institute of Public Health at the University of Southern Denmark. The analyses on the prevalence of drugs are based on a population aged between 16 and 44 years. In persons more than 44 years of age, use of illicit drugs is limited, and the 44-year-olds are therefore not included.

¹ SUSY stands for: Sundheds- og Sygelighedsundersøgelse [Health and Morbidity Survey]

² AiD stands for: Alcohol in Denmark (a survey on the adults' alcohol habits and attitudes towards alcohol as well as the use of illicit drugs)

³ MULD stands for: Monitorering af Unges livsstil og Dagligdag [Monitoring of Young People's Lifestyles and Everyday Life]

⁴ ESPAD stands for: Alcohol and Other Drug Use Among Students in Europe

Prevalence of cannabis

Results from the population surveys among the 16-44-year-olds conducted in 1994, 2000, 2005, 2008 and 2010 show increases in the experimental use of cannabis up to 2000. Following this, the figures stagnate. When considering the current use (used cannabis within the past year), 9% of the 16-44-year-olds report in 2008 and in 2010 that they have used cannabis within the past year. This applied to 7%, 10% and 8 % in 1994, 2000 and 2005, respectively. The current use of cannabis is more prevalent among men and women in the young age groups, and then decreases by increasing age (table 2.1.1 of the annex).

Table 2.1.2. The percentage of the 16-44-year olds who have used cannabis the last month, the last year and ever in 1994, 2000, 2005, 2008 and in 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, 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 an increase is seen from 2005-2010 in the proportion of 16-44-year-olds having tried cannabis ever, the results are also an indication of stabilized development, given that “current use” is considered to be the most reliable measure of 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 last year).

Table 2.1.3. Percentage of the 16-44-year-olds who have used one or several illicit drugs other than cannabis last month, last year and ever as recorded 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 National Board of Health based on SUSY 1994, SUSY 2000, SUSY 2005, AiD 2008 and SUSY 2010

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 2.1.4. The percentage of the 16-34-year olds who have used cannabis last month, the last year and ever in 1994, 2000, 2005, 2008 and in 2010

	1994 (n=1,639)	2000 (n=4,098)	2005 (n=2,502)	2008 (n=1,718)	2010 (n=3,323)
Cannabis used					
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 National Board of Health based on SUSY 1994, SUSY 2000, SUSY 2005, AiD 2008 and SUSY 2010.

Table 2.1.5. Percentage of the 16-34-year-olds who have used one or several illicit drugs other than cannabis last month, last year and ever as recorded in 1994, 2000, 2005, 2008 and 2010

	1994 (n=1,648)	2000 (n=4,019)	2005 (n=2,470)	2008 (n=1,710)	2010 (n=3,287)
Used one or several of the illicit drugs other than cannabis					
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 National Board of Health based on SUSY 1994, SUSY 2000, SUSY 2005, AiD 2008 and SUSY 2010

As table 2.1.4 indicates, half of the young adults (45 %) aged under 35 years in 2010 have tried cannabis ever, and 14 % are current users – ie reporting having used cannabis within the past year. 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. This is a small, but significant drop in the current use of drugs other than cannabis among the 16-34-year-olds from 2008 to 2010.

The current use of drugs is higher among the 16-24-year-olds than among the 25-34-year-olds. This means that the use of illicit drugs is most prevalent among the young under 25 years. However, this age group also accounts for the highest decline in the use of illicit drugs from 2008 to 2010. In 2010, 19% of the young people under the age of 25 years report having a current use of cannabis (reporting having used cannabis within the past year), which is more or less the same percentage as in 2008. However, 4% of the young people under the age of 25 years report in 2010 that they have a current use of illicit drugs other than cannabis, which is almost a 50% decline and significantly fewer than in 2008 when 8% had a current use of drugs.

Table 2.1.6. Percentage of 16-24-year-olds who had used cannabis last month, last year and ever in 1994, 2000, 2005, 2008 and in 2010

	1994 (n=735)	2000 (n=1,728)	2005 (n=919)	2008 (n=862)	2010 (n=1,643)
Cannabis used					
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 National Board of Health based on SUSY 1994, SUSY 2000, SUSY 2005 and AiD 2008 and SUSY 2010

Table 2.1.7. Percentage of 16-24-year-olds who have used illicit drugs other than cannabis last month, last year and ever in 1994, 2000, 2005 and 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 (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 National Board of Health based on SUSY 1994, SUSY 2000, SUSY 2005 AiD 2008 and SUSY 2010

When considering the drugs individually, amphetamine, cocaine and ecstasy are the second most prevalent drugs after cannabis. As it appears in table 2.1.8 and 2.1.9 below, the proportion of current use (drug 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 rises somewhat during the period. From 2008 to 2010, however, there appears to be a drop in the current use of all three drugs: amphetamine, cocaine and ecstasy. The drop in the current use of amphetamine is significant for the entire group of those aged 16-34 years, whereas the drop in the use of cocaine and ecstasy is significant among the 16-24-year-olds only. The trend towards a drop in the current use of amphetamine, cocaine and ecstasy during these years is thus particularly prevalent among the young population under 25years⁵. 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 2.1.8. Percentage of the 16-34 year-olds who have a current use of amphetamine, cocaine and ecstasy in 2000 2005, 2008 and 2010

	2000 (n=3,980)			2005 (n=2,456)			AiD 2008 (n=1,709)			SUSY 2010 (n=3,260)		
	men	women	total	men	women	total	men	women	total	men	women	total
16-34years												
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 National Board of Health based on SUSY 2000, SUSY 2005, AiD 2008 and SUSY 2010

⁵ The current use of the various illicit drugs, apart from amphetamine, cocaine and ecstasy among the 16-24-year-olds appears in table 2.1.10 of the annex.

Table 2.1.9. Percentage of the 16-24 year-olds who have a current use of amphetamine, cocaine and ecstasy in 2000 2005, 2008 and 2010

	SUSY 2000 (n=1,684)			SUSY 2005 (n=894)			AiD 2008 (n=857)			SUSY 2010 (n=1,612)		
	men	wome n	total	men	wome n	total	men	wome n	total	men	wome n	total
16-34 years												
Ampheta- mine 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 National Board of Health based on SUSY 2000, SUSY 2005, AiD 2008 and SUSY 2010

In summary, there is thus a falling trend in the use of the illicit drugs from 2008 and up until today. The downward trend the past year is particularly seen in the current use of amphetamine, cocaine and ecstasy, and especially among the young generation under 25 years, where the decline is significant.

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 % of 16-24 year-olds who had used cannabis within the past month. Almost 59 % of the users in this group had taken 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 taken, 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 comparisons were made on the prevalence of illicit drugs. The results clearly show that the prevalence of cannabis is the highest in the capital region and less prevalent in other regions. Among the young people under 25 years in the capital region, typically 10-15 percentage points more from this group have tried cannabis ever compared to the young people of the same age group in the other regions. As far as drugs other than cannabis are concerned, prevalence is more geographically even, and the regional differences in prevalence less pronounced. 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 regional areas of North Zealand, Zealand, and in the Copenhagen Region in the sequence mentioned.

2.2 Drug use in the school and youth population

As shown above, the younger age groups are those which account for the most prevalent use of cannabis and other drugs. In this section, reporting on use among the 16-20-year-olds is based on the "MULD"-surveys from 2000 to 2008 that show that the experimental use of illicit drugs in this age group has stabilized during the period.

MULD 2008 (MULD report 2009) is different from the other surveys in that it has applied another data collection strategy. Where the previous MULD surveys use a

mixture of mail questionnaires and internet responses, the MULDD 2008 is purely internet-based. In 2008, the respondents were thus recruited via a large internet panel as opposed to the previous surveys where random CPR-data were used for the samples. As the data collection method in 2008 was changed in relation to previous years, the results of the surveys as illustrated below are not directly comparable.

Table 2.2.1 below shows results from MULDD surveys during those particular years. Throughout the various surveys there is a significant decline in the use of cannabis among young people between 16-20 years from 2000 to 2006. Furthermore, there is a minor, however still significant drop in the use of amphetamine and psilocybin mushrooms from 2004 to 2006. The prevalence of the other drugs appears to have stabilized or slightly declined in use, although this could also be explained by arbitrary fluctuations and non-significant differences during the period 2000 to 2006.

Table 2.2.1. Percentage of 16-20 year-olds who have tried illicit drugs, 2000 -2008

	MULDD 2000 (n=2,046)	MULDD 2001 (n=2,090)	MULDD 2002 (n=2,041)	MULDD 2003 (n=1,768)	MULDD 2004 (n=1,772)	MULDD 2006 (n=1,964)	MULDD 2008* (n=1,539)
Cannabis tried ever	32	33	37	36	36	27	33
Cannabis last month	9	9	8	9	7	6	8
Amphetamine tried ever	8	9	6	7	6	5	4
Ecstasy tried ever	4	4	3	4	4	3	3
Psilocybin mushrooms tried ever	3	5	4	3	3	1	1
Cocaine tried ever	3	4	3	4	4	4	4
LSD tried ever	1	2	1	1	1	1	1
Heroin tried ever	0	0	0	1	0	1	1
Smokeable heroin tried ever	1	1	1	1	1	1	1
"Other drugs" *	1	1	3	2	2	2	2

Source: MULDD- surveys, 2000-2008

* The MULDD-survey in 2008 cannot immediately be compared to previous years, cf section 2.2

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

More than 30% of the young people aged between 16 and 20 years report in 2008 that they have tried smoking cannabis ever, and 8% have tried one or several drugs. Amphetamine and cocaine rank second after cannabis, with the two drugs being used by 4%. Then follows ecstasy that has been tried by 3%.

Among the 16-20-year-olds, there are distinct gender differences in the use of drugs, with the boys by far being more experienced in the use of drugs than the girls. Overall, in 2008, 9% of the boys and 6% of the girls between 16 and 20 years report having tried one or several drugs other than cannabis. As regards cannabis alone, 38% of the boys and 28% of the girls report having tried the drug.

Also the MULDD surveys confirm that there is a distinct correlation between having tried cannabis and having other psychoactive substances.

Starting age

Analyses of the experimental use of illicit drugs confirm that almost everybody experimenting with illicit drugs have started their drug use before the age of 20 (SUSY 2005). The MULD 2008 survey indicates 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.

Prevalence of illicit drugs among the very young (15 - 16-year-olds)

Ongoing surveys have been made on the experimental use of illicit drugs among the very young. The ESPAD surveys that have been conducted in 1995, 1999, 2003, and 2007 show an increase in the experimental use of cannabis and other illicit drugs among the 15-16-year-olds from 1995 to 1999. Then comes a stability in use up until 2007, however with small, but significant increases in the experimental use of cannabis, ecstasy and cocaine from 2003 and onwards.

As shown in table 2.2.2 below, a little less than ¼ of the 15-16-year-olds has tried cannabis ever, and approximately 10% has tried cannabis within the past month. Concurrently with the ESPAD results on the use of cannabis, the results from HBSC (Survey conducted in 2000 on school children) confirm the high level of experimental use of cannabis among the very young Danish school children. As regards ecstasy and amphetamine, these drugs have been tried by 5% of the very young population, whereas cocaine has been tried by 3%. 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 ecstasy has been tried by almost as many girls as boys.

Table 2.2.2. Percentage among the 15-16-year-olds who have tried illicit drugs in 1995, 1999, 2003, and 2007

	ESPAD 1995 (n=2234)	ESPAD 1999 (n=1548)	HBSC 2002 (n=1418)	ESPAD 2003 (n=2519)	ESPAD 2007 (n=881)
Cannabis tried ever	18,0	24,4	23.3	22.6	25.5
Cannabis last month	6.1	8.1	-	7.6	10.6*
Amphetamine tried ever	1.6	4.0	-	4.0	5.0
Cocaine tried ever	0.3	1.1	-	1.8	3.2*
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*
LSD tried ever	0.2	1.0	-	1.1	1.1
Psilocybin mushrooms tried ever	0.5	1.8	-	1.5	1.1
Sniffing tried	6.3	7.5	-	8,3	6.1*

Sources: ESPAD 1995 (1997); ESPAD 1999 (2000); ESPAD 2003 (2004); unpublished figures from ESPAD 2007

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

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

Table 2.2.2 illustrates the developments in experimental use of the various drugs among the 15-16-year-olds from 1995 and up until today. As regards some of the drugs, the percentages appear to rise significantly from 2003 to 2007. The

interpretation of figures, however, must take into account that apart from cannabis, the percentages are low and that variations on a few individuals may lead to large changes in percentages.

Compared to previous years, this year's random sampling was slightly less extensive. The reason is that a higher number of schools than usual did not want to participate. Class participating rates, however, reached last year's level of 90%.

Prevalence of khat among Somalis in Denmark

In 2008, the first Danish study on the prevalence of khat was conducted (Sundhedsstyrelsen [National Board of Health] 2009b). The study investigated the prevalence of khat among Danish-Somalis aged 15-20 years and also provides an outline of the knowledge and attitudes towards the use of khat. The study has 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 indicates 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 are categorized as heavy consumers (chew khat more than twice a week). The difference in gender is thus significant. However, the study also indicates that 65% of the Danish-Somalis in Denmark do *not* chew khat. 51% have *never* chewed khat, whereas 14% have *previously* chewed khat, but do not chew it any more. A very positive aspect of the survey is that the prevalence of khat is minimal among the young Danish-Somalis, and 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 and 24 years.

Not only gender, but also education and marital status have an impact on the use of khat. Far more Danish-Somali khat users are found among those who are not in the educational system as well as among those who are divorced/separated than among those who are not.

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% believe that khat is the cause of health, family and financial problems. As many as 37% of those asked have experienced such problems resulting from khat.

Although the use of khat exists among many Danish-Somalis in Denmark, and is the underlying cause of social and economic problems in many families, it is a positive trend that so many of the new generation of Danish-Somalis distance themselves from the use of the drug. This turnaround might reflect a change in attitude in the Somali environment, which in the long term could lead to better possibilities for integration into working life and to reducing the adverse social and family-related consequences of khat abuse.

3 Prevention

Prevention is one of cornerstones of the Danish drug policy. A fundamental principle of prevention is that each individual is responsible for taking care of him/herself and our closest relatives. Parents have great responsibility for their children and for teaching them about health and social consequences from using intoxicants. This applies to alcohol as well as drugs.

The public sector must undertake to support parent responsibility and the personal responsibility and to reduce the number of drug users through sustainable and persistent intervention. Young people and their parents are the most important target groups of drug prevention. Such intervention must be visible and, apart from including exchange of information, also address the young people's norms and behaviour.

Preventive intervention is carried out under the auspices of the municipalities. The municipality has close contact with its citizens, and on a local scale it is possible to plan universal, selective and indicated prevention in schools and to provide local leisure programmes in collaboration with associations, restaurants, bars and discotheques as well as in particularly vulnerable residential settings. The local drug prevention work is often carried in cross-sectoral collaboration between school, social administration and the police (the so-called SSP collaboration).

In this connection, the National Board of Health's responsibility is to support the municipalities' preventive intervention projects with informative material and knowledge sharing, methodology projects and specific counselling to municipalities and other interested partners. Furthermore, the National Board of Health must review and stipulate overall guidelines.

In 2010, the National Board of Health has published the report: "Mental sundhed blandt voksne danskere". (Mental health among adult Danes). The analyses of the report originate from the so-called Sundheds- og Sygelighedsundersøgelser (SUSY) [Health and Morbidity Surveys] and describe indicators in relation to the mental health of the Danish population. The report concludes that cannabis and other psychoactive substances correlate with poor mental health. The study is part of the overall counselling, review and guidance material which could prove beneficial in connection with preventive interventions within the drugs area

3.1 Universal prevention

Universal prevention includes interventions targeted at the whole or part of the population and does not include risk factors and risk behaviour. Elementary school is the most important intervention area 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 is obliged to teach its pupils about prevention and health in the subject "Health, sex and family".

Teaching about alcohol and drugs may be included in this subject, and it is up to the individual school and teacher to decide if and how intoxicants should be included in classes or at parents' meetings. Thus, there are no fixed guidelines for the form, contents and scope of tutorials on intoxicants. Often, this type of curricula is offered in grade 6. -9. Each teacher plans his/her own curricula. Classes in intoxicants typically deal with alcohol and cannabis which tend to be the most prevalent drugs among the

young people. In a rising number of municipalities, the SSP organisations have prepared local curricula aiming at psychoactive substance and drug use preventive information. The National Board of Health also supports interventions provided in elementary schools, and in 2009, the Board published a report on prevention and health promotion in Danish schools ("Forebyggelse og sundhedsfremme i skolen").

In its guideline "Vejledning for modelkommunerne i Narkoen ud af byen", [Guideline for model municipalities under "Drugs out of Town") (Sundhedsstyrelsen [the National Board of Health] 2005a), the Board formulated a number of research-based principles, according to which schools should plan their drug preventive interventions. Among others, it is recommended that the schools formulate a comprehensive drug and alcohol policy and that they cooperate with the parents on postponing young people's introduction to alcohol and avoiding experimental drug use. Furthermore, it is recommended that the schools teach in accordance with evidence-based principles, including the use of methods actively involving the pupils. One way to address the young people's perception of health is to introduce them to the research-based training material "Tackling". The material is originally American, but the National Board of Health and the publishing house Alinea have developed and tested it in a Danish version.

The National Board of Health's publication on prevention and health promotion in Danish schools "Forebyggelse og sundhedsfremme i skolen" (Sundhedsstyrelsen [the National Board of Health] 2009c), provides a description of other pupil democracy to be used within drug prevention and in other preventive areas. The methods are referred to as "active assessments" and "you decide", and can be used, among others, to focus on improvement of family relations, a very important aspect of drug prevention.

Furthermore, the focus on psychoactive substance prevention has generally increased in relation to youth educational programs during recent years and an increasing number of institutions are working with the implementation of alcohol and drug policies and counselling of the young in the Danish upper secondary schools, business colleges, technical colleges and production schools. The National Board of Health regularly updates and reprints the drug information pamphlet called "Stoffer - hvordan virker de, og hvordan ser de ud" (Drug - their action and appearance), which is an overall informative pamphlet on the most common illicit drugs. The drug facts pamphlet can also be used by staff as a supplement when working with drug and alcohol prevention in youth education programmes and in a local context.

3.2 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 increased. 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. Within party settings, the collaborative partners could be local government and the police as described in the section on national and local media campaigns, festivals and music venues. In numerous municipalities, restaurant owners and people working in the night life environment take part in special courses, and the cooperation among the players involved promotes shared attitudes on limiting the use and sale of drugs.

"Young and healthy" - health promotion initiatives for vulnerable young people

The social reserve grants for young people and their health are allocated to 13 municipal projects, the aim of which, from 2008 to 2011, is to test and develop ways to work with health among young people. Vulnerability in this context refers to young people who are at risk of dropping out of the educational system or becoming unemployed. The aim is to introduce the young to either the educational system or the labour market and keep them there. The projects are meant to gather new knowledge on methods to improve health among these young people – and to re-qualify the staff in daily contact with them. The projects focus on numerous lifestyle factors such as well-being, food, exercise, smoking, alcohol, sex, drugs, and sleep. A majority of the projects focus on intoxicants as one of several risk factors, and the project in Odense municipality has intoxicants as its overall preventive theme. The activities in Odense focus on the concept of intoxicant competence – the ability to deal with intoxicants in an appropriate manner – and comprise talks at the municipality's schools and "gymnasiums" (general upper secondary education), preparation of intoxicant policies and anonymous counselling of young people with drug use problems. The 13 municipal projects are all followed by an external evaluator.

Young people's use of alcohol and drugs

"Unges Misbrug" (Young people's use of alcohol and drugs) is a national knowledge centre providing counselling services to local authorities and their specialist staff involved in working with young people's drug and alcohol problems. The centre was founded in 2008 and makes up one of the 16 initiatives under the Government's Equal Opportunities strategy, the objective of which is to increase efforts for children and youngsters who have gotten off to a wrong start in life. The Centre is part of the Vulnerability Unit under the National Board of Social Services. The aim of the Knowledge Centre is to enable specialist staff to work and deal with the young people's problems from a broad perspective "Unges Misbrug" focuses on finding the young people who have a problematic use of drugs and on interventions targeted at reducing their drug and alcohol problems through large-scale intervention. The Centre is primarily targeted at specialist staff meeting the young people through their daily work. "Unges Misbrug" provides useful information and facts to specialist staff in the form of:

Website with up-to-date knowledge within the field (www.unges-misbrug.dk) in which specialist staff can find updated information on the most recent findings as regards young people with drug and alcohol problems, professional tools and legislation. Counselling services and training programmes to the municipalities. The programmes are dedicated to the focus areas and needs of the individual municipality or institution and add new knowledge to and support in structuring the existing work with a view to strengthening the overall and interdisciplinary work performed for the target group. Annual national conference on young people and their use of alcohol and drugs, gathering specialist staff across professional boundaries. Focus is made on dialogue and knowledge that can be translated into practical use in the daily routine. Counselling function, under which it is possible to phone or mail questions within the relevant area.

U-turn

The City of Copenhagen combines prevention and early detection in the institution "U-turn" under the Centre for Drug and Alcohol Use among Young People. The "U-turn" institution provides services to the under-25-year-olds who smoke cannabis or take drugs. It 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 and to counselling on schools, social centres and institutions. The project currently collects experience from the work with the young people and tremendous efforts are made to disseminate this information. The project's website www.uturn.dk has established an ideas bank for professionals working with prevention and treatment of alcohol and drug use among young people.

Texting advice

In 2005, the texting-based prevention initiative titled SMASH (SMS + HASH) was launched in a regional collaboration between the former West Zealand county and Frederiksberg Municipality. SMASH has been developed 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. SMASH addresses the 15-20-year-olds and is primarily based on the free subscription of a number of texting packages. In May 2009, SMASH launched a new website with a new design and contents (www.smash.dk). Concurrently with the website, the project has 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 website provides information about drugs, withdrawal symptoms, treatment and stories from other users. Young people can seek information about drugs, start discussions and receive anonymous and free counselling via text messaging.

In addition to SMASH, another project - netstof.dk - has existed since 1998. From being a small website, netstof.dk has now developed into a comprehensive and interactive gateway for the young. The target group is the 14-18-year-olds.

Both projects have been evaluated. Evaluations show, among others, that the two gateways and their texting services 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 believe that they have a drug problem.

Today, SMASH.dk and netstof.dk are run by the Alcohol and Drugs Centre in Slagelse with the participation of 27 member municipalities from all over Denmark, paying a small annual subscription fee contributing to the continued existence of the project. The aim is for a much higher number of municipalities to contribute to the young people's continued access to help and information about drugs and alcohol on the internet.

Project responsible alcohol serving

In 2009, the National Board of Health launched a project known as "Ansvarlig udsækning" (Responsible Alcohol Serving). The project is a sub project under the model municipality project "Alkoholforebyggelse i kommunen" (Prevention against alcohol use in the local community). The intention is to strengthen the local alcohol preventive intervention through development and implementation of drug and alcohol policies in 20 model municipalities. The project work in the model municipalities is financially backed through grants for the implementation of the various policies. Also, the National Board of Health wishes to encourage the municipalities to have a special focus on areas where there is evidence of effect, and where efforts prove to be cost efficient. This applies to the sub project "responsible alcohol serving" which was launched in 9 out of 20 participating municipalities. The sub project has the following goal:

- to encourage responsible alcohol serving in bars and occasional licenses

- to reduce violence and injuries caused by alcohol
- to create a safe nightlife, including a sound environment for the young people to move in.

The concept of "Ansvarlig udskænkning" is based on Danish experience from another project known as "Trygt natteliv" (Safe nightlife) and the model municipality project "Narkoen ud af byen" (Drugs out of town) together with experience from the Swedish STAD project "Ansvarsfuld alkoholservering i kromiljøer" (Responsible alcohol serving in pub environments).⁶ Evaluation of the project concurs with international research that there is a considerable effect from systematic and coherent intervention in relation to responsible alcohol serving. Responsible alcohol serving has also turned out to have a reduced effect on the prevalence of drugs in the night life.

The elements of the project include:

- To administer licensing with a focus on alcohol and drug prevention, including an overall serving strategy
- To establish permanent cooperation with the many people playing a role in the establishment of party environments (local community officials, police, restaurant owners, educational institutions, etc).
- To stipulate collaborative agreements on:
 - Avoiding aggressive marketing and drinks serving inviting to heavy, speedy intake of alcoholic beverages, e.g. "happy hour"
 - Education of waiters and police
 - Joint understanding of control tasks

The project "Ansvarlig udskænkning" (Responsible alcohol serving) will be finalised at the end of 2011 and will be evaluated in its entirety.

3.3 National and local media campaigns

Media campaigns and mass media communication aiming at the entire population or the broad target group are used in the drugs prevention in Denmark. The reason is that when all is said and done, the use of illicit drugs only exists in a fraction of young people, however receives much attention in the media. Therefore, the overall perception is 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 National Board of Health has been cooperating with the trade organisation Festival Danmark 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, yet another trade organisation was added to the list of Danish music halls, the so-called spillesteder.dk, with a similar anti-drug campaign in these musical settings. The party settings have been selected as the central arena, since the experimental 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

⁶ www.fsh.se

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.

Festival danmark Against Drugs

In 2010, the National Board of Health's cooperation with Festival danmark on a drug prevention campaign ("Against Drugs") was introduced at 15 festivals (www.festivaldanmark.dk). The primary target group of this collaboration is the young festival participants and in particular the 16-24-year-olds. The festivals have seen positive results from using the material which consists of printed and electronic elements. The festivals also have statements in their programmes and in their festival hand-outs. All elements contribute to signalling a joint attitude towards drugs.

At the Roskilde Festival, which is by far the largest of the festivals, the campaign is evaluated by means of surveys among the audience. In 2009, evaluations indicated that 83% had seen the campaign, whereas 28% had discussed the messages with their friends, and 91% of the audience were positive towards the festival taking a firm stance against drugs (Sundhedsstyrelsen [National Board of Health] 2009). In 2009, the evaluation of the campaign was expanded by a number of surveys among the audience at a number of the festivals (Samsø, Bork Harbour and Vig) in addition to the Roskilde Festival. (Sundhedsstyrelsen [National Board of Health] 2009a).

The three festivals address the various target groups and can therefore give a more diverse picture of the reception of the campaign in Denmark. The campaign material varied a bit at the three festivals, but slightly more than half of the participants had noticed the campaign, whereas less than 1/3 had discussed the messages at the three festivals. However, almost everybody thought it was a good idea for Festival danmark to demonstrate its attitude towards drugs. The evaluation of the 2010 campaign is expected to be completed in November 2010. Once again, the evaluation will be based on a representative selection of the festivals involved.

Festival danmark Young People and Alcohol

In 2009, 13 festivals participated in the National Board of Health's and Festival danmark's campaign targeted at young people and alcohol ("Unge og alkohol") with the slogan "Less Alcohol - More Party". The purpose of the campaign is to encourage compliance with age limits in relation to serving alcohol to young people. The primary target group of the campaign is therefore the young people's parents and employees at the festivals, but the campaign also addresses young people under the age of 16. The campaign material is available at the tent sites and in the bar areas and primarily includes printed media and web material. The evaluation for the 2009 festivals, which included those held at Samsø, Bork Havn, Vig Festival and Roskilde Festival, showed a good response to the overall message and the campaign material handed out to the young people, their parents and staff. The variation in response and results from the various festivals was high (between 29 and 82%) due to the varying exposure. Between 11-29% had discussed to message, and between 87-96% thought that the campaign was a good idea. Among the staff/parents at the Samsø and Vig festivals, the campaign gained ground (77-84%), and in general, the campaign received much acclaim. Also, there appears to be good knowledge of the rules of serving alcohol at the festival site. However, the percentages decrease when it comes to the rules on serving alcohol at the camping site. At the Roskilde Festival, only 1/3 of the total staff group had observed the alcohol campaign, but all the employees were in favour of it. In 2010, 15 festivals have contributed in a new version of the Young People and Alcohol Campaign, and an evaluation is expected to be finalised in November 2010.

Music against drugs

As a follow-up to the Festival danmark's "Against Drugs" campaign, the National Board of Health also entered into cooperation with the music venues in Denmark in 2009 on a similar campaign against drugs. 45 music venues registered for the campaign "Music against Drugs" which became effective during the autumn of 2009. The campaign addressed young people as well as employees at the venue. The primary target group included young people aged between 16 and 25 years, and the staff involved in the campaign included all personnel at the music venues. The campaign included printed as well as electronic media such as large screen spots before the concerts, websites, web banners, T-shirts, posters, go cards, cell phone ring tones, etc. Evaluation of the campaign has been limited. It shows good support among the target group as well as the staff, with this group having a positive attitude towards fighting the prevalence of drugs. These results concur with the evaluation of the festival campaigns. "Music against Drugs" will run again in 2010 at approximately 50 music venues in a new version.

4 Problem drug use

The most recent estimate on drug users in Denmark dates back to figures from 2009 (completed 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 in accordance with the guidelines set out by the European Monitoring Centre for Drugs and Drug use. The calculations thus adhere to European standards for such estimates. As mentioned in chapter 5, the National Board of Health has changed its requirements for reporting drug users admitted to treatment. This has meant that data from recent years have not been adequate, for which reason a new estimate was made in 2010 based on data from 2009. The admission register for treatment is a key source to calculating the number of drug users in Denmark.

For the first time in 2009, an estimate was made on the number of intravenous drug users in Denmark. The number of intravenous drug users in Denmark is estimated to be 13,000 with half of them living east of the Great Belt and the rest of them west of the Great Belt.

Apart from these estimates on the number of drug users and intravenous drug users, no estimates have been made on the number of drug users more specifically and in special groups in the population.

4.1 Estimated number of drug users in Denmark

The most recent estimate on the number of drug users in Denmark dates back to 2009 (Sundhedsstyrelsen [the National Board of Health] 2010). There is a great deal of uncertainty involved in estimating the number of drug users. The estimate is dependent, in one respect, on the definition of a drug user, and in another, on which methods and data material the estimate is based.

As in previous years, the estimate made in 2010 was made on the basis of the capture-recapture model⁷. The estimate is carried out based on the National Patient Register (LPR) and the national register of drug users who are receiving or have received treatment (SIB). The approach has been to investigate the total number of persons registered in the LPR with a drug-related diagnosis.⁸ An analysis is then carried out of how many of these people are also listed in the SIB.

The estimated number of drug users from 1996 to 2009 appears in table 4.1.1. Since calculations of the estimates throughout the years are based on "live" registers, the estimate for 2010 also included an adjustment of the estimates from previous years.

⁷ 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.

⁸ 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. Actual drug addicts are therefore included in the estimate, as well as stabilised drug addicts (e.g. those being treated with methadone). Users of cannabis and users of stimulants, opioids, etc. are included in the estimate.

Table 4.1.1. 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 National Board of Health 2010

In spite of the statistic uncertainty of the estimates, there is an increasing tendency in the estimated number of drug users from 2001 to 2009. This statistic uncertainty of the estimates for all the years has been calculated as a 95% confidence interval. In 2009, this means that the estimated number of drug users is 333,000 +/- 1,900 persons. In 2009, the number of drug users is estimated to be 33,000, of which 10,900 alone are considered to be cannabis users. As regards cannabis users, the number has increased throughout the period, as the estimated number of cannabis users was 7,900 in 2005.

In recent years, the "population" of drug users receiving treatment, which is one of figures used for calculating the estimate, has changed (the treatment population is described in the next section). There seems to be an actual, proportional 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 central stimulants. This shift is particularly apparent among the "new" recipients of drug addiction treatment. This shift must presumably also have an influence on the drug using population in that more people nowadays are addicted to cannabis and stimulants than before, while fewer are addicted to opioids/heroin.

4.2 Alcohol and drug use among the homeless

In 2009, a special "homeless count" was made showing that 70% of the homeless drug included in the count use drugs within at least one of the following four categories: Alcohol, cannabis/khat, narcotics or medicine. The prevalence is highest among rough sleepers and persons sleeping in night shelters. As much as 80% and 82%, respectively, have some type of abuse pattern. The percentage of drug users among those who sleep over at family's and friends' is 71% and thus equally as high as those sleeping in shelters, where the rate is 70%. This shows that those who stay the nights with family's and friends' have the exact same social and/or mental problems as the other groups.

4.3 Scope of intravenous drug use

During the period 2004-2008, the 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 (cf chapter 6), also by means of autopsies, it was examined whether or not the deceased suffered from hepatitis as a sign of intravenous drug use (Christensen et al 2006). Based on the this, the National Board of Health started to estimate the number of intravenous drug users by comparing DEADHEP with the

National Board of Health'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 with four sources of intravenous drug users: Newly admitted persons 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, and the remaining half in the rest of the country. Between half and 2/3 are unknown to the treatment system.

As shown previously in this chapter, the National Board of Health's overall estimate of the number of drug users is 33,000, of which 11,000 are cannabis users. As it is estimated that there are 13,000 intravenous drug users in Denmark, this means that 2/3 of the drug users (in which the cannabis users are not included) are addictive to intravenous drug use.

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 intravenous drug users 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 individuals recorded when using the capture-recapture method.

5 Drug-related treatment; treatment demand and treatment availability

Today, the municipalities are responsible for the referral to all kinds of drug-related treatment, ie to outpatient treatment, day care treatment or inpatient treatment. By far the majority of all drug-related treatment is targeted at drug use associated with social problems. Each municipality must ensure the requisite coherence between medical treatment and social treatment as well as any other social support.

Most drug users receive outpatient treatment. They are also offered day care treatment or inpatient treatment if more intensive care is required. When a drug user is given medical treatment, he/she will also be entitled to social treatment as required. However, the individual must always be presented to a treatment plan prior to initiation of treatment.

The number of drug users in treatment has increased steadily since in 1996 the 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, the number of drug users admitted to treatment declines, which primarily can be explained by changes in recording procedures and the transition to the new SEI recording system which changed admission and discharge procedures. In addition, recording procedures during these "transitional years" were influenced by the municipalities taking over previous county responsibilities at the turn of 2006/2007. From 2008 to 2009, the number of drug users admitted to treatment increases.

At present, there are 13,700 drug users registered in the National Board of Health's records on drug users receiving treatment. More than 7,750 of these drug users receive substitution treatment – either with methadone or buprenorphine.

Today, data on drug use are collated in various registers. The National Board of Health collects data for one register (the SIB). The National Board of Social Services obtains information for two registers (VBGS and DanRIS-ambulant), and the Centre of Alcohol and Drug Research collects data for one register (Dan-RIS-døgn). In order to simplify reporting for the municipalities and to avoid overlap of data, ongoing efforts are being made to consolidate all these data in one place under the auspices of the National Board of Social Services. The purpose of the consolidation is to simplify and untangle red tape procedures. This consolidation is expected to yield great advantages to the citizen, treatment facility, municipality, state and research.

5.1 The treatment system – strategy, politics and organisation

The Social Services Administration is responsible for referral to the medical and social treatment of drug use, 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 must be initiated through a referral which forms the basis of a service, including an individually planned treatment course in day, outpatient or inpatient treatment. In Denmark, drug users at the age of 18 years and

above, and in some cases under the age of 18, are guaranteed social treatment. This guarantee implies that the municipality is obliged to initiate a social treatment programme for the drug user within 14 days after he/she has contacted the local authorities with a request for treatment. The 14-day time limit is calculated from the first personal contact requesting for treatment. Drug users 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.

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 provide the aim of the process on a short term as well as a long term basis, and the agreements made in relation to it. Drug use treatment addresses the drug user's overall life situation. This means including the abuser's health and social focus and problems, if any, related to housing, crime, work and network.

Social treatment for drug use rests on a decision of an individually laid out plan, according to which the drug user is referred to a specific treatment programme on the basis of medical assessment. It is a prerequisite that the drug user's own wishes for treatment are attached great significance.

The Social Services Administration is under an obligation to provide free medical treatment with addictive substances for drug users (substitution treatment). This obligation is set out in Section 142, subsection 1 of the Danish Health Care Act. The 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 use primarily comprises examination and treatment of the drug use/dependence. 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.

Following the social reserve grants agreement for 2004, an amount was allocated to the establishment of higher quality in methadone treatment, which resulted in the National Board of Health's Guidance no. 42 of 1 July 2008 on the medical treatment of drug users in substitution agreement. The guideline is described in Chapter 17 in this report.

The medical treatment of drug use has been characterised by much variation, one of the reasons being the different backgrounds of the doctors and the different organisational structures involved. The guidance now incorporates overall guidelines for the substitution treatment and a description of the medical core services related to

substitution treatment. The purpose of the guidance is to support and strengthen comprehensive medical intervention using overall guidelines. Another purpose of the guidance is to contribute to reducing morbidity and mortality among drug users by ensuring harmonised and acceptable quality in medical treatment. In 2010, the guidance will be followed up by a quality assurance tool, in which the municipalities must record and report on medical core services to the National Board of Health. For further information, please see Chapter 7.

5.2 Drug users admitted to treatment

As of 1996, The National Board of Health has recorded all drug users admitted to treatment. Based on information collected from the "Register of drug users in treatment" it is possible to obtain a description of those persons seeking help for their drug use. The register includes a record of scope of treatment, ie outpatient or inpatient treatment as well as type of treatment (methadone, total abstinence etc) provided to the client.

Table 5.2.1 provides a few selected characteristics of the clients who were admitted in 2009.

Table 5.2.1. Clients admitted to drug use treatment with admission date in 2009	
Number of clients admitted to treatment in 2009	5,296
Number not treated previously (%)	35
Share of men/women (%)	78/22
Average age men/women (%)	31/31
Opioids as primary drug (%)*	35
Cannabis as primary drug (%)*	45
Central stimulants as primary drug (%)*	14
Injection, previously treated heroin users (%)	34
Injection, non-previously treated heroin users (%)	18
On payroll (%)	14
Daily cash benefits (%)	3
Cash benefits (%)	48
Early retirement pension (%)	13
Other income and uninformed income (%)	22
Own dwelling (%)	59
Single men/women (%)	77/67
Number of children living at home, under the age of 18 yrs	1,474
Number of children not at home, under the age of 18 yrs	562
Foreign citizenship (%)	6

Source: The National Board of Health's register of drug users in treatment

*Rate of those who report a primary drug

In 2009, a total of 5,296 persons were admitted to treatment in Denmark, which is higher than in 2008, but still lower than in 2006 when 5,426 persons were admitted to treatment. The total number of drug users admitted to treatment in 2009 was approximately 13,700. The number of drug users thus equals the level of 2006, when 13,441 persons were admitted to treatment.

The number persons who have not previously been admitted to treatment was more or less the same, ie 35% in 2009 compared to 32% in 2008, but still significantly higher

than in 2006. Separate figures and description of the “new” treatment will be provided later in this chapter.

Type of drug use

For the first time since the treatment register was established in 1996, it appears in 2009 that heroin and other opioids no longer were the most frequently prevailing drugs among the clients admitted to treatment during a treatment year. The new drug today is cannabis, which is most frequently reported as the primary drug among drug users admitted to treatment. By far the majority of drug users seeking treatment are polydrug users. In 2009, 44% reported having used more than one drug prior to admission. The percentage has dropped compared to last year, where it was 51%.

The stimulants that are the focus of young people's experimental use of drugs appeared to a lower degree as primary substances for users admitted to treatment in 2009. Only 9% report amphetamine, 5% report cocaine and less than 1% report ecstasy⁹ as primary drugs¹⁰. These drugs are thus mainly used as a supplement. Cannabis was the primary drug for 45 % of those admitted to treatment, and is also a very prevalent secondary drug as well. Thus, 21 % of those admitted to treatment in 2009 report using cannabis as their secondary drug. A total of 66% of those admitted to treatment are thus cannabis users.

Age and gender distribution

In 2009, there were 78 % men and 22 % women receiving treatment for drug use. The share of women is thus the same as in previous years. The average age of admission in 2008 was 31 years for men and women and thus almost unchanged compared to last year.

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 clients are on transfer income; only 14 % of the group have a job, which is slightly lower than in 2008. 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 9 % left elementary school before the 9th grade. The low level of education should be viewed in light of the fact that most start taking drugs at a very young age. The housing situation of drug users is also very bad. Only 59% have their own home – as many as 4% are actually homeless. As regards family, a large proportion of both male and female drug users were single, which is unusual for a group consisting primarily of young adults.

A total of 1,474 children lived together with a drug user admitted to treatment in 2009, whereas 562 children under the age of 18 were placed outside home. The number of children living with drug users in treatment - children living at home as well as outside home - has increased in previous years. The cause of the increase could primarily be the integration of client administrative systems. After the local government reform, drug

⁹ Here recorded as MDMA or similar drug.

¹⁰ The percentages have been calculated on the basis of the part of the treatment population who has reported a primary drug.

users receiving treatment have now also become a local issue, as has the client's transfer income and family cases. These newly integrated administrative client procedures have improved registration in terms of children and could most likely also be the explanation of the increase.

Foreign citizens

A minor portion of the drug users receiving treatment are foreign citizens, a total of 6%. The proportion of clients of foreign nationality receiving treatment more or less 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 and distribution of drugs, modes of administration in relation to 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 5.2.2 below provides information about the various types of newcomers.

Table 5.2.2. Clients admitted for treatment during the year and who have not been treated for their drug use earlier						
	2004	2005	2006	2007	2008	2009
Clients not treated earlier	1696 out of 5212	1578 out of 5228	1329 out of 5426	1515 out of 4661	1517 out of 4700	1827 out of 5296
	(33 %)	(30 %)	(24 %)	(33 %)	(32 %)	(34 %)
M/W (%)	77/23	75/25	76/22	78/22	74/26	76/24
Average age M/W	27/28	27/28	27/27	28/28	28/27	28/28
Opioids as primary drug (%)*	24	19	15	17	15	12
Cannabis as primary drug (%)*	47	46	50	52	56	65
Stimulants as primary drug (%)*	23	20	27	26	25	19
Injecting heroin abusers (%)	21	19	18	23*	22	18

Source: The National Board of Health's register on drug users admitted for treatment in 2001-2006

*Percentage of those reporting primary drug.

**An increase is seen from 2006 to 2007 in the share of newcoming intravenous drug users seeking treatment. This happens simultaneously with a drop in the category "uninformed risk behaviour" from 11% to 4%. This could be an indication of improved registration after the introduction of a new register procedure.

As it appears from table 5.2.2, 34 % of the admitted clients in 2009 had not been treated earlier. Not surprisingly, the average age was significantly 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

There is a significantly larger proportion of new recipients of treatment reporting cannabis as their primary drug compared to those who have been admitted for treatment before. Those reporting cannabis as their primary drug among the newcomers account for 65% in 2009, which is an increase compared to previous years. Among the 1,827 newcomers with a reported primary drug, only 12% have opioids as their primary drug, and 19% report having taken a stimulant (in this case amphetamine, cocaine or ecstasy), which is lower than compared to 2008, but a higher rate than among the treatment population as a whole.

As regards mode of heroin intake among the two "client groups", there is a difference, as 18% of those who have not been treated previously report having injected the drug, whereas 34% of those previously treated have injected heroin. The difference in mode of intake between the two client groups could be explained by a "shorter drug use career), and that new opioid drug users to a large extent smoke heroin.

Young people receiving drug treatment

Young drug users are making up 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 National Board of Health in autumn 2005, based on an extract from the National Board of Health's register of drug users receiving treatment (Sundhedsstyrelsen [National Board of Health] 2005).

From 2003 to 2006 the number of young people admitted to treatment increases by 5.4% from 4,466 to 4,706. From 2006 to 2007 this number dropped, which could be explained by the changed reporting procedures. In 2009, 4,613 of the clients receiving treatment are aged between 18 and 29 years, which is the same level as in 2006. When comparing the youth population in drug use treatment and the total number of Danish youngsters in the same age group, a figure of 4,613 means that 6.6 out of every 1,000 young people aged between 18 and 29 years were receiving treatment in 2009, which is more or less the same compared to previous years.

Table 5.2.3. Distribution of primary substance for clients admitted in 2003 and 2007 with a known primary drug (percentage)

	2003		2009	
	18 – 24-year-olds	All treated	18 – 24-year-olds	All treated
Cannabis	46.0	25.6	70	45.2
Heroin	15.3	30.2	4.5	16.0
Amphetamine	12.7	5.8	11.9	8.5
Cocaine	5.8	4.4	4.9	5.2
Ecstasy	4.0	1.2	0.7	0.3
Other opioids	4.8	20.1	3.4	19.4
Benzodiazepines	1.7	2.1	2.0	2.3
LSD	0.0	0.0	0.2	0
Other	9.8	10.5	2.5	2.8

Source: The National Board of Health's register of drug users in treatment

As it appears from table 5.2.3, what is characteristic of the youth population is that, to an increasing extent, cannabis and other stimulants are the main problems of their addiction. In 2003 and 2009, the number of young people seeking treatment for cannabis use exceeded those seeking treatment for heroin use. The overall number of young people under 30 seeking treatment for their heroin use dropped throughout the survey period from 746 persons in 1997, 493 in 2003 to 176 persons in 2009.

Drug users in substitution treatment

Previously, the National Board of Health 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 [The National Board of Health] 2008b).

From 2008, the records on the number of drug users in substitution treatment are based on data reported to the National Board of Health's register on drug users in treatment (SIB). As the recording method¹¹ and the data basis¹² are different from 2008 and up until today compared to the years before 2004, the results in the different periods are not directly comparable.

The data from the National Board of Health's register on drug users admitted to treatment show that among all the individuals receiving treatment for drug use, 7,275 people were in substitution treatment in 2009, which is the same level as in 2008. When including data from the Danish Prison and Probation Service, the total number of persons receiving substitution treatment with either methadone or buprenorphine amounts to approximately, 7,750 in 2009.

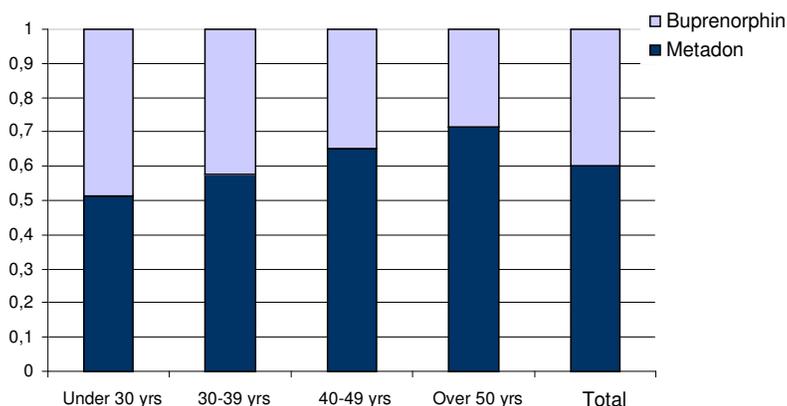
Buprenorphine and methadone are the substances applied in substitution treatment. The National Board of Health's guidance on the prescription of addictive medicines from 2008 sets out very clearly that buprenorphine should be used as a first-line preparation for opioid dependent drug users which had 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 receiving substitution treatment with buprenorphine has gone up. In 2009, approximately 1,200 persons received substitution treatment with buprenorphine compared to 950 persons in 2008. Numerous young people under the age of 30 are in substitution treatment with buprenorphine compared to persons in the older age groups. This indicates that the number of persons treated with buprenorphine decreases by age, cf figure 5.2.1.

¹¹ In previous statistical records, long-term substitution treatment was defined as receiving substitution treatment for 5 months. In the current records, the number persons receiving substitution treatment are defined on the basis of the definitions set out by the EMCDDA, ie recording persons in the year in question. For now, our records will include the most recently treatment program initiated for persons admitted to treatment in 2009.

¹² Former statistical recordings were based on figures provided by the prescription registry, whereas this material is based on the registry on drug users receiving treatment (SIB).

Figure 5.2.1. Proportion of persons in substitution treatment with buprenorphine and methadone, respectively, in 2009 in different age groups.



Among clients admitted to treatment for the first time in 2009, 40% and 60% receive substitution treatment with buprenorphine and methadone, respectively. This is an increase compared to 2008 when 31% and 69% received substitution treatment with buprenorphine and methadone, respectively. In other words, the share of drug users seeking treatment for the first time are offered substitution treatment with buprenorphine at the expense of methadone which is a positive trend and consistent with the National Board of Health's recommendations that buprenorphine to the widest extent possible must be used as first-line medication to opioid-dependent drug users.

90% of the newly admitted drug users in 2009 compared to 73% in 2007 are now in drug-free treatment.

5.3 Drug users and inpatient treatment

Special data on inpatient treatment are collected from the monitoring system DanRIS-Døgn, which has been developed since 2000. All inpatient institutions treating drug users are under an obligation to submit data to DanRIS. The number of inpatient institutions registered with DanRIS was 46 in 2009. Out of this number, 38 were dedicated inpatient institutions.

The table below shows the development in admissions every six months from 2004-2009.

Table 5.3.1. Drug users admitted to inpatient treatment during the half years of 2004-2009¹³

Time	N	Age	Women
1st half year 2004	731	32,7	27 %
2nd half year 2004	690	32.4	23 %
1st half year 2005	713	32.8	27 %
2nd half year 2005	531	32.7	24 %
1st half year 2006	623	33.1	26 %
2nd half year 2006	473	33.1	26 %
1st half year 2007	650	33.3	25 %
2nd half year 2007	578	33.0	25 %
1st half year 2008	726	34.0	27 %
2nd half year 2008	693	33.6	23 %
1st half year 2009	682	33.0	25 %
2nd half year 2009	577	33.1	22 %
All	7667	33,1	25 %

Source: Centre for Alcohol and Drug Research, Danish Registration and Information system, DanRIS. STOF 2009

As it appears in table 5.3.1, there is a drop in the number of individuals admitted in 2009 compared to 2008, whereas the number of admissions for inpatient treatment in 2009 equal that of 2007. The average age for drug users receiving inpatient treatment is the same throughout the years, and in 2009, it was 33 years. The proportion of women also appears to be stable across the period.

Compared to 2008, there are a few changes as regards the clients' use of drugs in the months prior to admission. In 2009, there is a significant reduction in the use of heroin, methadone and tranquillizers/sleeping tablets. Furthermore, the number of days with injections as the mode of intake has dropped significantly. The use of other opiates, stimulants, cannabis and heavy alcohol consumption prior to admission is, however, unchanged from 2008 to 2009¹⁴.

Table 5.3.2. Percentage of users of opioids and stimulants during the months prior to admission to inpatient treatment from 2001-2009

	2001 n=63 6	2002 N=740	2003 N=102 6	2004 N=132 5	2005 N=113 6	2006 N=996	2007 N=802	2008 N=970	2009 N=936
Opioids	76	75	71	67	70	64	65	61	58
Stimulants	47	49	48	52	50	50	51	50	51

Source: Centre for Alcohol and Drug Research, Danish Registration and Information system, DanRIS. STOF 2009

Note: "N" in all the years only indicates the clients who have answered all the questions listed in the European Addiction Severity Index.

¹³ One person can be admitted several times during a year, but at least 30 days must pass from discharge until a new admission can take place. The 1259 admissions recorded in 2009 have been applied by a total of 1163 persons.

¹⁴ At least 5 drinks daily for at least 4 days a week in the month leading up to admission.

Table 5.3.2 shows the development in the use of opioids and stimulants prior to admission to inpatient treatment from 2001 to 2009. The table also shows a drop in the percentage of drug users admitted to treatment in inpatient treatment, and with opioid use prior to admission. As regards the number of stimulant drug users prior to admission, the percentages are more or less the same throughout the period.

Completion and burden rate

The percentage of clients completing inpatient treatment as planned has gone up from 41 % in 2004 to 50% in 2007 and ended on 52 % in 2009. Furthermore, there was a minor increase in the number of inpatient treatment days from 114 days in 2004 to 139 days in 2008. From 2008 to 2009, there appears to be a minor fall from 139 to 133 days on average per treatment course, which, however, still is more than during the years prior to 2008.

In 2008 and 2009, the inpatient institutions had completed a EuropASI-form of 68% and 74%, respectively, on the clients admitted during the year. The ASI interview form shows, among others, the social burden, including residential status, employment/support status as well as psychiatric status.

Compared to 2008, the clients tend to have higher severity ratings as regards their residential and employment statuses. 44% of the clients have their own dwelling in 2008, however this percentage had dropped to 41% in 2009. Furthermore, the number of the admitted individuals with no current residence fell from 9% in 2008 to 7% in 2009. As regards source of income, the number of clients receiving salary the last 30 days prior to admission fell from 9% in 2008 to 6% in 2009, and the number of clients receiving daily cash benefits increased from 37% to 42% during the same period. The good thing is that the number of clients reporting to make an income from illegal activities dropped from 6% in 2008 to 3% in 2009.

There is only a minor change in the clients' psychiatric status on admission to inpatient treatment from an ASI interview score of 0.48 in 2008 to 0.46 in 2009.

The 1259 admissions in 2009 were recorded in 88 out of 98 Danish municipalities.

5.4 Other interventions concerning drug use treatment

From 2007 to 2010, the Government sought gradually to boost quality within treatment of drug users in order to ensure that the drug users receive proper case handling and qualified treatment. This quality boosting process comprised a number of initiatives that have resulted in a requalification of professional staff dealing with drug users. In April, the book "Stofmisbrug i et socialfagligt perspektiv" (Drug Use viewed from a social perspective) was published and distributed to drug use therapists, referral personnel, case handlers and others who are professionally engaged in drug use. The book provides an overall description of drug use and conveys knowledge, encourages reflection and gives inspiration to the daily work with drug users. Furthermore, a pamphlet on good case handling within drug use has been published to professional persons working within the area. Finally, a drug use conference was held in the spring of 2010 for 400 drug use professionals, the topic of the conference being social interventions for drug users.

Young people's drug use - Knowledge centre for professionals

The purpose of the Knowledge Centre is to prepare professionals for working with young people under the age of 18 who have drug and alcohol problems. Via a website

and conferences, teachers, SSP-staff, youth counsellors and other professionals can download information about the type of problems facing young people with drug and alcohol problems as well as information about legislation and tools worth applying when working with young people. The Centre also offers special courses in some municipalities, the focus of which is to optimise interdisciplinary routines. The aim is for professionals to be better to check out young people with either a drug or an alcohol problem and to either launch or support intervention measures. This national knowledge centre is an initiative under the Government's strategy Lige Muligheder (Equal Opportunities) from 2007 (see also section 3.2).

Cannabis and cocaine project

In order to meet the need for developing treatment methods offered to new groups of drug users, financial support in the amount of approximately DKK 9 mill (EUR 1.2 million) was granted in 2006 from the social reserve funds over a three year period to a Copenhagen City project known as the Cannabis and Cocaine Project. The project was launched in 2007.

After the completion of the three year project period, the cannabis and cocaine project has now been implemented as a permanent treatment project offered to new groups of drug users in the City of Copenhagen. A group therapy concept has been developed, the principle of which is motivating talks and cognitive and solution focused methods. During the project period, it was possible to participate in groups in the evening for those who either work or study, or in day teams where the participants are somewhat more socially vulnerable. The method has been described in a work catalogue.

The project period shows that it was possible to get in contact with the users, which had only had contact with the treatment system on a limited basis, no matter the length of their cannabis and/or cocaine use.

The typical participant in group treatment is a male either on the labour market or in training between 30 and 35 years and a user of cannabis or cocaine. As a cocaine user, he has been taking the drug for 10-12 years, as a cannabis user he has been taking the drugs for 18-20 years before seeking treatment. He may have symptoms of mental disturbances such as depression and concentration problems, but his problems are not sufficiently serious to be characterized as mental deviations. His problems revolve around his drug use. Furthermore, it is also characteristic of these user groups that they have no convictions, nor do they have a criminal record.

What is characteristic of the participants - be it cannabis or cocaine use - is that on the face of it, their drug use habits have no influence on their life in general, however they live under a tremendous pressure. They have been leading an ordinary life - without leading an ordinary life.

During the treatment period of approximately 4 months, 38% of the participants in the evening group and 30% of the participants in the day groups were clean. Furthermore, 15 and 16% of the participants in the two groups, respectively, reduced their drug use. More than half of the participants stayed in the project for more than 3 months, and 53% took part in more than 7 group sessions.

A selection of the participants was interviewed after termination of treatment. During these interviews, they described what they had learned from the project and how they would carry on with their lives. Several of them said they had realized that they should not set their goals too high, not experience too many failures, but accept themselves as

individuals and take one step at a time. Also, a few of the participants said that they had gotten a completely different picture of themselves, gained more self-confidence and allowed themselves to accept their achievements. They had discovered that "they had more guts than they thought". They said that their ability to reflect on things had improved, to "think in a major perspective" and control their cravings for drugs in situations where they would normally resort to drug use.

6 Health correlates and consequences

A number of health-related problems and consequences follow in the wake of drug use. Drug users have very high mortality rates, generally because of poisoning and diseases, including HIV and hepatitis, and drug users who are released from prison have particularly high mortality rates shortly after their release.

The number of drug-related deaths is recorded in two parallel registers: the National Commissioner's Register and the National Board of Health's Cause of Death Register. The latter is used in a European context and is based on a joint European definition.

The number of drug-related deaths has dropped during recent years. From 2008 to 2009, there is, however, a drastic increase in the number of deaths recorded in the National Commissioner's Register. Analyses of these deaths throughout the years show that they fall under the category of poisonings caused by polydrug use. According to the National Board of Health's Cause of Death Register, the number of drug-related deaths has been falling linearly since 2006. Statistics on drug-related deaths thus show an overall falling trend up until 2008. The fact that both registers describe the same trend substantiates the overall observations of a declining tendency.

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 are frequent, 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 indicate that there has been an increase in the number of patient admitted to psychiatric treatment where drug use is a contributory factor of admissions (comorbidity).

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 document that the number of individuals being admitted to emergency wards throughout Denmark as a result of poisoning with illicit drugs has been rising steadily throughout these years. Especially the stimulants are a cause of poisoning among the very young people, whereas opioids, including heroin and methadone, are the cause of poisoning among the slightly older population.

6.1 Drug-related deaths and mortality rates among drug users

The National Commissioner has recorded drug-related deaths since 1970. The register includes deaths involving reporting to the police for the purpose of post-mortem and where information of 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 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 National Board of Health has published a statistical summary on drug-related deaths since 1995. This summary is based on data collected from the National Board of Health's Cause of Death Register and includes the deaths that are drug-related according to the joint EU definition (Selection B).

The differences between the figures in the register of the National Commissioner's Office on drug-related deaths and the National Board of Health'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 National Commissioner's Register only records deaths that have been subject to post-mortem, whereas the National Board of Health's Cause of Death register records the total amount of deaths in Denmark.

When the European Monitoring Centre for Drugs and Drug Addiction (the EMCDDA) annually publishes comparable data on drug-related deaths on a European scale, these data primarily originate from the cause of death register of the individual country (as is the case from Denmark) and are referred to as the "national definition". Therefore, comparisons with other European countries should be based on data from the National Board of Health's Cause of Death Register. In a Danish context, the National Commissioner's Register on drug-related deaths is an important source of describing development over time and contains specific information on poisonings. However, as this register applies a different and a broader definition of drug-related deaths, and as the records only include medico-legal deaths, the data from the National Commissioner's cannot be used in European comparisons.

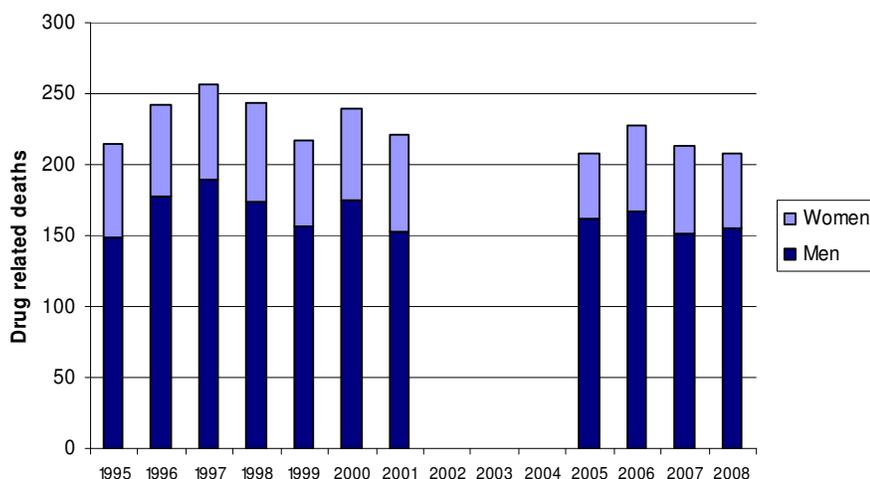
As it appears from the statistics on drug-related deaths, recorded in the National Board of Health's Register as well as the National Commissioner's Register, there is a declining tendency in the number of drug-related deaths up until 2008. The fact that both registers describe the same trend substantiates the overall observations of a declining tendency.

The National Board of Health's register, 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 6.1.1 shows the developments of drug-related deaths recorded in the National Board of Health's Cause of Death register for the period 1995-2008¹⁵.

Figure 6.1.1. Drug-related deaths 1995-2008



Source: The National Board of Health's Cause of Death Register

* Data for the years 2007 and 2008 from the Cause of Death Register are not complete. As the actual number of deaths is known from the CPR register, the data for 2007 and 2008 has been increased by 3 and 4 per cent, respectively, in order to be comparable to previous years.

In 2008, the number of recorded drug-related deaths arrives at 208, which is the same level as the number of drug-related deaths in 2007. When viewing the entire period 1995-2008, the number of deaths ranges from 200-250. The figures are lowest in 2005 with 207 deaths being recorded. In 2008, men accounted for 75 % (155) of all drug-related deaths. During the other years, their share of drug-related deaths among men is between 69% and 74%.

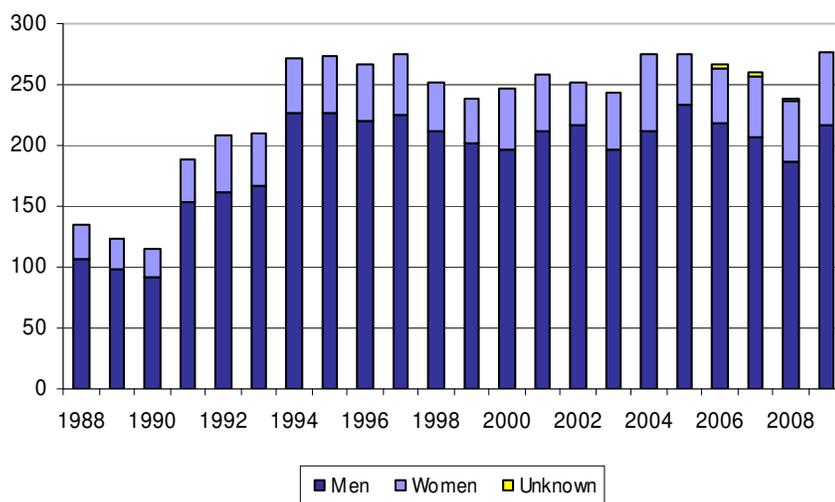
The National Commissioner's Register

From the mid-1990s (figure 6.1.2), the number of deaths recorded in the National Commissioner's Register has been more or less constant, however with annual fluctuations (see table 6.1.1 in the annex). In 2009, 276 drug-related deaths were recorded, which was the highest number during recent years. Out of the 276 deaths, 79% were men (217) and 21% were women (59). The number of drug-related deaths has been falling from 275 in 2005 to 266 in 2006, 260 in 2007 and 239 in 2008. After the declining trend in recent years, the number of drug-related deaths in 2009 has again reached the same level as in 2005.

The average age of death has been increasing for many years, In 1993, the average age of death was 33 years, whereas in 2009, it had gone up to 39.6 years. The average age of death for men in 2009 is 39.2 years and 40.8 years for women. Approximately 20% of all drug-related deaths each year occur among the young people under the age of 30.

¹⁵ Valid figures for drug-related deaths during the years 2002-2004 are not available. Furthermore, the figures for 2009 have not yet been compiled.

Figure 6.1.2. Drug-related deaths, 1988-2009



Source: National Commissioner of Police 2010

Out of the 276 deaths in 2009, 75 % (206) poisonings involved one or several drugs. As table 6.1.3 below shows, 36% of the poisonings (75 out of 206) are caused by heroin/morphine or heroin/morphine in combination with another substance, whereas 47% of the poisonings (96 out of 206) methadone or methadone in combination with another substance. Six of the poisoning cases in 2009 were caused by poisoning with either amphetamine (4) or cocaine (2). Of the 70 drug-related deaths, 276 cases were caused by another type of drug-related death – such as violence, accident other than poisoning, illness or an unknown cause of death.

Table 6.1.3. Poisoning deaths among drug users in the year categorized by the assumed main cause of death. The numbers in parenthesis are percentages

	1991	1997	2003	2004	2005	2006	2007	2008	2009
Heroin/morphine	94 (57)	153(71)	60 (30)	81 (38)	77 (37)	83 (37)	69 (34)	70(36)	75(36)
Methadone	51 (31)	46 (21)	97 (49)	95 (44)	89 (43)	92 (42)	84 (41)	82(42)	96(47)
Other	9 (12)	17 (8)	41 (31)	38 (18)	40 (20)	46 (21)	52 (25)	43(22)	35(17)
Poisonings total	154 (100)	216 (100)	198 (100)	214 (100)	206 (100)	221 (100)	205 (100)	195 (100)	206 (100)

Source: Rigspolitiet [National Commissioner’s Office], 2010

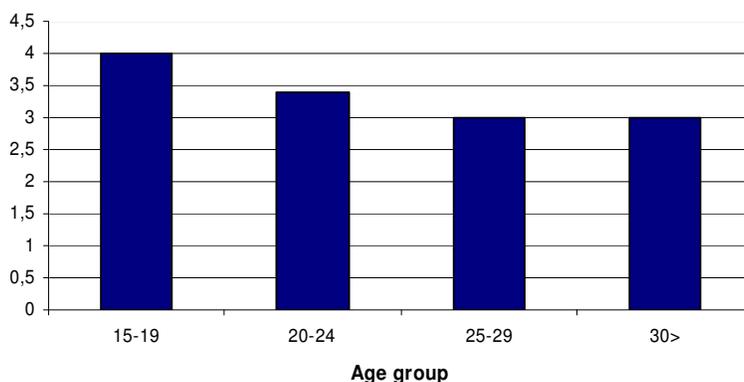
Table 6.1.3 shows the developments in deaths caused by poisoning during the years 1991, 1997 and from 2003 and up to 2009. In general, the poisoning deaths involving opioids (heroin/morphine and methadone) throughout the years account for the majority of the poisoning deaths.

However, from the 1990s there is a drastic change in the pattern of poisonings, as within the group of poisonings caused by opioids from 1997 to 2003, the number of

deaths primarily being caused by heroin/morphine poisoning drop. On the other hand, there is an increase in the number of deaths caused primarily by methadone. Finally, since 1997, there has been a very steep increase in the proportion of deaths with poisoning under the “other” category being stated as the primary cause. The group of “other” contains drugs such as amphetamine, cocaine and other (strong) opioids. However, from the period 2007 to 2009, there is a slight decline in the number and proportion of these types of deaths. In 2009, the category “other” included the following number of deaths caused by poisoning from drugs such as: amphetamine 4, cocaine: 2, ketobemidone: 1, other opioids (strong): 3, antidepressants: 2, other such as GHM and ketamine: 4¹⁶.

It should be mentioned that the drug mentioned in the left column of table 6.1.3 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. Also, other drugs such as benzodiazepines, alcohol found in the blood of the deceased have been recorded. Figure 6.1.3 shows the average number of drugs found in the blood of those who have died from an overdose in different age groups.

**Figure 6.1.3. Drugs found in poisoning deaths
(Average) in 2009**



Source: Rigspolitiet [National Commissioner’s Office], 2010

As it appears from the figure, between 3 and 4 different drugs are found on average in the poisoning deaths, which is evidence of a comprehensive polydrug use among those who die. This also applies to the very young age group.

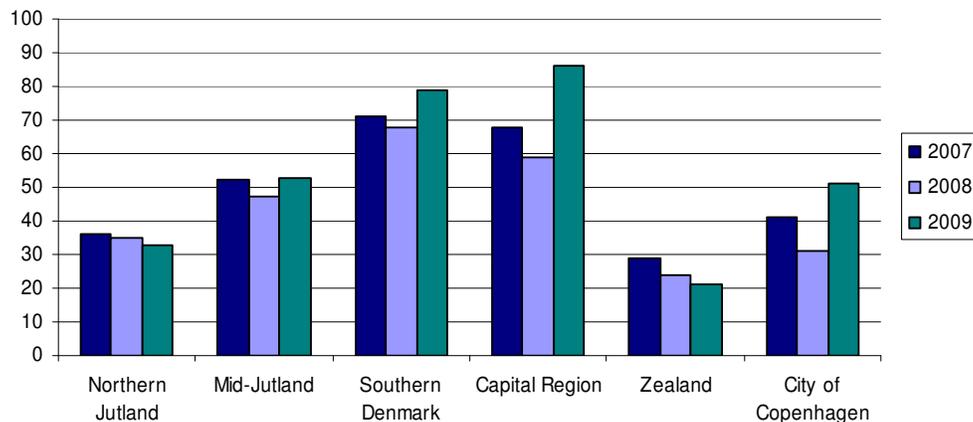
Geographic development

Out of the 276 drug-related deaths in 2009, 135, 110 and 31 were investigated and reported from the forensic departments/institutes in Jutland, Zealand and Funen, respectively. During recent years, there have been more drug-related deaths in Jutland than in Zealand and the lowest number of deaths was recorded in Funen.

Developments in the total number of drug-related deaths in 2007, 2008 and 2009 categorized by regions and the City of Copenhagen appears in figure 6.1.4 below.

¹⁶ Statistics on the group of “other” in previous years appears in the annex.

Figure 6.1.4. Drug related deaths categorized by regions and in the City of Copenhagen (Deaths in the City of Copenhagen are included in the bars of the Capital Region of Copenhagen)



Source: Rigspolitiet [National Commissioner's Office], 2010

As mentioned initially, there has been a drop in the number of drug-related deaths from 2005 to 2008, however with the numbers rising from 2008 to 2009. Figure 6.1.4 shows that the drop in drug-related deaths from 2007 to 2008 (from 260 to 239 deaths) is distributed on all regions and the City of Copenhagen. It also appears that the increase from 2008 to 2009 (from 239 deaths to 276 deaths) is distributed on all regions and the City of Copenhagen, except from the regions of Northern Jutland and Zealand, where the decline continues. The statistics are based on the municipality, in which the drug user was registered at the time of death, and not on the location, in which the death occurred.

6.2 Poisoning caused by illicit drugs

Data from the LPR (the National Patient Register) includes patients with poisoning as the main diagnosis, registered in the somatic or psychiatric casualty departments as well as among patients who have been hospitalized with poisoning symptoms and not first having been in contact with a casualty ward. Table 6.2.1 of the annex shows the scope and development in registered intoxications¹⁷ and poisonings caused by the various illicit drugs from 1999 to 2009. From 2000, coding practice was changed to the effect that it became possible to specify poisonings caused by amphetamine and khat. The fact that far from all poisoning cases are reported means that these statistics provide minimum figures only.

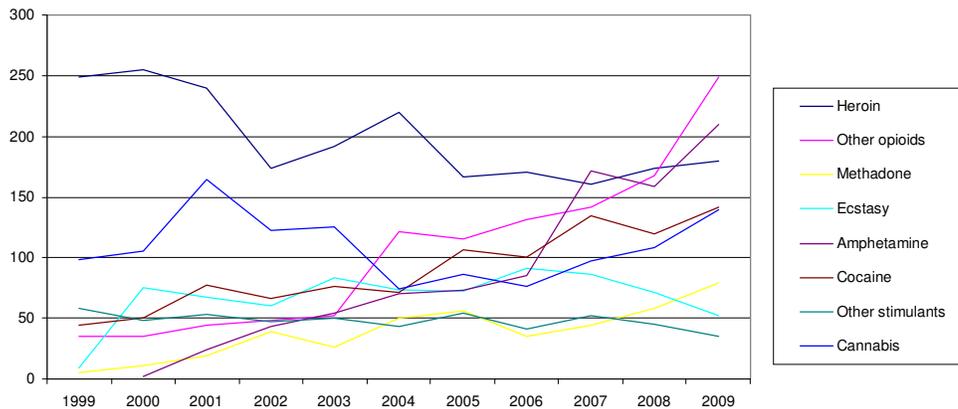
Each year from 1999 to 2009, between 1128 and 1662 people have been registered with poisonings caused by illicit drugs. While from 1999 to 2005 the number of poisonings had stabilized, there appears to be an increasing tendency from 1262

¹⁷ Within psychiatry, the term "acute intoxication" is applied to the diagnosis of mental illnesses and behavioural disturbances caused by psychoactive substances. This term does not clearly distinguish between intoxication and poisoning in the biomedical sense of the word, but with a precision to the fourth decimal place, complications of a varying degree can be indicated for intoxication (uncomplicated, with physical trauma, with other somatic complications, with delirium, with distorted perception and with coma).

poisonings in 2005 to 1662 poisonings in 2009 which equals an increase of 32% during the period. This increase is especially seen as a result of the intake of opioids (heroin, methadone, etc), stimulants (amphetamine, cocaine, etc) and cannabis. 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 15,115 cases of poisoning was recorded during the first 11 study years. A vast majority of these cases, almost 90%, were treated in somatic emergency wards, and the remaining 10% in psychiatric wards. As regards gender distribution, a little more than double as many men (67%) as women (33) have been registered with poisoning during the study years. The figure below shows the developments of poisonings caused by the various drugs and comprises 15,115 poisonings in all 11 years (figures shown in table 6.2.1 of the annex hereto).

Figure 6.2.1 Developments in hospital contacts due to intoxications and poisonings caused by illicit drugs from 1999 - 2009



Source: The National Board of Health's National Patient Register, data from May 2010

Figure 6.2.1 below shows that not surprisingly most of the opioid poisonings primarily occur among persons at the age of 30 and above and very rarely is seen among the very young people. As table 6.2.2 below indicates, most of the cases of poisoning are caused by opioids, not surprisingly, among persons over 30 years of age and are extremely rare among the very young. As it turns out, 70% and 60% of all poisonings with hallucinogens and stimulants are recorded among young people under the age of 24. 2,704 (18 %) of all cases involving poisoning during the study period have occurred among young people under the age of 20 years. Poisonings caused by stimulants are most frequently seen among young people, followed by polydrug use or drugs that cannot be specified.

Table 6.2.2. Visits to hospital after intoxications and poisonings caused by the various illicit drugs in all 11 study years (1999-2009) broken down by different age groups

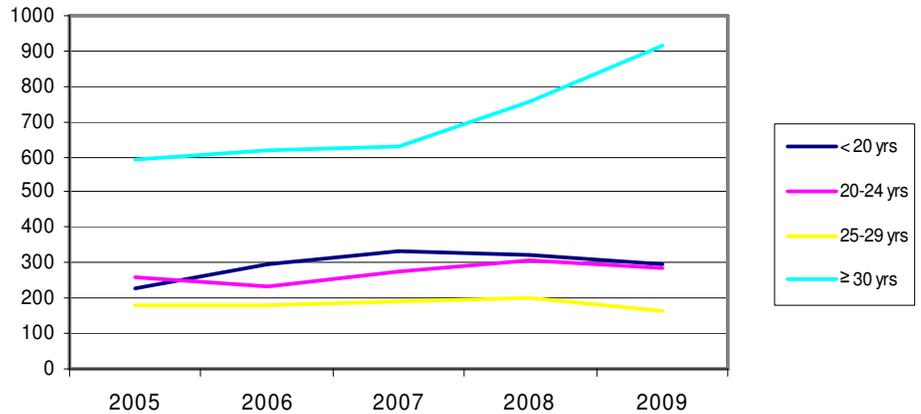
	< 20 years	20-24 years	25-29 years	≥ 30 years
Opioids	198	410	642	3223
Stimulants	1016	985	524	792
Mushrooms and hallucinogens	112	85	35	48
Cannabis	382	328	194	292
Polydrug use and unspecified	996	999	772	3183
Total	2704	2807	2167	7538

Source: The National Board of Health's National Patient Register, data from May 2010

As regards cocaine which falls under the category of stimulants, this drug accounts rather exceptionally for many of the cases of poisoning among the slightly older population, with persons older than 30 years and above accounting for 38% of the cases of poisoning (not shown).

Developments in the number of poisonings throughout the years in the various age groups are shown in table 6.2.3 of the annex and illustrated in figure 6.2.3 below.

Figure 6.2.3. Hospital contacts due to intoxications and poisonings categorized by age groups from 2005-2009



As mentioned earlier in this section, the number of poisonings from 2005 has gone up. This increase over the years is seen in the over 30s age group.

6.3 Drug-related infectious diseases

HIV/AIDS

Action taken in Denmark against HIV is based on the principle of voluntariness, 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 6.3.1 of the annex shows the number of reported newly diagnosed HIV positive subjects and out of this figure, the number of intravenous drug users the past 10 years¹⁸. 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 2009, 6 % (15 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 2009, 10 % of those diagnosed with AIDS were intravenous drug users, which were 3 out of a total of 30 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 6.3.2 in the Annex). During the same period, the proportion of acute cases of hepatitis where the infected person has been an intravenous drug user has been approximately 1% for hepatitis A, varying between 5% and 35% for hepatitis B and from 29% to 85% for hepatitis C. The number of reported cases, however, is so small that these percentages should be considered with some reservation. As hepatitis C is most often asymptomatic in the acute phase, the number of cases of hepatitis C reported is a gross underestimation of the actual incidence of hepatitis C. Consequently, the number of cases of chronic hepatitis C reported is also included in the register.

Studies into the spread of infectious diseases

As part of its qualification, harmonisation and mapping of the prevalence of infectious diseases among drug users in the EU, the National Board of Health supported from 2004-2008 a research project, in which the prevalence of infection diseases among drug users was investigated¹⁹. The investigation also included the prevalence of HIV and hepatitis B and C among the drug-related deaths (approximately 250 annually), which were registered in the National Commissioner's Register.

Analysis results from the 5-year study showed that the prevalence of hepatitis B and C among drug users over recent years is more or less constant and possibly declining and that the prevalence of HIV among drug users remains unchanged and relatively low. Depending on the year of study, approximately half of those tested had antibodies against hepatitis C, whereas approximately 1/4 had antibodies against hepatitis B (anti-

¹⁸ 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. Statens Serum Institut.

¹⁹ The initiative of the study was taken in the *national key indicator group for infectious diseases* and a member of the group, special consultant Dr Peer Brehm Christensen is the project leader for the study. The results of the study for 2004 have been published in the *European Journal of Epidemiology* 2006;21:383-387.

HBc), and 1/4 was protected against hepatitis B (anti-HBs positive). HIV infection in the study population was more or less the same during the period and less than 4%.

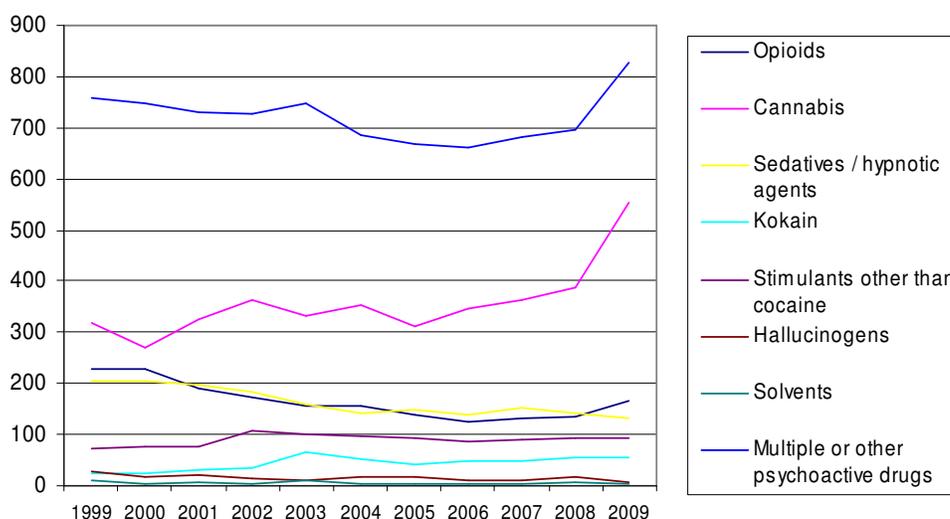
6.4 Drug users in psychiatric treatment

Mental disorders in drug users is a well-known 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.

In 2009, a total of 5,464 persons were admitted to psychiatric hospitals with a drug-related primary or secondary diagnosis (co-morbidity). This is more than in previous years (4,954 persons in 2008). The number of hospitalisations caused by secondary diagnoses alone and related to drug use is the same as in previous years and accounted for 3,718 persons in 2009 (3418 persons in 2008). The number of persons hospitalized with drug-related primary diagnoses in 2009 amounted to 1746 persons, which is slightly more than in previous years (1536 in 2008). 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 2009 included 32 % of persons in psychiatric treatment with a drug-related primary diagnoses. Persons with primary diagnoses related to cannabis have also gone up drastically in recent years. From 2008 to 2009, the number of persons hospitalised with cannabis-related primary diagnoses has increased from 388 hospitalisations in 2008 to 553 hospitalisations in 2009, which is an increase of 42%. During the entire period, the number of persons with opioid-related primary diagnoses has been decreasing slowly, however with a slightly rising trend the past few years.

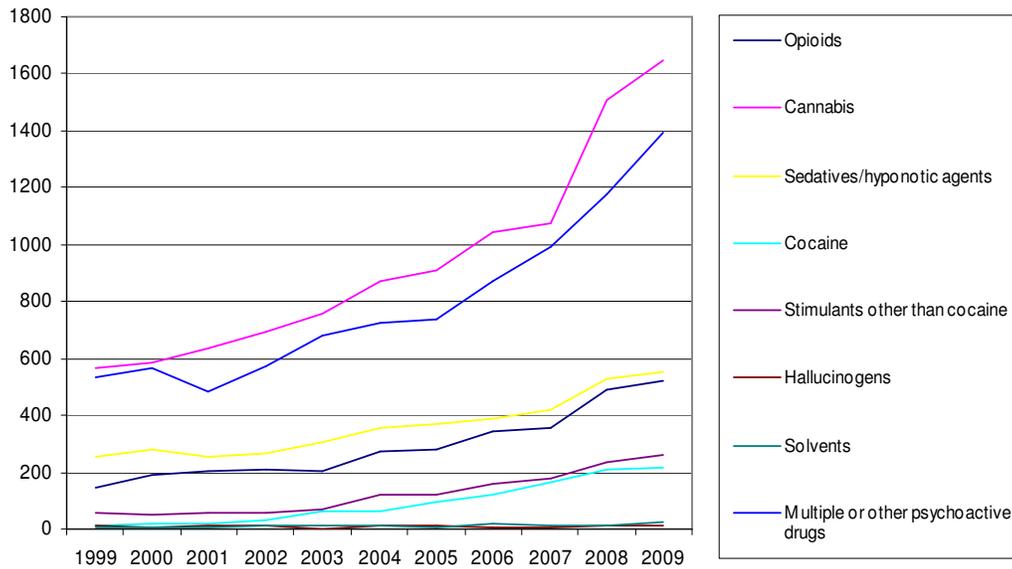
Figure 6.4.1. Persons recorded with drug-related primary diagnoses in psychiatric hospitals 1999-2009



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 included 566 persons in 1999 and 1646 persons in 2009. Also, there is a regular increase in the number of persons admitted to hospital with a secondary diagnosis related to cocaine and other central stimulants, although the number is significantly lower than compared to the hospitalisations related to cannabis secondary diagnoses. The number of hospitalisations involving "polydrug use" secondary diagnosis is considerable and accounts for more than 1/3 of the total number of hospitalisations with a secondary diagnosis related to drugs.

Figure 6.4.2. Persons recorded with drug-related secondary diagnoses in psychiatric hospitals 1999-2009



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

7 Health interventions

Often, the use of intoxicants has far-reaching consequences to an individual's health, such as physical and mental health injuries, which may be life-threatening on the one hand and cause the development of chronic diseases on the other.

Drug users account for a heavy prevalence of mental disorders and mentally ill patients are heavy users of intoxicants. A mental disorder may mean that it is difficult to treat a person for his/her drug use problems, which may worsen the course of a mental disease which is the basis of the drug use. Often, this situation involves complex conditions and complex causality.

Drug users also belong to a more exposed group in terms of somatic morbidity and higher mortality rates than the background population. Many diseases contracted by the drug user occur as a result of non-sterile and injurious intravenous use of drugs such as the infectious diseases, hepatitis and HIV. In addition, the drug users frequently suffer from diseases such as thrombosis and sepsis as well as complications in the form of amputation of legs and arms or cardiac valve infection. The drug users also suffer from other disorders such as illnesses of the test, trauma, lung disorders, tuberculosis and urogenital diseases. These are diseases that are not directly caused by the intravenous drug use, but are associated with the special lifestyle often seen in connection with active drug use.

In quite a few cases, drug use is not a chronic condition, nor is it a disease where cure in the form of abstinence equals recovery, but where treatment and other measures may relieve and reduce harmful effects. Harm reduction and specifically targeted health programmes are therefore to a great extent an integral element in drug policy.

Under its social reserve agreements, the Government has set aside funds in recent years, the aim of which is to initiate a variety of medical services and harm reducing projects to the drug user in and outside the established drug use treatment system.

7.1 Prevention of morbidity among drug users

Focus on interventions in recent years has been on launching a number of health promotion interventions to reduce the harm associated with drug use and to ensure that the drug user receives the medical advice and treatment required.

Via the social reserve agreements, one of the government's contributions is free vaccination against hepatitis A and B (Ministry of the Interior and Social Affairs 2006) since 2004. Another project is the scheme with addition of water ampoules to the syringe set already being dispensed to the drug users.

During recent years, there has also been focus on raising the quality of medical treatment of drug users. In 2008, the National Board of Health issued guidelines on the medical treatment of drug users in substitution treatment (Ministeriet for Sundhed og Forebyggelse [the Ministry of Health and Prevention] 2008) and in 2010, treatment using heroin has been introduced as a possible form of treatment to a limited group of drug users. The guidelines on substitution treatment provide new guidance on the choice of using the safer substitution agent buprenorphine as a first-choice substance. The heroin scheme is described in detail in section 7.4.

Finally, the Government has in recent years reserved funds under the social reserve agreements for a variety of interventions providing medical counselling and treatment to the drug users on location in the streets or in drop-in centres. Special regional family outpatient units for pregnant drug users and their children are being set up in 2010 (see descriptions under these interventions in section 7.5).

7.2 Prevention of drug-related deaths, infectious diseases and mental illness

As mentioned earlier, efforts have been made to enhance quality assurance and development of substitution treatment in Denmark. In practice, the National Board of Health reviewed the current medical treatment of drug users in substitution treatment. This critical study resulted in the guidelines on medical treatment of drug users in substitution treatment.

The aim of the guideline is to contribute to bring down morbidity and mortality among drug users by ensuring a uniform and acceptable quality in the most essential core medical services related to substitution treatment of opioid addicts. The purpose of the guidance is thus to support and strengthen overall intervention through provisions for the substitution treatment itself and a description of the medical core services related to the treatment. The guidelines on the medical treatment of drug users include a number of subjects: The guideline is described in Chapter 11 in this report.

Based on the 10 indicators of medical core services, the National Board of Health will establish a quality assurance tool by the end of 2010, when the municipalities will record local activities in the form of annual electronic reporting to the National Board of Health. By using this reporting system, the municipalities as well as the National Board of Health will gain an overview of the medical treatment within the area, and furthermore generate a possibility for proactive quality assurance of health care intervention targeted at drug users.

7.3 Prevention and treatment of infectious diseases

In 2007, the National Board of Health drew up an action plan for the prevention of hepatitis C. The launching of this plan was financed by the social reserve agreements adopted in 2006.

The action plan recommends that the municipalities ensure systematic preventive measures in the form of information and counselling on prevention of blood-borne infections to drug users, be they infected or not, and screening for hepatitis A, B, and C and HIV, partly vaccination against hepatitis A and B and finally, referral to treatment. The target group includes all intravenous drug users admitted to treatment. This also applies to drug users who have only injected themselves once and thus do not really consider themselves as real intravenous drug users.

The intended effect of the action plan is primary as well as secondary prevention, given that screening and counselling must create an awareness in those affected as well as the non-infected of the infection risk in general and convey that a clearing of virus in the body through treatment of those already infected will reduce the risk of these drug users transferring virus to others who are not infected. Finally, the aim is to launch relevant treatment to individuals infected with hepatitis C and for vaccination against

hepatitis A and B to protect a person's health if he/she has been infected with hepatitis C.

In continuation of the action plan, the National Board of Health has initiated a reporting system used for monitoring local intervention and services. This reporting scheme is expected to be ready by the end of 2010.

In order to identify how many activities had already been implemented in the municipalities as a result of the action plan from 2007, and before launch of the reporting system mentioned above, the National Board of Health asked the municipalities in 2009 for a more qualitative status on the actual implementation of the action plan. 85% of the municipalities gave their feedback to the National Board of Health. As it turned out, almost all the responding municipalities had taken action in the four main parameters (counselling, screening, vaccination and referral). As regards the fifth and sixth parameters (documentation and coordinator function), a majority of these municipalities would soon be implementing them or were determined to do so within shortly. Overall, there appears to be good overall compliance with the guidelines of the action plan.

Syringe exchange schemes

Following a request from the then Ministry of Health and Prevention in the summer of 2009, KL (Local Government Denmark - LCDK) investigated the prevalence of syringe exchange programmes locally in Denmark. In its report, KL concluded that the number of drug users with access to clean equipment is high. The reason is that all the major municipalities with a relatively large number of drug users provide clean injecting equipment. The study was not categorized by municipals, but KL still believes that the study gave an overall picture of local practice.

The dispensing of clean injecting equipment is typically carried out via drug use centres, the local pharmacies, drop-in centres/shelters or shelter rooms. In a few places, vending machines have been installed where the drug users can pick up their syringes and needles.

The municipalities are not obliged to hand out clean injecting equipment according to the law. Nevertheless, most municipalities have introduced a practice, under which this is possible. Expenses for dispensing clean injecting equipment are financed by the local operating budget. In accordance with the social reserve grant agreement for 2004, the municipalities receive DKK 800,000 (EUR 0.1 million) annually as compensation for dispensing water ampoules together with the injecting equipment already dispensed.

7.4 Treatment with injectable heroin

Treatment with prescription heroin was initiated in Denmark in 2010. The rules on the prescription of and treatment with heroin are laid down in the National Board of Health's guidelines from January 2010 (Indenrigs- og Sundhedsministeriet [the Ministry of the Interior and Health] 2010a), including laws and executive orders (Lægemiddelstyrelsen [the Danish Medicines Agency] 2009, Ministeriet for Sundhed og Forebyggelse [the Ministry of Health and Prevention] 2008, 2008a, 2008b, 2009, 2009a).

The social reserve agreements for 2009 and 2010 have set out that as of 2010, a total amount of DKK 63.4 million (EUR 8.5 million) has been set aside for permanent financing of the prescription heroin scheme. As is the case in all drug use treatment in Denmark, including social and substitution treatment with methadone and buprenorphine, treating drug users with heroin is free of charge.

The National Board of Health has estimated that approximately 10% of all drug users in long-term substitution treatment fulfil the criteria for treatment with heroin. Furthermore, the National Board of Health has assessed that approximately 300 drug users will receive heroin treatment in Denmark within the next few years.

With a view to an individual as well as an overall evaluation of the treatment method, it has been decided that the doctor responsible for treatment must complete the reports to the National Board of Health. This reporting procedure must take place upon initiation of treatment and then every six months on an ongoing basis. The reporting forms include questions on drug use, risk behaviour, prevalence of drug-related physical and mental diseases, self-assessed perception of health and questions on social burden and crime. Having reviewed the reporting forms, the National Board of Health will perform an individual as well as an overall evaluation of the treatment method, the first time at the end of 2011 and then decide whether or not there is a need for adjustment of the scheme.

Framework, requirements and criteria

Treatment with prescription heroin is assumed to be an integral part of each municipality's overall treatment and care services provided to drug users. Therefore, correlation between the medical treatment and the intervention targeted at each drug user's social problems is key.

Start-up of treatment with heroin can only be done in connection with treatment services provided for opioid addiction and can only take place in facilities granted special permission by the Danish Medicines Agency providing requirements for safety measures on the storage, reception and accountability of the drug (Ministeriet for Sundhed og Forebyggelse [the Ministry of Health and Prevention] 2009a). Also, the Danish Medicines Agency has prepared a special guideline on how the treatment facilities should order, receive and dispense the heroin (Lægemiddelstyrelsen [the Danish Medicines Agency] 2009). Treatment can take place either in the hospital or under the auspices of the Danish Prison and Probation Services.

Treatment with heroin falls under a medical speciality requiring special knowledge about treatment and patient safety. Treatment is more complex and risky than conventional, oral methadone treatment, and therefore requires specific medical competencies and higher staff allocation.

The National Board of Health must approve the doctors responsible for treatment, who must have a license to prescribe heroin, and the responsible doctor must have in-depth experience in drug use treatment. The doctor must be specialised within a certain speciality (such as general medicine, psychiatry, social medicine, internal medicine) and must be able to provide documentation for solid clinical experience in drug use treatment. This clinical experience must include thorough knowledge of substitution treatment targeted at opioid addiction, somatic and psychiatric comorbidity following from drug use and experience in overall drug treatment and the interface to social treatment intervention.

The doctor responsible for treatment may seek help from other medical personnel. These persons must have thorough knowledge of substitution treatment and the physical and mental comorbidity following from drug use. Furthermore, the medical staff must be able to assist the patients during injections and perform emergency treatment in the event of a life-threatening situation (anaphylaxis, over-dose, etc.). The doctor responsible for treatment is responsible for ensuring that the doctors in question and other certified healthcare staff complete a relevant training programme. Prescription heroin can only be taken through self-administration and under supervision of healthcare staff at the clinics. Typically, the patients will come to the clinic twice daily, ie in the morning and again in the afternoon, and for the night they will be given oral methadone to go. Heroin is dispensed to be administered at home, and the heroin clinic's opening hours are therefore 8-10 hours daily all year round.

As a minimum, treatment with heroin requires presence/availability of a doctor as well as the presence of at least two certified healthcare professionals during clinic opening hours.

The indication for treatment with heroin is continuous intravenous use of prescribed or illicit opioids in spite of long-term substitution treatment and oral methadone, where the patient is facing or risks facing severe health complications. Treatment with injectable heroin also requires:

- Age above 18 years
- Regular intravenous use of prescribed or illicit opioids in spite of oral methadone treatment within the past 12 months.
- No active or untreated severe mental disorder causing the patient to stay away from injection treatment.
- No severe somatic illness acting as contraindication for treatment.
- No significant alcohol use, ie the patient must be capable of coming to the clinic twice daily without being inebriated or display alcohol withdrawal symptoms.
- No significant benzodiazepine use. Patients stabilized on benzodiazepines will not be excluded from injection treatment.
- No pregnancy, breast-feeding nor current plans of becoming pregnant.
- Acceptance of personal appearance at the clinic and supervised self-administration of injection treatment.

The medical indication of treatment with injectable heroin must be assessed every six years as a minimum and will always take place in connection with oral methadone treatment.

Initial experiences with heroin treatment

So far, 3 clinics have been established and started treatment with heroin in Copenhagen, Odense and Hvidovre municipalities. In Aarhus and Esbjerg municipalities, heroin treatment is expected to start at the end of 2010.

In Copenhagen, a separate heroin clinic has been established, in which only patients in heroin treatment appear. In Odense and Hvidovre, heroin treatment is provided in already existing methadone treatment facilities, where a special injection room has been set up.

The initial response has been positive among the drug users, but so far, relatively few have availed themselves of the possibility. As of July 2010, approximately 30 drug

users were in heroin treatment. It is expected that approximately 100 drug users will receive treatment with heroin during 2010 and within the next 2 years, the number will reach a total of approximately 300. The City of Copenhagen plans to establish a clinic capable of serving approximately 120 drug users, whereas the other 4 clinics in the region are expected to administer heroin treatment to approximately 40 drug users.

The initial experiences with heroin treatment suggest that one of the major challenges is the preparatory phase preceding the actual heroin treatment. A large part of the drug users included in the treatment scheme have been rather sceptical towards the requirement of being examined for physical and mental illness, blood sampling and stabilized methadone treatment prior to being enrolled in the heroin treatment programme. In a few cases, it has thus been a challenge to stabilise and prepare the drug users prior to the initiation of the drug treatment. Also, there have been a few incidences of slight over-dosage, but it has been possible to control them through close observation and without using an antidote, however with subsequent dosage adjustment. Finally, some of the drug users have had problems with finding suitable veins for injection, for which reason intramuscular administration has had to be applied.

Overall, the initial experiences with the establishment of heroin treatment have been positive. Injection treatment with heroin has been performed successfully in the referred individuals, and it turns out that their general condition as well as their cognitive functions have improved significantly. It has also appears that most of the patients in methadone treatment accept the offer of accompanying social support, activities, food scheme, etc, and only a few of these patients actually appear for injections alone.

The staff has primarily been recruited from the existing methadone treatment programmes and typically work at the heroin clinic as well as in the facilities providing methadone treatment. As a result, the doctors, nurses, care staff and social workers all have extensive experience in drug use treatment.

Training programme

In connection with qualification of the staff at the heroin clinics, the National Board of Health and KABS Knowledge²⁰ have developed a national training programme. This training programme is a guarantee that the medical staff has been trained in the legal framework of treatment; that they have in-depth knowledge of the National Board of Health's and the Danish Medicines Agency's guidelines on treatment and drug handling; that they gain thorough knowledge of the pharmacological principles of treatment with injectable heroin in combination with oral methadone and are capable of performing safe and flexible administration of medicine. In connection with the training programme, a joint IT tool has been made for the calculation of correlated dosages of injectable heroin and oral methadone with a view to ensuring easy and safe flexible dosages.

The course includes training in drug use-related diseases and in management of emergency intoxicant poisoning. The training programme has included teachers from heroin clinics in the UK and Switzerland.

Research activities in heroin treatment

²⁰ KABS Viden is an organisation in KABS, which is a drug centre in Glostrup Municipality. In 2009, KABS provided drug user treatment to approximately 1,200 citizens from 38 municipalities.

In August 2008, KABS-VIDEN and the Institute of Anthropology, Copenhagen University launched a research project, the aim of which is to monitor heroin treatment in Denmark over a couple of years. The project is financed by KABS-VIDEN and is carried out in collaboration with the treatment institutions providing heroin treatment in Denmark. The focus of the research project is the users' perception of heroin treatment as well as the social, cultural and organisational conditions associated with heroin treatment. The research project will apply a combination of qualitative and quantitative methods and will consist of interviews with users as well as staff. Also, a quantitative study of self-reported quality of life will be made supplemented with data from the National Board of Health's central registers.

7.5 Other health care services

In addition to the activities described above, many other interventions are carried out locally and in the municipalities, aiming at reducing the health-related injuries and consequences of drug use. The purpose of many of these activities is to provide health counselling and treatment to the drug users in the streets or in shelters, and if needed, act as the link to the general health care system, the drug use treatment system and the social aid system.

HealthTeam in the City of Copenhagen

The HealthTeam is a health care and socially oriented clinic, the task of which is to receive and treat drug users with health problems from the local drug community living around the Central Station. This area of Copenhagen is characterized by extensive drug dealing activities and a large part of the drug users buying drugs live and take their drugs there.

The HealthTeam also provides help in the form of early care of infections, pain and wounds. People seeking help at the HealthTeam may receive qualified aid in the form of wound dressing, dispensing of syringes and needles, etc. In addition, patients have access to doctor's consultation at fixed hours. The HealthTeam also includes a number of social workers who may provide speedy help in connection with social problems.

The HealthTeam also provides more long-term health work in the form of re-establishing the drug user's contact to the social system, restorage of his/her health condition and re-establishment of contact with the health care system, including general practice in particular. The workers at the HealthTeam also undertake outreach work in the local area, and their aim is, among others, to ensure continuity in the drug user's treatment programme, whether the drug user comes to the clinic or not.

Experiment with Naloxone

In order to prevent against overdoses among drug users in the area, the HealthTeam has also taken on a project from January 2010 on a project in collaboration with the Brugerforeningen for Aktive Stofmisbrugere [The Users' Association for Active Drug Users]. The purpose of the project is to investigate whether handing out Naloxone to a group of drug users from the local area combined with training in resuscitation technique, etc can be done in practice and whether or not this is safe and makes sense. The project originates from other major cities in Europe and the US, where they have had success in bringing down the number of overdoses among the drug users via a similar project.

Naloxone is dispensed to the drug users participating in the project. They are registered as the prescribing doctor's assistant and are instructed in their responsibility through delegation of treatment competence.

During the first half year of 2010, 5 courses have been conducted for drug users in collaboration with the Brugerforeningen for Aktive Stofmisbrugere [The Users' Association for Active Drug Users]. The courses last two hours and include instructions in the administration of Naloxone as a nasal spray and as intramuscular injection, training in artificial ventilation and opening of free airways. Also, the course focuses on the importance of the drug user being familiar with the procedure and particularly the importance of calling ambulance services. After the course, the participant is given a personal certificate which documents that the person in question has been operating as the doctor's assistant and that the course has been completed. The participant also gets a special purse containing equipment for resuscitation and 3 doses of Naloxone in ampoules. The purse with the overdose kit is also a user involvement project, as the production and development are carried out in collaboration with the workshop at Center for Opsøgende Arbejde på Sundholm. [Centre for Outreach Work at Sundholm].

A follow-up of the course includes feedback from the drug users who have completed the course on the functionality of the overdose kit and the experience gained from any resuscitation attempts made. In between the course and the follow-up, the drug users involved in the project must contact the HealthTeam after having used a Naloxone dose and give a debriefing of the event and receive new supplies of Naloxone. Until June 2010, a total of 15 persons have completed the course and 3 overdose cases have been treated.

The first part of the project has been evaluated throughout the summer of 2010. More information about the Naloxone project can be downloaded from www.hjemlosesundhed.dk/Naloxoneprojekt

Health care programmes to the most marginalised

The social reserve parties have set aside a total of 28 million (EUR 3.7 million) for the years 2006-2009, the purpose of which is to launch dedicated health care programmes for the most marginalised drug users. Not all the social reserve funds resulted in projects, and it is therefore expected that the current projects will be extended and strengthened in 2011.

The purpose of the projects is to improve the health condition of the drug user in general by increasing access to relevant health care programmes, and by counteracting structural changes in order to improve the health condition among the homeless drug users (direct links and treatment continuity). The funds from the social reserves have been allocated to Copenhagen, Esbjerg, Aarhus, and Guldborgsund municipalities.

Experience from the projects shows that the drug users know about the projects and avail themselves of the programmes and have knowledge of fundamental measures and of assistance in relation to the general health care system. The projects have proven very useful, as the link between social intervention on a street level and health care intervention is pivotal to the health condition of exposed drug users. The preliminary results thus show that these health care projects are much in demand by the target group and fulfil needs so far unfulfilled.

From January 2009, a reporting system of the clients' health condition on admission has been implemented in the projects and in the treatment services provided under the projects. The reporting now facilitates systematic documentation and evaluation of the interventions. The reports show that the drug users have many different somatic and psychiatric problems, and many of the same diseases are seen in the drug users across the projects - eg chronic hepatitis, asthma, seizures and paranoid schizophrenia. Many of the drug users are in prescribed substitution treatment and often they take intoxicant drugs or medicine in combination with their substitution medicine.

So far, drug users participating in these projects tend to mistrust the health care system as well as the medical professionals, and it will be a bit of a challenge to create better relations for the benefit of the individual drug user. The staff at the drop-in centres emphasizes the importance of creating confidence and of being persistent, understanding and attentive. They also find it important to form a joint platform among professionals and co-workers who today have different perceptions of the target group's problems, possibilities and needs.

Health promotion and prevention and drop-in centres

Under the social reserve agreement in 2006, an amount of DKK 22.5 million (EUR 3.0 million) was set aside over a three-year-period (2007-2010) to enhance health promotion and prevention in relation to the most vulnerable alcohol and drug users as well as the homeless. The overall purpose of the social reserves is to ensure the most marginalised drug users necessary health care treatment as well as to test and develop methods to find and retain the socially most marginalised group of individuals in public programmes.

Fredericia, Herlev, Langeland, Nakskov, Odense, Randers, Silkeborg and Aalborg municipalities have received grants from the social reserve funds. The projects are based on collaboration between the municipalities and the drop-in centres and aim at direct health promotion activities - including programmes related to nutrition, exercise, dental care, smoking cessation, etc and the development of interdisciplinary and intersectoral collaboration as well as physical examination.

The projects have been running since June, 2008. In the two years that have passed, the projects have succeeded in integrating health as a natural part of the daily routines at the drop-in centres. 80% of the users have had a physical examination performed as well as a medical follow-up or have had a talk with the projects' permanent health care professionals and most of the projects now see heavy demand for these programmes. For instance, many users have recommended that their friends participate. Also, the other programmes under the projects are much in demand, eg food schemes, exercise activities and smoking cessation.

The preliminary evaluation shows that 3/4 of the users find that they have had a need for help from the health project to get in contact with the established health care system. In addition, an increasing number of users have become inspired to seek contact with the system themselves. The projects report in particular about better contact to the GP.

The projects will terminate in June 2011, following which the final evaluation will take place.

National outpatient centres

The Budget of 2008 reserved funds for the establishment of regional family outpatient centres in the hospitals of all regions. The family outpatient centres are intended to provide specialized pregnancy care of pregnant women with drug problems and specialized paediatric follow-up of children who were exposed to intoxicants during their foetal stage. The aim of the family outpatient centres is to ensure an interdisciplinary and comprehensive solution to the mother, her child and a partner, if any, 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.

The planning and establishment of family outpatient centres is currently underway in all the five regions in Denmark and it is expected that all the family outpatient centres will be up and running within the last six months of 2010.

Together with the launching of the family outpatient centres, funds were set aside for the establishment of a counselling facility at Hvidovre Hospital with the purpose of assisting the regions in connection with the establishment of the new family outpatient centres. The counselling facility was established in April 2009 as a Center for Prevention of Substance Effects on the Development of Children.

This Centre has prepared informative material, courses and professional guidelines. Furthermore, the Centre has set up a cross-regional coordination group, where clinical and administrative representatives from the five regions prepare joint professional guidelines, project protocols and other central joint references. This means that joint guidelines are in place from the beginning, and uniform data are generated from all the five family outpatient centres.

The guidelines for the family outpatient centres appear on the National Board of Health's website www.sst.dk. The Center's website is: www.familieambulatoriet.dk.

Project Social Nurse

The purpose of this project is to create "the good patient pathway" for drug users that are hospitalized and to give them a better feeling of coherence in their treatment from hospitalization and until being handed over to the municipal system. The rationale of the project is that drug users' stay in the hospital is often problematic and too short. One of the reasons is that drug users are often perceived as troublesome, another is that the staff does not have the necessary tools to handle such complex problems which often walk hand in hand with patients that have a drug use problem.

The project is financed by the National Board of Health and stretches over a period of more than 3 years with the project starting on 1 February 2010.

The project hires social nurses who know how to act as mediators between drug users and the staff, help the staff to gain the knowledge required, help the drug users adjust to a hospital situation and ensure that follow-up is made after they have been discharged.

There are four hospitals/centres involved in the project: Hvidovre Hospital, Bispebjerg Hospital, Psychiatric Center Glostrup and Psychiatric Center Hillerød. In a pilot project at Bispebjerg Hospital, the social nurses have proven useful in the somatic department and their experience will now be tested in a psychiatric department, where many mentally ill drug users feel they do not fit in.

In all the four hospitals, a working group has been established, and in addition, the municipalities, hospitals and drug centres involved take part in a follow-up group providing the necessary professional contributions and ensuring the subsequent implementation.

Up until now, all the hospitalised drug users in the involved hospitals/centres have accepted the offer of taking part in the project, which until 15 June 2010 counted a total of 80 drug users. Feedback from drug users as well as staff is very positive. Collaboration partners in the municipalities have also had a favourable impression of the project and make use of the social nurses. The project will be evaluated later.

8 Social correlates and social reintegration

The Ministry of Social Affairs and the Ministry of Employment are responsible for coordinating intervention in terms of social integration (social intervention as a whole) of drug users. No special organisation has been established, but these ministries are overall responsible for coordinating and implementing the above intervention areas aiming at drug users as one of the target groups in the group of “socially marginalised”.

8.1 Social exclusion and drug use

In Denmark, there is a clear correlation between drug use and problematic social and economic life conditions and consequences. The social marginalization of drug users is high. When taking a look at the social, residential and educational conditions among the drug users in treatment, it is clear that they are a marginalized group compared to the rest of the population. They are more often homeless, they more often have a short educational background and they are more frequently provided for through cash benefits and pensions.

As mentioned in chapter 5, the group of drug users admitted to treatment are characterized by having a relatively remote affiliation to the labour market. Thus, only 14 % of them who were in treatment in 2009 were on payroll and as many as 64 % were on transfer income. Furthermore, “only” 26% have completed an education beyond “folkeskole” (primary and secondary school) and as many as 9% have left school before the 9th grade.

Although these figures indicate that we are dealing with a relatively marginalised group, it is also important to point out that the number of drug users employed has gone up the last year as has the educational level, which to a high extent is attributable to the change in drug use patterns.

As regards the housing situation of those who are admitted to treatment, only 59% of them report having a home of their own, whereas 4% report that they are homeless.

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 municipality’s report on each decision on placement of a child or a young person. The obligation to report includes different basic information about the child/young person and the circumstances involved – including the event that has triggered the placement such as drug use problems at home/with the parents and in the children/young people (Ankestyrelsen [National Social Appeals Board] 2009). Abuse problems include alcohol and/or drug use.

In 2008, decisions were made on the placement of 3,497 children and young people. 69 % of these were between 12 and 17 years old, and 11% were younger than 3 years. At the end of 2008, there were a total of 12,346 children and young people between 0-17 years placed out-of-home. The number of decisions and placements at the end of the year has been relatively constant throughout the past 3 years.

As mentioned above, the municipalities report the causes of the placement and often there are several reasons why children and young people are subjected to out-of-home

placement. Statistics show that in 17% of the cases, abuse problems at home/parental abuse problems were the triggering factors for the placement. This came in second to the category "severe disharmony in the family" (38% of the cases) followed by the parents' suffering from mental disorders (13%). When considering what made the child/young person become the triggering cause of placement, abuse problems turned out to be the cause in 12% of the cases.

8.2 Social reintegration

The Ministry of Social Affairs coordinates interventions in accordance with the programme "The Joint Responsibility II". The Ministry of Employment focuses on the socially marginalised individuals receiving cash benefits as part of the government's "Nye veje til arbejde" (New ways to work) programme, under which a considerable part of the target group are drug and/or alcohol users.

The overall aim of this measure is to support socially marginalised groups in taking the necessary steps towards employment and to focus on enhancing the individual's quality of life and competences. The aim is to create better opportunities for self-procurement, better opportunities of being assimilated in social networks and gaining a better structure to everyday life. Overall, it is the Government stepping up its involvement in new initiatives and economic resources. The activities are designed specifically to the individual drug user, the private labour market and the local case handlers.

In accordance with Section 141 of the Consolidated Act on Social Services, the municipality is obliged to offer drug users a social action plan, with goals and strategies being discussed together with the individual drug user as regards his/her future housing situation, financial situation and other situations in life. Thus, the local case handlers are those with the action competence to begin with in terms of social integration of the drug users in a number of areas.

Homelessness, housing services and housing grants

In 2007, a count was made and it turned out that in week 6 in 2007, there were approximately 5,000 homeless people in Denmark. They were particularly concentrated in the larger cities and especially in the capital city and its suburban municipalities.

A new count in week 6 in 2009 shows that the total number of persons who have been homeless one way or the other is almost the same in 2009 as in 2007. The figures indicate that 70% of the homeless are abuse drugs, cannabis, alcohol and medicine. Also, according to statistics, it turns out that 37% of the homeless have a mental disorder. This, however, is based on an estimate, as the respondents have not been interviewed about diagnosed mental disease. 25% of the homeless drug users are mentally ill and abusers at the same time. For quite a few of the homeless, abuse and mental disorder are recorded as primary causes of homelessness (Benjaminsen 2009).

A number of services has 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. Interventions targeting at improvement of housing conditions are generally considered as an important measure in terms of social integration, as a means as well as an end itself.

Under Section 110 of the Consolidation Act on Social Services, the homeless are offered shelter in temporary nursing homes to sort out their 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 have been 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. Drug users 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 settings referred to as "alternative homes".

In addition, there are "alternative nursing homes" which are a service including long-term accommodation in accordance with Section 108 of the Danish Consolidation Act on Social Services to, among others, drug users, who are unable to look after themselves and who do not fit into traditional nursing homes for the elderly due to abuse, dementia or problematic behaviour. The "alternative nursing homes" are often established in the same settings as the temporary nursing home.

In August 2007, the Government launched a strategy for the homeless. The overall goal of this strategy is to contribute to removing homelessness in Denmark.

The strategy has four long-term goals:

1. 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.

2. Basically, young people should not stay in a temporary nursing home but should be offered other alternatives under the Danish Social Services Act or 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.

3. 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 reintegration it is important that support is provided and that alternative homes, reintegration homes, temporary local housing services and community homes are increased in numbers.

4. Release from prison and discharge from hospital or treatment services should be made conditional upon a housing alternative.

The objective here is that the person either discharged from hospital or released from prison has a home to move into. Focus here is made on these transitions in life and a better coordination between the authorities involved in terms of action plans. The homeless strategy runs until the end of 2010 and will be finalised with a cross-evaluation of interventions.

Social skills and networking

A large part of the social work with drug users is carried out at drop-in centres. These programmes offer rest, food and warmth, social care, an opportunity to create a social community and support for change. The activities at these drop-in centres have developed in recent years and today, more network-inspiring and activating activities are being offered. In the government programme "Det fælles Ansvar II" (Joint Responsibility II), plans are made to develop these activities further.

Education and employment programmes

Many drug users perform poorly at school and only have a very basic educational background when leaving school. Opportunities for catching up on lost schooling after leaving school are good in Denmark, especially through the regional Adult Education Centre (VUC). There are special programmes for those who are poor at reading; it is possible to complete the basic primary education by taking subjects separately, as well as take the school leaving certificate or Higher Preparatory Exam at secondary level at night school, either as single subjects or as a special course. There are also day-time secondary school programmes offering education of a non skills-based nature. The aim of this is to increase the individual's general and technical knowledge and skills, thereby increasing their ability and desire to take responsibility for their own lives and to take part actively in society.

In the case of long-term unemployed drug users and other socially marginalised individuals, a national training course has been established ("Next stop job" under the Joint Responsibility II project) for the socially marginalised unemployed who have previously taken an education or who have previously had a job and thus have competencies within a given area. The aim is to rekindle their professional competencies in order to further their opportunities of being activated or employed. Furthermore, the course allows for entering into groups that create a structure in everyday life and render it possible for the individual to be part of a social group, boost self-esteem and self-respect.

Employment programmes and benefits

Previous drug users are typically provided the same employment promoting programmes as other cash benefit recipients or unemployed. The drug users in long-term substitution treatment are, however, primarily offered programmes involving activities and social gatherings, often in relation to a drug use centre or a drop-in centre.

To facilitate the transition from a social back-to-work programme to actual employment, mentor schemes have been established at drop-in centres in connection with drug use treatment or in a specific local programme, where a person associated with the drop-in centre helps vulnerable users to find a job, supporting them with advice and guidance about how to function at the workplace. In addition, the mentor is supposed to relieve the company of the difficulties arising in connection with the employment.

Another project involves company courses (the project “From Exposed to Employed” under the Joint Responsibility II). The aim of this project is to prepare the companies for receiving socially marginalised drug users who have been unemployed. The means are knowledge and tools provided at the courses, the objective of which is to prepare the companies to take care of this vulnerable group.

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

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.

9.1 Drug-related crime

Drug-related crime is punishable under the law of psychoactive substances and Section 191 of the Danish Criminal Code. Violations of the Act on Psychoactive Substances will be punished by fine or prison for a period of no more than 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.

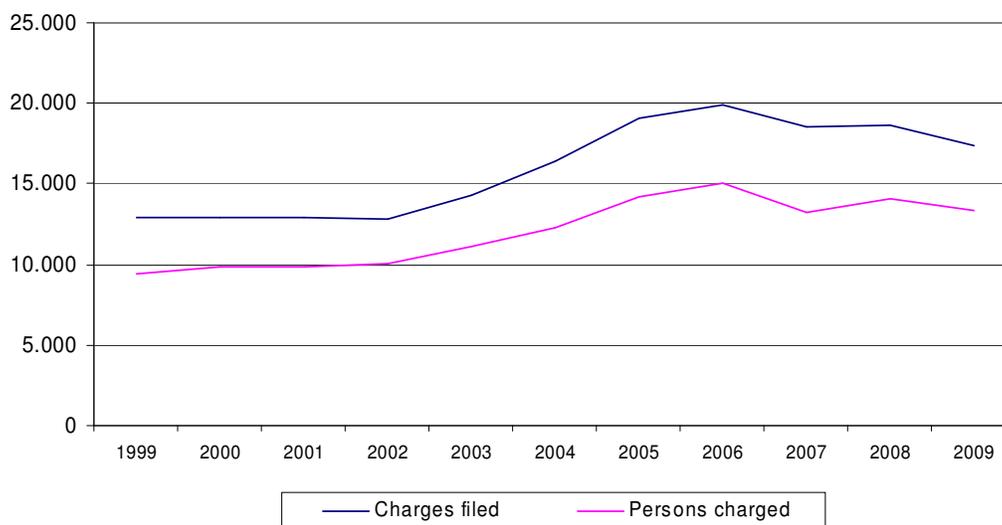
Section 191 of the Danish Criminal Code provides for stricter punishment on qualified violations of the Act on Psychoactive Substances. This means that if the transfer of psychoactive substances is made to a large number of people against considerable remuneration or under other particularly incriminating 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 2009, a total of 17,403 reports were filed including one or several charges for violation of the Act on Psychoactive Substances and the Criminal Code. During the same year, 13,354 persons were charged for violating the Act on Psychoactive Substances and the Criminal Code. Some persons were thus charged for several counts on violation of the two acts mentioned.

Figure 9.1.1 shows the trends in the number of reports filed on violation of the Act on Psychoactive Substances as well as the Criminal Code and the number of persons charged under the two acts during the period 1999-2008.

Figure 9.1.1. Drug-related crime 1999-2008. Charges filed and number of persons charged



Source: Rigspolitiet [National Commissioner's Office], 2010

Drugs in traffic

Until 1 July 2007, driving under the influence of psychoactive substances was only punishable if the person was in such a condition that he/she was unfit for safe driving of the motor vehicle (the driver's ability criterion). In practice, this meant that punishment only became relevant in cases where it could be proved that the person in question had taken drugs and 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 thus required 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. According to the new rules, cf Section 54 (s1) of the Danish Road Traffic Act, the prosecution needs 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, they were given 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 and 1,502 in 2009.

Violation of Section 54 (ss1) of the Danish Traffic Act is punishable by fine as a minimum. However, in particularly aggravating instances, punishment may increase to prison for a period of up to 1 year and 6 months.

9.2 Prevention and treatment of drug problems in Danish prisons

On 1 January 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 receive such treatment within a fortnight. The treatment includes so-called 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 completely from the rest of the inmates.

The treatment in the prisons is carried out by private and publicly approved treatment institutions in collaboration with the Danish Prison and Probation Service. In 2009, the treatment guarantee was observed in almost 88 % of all cases. In the majority of cases where the deadline was not observed, the treatment was initiated no later than 14 days after the expiry of the deadline. In 2009, there were approximately 1,100 people in treatment in the prisons.

According to the national strategy on criminal drug users, the treatment of drug users must to the widest extent possible be undertaken by the social authorities. The strategy is based on the Prison and Probation Service's principle program, in particular the principle on normalization. This principle implies that inmates who are not considered dangerous or who are not at risk of running away and therefore not considered to insult the general feeling of justice in the population are transferred to specially qualified treatment institutions within the jurisdiction of the social authorities.

Rather surprisingly, there has been a drop during the past four years in imprisoned drug users serving their time in such an institution outside the jurisdiction of the Prison and Probation Service. Over the past 5 years, the number of cases treated in prisons has thus dropped from 160 to 97.

During 2008, there was an increasing need for detox with systematic support prior to the initiation of actual treatment. Also, there turned out to be a relatively high demand for follow-up treatment, and it became clear that certain groups of inmates such as sex criminals are difficult to include in the existing services due to their placement in special departments for protective purposes. The Danish Prison and Probation Service has received grants for 2010 to strengthen follow-up treatment and detox treatment and the Service continues to find ways to finance the need for drug use treatment of sex criminals in prison.

Initiatives to prevention of inmates' drug-related diseases

For the purpose of preventing against drug-related diseases, physical withdrawal symptoms, and mental craving for drugs, the Danish Prison and Probation Service provides medical substitution treatment. This treatment may extend over weeks or months. This temporary treatment is very often followed by continuous substitution treatment that may last up to several years when deemed necessary by an interdisciplinary panel of people –which is more the rule than the exception. 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 health care checks, including information about the above diseases and general exams on an equal footing with the rest of the population. Inmates, however, do not have access to free syringes and needles.

Reintegration of drug users after their release

When drug-users are in treatment during their imprisonment and then released, the municipal drug use 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 drug use 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 intended 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 proven difficult to establish coordination between the municipalities, the Directorate of the Danish Prison and Probation Service, the Ministry of the Interior and Social Affairs, the Ministry of Employment, which is the reason why the Prison and Probation Service focuses on coordination of action plans with the aim of improving 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 is 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 and drug use centres which are important players when it comes to generating coherence in intervention.

The project was finalised mid-2009 and focused on a number of barriers to the good collaboration and recommended a specific approach to this collaboration - a so-called "traffic plan for the good release". These recommendations are currently being implemented. Thus the first step is for a number of specific collaboration agreements to be signed with all the municipalities in Denmark. The reason is that the municipalities are not organised in the same way.

9.3 Drug use in prisons

The Alcohol and Drug Study from 2002 (Kramp et al 2003) that ¾ of the Prison and Probation Service clientèle has tried cannabis, more than half of them have tried stimulants such as cocaine and amphetamine, whereas 1/3 has tried heroin and/or morphine substances. Half of the entire clientèle under the Danish Prison and Probation Service has a drug use problem (alcohol use included)²¹.

As of 1 October 2004, a new recording module was implemented in the client system of the Danish Prison and Probation Service. This module contains records of all the new inmates' use of drugs and alcohol in prison. With the introduction of a treatment guarantee for drug users under the Prison and Probation Service as of 1 January 2007, the module was expanded with a number of further data.

The Danish Prison and Probation Service has thus developed and tested an IT-supported documentation template, the purpose of which is to support case handling locally and to be used as a control tool for treatment intervention in the institutions under the Danish Prison and Probation Service. There are still some difficulties associated with documenting intervention, but it is expected that some time in 2009, a quality assured version will be incorporated in the registration module mentioned above.

Another element in client registration is the electronic reporting to the National Board of Health on the number of methadone prescriptions handed out to inmates. Figures from 2009 state that approximately 475 people received substitution treatment with methadone or buprenorphine on a monthly basis.

²¹ Drug use is defined as the consumption of drugs twice a week or more in the month prior to imprisonment/registered supervision. Alcohol use is defined as the consumption of 11 drinks or more daily in the 6 months prior to imprisonment/registered supervision, 10 incidences of inebriation or more in the month prior to imprisonment/registered supervision and/or ongoing treatment for alcohol use.

10 Drug markets

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. This means that seizure statistics give a very rough indication of the quantity of drugs available on the illicit market and are both an indicator of quantity as well as an indicator of police activity.

Results from the forensic analyses of substances of the past few years show that the purity and drug concentration of the illicit drugs varies significantly.²² The variation is seen in the more traditional drugs such as heroin, amphetamine and cocaine, and in the new synthetic substances typically found in ecstasy pills. As the concentration and contents of the drugs therefore are often unknown, this implies a special risk upon intake. Up through 2008 and 2009, the relatively new drug mCPP is found to an increasing extent in ecstasy pills, but now appears to be declining again. mCPP is a substance having a stimulating as well as a hallucinating effect and is compared to MDMA (ecstasy) in terms of effect. As a replacement, the hallucinogen 2C-B is appearing more frequently in the pills in 2009 and during the first quarter of 2010. Rather surprisingly, MDMA "only" appears in 14% of the pills in 2009, where MDMA in previous years was contained in approximately 80% of the pills.

10.1 Drug supply and demand

The National Commissioner's Office gathers information about the countries which produce and distribute the illicit drugs seized in Denmark. As in previous years, Morocco is still the key country where cannabis is produced for the Danish market, with Spain, Portugal and the Netherlands being the key distribution countries. As regards heroin, the vast majority comes to Denmark from Afghanistan and Pakistan, whereas amphetamine seized in Denmark has primarily been produced in Holland and Belgium. A minor, however not insignificant part of the amphetamine available in Denmark is also produced in Poland and the Baltics. Cocaine is produced mainly in South America and usually distributed via the Netherlands and Spain. The cocaine is primarily produced in South America and is further distributed 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.

10.2 Seizure of drugs

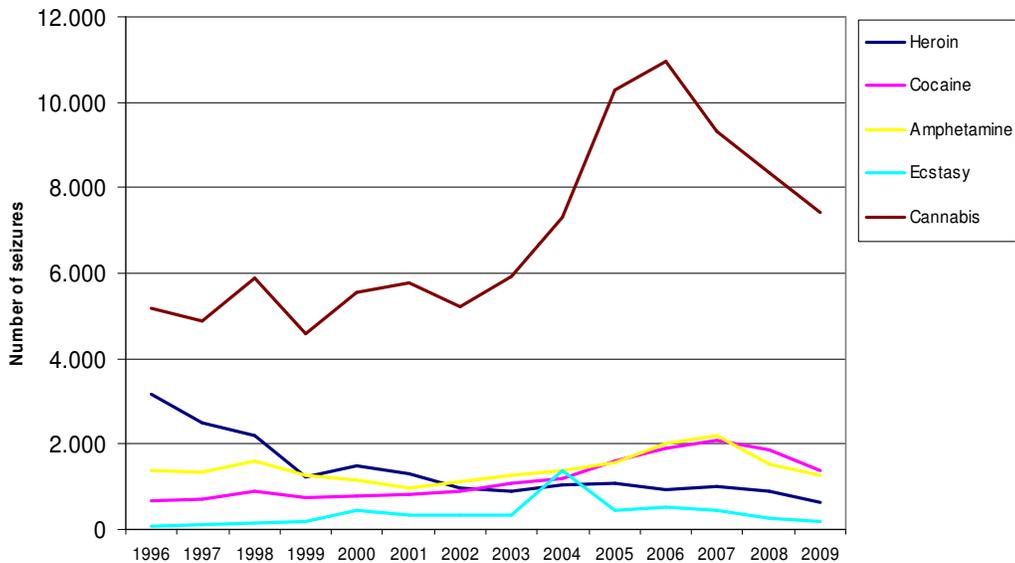
Police and customs keep ongoing records of the quantity of illicit drugs seized and the number of seizures of illicit drugs made at borders, airports and ports in connection with major investigations, as well as street-level confiscations. The data on seizures is regularly reported to the National Centre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

²² 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.

publishes annual statistics based on this data (National Commissioner's Drug Statistics).

It appears from the National Commissioner's Drug Statistics (Rigspolitiet [the National Commissioner's Office] 2010) that the number of seizures of most types of drugs has gone up throughout the years.

Figure 10.2. Drug seizures 1996-2009



Source: National Commissioner's Drug Statistics 2010

As regards the quantity seized, major fluctuations are seen in most drug types from one year to the other. In spite of a drop in number of seized drugs from 2008 to 2009, police statistics show that cocaine and ecstasy have been seized in increasing quantities. The quantity of cocaine seized rose from 56 kilos in 2008 to 72 kilos in 2009. The quantity of ecstasy seized rose from 17,631 pills in 2008 to 53,929 pills in 2009. As in previous years, some of the seizures included different substances in large quantities. (See table in the Annex of quantities and number of the various drugs seized).

10.3 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 on the market. The results from the "Street Level Project" and the "Ecstasy Project" are described below.

Drug dealing in the streets

Data material from the Street Level Project" consists of small snapshot based seizures from 5 police districts in Denmark (Copenhagen, Aarhus, Odense, Aalborg and Esbjerg), which are submitted for analysis in the forensic institutions²³. Table 10.3.1 of the Annex shows the distribution of types of drugs seized in Denmark from 1998 to 2009.

Out of the 195 samples analysed in 2009, 66% contained stimulants such as amphetamine and cocaine, which equals the distribution in 2008. During recent years, the presence of the stimulants - especially cocaine - in the project has been increasing, whereas heroin has been decreasing. 28 % of all samples in 2009 on a national scale included heroin. By comparison, 74% of the samples analysed at the start of the project in 1995 was heroin.

In Copenhagen and Aalborg, cocaine is the predominant drug (51 % and 48 %, respectively, of all samples), whereas amphetamine is the predominant drug in Esbjerg and Aalborg (58 %, 42 %, respectively, of all samples). In Odense, heroin is the predominant drug and found in 37% of all samples in 2009.

The prevalence of methamphetamine has generally been increasing in recent years. In 2009, however, only 3% of the samples collected under the Street Level Project were 3%, which is a decline compared to, for instance, 2005 when 5% of the samples were methamphetamine²⁴. An additional 3 % of the drugs contained various drug mixtures (3%) and non-psychoactive drugs (2%).

Table 10.3.2 of the annex shows the balance between heroin base ("smokeable heroin") and heroin chloride (white heroin to injection) from 1998-2008. Heroin base continues to be the dominant drug among the heroin samples on a national scale. In 2009, the balance between heroin base and heroin chloride is 69 % and 31 %, 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 2009, the heroin samples (92 %) from Odense thus contained white heroin for injection purposes, whereas 8% contained heroin base for smoking. In comparison - and quite reverse - 92% of the heroin samples collected in Copenhagen contained the brown heroin for smoking, whereas 8% of the samples contained white heroin.

Purity of drugs

Table 10.3.3 shows the purity of various drugs from 1998 to 2009 in the samples analysed from the Street Level Project.

²³ 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 Plan Project does not include cannabis or other cannabis products. Another thing is that ecstasy was excluded from the "Street Plan Project" as of 2003 and is now being monitored independently.

²⁴ See also the prevalence of methamphetamine in ecstasy pills later on in the chapter.

	1998*	1999*	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Heroin chloride	70%	69%	59%	52%	50%	64%	63%	67%	53%	29%	52%	41%
Heroin base	31%	30%	40%	48%	25%	25%	22%	28%	18%	21%	16%	14%
Amphetamine sulphate	15%	9%	12%	9%	13%	9%	9%	10%	7%	6%	8%	5%
Cocaine chloride	51%	54%	37%	43%	36%	37%	24%	25%	18%	16%	19%	11%

Source: Lindholst et al 2010

* In 1998 and 1999, figures from Elsinore police district are included

As shown in table 10.3.3, the purity of drugs changes throughout the years. The general trend is that purity of the various drugs has dropped, however with annual fluctuations. The purity of the white heroin, heroin chloride, however, dropped significantly from 52 % in 2008 to 41 % in 2009. The purity of cocaine dropped evenly throughout the years from 51% in 1998 to 11% in 2009.

Over the years, there have been no fundamental differences observed in the purity 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 purity have been found on the market at the same time. It was not possible to pinpoint periods of the year when purity was particularly high or low for any of the drugs.

Ingredients in ecstasy pills and their appearance

Since 2001 the National Board of Health, in collaboration with the National Commissioner's Office and the three institutes of forensic chemistry, have been monitoring the prevalence of ecstasy pills in Denmark. The procedure involves sending samples from ecstasy seized by the police districts to one of the three forensic institutes. The pills are examined and described in terms of drug concentration, substance mix and appearance²⁶. A regular quarterly update of the analysis results and a more extensive annual report are available at the National Board of Health's website: www.sst.dk.

.In 2009, a total of 43,055 ecstasy pills broken down in 117 seizures were sent from the police districts to the forensic institutes for analysis. This is a small decline in the number of seizures, but a significant increase in the number of pills examined compared to 2008. In 2008, a total of 9,385 ecstasy pills broken down in 150 seizures were examined at the forensic institutes. According to the National Commissioner's Office, the police districts seized a total of 48,643 ecstasy pills in 2009 broken down in 139 seizures. Despite the intention that all seizures were to be submitted for forensic

²⁵ 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.

²⁶ 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.

analysis, only 117 of the 139 seizures were submitted and analysed, which corresponds to 65 % of all seizures.

The conclusion on the ecstasy market in 2009 must be that there appears to be an increase in the relatively new substance mCCP in the pills, both alone and in mixtures. In 2009, mCCP was contained in 68% of the pills. Furthermore, it turns out that the hallucinogen 2C-B appears increasingly in the pills and was contained in 7% of the pills throughout the year. Finally, MDMA (ecstasy) is found in "only" 14% of the pills, which is a drastic decline compared to the last 3 years, when approximately 80% contained MDMA - either alone or in compounds.

Logos, shape and colours

The variation of ecstasy on the market as regards contents and appearance is large. Since the start of monitoring in 2001, a total of 574 different variations of ecstasy pills have been identified. In 2009 alone, 34 different new variants were identified. The pills are white, beige, grey, yellow, red, and blue and almost always round. However, the pills can also be square, triangle or formed as four-leave clovers.

In 2009, the analyses also contain capsules from two cases.

Among the samples in 2009, 18 different logos were found, with 8 of these logos not having been seen earlier - ATOM 30 and Svamp. Many of the logos are only seen in one variant, whereas other pills with the same logo are found in several variants. For instance, when monitoring started, 51 variants of pills were discovered with a Mitsubishi logo. The pills vary in diameter, colour, weight, height, type and quantity of active substance.

New ingredients

New and dangerous substances appear regularly in ecstasy pills – in Denmark and in the rest of Europe. In Denmark in 2005, a total of 8 new ingredients were identified in the pills. In 2006, no new substances were found, whereas in 2007 and 2008, a new drug was discovered. In 2009, no new ingredients were found in the pills.

Table 10.3.4. Prevalence of some of the ingredients in ecstasy from 2003 to 2009

	2003 (n=337)	2004 (n=498)	2005 (n=335)	2006 (n=434)	2007 (n=311)	2008 (n=164)	2009 (141)
MDMA	96 %	85 %	43 %	63 %	90 %	82 %	8 %
MDMA + other	1 %	15 %	50 %	34 %	2 %	3 %	4 %
Other ingredient	3 %	0 %	7 %	3 %	8 %	15 %	88 % *

Source: Aarhus University 2010

*In 2009, 68% of the ecstasy pills contained mCCP alone or a combination of other types of drugs, and 7% of the pills contained 2C-B

In previous years, the prevalence of pills containing MDMA only (as shown in table 10.3.4) has varied between 43% and 96%. The year 2009 deviates from previous years by containing the relatively new drug mCCP to a large extent. However, according to the most recent quarterly report in 2010, this new drug appears to be less represented in the pills currently on the market. The former, very frequent variants with MDMA mixed with amphetamine, methamphetamine and MDE/MDA have more or less disappeared from the market.

Most recent quarterly report in 2010

As mentioned earlier in this chapter, the National Board of Health publishes on its website www.sst.dk a quarterly report on the current ingredients in and concentration of the pills on the market. In the 2nd quarter of 2010, mCCP is found in 44% of the pills compared to 83% of the pills in the 2nd quarter of 2009. On the other hand, 48% of the pills in the 2nd quarter of 2010 contain the hallucinogen 2C-B, which appears to strengthen the trend of a current increase in the drugs from the 1st quarter 2010, when 2C-B was contained in 36% of the pills. In the 2nd quarter of 2010, "only" 8% of the ecstasy pills contained actual MDMA (ecstasy), which corresponds to the development seen throughout 2009.

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 on intake. During recent years, there is a trend towards the capsules and tablets in particular having looking differently, for instance being either very small or very large, containing very pure substance or substance of a type different from MDMA. Also in 2009, the capsules and pills deviate from the norm, but more surprisingly, more of the "new" substances appear in pills that cannot immediately be distinguished from other pills on the market. In 2009, the quantity of MDMA varies between 1mg and 94mg per tablet. The quantity of the active substance mCCP varied between 1mg and 52mg, and the quantity of 2C-B in 2009 ranged from 4mg to 7mg per pill.

All other things being equal, ecstasy on the market appears to be unpredictable in terms of strength, ingredients and drug combinations.

The systematic ecstasy monitoring in Denmark is believed to give a good overview of the type of ecstasy pills available on the market and their contents. 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, there are still many seizures that are not submitted by the police districts and that would, if submitted, qualify the monitoring process. Another thing is that far from all ecstasy being distributed and sold on the market is seized. In 2007, The Institute of Forensic Chemistry in Aarhus carried out a study, in which it was estimated that only 5% of the pills prevailing on the Danish market are seized and thus sent to possible forensic analysis.

Prices

The National Commissioner's Office of Police estimates that the street price for cannabis is around DKK 50-70 per gram (EUR 6.7-9.3). The price for cannabis is no longer fixed as it once was. Police districts report about prices between DKK 30-80 (EUR 4-10.7) for one gram of cannabis. The price per gram for selling heroin on the streets is estimated to be between DKK 1000 (EUR 133.3) and 1500 (EUR 200) for white heroin and between DKK 500 (EUR 66.7) and 1000 (EUR 133.3) for brown heroin. The price for cocaine traded in the street is estimated to be between DKK 400-600 (EUR 53.3-80.0) per gram. As for amphetamine, the price in the streets is estimated to be between DKK 100 to 200 (EUR 13.3-26.7) per gram, whereas the price for an ecstasy pill is estimated to be between DKK 30-50 (EUR 4-6.7).

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 National guidelines for the treatment of drug use

In recent years, focus has been on quality development of drug use treatment in Denmark. The reason has been a wish to develop effective treatment methods and secure treatment quality. In this connection, there has been increasing focus on requirements governing documentation and quality provided to citizens, administrators and politicians. This theme chapter provides a description of the development of national guidelines in drug use treatment in Denmark as part of this quality development.

11.1 From disagreement to agreement

Throughout the years, the drug use area has been characterized by very diverging ideas of treatment interventions and thus also lacking consensus on goals for treatment effect. The lack of defined treatment services and references has contributed to difficulties in defining the professional understanding of treatment effect. In spite of a large volume of scientific literature within drug use, practice has often been far away from scientific evidence. Useless and varying recording methods in terms of treatment interventions have also made everything more complicated.

Therefore, there is an increasing need for establishing an overall content description of the various treatment interventions, for consensus on quality goals of treatment and for uniform recording principles in order to perform a qualified assessment of practice.

The medical treatment of opioid addicts is primarily made in the municipal drug use treatment systems and is assumed to be an integral part of each municipality's overall treatment and care services provided to drug users. Medical treatment of drug users is carried out in general practice, in hospitals and within the Danish Prison and Probation Service. The medical treatment of drug use has been characterised by much variation, one of the reasons being the different backgrounds of the doctors and the different organisational structures involved.

Also substitution treatment of opioid addicts in Denmark has been characterised by the same variation, in clinical practice as well as in treatment results. The Government's drug action plan from 2003 "The Fight against Drugs" thus stipulated the importance of strengthening medical treatment intervention in drug use treatment. In order to retain and expand the existing treatment intervention, an amount of DKK 3 mill (EUR 0.4 million) was set aside under the social reserve agreement for 2004 for the completion of quality assurance and development of substitution treatment. Following this, the National Board of Health launched a proactive investigation of the overall medical treatment of drug users in substitution treatment. The outcome was new professional guidelines for medical treatment of drug users in substitution treatment.

The purpose of the guideline is to contribute to reducing morbidity and mortality among drug users and improve the drug user's quality of life as well as reduce the use of illicit drugs. Another purpose of the guideline is thus to support and strengthen overall intervention using guidelines for the substitution treatment itself and a description of the medical core services related to the treatment. The contents of the guideline are described below.

As regards national guidelines and guidance for the social element of drug use treatment, guideline 4 on the Act on Social Services (VEJ #95 of 5 Dec 2006) describes the type of treatments that should be included in the municipal intervention for drug users, ie inpatient and outpatient services, and that the planning of treatment services should provide services to all drug users. Furthermore, the guideline also includes provisions and objectives for re-integration and after-treatment as well as drug relapse treatment.

Furthermore, the National Board of Social Services has prepared a methodology book for professionals working with drug users, "Stofmisbrug i socialfagligt perspektiv" (Drug Use in a Social Perspective) and the pamphlet "God sagsbehandling på stofmisbrugsområdet" (Good case handling within drug use) which addresses case handlers. The main objective is to ensure correct case handling and legal safety for the citizens. The aim of the pamphlet is also to act as a daily working tool to brush up applicable rules and good practice in specific situations within municipal administration or at the drug use centre. The Danish National Centre for Social Research (SFI) has described the social treatment of drug use in the report "Den sociale stofmisbrugsbehandling i Danmark" (Social Treatment of Drug Users in Denmark).

11.2 Guideline in medical treatment of drug use

According to the Danish Authorization Act (Ministeriet for Sundhed og Forebyggelse [the Ministry for Health and Prevention] 2006), a doctor must practice medicine carefully and conscientiously. The purpose of the guideline is to specify the National Board of Health's requirements for medical diligence and conscientiousness in connection with the medical treatment of opioid addicts in substitution treatment.

The guideline is a specification of the rules already in force for the medical treatment of drug use. Although the same, the professional guidelines provide for the medical substitution treatment with buprenorphine and methadone. As a new feature of the guideline, the professional guidelines are described in more detail in terms of diagnostic assessment and treatment of drug use, including polydrug use, diagnostics and treatment of somatic comorbidity resulting from drug use, including HIV and hepatitis, assessment of and general principles the treatment of mental comorbidity, principles governing prevention of unwanted pregnancy and handling of pregnant drug users as well as the use of urine sampling when treating drug users. Also, the guideline contains a section about the regulatory and organisational framework for treatment as well as a section on patients' rights.

The target group and contents of the guideline

The guideline aims primarily at doctors who are responsible for substitution treatment of opioid addicts in the municipalities. The medical treatment of drug use comprises, apart from specific diagnostics and treatment, also diagnostics and treatment of comorbidity which involves many specialities, such as psychiatry, infectious medicine, traumatology, obstetrics/gynaecology, etc. The guideline describes the medical tasks in the municipalities in relation to handling of the often multi-faceted comorbidity resulting from drug use which comprises general diagnostics and treatment of the above disease areas, including coordination of the necessary treatment in general practice and on a specialist level.

The guideline also addresses any doctor treating a drug user as a patient and other health care professionals as well as municipal and institutional administrators who are engaged in treatment of drug users.

11.3 The background and follow-up of the guideline

The guideline was prepared by the National Board of Health during the period 2005-2008. It was prepared on the basis of the current international and national scientific evidence and best knowledge within the area. During the process, core areas were defined, existing knowledge and experience was obtained, structure and content, etc was drawn up.

The provisions of the guideline include the overall general practice for the medical treatment of drug users in substitution treatment. If a doctor assesses that in this specific case there is a need for treating a patient outside the framework of the guideline, this must be explained in detail and documented in the patient's medical chart.

The National Board of Health has distributed the guideline to all municipalities in Denmark, the regions, hospital managements, the Danish Prison and Probation Service, etc and has asked the receivers to make sure that all relevant doctors in treatment institutions, departments, etc are informed about the guideline. The guideline has been printed in a hardback version and distributed to all municipalities, municipal drug use institutions, regions, the Danish Prison and Probation Service, etc. Furthermore, the guideline is presented and discussed in meetings held at treatment facilities and presented at conferences dealing with drug use.

Documentation and follow-up on the guideline

As a follow up on the guideline no. 42 on the medical treatment of drug users in substitution treatment of 1 July 2008, it was imposed on the National Board of Health to establish a quality assurance tool in the form of a recording and reporting scheme. Based on the 10 indicators of medical core services, the National Board of Health will establish a quality assurance tool by the end of 2010, when the municipalities in the form of annual electronic reporting to the National Board of Health will record activities on a local basis. By using this reporting system, the municipalities as well as the National Board of Health will gain an overview of the medical treatment within the area, and furthermore generate a possibility for proactive quality assurance of health care intervention targeted at drug users. The National Board of Health will annually give feedback on the reported data, hold an audit meeting with a view to discussing data, and the municipalities will be given access to data with a view to ongoing benchmarking.

12 Financing of drug use treatment in Denmark

This theme chapter describes the manner in which drug use treatment is financed by public means. The chapter focuses primarily on the social aspect of drug use treatment, but also explains how the medical treatment of drug use interacts with the social treatment.

In order to describe the Danish model of drug use treatment and financing, the following registers have been applied. Center for Drug and Alcohol Research, Danish Registration and Information System (DanRIS), Statistics Denmark, the "Drug Use Database" under the National Board of Social Services, and the "Tilbudsportalen".(Social Services Portal)

12.1 Organisation of drug use treatment

As mentioned in chapter 5 of this report, the responsibility for the social and medical treatment of drug users was transferred from the counties to the municipalities in 2007. Today, the municipalities have the main responsibility for drug use treatment, including the implementation of the social treatment guarantee according to the National Social Services Act, under which the municipal council is obliged to offer treatment to drug users no later than 14 days after a drug user has requested treatment. The treatment guarantee provides that the drug user may choose between publicly and privately approved treatment services of a nature similar to the one, to which the municipality has referred. The medical treatment is given under the Danish Health Care Act, but is not comprised by the treatment guarantee.

In general, there are two different treatment services: outpatient and day care/inpatient treatment. Day care and inpatient treatment are primarily private services, whereas outpatient treatment is public. Treatment of drug use - social as well as medical - is provided free of charge.

The municipalities may refer the drug user to approved treatment services which are listed under the so-called "Tilbudsportal" (Social Services Gateway on the internet) At present, there are 120 treatment services listed under Tilbudsportalen, providing drug use treatment as the primary service, where there are 13 treatment services providing drug use treatment as a sub-service²⁷.

The average rate charged for drug use services is - limited to the age group from 18 years and up - for outpatient treatment: DKK 914 (EUR121.9) and DKK1,339 (EUR 178.5) for inpatient treatment per person per 24 hours. In connection with these figures it is important to note that the rates for treatment in connection with the various offers may vary a great deal. The treatment services within both categories thus range between no charge to, for instance, a rate of more than DKK 9,000 (EUR1200) per person²⁷.

This applies in particular to financial agreements on the treatment of drug users under the Danish Prison and Probation Service. The Danish Prison and Probation Service is responsible for the treatment of drug users imprisoned for more than 3 months. In order to put the treatment guarantee into effect in the face of the limitations associated with

²⁷ Tilbudsportalen ("Social Services Gateway") www.tilbudsportalen.dk/portal

being in a prison, the Danish Prison and Probations Service has launched numerous projects during the past few years, including drug use treatment for prisoners, involving motivation projects in all the prisons in Denmark, establishment of treatment departments inside the prisons and cannabis treatment services.

12.2 Financing

The overall responsibility for financing drug use treatment in Denmark lies with the municipalities. Thus, the municipalities are financially responsible for recruiting, treatment, case handling and all other elements of the treatment course. Furthermore, some of the items are covered by public funds, including the Danish Prison and Probation Service's drug use treatment of inmates.

Each year, the Government and Local Government Denmark (KL) enter into an agreement which sets out the overall economic framework for the next year. This municipal agreement applies to all municipalities and thereby enables each municipality to adjust its service expenditures to local preferences and needs. As a main element of the municipal agreement, there is a level for the municipalities' services expenditures in the following year and a calculation of the governmental block grants channelled to the municipalities in the following year to ensure full financing of the agreed service level. As a result, all municipalities can afford the statutory treatment guarantee and other centrally stipulated requirements for the provision and contents of treatment programmes. However, the municipality will have to plan and implement the various activities.

Thus, it is the municipality's responsibility to organize treatment interventions, but the municipal board may choose to transfer treatment to the regional council, with the municipality, however, still being financially responsible.

Public expenditure

The 2009 municipal accounts show that total expenditure on drug use treatment in the municipalities was DKK 888.452 million (EUR 117.661 million). Out of this figure, expenditure on outpatient and day care treatment was DKK 572.627 million (EUR, 76.350 million) whereas expenditure on inpatient treatment was DKK 281.852 million (EUR 37.580 million). In addition to this amount, DKK 54.547 million (EUR 7.3 million) was recorded as the total of unauthorised categories, ie expenditure borne by the municipality, but not recorded under the categories mentioned above.

Compared to previous years, municipal expenditure on drug use treatment in 2009 has gone up. From 2007 to 2008, total expenditure on drug use treatment increased by DKK 101.698 million (EUR 13.560 million), whereas from 2008 to 2009, the increase amounted to DKK 34.291 million (EUR 4.57 million) (EUR (Danmarks Statistik [Statistics Denmark] 2010).

As mentioned earlier, the Danish Prison and Probation Service finances drug use treatment of imprisoned drug users. The Danish Prison and Probation Service assigns drug use treatment to either private or public treatment programmes. Expenditure is primarily covered by the so-called social reserve grants (see below) and then directly by the Budget. The Danish Prison and Probation Service's total budget for drug use treatment of imprisoned drug users in 2009 was DKK 78.4 million (EUR 10.5 million) (Kriminalforsorgen [Danish Prison and Probation Service] 2010).

Special social reserve grants

In addition to the amounts reserved by the municipalities for drug use treatment, which are, among others, spent on statutory treatment, amounts are set aside via the social reserve grants for new initiatives.

The social reserve grant scheme has existed since 1990 and is applied for special interventions within the social, health care and labour markets with the objective of improving the conditions for receivers of transfer income and marginalised groups. The grants are thus also used for initiatives targeted in particular at drug users, including the drug use treatment area. The size of the grants depends on the general increase in wages and salaries in Denmark from 2 years preceding the finance year and increases each year when the total increase in salaries ranging between 2.0 and 2.3 per cent are added to the grants.

The social reserve grants are thus a means to finance initiatives primarily targeted at transfer income recipients and particularly marginalised groups (Finansministeriet [Ministry of Finance] 2010). Examples of initiatives financed by social reserve grants are special methodology development projects, work with relatives, health promotion and prevention in the most marginalised groups at the drop-in centres, health care programmes to the most marginalised drug users as well as to pregnant drug users and special treatment programmes for women. Furthermore, the social reserve grants have also financed the introduction of the prescription heroin scheme associated with substitution treatment of drug users (read more about these initiatives in chapter 7 of this report). A number of these initiatives were originally introduced and financed by the social reserve grants and have since then been transferred to the permanent grants on the Finance Budget.

Other sources of financing

As mentioned, the financing of drug use treatment in Denmark lies primarily with the municipalities and to a lesser extent with the Danish Prison and Probation Service. Furthermore, private initiatives and institutions may apply trusts and funds for financing.

In Denmark, private insurances for drug use treatment are not common practice as treatment in Denmark is provided free of charge.

13 Annex

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Studies applied

”Alkohol i Danmark - Voksnes alkoholvaner og holdninger til alkoholpolitik” (AiD 2008), Sundhedsstyrelsen, Statens Institut for Folkesundhed og Syddansk Universitet

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 sub-stances. 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”. Sundhedsstyrelsen, 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 questionnaires were 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

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%.

”Monitorering af unges livsstil og dagligdag 2003” (MULD 2003), Sundhedsstyrelsen og Kræftens Bekæmpelse

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. 1,964 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 60%.

"Monitorering af unges livsstil og dagligdag 2004" (MULD 2004), Sundhedsstyrelsen og Kræftens Bekæmpelse

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. The survey respondents included 1772 young people between the age of 16 and 20 years. Data collection was made via questionnaires mailed to the respondents. The response rate was approximately 58%.

"Monitorering af unges livsstil og dagligdag 2006" (MULD 2006), Sundhedsstyrelsen og Kræftens Bekæmpelse

This report is based on the Danish ESPAD 1999 study (see above).

"Monitorering af unges livsstil og dagligdag 2006" (MULD 2006), Sundhedsstyrelsen og Kræftens Bekæmpelse

In 2006, 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 included 1964 young people between the age of 16 and 20 years. Data collection was made via questionnaires mailed to the respondents. The response rate was approximately 68%.

"Rusmiddelforbruget – i folkeskolens afgangsklasse og udviklingen fra 1995-1999" Institut for Epidemiologi og Socialmedicin, Aarhus Universitet (Sabroe & Fonager 2002)

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)

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)

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 was 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)

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. Data collection was carried out as 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. In the self-assessment questionnaire, the questions on drugs were put 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)

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. Data collection was carried out as 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. In the self-assessment questionnaire, the questions on drugs were put to all age groups. Interviews were carried out with 14,566 persons – a total response rate of 66.7 %. The self-assessment questionnaire was completed by 51.5 % of the selected respondents.

”Sundhed og sygelighed i Danmark 2010, Statens Institut for Folkesundhed, Syddansk Universitet

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.

”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 2234 Danish pupils participated, which equals a response rate of 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 “folkeskoler”, 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.

“Unge og Rusmidler – En undersøgelse af 9. klasses elever” Institut for Epidemiologi og Socialmedicin, Aarhus Universitet (Sabroe & Fonager 1996)

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 of participating pupils went up to 2545.

Unges erfaringer med rusmidler – i 2003 og udviklingen siden 1995. Institut for Epidemiologi og Socialmedicin, Aarhus Universitet (Sabroe & Fonager 2004)

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.

”Unges Livsstil og Dagligdag 2000 – forbrug af tobak, alkohol og stoffer” (MULD 2000), Sundhedsstyrelsen og Kræftens Bekæmpelse 2000 (Sundhedsstyrelsen & Kræftens Bekæmpelse 2002)

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 %.

”Unges Livsstil og Dagligdag 2001 – geografiske forskelle og ligheder” (MULD 2001), Sundhedsstyrelsen og Kræftens Bekæmpelse, (Sundhedsstyrelsen & Kræftens Bekæmpelse 2003)

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. 3048 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 %.

”Unges livsstil og dagligdag 2008” (MULD 2008), Sundhedsstyrelsen og Kræftens Bekæmpelse

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.

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Table 2.1.1. 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 2008

		1994	2000	2005	2008	2010
		n=2,521	n=6,887	n=4,484	n=2,229	n=5,748
16-19- years	Men	19	29	23	28	23
	Women	10	20	19	17	15
20-24- years	Men	14	24	26	23	24
	Women	9	12	16	19	16
25-29- years	Men	8	16	17	17	14
	Women	5	6	5	7	8
30-34- years	Men	9	10	10	5	10
	Women	2	3	3	3	4
35-39- years	Men	6	8	5	9	6
	Women	2	2	2	0	1
40-44- years	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 2.1.3.1. The proportion of the 16-44-year-olds (percentage) 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 of "Other drugs" covers GHP, various medicines, etc. **A combined category including "used an illicit drug other than cannabis"

Table 2.1.10. 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 past 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 National Board of Health based on SUSY 2000, SUSY 2005, AiD 2008 and SUSY 2010

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

Table 2.1.11 The proportion of the 16-24-year-olds (percentage) who have tried one or several of the different illicit drugs within the last 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 National Board of Health based on SUSY 2010

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

Table 6.1.1. Drug-related deaths in the year in question. Distribution by gender

Year	Total	Men	Women	Year	Total	Men	Women
1995	214	149	65	2002	-	-	-
1996	242	177	65	2003	-	-	-
1997	256	189	67	2004	-	-	-
1998	243	174	69	2005	208	162	46
1999	217	157	60	2006	227	167	60
2000	240	175	65	2007*	211	148	63
2001	221	153	68	200	211	155	53

Source: Cause of Death Register, August 2010

*The figures for 2007 and 2008 have increased by 2.9 per cent. and 4.5 per cent, respectively, in relation to the reported number of death certificates in order to be comparable to previous years.

Table 6.1.2. Drug-related deaths in the year in question. Based on the National Commissioner's register on drug-related deaths. Distribution by gender

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

Source: Rigspolitiet [National Commissioner's Office], 2010

*Gender not informed for 2 persons

** Gender not informed for 3 persons

Table 6.1.4. Drug-related deaths categorized by regions

	2007	2008	2009
Northern Jutland	36	35	33
Mid-Jutland	52	47	53
Southern Denmark	71	68	79
Capital Region	68	59	86
Zealand	29	24	21
City of Copenhagen	41	31	51

Source: Rigspolitiet [National Commissioner's Office] 2010

Table 6.2.1. Developments in hospital contacts after intoxications and poisonings caused by illicit drugs from 1999-2009

	Code*	1999	2000	2001	2002	2003	2004	2005	2006	2007 ²⁸	2008	2009
Heroin	T40.1	249	255	240	174	192	220	167	171	161	174	180
Other opioids	T40.2+ T40.2A +T40.2B	35	35	44	48	52	121	115	131	141	168	249
Methadone	T40.3	5	11	19	39	26	50	56	35	44	58	79
Opioids	F11.0	67	79	67	53	55	49	65	48	60	72	64
Opioids total		356	380	370	314	325	440	403	385	406	472	572
Designer drugs (excl. ecstasy)	T40.6A +T43.8A	*	2	14	21	12	15	3	6	10	40	37
Ecstasy	T40.6B +T43.6B	9	75	67	60	83	73	72	91	86	71	52
Amphetamine	T43.0A +T43.6A	*	2	24	43	54	70	73	85	172	159	210
Cocaine	T40.5 +F14.0	44	50	78	66	76	71	106	100	134	119	141
Other stimulants	F15.0	58	48	53	47	50	43	54	41	52	45	35
Stimulants total		111	177	236	237	275	272	308	323	454	434	475
Psychoactive mushrooms	T40.6C +T40.9A	7	5	10	8	3	10	6	13	13	7	12
LSD	T40.8	3	3	12	2	1	2	8	11	16	26	7
Hallucinogens	F16.0	10	15	16	5	4	6	11	5	12	8	2
Hallucinogens total		20	23	38	15	8	18	25	29	41	41	21
Cannabis	T40.7 +F12.0	98	102	164	122	125	74	86	76	97	108	139
Polydrug use and unspecified**	T40.4 +T40.6 +T40.6W +40.6X +T40.9 +F19.0	543	632	571	657	704	469	440	504	415	529	455
Intoxications and poisonings total		1128	1315	1379	1345	1437	1273	1262	1317	1413	1584	1662

Source: National Patient Register (LPR) under the National Board of Health. For 2009, data were compiled in May 2010

*New codes have been introduced in 2000 and 2004

**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

²⁸ The figures for 2007 are preliminary and data collected from the LPR effective July 2008. The final figures for 2007 may therefore change in subsequent statistics.

Table 6.2.3. Hospital contacts resulting from intoxications and poisonings categorized by age groups from 2005-2009

Age group	2005	2006	2007	2008	2009
< 20 years	230	297	332	322	296
20-24 years	260	234	273	306	287
25-29 years	182	179	188	201	166
≥30 years	594	620	629	757	913
Total	1266	1330	1422	1586	1662

Source: National Patient Register (LPR) under the National Board of Health

Table 6.3.1. Number of newly diagnosed HIV positive and AIDS diagnosed in the entire population, including the proportion of intravenous drug users, 1999-2009

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Newly diagnosed, HIV positive total	287	260	320	289	270	307	264	245	312	285	231
Newly diagnosed HIV positive with intravenous drug use (percentage of all newly diagnosed)	26 (9%)	20 (8%)	31 (10%)	31 (11%)	24 (9%)	13 (4%)	17 (6%)	10 (4%)	21 (7%)	13(5%)	15 (6%)
Newly diagnosed AIDS cases	76	59	71	45	41	61	45	53	48	34	30
Newly diagnosed AIDS cases with intravenous drug use (percentage of all newly diagnosed)	7 (9%)	7 (12%)	10 (14%)	4 (9%)	11 (27%)	4 (7%)	4 (9%)	3 (6%)	4 (8%)	6 (18%)	3 (10%)

Source: Unpublished data from the State Serum Institute. For 2009, data were compiled in March 2010

Table 6.3.2. Registered number of acute cases of hepatitis A, B, and C in the entire population, including intravenous drug users, 1999-2009

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Hepatitis A, total	88	81	63	84	71	241	48	42	28	43	33
Hepatitis A with intravenous drug use (% of all diagnosed)	0	0	0	0	0	9 (4%)	1 (<1%)	0	1 (<1%)	0	0
Hepatitis B, total *	57	64	49	62	36	44	30	20	24	25	22
Hepatitis A with intravenous drug use (% of all diagnosed)	13 (23%)	20 (32%)	12 (24%)	12 (19%)	7 (19%)	9 (21%)	3 (10%)	1 (5%)	2 (8%)	5 (19%)	2 (9%)
Hepatitis C, total *	13	15	6	5	7	8/368*	2/364	7/385	9/382	5/296	4/246
Hepatitis C with intravenous drug use (% of all diagnosed)	11 (85%)	9 (60%)	3 (38%)	1 (50%)	2 (29%)	3/274 (37%/74%)	0/250 (0%/69%)	6/272 (85%/71%)	4/277 (44%/73%)	1/197 (20%/67%)	0/173 (0%/70%)

Source: Unpublished data from the State Serum Institute. For 2009, data were compiled in March 2010

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

** ** acute/chronic hepatitis C cases

Table 6.4.1. Persons registered with drug-related primary diagnoses in psychiatric hospitals, 1999-2009

Diagnosis code	Mental illnesses or disorders caused by the use of:	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
F11	Opioids	227	227	189	172	156	155	138	123	133	136	166
F12	Cannabis	317	270	327	364	333	354	312	347	364	388	553
F13	Sedatives /hypnotic agents	204	205	199	182	159	143	150	140	154	141	130
F14	Cocaine	23	23	31	36	65	53	42	49	49	56	57
F15	Stimulants other than cocaine	71	76	75	109	99	98	93	87	91	94	95
F16	Hallucinogens	26	18	21	14	9	17	16	10	10	18	6
F18	Solvents	10	2	6	2	10	5	3	3	4	7	3
F19	Multiple or other psychoactive drugs	758	749	732	726	747	684	668	660	682	696	826
Persons with primary diagnoses, total		1636	1570	1580	1605	1578	1509	1422	1419	1487	1536	1746

Source: Unpublished figures from the psychiatric central register at the department of psychiatric demography of the Institute for Psychiatric Basic Research, Psychiatric Hospital in Aarhus. Table 6.4.1 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 to F16.x and F18.x to 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 6.4.2. Persons registered with drug-related secondary diagnoses in psychiatric hospitals, 1999-2009

Diagnosis code	Mental illnesses or disorders caused by the use of:	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
F11	Opioids	146	190	204	208	201	271	280	341	358	492	522
F12	Cannabis	566	584	637	691	759	873	908	1040	1072	1507	1646
F13	Sedatives /hypnotic agents	253	283	257	266	307	359	367	385	417	529	554
F14	Cocaine	15	17	19	34	61	66	97	118	163	210	217
F15	Stimulants other than cocaine	58	52	58	56	73	123	120	162	179	235	261
F16	Hallucinogens	11	9	11	10	2	13	14	8	8	13	14
F18	Solvents	9	7	7	13	12	11	8	18	13	13	24
F19	Multiple or other psychoactive drugs	534	566	485	574	679	728	736	874	995	1176	1396
Persons with secondary diagnoses total		1506	1630	1593	1747	1844	2074	2102	2430	2632	3418	3718

Source: Unpublished figures from the psychiatric central register at the department of psychiatric demography of the Institute for Psychiatric Basic Research, Psychiatric Hospital, Aarhus. Table 6.4.2 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 to F16.x and F18.x to F19.x (secondary diagnosis) used as retrieval criteria. Since a patient can have several drug-related secondary diagnoses, the "total" category is not a summation.

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Filed reports leading to charge	12,928	12,956	12,902	12,851	14,272	16,390	19,037	19,900	18,506	18,692	17,403
Source:	9,424	9,899	9,858	10,021	11,160	12,313	14,204	15,060	13,294	14,093	13,354

Source: National Commissioner's Drug Statistics 2010

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Heroin													
Kg	37.9	55.1	96.0	32.1	25.1	62.5	16.3	37.5	27.0	28.9	48.1	43.9	22.4
No. of seizures	2,509	2,199	1,230	1,499	1,304	966	894	1041	1064	927	1,016	906	648
Cocaine													
Kg	58.0	44.1	24.2	35.9	25.6	14.2	104.0	32.3	57.0	76.2	91.8	56.1	72.4
No. of seizures	723	885	744	780	815	881	1,095	1,207	1,615	1,901	2,098	1,858	1,365
Amphetamine													
Kg	119.4	25.2	31.6	57.1	160.6	34.9	65.9	63.0	195.0	79.4	70.4	119.8	103.8
No. of seizures	1,324	1,609	1,250	1,152	954	1,134	1,264	1,388	1,573	2,022	2,215	1,543	1,260
Ecstasy													
Kg	5,803	27,039	26,117	21,608	150,080	25,738	62,475	38,096	44,195	22,712	82,390	17,631	53,929
No. of seizures	110	143	197	444	331	340	322	1388	461	540	452	251	200
LSD													
Doses	381	105	83	1,108	156	38	22	483	1201	521	47	482	468
No. of seizures	15	24	15	18	29	8	7	13	12	8	13	21	18
Cannabis													
Kg	467	1,572	14,021	2,914	1,763	2,635	3,829	1,758	1,406	1,035	877	2,914	1,220
No. of seizures	4,886	5,904	4,569	5,561	5,788	5,234	5,942	7,313	10,292	10,962	9,301	8,365	7,430

Source: National Commissioner's Drug Statistics 2010

Table 10.3.1. Distribution between drug types on a user level, 1998-2009

Year	1998*	1999*	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
	n=208	n=216	n=188	n=152	n=198	n=188	n=200	n=196	n=203	n=200	n=195	n=195
Heroin	56%	45%	44%	45%	40%	39%	33%	34%	33%	30%	27%	28%
Amphetamine	17%	23%	17%	22%	24%	20%	29%	23%	34%	30%	31%	29%
Cocaine	23%	27%	24%	22%	30%	32%	34%	36%	30%	34%	35%	37%
Ecstasy*	<1%	3%	7%	9%	2%	-	-	-	-	-	-	-
Methamphetamine***	-	-	-	-	-	4%	1%	5%	1%	2%	3%	3%
Other psychoactive substances/drug combinations	1%	1%	5%	1%	3%	4%	3%	1%	2%	2%	3%	3%
Non-psychoactive	1%	<1%	3%	1%	2%	1%	-	2%	1%	2%	2%	1%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Source: Kaa et al. 1998 to 2005; Lindholst et al 2008; Lindholst et al 2009, Lindholst et al 2010

*In 1998 and 1999 figures were included from Elsinore Police District

** Ecstasy was excluded from the "Street-Level Project" from 2003 and is now monitored independently. See "Monitoring of ecstasy pills on the market" in the next section.

***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. Methamphetamine appears rarely and sporadically in the early years and is contained in the category "other psychoactive substances/drug compounds" until 2003. The latter category for the entire period also includes the samples, in which methamphetamine occurs in combination with other substances

Table 10.3.2. Distribution between heroin base and heroin chloride, 1998 – 2009

	1998*	1999*	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
	(n=118)	(n=97)	(n=82)	(n=69)	(n=80)	(n=73)	(n=66)	(n=66)	(n=66)	(n=60)	(n=52)	(n=54)
Heroin base	72%	71%	61%	77%	76%	84%	77%	76%	65%	72%	77%	69%
Heroin chloride	28%	29%	39%	23%	24%	16%	23%	24%	35%	28%	23%	31%

Source: Lindholst et al 2010

*In 1998 and 1999 figures were included from Elsinore Police District