



European Monitoring Centre  
for Drugs and Drug Addiction

 **Sundhedsstyrelsen**  
National Board of Health

**2011 NATIONAL REPORT  
(2010 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 2011 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 the 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 abuse. In addition, the report provides an outline of applicable Danish law and politics within the drugs area.

Ms Kari Grasaasen, specialist drug consultant, has had the coordinating responsibility for the preparation of the report as well as the chapters on epidemiology. Ms Maria Koch Aabel, academic office at the National Board of Health has prepared the chapter on prevention and Ms Helle Petersen, staff specialist at the National Board of Health, has prepared the chapter on health care interventions in relation to drug abuse and the theme chapter on treatment guidelines. Mr Niels Løppenthin, chief consultant at the Directorate of the Prison and Probation Services, has written the chapter on drug abuse in the prisons, and Maj Olofsson, chief consultant, Hvidovre Hospital, has written the theme chapter on drug abusers with children. The remaining sections of the report have been prepared through contributions from various units at the National Board of Health, especially Documentation of Public Health by expert consultant Claudia Ranerier. Other institutions involved in the drafting of this report include the Ministry of Health, the Ministry of Social Affairs and Integration, the Ministry of Justice and other authorities and collaborative partners.

The National Board has appointed a reading panel which has contributed with comments and constructive criticism. The reading panel is made up of medical consultant Henrik Sælan, Peter Ege, expert drug abuse adviser to the National Board of Health, Mads Uffe Petersen, senior lecturer, Steen Møller Bach, Leader of SSP and Preventive Intervention, and Anne-Marie Sindballe, expert consultant. Layout and proofreading was made by Ms Birgitte Neumann, the National Board of Health.

November 2011

Else Smith  
Director General

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# Summary

## **The current drug situation in Denmark**

In 2010, the National Board of Health made a new estimate on the number of drug abusers in Denmark. This estimate shows that the number of drug abusers in Denmark is 33,000, of which 11,000 are cannabis abusers. Compared to previous years, this is an increase. In 2006, the number of drug abusers was estimated to be 27,000, of which more than 7000 were drug abusers. This increase in the estimated number of drug abusers is thus dominated by an increase in the estimated number of cannabis abusers from a little over 7000 in 2006 to 11,000 in 2010. Statistics do not include experimental drug consumption, but estimates the number of individuals with a more constant use of drugs leading to physical, mental and/or social injuries. Drug addicts are thus included in the estimates, including those in substitution therapy. At present, it is estimated that 13,000 drug abusers inject the drugs. Injecting drug users are particularly at risk of developing serious injuries and diseases.

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

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

In spite of the recorded drop in the experimental use of drugs, there appears to be an increase in poisoning cases arriving at the emergency wards in Denmark. The number of recorded poisonings resulting from illicit drugs reached its peak in 2010 with 1868 cases, and it is assumed that this is a conservative estimate. 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. Over the past 10 years, the increase in poisonings is particularly attributed to the stimulants, including poisonings caused by amphetamine and cocaine.

Also, the psychiatric admissions involving drug diagnoses appear more frequently these years, however with a minor decline being recorded from 2009 to 2010. In 2010, 5,031 persons were reported with an actual co-morbidity diagnosis, and it appears that mental illness and drug abuse walk hand in hand. Polydrug use is a dominant factor in the co-morbidity diagnosis complexity. When considering the various drugs individually, cannabis is the most dominant drug on the market. The number of people admitted to psychiatric treatment with a drug-related secondary diagnosis, including cannabis abuse, totalled more than 1,700 in 2010, and the number has almost tripled over the past 10 years. Admissions involving cocaine abuse as a drug-related secondary diagnosis (214 persons in 2010) are significantly fewer in numbers, but also here we have seen an increase in recent years. Stimulants other than cocaine are to an increasing extent a contributory cause of the psychiatric admissions these years.

Among the health consequences of drug abuse, increased mortality should be mentioned. Drug abusers have very high mortality rates, generally because of poisoning and diseases, including HIV and hepatitis, and drug abusers released from prison have particularly high mortality rates shortly after their release due to poisonings. After a few years of decline in the recorded drug-related deaths, there appears to be an increase again from 2008 to 2009 with drug-related deaths rising from 239 to 276. The same level as in 2009 is recorded in 2010 with 273 drug-related deaths. Most of the drug-related deaths are caused by poisoning, with others being caused by violence, suicide and diseases. Annual analyses show that on average more than 3 different drugs are detected in the blood of a person whose death is drug-related, which documents a prevalent polydrug use among the drug users who die.

Finally, the consequences of drug use have also become apparent in the statistics on drug abusers admitted to treatment. In 2010, slightly less than 14,600 individuals were admitted to drug abuse treatment in Denmark, which is the highest number of recorded drug users in treatment ever. Data from all the years show that especially the young people are the ones being admitted as newcomers to treatment, typically with cannabis and/or stimulants as their abuse problem. In 2010, almost 3/4 (73 %) of the young population aged between 18 and 24 years was admitted to treatment for cannabis use as their primary problematic drug, whereas 12 % and 4 % of the young population was admitted to treatment for use of amphetamine and cocaine, respectively, as their primary problematic 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 abuse.

As a result of the increase in the drug-related deaths these years, the National Board of Health has initiated a study, the purpose of which is to determine the cause of death patterns more specifically. Due to the many poisonings caused by the illicit drugs, the National Board of Health is also working on a set of guidelines for the health care staff on how to handle patients arriving at the emergency wards with a poisoning diagnosis.

### **New developments within prevention, treatment and harm reducing initiatives**

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

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

As a result of the national action plan from October 2010 targeted at drug abuse, the National Board of Health earmarked a new social reserve fund of 2.3 million EUR in the autumn of 2011 to model municipalities, where focus on the intervention would be promotion of a drug preventive environment in youth education institutions and early intervention in relation to young people on their way to drug abuse. During the past few

years, the National Board of Health's drug preventive activities have focused on party settings as a risk arena, with projects dedicated to responsible serving of alcohol and the campaigns "Against Drugs" and "Young People and Alcohol". The campaign senders are the live music stakeholders. This is the way for them to show that they have an attitude towards drugs. The aim of these projects and campaigns is also to create a safe nightlife, reduce violence and promote the compliance of age maximum age for serving alcohol.

In connection with the social reserve fund agreements in recent years, a number of treatment and harm reducing initiatives have been taken. A portion of the funds have been set aside for experiments with health rooms, funds for additional drug abuse treatment of prison inmates, funds for quality assurance of the medical cocaine treatment and for the prescribed heroin scheme. Furthermore, a number of initiatives have been taken within the social area. These initiatives have been financed via the drug reserve funds under the Ministry of Social affairs and Integration.

### **New drugs and new legislation**

The National Board of Health and the National Commissioner of Police together with the three Danish forensic institutes continue to monitor drugs abused on the illicit market. In the process, a number of new drugs emerge in Denmark and are placed on the list of drugs banned by the National Board of Health. During the past few years, the synthetic cannabinoids have particularly entered the drug markets in Denmark and Europe.

Since the publication of last year's drug report, the following drugs have been made subject to control by the National Board of Health. In executive order no. 187 of 8 March 2011 on the amendment of executive order on psychoactive substances it was laid down that the mescaline cactus, methyl amphetamine and 22 synthetic cannabinoids (3-(1-adamantoyl)-1-pentylindol; AM-694; AM-2201; CP 47,497; CP 55,940; CRA-13; HU-308; 3-(4-hydroxymethylbenzoyl)-1-pentylindol (4-hydroxymethylphenyl-(1-pentylindol-3-yl)methanon); JWH-007; JWH-015; JWH-019; JWH-020; JWH-081; JWH-098; JWH-122; JWH-147; JWH-182; JWH-203; JWH-210; JWH-251; RCS-4; WIN 55,212-2) shall only be used for medical and scientific purposes. The order became effective on 11 March 2011.

### **Selected issues**

The theme chapters on *Drugs Policy and Prison and Probation Service Programs* describe the policy, legislation, framework and the services applying in the Danish prisons. The theme chapter on *Drug Users and their Children* focuses on the price the children pay and the risks involved in growing up with parents who are drug addicts.

# 1 Drug policy; legislation, strategies and economic analysis

The national action plan against drug abuse from October 2010 indicates that Danish drug policy is based on four basic elements: prevention, treatment, harm reduction and control. Prohibition and control intervention will not solve the problem alone. There is also a need for targeted and persistent intervention in order to prevent, intervene, treat and reduce injury. And even more - to reduce supply of and demand for drugs.

Viewed against a relentless fight against drugs and the hope for a drug free society, the existing harm reduction initiatives may appear in conflict. However, the fact is that these initiatives are pragmatic and sensible and launched in consideration of the weakest drug abusers and society. Harm reduction will therefore continue to be a fundamental pillar in drugs policy in Denmark.

Drugs policy is based on the ban against any non-medical and non-scientific use of drugs.

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

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

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

The National Board of Health is also responsible for the national tasks in relation to the medical focus on treatment of drug abusers. In this connection, the Board sets out guidelines for medical treatment to be implemented by the municipalities. Furthermore, the Board should also monitor treatment intervention as well as follow up on the municipalities in this respect.

Finally, the National Board of Health is responsible for the overall drug monitoring, for the preparation of surveys and analyses of drug abuse in the population and the drug market, for collecting data and qualifying the data on an ongoing basis, and ultimately to act as the national focal point for the European Monitoring Center for Drugs and Drug Addiction (EMCDDA).

The Danish Medicines Agency which is placed under the Danish Ministry of Health ad-



ministers the handling of psychoactive substances for legal use. The Danish Medicines Agency issues authorisations to companies requesting to handle euphoriant for scientific or medical purposes and performs control on these drugs through inspections. The Danish Medicines Agency issues certificates for the transport of euphoriant across borders and is responsible for reporting to the International Narcotics Control Board (INCB) in accordance with the conventions of 1961 and 1971 on narcotic and psychotropic substances.

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

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

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

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

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

The distribution of responsibility on a central level requires coordination. This is handled by the Ministry of Health which acts as the central coordinator of projects carried out by various authorities. This Ministry regularly assesses the overall drugs policy, including the need for adjustment. This also includes the need for interdisciplinary initiatives as a response to current and future challenges. The Ministry is also responsible for the necessary follow-up on the implementation of the interdisciplinary initiatives which are reflected in the national action plan against drug abuse.

### **1.1 New legal framework, including new drugs under control**

In 2011, the following laws have been adopted within the drugs area:

- Act no. 183 of 8 March 2011 on the amendment of the act on the enforcement of punishment, etc. This act sets out initiatives regarding, among others, extended treatment guarantee for drug users serving time in the institutions of the Danish Prison and Probation Service in order for those with a short prison sentence and remand prisoners to be included in the treatment guarantee. Another initiative enables the Danish Prison and Probation Service to investigate the type of items that a prisoner has in his possession in his room or on himself. The initiatives are carried out as part of the action plan "The Fight against Drugs II" from 2010.

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

- In executive order no. 187 of 8 March 2011 on the amendment of executive order on psychoactive substances it was laid down that the mescaline cactus, methyl amphetamine and 22 synthetic cannabinoids (3-(1-adamantoyl)-1-pentylindol; AM-694; AM-2201; CP 47,497; CP 55,940; CRA-13; HU-308; 3-(4-hydroxymethylbenzoyl)-1-pentylindol (4-hydroxymethylphenyl-(1-pentylindol-3-yl)methanon); JWH-007; JWH-015; JWH-019; JWH-020; JWH-081; JWH-098; JWH-122; JWH-147; JWH-182; JWH-203; JWH-210; JWH-251; RCS-4; WIN 55,212-2) shall only be used for medical and scientific purposes. The order became effective on 11 March 2011.

During the parliamentary year of 2010-2011, the following bills have been introduced:

- Bill no. B 88 on the treatment with smokeable heroin, etc. When the bill was introduced, the government was urged to change the rules for dispensing heroin to the effect that the users are offered treatment with smokeable heroin and that the advantages and disadvantages of prescribing heroin as "take-way" doses are considered. The bill did not pass the second reading and therefore not voted on, but during the 1st reading, the government pointed out that an investigation would be initiated to look into the possibilities of expanding the scheme with administration methods other than injectable heroin. This investigation which has been undertaken by the National Board of Health will, however, not include an assessment of "take-away" heroin doses.

## **1.2 National strategies within the drugs area**

In spite of additional and improved programmes launched for drug abusers, society is still faced with major challenges to fight drugs. During recent years, there has been a reduction in the number of drug abusers seeking treatment for their heroin abuse, and at the same time there is an increasing number of cannabis and cocaine abusers. This shift is assumed to reflect a change in the drug use pattern in Denmark. Today, there are an increasing number of users who are dependent on cannabis and cocaine, whereas a fewer number are addicted to heroin. This has changed the intervention approach.

A national action plan has been intensified against drug abuse from October 2010, with 19 specific and new initiatives being launched within each of the four basic elements of drug policy: Prevention, treatment, harm reduction and control. The action plan also included a follow-up on a report prepared by an expert panel on cocaine abuse and submitted to the Minister of the Interior and Health in May 2010.

The action plan has led to the signing of the social reserve agreement for 2011, with a total of 9.66 million EUR being set aside for initiatives including prevention, treatment and harm reduction. Furthermore, a number of the initiatives set out in the action plan are financed at 6.5 million EUR from the Drug Funds administered by the Ministry of Social Affairs and Integration.

The social reserve agreement for 2011 is a follow-up on the social reserve agreements from 2004, 2006, 2008 and 2009 which include a number of specific initiatives, all aiming at reducing drug abuse and the ensuing injuries.

These initiatives are monitored on an ongoing basis and evaluated with a view to making necessary adjustments of the national drug policy.

### 1.3 Budget and funding schemes

With the aim of strengthening interventions within the drug abuse area, a broad majority of the Danish parliament adopted the social reserve grant agreement for 2004. In the agreement, a total of 19.5 million EUR was set aside for 2004-2007 for specific initiatives to combat drugs. To boost this intervention, a majority of the parliament adopted the social reserve grant agreement for 2006. In the agreement, 33.6 million EUR were set aside for the years 2006-2009 for additional specific initiatives to combat drugs. And this agreement was strengthened even further for 2008 and 2009 when 16.4 million EUR were set aside for new specific initiatives. Financing of most of the initiatives in the two agreements is permanent, which means that the initiatives stretch beyond the agreement period.

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

As a follow-up on the national action plan against drug use, the following amounts have been reserved:

- In the social reserve funds for 2011, 2.5 million EUR have been set aside for a model municipality project targeted at young people and drugs.
- In the social reserve funds for 2011, 134,410 EUR have been set aside for a quality assurance of the medical treatment of cocaine abuse.
- In the social reserve funds for 2011, 3.43 million EUR have been set aside for the years 2011-2014 for an experiment with health rooms.
- In the social reserve funds for 2011, 3.5 million EUR have been set aside for the years 2011-2014 for additional treatment of imprisoned drug abusers.
- In the Drug Funds allocated by the Ministry of Social Affairs and Integration, a total of 6.5 million EUR has been set aside for initiatives within the social area.

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

In recent years, the treatment of drug users in prisons has been upgraded significantly in the budget. The budget figure for 2001 was 834,000 EUR, whereas the similar budget figures in 2011 were 12.8 million EUR.

As regards municipal expenditure, the accounts and budgets show a heavy increase since 1995 in the funds set aside for socially oriented drug abuse treatment. The figures for 2010 were thus 120 million EUR (2011 price and salary level), whereas the same figures for 1995 were 37.3 million EUR (2001 price and salary level). The municipalities' expenditure for the prevention of drug abuse and the medical treatment of drug abusers cannot be retrieved separately from the municipal accounts and budgets.

## 2 Drug use in the general population and specific targeted-groups

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. Population surveys show that the experimental use of drugs reaches its peak among the 16-19-year-olds, and very few people try drugs for the first time after the age of 20. Among those at the age of 40 years and above, only a small percentage has tried any kind of drugs within the

past year. By and large, it is the same group of young people who expose themselves to different kinds of risky behaviour. Studies document often, the same young people make up the group of heavy drinkers, daily users of tobacco and cannabis users. Also, there appears to be a significant co-variation between having used cannabis and having used one or several illicit drugs.

Results of the surveys of recent years indicate that the experimental use of cannabis and other illicit drugs in Denmark is at a historically high level, however with a falling tendency the past few years.

The most recent population survey from 2010 shows that slightly less than half (45%) of the young adults under the age of 35 years have experimented with cannabis ever, and that 14% in the same age group have tried ever illicit drugs other than cannabis. Among the adolescents under the age of 25 years, 38% have ever experimented with cannabis, and 11% have ever tried illicit drugs other than cannabis. When considering the prevalence of the drugs individually, there appears to be a falling trend in 2010 compared to 2008 in the current use of cocaine and in the use of the other stimulants such as amphetamine and ecstasy. This positive trend is particularly seen among the under 25-year-olds.

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

For the first time, a night club survey has been made in Denmark. The night club survey is part of a research project referred to as YODA<sup>1</sup>. The main results from the survey on drugs in the nightlife are described at the end of this chapter.

The various surveys referred to in the following chapters and describing the developments in the experimental use of illicit drugs among the adult population (SUSY<sup>2</sup> and AiD<sup>3</sup>), the young adults (MULD<sup>4</sup>) the very young (ESPAD<sup>5</sup>) and the night club survey provide data and methodology at the end of this report.

## **2.1 Use of illicit drugs in the population**

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

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<sup>1</sup> YODA is the abbreviation for Youth, Drugs and Alcohol.

<sup>2</sup> AiD stands for: Sundheds- og Sygelighedsundersøgelse.

<sup>3</sup> AiD stands for: Alkohol i Danmark.

<sup>4</sup> MULD stands for: Monitorering af Unges livsstil og Dagligdag [Monitoring of Young People's Lifestyles and Everyday Life]

<sup>5</sup> ESPAD stands for: Alcohol and Other Drug Use Among Students in Europe

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

### Prevalence of cannabis

The results from the population surveys among the 16-44-year-olds completed during the years 1994, 2000, 2005, 2008 and 2010 show increases in the experimental use of cannabis up to 2000. And then the figures stagnate. When considering the current use (used cannabis within the past year), 9% of the 16-44-year-olds in 2008 as well as in 2010 report having used cannabis within the past year. This applied to 7%, 10%, and 8% in 1994, 2000 and 2005, respectively. Among men as well as women, the current use of cannabis was the highest in the younger age groups (16-24 years) and then decreases by increasing age (table 2.1.1 in the Annex).

**Table 2.1.2. Percentage of 16-44 year-olds who took cannabis during the last month, last year and ever in 1994, 2000 and 2005, 2008 and 2010**

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

Source: Unpublished figures from the National Board of Health based on SUSY 1994, SUSY 2000, SUSY 2005, AiD in 008 and SUSY 2010

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

### Prevalence of other illicit drugs

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

**Table 2.1.3. Percentage of 16-44 year-olds who took cannabis during the last month, last year and ever in 1994, 2000 and 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 and AiD in 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. Percentage of 16-34 year-olds who took cannabis during the last month, last year and ever in 1994, 2000, 2005, 2008, and 2010**

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

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

**Table 2.1.5. Percentage of 16-34 year-olds who took cannabis during the last month, last year and ever in 1994, 2000, 2005, 2008 and 2010**

Used one or several of the illicit drugs other than cannabis	1994 (n=1,648)	2000 (n=4,019)	2005 (n=2,470)	2008 (n=1,710)	2010 (n=3,287)
Last month	0.1	1.8	1.5	1.4	1.3
Last year (Last month included)	0.6	5.0	4.0	4.9	3.4
Ever	4.2	13.3	16.4	16.0	14.4

Source: Unpublished figures from the National Board of Health based on SUSY 1994, SUSY 2000, SUSY 2005, AiD in 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. There is a small, however significant decrease in the current use of drugs other than cannabis among the 16-34-year-olds from 2008 to 2010.

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

**Table 2.1.6. Percentage of 16-24 year-olds who took cannabis during the last month, last year and ever in 1994, 2000, 2005, 2008 and 2010**

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

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

**Table 2.1.7. Percentage of 16-24 year-olds who took cannabis during the last month, last year and have used illicit drugs other than cannabis ever in 1994, 2000, 2005, 2008 and 2010**

Used one or several of the illicit drugs other than cannabis	1994 (n=740)	2000 (n=1,690)	2005 (n=900)	2008 (n=858)	2010 (n=1,619)
Last month	0.0	3.0	2.0	2.3	1.7
Last year (Last month included)	0.7	8.0	5.3	8.0	4.3
Ever	3.0	14.5	14.2	15.2	10.6

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

When considering the drugs individually, amphetamine, cocaine and ecstasy are the second most prevalent drugs after cannabis. As it appears in table 2.1.8 and 2.1.9 below, the proportion of the current use (substance used with 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 is a decline in the current use of all three substances, ie amphetamine, cocaine and ecstasy. This drop in the current use of amphetamine is significant for the entire group of 16-34-year-olds, whereas the drop in the use of cocaine and ecstasy is significant among the 16-24-year-olds only. The trend towards a decline in the current use of amphetamine, cocaine and ecstasy in these years is thus seen particularly among the young people under 25<sup>6</sup>. It also appears from the tables that a considerably higher number of men than women are current users of amphetamine, cocaine and ecstasy.

<sup>6</sup> The current use of the various illicit drugs exclusive of amphetamine, cocaine and ecstasy among the 16-24-year-olds appear from table 2.1.10 of the Annex.

**Table 2.1.8. Percentage of the 16-34-year-olds who had a current use of amphetamine, cocaine and ecstasy in 2000, 2005, 2008 and 2010**

	2000 (n=3,980)			2005 (n=2,456)			2008 (n=1,709)			2010 (n=3,260)		
	men	women	total	men	women	total	men	women	total	men	women	total
16-34 years												
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 1994, SUSY 2000, SUSY 2005, AiD in 2008 and SUSY 2010

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

	2000 (n=1,684)			2005 (n=894)			2008 (n=857)			2010 (n=1,612)		
	men	women	total	men	women	total	men	women	total	men	women	total
16-24 years												
Amphetamine tried within the past year	9.0	3.1	5.9	6.5	2.4	4.1	9.8	2.1	5.4	4.9	1.2	2.8
Cocaine tried within the past year	4.6	1.3	2.8	5.4	1.9	3.3	9.8	2.4	5.6	5.3	1.1	2.9
Ecstasy tried within the past year	3.3	1.5	2.3	3.1	0.4	1.5	4.0	1.0	2.3	1.7	0.6	1.1

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

Overall, there appears to be a falling trend in the use of illicit drugs from 2008 up until today. This positive falling trend these past few years is particularly observed in the current use of amphetamine, cocaine and ecstasy and particularly among the under 25-year-olds, where the decrease is significant.

### Frequency in the use of illicit drugs

In the SUSY survey in 2010, those who were currently using cannabis or other illicit



drugs within the previous month were asked how many times they had taken drugs. There was a total of 7 % among the 16-24 year-olds who had used cannabis during the previous month. Almost 59 % of these used the drug 1-3 times. The remainder took drugs more frequently (17 % used drugs 4-9 times and 24 % more than 10 times during the previous month). When it comes to indications of how frequently drugs are 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 the SUSY 2010 surveys, regional benchmarking was made on the prevalence of illicit drugs. The results show that the prevalence of cannabis is the highest in the Copenhagen area and less prevalent in the other regions. Among the young people under the age of 25 years in the Copenhagen region, it turns out that 10 - 15 percentage point more of these young people have tried cannabis ever compared those within the same age group in the other regions. As far as drugs other than cannabis are concerned, the prevalence is geographically more even and the regional differences in prevalence smaller. However, it should be mentioned that the prevalence of drugs other than cannabis among the young people under the age of 25 years peaks in the regions of Northern Jutland, Zealand and in the Copenhagen region.

### **Starting age**

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

## **2.2 Drug use in the school and youth population**

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

As shown in table 2.2.1 below, a little less than 1/5 of the 15-16-year-olds has tried cannabis ever, and approximately 6% have tried cannabis within the past month. This reflects a decrease in the experimental use of cannabis among the very young Danish school children from 2007 until today, however the level is still high. As regards amphetamine, the drug has been tried by slightly less than 3%, whereas cocaine and ecstasy have been tried by approximately 2% of the young school children in 2011. This is a 50% decrease in the experimental use of these drugs from 2007 to 2011, and this drop is significant.

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

**Table 2.2.1. The percentage among the 15-16-year-olds who tried illicit drugs in 1995, 1999, 2002, 2003, 2007, and 2011**

	ESPAD 1995 (n=2.234)	ESPAD 1999 (n=1.548)	HBSC 2002 (n=1.418)	ESPAD 2003 (n=2.519)	ESPAD 2007 (n=881)	ESPAD 2011 (n=2.190)
Cannabis tried ever	18.0	24.4	23.3	22.6	25.5	18,1***
Cannabis last month	6.1	8.1	-	7.6	10,6*	6,2***
Amphetamine tried ever	1.6	4.0	-	4.0	5.0	2,5***
Cocaine tried ever	0.3	1.1	-	1.8	3,2*	1,9***
Heroin (injection) tried ever	0.2	0.1	-	0.7	0.5	.
Smokeable heroin tried ever	1.5	1.3	-	1.0	-	.
Ecstasy tried ever	0.5	3.1	2.4	2.5	5,2*	1,5***
LSD tried ever	0.2	1.0	-	1.1	1.1	0.7
Psilocybin mushrooms tried ever	0.5	1.8	-	1.5	1.1	0.7
Sniffing tried	6.3	7.5	-	8.3	6,1**	3,9***

Sources: ESPAD 1995 (1997); ESPAD 1999 (2000); ESPAD 2003 (2004); ESPAD 2007 (2009), HBSC 2002, unpublished figures from ESPAD 2011 (unpublished)

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

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

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

Table 2.2.1 illustrates the developments in experimental use of the various drugs among the 15-16-year-olds from 1995 and up until today. Although for some of the drugs, the percentages appear to be rising drastically from 2007 to 2011, it should be taken into account when interpreting the figures that apart from cannabis, the percentages are low and show that variations on a few individuals may lead to large changes in percentages.

Compared to 2007, the random sampling made in 2011 is rather extensive. However, almost half of the selected schools did not wish to participate. Class participating rates, however, reached last year's level of approximately 90 %.

### 2.3 Drug use in special environments and among special groups

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

#### Experience with illicit drugs in night clubs

For the first time, a night club survey has been made in Denmark. (Järvinen et al 2010).

The survey has been initiated by scientists from the Centre for Drug and Alcohol Research at the Aarhus University and the SFI - the National Research Centre for Welfare, and is based on qualitative as well as quantitative study methodology. Focus of the survey is to attain knowledge about the young people's attitudes and risk perspectives on drugs and their own experience in using them.

The night club survey shows that 40% of the young club guests (at an average age of 21 years) report that at some point in their lives, they have tried an illicit drug other than cannabis (typically cocaine, amphetamine and/or ecstasy). 58% of the guests have at some time in their lives tried cannabis. When comparing these results with results from representative surveys on drug experience among the young people in general (and which is seen in the results from the SUSY survey described in the previous chapter), a significantly higher number of the young club guests have thus tried to use illicit drugs. The survey thus shows that the key cause for the higher prevalence of drugs - particularly prevalence of drugs other than cannabis - among the club guests is that these young people are oriented towards a lifestyle and a party culture, including frequent parties and a particularly high intake of alcoholic beverages.

The survey also shows that in addition to the most prevalent drugs - amphetamine, cocaine and, to some extent, ecstasy - a large part of the night club guests also have experience in the use of the less prevalent and less known illicit drugs, such as ketamine, GBH (fantasy), mushrooms and/or LSD. Approximately 10% of the club guests have all tried these drugs, which again confirms a riskier party culture among these young people than among the other young people

Polydrug use is prevalent among the club guests using illicit drugs. For instance, 19% of the young people who have tried cocaine have also tried other illicit drugs. The general idea that cocaine is a drug used in higher circles and associated with status is overthrown in the survey, which points out that the "exclusive" cocaine user - ie, one who uses cocaine exclusively and who does not experiment with other drugs - is non-existing. The survey also maintains that the cocaine rush is often combined with a very large intake of alcohol. According to the young people, cocaine is often used to prolong and intensify the alcohol rush and the "cocktail" of alcohol-cocaine represent the ultimate party rush in the clubs.

### **Attitudes and risk assessment among the young people in Denmark**

Another focus point of "drugs and nightlife" is the Danish young people's knowledge of drugs and their perception of risk in relation to various drugs. These results are not based on the ongoing nightlife survey, but on focus group interviews among the pupils in business colleges and high schools, of which some have tried cannabis, whereas the majority of them have limited experience in drug use. They are thus not different from typical young people in Denmark. Due to their own lacking experience in drugs, they build their knowledge and perceptions of various drugs on the experience and perceptions of their friends. These perceptions - known as discourse - are interesting, as often they are crucial to the young people's willingness to experiment with a drug. The survey thus shows us that to a large extent, cannabis is perceived as a harmless drug, because it is associated with normality and because smoking a joint is not as deterring as injecting or sniffing a drug. Ecstasy, on the other hand, is a drug considered to be very dangerous, because according to the young people, nobody knows what a pill contains, and because the use of ecstasy is associated with abnormality and uncertainty. Finally, cocaine is described later in the survey as a drug placed in a mid-position between dangerous and harmless. On the one hand, the young people perceive it is harmless, one of the reasons being that it is typically sniffed, and because it is associ-

ated with addiction. On the other, the drug is perceived as one without any impact on one's life as a whole and that it may even act as a "performance booster".

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

### **Alcohol and the party culture's influence on drug use**

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

Various socio-economic factors, such as the parents' educational background, the parents' drinking habits and the young people's educational level influence their intake of alcohol and their experience with illicit drugs. The extent of the parents' weekend alcohol intake also has an influence on the young people's alcohol intake and their experience with illicit drugs. The survey indicates that where a high proportion of drug-experienced young people whose parents have a lower education, the reverse is seen with alcohol abusing young people whose parents have a higher educational background.

### **Prevalence of khat among Somalis in Denmark**

In 2008, the first Danish study on the prevalence of khat was conducted (Sundhedsstyrelsen 2009b). The survey tries to draw a picture of the prevalence of and attitudes towards khat among the Danish-Somali population. 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 anymore. A very positive aspect of the survey is that the prevalence of khat is minimal in 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 to 24 years. Not only gender, but also education and marital status have an impact on the use of khat.

The attitudes towards khat among the Somalis are divided. Although two-thirds of the Danish-Somalis consider khat to be part of the Somali culture, a large share of the population finds that khat should be prohibited, which in fact it also is today. Khat use is

also considered by the Danish-Somalis to be an addictive substance (in 64% of those asked) and up to 75% 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.

### 3 Prevention

A national action plan against drug abuse from October 2010 describes the importance of targeted and persistent intervention to prevent and intervene at an early stage to fight incipient abuse. The action plan claims prevention to one of the basic elements of the drugs policy.

Young people and their parents are the most important target groups in the drug prevention programme. There needs to be an obvious focus and in addition to communicating knowledge, it must address the young people's norms and behaviour.

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

One of the National Board of Health's tasks is to support the municipalities' preventive intervention activities with informative material and communication of knowledge, methodology projects and through specific counselling of the municipalities and other stakeholders. Furthermore, the National Board of Health monitors and sets out the overall guidelines.

For several years, the National Board of Health has paid attention to the inequality of health and as a result published the report "Ulighed i sundhed - årsager og indsatser" (Inequality of Health - causes and interventions"). One of the report's focus areas is to reduce the gap in lifetime expectancy and health, including a definition of the various types of determinants each in their own place affecting the mechanisms that are the underlying cause of inequality of health some of the, some of the determinants being alcohol, tobacco and drugs. The report also addresses the significance of a coordinated and inter-political reduction of the social inequality in society. Health and inequality of health are indeed influenced by elements other than the health care system, for instance employment, social issues, etc. and it is therefore important to involve the different sectors. The same principle applies to the preventive intervention associated with alcohol and drugs. For instance, interventions involving the retention of young people in an education programme could be instrumental in preventing young people's risk behaviour related to drugs - and vice versa. The National Board of Health's publication "Sundhed på tværs" (Health across Administrative Sectors) (Sundhedsstyrelsen 2010c) focuses on the collaboration between local administration in terms of health and prevention.

#### **Universal prevention**

Universal prevention includes interventions targeted at the entire or segments of the population irrespective of risk factors and risk behaviour. Elementary school is an important intervention arena for universal prevention, as it holds the possibility of getting into contact with almost all children and young people as well as their parents. The elementary school is obliged to teach its pupils about contraception and health in the subject "Health, sex and family". Intervention in elementary school carries on as in the previous years. In the autumn of 2011, the National Board of Health published two pamphlets for parents and teachers and management on an elementary school level as

regards children, young people, and drugs and alcohol, including the drafting of parent agreements, etc.

In its publication "Vejledning for modelkommunerne i Narkoen ud af byen" [Guidance for model municipalities on "Drugs out of Town"], the National Board of Health has formulated a number of research-based principles, on which schools should base their drug preventive interventions. It is recommended that the schools formulate a drug and alcohol policy, and that they enter into collaboration with the parents on delaying their children's starting age for alcohol and on avoiding experimental drug use. Furthermore, it is recommended that the schools teach in accordance with evidence-based principles, including the use of pupil-involving methods.. A means to work with the young people's health perceptions is the research-based teaching material "Tackling". The teaching material is originally American, but in cooperation with the printing house Alinea, the National Board of Health has developed and tested it in a Danish version.

In the National Board of Health's publication "Forebyggelse og sundhedsfremme i skolen" (Prevention and health promotion in schools") (Sundhedsstyrelsen 2009a), other pupil-involving methods are described. They can be used both as drugs prevention and in other preventive areas. The methods are called "active assessments" and "you decide", and may be used to work with improvement of family relations, an important aspect of drug prevention.

The National Board of Health regularly updates and reprints the drug facts pamphlet "Stoffer - hvordan virker de, og hvordan ser de ud" (Drugs - how they affect you, and how they look) which acts as overall informative material on the most common illicit drugs. The drug facts pamphlet can also be used by personnel working with drug and alcohol prevention in youth education institutions and in a local prevention context.

In 2011, there has been an increasing debate on the role of the youth education institutions in the preventive work. In the autumn of 2011, the National Board of Health published two pamphlets for parents and teachers and management on young people's use of drugs and alcohol in the youth education institutions. The pamphlets were published alongside the Danish national radio's broadcasting of Danish young people's alcohol culture.

The National Board of Health is also responsible for administering a new social reserve fund dedicated to young people, alcohol and drugs. The purpose of this fund is, among others to test whether a binding collaboration between the local authorities and the youth education institutions may have a positive effect on the prevalence of drugs and alcohol among young people. The contents of this project are to combine universal preventive intervention in the form of alcohol and drug policies with selective/indicated intervention aiming at the young people who are problematic uses of drugs and alcohol (see the chapter on selective prevention).

The building focus on alcohol and drug prevention in youth education institutions also means that in an increasing number of municipalities, this combination of universal intervention and intervention aiming at young people at risk is being launched, e.g. through implementation of alcohol and drug policies and counselling of young people in colleges, business colleges, technical colleges and production colleges. In Holstebro Municipality, one of the interventions launched is known as "Åben mobil rådgivning" [Open mobile counselling in youth education institutions, where 2 employees via contact from teachers, pupils or student counsellors reach out to young people who are dysfunctional and at risk of ending as abusers.

### 3.1 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 it is described in the section on national and local media campaigns, festivals and music venues. In numerous municipalities, courses are offered for restaurant owners and people working in the nightlife environment, and 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 10 municipal projects, the aim of which, from 2008 to 2011, is to test and develop ways to work with health among young people. The fund has also supported 3 projects which have been involved in upgrading the professional staff working with young people. The aim has been to connect and retain the young people in either the educational system or the labour market. The projects focus on numerous lifestyle factors such as well-being, food, exercise, smoking, alcohol, sex, drugs, 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 evaluation of the social reserve grant from May 2011 and a summary case collection provide different and very action oriented suggestions in terms of how to work with health for the group of vulnerable young people. In general, the evaluation indicated that the production schools, business colleges, and the student counselling sectors are important arenas for health care promotion as these places are where we find the vulnerable young people. The evaluation also shows that it is important to define a clear policy on health and well-being and to include this policy consistently when launching activities and that competence development of teachers and other professionals may contribute to inspiring the young people. A great deal of the projects have concluded that the young people prefer to live in a healthy environment and to have an influence on their surroundings. Last, but not least, the evaluation shows that there is a correlation between a healthy lifestyle and well-being and that it is important with dialogue-based and recognizing methods when addressing the problems of the young people. Evaluations and other material from the project can be downloaded at [www.sst.dk/ungogsund](http://www.sst.dk/ungogsund).

The activities in Odense focus on the concept of intoxicant competencies – the ability to deal with intoxicants in an appropriate manner – and comprises talks in the municipality's schools and colleges (general upper secondary education), preparation of intoxicant policies and anonymous counselling of young people with drug use problems. The results of the project indicate that the young people need to discuss the use of intoxicants with adults, and they seek respect and a no-nonsense approach from the adults. However, this is not always a given - drugs and alcohol are often taboos in the adult world. The approach involving a dialogue with the young people in the project has been based on recognition and respect, leading to good results.

#### **Young people's use of alcohol and drugs**

"Unges Misbrug" (Young people's use of alcohol and drugs) is a national knowledge centre providing counselling services to local authorities and their specialist staff in-



volved in working with young people's drug and alcohol problems This knowledge centre was established in 2008 and 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 tracking down the young people who have a problematic use of drugs and alcohol and on interventions targeted at reducing their drug and alcohol problems through large-scale intervention. "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](http://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. 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 Copenhagen Municipality 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. This project concentrates on open anonymous counselling and long-term programmes, under which young people can get help for their use of cannabis and other intoxicants. This project provides group as well as individual counselling. Also, counselling is provided to families, friends and boy/girlfriends of young people who wish to cut down on their use of intoxicant as well as to consultants working in schools, social centres and institutions. The project collects experience from the work with the young people and does a tremendous effort to convey this information. One of the features of the project is an inspiration bank on its website [www.urn.dk](http://www.urn.dk) for professionals working with prevention and treatment of young drug users.

During the period 2009-2010, U-turn ran a group treatment project with young people in production schools in the Copenhagen Municipality. The target group was young people using cannabis. Evaluation of the project in 2011 indicates that the cannabis groups have had a positive outcome, both in relation to making the young people stop smoking cannabis and to smoking less. For instance, the share of daily smokers within the group was reduced by 87% and 6 of the 18 youngsters stopped smoking altogether. And this was still in effect three months after the termination of the project. Furthermore, a large portion of the group of young people succeeded in continuing their education or work (U-turn 2011).

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

As mentioned earlier in this chapter, the National Board of Health activated a new social reserve fund in the autumn of 2011. This fund was named "Unge, alkohol og stoffer" [Young people, alcohol and drugs] and its purpose was to test whether increased and binding cooperation between the local authorities and the youth education institutions could be a means to limiting the prevalence of drugs and alcohol among young people. A total of DKK 2.28 million EUR has been reserved for a local application fund, and it is expected that grants will be given to between 5 and 7 model municipal projects. The aim is to enhance the municipalities' interventions in relation to prevention against alcohol and drugs among young people. The project is supposed to contribute to the development of methods for promoting a drug-preventive environment in the youth education institutions and to early counselling/guidance for the young people heading for problematic use of intoxicants. Furthermore, the project will test whether drug and alcohol policies, action plans, tracking and early intervention in youth education institutions can be strengthened through binding cooperation between the local administrative authorities and the local youth education institutions. The project will be running until 2014.

### **Texting advice**

In 2005, the texting-based prevention initiative titled SMASH (SMS + HASH) was launched as an anonymous support and counselling project for young cannabis users with the purpose of providing harm reduction, information and support in relation to stopping cannabis smoking. 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](http://www.smash.dk)) and expanded its activities with counselling and support in relation to "faster" drugs such as amphetamine, ecstasy and cocaine as well as an alcohol package.

In addition to SMASH, another project - [netstof.dk](http://netstof.dk) - has existed since 1998. From being a small website, [netstof.dk](http://netstof.dk) has now developed into a comprehensive and interactive gateway for the young people. 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.

### **Project responsible alcohol serving**

In 2009, the National Board of Health launched a project known as "Ansvarlig udskænkning" (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 urges these model 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 subproject has the following goals:

- to encourage responsible alcohol serving in bars and occasional licenses
- to reduce alcohol-provoked violence and injuries
- to create a safe nightlife, including the creation of a sound environment for the young people to move in.

The project is based on the Danish experience gained from projects such as Safe Nightlife and Drugs out of Town as well as experience from the Swedish STAD-project "Ansvarsfull alkoholserving i kromiljöer". Evaluation of this project concurs with international research that there is a considerable effect from systematic and coherent intervention in order to promote responsible alcohol serving. Responsible alcohol serving has also turned out to have a reduced effect on the prevalence of drugs in the nightlife. 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, education institutions, etc). This cooperation should lead to:
  - Avoiding aggressive marketing and drinks serving inviting to heavy, speedy intake of alcoholic beverages , e.g. "happy hour"
  - Education of waiters and police
  - Common understanding of control tasks

Midterm evaluation of the project from April 2011 shows that the collaboration in the municipalities works well, and that a collaborative forum is a sound basis for a constructive dialogue between the parties. All the municipalities have established a license board, and the preparation of alcohol serving plans and plans for occasional drinks serving are well underway. The major challenges of the projects are of an organisational nature and include a definition of how time consuming it is to get this type of collaboration to work internally and externally. The final evaluation of the project is expected to be completed in October 2011.

### **3.2 National and local media campaigns**

Media campaigns in the form of mass media communication aiming at the entire population or the broad target group are not used in the drugs prevention in Denmark. The reason is that when all is said and done, the use of illicit drugs only exists in a fraction of young people, however receives much attention in the media. Therefore, 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

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<sup>7</sup> [www.fhi.se](http://www.fhi.se)

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 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**

The National Board of Health's collaboration with the live music organisation, Danish Live, on a drug preventive "Against Drugs" campaign was launched on 15 festivals in 2011 ([www.festivaldanmark.dk](http://www.festivaldanmark.dk), [www.dansklive.dk](http://www.dansklive.dk)). Primary target group of this collaboration is the young festival participants and in particular the 16-25-year-olds. The festivals have good experience in using the material, which consists of printed and electronic elements. The festivals also have statements in their programs and festival newspapers. All elements contribute to signalling a common stance on 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 2010, the survey among the Roskilde Festival audience showed that more than 85 % had seen the campaign, whereas 29 % had discussed the statements with their friends, and 94 % of the audience liked that the festival has an attitude towards drugs (Sundhedsstyrelsen 2010b). Since 2009, the evaluation of the campaign has been expanded by a number of surveys among the audience at three other festivals (in 2010 Jelling, Samsø, Skive) than the one in Roskilde.

The three festivals address various target groups and may therefore give a more nuanced image of the campaign's reception on a national basis. The campaign material varied a bit at the three festivals, but 65% of the festival participants had seen the campaign in 2010, whereas less than 1/3 had discussed the message at the three festivals. On the other hand, almost everybody thought it was a good idea that the festivals voiced their attitude towards drugs. Evaluation of the 2011 campaign is expected to be completed in October 2011. This evaluation will again be based on a representative selection of the festivals involved.

### **Festival danmark: Young people and Alcohol**

In 2010, 15 festivals participated in the National Board of Health's and Festival danmark's campaign "Young people and Alcohol with the slogan: "Less drinking - More party". The aim of the campaign is to encourage the enforcement of age limits when serving alcohol to young people. The primary target group of the campaign is the young people's parents and employees at the festivals, but the campaign also addresses the young people under the age of 16 years. The campaign elements are located near the tent sites and in the bar areas and consist primarily of printed media as well as a website.

The evaluation for the 2010 festivals, which included those held in Jelling, Samsø, Skive, 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. Approximately 60% of the festival participants in Jelling and Samsø had noticed the campaign, whereas it did not really gain ground in Skive, where only a mere 50% had noticed it. Between 14-19% had discussed the message. Among the staff/parents at the festivals, the campaign gained ground (74-87%), and in general, the campaign received much acclaim. Overall, the Young People and Alcohol campaign was most seen on fence banners, the festival programme, bar posters and badges. At the Roskilde Festival, the audience noticing the campaign was larger than in 2009, when 46% of the

festival goers had seen the campaign compared to 29% in 2009. Also a higher number of the staff had noticed the campaign in 2010. The percentages here were 63% compared to a mere 33% in 2009. Almost all the employees supported the campaign. In 2011, 14 festivals have been included in a new edition of the Young People and Alcohol campaign and an evaluation is expected to be finalised in October 2011.

### **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 2010. 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, wardrobe numbers, stickers, go cards, etc. Feedback from the audience and the staff for the 2010 campaign was very positive with the group being in favour of the music venues displaying an attitude towards drugs. However, the feedback also indicates that it is more difficult to get the message through at the music venues than at the festivals. In 2011, the campaign will run from September until year-end with the same focus: that the music is capable of giving the positive experiences that some people try to find in drugs.

## 4 Problem drug use

The current estimate on the number of drug abusers in Denmark is based on figures from 2009 (completed in 2010). The estimate has been made using a capture-recapture method and has been prepared in accordance with guidelines from the European Monitoring Centre for Drugs and Drug Addiction, EMCDDA. The calculations thus adhere to European standards for such estimates.

The number of drugs abusers in Denmark is estimated to be 33,000, of which almost 11,000 are cannabis users only. Compared to 2001, 2003, and 2005, there appears to be an increase in the estimated number of drug abusers. During the period from 2005 and until 2009, the increase in the estimated number of drug abusers is primarily among cannabis users.

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

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

### 4.1 Estimated number of drug abusers in Denmark

The current estimate on the number of drug users in Denmark dates back to 2009 (Sundhedsstyrelsen 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, which was made in 2010, was based on the capture-recapture model<sup>8</sup>. 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 aim was to investigate the total number of persons registered in the LPR with a drug-related diagnosis<sup>9</sup>. An analysis was then made 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.

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

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<sup>8</sup> 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.

<sup>9</sup> 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.

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 abusers in Denmark 1996-2009**

	1996	1998	2001	2003	2005	2009
Estimate of drug abusers in DK	20,284	24,394	25,514	26,468	27,896	33,074
95 % confidence interval	± 1.592	± 1.937	± 1.789	± 1.590	± 1.628	± 1.923

Source: The National Board of Health 2010

In spite of the statistic uncertainty of the estimates, the number of drug users rises 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 abusers is 33,000 +/- 1,900 persons. In 2009, the number of drug abusers is estimated to be 33,000, of which 10,900 alone are considered to be cannabis abusers. As regards cannabis abusers, the number has increased throughout the period, as the estimated number of cannabis abusers was 7,900 in 2005.

In recent years, the "population" of drug abusers receiving treatment, which is one of the 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 abusers seeking treatment for opioids/heroin addiction, while there is an increasing number of abusers seeking treatment for addiction to cannabis and 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-abusing 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 families 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 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 abusers is 33,000, of which 11,000 are cannabis abusers. As it is estimated that there are 13,000 intravenous drug users in Denmark, this means that 2/3 of the drug abusers (in which the cannabis users are not included) are addictive to intravenous drug use.

The 13,000 intravenous drug abusers 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, be it outpatient treatment, day care treatment or inpatient treatment. By far the majority of all drug-related treatment is targeted at drug use and the ensuing social and health problems. Each municipality must ensure the requisite coherence between medical treatment and social treatment as well as any other social support.

Most drug abusers 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 should always be given an offer for social treatment as required. However, a treatment plan prior to initiation of treatment must always be set out.

The number of drug abusers in treatment has increased steadily since the National Board of Health in 1996 started recording drug abusers 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 abusers 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 2010, the number of drug abusers admitted to treatment increases.

At present, there are 14,000 drug abusers in the National Board of Health's records on drug abusers receiving treatment. In 2010, more than 8,000 of these drug abusers received 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.

As a consequence of the new drug action plan from 2010, a number of new treatment programmes have been initiated in 2011, see section 5.4 for further information.

### 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 abuse, and for preparing a treatment plan for the following course of treatment. This treatment plan must follow the action plan in accordance with section 141 of the Social Services Act.

The social treatment of drug addicts must be initiated through a referral which includes

an individually planned treatment course of day, outpatient or inpatient treatment. In Denmark, drug abusers 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 abuser 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 abusers who have been referred to treatment are entitled to choose between public treatment programmes 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 abuser is to secure correlation between the medical and the social aspects of drug abuse treatment as well as the other social problems resulting from drug abuse.

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 abuser. 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 abuse treatment addresses the drug abuser'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 abuse rests on a decision of an individually laid out plan, according to which the drug abuser is referred to a specific treatment programme on the basis of medical assessment. It is a prerequisite that the drug abuser'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 abusers (substitution treatment). This obligation is laid down in Section 142, ss 1 of the 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.

## **5.2 Drug abusers admitted to treatment**

As of 1996, The National Board of Health has recorded all drug abusers 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 addiction. 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 2010.

<b>Table 5.2.1. Clients admitted to treatment for drug abuse with admission date in 2010</b>	
Clients admitted to treatment in 2010	5,337
Number not treated previously (%)	35
Share of men/women (%)	77/23
Average age men/women (%)	31/31
Opioids as primary drug (%)*	32
Cannabis as primary drug (%)*	49
Stimulants as primary drug (%)*	13
Injection, previously treated heroin users (%)	37
Injection, non-previously treated heroin users (%)	14
On payroll (%)	12
Daily cash benefits (%)	3
Cash benefits (%)	50
Early retirement pension (%)	13
Other income and uninformed income (%)	22
Own dwelling (%)	59
Single men/women (%)	76/69
Number of children living at home, under the age of 18 yrs	1,251
Number of children not at home, under the age of 18 yrs	406
Foreign citizenship (%)	7

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

\* Rate of those who report a primary drug

In 2010, a total of 5,337 persons were admitted to treatment in Denmark, which is lower than in 2009. The total number of drug users admitted to treatment in 2010 was approximately 14,600 and thus the highest number of recorded drug users admitted to treatment since the start of the register.

The share of persons who have not previously been admitted to treatment was the same in 2010 compared to 2009 – 35%. A more elaborate description of the “newcomers” to treatment will be provided later in this chapter.

### **Type of drug abuse**

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. This trend continues in 2010 with cannabis re-appearing as the drug which is most frequently reported as

the primary drug among drug abusers admitted to treatment. By far the majority of drugs abusers seeking treatment, however, use several drugs. 44% report in 2010 having used more than one drug prior to admission. The proportion is thus at the same level as last year.

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 ecstasy<sup>10</sup> as their primary substance<sup>11</sup>. These drugs are thus mainly used as a supplement. Cannabis was the primary drug for 49 % of those admitted to treatment, and is also a very prevalent secondary drug as well. Thus, 18% of those admitted to treatment in 2010 report using cannabis as their secondary drug. A total of 67% of those admitted to treatment are thus cannabis users.

### **Age and gender distribution**

In 2010, there were 77% men and 23% women receiving treatment for drug use. The share of women is thus the same as in previous years. The average age of admission in 2010 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 12 % of the group have a job, which is slightly lower than in 2009. More than half of them either receive unemployment benefits or cash benefits. In all, 25% have completed an education beyond elementary school (primary and secondary school), and 8% left elementary school before the 9th grade. The low level of education should be viewed in 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 1,251 children lived together with a drug abuser admitted to treatment in 2010, whereas 406 children under the age of 18 were placed outside home. The number of children living with drug abusers in treatment - children living at home as well as outside home - has thus decreased in previous years.

### **Foreign citizens**

A minor portion of the drug users receiving treatment are foreign citizens, a total of 7%. 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.

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<sup>10</sup> Here recorded as MDMA or similar drug.

<sup>11</sup> The percentages have been calculated on the basis of the part of the treatment population who has reported a primary drug.

## 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 abusers 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 abuse and the recruitment of new drug abusers. 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**

	2005	2006	2007	2008	2009	2010
Clients who have not been treated earlier	1,578 out of 5,228	1,329 out of 5,426	1591 out of 4911	1,742 out of 5,394	1,937 out of 5,659	1,882 out of 5,377
	(30 %)	(24 %)	(32 %)	(32 %)	(34 %)	(35 %)
M/W (%)	75/25	76/22	78/22	74/26	77/23	77/23
Average age M/W	27/28	27/27	28/28	28/27	28/28	27/27
Opioids as primary drug (%)*	19	15	17	15	12	11
Cannabis as primary drug (%)*	46	50	53	56	65	67
Stimulants as primary drug (%)*	20	27	26	25	19	19
Injecting heroin abusers (%)	19	18	24**	23	17	14

Source: The National Board of Health's register on drug users admitted for treatment in 2005-2010.

Data for the period 2007 to 2009 has been updated in accordance with previous publications.

\*Percentage of those reporting primary drug.

\*\*An increase is seen from 2006 to 2007 in the share of newcomers 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, 35 % of the admitted clients in 2010 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 substance 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 67% in 2010, which is an increase compared to previous years. Among the 1,882 newcomers with a reported primary substance, only 11% report opioids as their primary substance, and 19% report having taken a stimulant (in this case amphetamine, cocaine or ecstasy), which is the same level as in 2009, 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 14% of those who have not been treated previously report having injected the drug,

whereas 37% of those treated have previously 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 abusers 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 abusers receiving treatment (Sundhedsstyrelsen 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 2010, 5,183 of the clients receiving treatment are aged between 18 and 29 years, which is the highest level since the start of the register. When comparing the youth population in drug abuse treatment and the total number of Danish youngsters in the same age group, a figure of 5,183 means that 6.7 out of every 1,000 young people aged between 18 and 29 years were receiving treatment in 2010, which is the same level as last year.

**Table 5.2.3. Distribution of primary substance for clients admitted in 2003 and 2010 with a known primary drug (percentage)**

	2003		2010	
	18 – 24-year-olds	All treated	18 – 24-year-olds	All treated
Cannabis	46.0	25.6	72.7	49.1
Heroin	15.3	30.2	3.9	13.0
Amphetamine	12.7	5.8	11.5	8.2
Cocaine	5.8	4.4	4.3	5.0
Ecstasy	4.0	1.2	0.6	0.3
Other opioids	4.8	20.1	2.1	18.7
Benzodiazepines	1.7	2.1	1.6	2.1
LSD	0.0	0.0	0.2	0.1
Other	9.8	10.5	3.1	3.6

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 2010, the number of young people seeking treatment for cannabis use exceeded that of 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 144 persons in 2010.

### Drug abusers 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 re-

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 2008b).

From 2008, the statistics have been based on the number of drug abusers in substitution treatment. As the statistical method<sup>12</sup> and the data basis<sup>13</sup> are different from 2008 and onwards compared to the years before 2004, the results in the various periods are not immediately comparable.

The data from the National Board of Health's register on drug abusers admitted to treatment show that among all the individuals receiving treatment for drug abuse, 7,370 people were in substitution treatment in 2010, which is the same level as in 2009. 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, 7,850 in 2010.

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 abusers who have not previously been treated and that this drug in any event should be used to the greatest extent possible in substitution treatment.

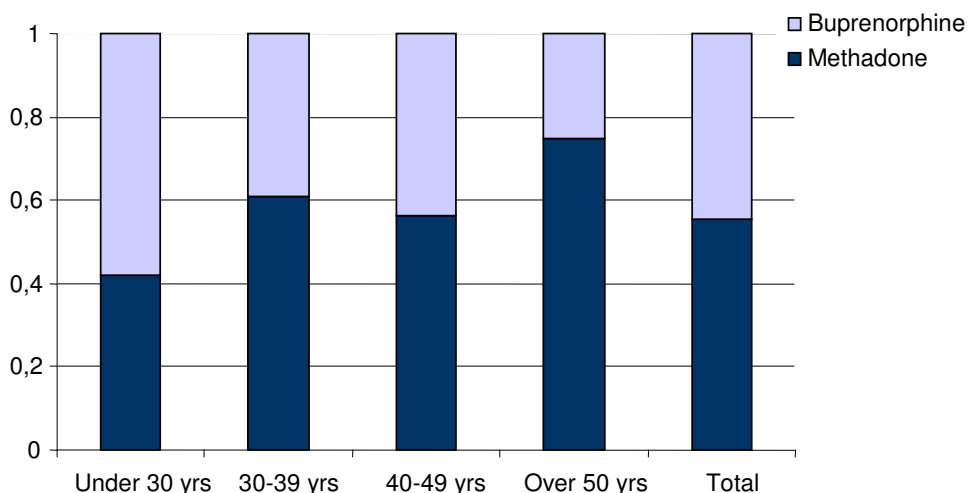
The number of individuals in substitution treatment with buprenorphine was approximately 1,280 people in 2010 and thus on the same level as in 2009. An increasing number of young people under the age of 30 years are in substitution treatment with buprenorphine compared to persons in the older age groups, cf figure 5.2.1.

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<sup>12</sup> 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 2010.

<sup>13</sup> Former statistical recordings were based on figures provided by the prescription registry, whereas this material is based on the register on drug users receiving treatment (SIB).

Figure 5.2.1 Proportion of persons in substitution treatment with buprenorphine and methadone in 2010 in different age groups



Source: the National Board of Health's register on drug abusers admitted to treatment

Among the clients admitted to treatment for the first time in 2010, 44% and 56% are being treated with buprenorphine and methadone, respectively. This is on the level of the updated data for 2009. 92 % of the newly admitted in 2010 are in drug-free treatment.

### 5.3 Drug abusers and inpatient treatment

Special data on inpatient treatment are collected from the monitoring system DanRIS-Døgn, which has been under development 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 44 in 2010. Out of this number, 37 were dedicated inpatient institutions. The table below shows the development in admissions every six months from 2005-2010.



**Table 5.3.1. Drug abusers admitted to inpatient treatment during the half years of 2005-2010**

Time	N	Age	Women
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 %
1st half year 2010	564	31.9	22 %
2nd half year 2010	446	33.4	24 %
All	7256	33.1	25 %

Source: Centre for Alcohol and Drug Research, DanRIS. STOF, 2010.

At it appears from table 5.3.1, there is a decrease in the number of admitted drug abusers in 2010 compared to 2009. The number of admitted drug abusers admitted to inpatient treatment in 2010 is also lower than in 2006, when the number of admissions was very low. The average age for drug abusers receiving inpatient treatment has not changed significantly throughout the years, and is 32.6 years in 2010. Apparently, the proportion of women has stabilised throughout the period. A person may have several admissions per year. However, at least 30 days must pass from discharge before a return to the hospital is considered a new admission. A total of 943 persons account for the 1010 admissions recorded in 2010.

The admitted drug abusers who have been recorded in DanRIS and who have completed a EuropASI-form can be categorized by their type of drug use (Table 5.3.2). The heroin group includes all those who have used heroin within the past 30 days prior to admission; the group of methadone (other opiates) abusers are all those who do not report using heroin, but who use either methadone or other opiates (for instance buprenorphine and ketogan), the group of stimulants (CSS) are individuals who have not reported any use of heroin/opiates, but who state having used either cocaine or amphetamine/ecstasy. Finally, there is the group of cannabis abusers who include individuals who do not state heroin/opiates or stimulants, but who report using cannabis.

The group of those who do not state use of any of the drugs mentioned above, but who report using either tranquillizers, sleeping pills, inhalants, hallucinogens or other (non-specified) drugs are stated as NIHA, whereas “none” includes persons who report not

having used any of the above drugs for the past 30 days prior to admission.

**Table 5.3.2 Distribution of substance groups in 2008, 2009, and 2010. Stated by clients who have completed the EuropASI form in connection with admission.**

Substance group	2008	2009	2010
Heroin	393 (40,7 %)	338 (36,5 %)	266 (35,4 %)
Methadone/opiates	199 (20,6 %)	202 (21,8 %)	157 (20,8 %)
CSS	155 (16,1 %)	159 (17,2 %)	132 (17,5 %)
Cannabis	92 (9,5 %)	123 (13,2 %)	113 (15,0 %)
NIHA	35 (3,6 %)	27 (2,9 %)	33 (4,4 %)
None	92 (9,5 %)	78 (8,4 %)	52 (6,9 %)
Total*	966 (100 %)	927 (100 %)	753 (100 %)

Source: Centre for Alcohol and Drug Research, DanRIS. STOF, 2010.

As it appears in table 5.3.2, especially the heroin group has been reduced from 2008 to 2010, ie a decrease from 393 to 266 persons (a total of 127 persons = 32%) in this group. Also the group using methadone and other opiates has been reduced. In this case, the reduction is 40 persons (21%), whereas the stimulants group has dropped by 23 persons (15%) in 2010 compared to 2009. The largest relative reduction is seen in the “none” group which has been reduced by 43% from 2008 to 2010. However, this is a small group which accounts for 7% and 10% of the total number of admitted drug abusers who have completed the ASI form. In comparison, the heroin group is the largest group accounting for 35% - 41% of the total number. Finally, it should be noted that there has been a slight increase in the cannabis group in 2009 (increase of 34%) and 2010 (increase of 23%) compared to 2008. As with the “none” group, this is, however, a small group (from 10% of the total number in 2008 to 15% of the total number in 2010). Overall, the composition of the substance groups appears to be constant from 2008 to 2010 with a slight decrease in the number of referred individuals from the heroin group and a slight increase in the share of referred individuals from the cannabis group.

### **Completion and burden rate**

The percentage of clients completing inpatient treatment as planned has increased a bit from 52 % in 2009 to 54 % in 2010. The average number of admission days in 2009/2010 is 133 days and has thus dropped by approximately one week compared to the 139 days in 2008.

In 2009 and 2010, the inpatient treatment institutions had completed the EuropASI feedback form for 74% and 75%, respectively, of the clients admitted the year before. Based on the forms, calculations were made on, among others, social burden, including housing and income.

Compared to 2009, the burden rate appears to be higher in 2010 as regards the clients' housing and income within a few areas. The number of admitted individuals without a home went up from 7% in 2009 to 11% in 2010. The proportion of clients who report making their primary living from illegal activities has gone up from 3% in 2009 to 6% in 2010.

The 1010 admissions in 2010 have been reported from 88 out of the 98 Danish municipalities.

#### **5.4 Other interventions concerning drug abuse treatment**

From 2007 to 2010, the Government sought gradually to boost quality within treatment of drug abusers in order to ensure that the drug abusers 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 abusers. In April, the book "Stofmisbrug i et socialfagligt perspektiv" [Drug Use viewed from a social perspective] was published and distributed in April 2010 to drug abuse therapists, referral personnel, case handlers and others who are professionally engaged in drug abuse. The book provides an overview, knowledge of and issues for drug reflection and inspiration in the daily work with drug users.

The following lines elaborate on the treatment oriented initiatives in the national action plan against drug abuse from October 2010, and the current status of these initiatives.

##### **Using restraint in treatment**

It is necessary to consider other countries' experience in forceful restraint in order to determine whether or not restraint should be applied in Denmark.

SFI Campbell has conducted a study on research within restraint in treatment of drug abusers. The study includes an in-depth analysis of the experience from Sweden and Norway, where today it is possible to restrain drug abusers by force without their consent. The findings of SFI Campbell does not clearly conclude the effects of forceful restraint in drug abuser treatment, whereas the findings from Norway in particular show that forceful restraint of pregnant drug abusers may be a supplementary tool to protecting the foetus during pregnancy.

Based on this, a working group has been appointed to look into the possibilities of preparing a Danish model for forceful restraint of pregnant drug addicts and alcoholics. The model is considered to include two parts: 1) The actual restraint of the pregnant female and 2) medical and social treatment programmes, including medical stabilisation/gradual withdrawal/detox aiming at the individual women during her restraint.

The working group consists of representatives from the Ministry of Social Affairs and Integration and the Ministry of Health together with the National Board of Health and the National Board of Social Services. Forceful restraint of pregnant drug abusers falls under the jurisdiction of the Ministry of Social Affairs and Integration and forceful restraint of pregnant alcoholics falls under the jurisdiction of the Ministry of Health.

##### **Combined treatment of cocaine and cannabis abusers**

This initiative involves developing treatment models that combine treatment of cocaine abuse with cannabis and alcohol abuse. The models should be made available to the municipalities for inspirational purposes. Experience from the Copenhagen Municipality shows that the cannabis and cocaine abusers enter into good relations when gathered in groups and that the groups have a more equal gender distribution. A total of DKK 8 million has been reserved for this initiative which will be running from 2011-2014. The National Board of Social Services is currently preparing guidelines and material.

### **Drug abuse training programmes for professionals**

In 2010-2013, training should be provided to professionals working with drug abusers with a focus on a broad upgrade of drug abuse therapists in relation to the social treatment plans. This training will be part of the current social diploma programme, the purpose of which is to convey recent information about the social drug abuse area as regards methods, theory, evidence-based treatment, interdisciplinary and overall intervention, user involvement, legal safety, cooperation with and in relation to the abusers, organisation within the drug abuse area, the social consequences of drug addiction and special drug abuse groups, including abusers with mental disorders. This programme is thus meant to provide a solid basis for working with drug abusers in terms of methodology and legal framework. 800,000 EUR have been set aside in 2010-2013 for this initiative. Status at present is that four schools for social education have developed modules for drug abuse in their diploma programme, and they have been offered in May 2011. The programmes start in the autumn, 2011, and the financial grant schemes have been established.

### **Competence development in relation to the socially marginalised with chaotic polydrug use**

Professionals working with socially marginalised with a chaotic polydrug use must develop their competencies. This, in particular, applies to the development of competencies of the front office employees who must be trained to handle coordination and guidance tasks as well as plan overall intervention. This initiative is part of the "Drug Abuse Training Programmes".

### **Study of the socially marginalised with chaotic polydrug use**

A study will be conducted on the scope of cocaine abuse in socially marginalised persons with a chaotic polydrug use. The study will include the type of intervention problems associated with this group as well as identify the presence of special risk groups within the group, for instance immigrants and the mentally ill, whose problems complicate intervention further. Such a study will provide a deeper insight into the issue and thus ensure that the development initiatives are targeted at the specific cocaine problem. Status at present is that the tender has been drafted.

### **Better information about citizens with co-morbidities**

The knowledge level among professionals working with individuals with a co-morbidity locally as well as regionally needs to be upgraded. The fact is that many drug abusers have a mental disorder, and that many of these citizens do not really fit into the treatment system. As a result, information material is being prepared, in which the distribution of responsibility between the various sectors is outlined, and the good experience and good cooperation between the sectors described, so that in practice it will work more optimally. A total of 67,000 EUR has been set aside in 2011 for this initiative.

### **Development of model projects with a focus on screening and diagnosis of drug abusers with mental disorders**

Based on the experience from two screening and diagnosis projects in Aarhus and Fredericia, model projects will be developed to qualify screening and diagnostic practice of abusers with co-morbidities. The aim of the model projects is to test and develop screening and diagnostic models and thereby identify the users' treatment needs in drug user centres or in psychiatric treatment. Furthermore, the coordinating collaboration between drug abuser treatment and psychiatry should be enhanced in relation to screening and diagnosis of the target group – in order to improve the overall treatment course for the abuser. The present status is that four project municipalities have been selected, and they will start their project work in the autumn, 2011. A total of 1.9 million

EUR has been set aside i 2011-2014.

### **Project with external intervention in young people with abuse problems**

A fund has been set up for experimenting with external intervention in youth education institutions. This could, for instance, be a drug abuse therapist visiting the educational institution a few hours each week or through some kind of link between the drug abuse centre and the educational institution in order for the student to receive easily accessible counselling. This could include tracking, counselling and motivating activities with the aim of retaining the young people in the educational system. The projects will be evaluated and their results communicated to the rest of the country. The funds set aside for the various applications will be publicised in 2011, and the evaluation is being planned and expected to be initiated in 2012.

### **Good treatment of young people**

Examples of principles for good treatment/good aid to young drug abusers must be disseminated with a view to inspiring the municipalities to perform better in relation to the young people. The informative material will be published early 2012.

## **5.5 Current research in drug abuser treatment**

The research focus areas within treatment of drug abuse are changed on an ongoing basis. At present, the Centre for Alcohol and Drug Research has placed its attention on the following four areas:

**Treatment of special groups of clients using specific methods, e.g. personality disorders, ADHD and trauma, etc.** In a number of ongoing projects it is studied how specific methods may influence specific psychiatric conditions such as anxiety, depression and antisocial personality disturbance (ASPD). Focus is particularly placed on ASPD. Furthermore, two PhD projects have recently been initiated with a special focus on ADHD and post traumatic stress syndrome (TSD). Finally, under this category, a study has been made on the effect of Client – Directed – Outcome – Informed, which is a treatment of young people aged between 18-30, who have developed cannabis abuse. These studies are all randomised experiments.

**Treatment of young drug abusers.** Currently as well as in recent years, there has been a high degree of focus on treatment of young people under the age of 18 who have developed into drug abusers. A major study is being conducted on, so far, 650 young people under the age of 18 who have been admitted for treatment of their drug abuse. A follow-up study has also been initiated. Furthermore, two PhD projects have been running since 2010 with a special focus on the young people's lives and the treatment provided to them.

**Treatment in a planning and target group perspective.** There is very little national and international research into the overall target group as far as planning and benefit from treatment is concerned. This current project includes a major survey in four Danish municipalities, where 13,200 randomly selected subjects are contacted. Furthermore, there is a coordination of national treatment registers and crime registers for all municipalities with a special focus on the four selected municipalities. A survey is also being conducted into municipalities' planning of drugs and alcohol treatment and the political decisions, on which this planning is based. For instance, it is investigated how many from the target group who receive treatment, who reaches the highest number from the target group, and the results of the treatment (based on register coordination). The last project worth mentioning here is **"Prison-based drug treatment in the Nor-**

**dic countries. Control and rehabilitation in Welfare State institutions**", which is a major sociological/anthropological survey of the prison-based drug use treatment in four Nordic countries. In Denmark, the project includes a survey of the treatment in three prisons and a PhD project.

## 6 Health Correlates and consequences

A number of health-related problems and consequences follow in the wake of drug abuse. Drug abusers have very high mortality rates, generally because of poisoning and diseases, including HIV and hepatitis, and drug abusers 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 dropped from 2005 to 2008 according to the National Commissioner's Register. From 2008 to 2009, there was an increase in the number of deaths, and the number for 2010 has been on the same level as in 2009. 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, but also here there appears to be an increase from 2008 to 2009.

Drug abusers 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 abusers are infected with Hepatitis C, whereas approximately 35% are infected with Hepatitis B. Less than 5% are infected with HIV.

Mental disorders in drug abusers are frequent, given that drug abuse 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 of Police 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 abuse 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. The definition includes a number of ICD10 codes on causes of death which make up a core group of drug-related deaths.

The differences between the figures in the National Commissioner's Register on drug-related deaths and the National Board of Health's Cause of Death Register are attributable to the differences in the background populations, from which the drug-related deaths have been retrieved and the differences in definitions of a drug-related death.

When the European Drug Monitoring Centre for Drugs and Drug Addiction, the EMCDDA, annually publishes comparable data on the drug-related deaths on a European scale, the data applied are primarily retrieved from the countries' Cause of Death registers (as it is in Denmark) in accordance with the definitions mentioned above. Such retrieved data are referred to as the "national definition". On this basis, the benchmarking with other European countries should be based on the "national definition" in order to ensure maximum comparability.

In a Danish context, the National Commissioner's Register on drug-related deaths is an important source in describing developments over time and contains valuable information on poisoning.

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 number then rises again.

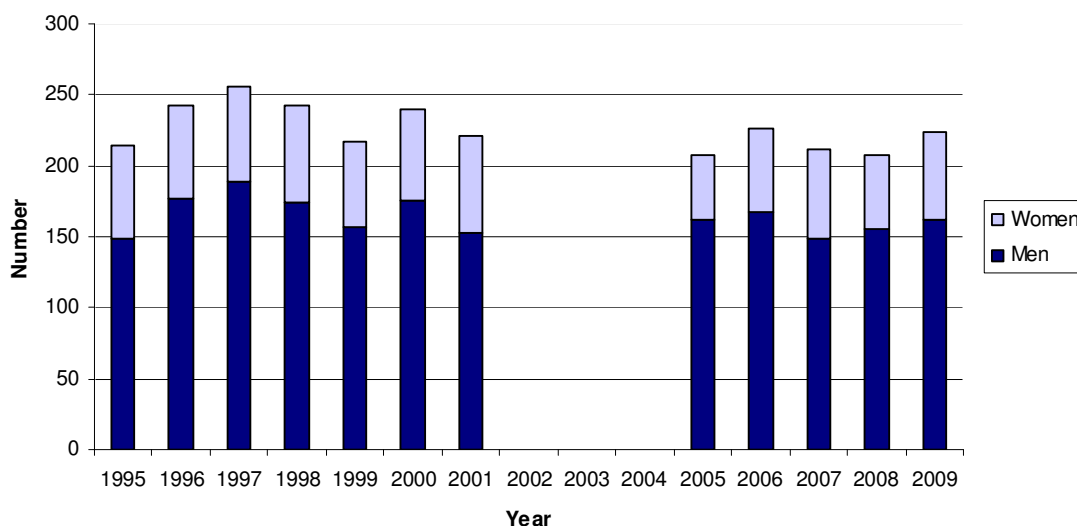
#### **The National Board of Health's register, based on the Cause of Death Register**

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 resulting from traffic accidents or other accidents, in which illicit drugs were involved have not been included here, but in the National Commissioner's Register.



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 1995-2009<sup>14</sup>.

**Figure 6.1.1. Drug related deaths 1995-2009\***



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

The data for 2007 to 2009 in the Cause of Death Register are not complete. Based on the actual number of deaths known from the CPR Register, the bars shown (and table in the Annex) for 2007, 2008, and 2009 have been increased by 2.4; 2.8, and 3.4 per cent in order to compare with previous years.

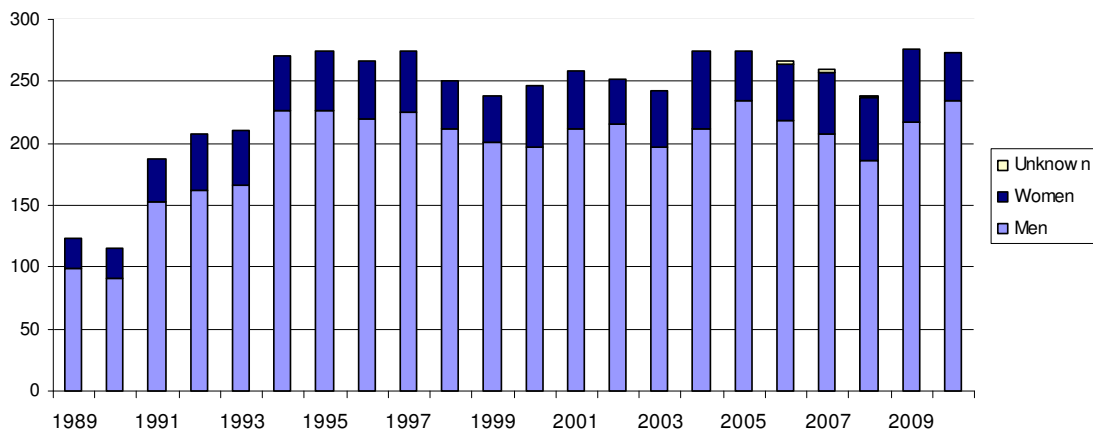
In 2009, the number of recorded drug-related deaths arrives at 222, which is higher than the number of drug-related deaths in 2008. When viewing the entire period 1995-2009, the number of deaths ranges from 200-250. The figures are lowest in 2005 and 2008 with 208 deaths being recorded. In 2009, men accounted for 73 % (161) of all drug-related deaths. During the other years, the share of drug-related deaths among men is between 69% and 74%.

From the mid-90s (figure 6.1.2), the number of deaths recorded in the National Commissioner's register is more or less the same, however with annual fluctuations (see table 6.1.1 of the Annex). In 2010, 273 drug-related deaths were recorded, and the number is thus the same as last year. Out of the 273 deaths, 86% were men (234) and 14% were women (39). The average age of death has been increasing for many years. In 1993, the average age was 33 years, whereas in 2009, it had gone up to 39.6 years. In 2010, the average age was 38.7 years and thus slightly lower than last year. The average age of death among men in 2010 was 38.2 years in 2010, whereas for women it

<sup>14</sup> Valid figures for drug-related deaths during the years 2002-2004 are not available. Furthermore, the 2010 figures have not yet been compiled.

was 41.9 years in 2010. Approximately 22% of all drug-related deaths per year occur among the young under 30 years.

Figure 6.1.2. Drug-related deaths, 1989-2010, recorded in the national Commissioner's register



Out of the 273 deaths in 2010, 75 % (204) was caused by poisonings with one or several drugs. As table 6.1.3 shows, 33 % of the poisonings (67 out of 204) were caused by heroin/morphine or heroin/morphine combined with another drug, whereas 44 % of the poisonings (89 out of 204) were caused by methadone or methadone combined with another drug. Seven of the poisoning cases in 2010 were caused by poisoning with either amphetamine (3) or cocaine (1) or ecstasy and ecstasy-like drugs (3). Of the 69 drug-related deaths, 273 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	2010
Heroin/ morphine	94 (57)	153(71)	60 (30)	81 (38)	77 (37)	83 (37)	69 (34)	70(36)	75(36)	67(33)
Methadone	51 (31)	46 (21)	97 (49)	95 (44)	89 (43)	92 (42)	84 (41)	82(42)	96(47)	89(44)
Other	9 (12)	17 (8)	41 (31)	38 (18)	40 (20)	46 (21)	52 (25)	43(22)	35(17)	48(24)
Poisonings total	154 (100)	216 (100)	198 (100)	214 (100)	206 (100)	221 (100)	205 (100)	195 (100)	206 (100)	204 (100)

Source: National Commissioner of Police, 2011

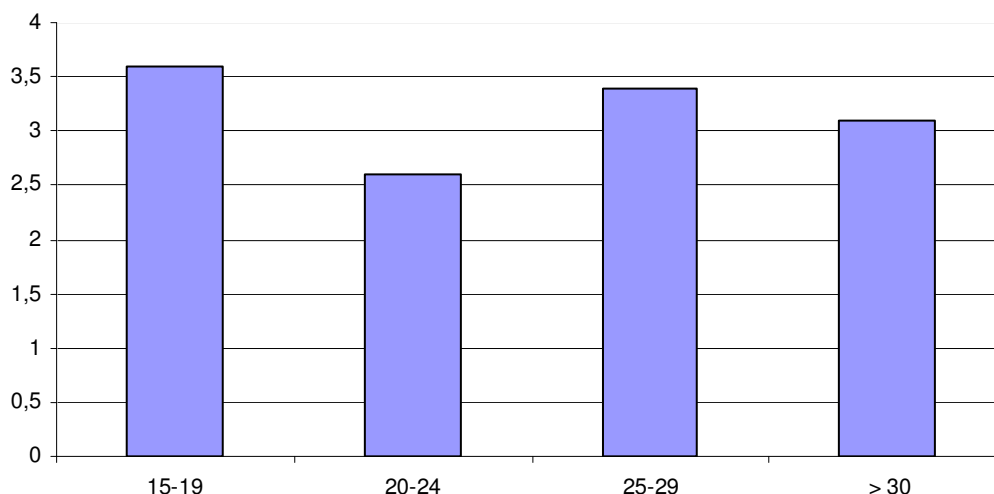
Table 6.1.3 shows the developments in deaths caused by poisoning during the years 1991, 1997 and from 2003 and up to 2010. In general, the poisoning deaths involving opioids (heroin/morphine and methadone) throughout the years account for the majority of the poisoning deaths.

From the 90s and until today, however, there appears to be a drastic change of the poisoning pattern, as within the group of poisonings with opioids from 1997 to 2003 there

is a decline in the number of deaths, where poisoning caused by heroin/morphine is reported as the primary cause, whereas there is a similar increase in the share of deaths, where poisoning caused by methadone is reported as the primary cause. Finally, since 1997 there has been a steep increase in the number of deaths where poisoning caused by “other” has been stated as the primary cause. The group of “other” contains drugs such as amphetamine, cocaine and other (strong) opioids. From the period 2007 to 2010, there is, however, a slight decline in the number and the share of these types of deaths. In 2010, the category “other” accounted for the following deaths caused by poisoning; other opioids (strong): 7, ketobemidone: 4, amphetamine: 3, ecstasy and ecstasy-like drugs: 3, anti-depressants: 2, other, e.g GHB and ketamine: 2<sup>15</sup> and cocaine: 1<sup>16</sup>.

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, etc were found in the blood of the deceased. Figure 6.1.3 shows the average number of drugs found in the blood of those who died from an overdose in different age groups.

**Figure 6.1.3. Average number of drugs found in deaths caused by poisoning in 2010 in various age groups**



Source: National Commissioner, 2011

As the figure indicates, between 3 and 4 different drugs on average are found in the deaths caused by poisoning. This is proof of a widespread polydrug use among those who die. This particularly applies to the very young.

### **Geographical developments**

Out of the 273 drug-related deaths in 2010, 110, 106 and 57 were investigated and re-

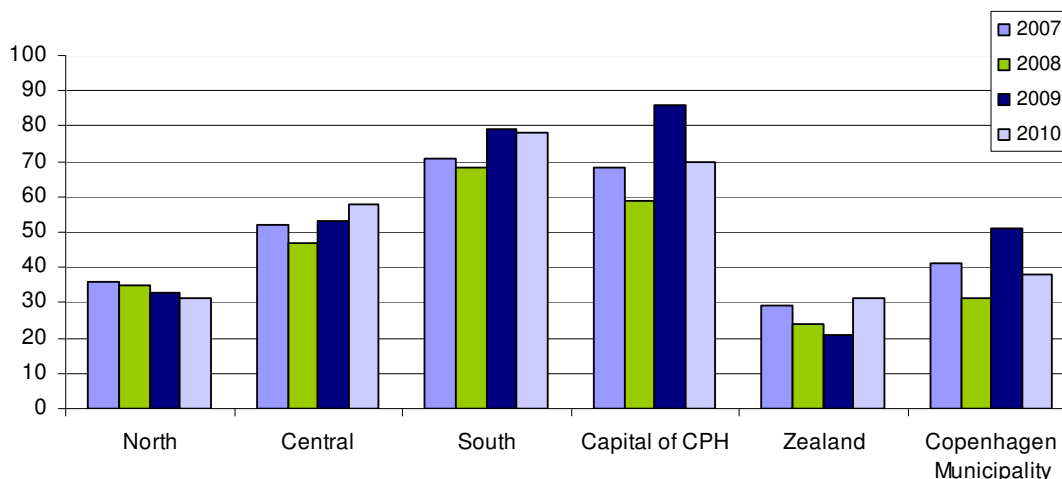
<sup>15</sup> Statistics on the group of "other" in previous years appears in the annex.

<sup>16</sup> See table 6.1.4 of the Annex for an overview of such deaths in recent years.

ported 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, 2009, and 2010 broken down by regions and the Copenhagen Municipality appears in figure 6.1.4 below.

**Figure 6.1.4. Drug-related deaths broken down by regions and in the Copenhagen Municipality**



Note: deaths in the Copenhagen Municipality are included in the bars of the Capital Region of Copenhagen

Source: National Commissioner of Police, 2011

As mentioned earlier, there has been a drop in the number of drug-related deaths from 2005 to 2008 and then again an increase from 2008 to 2010. This appears from figure 6.1.4 and table 6.1.4 in the Annex where the decrease in the drug-related deaths from 2007 to 2008 (from 260 to 239 deaths) is distributed among all the regions and the Copenhagen Municipality. Also, it appears that the increase from 2008 to 2009 (from 239 to 276 deaths) is distributed on all regions and the Copenhagen Municipality, with the exception of the North Denmark Region and Region Zealand, in which the decline continues. From 2009 to 2010 there is a decline in the number of drug-related deaths in the North Denmark Region and in the Capital region of Copenhagen, whereas there is an increase in the other three regions. These figures are based on the municipality, in which the drug abuser was registered at the time of death, and not where he/she died.

## 6.2 Poisoning caused by illicit drugs

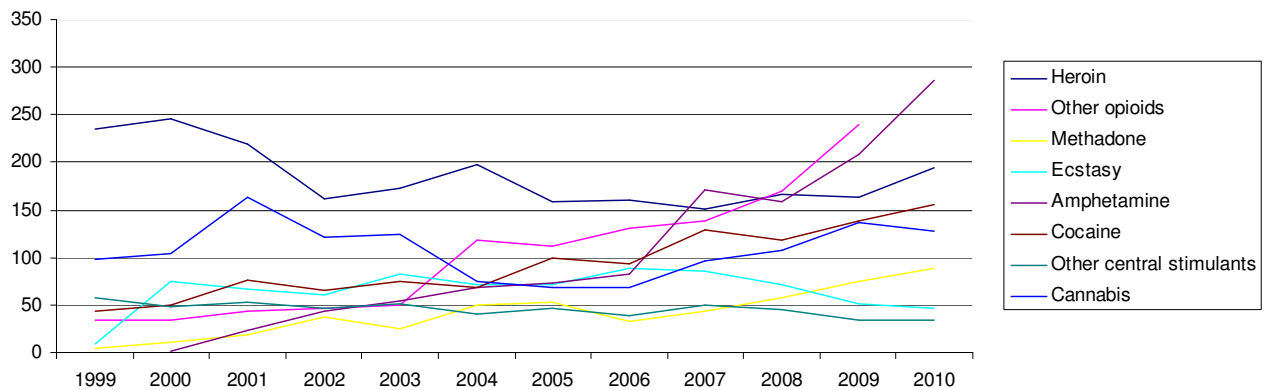
Data from the LPR (the National Patient Register) include hospital contacts following poisoning as the action diagnosis recorded at the public or private somatic or psychiatric hospitals in Denmark. This contact includes visits to the emergency ward and hospitalizations where the patient was not transferred from an emergency ward.

Table 6.2.1 of the Annex shows the scope and development of the recorded poisonings with the various illicit drugs from 1999 to 2010. 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. In 2010, different data retrieval criteria have been used, which has meant that the statistics of previous years are not identical to the ones today. Also, it should be noted that as far as data for 2010 are concerned, these were retrieved in August 2011, whereas previously they were retrieved in May/June after the year in question. This might mean that the increase from 2009 to 2010 is slightly higher than if the data had been retrieved a few months earlier instead. As mentioned earlier, the figures are stated with some uncertainty and should be read with reservation due to diagnostic and other sources of error.

A total of 16,308 cases of poisoning was recorded during the first 12 study years. A vast majority of these cases, almost 90%, were treated in somatic emergency wards/hospitals, and the remaining 10% in psychiatric emergency wards/hospitals. 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 16,308 poisonings in all 12 years (figures shown in table 6.2.1 of the Annex hereto).

**Figure 6.2.1. Developments in hospital contacts resulting from poisoning and intoxication with illicit drugs from 1999-2010**



Source: The National Board of Health's National Patient Register, data retrieved in August 2011

Annually, between 1147 and 1868 poisonings caused by illicit drugs have been registered from 1999 to 2010. Overall, the trend has been falling linearly during the period from 1147 poisonings in 2005 to 1868 poisonings in 2010, which equals an increase of more than 50%. This increase is particularly a result of intake of heroin and other opioids as well as the stimulants, especially amphetamine and cocaine.

As table 6.2.2 below indicates, most of the cases of poisoning are, not surprisingly, caused by opioids used by persons over the age of 30 and are extremely rare among the very young. On the other hand, poisonings caused by hallucinogens and stimulants are most frequently seen in the young people. 71 % of all poisonings caused by hallucinogens and the stimulants are recorded among the young people under the age of 24. 2,939 (18%) poisonings during this period occurred among the young people under 20. 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. Hospital contacts following intoxications and poisonings caused by the various illicit drugs throughout all study years (1999-2010) broken down by various age groups**

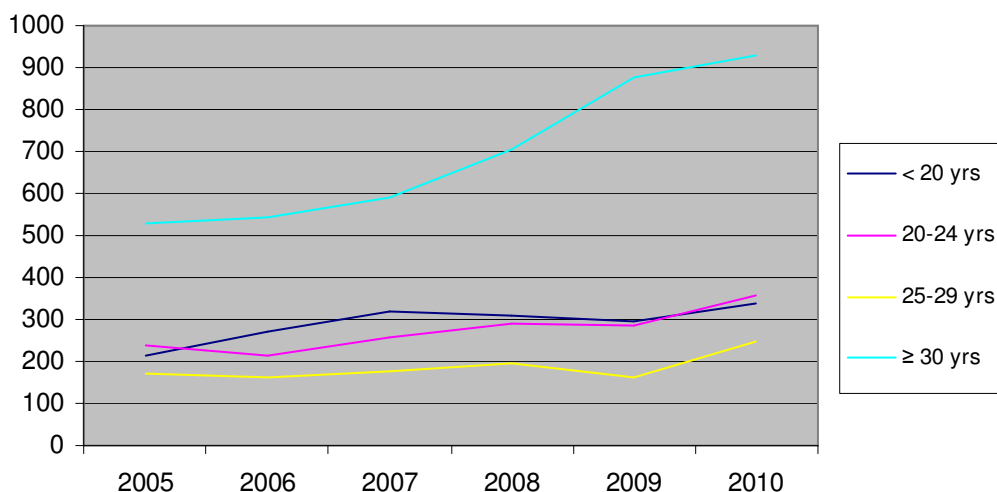
	< 20 years	20-24 years	25-29 years	≥ 30 years
Opioids	222	417	680	3543
Stimulants	1171	1156	612	893
Mushrooms and hallucinogens	125	89	36	52
Cannabis	435	363	199	297
Polydrug use and unspecified	986	1029	779	3224
Total	2939	3054	2306	8009

Source: The National Board of Health's National Patient Register, data retrieved in 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 30% 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 following intoxications and poisonings broken down by age groups, 2005-2010**



Source: Sundhedsstyrelsens Landspatientregister, data retrieved in August 2011

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, openness, direct and honest information and security for individuals in their contact with the health authorities. HIV testing is therefore voluntary and people who are HIV-infected are reported anonymously. The HIV reporting system includes age, gender, history of 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. In table 6.3.1 of the Annex, the number of reported newly diagnosed HIV positive patients appears, and out of these, the number of injecting drug users within the past ten years<sup>17</sup>. 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 abuse. In 2010, 5 % (14 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 2010, 11 % of those diagnosed with AIDS were intravenous drug users, which accounted for 5 out of a total of 44 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 past 10 years, 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 0% and 32% for hepatitis B and from 0% to 85% for hepatitis C. However, the share of persons reported with chronic hepatitis C due to intravenous drug use has been relatively stable at a level between 67-75%. The number of reported acute cases of hepatitis B, 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.

#### Studies into the spread of infectious diseases

As part of its qualification, harmonisation and mapping of the prevalence of infectious diseases among drug abusers 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 investigated<sup>18</sup>. The investigation also included the prevalence of HIV

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<sup>17</sup> 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.

<sup>18</sup> 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.

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 abusers over recent years is more or less constant and possibly declining, and that the prevalence of HIV among drug abusers 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-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 abusers in psychiatric treatment**

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

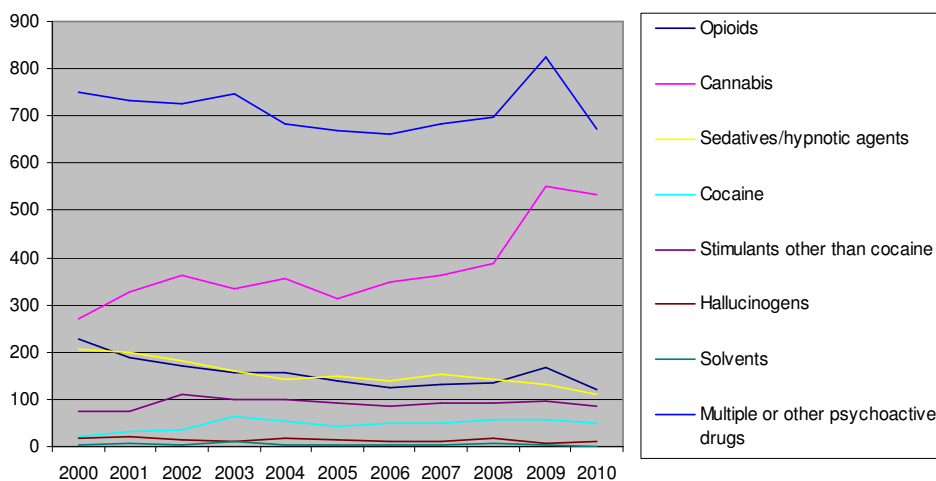
In 2009, a total of 5,031 persons were admitted to psychiatric hospitals with a drug-related primary or secondary diagnosis (co-morbidity). This is slightly less than in 2009, when 5,464 persons were hospitalized with co-morbidity. The decline from 2009 to 2010 appears after a linear increase during recent years in the number of persons admitted to psychiatric hospitals with a drug-related diagnosis (see table 6.4.1 and 6.4.2 of the Annex).

The number of persons admitted with secondary diagnoses only related to drug use has been increasing until 2009, but with a slight decline in 2010. In 2010, the number of secondary diagnoses was 3445 (3718 in 2009). The number of persons admitted with drug-related primary diagnoses has also been increasing up until 2009, but similar to the secondary diagnoses, the figure dropped a little in 2010. In 2010, 1586 persons were admitted to hospital with a drug-related diagnosis (1746 in 2009). The number of persons and admissions associated with primary or secondary diagnoses appears in the table of the Annex and illustrated in the figure 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 2010 included 34 % of persons in psychiatric treatment with a drug-related primary diagnoses. The number of persons with primary cannabis-related diagnoses has also gone up drastically in recent years, but in 2010 the numbers are almost on the same level as in 2009. During the period, the number of persons with an opioid-related primary diagnosis has been slightly declining, except for the period from 2006 to 2009. In 2010, the number of persons with an opioid-related primary diagnosis drops again.



**Figure 6.4.1. Persons registered with drug-related primary diagnoses in psychiatric hospitals, 2000-2010**

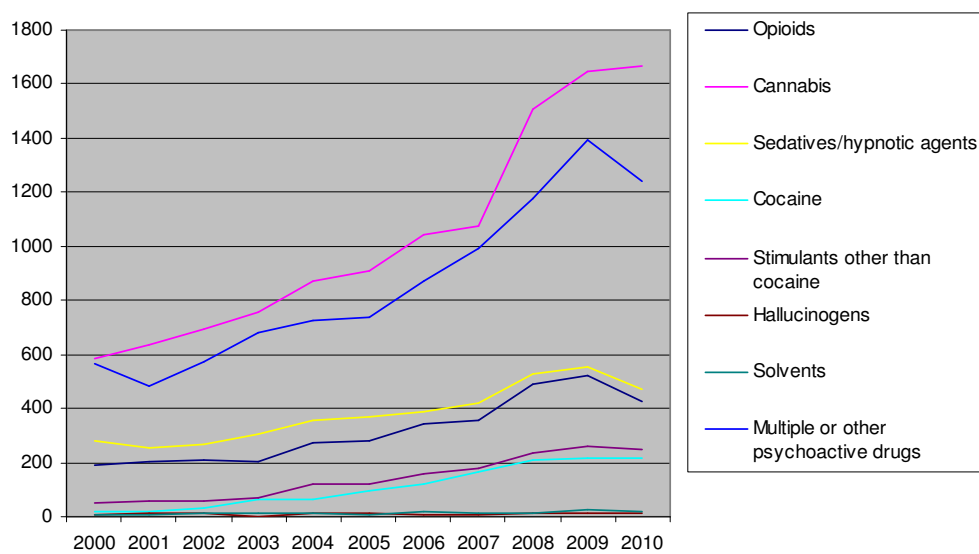


Source: Selected data from the Psychiatric Central Register at the Dept of Psychiatric Demography at Institut for Psykiatrisk Grundforskning, Psychiatric Hospital, Århus

The number of persons with a cannabis-related secondary diagnosis has tripled throughout the past 10 years. In 1999, the group included 566 persons; in 2010, it had gone up to 1668 persons.

Up until 2009, there is also an increase in the number of persons admitted to hospital with cocaine and other stimulant-related secondary diagnoses, although this figure is significantly lower than the cannabis-related secondary diagnoses. In 2010, the cocaine-related admissions, however, remain at the same level as in 2009. The number of admissions resulting from “polydrug use”-related secondary diagnoses is considerable and accounts for more than 1/3 of the total number of admissions with a secondary diagnosis related to drugs, although the number of these has dropped as well.

**Figure 6.4.2. persons registered with drug-related secondary diagnoses in psychiatric hospitals, 2000-2010**



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

## 7 Responses to Health Correlates and Consequences

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 abusers 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 abuse problems, which may worsen the course of a mental disease which is the basis of the drug abuse. Often, this situation involves complex conditions and complex causality.

Drug abusers 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 abuser 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 abusers 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 abusers 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 their drug abuse, but are associated with the special life conditions and lifestyle often seen in connection with active drug abuse.

In many cases, drug abuse is a long-term chronic condition or disease, where recovery in the form of being drug-free far from can be expected, 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.

With the introduction of the social reserve funds in recent years, it has become possible for a broad majority of the Danish parliament to set aside means for the launching of various health care programmes and harm reducing projects offered to drug abusers in and outside the established drug abuse treatment system.

### 7.1 Prevention of morbidity among drug abusers

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

Via the social reserve agreements, a broad majority of the Danish parliament has, since 2004, contributed to offering drug abusers free vaccination against hepatitis A and B. Another project is the scheme with addition of water ampoules to the syringe set already being dispensed to the drug users.

Also, there is an ongoing focus on improving the quality of the medical treatment of drug abusers. To begin with, the National Board of Health prepared guidelines in 2008 for the medical treatment of drug abusers receiving substitution treatment, and then in 2010, treatment with heroin was initiated as a possible type of treatment to a limited

group of drug abusers. 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 have been established in 2011. For further information, see section 7.5 of this report.

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

As mentioned earlier in this report, the action plan against drug abuse "The Fight Against Drugs II" was published in October 2010. In this plan a number of new initiatives were presented in the fight against drug abuse. One of the initiatives is to introduce quality into the medical treatment of drug abusers by preparing guidance on the treatment of acute poisoning cases. Many doctors do not have sufficient knowledge about treating such complex clinical conditions associated with poisoning caused by intoxicants and which particularly occur during polydrug use. The guidance on treatment of acute poisonings must therefore ensure quality in medical treatment in, among others, acute receiving units, so that the hospital staff are better prepared for the acute cases of poisoning which, in worst case, may be fatal. The guidance is expected to be published early 2012.

During recent years, initiatives have been launched to implement quality assurance and development of substitution treatment in Denmark. In practice, the National Board of Health initiated a proactive review of the overall medical treatment of drug abusers in substitution treatment. This review resulted in the guidelines on medical treatment of drug abusers in substitution treatment (Ministeriet for Sundhed og Forebyggelse 2008).

The aim of the guidance is to contribute to bringing down morbidity and mortality among drug abusers by ensuring uniform and acceptable quality in the most essential core services related to substitution treatment of opioid addicts. The purpose of the guidance is thus to support and enhance overall intervention through guidelines for the substitution treatment itself and a description of the medical core services associated with this type of treatment.

Based on the 10 indicators of medical core services, the National Board of Health has introduced a quality assurance tool on 1 January 2011, under which 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 abusers admitted to treatment. This also applies to drug abusers 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 abusers 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 this action plan, the National Board of Health established as at 1 January 2011 a reporting system for monitoring of the municipalities' interventions and services.

In order to identify the number of programmes that 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 abusers with access to clean equipment is high. The reason is that all the major municipalities with a relatively large number of drug abusers 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 abuse centres, the local pharmacies, drop-in centres/shelters or shelter rooms. In a few places, vending machines have been installed where the drug abusers 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 107,000 EUR 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 launched 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 together with associated legal framework and executive orders.

The social reserve agreements for 2009 and 2010 provide that as of 2010, a total amount of 8.5 million EUR must be set aside for permanent financing of the prescription heroin scheme. Similar to any drug use treatment schemes in Denmark, including social and substitution treatment with methadone and buprenorphine, heroin treatment is provided free of charge.

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

The doctor responsible for treatment of the drug abuser is obliged to provide an individual-based report 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 abuse, risk behaviour, 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 make out 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. Final evaluation of the scheme will be made 2 years after all clinics have been established.

### **Framework, requirements, criteria and education**

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

Start-up of treatment with heroin must take place in connection with treatment programmes for opioid addiction and can only take place in facilities granted special permission by the Danish Medicines Agency in accordance with the Agency's requirements for safety measures on the storage, reception and accountability of the drug (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 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. These doctors must be able to document in-depth experience in drug abuse treatment, including solid clinical experience in substitution treatment provided to opioid addicts, somatic and psychiatric co-morbidity caused by drug abuse

and experience in overall drug abuse treatment and the interface to social treatment intervention.

The doctor responsible for treatment may ask other medical professionals for help under the condition that they have attended a particularly relevant training programme. In this connection, the National Board of Health and KABS Viden<sup>19</sup> have established a national training programme to ensure that the medical professionals have been trained in the legal framework for the treatment, and that they receive thorough instruction in the National Board of Health's and the Danish Medicines Agency's guidelines on treatment and medicine handling as well as the pharmacological principles for treatment with injectable heroin in combination with oral methadone. The end-goal of this training is to perform safe and flexible dispensing of medicine. The course also includes training in abuse in general, abuse-related diseases and in handling of acute drug intoxication.

The intake of prescription heroin is solely done by self-administration and under supervision of the medical staff at the clinics. Typically, the patients appear for their medication 2 times daily, in the morning and again in the afternoon and are given oral methadone for the night. Heroin is never given as a "take-away" drug and the heroin clinic therefore will have to be open for 8-10 hours daily every day of the year.

The indication for treatment with heroin is continued intravenous drug abuse of prescribed or illicit opioids in spite of long-term substitution treatment with oral methadone, where the patient is or has been in danger of serious health complications.

### **Preliminary experience with heroin treatment**

At the end of 2010, all planned 5 clinics in Copenhagen, Odense, Hvidovre, Aarhus, and Esbjerg had been established.

In Copenhagen, it has been decided to establish an independent heroin clinic, providing treatment to heroin abusers only. The other 4 clinics have placed their heroin treatment in already existing methadone treatment programmes, where a separate injection room has been established.

The initial interest in the heroin treatment has been very high among the drug abusers, whereas the actual use of the treatment programme has, as expected, been moderate. As at June 2011, approximately 130 drug abusers have availed themselves of the heroin treatment scheme. As mentioned earlier in this chapter, it is expected that 2 years after the launch of the scheme, there will be approximately 300 drug abusers receiving heroin treatment. In the Copenhagen Municipality it is expected that approximately 120 drug abusers will visit the clinic, whereas the other 4 clinics expect the number of drug abusers in heroin treatment to be around 40.

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 has improved significantly. It has also turned out that most of the patients in methadone treatment accept the offer of accompanying social support, activities, food

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<sup>19</sup> KABS Viden is an organisation under KABS, which is Glostrup Municipality's abuse centre. In 2009, KABS carried out drug abuse treatment for approximately 1,200 citizens from 38 municipalities.

scheme, etc, and only a few of these patients actually appear for injections only.

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 abuse treatment.

### **Preliminary research results of heroin treatment**

In August, KABS-VIDEN joined forces with the Institute of Anthropology at the University of Copenhagen in a research project, the purpose of which was to monitor heroin treatment in Denmark over the first few years. The project has been financed by KABS-VIDEN and is carried out in collaboration with the treatment institutions providing heroin treatment in Denmark. The research project focuses on the users' perception of heroin treatment as well as the social, cultural and organisational conditions associated with treatment. This research project applies a combination of qualitative and quantitative methodology. It is still too early to say anything about the results from the quantitative parts of the study, and the lines below merely present some of the findings from the qualitative part. The study is based on comprehensive participant observation and interviews at the two clinics in the Copenhagen area as well as short study visits to Odense, Aarhus and Esbjerg.

The preliminary research shows that the five Danish heroin clinics, within the framework of the National Board of Health's guidance, have chosen to organise their work very differently. The Copenhagen Municipality has chosen to set up an independent clinic for heroin treatment only, whereas the other four clinics have set up their heroin treatment in connection with the already existing methadone treatment institutions. At these four clinics, a relatively small group of users are receiving heroin treatment with a rather large group of methadone users. The preliminary research results indicate that a great deal of the methadone users have found this concept difficult to accept. Their point is that heroin has nothing to do with treatment, and that the users who have been given heroin treatment go into a state of rush and euphoria. At the four clinics where heroin treatment is provided in the same facilities as methadone treatment, a relaxation and observation room has been established where the users of heroin treatment may stay after they have been administered their heroin, and where they can feel the rush of the drug without being a nuisance to others.

Other variations between the clinics involves how the users are assessed before and after the injection, whether or not they are asked to take an alcohol meter test prior to injection, and whether or not the users should take their evening methadone under inspection at the clinic in connection with the afternoon injection, or whether they may take their methadone doses with them (Johansen et al 2010).

The results indicate that the social treatment which is an obligatory part of the heroin treatment plan has turned out to a challenge to all the clinics. There has been some doubt as to how the programme could best meet the users' needs. Some of the clinics have chosen for the users to continue with the social treatment they received while in methadone treatment; others have chosen to tailor-make programmes for the users receiving heroin treatment. And yet again other clinics have tried to combine the two. However, in all the clinics, the staff sees that after a few months of treatment, some of the users ask for more than the heroin, typically for talk sessions, group treatment, activation or something along those lines in order to create more long-lasting changes in their lives.



According to the research results so far, the users who have been admitted to heroin treatment are pleased with the treatment. They are content with being administered the drug that works best for them and to stop treatment with methadone and its many side effects. It is also a positive experience that they no longer have to get the drug illegally and no longer have to “earn” money through crime or prostitution. The downside of the scheme is the time they spend on the treatment and the fact that they cannot bring the heroin with them. (Johansen et al 2010a).

## **7.5 Other healthcare 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 abuse. The purpose of many of these activities is to provide health counselling and treatment to the drug abusers in the streets or in shelters, and if needed, act as the link to the general health care system, the drug abuse treatment system and the social aid system.

### **Health care programmes to the most vulnerable**

The parties who have signed the social reserve fund agreements have set aside a total of 3.8 million EUR 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 the current projects will therefore be extended to 2011.

The purpose of the projects is to improve the health condition of the drug abuser 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 abusers through direct links and treatment continuity. The funds from the social reserves have been allocated to Copenhagen, Esbjerg, Aarhus, and Gulborgsund municipalities.

Experience from the projects shows that the drug abusers 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 social intervention on a street level and health care intervention represent a link to the established healthcare system, including the hospitals, where the most marginalised drug abusers currently need treatment for their overall health condition. The preliminary results thus show that these health care projects are much in demand by the target group and fulfil needs that have so far been unfulfilled.

Based on the reports on the individual following these programmes, it appears that the drug abusers have many different somatic and psychiatric problems, and many of the same diseases are seen in the drug abusers across the projects - eg chronic hepatitis, asthma, seizures and paranoid schizophrenia. Many of the drug abusers receive prescribed substitution treatment and often they take psychoactive substances or medicine in combination with their substitution medicine.

Experience from the projects so far shows that drug abusers 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 abuser. 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.

Included in the healthcare programmes mentioned above for the most marginalised drug abusers is the Health Room in the Copenhagen Municipality, which is a health-care and social treatment clinic receiving and treating drug abusers with health problems. The Health Room provides aid in the form of early nursing of infections, pain and wounds. Individuals coming to the Health Room may receive qualified help in bandage dressing and wound healing, dispensing of syringes and needles, etc. Furthermore, there are fixed consultation hours. For instance, since the opening of the Health Room, tinfoil for smoking purposes has been dispensed to heroin smokers.

The Health Room also provides more long-term health care in the form of re-establishment and promotion of the health condition and re-establishment of contact with the health care system, including general practice. The drug abuser's contact to the social system is also a task of the Health Room. The Health Room's employees are also involved in outreach work in the local area, and they try to ensure continuity in the drug abuser's treatment path, irrespective of whether or not the drug abuser comes to the clinic or not. From an organisational perspective, a number of changes have been made in relation to the Health Room at the end of 2010. A final report evaluating the projects will be available in 2012.

### **The Naloxone project**

In order to prevent against overdoses among drug abusers 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 abusers via a similar project.

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

Under this project, 28 drug abusers have followed a course in collaboration with the Brugerforeningen for Aktive Stofmisbrugere [The Users' Association for Active Drug Users]. The course lasts for one hour and includes 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 abuser 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 abusers 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 2011, a total of 84 doses of Naloxone have been dispensed and 7 overdoses have been avoided.

The experience so far indicates that the above practice might be implemented on a national level. The project will stop mid-2011 with interviews of the participants, and full debriefing of the project will be given.

### **Health promotion and prevention in drop-in centres**

Under the social reserve agreement in 2006, an amount of 3 million EUR 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 intersector collaboration as well as physical examination.

The projects have been running since June, 2008. In the three years that have passed, the projects have succeeded in integrating health as a natural part of the daily routines at the drop-in centres. A majority 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 their friends to the project. Also, the other programmes under the projects are much in demand, eg food schemes, exercise activities and smoking cessation.

The preliminary evaluation shows that a majority of the users find that they have needed help from the health project to establish contact with the 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, and a complete and final evaluation will be available in September 2011. A national conference is planned to be held at the beginning of 2012 with a focus on health care intervention targeted at drug abusers, alcoholics and the homeless. At this conference it is planned to present project methods and results.

### **National family outpatient centres**

In the Budget for 2008, 17million EUR was reserved over a period of 4 years (2010-2013) for the establishment of regional family outpatient functions in the hospitals in the five 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 (see also theme chapter 12 in this report).

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 neglect in children born of women with drug problems.

All five regional family outpatient centres have been approved by the National Board of Health and have started up consultations. Some of the regions are still in the establishing phase.

In the Budget for 2008, funds were also reserved for the establishment of a counselling function at Hvidovre Hospital, the purpose of which is to assist the regions in connection with the establishment of the new family outpatient centres. This counselling function was established in April 2009 under the name Center for Prevention of Substance Effects on the Development of Children.

The Center has prepared informative material, courses and professional guidelines. Also, it has appointed a cross-regional coordination group, under which clinical and administrative representatives from the five regions prepare common professional guidelines, project protocols and other central common frames of reference. This means that from the outset, all five family outpatient centers work together on a common set of guidelines and commonly generated data. The Center has also received funds from Trygfonden for a common clinical database to the family outpatient centres and for a project aiming at upgrading the nurses who are going to work in the outpatient centres.

The five regional family outpatient centres as well as the counselling function at Hvidovre Hospital will be subject to evaluation.

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

### **Project nurse – the good patient pathway**

The purpose of this project is to create "the good patient pathway" for drug abusers 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 abusers' 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 administered by KABS-VIDEN. In addition to a project manager, there are four social nurses performing daily tasks. The four hospitals/centres involved in Project Social Nurse are Hvidovre Hospital, Bispebjerg Hospital, Psychiatric Centre Glostrup and Psychiatric Centre Northern Zealand. The project started on 1 February 2010 and stretches over a 3-year period. COWI will carry out the final evaluation of Project Social Nurse.

In their daily work, the social nurse will approach the admitted drug abusers and offer care and support throughout the hospitalization period. She is the patient's spokeswoman in relation to the staff. Through her efforts, she ensures proper pain relief and treatment of withdrawal symptoms, and she draws up plans for the good discharge. The social nurse is the mediating contact to the abuse centre, the nursing clinic or homeless shelter. As regards relations to the staff, she is the sparring partner in simple, complex and challenging patient pathways. She trains and handles attitudes.

The social nurse has special competencies as a result of her broad experience within the drug abuse area and social psychiatry. That kind of knowledge and expertise is key if the concept of social nursing is to gain optimum ground and provide qualified input. Feedback from drug abusers, staff and municipal partners has been extremely positive.

### **A typical example of a patient pathway**

*A 52-year-old man contacts a shelter with pain in his hand due to an abscess near his left wrist. The shelter contacts the social nurse and she is then ready to receive the patient when he arrives.*

*Earlier that week, the patient has left another hospital before finalisation of treatment and has gone to Istedgade. He is very intoxicated when he arrives. He can't stand on his legs and keeps falling asleep while the nurse is taking down his medical data. The social nurse has talked to the emergency where the staff agrees to examine him quickly, and he is accompanied to the department, where he is going to be admitted. The staff is extremely caring and patient, and the social nurse follows him through the entire admission procedure.*

*The social nurse contacts the patient's abuse centre and checks his medication. She cooperates with the doctor and makes sure that the patient receives adequate pain relief following surgery. The patient undergoes surgery and is treated for his infection, and his hospitalization proceeds without any problems.*

*The patient is homeless, but many years ago, he stayed in a shelter which he enjoyed. Therefore, the social nurse contacts the shelter, and it just so happens that there is a vacancy for him, at there are nurses there to carry out wound management. After three days, the patient is discharged to the shelter.*

## 8 Social correlates and social reintegration

The Ministry of Social Affairs and Integration and the Ministry of Employment are responsible for coordinating intervention in terms of social integration of drug abusers, who are part of the target group referred to as “socially vulnerable”.

### 8.1 Social exclusion and drug abuse

In Denmark, there is a clear correlation between drug abuse and problematic social and economic life conditions. The social marginalization of drug abusers is high. When taking a look at the social, residential and educational conditions among the drug abusers 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 abusers admitted to treatment are characterized by having a relatively remote affiliation to the labour market. Thus, only 12 % of them who were in treatment in 2010 were on payroll and as many as 66 % were on transfer income. Furthermore, “only” 25% have completed an education beyond “folkeskole” (primary and secondary school) and 8% 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 abusers 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 adolescents that are placed out-of-home. Statistics are based on the municipality’s report on each decision on placement of a child or an adolescent. The obligation to report includes different basic information about the child/adolescent and the circumstances involved – including the event that has triggered the placement such as drug abuse at home/with the parents and in the children/young people (Ankestyrelsen 2010). Abuse problems include alcohol and/or drug abuse.

The most recently published figures on out-of-home placement concern 2009. This year, decisions on out-of-home placement affected 2,807 children and adolescents. 68% of these were between the age of 12 and 17, and 12% were children under the age of 3. By the end of 2009, a total of 12,654 children and adolescents were placed out-of-home.

As mentioned above, the municipalities report the triggering causes of the placement and often there are several reasons why children and adolescents are subjected to out-of-home placement. Statistics show that in 2009, abuse problems at home/parental abuse problems were the triggering factors for the placement in 17% of the cases. When considering the causes triggering children’s and adolescent’s out-of-home placement, it turns out that abuse problems in 2009 was 11% of the cases. These per-

centages do not deviate significantly from 2008.

## **8.2 Social reintegration**

In accordance with Section 141 of the Consolidated Act on Social Services, the municipality is obliged to offer drug abusers a social action plan, with goals and strategies being discussed together with the individual drug abuser as regards his/her future housing situation, financial situation and other situations in life. Thus, the local case handlers are those who take action to integrate drug abusers socially.

In 2010, the Ministry of Social Affairs also played a role in social integration through its programme "Our Common Responsibility II". The two goals of the programme are to develop methods to support socially vulnerable citizens in approaching the labour market and to enhance the quality of life of the individual.

The Ministry of Employment has also directed its attention to the socially vulnerable receiving cash benefits as part of the government programme "New ways to work", where a considerable segment of the target group has a drug and/or alcohol problem. The focus of this programme is to help the citizens to get back to work through training and upgrading of education, preferably within a company framework.

### **Homelessness, housing services and housing grants**

In 2009, a census was made, which showed that in the 2nd week of February 2009, there were approximately 5,000 homeless people in Denmark. They were mainly presented in the larger cities and especially in Copenhagen and its suburbs. The analysis of the figures showed that 70% of the homeless were abusers of drugs, cannabis, alcohol or medicine and that 37% of the homeless suffered from a mental disorder. The latter, however, was only an estimate as the questions did not provide for diagnosed mental illness. For quite a few of the homeless, abuse and mental disorder are recorded as primary causes of homelessness (Benjaminsen 2009).

A number of services have been established of a temporary as well as a permanent nature, the purpose of which is to help drug abusers 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 abuser who has been living in a temporary nursing home, inpatient treatment facilities or in some other kind of residential setting. Drug abusers 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 abusers, 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 reducing 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 2012 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 heat, social care, and 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.



### **Education and employment programmes**

Many drug abusers perform poorly at school and only have a poor 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 actively take part in society.

For the long-term unemployed drug abuser and other socially vulnerable unemployed individuals, a national training programme has been developed for those who have an education or some kind of professional background and competencies within a given area (project "Next Stop Job under Our Common Responsibility II). 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**

Former drug users are typically offered the same employment promoting programmes as other cash benefit recipients or unemployed. The same applies to active drug abusers who, concomitantly with being treated for their drug abuse, are given the opportunity in some form to gain access to the job market. 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.

It is crucial that in the efforts to integrate the socially vulnerable into the job market that the training and upgrading of them is carried out in companies. This could, for instance, be done through "company centres", where a local job centre and a public or private company agree that a number of individuals who are not immediately suitable for managing a job and who have problems other than just unemployment, are offered a traineeship with ongoing follow-up by the Job Centre.

At the end of 2010, the project "Fra udsat til Ansat" [From No Job to A Job] which was also part of Our Common Responsibility II was terminated. The aim of the project was for private and public companies to become more aware of and understand the conditions that apply when people at the edge of the job market have to get used to having co-workers and colleagues at a workplace. At the end of the project, 9000 persons had participated in one of the project courses. The courses are still active in the participating business colleges.

## 9 Drug-related crime, prevention of drug-related crime in 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 abusers 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.

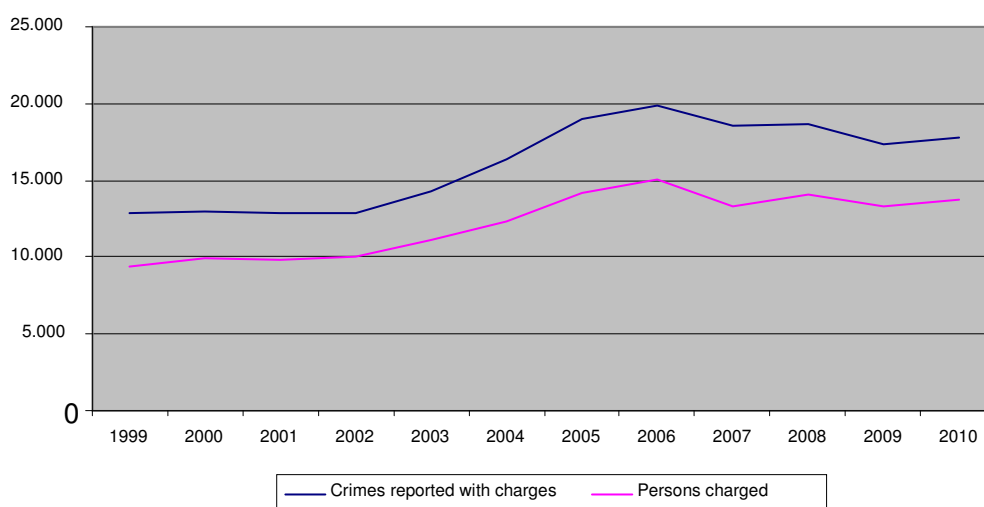
Section 191 of the Danish Criminal Code provides for stricter punishment on qualified violations of the Act on Psychoactive Substances. This means that if the transfer of psychoactive substances is made to a large number of people against considerable remuneration or under other particularly incriminating 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 2010, a total of 17,825 crimes were reported including one or several charges for violation of the drugs act. During the same year, 13,749 persons were charged for violating the Drugs Act. Some persons were thus charged for several counts on violation of the Drugs Act.

Figure 9.1.1 shows the trends in the number of crimes reported on one or several charges in accordance with the Drugs Act and the number of persons charged under the Drugs Act during the period 1999-2010.

**Figure 9.1.1. Drug crime from 1999-2010. Crimes reported with charges  
And the number of persons charged**



Source: National Commissioner of Police, 2011

### **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 before-said condition. 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, 1,502 in 2009 and 1,622 charges in 2010.

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.

By Act no. 183 of 8 March 2011 on the amendment of Act on the Enforcement of Punishment, etc. which became effective on 1 June 2011, the treatment guarantee was expanded to include prisoners in remand custody as well as prisoners with short-term sentences. In other words all prisoners placed in the institutions under the Probation and Prison Service. The treatment deadline of 14 days also applies.

The treatment includes so-called day treatment where the inmate serves his sentence in the so-called common departments 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. (See also the chapter on drug abusers in prisons).

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 2010, 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 2010, there were approximately 2,000 people who started treatment in the prisons, which is a drastic increase compared to previous years.

According to the national strategy on criminal drug abusers, the treatment of them must to the widest extent possible be undertaken by the social authorities. The strategy is based on the Prison and Probation Service's program of principles, 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 recent years in the number of imprisoned drug users serving their time in such an institution outside the jurisdiction of the Prison and Probation Service. In 2005, 160 inmates were imprisoned under treatment conditions, whereas the number had dropped to 97 in 2009 and remained at this level in 2010.

The number of treatment projects in the prisons has, however, increased the past five years, and in 2010, the prisons were granted additional funds for the enhancement of follow-up treatment and detoxification.

### **Initiatives for the 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 temporary treatment may extend over weeks or months. It is very to a wide extent 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 ab-

scesses, 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 assistance, including information about the above diseases and general medical treatment on an equal footing with the rest of the population. Inmates, however, do not have access to free syringes and needles.

### **Reintegration of drug abusers after their release**

When drug abusers are in treatment during their imprisonment and then released, the municipal drug abuse 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 (now The Ministry of Social Affairs and Integration) 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 (now The Ministry of Social Affairs and Integration) 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 Social Affairs and Integration, and 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 Health (now The Ministry of Health), The Ministry of Social Affairs (now The Ministry of Social Affairs and Integration), the Ministry of Employment and the Directorate of the Danish Prison and Probation Service jointly launched a project in 2006, the aim of which 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 abuse 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.

The process is time-consuming and in 2010, the first agreements were signed. At present, agreements have been made with 25% of the municipalities in Denmark, and it is expected that in the course of the years to come, similar agreements will be signed with all the municipalities.

### **9.3 Drug abuse in prisons**

The Alcohol and Drug Study from 2002 (Kramp et al. 2003) showed that 3/4 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)<sup>20</sup>.

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 to record additional 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. The 2010 figures show that approximately 480 people received substitution treatment with methadone or buprenorphine on a monthly basis.

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<sup>20</sup> 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.

Illicit drugs carry no statement of contents, and there are many different drugs hidden in the tablets and the powder which is sold as, among others, "ecstasy". The relatively new stimulating and hallucinating drug mCPP has increasingly been detected in the ecstasy pills, but now appears to be on the decline. Instead, the hallucinogenic 2C-B is found more frequently in the pills and was contained in as much as 34% of the pills analysed in 2010. It is somewhat remarkable that MDMA (ecstasy) only appears in 7% of the pills in 2010, where before it was typically found in approximately 80% of the pills. The overall conclusion is that there is a drastic shift of the contents in ecstasy pills from MDMA to mCPP or 2CB.

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<sup>21</sup>. The variation is seen in the more traditional drugs such as heroin, amphetamine and cocaine, and in the new synthetic drugs typically found in ecstasy pills. As the concentration and contents of the drugs therefore are often unknown, this implies a special risk upon intake.

The systematic monitoring of "new" drugs in Denmark was adjusted via a new agreement between the National Commissioner of Police, The National Board of Health and the three institutes of forensic chemistry in 2011. Before 2011, only "ecstasy" pills were submitted and analysed systematically. As of 2011, powder and liquids have been included in the systematic monitoring process as well. This change has been made in recognition of the fact that many of the new substances which appear on the market today are introduced this way. Results of the first half year of the monitoring are presented in table 10.3.5.

### 10.1 Drug supply and demand

The National Commissioner of Police 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. Kokainen produceres primært i Sydamerika og videredistribueres typisk via Spanien og Holland. Large quantities of cocaine are also distributed to Europe via countries in West Africa and countries in the

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<sup>21</sup> 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.

Baltic region.

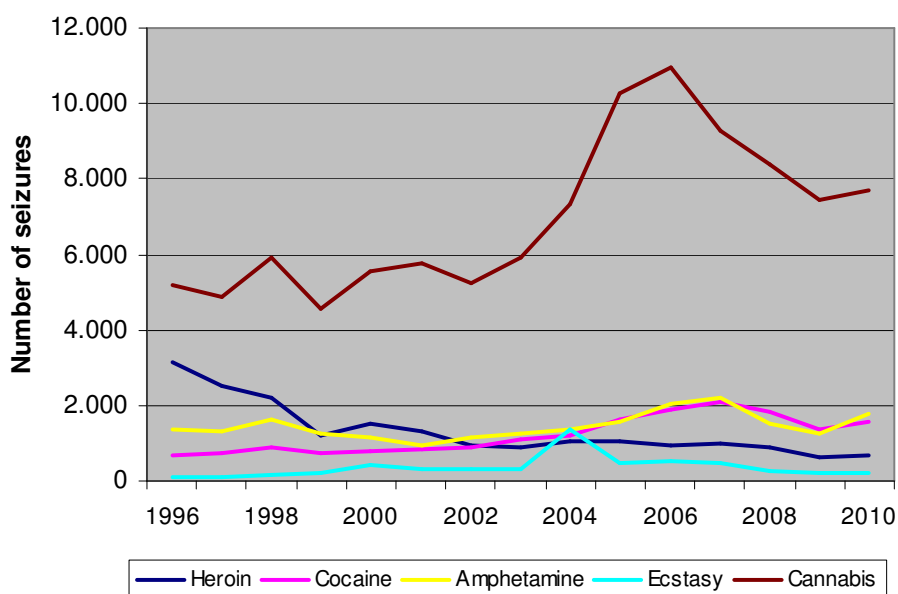
As far as drug supply is concerned, seizure statistics show that the various illicit drugs are spread all over Denmark. In almost all police districts, seizure of the various drugs is seen.

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

It appears from the National Commissioner's statistical material (Rigspolitiet 2011) that the number of seizures has declined the past few years for all types of drugs. From 2009 to 2010, however, there appears to be a slight increase in the number of seizures of most drugs.

Figure 10.2. Drug seizures, 1996-2010



Source: The National Commissioner's drug statistics 2011

As regards the quantity seized, major fluctuations are seen in most drug types from one year to the other. In spite of the increase in the number of cocaine seizures from 2009 to 2010, the quantity of cocaine seized has, however, dropped from 72 kilos in 2009 to 54 kilos in 2010. The quantity of the amphetamine seized, however, rose drastically from 104 kilos in 2009 to 194 kilos in 2010. Also, the seized quantity of cannabis rose drastically from 1,220 kilos in 2009 to 2,318 kilos in 2010. As in previous years, the individual seizures of the various types of drugs were made on large quantities



(See table of the Annex on the quantity and number of seizures of the various drugs).

### 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 institutions<sup>22</sup>. Table 10.3.2 of the Annex shows the distribution of types of drugs seized in Denmark from 2000 to 2010.

Out of the 195 samples analysed in 2009, 70% contained stimulants such as amphetamine and cocaine, which is a slightly higher proportion than in 2009. During recent years, the presence of the stimulants - especially cocaine - in the project has, however, been increasing, whereas heroin has been decreasing. 21 % of all samples selected in Denmark in 2010 included heroin. By comparison, 44% of the samples analysed in 2000 was heroin. Furthermore, 6% of the samples in 2010 contained other psychoactive substances and substance compounds such as metamphetamine, ketamine and 2C-B, and 3% contained non-euphoriant substances.

In Copenhagen and Aarhus, cocaine is the predominant drug in 2010 (62 % and 44 %, respectively, of all samples), whereas amphetamine is the predominant drug in Esbjerg, Aalborg and Odense (62%, 42 %, and 44%, respectively, of all samples).

Table 10.3.2 of the annex shows the balance between heroin base ("smokeable heroin") and heroin chloride (white heroin to injection) from 2000-2010. 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 64% and 36%, 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 2010, all heroin samples (100 %) from Odense thus contained white heroin for injection purposes. By comparison, 80% of the heroin samples collected in Copenhagen contained the brown heroin for smoking, whereas 20% of the samples contained white heroin.

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<sup>22</sup> 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.

## 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.

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Heroin chloride	59%	52%	50%	64%	63%	67%	53%	29%	52%	41%	46%
Heroin base	40%	48%	25%	25%	22%	28%	18%	21%	16%	14%	20%
Amphetamine sulphate	12%	9%	13%	9%	9%	10%	7%	6%	8%	5%	6%
Cocaine Chloride	37%	43%	36%	37%	24%	25%	18%	16%	19%	17%	21%

Source: Lindholst et al 2011

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 67% in 2005 to 46 % in 2010. The purity of cocaine dropped evenly throughout the years. However, the purity of cocaine in 2010 is 21%, which is the highest level in years.

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.

## Monitoring ecstasy pills

Since 2001 the National Board of Health, in collaboration with the National Commissioner of Police and the three institutes of forensic chemistry, have been monitoring the prevalence of ecstasy pills in Denmark. Analysis samples from ecstasy seized by the police districts are sent to one of the three forensic institutes. The pills are examined and described in terms of drug concentration, substance mix and appearance<sup>24</sup>. A regular update every six months of the analysis results and a more extensive annual report are available at the National Board of Health's website: [www.sst.dk](http://www.sst.dk).

<sup>23</sup> 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.

<sup>24</sup> 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.

In 2010, a total of 33,725 "ecstasy pills" distributed on 61 seizures were sent from the police districts to the departments of forensic chemistry for analysis. According to the National Commissioner of Police, the police districts seized a total of 38,363 ecstasy pills in 2009 broken down in 130 seizures. Despite the intention that all seizures were to be submitted for forensic analysis, only 61 of the 130 seizures were submitted and analysed, which corresponds to 47 % of all seizures.

An overall summary of the 2010 ecstasy market is that the relatively new substance mCPP still appears in the pills – alone as well as in compounds, although its presence is declining. In 2010, mCPP was contained in 48% of the pills. Furthermore, the hallucinogenic substance 2C-B appears to an increasing extent in the pills and was contained in 34% of the pills during the year. By comparison, "only" 7% of the pills contained 2C-B in 2009. Finally, MDMA (ecstasy) is "only" seen in 7% of the pills, which is a rather drastic decline compared to previous years, where approximately 80% of the pills contained MDMA – either alone or as a compound. There is also a drastic shift of the contents in the majority of the ecstasy pills from MDMA to mCPP or 2C-B.

### 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, there have been almost 600 different variants of ecstasy pills. In 2010 alone, 9 different variants have been 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.

Among the samples in 2010, 17 different logos were identified. Many of the logos are only seen in one variant, whereas other pills with the same logo are found in several variants. For instance, from the start of monitoring, 54 variants of the pills were found 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, a new ingredient was identified in the pills in 2007 and in 2008, whereas 2 new ingredients were identified in the pills in each of the years 2009 and 2010.

**Table 10.3.4. Prevalence of some of the ingredients in ecstasy from 2003 to 2010**

	2003 (n=337)	2004 (n=498)	2005 (n=335)	2006 (n=434)	2007 (n=311)	2008 (n=164)	2009 (n=141)	2010 (n=71)
MDMA	96 %	85 %	43 %	63 %	90 %	82 %	8 %	6 %
MDMA + other	1 %	15 %	50 %	34 %	2 %	3 %	6 %	2 %
Other ingredient	3 %	0 %	7 %	3 %	8 %	15 %	86 %	92 % *

Source: Aarhus University 2011

\* In 2010, 48% of the ecstasy pills contained mCPP alone or a combination with other types of drugs, and 34% 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 6% and 96%. The years 2009 and 2010 deviate from previous years in that the proportion of mCPP and 2C-B has increased and the variants

with MDMA in combination with amphetamine, metamphetamine and MDE/MDA have more or less disappeared from the market.

### First half year of 2011

As mentioned initially in this chapter, the inclusion criteria for monitoring "new" drugs in Denmark were changed in 2011. In addition to systematic monitoring and forensic analyses of "ecstasy" pills seized and submitted for chemical analysis, monitoring is also being made on powder and liquid substances.

The results from the first six months of 2011 show that mCPP is found in 39% of the pills compared to 75% of the pills in the last quarter of 2010. Instead, as many as 31% of the pills contain no active substances. By comparison, this was 8% during the last quarter of 2010. 19% and 12% of the pills during the first half of 2011 contained the actual substance ecstasy (MDMA) and 2C-B. None of the pills during the last quarter of 2010 contained MDMA, whereas 17% of the pills contained 2C-B during the period. Table 10.3.5 shows the total result of the active substances identified in powder and liquids that were submitted and analysed.

Table 10.3.5. Ingredients in powder and liquids traded as ecstasy, spice etc.	1 <sup>st</sup> half year 2011
MDMA	49
Ketamine	18
Metamphetamine	11
GHB*	5
p-Fluoramfetamin	5
2-methylamphetamine	2
4-methylethcathinon	2
Mephedrone	1
Flephedrone	1
2C-B	1
mCPP	1
MDPV	1
JWH-073	1
JWH-122	1
JWH-203	3
JWH-210	1
JWH-250	1
I alt antal sager	104

\*GHB in liquid form

When considering the table above, it is worth noting that 47 of the powder samples analysed during the first six months of 2011 contain MDMA (ecstasy), which confirms

that not only is ecstasy found in pills, but it is indeed also sold on the market as a powder. 5 synthetic cannabinoids (the JWH substances) have been found in the powder samples. These have all been banned during the spring, 2011. Also worth noting is that 15 samples contain the relatively new abuse substance ketamine. Ketamine which is an anaesthetic agent may have a hallucinogenic effect, and there are reports on increasing prevalence in recent years.

A half-yearly overview of the results from this monitoring of the current ingredients in and concentration of the pills on the market is published on the National Board of Health's website: [www.sst.dk](http://www.sst.dk).

### **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. In 2010, the quantity of MDMA varied between 1 and 70 mg per tablet. The quantity of the active substance mCPP varied between 11 and 42 mg, and the quantity of 2C-B in 2010 was between 3 mg to 7 mg 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 which 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 of Police estimates that the street price for cannabis is around 6.5-9.5 EUR per gram. The price for cannabis is no longer fixed as it once was. Police districts report about prices between 4-13 EUR for one gram of cannabis. The price per gram for selling heroin on the streets is estimated to be between 135-200 EUR for white heroin and between 68 -135 EUR for brown heroin. The price for cocaine traded in the street is estimated to be between 67-80 EUR per gram. As for amphetamine, the price in the streets is estimated to be between 13-26 EUR per gram, whereas the price for an ecstasy pill is estimated to be between 4-11 EUR.

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 Drug use among prison population: Scope and responses

## 11.1 The prison system and the prison population

In Denmark, there are 13 prisons, 42 local prisons/prison units, 8 pensions (half-way houses) and 14 departments of the Prison and Probation Service in Freedom. In 2010, 14,469 people were incarcerated, of which 1,143 were women. A total of 10,004 sentences were reported, of which almost one-third were short-term sentences of 3 months or less. 7% of the sentences were for more than 2 years.

The average occupancy in 2010 was 3965 inmates per day, which corresponds to 96.3% of the total capacity. The average occupancy of young people under the age of 18 was 20 inmates per day. The minimum age for criminal responsibility is 14 years. In 2010, the inmates accounted for 891 in closed prisons, 1,343 in open prisons and 1,731 in local prisons.

## 11.2 Organisation of healthcare policy and provision of prison services

Before 1997, there was no actual social treatment of abusers in the form of therapy, supportive/motivating talks, etc in the institutions under the Prison and Probation Service. Only a small group could receive treatment in the institutions outside the prisons in accordance with Section 78 of the Act on Punishment, but by far the largest part of the population of inmates were deprived of treatment. Today, it is not a question *if* a person should be offered treatment; today, it is a question of *which* treatment.

The national drug treatment strategy for the Prison and Probation Service's clientele is based on the main principles for its activities: the *normalisation principle* which provides that the conditions in prison must resemble those in society as much as possible, and that the inmates to a large extent must have access to the same programmes as the remaining society.

In practice, this means that the Prison and Probation Service's clientele must be able to use the remaining society's drug abuse treatment schemes. The clients who have been released or those with a conditional sentence must have the same opportunities as those who have no criminal record. This means they should be able to seek treatment in their municipality and be transferred from the prison to a suitable treatment institution. In order to be transferred, the inmate should not be prone to escape, not be considered dangerous or otherwise insult the general feeling of justice. Only inmates who fulfil the requirements above can use the social abuse treatment provided in the prisons.

However, the scheme does not work satisfactorily, as the municipalities and the Prison and Probation Service often assess the inmates' treatment requirements differently with the result that the inmates are not offered treatment in accordance with Section 78 of the Act on Punishment, but are referred to treatment in a prison instead. In 2010, 160 convicted persons alone were imprisoned in accordance with Section 78 with a view to abuser treatment. The number of placements for abuser treatment has been declining the past 5-7 years. Whether or not a *medical* treatment should be initiated, is solely based on a medical assessment. However, practice in the medical treatment for more than 20 years has been that inmates who received medical treatment prior to impris-

onment should continue to receive this treatment during their imprisonment. Practice has also been that inmates who have not been treated earlier and who state that they are active drug abusers will be assessed by the medical staff at imprisonment with a view to possible initiation of a medical slow withdrawal process.

The medical treatment of imprisoned opioid addicts must follow the National Board of Health's guidance on medical treatment of drug abusers in substitution treatment in relation to the treatment of the abuser condition, diagnostic strategy and guarantee of treatment for the physical and mental disorders resulting from drug abuse.

### **The healthcare system in general**

Basically, the treatment of the sick prisoners must be handled by the national treatment system providing differentiated treatment services rendering it possible to comply with the individual's treatment needs in an optimum manner.

Inmates imprisoned in the Prison and Probation Service's institutions have, as all other citizens in society, a right to treatment in a hospital. Thus, the inmates also have a free choice in terms of hospital in which they wish to be treated. However, this may be limited for safety reasons or in consideration of law enforcement. It is the doctor at the institution who refers an inmate to treatment at the hospital, and the hospital that performs an assessment of whether or not the inmate should be admitted.

However, a health care scheme in the Prison and Probation Service's prisons and local prisons has been established for economic and safety reasons. This health care scheme implies that all prisons and local prisons have their own doctor, typically a general practitioner from the local area. He/she will visit the institution 1-2 times a week for a given number of hours. All the prisons and the major local prisons have their own nurse working either full-time or part time. All prisons also have their own psychiatrist, typically on a consultancy basis, which means that a specialist doctor is present in the institution a given number of hours a week. Most prisons also have a psychologist, typically on a consultancy basis. Furthermore, the largest prisons have a dental clinic, where a dentist from the local area carries out dental work in the prison a few hours each week.

Established routines ensure that as soon as possible after imprisonment all inmates are informed about the institution's health scheme and verbally are offered a talk with the institution's doctor or nurse. In Denmark, it is legally provided that all contact with the health care system as a principle only takes place as requested by the patient, and the initial contact with the medical staff is only made if the prisoner agrees to this.

There is a considerable number of inmates in the Prison and Probation Service's prisons and local prisons who periodically or perhaps during the whole term need psychiatric/psychological support and assistance or who for health reasons cannot serve their sentence in an ordinary prison department. Therefore, the Prison and Probation Service must provide the treatment which can reasonably comply with the existing need for psychiatric/psychological and somatic treatment.

The prison at Herstedvester that has a capacity of 147 places is a treatment institution for inmates with a special need for psychiatric/psychological treatment. The prison that has a national function has full-time psychiatrists and psychologists. Its main task is to receive male and female convicted persons and to a limited extent prisoners in remand custody from all over Denmark who are not insane, but who need psychiatric/psychological treatment.

Vestre Hospital under Copenhagen Prisons is a hospital unit (36 beds), but it also has a national function as a somatic hospital unit for the entire Prison and Probation Service.

The Prison and Probation Service has four health consultants: a general practitioner, a psychiatrist, a dentist and an HIV/AIDS consultant. These consultants help the directorate and the Prison and Probation Service's institutions answer questions within their practice area and prepare guidelines and guidance where the general health care system's services are inadequate or insufficient in relation to the special conditions in the prison institutions.

The National Agency for Patients' Rights and Complaints is the institution treating cases involving complaints on medical staff's treatment or treatment course, and the National Board of Health and the Medical Officer institutions carrying out inspection of the medical staff. The Prison and Probation Service employs a total of 138 people within the medical profession.

### **Abuse-related health policy and strategy for inmates**

In 2003, a treatment guarantee was introduced for drug abusers in Denmark. The Act on Social Service, however, did not apply to inmates in the Prison and Probation Service institutions. In the subsequent years, efforts were made to include the Prison and Probation Service's inmates in such a guarantee.

This is what moved the Prison and Probation Service within a period of 10 years from being an institution without treatment service to being one of Denmark's largest single providers of treatment.

The treatment guarantee in the prisons which is provided for in the Act of Punishment became effective on 1 January 2007 and equals more or less the treatment guarantee in the Danish Social Services Act. The guarantee thus applies to the *social* treatment and not the medical.

The main element of the guarantee for social treatment is the so-called 14-days' clause which means that the Prison and Probation Service as much as possible must have defined the treatment needs, have referral made and treatment initiated within a period of 14 days from the time when the inmate has requested treatment. To begin with, the treatment guarantee did not apply to inmates with short-term sentences and not for prisoners in remand custody, but as of 1 June 2011 all prisoners were included. The treatment guarantee has been observed within the time limit in 88% of the cases recorded in 2010.

Although during the first years, the treatment only applied to short-term sentenced inmates and prisoners in remand custody, it has been the intention since 1 January 2007 that everybody should be offered drug treatment, irrespective of status. Everybody who has requested treatment for their drug abuse has therefore been assessed in relation to eligibility and motivation. As far as the short-term prisoners are concerned, the treatment initiated in the prison should preferably be continued in a local (or private) context following release. For the prisoners in remand custody, the aim is primarily to define, motivate and prepare them to start an actual treatment course after their conviction, irrespective of whether treatment should be given in freedom or during imprisonment.



All primary drug treatment programmes under the Prison and Probation Service must follow an accreditation procedure, in which an expert panel assesses whether or not the treatment programme complies with the standards for good treatment. As per 1 September 2011, 12 out of 15 primary treatment programmes have been awarded accreditation, whereas three treatment programmes await the expert panel's assessment.

### **Strategy and the individual programmes**

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

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

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

### **The various treatment programmes in the prisons**

There are several types of treatment programmes in the prisons. There are the so-called *motivation and pre-treatment projects* in the local prisons all over Denmark. These projects are primarily based in the abuse centres of the local municipality, and the aim is to prepare the remand prisoners for the treatment provided to them in the prisons when serving their sentence or after release from remand custody. The motivation and pre-treatment projects are not part of the treatment guarantee.

A counterpart to the traditional inpatient treatment which to a broad extent focuses on complete abstinence from drugs is the so-called *treatment units* (as opposed to the common units, which is the name of those units, where the inmates are normally placed if they do not have special need or are particularly weak or negatively powerful). The treatment units are completely isolated from the ordinary prison environment and are thus defined as inpatient treatment units, given that the inmates move about in a therapeutic treatment environment. These projects have been selected under the normalisation principle, in that contracts have been signed with a number of the treatment institutions which the municipalities typically use when their citizens need inpatient treatment. Today, such units exist in almost all prisons. Only one treatment unit, "Mælkebøtten" (the Dandelion) at the state prison in central Jutland does not have a primary aim of complete drug abstinence, given that this prison's group of inmates require special support in connection with a medicine-backed treatment (substitution treatment).

There are so-called *follow-up treatment units* in selected prisons for inmates who have long-term sentences and who have completed primary treatment. Primary treatment can rarely stand alone, and the inmates who have completed such a treatment normally need follow-up treatment in an environment where the inmate gradually assumes more responsibility and where the degree of freedom is increased. The follow-up treatment has major focus on education /employment and re-integration and is car-

ried out according to the import model.

In this connection, there are programmes for psycho-social **support in connection with substitution treatment** (medical treatment with methadone/subotex) across the existing department in all prisons. Quite a few inmates are given substitution treatment, but medical treatment should not stand alone, but should be followed up by supportive sessions.

Similarly, there are programmes for cocaine abuse treatment for inmates in open prisons and programmes for **cannabis abusers** in all the prisons. The cocaine, cannabis and substitution programmes have been planned as day treatment (outpatient treatment), during which the inmates are referred to joint departments where they participate in treatment for a short or long period as supplement to or instead of training/other type of employment. These programmes are also based on the import model, and local as well as private professionals are used for the task. The cannabis and substitution projects are primary treatment, but are less intensive than the treatment provided in the specialised treatment units.

Finally, there are the **special so-called contract departments**, where no treatment takes place, but where inmates who do not wish to serve their sentence with drug abusers can be sure of serving their sentence in a completely drug-free environment. This is done by a higher number of urine tests and a generally increased control level. In some of these departments, a room may be offered to drug abusers who have finalised treatment. These units provide limited follow-up treatment.

The Prison and Probation Service also has 8 re-integration pensions.

### **11.3 Orders/provisions concerning abuse-related health intervention in prisons**

#### **Prevention, treatment, rehabilitation and harm reduction**

When in connection with a routine examination or in connection with a specific suspicion, inmates are identified as drug abusers, they will be offered treatment. This can be given by the Prison and Probation staff or by the staff treating inmates in that particular prison.

If the inmate is motivated to receive treatment, a further assessment is made as to which type of treatment would be most suitable. This assessment is made on the basis of experience with previous treatment courses, if any, and compared with the inmate's present situation. The inmate's own assessment is also taken into consideration.

#### **Inmates in drug treatment and type of abuse treatment**

Overall from 1997 and until today, capacity has been expanded from 18 to approximately 275 places in treatment units. In addition, there are the contract department places and a varying number of inmates who receive day treatment.

It was estimated that 550 persons out of 4000 inmates were included in one of the Prison and Probation Service's treatment programmes on one given day (15 October 2010), which is equal to 15% of all inmates being enrolled in a treatment course. The figures are, however, compiled with some uncertainty as not all recordings of the treatment courses have been made correctly in the prisons.

Table 11.3.1 below shows number of treatments and individuals who have been en-

rolled in treatment in 2010, irrespective of when they have applied, categorized by type of treatment.

**Table 11.3.1. Number of treatments for inmates in drug treatment, categorized by type of treatment**

Type of treatment	Number of persons	Number of treatments initiated
Treatment of alcoholics	196	207
Treatment of cannabis abuse	521	576
Motivation treatment	885	988
Drug abstinence treatment	455	525
Substitution treatment	124	130
Total	2181	2426

Source: The Prison and Probation Service 2010

Note: The Annual Drug Report for 2010 states that in 2010 there 2000 cases where an inmate or a client started treatment. The figure is estimated on the basis of preliminary recordings early 2011

Note: Date of retrieval: 28.8.2011

Table 11.3.2 shows the use of intoxicants prior to imprisonment

**Table 11.3.2 Intoxicants used 30 days prior to imprisonment. Share of inmates with disclosed use. Stated at 18 December**

	2009		2010	
	n	%	n	%
Opioids	484	23.2	572	23.4
Stimulants	1295	62.1	1533	62.8
Alcohol	1458	70.0	1681	68.9
Benzodiazepines	705	33.8	862	35.3
Hallucinogens	252	12.1	340	13.9
Other	61	2.9	71	2.9
Other	138	6.6	159	6.5

Source: The Prison and Probation Service 2010

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

### Harm reduction

In order to minimise the risk of transferring infectious diseases (HIV and hepatitis), the inmates in the prisons and local prisons have access to disinfection fluids for cleaning of used syringes and needles. The scheme is being reconsidered, and in this connection the advantages and disadvantages of introducing a syringe exchange programme are put to debate.

Informative material on correct disinfection of syringes and needles with cleansing fluid are available to the inmates in the prisons and local prisons under the Prison and Probation service. The informative pamphlet is available in a number of foreign languages. The medical staff in the institutions informs the inmates about infection risks in general, and the informative material on hepatitis B and C as well as HIV are available in the institutions and translated into a number of foreign languages. Written information for staff only on infectious diseases is also available in the Prison and Probation Service institutions. Condoms are handed out free of charge and are placed in the visiting rooms where the inmates receive visitors.

Imprisoned drug abusers must be offered vaccination against hepatitis B and must be offered substitution treatment in accordance with applicable guidelines provided by the National Board of Health and thus reflect the treatment provided to the citizens in society in general.

### **Collaboration between authorities and treatment continuity**

When a prisoner is released, the Prison and Probation Service is obliged under the law to coordinate various action plans and to make sure that the inmate gets the necessary help and support, cf Act on Social Services and the Prison and Probation Service action plan circular. In this connection, a treatment course may be outlined and the type of intervention is assessed with a view to continued treatment. Depending on the duration of the sentence or the timing of initiated treatment, the inmate will be in a certain phase/intensity in the treatment course. What is important subsequently is that the municipalities who are responsible for the treatment of abusers continue the work of the Prison and Probation Service. In practice, this is not always possible, but nevertheless it is crucial that there is a dialogue and coordination of action plans.

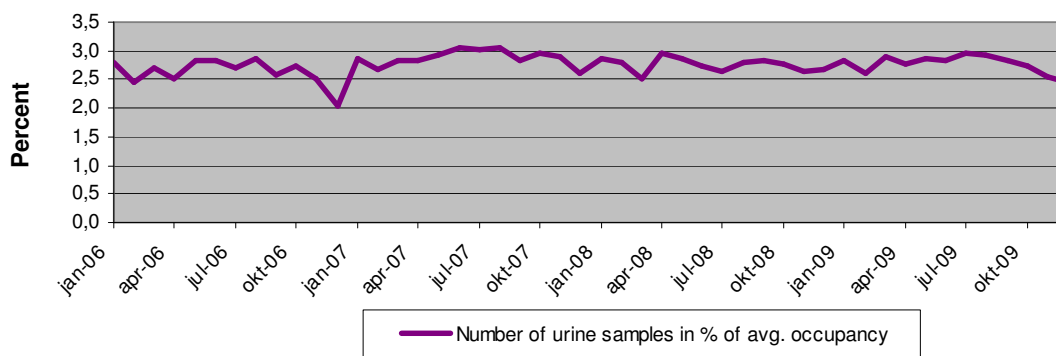
In 2010, the Prison and Probation Service started entering detailed collaboration agreements with all the municipalities in Denmark. The idea is that the municipalities can be certain that the cooperation is carried out in the same manner for all of the institutions under the Prison and Probation Service. At present, agreements have been signed with almost 25% of all the municipalities.

### **Drug test**

In 2004, a zero tolerance policy was introduced in the Prison and Probation Service's institutions. The main elements in this policy are that trafficking of drugs into prison should be made difficult; that checking the inmates must be intensified (urine samples); that consistency must prevail on the discovery of drug abuse, and that treatment options for drug abusers should be improved. As a part of this strategy, the clients of the Prison and Probation Service are subjected to a drugs test, corresponding to a minimum of 2% of the occupancy rate.

During the period from June 2005 until March 2010, a total of 186,283 were subjected to a drugs test, which equals an average of 3,212 drug tests per month or 106 tests a day. Figure 11.3.1 shows the monthly number of drug tests compared to the average occupancy rate per month for all prisons and local prisons during the years from 2006 to 2009.

**Figure 11.3.1. Number of drug tests in percentage of the average monthly occupancy in the entire Prison and Probation Service, 2006-2009**



Source: The Prison and Probation Service

On average for the entire period, the proportion has been 2.8%, whereas on an annual basis from 2006 to 2009, it was 2.6%, 2.9%, 2.8% and 2.8%.

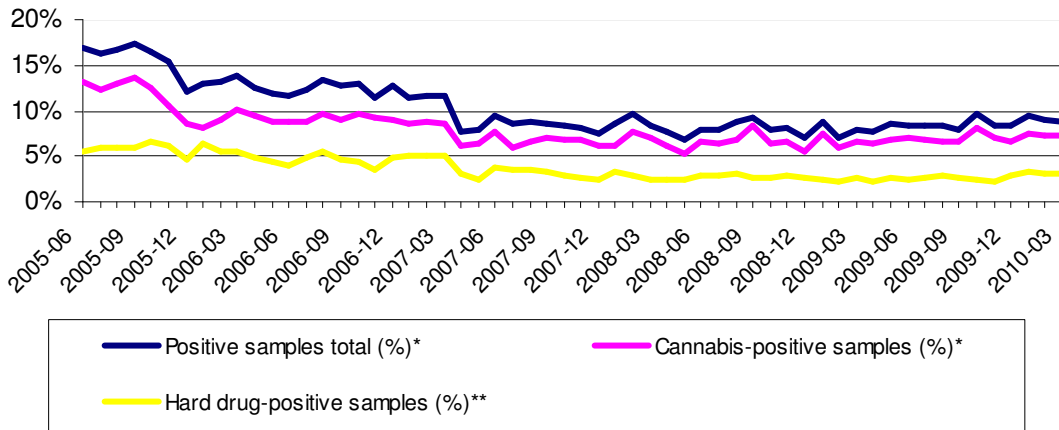
The test plate applied for drugs control includes a test for cannabis, opiates, benzodiazepines, cocaine, methamphetamine, amphetamine and methadone.

The test plates can trace cocaine and amphetamine in the urine for one to two days after intake, and cannabis for up to eight weeks of intake. This means that not until these time spans have been exceeded is it certain that the drugs have been taken in the Prison and Probation Service institution. The positive tests that appear within these time spans are not recorded as positive unless the inmate, as an exception, admits having taken the drugs in the institution.

Figure 11.3.2 shows that the proportion of positive tests has been declining during the period from June 2005 to June 2007. After June 2007, the level of positive tests has varied around 8%. In 2005, the total share of positive tests was a little less than 16%, and this share has obviously dropped to a little above 8% in 2008-2009. During the first quarter of 2010, the proportion of positive tests appears to have gone up a little. In 2009, the proportion was 8.3%, whereas during the first quarter of 2010, it was 9.1%.

If, as it is done in figure 11.3.2, the total number of positive urine samples is broken down into cannabis/hard-drug positive samples, it appears that the trend for these two types of drugs is parallel over time. The proportion of cannabis-positive tests has been more or less constant since late 2007, ie around 6.8%, and the proportion of hard drugs-positive tests around 3%.

**Figure 11.3.2. Positive urine samples, total, and cannabis/hard drug-positive urine samples in the entire Prison and Probation Service from June 2005 to March 2010, in %**



\*The Prison and Probation Service's urine samples can trace cannabis for up to eight weeks of intake. Therefore, eight weeks must pass before it can be determined in certainty that the intake of cannabis has been done in the Prison and Probation Service institution. Samples that are cannabis-positive within eight-weeks after admission are therefore not considered as positive in the Prison and Probation statistics.

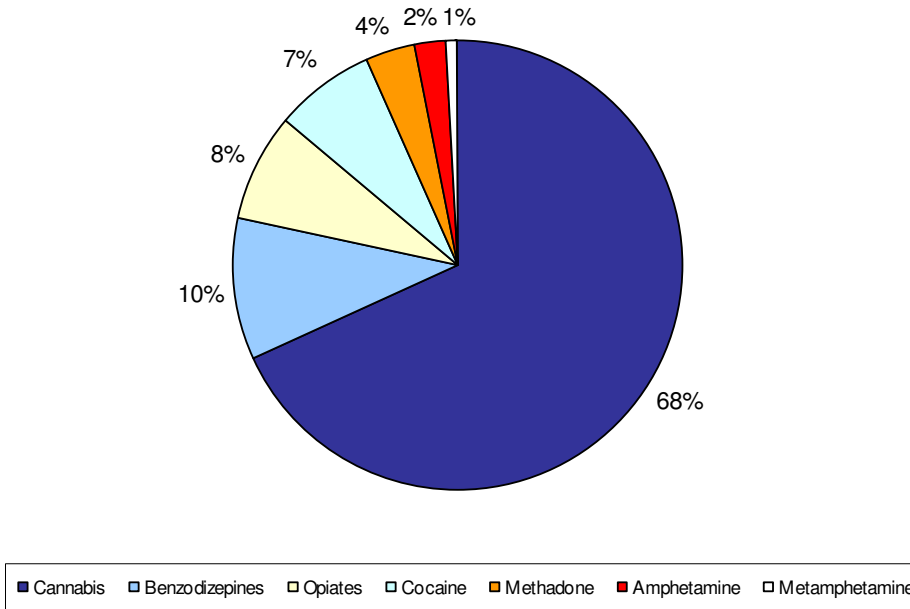
\*\*Hard drugs is the overall term for opiates, benzodiazepines, cocaine, metamphetamine, amphetamine and methadone."

Figure 11.3.2 also reveals that there is no immediate "substitution effect". This indicates that there is no trend suggesting that the proportion of hard drugs-positive tests increase as a result of the clients substituting cannabis with hard drugs.

The concern about a substitution effect is based on the fact that the probability of being tested hard drug-positive is smaller than that of being tested cannabis-positive due to the longer half-time elimination associated with cannabis. The inmates would therefore tend to substitute the use of cannabis with the use of hard drugs to minimise the risk of being tested positive. Although substitution may take place in some cases, there is no statistical evidence that this is taking place.

The vast majority of the positive tests are related to cannabis. In 2009, where 8.2% of the tests were found positive, cannabis accounted for 68% of the positive tests.

**Figure 11.3.3. Positive tests broken down by type of substance, in the entire Prison and Probation Service, 2009**

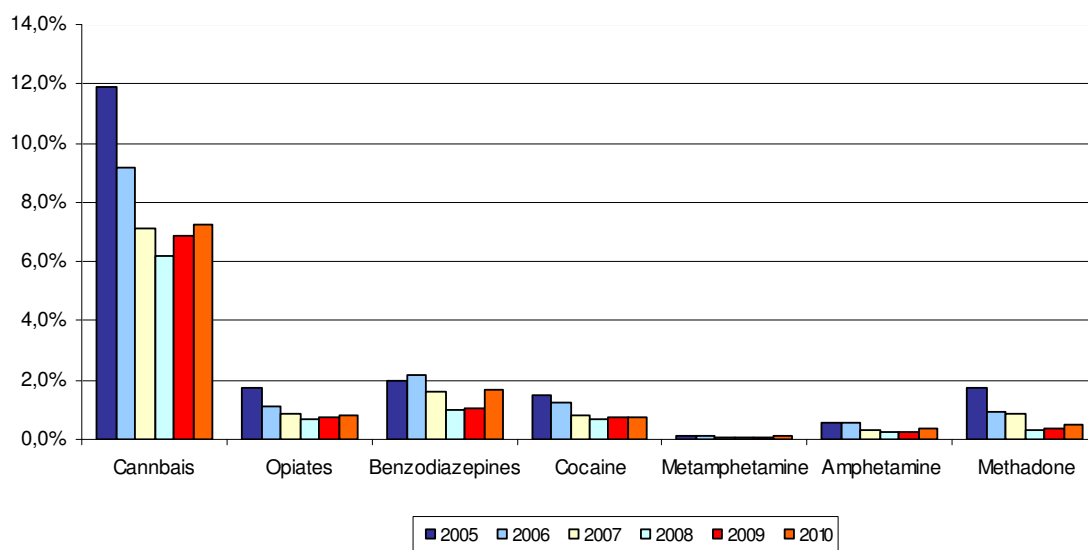


Source: The Prison and Probation Service

In general, it can be maintained that the sedative drugs such as cannabis, benzodiazepines, opiates and methadone together account for 90% of all the positive tests in 2009, whereas the stimulants such as cocaine, amphetamine and metamphetamine account for the remaining 10% of the positive tests.

It appears in figure 11.3.4 below that from 2005 to 2009 there was a drop in the proportion of positive tests for all the drugs being tested. Only the benzodiazepines account for an increase from 2005 to 2006.

**Figure 11.3.4. Positive urine samples categorized by type of drug in the entire Prison and Probation Service from June 2005 to March 2010, in %**



## 11.4 Quality services

### Standards for drug abuse health care services

Accreditation of the drug abuse treatment is the first part in the directorate's evaluation of drug abuse treatment in the Prison and Probation institutions.

Accreditation is a method, in which a recognised and independent body - the accreditation panel - assesses whether or not a treatment programme has developed or is capable of developing the optimum processes and frameworks for generating quality treatment. Accreditation is a formal recognition of the treatment facility's competency in practising treatment of drug abusers in prison and its capability of contributing positively to the inmate's resocialisation process. The evaluation of the treatment facility is based on the knowledge available within treatment research on what has an effect, and what does not have an effect in a prison environment. Accreditation may thus be considered as a scientific quality assurance measure.

The Directorate has also initiated intensive monitoring of the accredited treatment programmes. The aim of this is to make sure that the accredited treatment programmes currently provide the accredited services and that the treatment constantly rests on a solid scientific basis.

Experience from accreditation and follow-up practise is included in the Directorate's deliberations on the type of treatment programmes that should be used in prisons and local prisons, see also section 11.3.

### 11.5 Methodological limitations and challenges

In Denmark, health care of inmates is administered by the Prison and Probation Service which falls under the Ministry of Justice. The Directorate for the Prison and Probation Service or the institution's management team has no instruction authority in relation to the medical treatment of the inmate. The medical professional must solely ad-



here to the rules laid down by the health authorities. However, the individual institution is responsible for providing health care service programmes, see also section 11.2.

Placement of responsibility for health care services provided to inmates has not been subject to deliberations in the Danish prison and probation system, but the Directorate of the Prison and Probations service is aware that within the auspices of the WHO it is being discussed whether the responsibility for health care of inmates in prisons and local prisons should ideally be placed under the Ministry of Justice or the Ministry of Health.

The Prison and Probation Service does not submit reports to the national register for drug abusers in treatment (SIB). Instead, the Prison and Probation Service has an electronic client system, with a special "drugs module" recording data on the inmates' drug and alcohol abuse, treatment initiatives, etc. The Prison and Probation Service will consider regularly if it is possible to submit reports to the SIB system within the existing economic framework.

## 12 Drug users with children

Children in families with drug abuse are a very vulnerable group, given that the environment, in which they grow up is characterised by the parents' drug abuse-related problems of a health psychological and social nature and of the parents' often troublesome childhood and background. As a result, the parents' personal resources and caring ability may be considerably reduced with serious consequences to their own children in the form of neglect. The negative social legacy hits down hard in this group.

Drug abuse during pregnancy may lead to serious congenital injuries, partly caused by the drugs' specific foetotoxic effect, partly due to the pregnant woman's physical and mental condition of health, her life conditions and lifestyle. Female drug abusers often have missing or heavily irregular periods and often fail to use any contraception. Their pregnancies are often unplanned and complex, are discovered late and contact to the doctor and midwife is often late and unstable.

The congenital injuries and illnesses in the children include malformations, growth reduction, premature birth, anoxia and brain damage, as well as withdrawal symptoms, HIV, hepatitis and other infections. Furthermore, many of the children grow up under very insecure and unstable conditions, where they are deprived of the contact, stimulation and care necessary for a healthy and normal upbringing. It is a well-known fact that children with congenital injuries are much more sensitive to a bad childhood environment than those who have been born healthy and normal, and children with congenital injuries are by far more at risk of understimulation, neglect and assault than other children.

A bad childhood environment during the first years of life may enhance the impact of congenital injuries on the child's further development, whereas a good childhood environment during the first years of life may significantly reduce the impact of any congenital injuries. Therefore, early and qualified intervention for this risk group is essential for their prognosis.

### 12.1 Scope of the problem

As of 2006, the National Board of Health has systematically recorded the number of drug abusers admitted to treatment, including whether they have children, the children's age, where they live and the kind of contact with the children. As shown in chapter 5 in this report (table 5.2.1), there are, out of the 5,337 drug abusers admitted to treatment in 2010, 1,251 children under the age of 18 living at home. Additionally, there are 406 children under the age of 18 who do *not* live together with both their addictive parents (2011a). Also, the National Board of Social Services maintain records on drug abusers in treatment, in which it appears whether the female addict is pregnant on admission. The statistics mentioned only include drug abusers in treatment, for which reason the problems in relation to children of drug addicts must be higher than provided for in the statistics.

Many children of drug abusers will be recorded under other diagnoses, which indicate nothing about the connection to – or possible connection to – drug addiction. Such diagnoses include low birth weight, premature birth, neonatal cramps, poor well-being or colic, congenital heart problems, delayed development, mental illnesses, behavioural disorders, learning problems, neglect, "battered child syndrome", sexual assault and

sudden unexpected infant death. The children also appear in statistics on children placed out-of-home and the cause of this, out of which the main categories are equally distributed between abuse, mental illness and “other causes” in the parents. At the end of 2008, a total of 12,346 children were placed out-of-home. In 2009, another 2,802 children were added to the statistics (Ankestyrelsen 2010).

### **The children at risk**

Apart from the statistical records mentioned above, the National Board of Health made an estimate in 1992 on how many children live in drug addict families and gave a description of the childhood conditions, their health and development problems.

Since 2010, the family outpatient centre at Hvidovre Hospital has been in contact with 290 intoxicant using pregnant females (out of which half of them are drug addicts), and had that same year admitted 285 children in the age from 0 – 7 years for follow-up treatment by a specialist doctor or a psychologist.

A survey made by the Copenhagen and Frederiksberg Medical Officers for Health in 2004 on pregnancies and births among drug abusers in Denmark 1990-2001 showed that drug addicts have the same number of children as the background population, ie 1.7 children per female, and that drug addicts have 2.5 times as many miscarriages as other women. The survey also showed that more children of drug addicts are born in western Denmark than in eastern Denmark, and that the mortality among live born children of drug addicts is 3 times higher than in the rest of the population (17 per 1000 live born child compared to 6 per 1000), especially for the age group 0-2 years, and 3 times higher in west Denmark than in east Denmark. The survey is national and includes 4698 women and 2424 children and a control group of 46,819 women. The survey has been made in the individual counties and municipalities.

The survey also shows that there were 518 newborn infants who had been diagnosed with neonatal withdrawal symptoms during this period, out of which 243 of their mothers were not known to the treatment system for drug abusers, neither before nor after birth. In future, the new regional and national family outpatient centres will facilitate the work of uncovering the number of children involved using common and uniform data recording of medical, psychological and social data related to pregnant women and children up until the children start in school.

## **12.2 Policy and legislation**

In Denmark, all citizens have a *notification obligation*, which means mandatory reporting to the social authorities if they become aware of children living under conditions that may be detrimental to their physical and mental health and development. This obligation also applies if they are aware of expectant parents living under conditions assumed to pose serious danger to the unborn child (Section 154 of the Act on Social Services)

*The enhanced notification obligation* applies to citizens, who in the course of their work, become aware of children or pregnant women (expectant parents) with the problems mentioned above (section 153 of the Social Services Act). According to the law, the local social administration office is responsible for the children and young people in the municipality (section 46 of the Social Services Act) and is thus the body holding the decision competence in the cross-sector collaboration in terms of type and scope of measures that might help the children and family, including whether or not the children should stay in their own home or be placed out-of-home.

### **Statutory local programmes**

The local treatment programmes provided to drug abusers includes outpatient centres targeted specifically at drug abusers with children (see focus areas) and there are also private institutions providing inpatient treatment to this group.

The inpatient programmes also include placement of the mother and child and/or the father and child together in a foster family, often under conditions where the child and parent are placed on special terms (parent and child placement), which means that the parents are not allowed to take the child with them if they unexpectedly leave the foster family or experience recurrence of their drug abuse. The family project is a unit under the private institution "Dag og Døgncenteret" (the Day Care and Inpatient Centre), which has this focus method as their speciality. In 2010, 33 children born of active drug addictive females were admitted for treatment of withdrawal symptoms when they were born.

Another inpatient programme is the family institutions for mother and child/parents with child/children, where observation may take place and support given in relation to the mother's/parent's caring for their child. These institutions are not specifically targeted at drug abusers with children, but at all children and families with psycho-social problems and a risk of neglect. Often a parent capability test is made on behalf of the social authorities in order for them to assess the help needed, the scope and type of it, including an assessment of whether or not the child can stay at home or should be subjected to out-of-home placement. Some children are brought to an observation and nursing home after delivery, and some are placed with foster carers without their family in a private or local context.

There are also private educational centres for children and their parents, whether they can go either together or separately. According to the law, the local social authorities are responsible for children and adolescents in the municipality (section 46 of the Social Services Act). If the social authorities cannot obtain parental consent to a given programme, the case is submitted to the Children and Young Person's Committee for decision (section 58 of Act on Social Services). It is possible for an adoption decree to be granted for adoption of a child under the age of 1 year, "if it is established that the parents will permanently not be in a position to take care of the child and will also not be able to play a positive role for the child in connection with contact" (ss 2, 3, and 4 of section 9 of the Danish Adoptions Act). It is possible to retain pregnant drug abusers in treatment if they sign a contract to that effect (Act on Retention of Drug Abusers in Treatment no. 190, ss 1 of section 1 as amended by law no. 542).

Currently, a working group has been appointed by the Ministry of Social Affairs and Integration and the Ministry of Health. The task of this group is to investigate whether or not there is a need for a legislation rendering it possible to retain pregnant drug abusers without their consent in order to prevent against serious damage to their children.

### **12.3 Special focus areas**

Apart from the statutory programmes mentioned above, the family outpatient centres in Denmark are instrumental in preventive as well as treatment interventions for drug abusers and their children (Sundhedsstyrelsen 2010a).

The family outpatient centre at Hvidovre Hospital is a special unit for pregnant women and families with intoxicant problems. The target group is pregnant women who are regular users of intoxicants/and or addictive medicines, pregnant women with a previ-

ous intoxicant problems and pregnant women, whose partner/father of the child has a problem with intoxicants. In this connection, the other part of the target group is children aged from 0 to school age, and who during their foetal life have been exposed to intoxicants. All these children, whose mothers have been admitted to treatment in the family outpatient centre during pregnancy, are offered follow-up treatment with a specialist doctor and a psychologist until they reach school age.

The purpose of the family outpatient centre is to prevent against congenital injuries, defective development, neglect and assault resulting from intoxicants. Organisationally, the family outpatient centre is placed under the department of gynaecology and obstetrics with a function reaching out to the neonatal and children's unit. The department has a group of specialist doctors, psychologists, midwives, social workers and secretaries working in interdisciplinary teams and with the overall medical treatment responsibility from early pregnancy and until the child and family are discharged from the family outpatient centre. Thus, the Centre's work is carried out in close collaboration with the primary health care sector and the social sector and other relevant professionals and bodies.

The results from the family outpatient centre interventions have shown that the number of pregnancy and birth complications in the target group has dropped significantly as has the number of children with congenital injuries and neonatal diseases such as withdrawal symptoms. Also the number of children with defective development and neglect has dropped considerably compared to the children who were born by pregnant drug abusers prior to the opening of the unit. Approximately 10% of the pregnant drug abusers choose abortion following advice from the family outpatient centre and by the majority accept establishment of contraceptive measures prior to discharge from the hospital after birth or abortion.

Prior to the development of the family outpatient centre's interdisciplinary and intersectoral intervention model and establishment, Rigshospitalet's [the Copenhagen University Hospital] neonatal unit conducted a follow-up survey on 89 children born by drug addictive mothers. At the time of the survey, the children were aged between 1 and 10 years. The survey showed that only 25% of the children were developed normally, and that 54% of them were currently on an out-of-home placement scheme. 80% of the children had been placed once or several times away from home and had experienced a shift in primary carer up to 30 times. Their childhood environment was characterized by severe instability and lack of network, and 81% of the mothers had continued their drug abuse, irrespective of whether they had given birth 1 year or 10 years ago. 75% of the children who did not develop normally had a combination of organic injury (brain damage), under stimulation and neglect.

### **Family outpatient centres on a national scale**

In 2008, the Danish parliament granted a large amount via the social reserve funds to a nationally enhanced focus on pregnant women with intoxicant problems and their children until school age. The funds should be used for the establishment of regional family outpatient centres – one in each region – according to the same model as that of the family outpatient centre at Hvidovre Hospital. In 2009, the National Board of Health prepared guidelines on this to be used in the regions (Sundhedsstyrelsen 2009).

This social reserve grant runs until the end of 2013, following which financing of the future new outpatient centres is secured via an increase in bloc grants for the regions. The grants also include the establishment of a "Center for Prevention of Substance Effects on the Development of Children", the purpose of which is to assist the regions in

establishing this type of intervention through counselling (via e-mail and phone), communication of professional know-how and experience via a professional website, courses and other training and communication facilities.

The Center was established in November 2008, and the regional family outpatient centres have been established in 2010 and the beginning of 2011. Family outpatient centres' target group is pregnant women using intoxicants and children aged from newborn to school age who in the foetal stage have been exposed to intoxicants and/or addictive medicines, pregnant women with former intoxicant problems, and pregnant women whose partner has a problem with intoxicants. Based on the number of births and of pregnant woman admitted to the family outpatient centre at Hvidovre Hospital it is estimated that in Denmark, at least 900 pregnant women and their children will be admitted annually. The Center has set up a cross-regional collaboration between the five family outpatient centres which ensures that work is made according to consistent professional guidelines in accordance with those set out by the National Board of Health.

### **Other preventive interventions**

Apart from the preventive interventions mentioned above via the family outpatient centres, there are a number of other initiatives and projects established in Denmark. The KFUK's drop-in centre Reden in Copenhagen has a "Health Project" providing free counselling, contraception and pregnancy testing of the Reden's target group who are prostitutes, of which many are drug addicts. Female drug addicts are offered free sterilisation in hospitals, and many places also offer free contraception in connection with abortions and births. There are also the social reserve fund interventions carried out in the social as well as the health care sectors on a local and a national basis, where pregnant alcoholics and drug abuser and their children are a focus of the interventions.

## **12.4 Summary and perspectivation**

Injuries on children's lives and mobility are serious and expensive for society. The children are at risk of lifelong disability which, apart from the human sacrifices involved, also inflicts a burden on the health care system as well as the social system and thus on the entire national economy. The negative social legacy has a massive impact on this group with these children being at risk of developing drug abuse later in life. From the outset, these children have a normal development potential and would be able to develop into healthy, normal children and well-functioning adults if from their early foetal stage and up through their childhood and adolescence they had not been injured by intoxicants and exposed to various other risk factors. Therefore, it is important to prevent these children from suffering such injuries through early intervention and qualified help. Harm reducing projects addressing pregnant women and their children in relation to drug abuse should be on the priority list nationally as well as internationally. International congresses are being held on the detrimental effects and harm reduction of drug abuse, but often the children are not mentioned at all in this connection, or they are only mentioned to a limited extent. There is large economical potential in giving priority to preventive intervention vis-a-vis pregnant drug abusers and their children.

Furthermore, there is a heavy demand for research within the area of "drug abuse and children". The knowledge on long-term effects on children is very limited. Not only on growing up as a child in an abuse environment, but the impact of intoxicant exposure during the foetal stage. At the family outpatient centre at Hvidovre Hospital, a follow-up survey is currently being conducted on children born in the years from 1993-1995 who were admitted to the family outpatient centre with their mothers in connection with pregnancy and birth and during the first years of their lives. "How have the children

managed” is the title of the survey. The family outpatient centre has a comprehensive and systematic set of data material from 1992 and up until today. This material will form the basis of significant research with this problematic field. The new regional family outpatient centres with their common database and the Center for Prevention of Substance Effects on the Development of Children are expected also in future to contribute to enhanced research and development within this field.

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## The surveys applied

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

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

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

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

### **”Brug af khat blandt personer med somalisk baggrund i Danmark – en undersøgelse af omfang og holdninger”. Sundhedsstyrelsen, 2009 [Use of khat among persons with a Somali background in Denmark – prevalence and attitudes]**

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 [Monitoring of young people’s lifestyle]**

In 2002, the National Board of Health and the Danish Cancer Society conducted a representative survey on the lifestyles and daily routines of 16-20 year-olds. 2,041 young people aged between 16 and 20 were chosen according to systematic selection. Data collection was made via questionnaires mailed to the respondents. The response rate was approximately 70%.

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

In 2003, the National Board of Health and the Danish Cancer Society conducted a representative survey on the lifestyles and daily routines of 16-20 year-olds. 1,964 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 [Monitoring of young people's lifestyle]**

Sundhedsstyrelsen gennemførte i 2004 i samarbejde med Kræftens Bekæmpelse en repræsentativ undersøgelse af de 16-20-åriges livsstil og dagligdag. Der blev ved systematisk udvælgelse udtrukket 1772 unge mellem 16 og 20 år. Dataindsamlingen foregik ved postspørgeskemaer. Undersøgelsen opnåede en svarprocent på 58%.

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

A special survey on well-being, health and health habits among the 16-20-year-olds in Denmark.

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

In 2006, the National Board of Health and the Danish Cancer Society conducted a representative 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%.

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

In 2008, the National Board of Health and the Danish Cancer Society conducted a representative internet-based survey on the 16-20-year-olds' lifestyles and daily routines. The survey respondents were recruited via Userneeds Danmarkspanel and included a total of 1,539 individuals. While the former MULD surveys were conducted via questionnaires sent by ordinary mail, the 2008 survey was only internet-based and the questionnaire was completed electronically over the internet. In the new data collection methods, sources of error are not yet known, for which reason the results from 2008 cannot be directly compared to the results of previous years.

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

This report was based on the Danish ESPAD 1999 study (see above) The random sampling of the report was expanded compared to ESPAD 1999 and included pupils from the 9th grade. Therefore, in addition to the 15-16 year-olds, pupils aged 14-17 were also included, since they attend the 9th grade as well. Thereby, the number par-

ticipating 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) [Health and morbidity in Denmark]**

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) [Health and morbidity in Denmark]**

A national survey was conducted in three data collection rounds in February, May and September 2000 among a representative segment of the Danish population aged 16 and above. The survey included, as in 1994, questions on a variety of health issues. The sample population of a total of 22,486 persons was selected in three random sampling rounds. 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) [Health and morbidity in Denmark]**

A national survey conducted from May 2005 to March 2006 among a representative segment of the population aged 16 and above. The survey included, as in 1994 and 2000, questions on a variety of health issues. The sample population of a total of 21,832 persons was selected at random. 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.

**"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 (upubliceret)**

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

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

In 2011, the surveys from 1995, 1999, 2003, and 2007 were repeated among a representative selection of 15-16-year-old pupils in the 9th grade at randomly selected public schools, private schools and continuation schools. Data collection was made by handing out the questionnaire to the respondents in the class rooms. A total of 2772 ninth grade pupils took part in Denmark. Practically all the ninth grade students who were in school on that particular day took part in the survey. On average, approximately 90% of the pupils are in school on a random day. There were quite a few schools (approximately 50%) where either the school board or the principal were not interested in taking part in the survey. The reason was often that in the 9th grade, teaching hours had been spent on taking part in other surveys such as the PISA-survey.

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

This report was based on the Danish input to the ESPAD 1995 study (see above). The random sampling of the report was expanded compared to ESPAD 1995 and included pupils from the 9th grade. Therefore, in addition to the 15-16 year-olds, pupils aged 14-

17 were also included, since they attend the 9th grade as well. Thereby, the number participating pupils went up to 2545.

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

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

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

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

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

In 2001, the National Board of Health and the Danish Cancer Society conducted a representative survey on the lifestyles and daily routines of 16-20 year-olds. 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 %.

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

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

- A large quantitative survey conducted in 2008. This survey is partly a cross-section survey (a questionnaire survey among 3000 Danish young people aged 17-19 years, selected from the CPR register) and partly a panel survey (a questionnaire survey among 2000 young people born in 1989, also selected from the CPR register). In 2005, the young people from the panel survey have, at the age of 15-16 years, completed a large questionnaire on alcohol and parties and their responses from 2008 thus make it possible to monitor them over time.
- A focus group survey among typical Danish young people conducted during the spring and summer, 2008. The purpose of this survey was to analyse these young people’s attitudes towards and knowledge about drugs.
- A nightclub survey conducted in the autumn and winter 2008-2009. The purpose of this survey was to analyse the prevalence of drugs in the nightlife and make contact with young people with broader drug experience than the typical Danish young people in the focus group survey mentioned above. The nightclub survey consists of a brief questionnaire survey conducted in the night clubs, an internet-based questionnaire survey, ethnographic observations from the night

clubs and finally qualitative interviews (focus group interviews and individual interviews) with nightclub guests regularly using drugs.

The YODA project has been financed by the Rockwool Foundation and the results are described in the book "Stoffer og natteliv" [Drugs and Nightlife] (Järvinen 2010).

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Table 2.1.3. The percentage of the 16-44-year-olds who last month, last year and ever used one or several illicit drugs other than cannabis 1994, 2000, 2005, 2008, and 2010.

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## Supplementary tables

**Table 2.1.1. Percentage of women and men in the various age groups who used cannabis within the past year in 1994, 2000, 2005, 2008, and 2010**

		1994 n=2,521	2000 n=6,887	2005 n=4,484	2008 n=2,229	2010 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 percentage of the 16-44-year-olds who 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 percentage of the 16-24-year-olds who have a current use of illicit drugs (tried one or several of the 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 1994, SUSY 2000, SUSY 2005 and AiD in 2008, and SUSY 2010

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



**Table 2.1.11. The percentage of the 16-24-year-olds who tried one or several of the various illicit drugs within the past month, last year and ever in 2010**

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

Source: Unpublished figures from the 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 each year. Distribution by gender**

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

Source: Cause of Death Register, August, 2011

\*Figures for 2007, 2008, and 2009 have been increased by 2.4 %, and 2.8% and 3.4%, respectively in relation to the reported number of death certificates in order to compare with previous years.

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

Year	Totalt	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	2010	273	234	39

Source: National Commissioner of Police, 2011

\*Gender not informed for 2 persons

\*\* Gender not informed for 3 persons

**Table 6.1.4. Drug-related deaths broken down by the regions in each year**

	2007	2008	2009	2010
Northern Jutland	36	35	33	31
Central Jutland	52	47	53	58
Southern Jutland	71	68	79	78
The Capital Region of Copenhagen	68	59	86	70
Zealand	29	24	21	31
Copenhagen Municipality	41	31	51	38

Source: National Commissioner of Police 2010

**Table 6.2.1. Trend in hospital contacts following intoxications and poisonings caused by illicit drugs in each year**

	KCod e*	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010 <sup>25</sup>
Heroin	T40.1	235	246	219	161	173	197	159	160	151	166	163	195
Other opioids	T40.2 +T40. 2A +T40. 2B	34	35	43	47	50	119	112	130	139	169	240	279
Methadone	T40.3	5	11	19	38	25	50	53	32	44	57	74	89
Opioids	F11.0	66	79	66	52	60	49	60	43	60	72	63	73
<b>Opioids total</b>		<b>340</b>	<b>371</b>	<b>347</b>	<b>298</b>	<b>308</b>	<b>415</b>	<b>384</b>	<b>365</b>	<b>394</b>	<b>464</b>	<b>540</b>	<b>636</b>
Designer drugs (excl. ecstasy)	T40.6 A + T43.8 A		2	14	21	12	15	3	6	10	40	37	61
Ecstasy	T40.6 B +T43. 6B	9	74	67	60	82	72	72	89	86	72	52	46
Amphetamine	T43.0 A + T43.6 A		2	24	43	54	68	73	83	171	158	208	286
Cocaine	T40.5 +F14. 0	43	50	76	65	75	69	100	93	129	119	139	155
Other stimu- lants	F15.0	58	48	53	46	51	41	47	39	50	45	34	35
<b>Stimulants total</b>		<b>110</b>	<b>176</b>	<b>234</b>	<b>235</b>	<b>274</b>	<b>265</b>	<b>295</b>	<b>310</b>	<b>446</b>	<b>434</b>	<b>470</b>	<b>583</b>
Psychoactive mushrooms	T40.6 C +T40. 9A	7	5	10	8	3	10	6	13	13	7	12	5
LSD	T40.8	3	3	12	2	1	2	7	11	16	27	7	8
Hallucinogens	F16.0	10	16	15	5	4	6	11	4	12	8	2	11
<b>Hallucinogens total</b>		<b>20</b>	<b>24</b>	<b>37</b>	<b>15</b>	<b>8</b>	<b>18</b>	<b>24</b>	<b>28</b>	<b>41</b>	<b>42</b>	<b>21</b>	<b>24</b>

Source: National Commissioner of Police, 2011

\*Gender not informed for 2 persons

\*\* Gender not informed for 3 persons

<sup>25</sup> The figures for 2010 are preliminary and have been retrieved from the LPR in August 2011. The final figures for 2010 may change in subsequent statistical material.

**Table 6.2.1. Trend in hospital contacts following intoxications and poisonings caused by illicit drugs in each year**

Cannabis	T40.7 +F12. 0	98	105	164	122	125	74	68	68	97	108	137	128
Polydrug use and unspeci- fied**	T40.4 +T40. 6 +T40. 6W +40.6 X +T40. 9 +F19. 0	540	622	568	645	694	391	376	422	367	449	447	497
Intoxikations and poisonings total		1108	1298	1350	1315	1409	1163	1147	1193	1345	1497	1615	1868

Source: The National Board of Health's National Patient Register. Data for the year 2010 were retrieved in August 2011

\*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

**Table 6.2.3. Hospital contacts following intoxications and poisonings broken down by age groups in each year**

Age group	2005	2006	2007	2008	2009	2010
< 20 years	212	272	317	309	295	336
20-24 years	238	216	259	292	284	356
25-29 years	170	160	177	193	162	247
≥ 30 år	527	545	592	703	874	929
Total	1147	1193	1345	1497	1615	1868

Source: National Board of Health's National Patient Register, data retrieved in August 2011

**Table 6.3.1. Number of newly diagnosed HIV positive and AIDS diagnosed in the entire population and the proportion of intravenous drug users hereof, in each year**

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Newly diagnosed, HIV positive total	287	260	320	289	270	307	264	245	312	285	231	274
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%)	14 (5%)
Newly diagnosed AIDS cases	76	59	71	45	41	61	45	53	48	34	30	45
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%)	5 (11%)

Source: Unpublished data from the State Serum Institute. The 2009 data are based on figures from March 2010

**Table 6.3.2. Recorded number of acute cases of hepatitis A, B, and C in the entire population and the proportion of intravenous drug users hereof, in each year**

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Hepatitis A, total	88	81	63	84	71	241	48	42	28	43	33	47
Hepatitis A with intravenous drug use (% of all diagnosed)	0	0	0	0	0	9 (4%)	1 (<1%)	0	1 (<1%)	0	0	0
Hepatitis B, total *	57	64	49	62	36	44	30	20	24	25	22	27
Hepatitis B 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%)	0
Hepatitis C, total *	13	15	6	5	7	8/368**	2/364	7/385	9/382	5/296	4/246	6/275
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%)	3/207 (50%/75%)

Source: Unpublished data from the State Serum Institute. The 2010 data are based on figures from May 2011

\*Among cases with acute hepatitis B og C a certain common quantity is included

\*\* acute/chronic hepatitis C in common

#### 6.4.1. Persons recorded with drug-related primary diagnoses in psychiatric hospitals in each year

Diagnosis code	Mental diseases or disorders caused by the use of:	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
F11	Opioids	227	189	172	156	155	138	123	133	136	166	120
F12	Cannabis	270	327	364	333	354	312	347	364	388	553	533
F13	Sedatives /hypnotic agents	205	199	182	159	143	150	140	154	141	130	112
F14	Cocaine	23	31	36	65	53	42	49	49	56	57	51
F15	Stimulants other than cocaine	76	75	109	99	98	93	87	91	94	95	86
F16	Hallucinogens	18	21	14	9	17	16	10	10	18	6	11
F18	Solvents	2	6	2	10	5	3	3	4	7	3	1
F19	Multiple or other psychoactive drugs	749	732	726	747	684	668	660	682	696	826	672
Persons with primary diagnoses, total		1570	1580	1605	1578	1509	1422	1419	1487	1536	1746	1586

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 6.4.1 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. As a patient cannot have several drug-related secondary diagnoses, the "total" category is not a summation.

#### 6.4.2. Persons recorded with drug-related secondary diagnoses in psychiatric hospitals in each year

Diagnosis code	Mental diseases or disorders caused by the use of :	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
F11	Opioids	190	204	208	201	271	280	341	358	492	522	428
F12	Cannabis	584	637	691	759	873	908	1040	1072	1507	1646	1668
F13	Sedatives /hypnotic agents	283	257	266	307	359	367	385	417	529	554	468
F14	Cocaine	17	19	34	61	66	97	118	163	210	217	214
F15	Stimulants other than cocaine	52	58	56	73	123	120	162	179	235	261	251
F16	Hallucinogens	9	11	10	2	13	14	8	8	13	14	14
F18	Solvents	7	7	13	12	11	8	18	13	13	24	17
F19	Multiple or other psychoactive drugs	566	485	574	679	728	736	874	995	1176	1396	1239
Persons with secondary diagnoses total		1630	1593	1747	1844	2074	2102	2430	2632	3418	3718	3445

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. As a patient cannot have several drug-related secondary diagnoses, the "total" category is not a summation.

#### Table 9.2.1. Drug crimes in each year. Crimes reported with charges and number of persons charged

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Persons charged	12,956	12,902	12,851	14,272	16,390	19,037	19,900	18,506	18,692	17,403	17,825
Source:	9,899	9,858	10,021	11,160	12,313	14,204	15,060	13,294	14,093	13,354	13,749

Source: National Commissioner's Drug Statistics 2011



**Table 10.2.1. Drug seizures in each year**

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
<b>Heroin</b>														
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	39.4
No. of seizures	2,509	2,199	1,230	1,499	1,304	966	894	1,041	1,064	927	1,016	906	648	699
<b>Cocaine</b>														
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	54.16
No. of seizures	723	885	744	780	815	881	1,095	1,207	1,615	1,901	2,098	1,858	1,365	1,589
<b>Amphetamine</b>														
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	193.9
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	1,764
<b>Ecstasy</b>														
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	45,360
No. of seizures	110	143	197	444	331	340	322	1,388	461	540	452	251	200	200
<b>LSD</b>														
Kg	381	105	83	1,108	156	38	22	483	1,201	521	47	482	468	159
No. of seizures	15	24	15	18	29	8	7	13	12	8	13	21	18	16
<b>Cannabis</b>														
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	2,318
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	7,689

Source: National Commissioner's Drug Statistics 2011

**Table 10.3.1. Distribution between types of drugs on a user level in each year**

Year	2000 n=188	2001 n=152	2002 n=198	2003 n=188	2004 n=200	2005 n=196	2006 n=203	2007 n=200	2008 n=195	2009 n=195	2010 n=204
Heroin	44%	45%	40%	39%	33%	34%	33%	30%	27%	28%	21%
Amphetamine	17%	22%	24%	20%	29%	23%	34%	30%	31%	29%	33%
Cocaine	24%	22%	30%	32%	34%	36%	30%	34%	35%	37%	37%
Ecstasy**	7%	9%	2%	-	-	-	-	-	-	-	-
Metamphetamine ***	-	-	-	4%	1%	5%	1%	2%	3%	3%	1%
Other euphoriant/ drug combinations	5%	1%	3%	4%	3%	1%	2%	2%	3%	3%	5%
Non-euphoriant	3%	1%	2%	1%	-	2%	1%	2%	2%	1%	3%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Source: Kaa et al. 2000 til 2005; Lindholst et al fra 2005 til 2011

\*\* 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. Metamphetamine appears rarely and sporadically in the previous years and is included in the category "other euphoriant/drug combinations" until 2003. The latter category for the entire period is also included in the samples where metamphetamine appears in combination with other drugs.

**Table 10.3.2. Distribution between heroin base and heroin chloride in each year**

	2000 (n =82)	2001 (n =69)	2002 (n=80)	2003 (n=73)	2004 (n=66)	2005 (n=66)	2006 (n=66)	2007 (n=60)	2008 (n=52)	2009 (n=54)	2010 (n=42)
Heroin base	61%	77%	76%	84%	77%	76%	65%	72%	77%	69%	64%
Heroin chlo- ride	39%	23%	24%	16%	23%	24%	35%	28%	23%	31%	36%

Source: Lindholst et al 2011