DANISH HEALTH AUTHORITY

Denmark

Country Drug Report 2017

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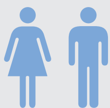
THE DRUG PROBLEM IN DENMARK AT A GLANCE

Drug use

in young adults (16-34 years) in the last year

Cannabis

17.6 %



13.8 % 22.5 %

Other drugs

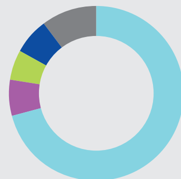
Cocaine	2.4 %
Amphetamines	1.4 %
MDMA	0.7 %

High-risk opioid users

No data

Treatment entrants

by primary drug



- Cannabis, **71 %**
- Amphetamines, **7 %**
- Cocaine, **5 %**
- Heroin, **7 %**
- Other, **10 %**

Opioid substitution treatment clients

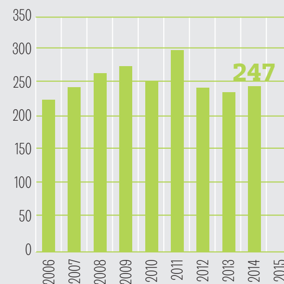
6 268

Syringes distributed

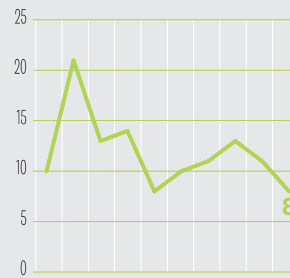
through specialised programmes

No data

Overdose deaths



HIV diagnoses attributed to injecting



Source: ECDC

Drug law offences

26 290

Top 5 drugs seized

ranked according to quantities measured in kilograms

1. Cannabis resin
2. Herbal cannabis
3. Cocaine
4. Amphetamine
5. Heroin

Population

(15-64 years)

3 645 939

Source: EUROSTAT
Extracted on: 26/03/2017

NB: Data presented here are either national estimates (prevalence of use, opioid drug users) or reported numbers through the EMCDDA indicators (treatment clients, syringes, deaths and HIV diagnosis, drug law offences and seizures). Detailed information on methodology and caveats and comments on the limitations in the information set available can be found in the EMCDDA Statistical Bulletin.

About this report

This report presents the top-level overview of the drug phenomenon in Denmark, covering drug supply, use and public health problems as well as drug policy and responses. The statistical data reported relate to 2015 (or most recent year) and are provided to the EMCDDA by the national focal point, unless stated otherwise.

An interactive version of this publication, containing links to online content, is available in PDF, EPUB and HTML format: www.emcdda.europa.eu/countries

National drug strategy and coordination

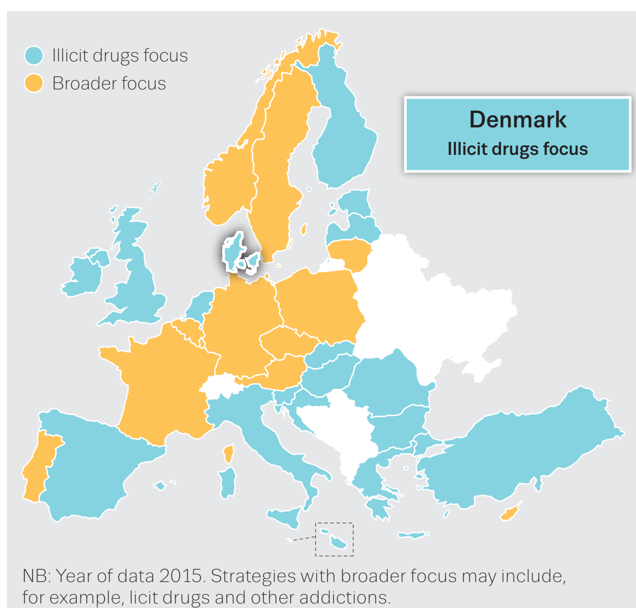
National drug strategy

Denmark's national illicit drug policy is comprehensive and covers prevention and early intervention, treatment, harm reduction and law enforcement. Currently, Denmark does not have a national drug strategy document. However, the national drug policy is defined in strategic documents in different policy areas and in legislation and concrete actions. As a result, Danish drug policy covers all the areas that are relevant to a comprehensive approach to drug issues (Figure 1).

As in other European countries, Denmark evaluates its drug policy and strategy through ongoing indicator monitoring and specific research projects. This approach is used to assess the overall drug policy and to fine-tune specific interventions. For example, the Danish Health Authority regularly monitors a range of key epidemiological indicators that give insights into drug problems and there have been recent specific evaluations of programmes for drug consumption rooms, heroin-assisted treatment and the provision of anonymous drug use.

FIGURE 1

Focus of national drug strategy documents: illicit drugs or broader



NB: Year of data 2015. Strategies with broader focus may include, for example, licit drugs and other addictions.

National coordination mechanisms

Denmark has no special body with the sole task of coordinating drug policy. The Ministry of Health is responsible for central coordination in the drugs field. Coordination is based on frequent informal contact between relevant national authorities. The Ministry of Health is responsible for legislation governing controlled substances; monitoring the legal use of controlled substances; and tasks at the national level concerning drug use prevention and drug treatment within the Danish healthcare system, including, but not limited to, the treatment of drug users and harm reduction interventions. The Danish Health Authority develops professional guidelines, monitors drug use through surveys of the population and the drug markets and acts as the national focal point to the EMCDDA.

The Danish Medicines Agency issues authorisations to companies seeking to transport psychoactive substances for medical purposes and works with the International Narcotics Control Board in this respect. The Ministry for Children and Social Affairs is the central authority responsible for tasks related to social interventions that target drug users and any other social services that are regulated by the Danish Social Services Act. The National Board of Social Services is responsible for communicating information on effective social intervention practices and methods for drug users, as well as assisting in the general and special counselling of the municipalities and regions. The Ministry of Justice governs the police force and is in charge of interventions that target prisoners with a drug use problem. The Ministry of Taxation and the Danish Customs and Tax Administration is responsible for customs, including the monitoring and control of the legal use of and trade in drugs precursors. The Ministry of Foreign Affairs is responsible for the overall foreign, security and development cooperation policies, including support to initiatives that aim to assist drug-producing countries

and transit countries in their work to limit the supply of and demand for drugs. At a local level, the municipalities are responsible for carrying out prevention and harm reduction interventions, as well as the medical and social treatment of drug users, which is the responsibility of the regions during hospitalisation. The role of the municipalities in this context is supported by the central authorities in the form of monitoring, providing overall guidelines and documentation, facilitating the exchange of data, etc.

Denmark's national illicit drug policy is comprehensive and covers prevention and early intervention, treatment, harm reduction and law enforcement

Public expenditure

Understanding of the costs of drug-related actions is an important aspect of drug policy. Some of the funds allocated by governments to expenditure to tasks related to drugs are identified as such in the budget ('labelled'). Often, however, the bulk of drug-related expenditure is not identified ('unlabelled') and must be estimated using modelling approaches.

In Denmark, multiannual drug budgets are associated with a number of interventions in the field of drugs under the format of the Social Reserve Grants Agreement. Available data on drug-related public expenditures are multiannual and include only labelled expenditure.

The Social Reserve Grants Agreement had a planned budget of EUR 19.5 million for drug-related initiatives between 2004 and 2007. In 2006, this budget was reinforced and a new budget of EUR 33.6 million was defined for the period 2006-09. This agreement was strengthened in 2008 and 2009 with an additional EUR 16.4 million. In 2011, an additional EUR 9.6 million was set aside. In 2012, a total of EUR 3.2 million was budgeted for the years 2012-15. In 2015, several treatment and social reintegration programmes were launched with assigned budgets (e.g. EUR 4.7 million to co-finance drug consumption rooms; EUR 1.2 million to support programmes for anonymous treatment of drug users; EUR 1 million for naloxone programmes; EUR 1.2 million for interventions reaching young people with cannabis-related psychosis and; EUR 0.4 million for prevention programmes among students). A budget of EUR 13.8 million was assigned for the period 2013-18 at central government level. The data available for local government expenditures indicate that EUR 120.9 million was spent on drug treatment in 2014 and EUR 124 million (which represents an annual increase of 2 %) in 2015. Data for the budgets of the municipalities are not available.

The available information does not allow the reporting of drug-related annual public expenditure actually spent or the trend over time.

Drug laws and drug law offences

National drug laws

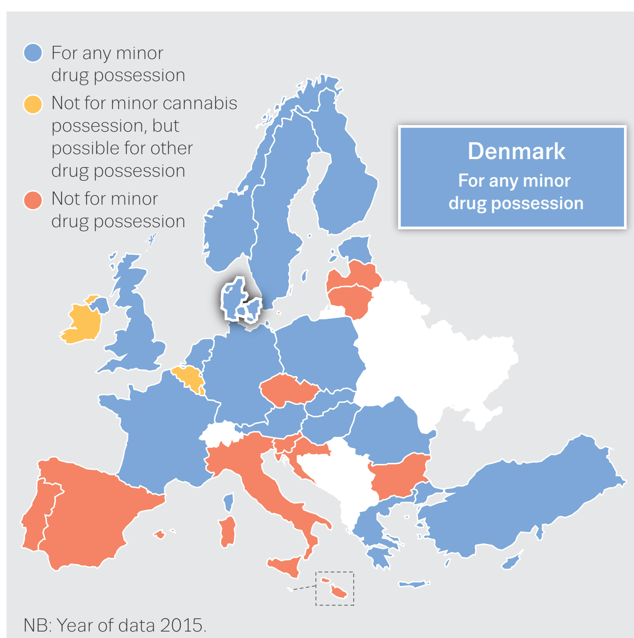
According to the Consolidated Euphoriant Substances Act of 2008, the import, export, sale, purchase, delivery, receipt, production, processing and possession of drugs are defined as criminal offences. The penalty under this Act is a fine or imprisonment for a maximum of two years. Use itself is not mentioned as an offence. Illegal possession for personal use usually involves a fine, the size of which varies depending on the type and quantity of drugs involved. In some cases, the possession of dangerous drugs for personal use can also result in a penalty of short-term imprisonment (Figure 2). The Act was amended in 1996 to increase the penalty for professional drug dealers, who had previously avoided serious sanctions by carrying only very small quantities of drugs at any time. Since 2004, the distribution of drugs in restaurants, discotheques or similar places frequented by children or young people has been deemed to be a significantly aggravating circumstance that should always be punished with a prison sentence.

More serious offences are punished under Section 191 of the Criminal Code, rather than the Euphoriant Substances Act, if they involve the transfer of, or the intention to transfer, at least 25 g of heroin or cocaine, 50 g of amphetamines or 10 kg of cannabis. Since 2004, the penalty under Section 191 of the Criminal Code has been imprisonment for 10-16 years, which can be extended to 25 years in particularly serious cases.

No alternatives to punishment are specified for drug-related offences. However, probationary measures can be applied at the sentencing stage, if the court finds punishment unnecessary (this may be applied in the case of any crime) and the law mentions an obligation to undergo treatment as one of these measures.

FIGURE 2

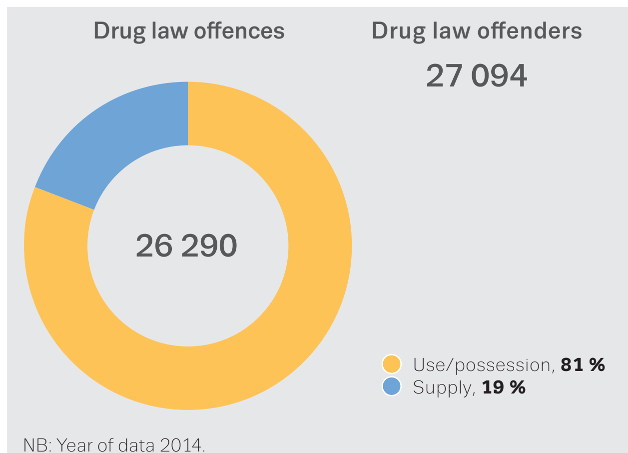
Legal penalties: possibility of incarceration for possession of drugs for personal use (minor offence)



NB: Year of data 2015.

FIGURE 3

Reported drug law offences and offenders in Denmark



NB: Year of data 2014.

A new law to allow the medical prescription of heroin to addicts became effective on 1 July 2008; in 2012, a law allowing the Minister of Health to grant permission for drug consumption rooms to be opened and operated also came into effect.

On 1 July 2012, group bans on psychoactive substances came into force following the amendment of the Euphoriant Substances Act, and Denmark can apply a 'generic classification' to control certain new psychoactive substances (NPS) entering the country.

Drug law offences

Drug law offence (DLO) data are the foundation for monitoring drug-related crime and are also a measure of law enforcement activity and drug market dynamics; they may be used to inform policies on the implementation of drug laws and to improve strategies.

The statistical data from Denmark indicate a stable situation with respect to DLOs in recent years; the majority of DLOs are linked to the use/possession of illicit drugs, while fewer than one fifth of offences are related to supply (Figure 3).

Drug use

Prevalence and trends

In Denmark, the prevalence of use of most illicit substances, with the exception of cannabis, has fallen over the last 15 years. Cannabis is the most commonly used illicit drug among the Danish adult general population, followed by amphetamines, cocaine and MDMA/ecstasy. Drug use is concentrated among young people and experimentation with illicit drugs peaks at 16-19 years.

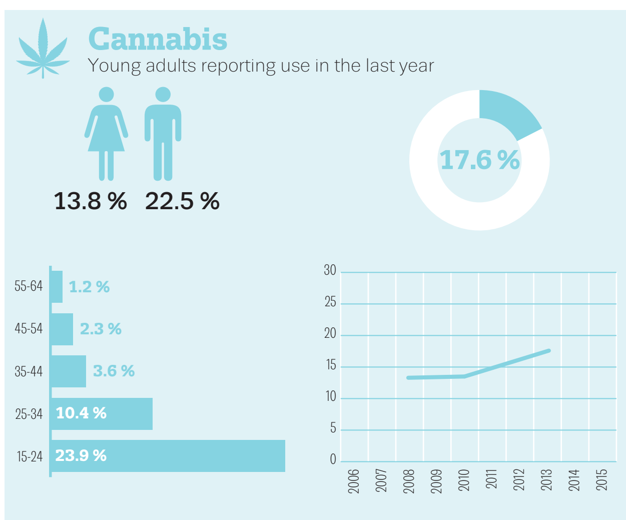
Data from a 2013 general population survey showed that one in two young adults aged 16-34 years had ever tried cannabis, while 1 in 10 had ever tried cocaine. Slightly fewer than one fifth of young adults had used cannabis in the last year and the last-year prevalence rates were highest among those aged 16-24 years.

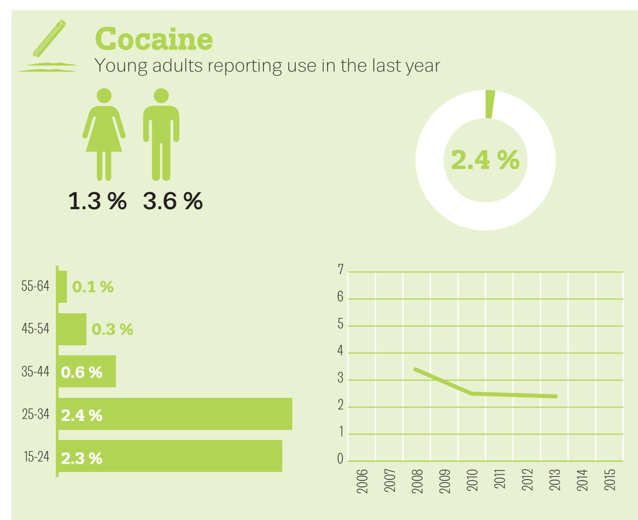
These data, when compared with previous studies, indicate that there has been a slight upwards trend in cannabis use among young adults since 2010.

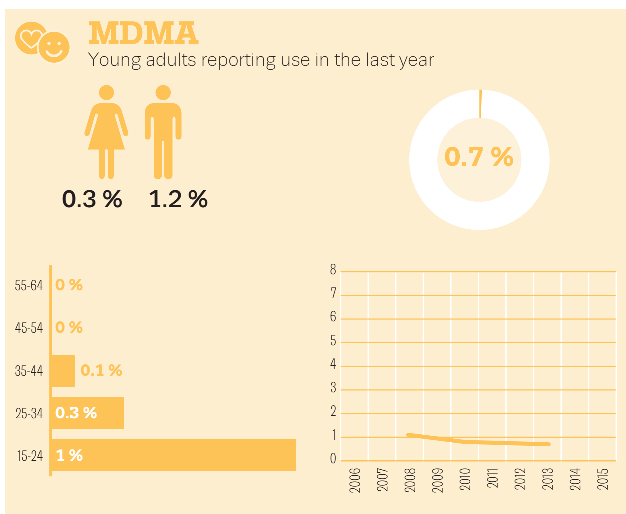
The most recent survey also indicates a decreasing trend in use of amphetamines and MDMA among young people, while cocaine use remained reasonably stable during that period among this age group. Males generally report higher prevalence rates than females (Figure 4).

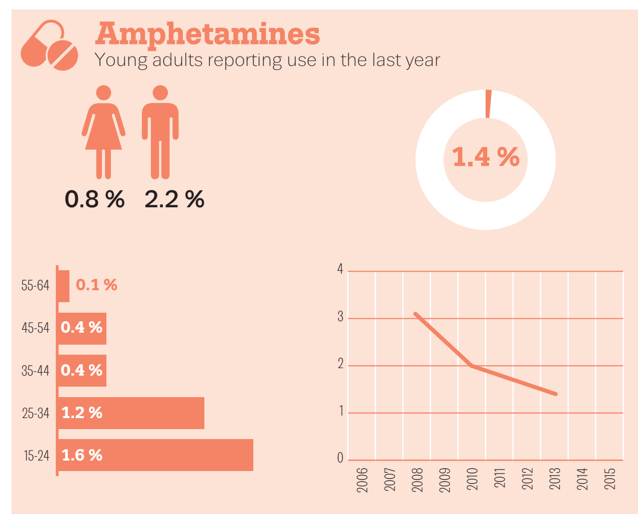
FIGURE 4

Estimates of last-year drug use among young adults (16-34 years) in Denmark





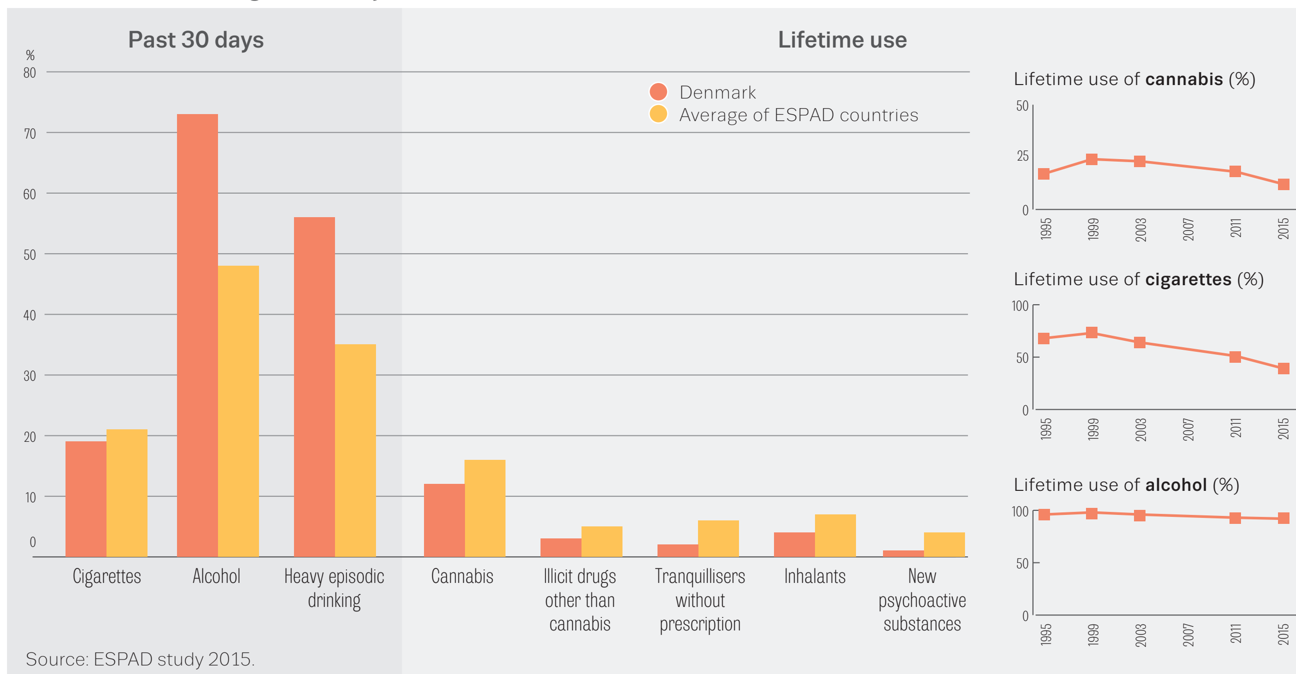




NB: Estimated last-year prevalence of drug use in 2015.

FIGURE 5

Substance use among 15- to 16-year-old school students in Denmark



Source: ESPAD study 2015.

Drug use among students aged 15-16 years is reported in the 2015 European School Survey Project on Alcohol and Other Drugs (ESPAD). These surveys have been conducted regularly in Denmark since 1995. Lifetime use of cannabis, use of illicit drugs other than cannabis and use of NPS were slightly lower than or close to the ESPAD average (35 countries). Trends show that lifetime prevalence of cannabis use increased until 1999, stabilised between 1999 and 2003 and has declined since then. In 2015, Danish students reported prevalence rates considerably higher than the ESPAD average for alcohol use in the last 30 days and for heavy episodic drinking during the last 30 days (Figure 5).

High-risk drug use and trends

Studies reporting estimates of high-risk drug use can help to identify the extent of the more entrenched drug use problems, while data on the first-time entrants to specialised drug treatment centres, when considered alongside other indicators, can inform understanding on the nature and trends in high-risk drug use (Figure 7).

In 2009, the number of people who inject drugs (PWID) was estimated to be approximately 13 000.

The general population survey suggested that approximately 0.4 % of the Danish population aged 15-64 years used cannabis daily or almost daily in 2013.

The long-term analysis indicates an overall increase up to 2009 in the estimated number of people who may experience physical, psychological and social consequences related to drug use, including cannabis use. More recent estimates of high-risk drug use are not available (Figure 6).

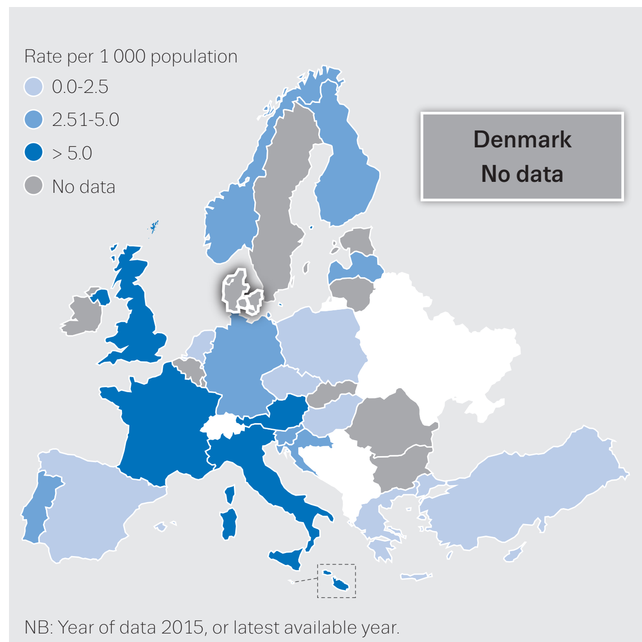
In 2009, the number of people who inject drugs was estimated to be approximately 13 000

The available data from specialised treatment centres indicate that cannabis is increasingly mentioned as the most frequently reported primary drug and that most new treatment clients enter treatment as a result of primary cannabis use. In contrast to the trend observed among cannabis users, the number of new clients seeking treatment as a result of primary heroin use has declined over recent years. Injecting is becoming less common among heroin users and, in particular, among those entering treatment for the first time. In general, most of those entering treatment for the first time are under 30.

Approximately one quarter of the clients in treatment are female; however, the proportion of females in treatment varies by type of drug and type of programme (Figure 7).

FIGURE 6

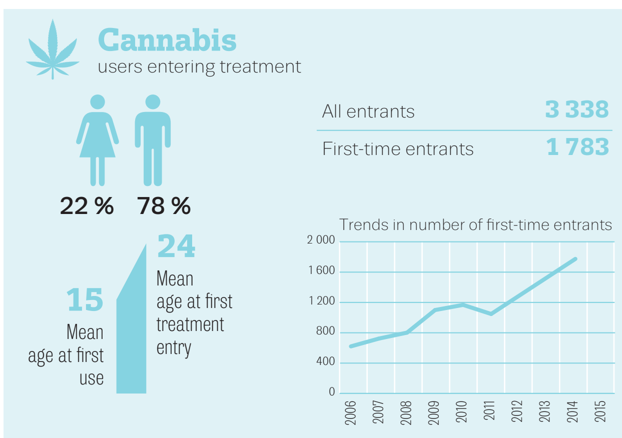
National estimates of last year prevalence of high-risk opioid use

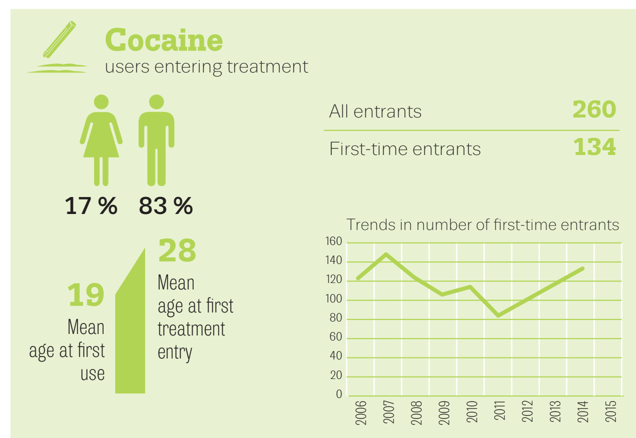


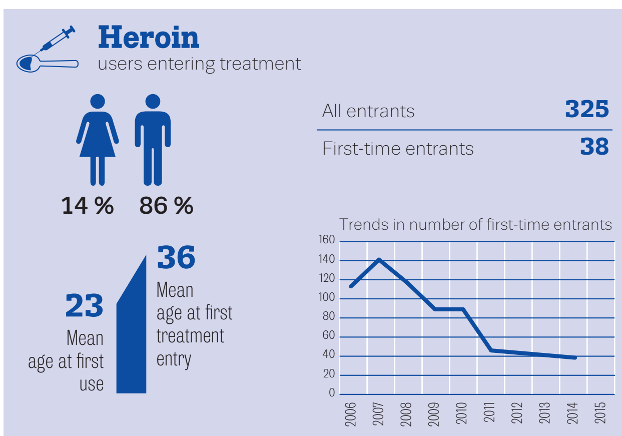
NB: Year of data 2015, or latest available year.

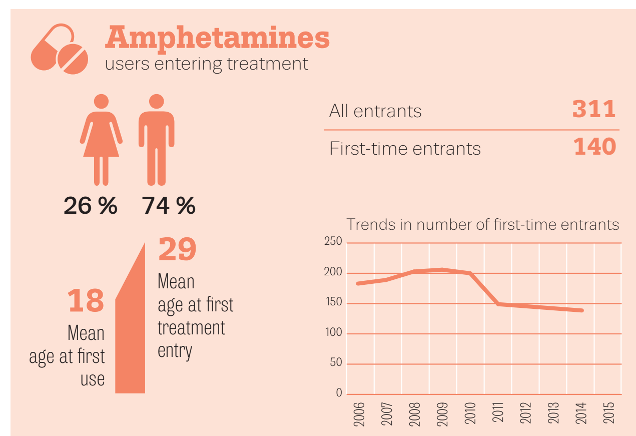
FIGURE 7

Characteristics and trends of drug users entering specialised drug treatment services in Denmark









NB: Year of data 2014. Data is for first-time entrants, except for gender which is for all treatment entrants.

Drug harms

Drug-related infectious diseases

In Denmark, notifications of human immunodeficiency virus (HIV) infection, which are based on diagnostic reporting following voluntary testing, are registered by the Statens Serum Institut. The number of newly diagnosed HIV cases that can be attributed to drug injecting is relatively low (approximately 3 % of all newly notified HIV infections in Denmark in 2015) and has remained stable over recent years (Figure 8).

Drug-related infectious diseases may be under-diagnosed in Denmark, since drug users are not regularly tested. The latest data on HIV prevalence among PWID are from 2004-08, when a special study indicated that the HIV prevalence rate among PWID was 2.1 % (Figure 9).

Cases of hepatitis C virus (HCV) infection are frequently linked to injecting drug use, and HCV remains the most common drug-related infectious disease among PWID. In contrast, hepatitis B virus (HBV) infection is less frequently linked to drug injecting. The proportion of chronic HBV cases that can be attributed to injecting drug use has varied between 2 % and 7 %, whereas, for chronic HCV, this proportion has varied between 56 % and 75 % in the last decade. The proportion of acute HBV cases linked to injecting drug use has varied between 4 % and 42 %, and acute HCV cases have varied between 0 and 86 %.

The latest data on the prevalence of HCV among PWID date back to a 2008 study that reported a rate of around 52.5 % (Figure 9). It is estimated that approximately one quarter of drug users are infected with HBV.

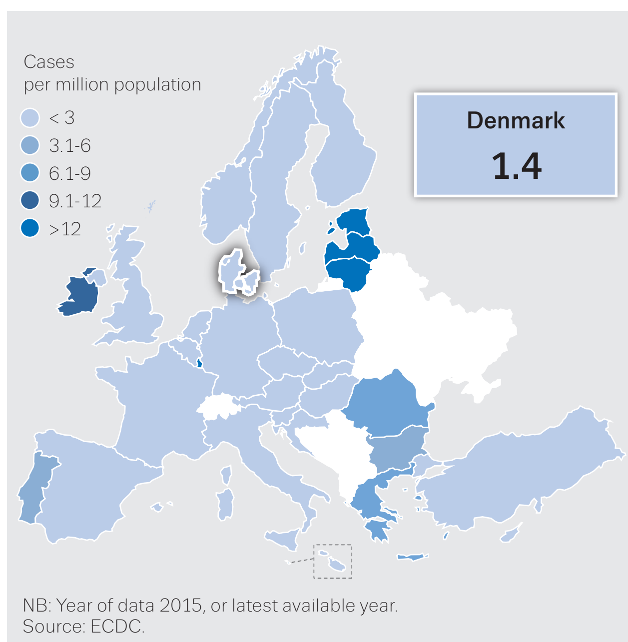
Drug-related emergencies

Drug-related emergency data originate from the National Patient Register and refer, from 2014, to patients contacting acute outpatient facilities.

In 2015, a total of 2 484 case of poisoning with illicit substances were reported (up from 2 280 cases in 2014). Opioids remain the main cause of non-fatal poisoning in Denmark in 2015; however, the number of emergency cases linked to heroin has fallen, whereas the number of poisonings as a result of other opioids (mainly methadone) has increased. In 2015, there were 510 cases related to 'other opioids' and 498 cases related to 'polydrug use and unspecified'. Those who experience non-fatal overdoses from opioid use are older than those who require emergency care as a result of synthetic stimulants (mainly amphetamines). In 2015, more than one third of drug-related poisonings were among those under 25.

FIGURE 8

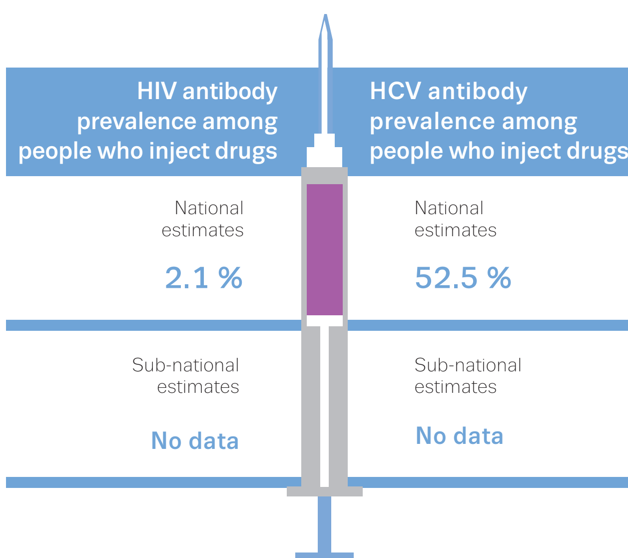
Newly diagnosed HIV cases attributed to injecting drug use



NB: Year of data 2015, or latest available year.
Source: ECDC.

FIGURE 9

Prevalence of HIV and HCV antibodies among people who inject drugs in Denmark

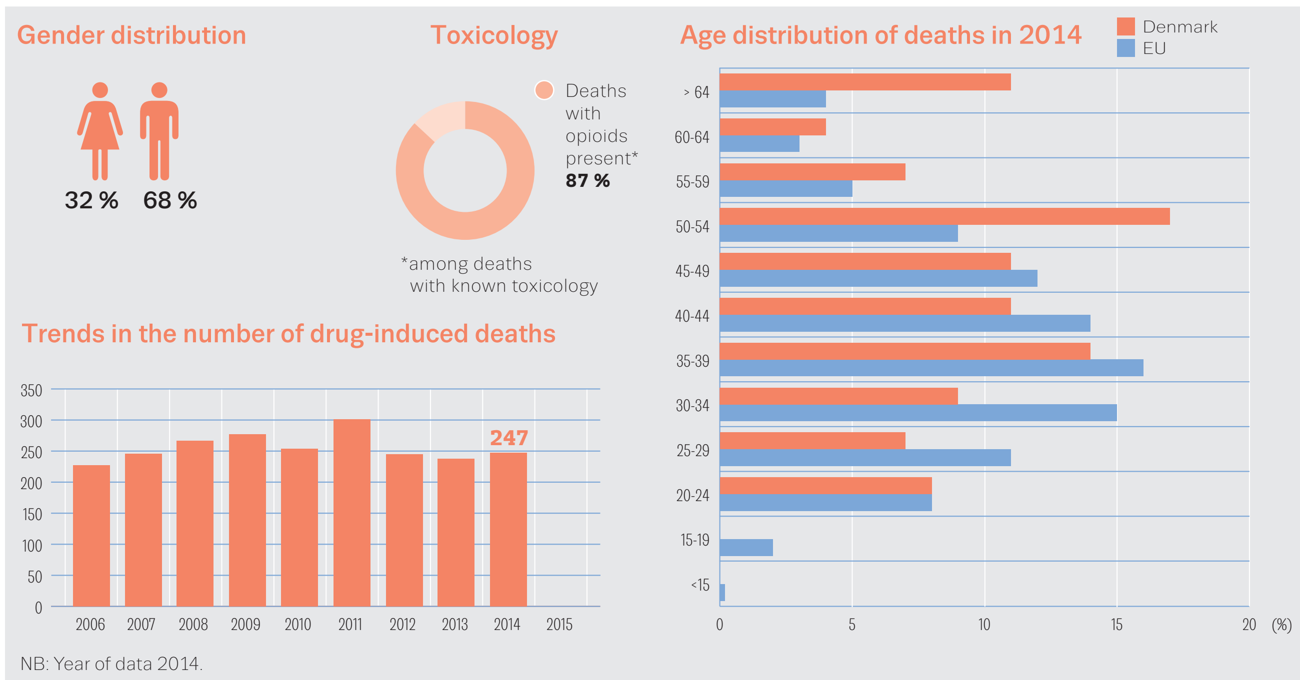


NB: Year of data for HIV is 2006, for HCV is 2008.

An emergency room in a Roskilde hospital participates in the European Drug Emergencies Network (Euro-DEN) project, which was established in 2013 to monitor acute drug toxicity in sentinel centres across Europe.

FIGURE 10

Characteristics of and trends in drug-induced deaths in Denmark



NB: Year of data 2014.

Drug-induced deaths and mortality

Drug-induced deaths are deaths directly attributable to the use of illicit drugs (i.e. poisonings and overdoses).

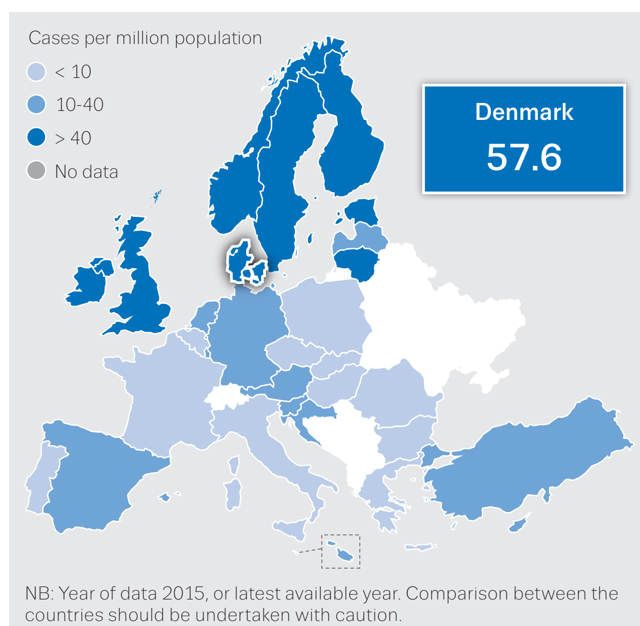
In Denmark, drug-induced deaths are recorded in the National Police Register and the Cause of Deaths Register of the Statens Serum Institut. The data extracted from the Cause of Deaths Register are in line with the EMCDDA recommendations and are used for the European comparisons. The number of drug-induced deaths recorded in the Cause of Deaths Register was slightly higher in 2014, compared with 2013. The toxicological results show that opioids were the principal drug involved in drug-induced deaths. The victims are generally older than the average age of victims of drug-induced death in Europe (Figure 10). Some of the fatal overdoses reported among people over 64 years may relate to opioid-related deaths in the context of cancer/chronic pain treatment, rather than in the context of problem drug use.

The latest European average of drug-induced mortality rate among adults (aged 15-64 years) was 20.3 deaths per million. In Finland, this rate was 57.6 deaths per million in 2014 (Figure 11). Comparison between countries should be undertaken with caution. Reasons include systematic under-reporting in some countries, different reporting systems and case definition and registration processes.

The National Police Register collates information on all reported deaths for the purpose of post-mortem examination. It constitutes an essential source of information and includes specific information on poisonings that cannot be retrieved from the Cause of Death Register. A total of 167 direct drug poisonings out of a total 245 drug-related deaths (including deaths due to other causes) were recorded in 2015. The number of direct drug poisonings has been stable over the last 10 years. The majority of the poisoning deaths reported through the National Police Register involved more than one psychoactive substance, which indicates that polydrug use is a common cause of death in Denmark. Nevertheless, the presence of opioids (heroin, morphine or methadone) was detected in most cases.

FIGURE 11

Drug-induced mortality rates among adults (15-64 years)



NB: Year of data 2015, or latest available year. Comparison between the countries should be undertaken with caution.

Prevention

In Denmark, drug prevention is provided within the wider context of comprehensive measures that are implemented by various actors with the aim of enhancing mental health and overall well-being by reducing inequalities among different social groups. In this context, the prevention of illicit substance use is usually addressed together with the prevention of alcohol and tobacco use. A particular focus in recent years has been given to prevention activities in high school and for young people with mental problems.

The main responsibility for the implementation of prevention interventions lies with the municipalities, with the assistance and support of the Danish Health Authority. The municipalities are responsible for organising prevention activities in close cooperation with local stakeholders, while the Danish Health Authority provides support by producing information material, developing prevention projects and monitoring and providing overall guidance.

Prevention interventions

Prevention interventions encompass a wide range of approaches, which are complementary. Environmental and universal strategies target entire populations, selective prevention targets vulnerable groups that may be at greater risk of developing drug use problems and indicated prevention focuses on at-risk individuals.

Universal prevention interventions are increasingly implemented in educational institutions and cover both licit and illicit substances. There are few national guidelines on the form, content and scope of interventions for school-based prevention, and manual-based prevention programmes are rarely implemented. The municipalities usually recommend several interventions for implementation. These subjects are very often taught in grades 6 to 9, with the individual teacher organising the lesson. Municipality alcohol and drug counsellors support this work. Six model communities were involved in testing new ways of developing cooperation between the educational system and alcohol and drug counsellors during 2011-14. In 2015, the social reserve agreement allocated funding to develop cannabis prevention initiatives in vocational schools and technical colleges (Figure 12).

Selective prevention is mostly carried out in recreational settings, with close cooperation between the main players involved in this area (municipalities, police and restaurant owners). The municipalities' licensing boards are increasingly using plans for restaurants as a means of prevention in a nightlife context and are working closely with restaurant owners' associations.

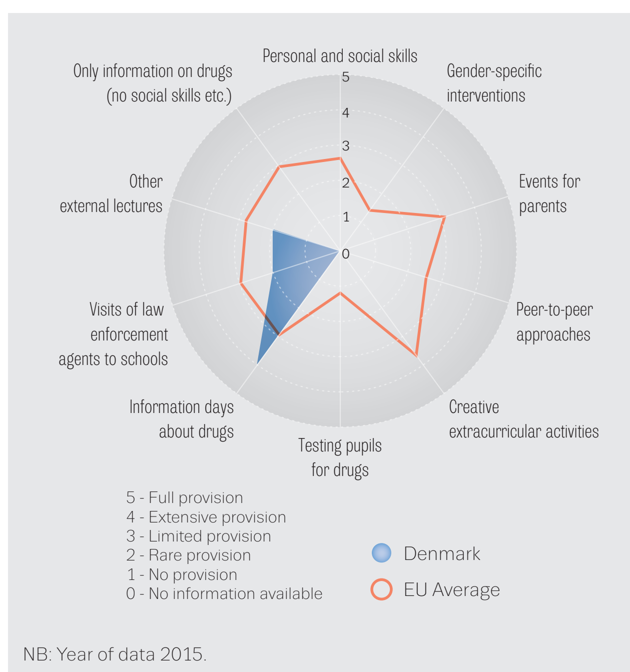
Numerous municipalities offer courses on prevention to restaurant owners. Although they are focused on alcohol, the evidence from similar projects elsewhere indicates that these activities have also contributed to a reduction in the prevalence of drugs in nightlife settings. An evaluation found a high level of interest among all actors in cooperating with and contributing to a safer nightlife environment. The Danish Health Authority launches an annual campaign, 'Music Against Drugs', at music festivals and music halls, including Denmark's largest music festival, the Roskilde Festival.

In order to reach those who experiment with drugs and those who are hard to reach, several web-based services are available in Denmark. An internet-based portal provides information and advice on cannabis and other drugs for young people (www.netstof.dk).

In the area of indicated prevention, Copenhagen has established a prevention and early detection centre, U-Turn, which offers services to drug (mainly cannabis) users who are under the age of 25. The U-Turn model has been extended to six other municipalities and targets young people in vocational education settings who have drug use problems that do not require treatment interventions.

FIGURE 12

Provision of interventions in schools in Denmark (expert ratings)



NB: Year of data 2015.

Harm reduction

Harm reduction concept is embedded in all relevant areas of the Danish drug policy. The Ministry of Health has overall responsibility for harm reduction initiatives at the national level, while the municipalities play a crucial role in the organisation of harm reduction activities on the ground. In 2014, two thirds of municipalities in Denmark provided some kind of harm reduction intervention.

Harm reduction interventions

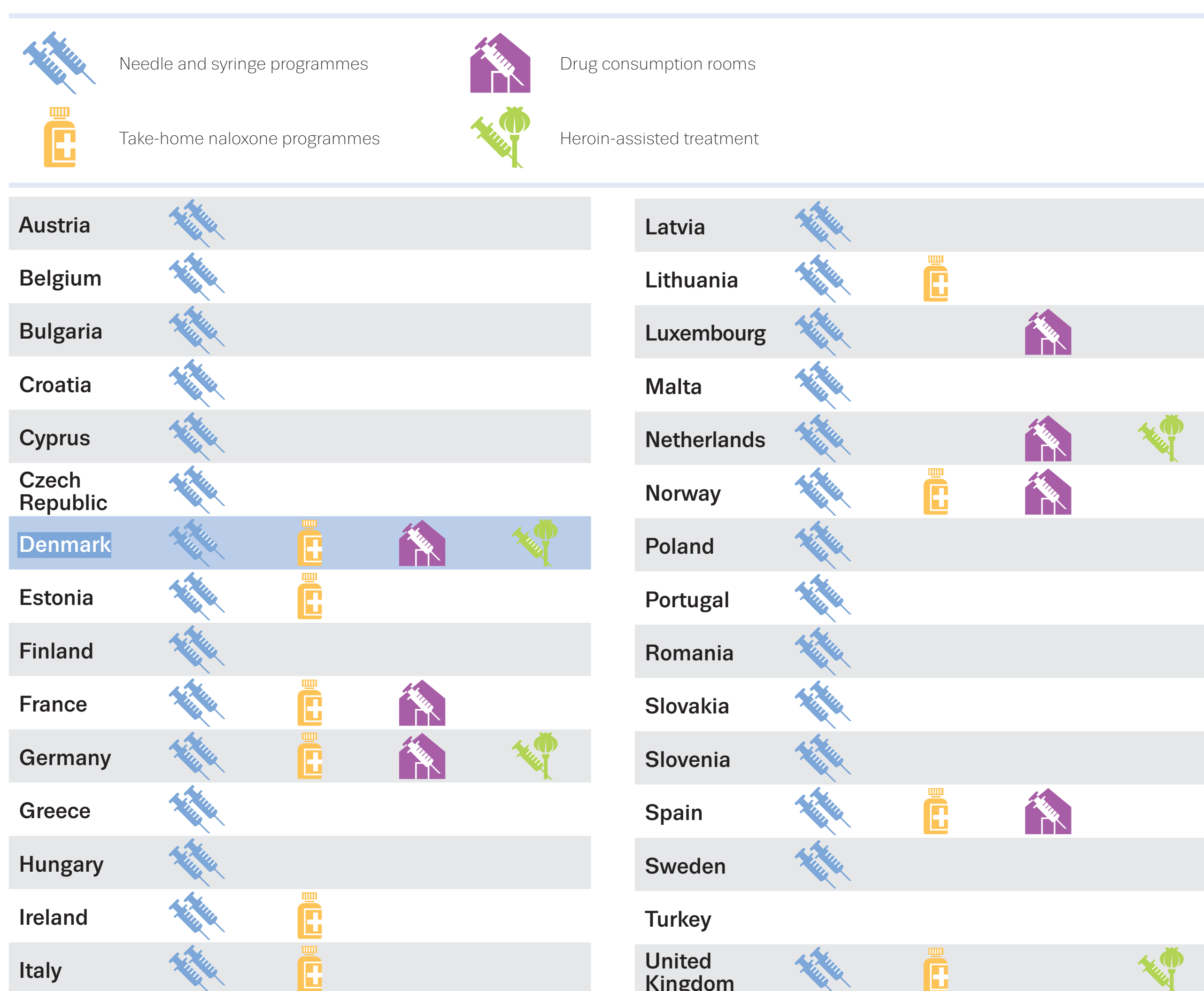
In Denmark, a comprehensive package of harm reduction interventions has been designed to prevent infectious diseases, drug-related intoxication and deaths caused by drug overdoses. The key components of the harm reduction response include needle and syringe distribution schemes, take-home naloxone programmes, drug consumption rooms and heroin-assisted treatment (Figure 13). In addition, prevention and treatment of drug-related infectious diseases is provided, including counselling, screening and vaccination against the hepatitis A and B viruses. Recently, programmes to facilitate access to general health services for marginalised drug users have also been implemented. Active referral of individuals with newly detected HIV, HBV and HCV infection for further examination, counselling and treatment is also encouraged.

Needle and syringe programmes have been established in Denmark since 1986. The number of syringes given out by these programmes is not currently monitored, but a 2009 evaluation confirmed that drug users had high levels of access to clean injecting equipment in all the municipalities.

Syringe provision is administered through the free dispensing of syringes and syringe sales at pharmacies, through treatment institutions, in drop-in centres or through syringe dispensing machines at public sites.

FIGURE 13

Availability of selected harm reduction responses



NB: Year of data 2016.

Some municipalities also dispense needles and syringes at shelters and hostels. The provision of sterile water and other injecting equipment is common.

In 2013, a take-home naloxone programme to prevent opioid-induced deaths was implemented, funding for which is provided through the government social reserve grant. The first three-year phase was evaluated as successful and the programme was expanded from the initial four municipalities to six.

Supervised drug consumption facilities operate on the basis of the legal provisions that were made in 2012 to allow Danish municipalities to set up these services. Currently, there are five facilities in four municipalities that serve injecting drugs users, three of which also serve those using inhaled drugs. A recent evaluation indicated that, during the first three years, drug consumption rooms provided services to more than 6 000 drug users and supervised more than 620 000 drug use episodes, without any fatal outcomes.

Heroin-assisted treatment has been available for hard-to-treat opioid users in five locations across Denmark since 2010. Clients of these programmes receive heroin for self-injection or oral use.

Five drug consumption rooms operate in four Danish municipalities

Treatment

The treatment system

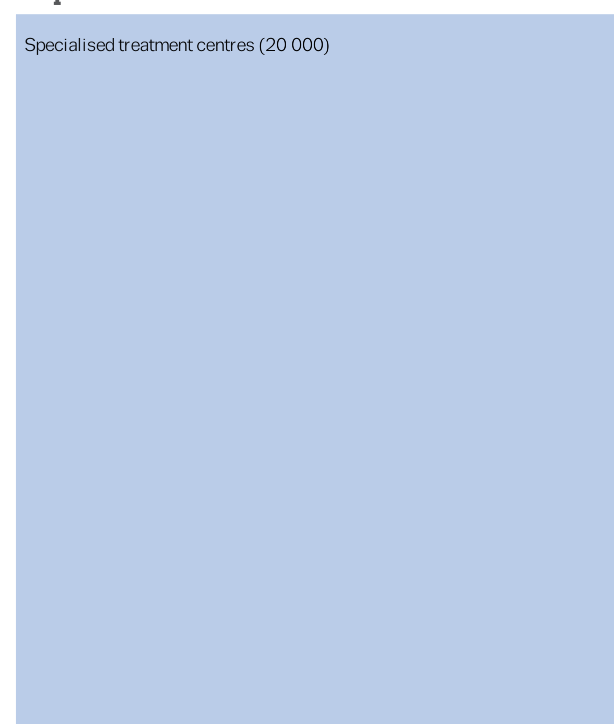
The main goals of Danish drug treatment policy are to achieve a reduction in drug use or to attain full abstinence through enhanced use of psychosocial interventions and systematic follow-up of treatment and to tackle problems other than those of illicit drug use. The municipalities are responsible for organising both the social and medical treatment of drug users, while the regions are responsible for psychiatric, primary and public healthcare. However, the Danish Health Authority and the National Board of Social Services bear responsibility at the central level for advising service providers on balanced and effective treatment interventions. The municipalities are responsible for referrals for medical and social treatment for drug use, and the preparation of a treatment plan is a mandatory action according to the Social Service Act.

Access to drug treatment is guaranteed within 14 days of the first contact or request from drug users over the age of 18 and, in some cases, for users who are under 18. People who are entitled to treatment may choose between public and private treatment programmes within a framework of a prescribed treatment plan, which is free of charge to

FIGURE 14

Drug treatment in Denmark: settings and number treated

Outpatient

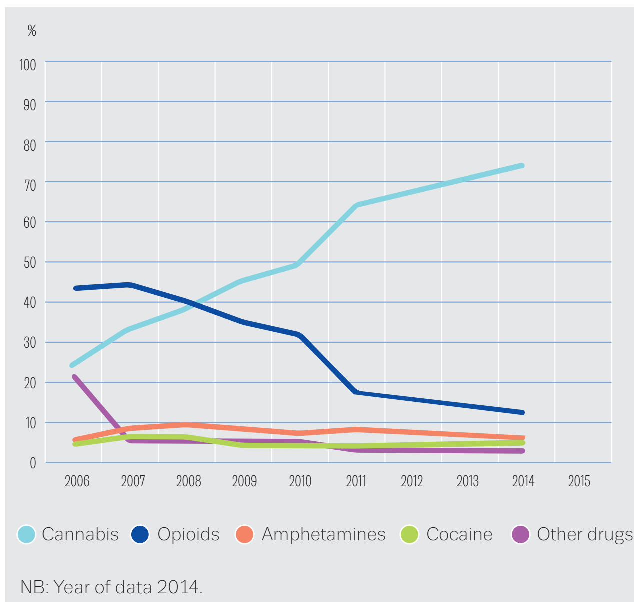


Inpatient

NB: Year of data 2015.

FIGURE 15

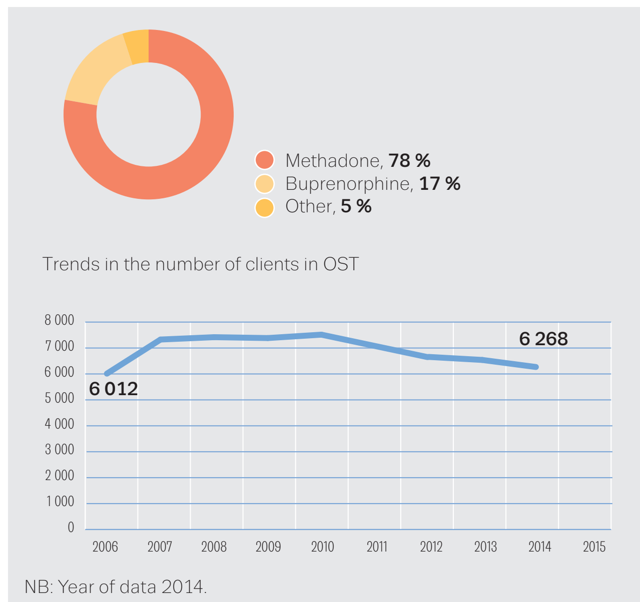
Trends in percentage of clients entering specialised drug treatment, by primary drug in Denmark



NB: Year of data 2014.

FIGURE 16

Opioid substitution treatment in Denmark: proportions of clients in OST by medication and trends of the total number of clients



NB: Year of data 2014.

the client. Drug treatment includes medical and social interventions and is delivered in close cooperation between the health and social sectors.

The most prevalent approaches to treatment in Denmark are cognitive, socio-educational and solution focused. Opioid users are predominantly treated in opioid substitution treatment (OST) programmes, in which pharmacological treatment is accompanied by psychosocial counselling. Outpatient treatment is available through specialised drug treatment centres, in drop-in centres and in low-threshold services. Inpatient treatment services mainly provide assessment for OST, focus on detoxification and provide non-hospital-based residential treatment programmes (such as 'halfway houses'). Many inpatient units are privately owned. In recent years, new initiatives, such as a cannabis and cocaine project in Copenhagen, have been developed to address a specific demand for the treatment of cannabis and cocaine users, and several initiatives for socially marginalised drug users, drug users with concurrent mental disorders and underage young people are also supported.

Treatment provision

Most of 6 275 clients admitted for treatment in 2014 were treated in outpatient settings, and the number of clients treated in inpatient settings has decreased significantly (Figure 14). Nevertheless, the Danish treatment system permits flexibility and a client may be referred for day or inpatient treatment if a change in environment and/or a more structured intervention is needed.

Approximately 4 out of 10 clients admitted for treatment in 2014 were entering treatment for the first time. Most clients admitted to treatment in 2014 were treated for primary cannabis use. Moreover, approximately half of clients entering treatment reported the use of more than one illicit drug (Figure 15).

The provision of OST has decreased slightly in recent years, and the majority of clients in OST are treated with methadone. However, among new OST clients, the proportions treated with methadone and with buprenorphine-based medication are about equal. Approximately 450 people had been admitted for treatment with medically prescribed heroin up to the end of 2015, while the latest available data indicate that 6 268 opioid users received OST in 2014 (Figure 16). These data must be interpreted with caution, however, as there have been changes in registration practice.

Drug use and responses in prison

In Denmark, approximately 60 % of prisoners report having ever used illicit drugs, and regular cannabis use is common among prisoners.

The national strategy for drug treatment in prisons calls for the same level of drug treatment and care to be available as in society in general. As a result, drug treatment services in prisons are provided by private and public treatment institutions. Prisons have introduced a treatment guarantee, which means that treatment should be provided to all inmates who request it within two weeks. This treatment is provided through health professional and social programmes and is administered by the Department of Prison and Probation Service under the auspices of the Danish Ministry of Justice. The social drug treatment programmes include motivation and pre-treatment, intensive therapeutic treatment in special treatment units, outpatient treatment programmes, support for OST and post-treatment programmes. All prisons have treatment programmes for cannabis users and some have specific programmes for cocaine users. Outpatient treatment programmes include special programmes for stimulant users, short detox programmes and OST programmes. Regarding health professional drug treatment programmes, the Prison and Probation Service provides medical treatment of withdrawal symptoms and long-term OST. OST and other long-term drug treatment programmes are also coordinated with public treatment services to ensure continuation in the post-release period. Drug-free prison wings are also available.

To prevent drug-related infectious diseases, the Prison and Probation Service offer inmates chlorine disinfectants, although another model for disinfectants is being considered. Vaccination against hepatitis A and B viruses and general healthcare assistance are also offered.

All prisons have treatment programmes for cannabis users and some have specific programmes for cocaine users

Quality assurance

The Act on Social Services and the Health Act set the main quality assurance-related objectives for medical and social treatment for drug use.

The general promotion of the quality assurance of medical services is the responsibility of the Danish Health Authority. At a state level, the Danish Health Authority's mission includes supporting the municipalities' prevention interventions by providing informative material of all kinds and by initiating projects. It oversees and communicates overall guidelines for the intervention work of the municipalities.

In 2012-13, prevention packages for the municipalities on alcohol, drug use among young people, mental health and tobacco were published. The prevention packages provide guidelines to the municipalities on evidence- and research-based prevention initiatives for universal, selected and indicated prevention. The publication 'Drugs out of town' provides further guidance to schools on how to formulate alcohol and drug preventative policies in schools, enhance cross-sectoral cooperation between schools, administration and the police and deliver evidence-based interventions.

Efforts to carry out quality assurance for and development of OST in Denmark led to the publication of guidelines for the medical treatment of drug users in OST in 2016.

With regards to the social treatment of drug users, the National Board of Social Services works to obtain the best knowledge available of effective methods and practice within the field of social work, including the social treatment of drug use, and to disseminate and implement these methods and practices throughout the social drug use treatment system. All providers of social services that are covered by the Act on Social Supervision are approved by the social supervisory authorities. All primary drug treatment programmes under the Prison and Probation Service are also subject to an accreditation process.

There are no specific education systems for professionals working in the field of demand reduction. However, Aarhus University offers a European Master of Drug and Alcohol Studies in cooperation with Avogadro University. This master's programme is aimed at professionals working in the field of demand reduction and offers a theoretical and knowledge-based perspective on interventions, policies, evaluations, etc., in the field.

All providers of social services covered by the Act on Social Supervision are approved by the social supervisory authorities. All primary drug treatment programmes under the Prison and Probation Service are also subject to an accreditation process

Drug-related research

Drug-related research in Denmark is funded mainly by government grants and can be characterised as applied research. It is often based on the evaluation of public services and is commissioned mainly by ministries and undertaken by academic centres and government institutes. Healthcare planning and the setting of priorities are also primary concerns in this area, and surveys are therefore often initiated and partly funded by the national focal point at the Danish Health Authority. Dissemination of results takes place through a wide variety of channels, including reports, websites, conferences and thematic days. The Danish Health Authority has formulated a number of research-based principles on which the municipalities should base their drug prevention interventions (prevention package). Recent drug-related studies have focused mainly on aspects related to population-based (including ethnographic) studies and on responses to the drug situation; however, other topics, such as supply and markets and drug policy, have also been investigated.

Recent drug-related studies focused on aspects related to population-based studies and on responses to the drug situation

Drug markets

The Danish illicit drug market is considered stable, with cannabis, cocaine and amphetamines the most prevalent drugs (Figure 17). The market is highly structured and is regulated by domestic organised crime groups and gangs (except for heroin and NPS).

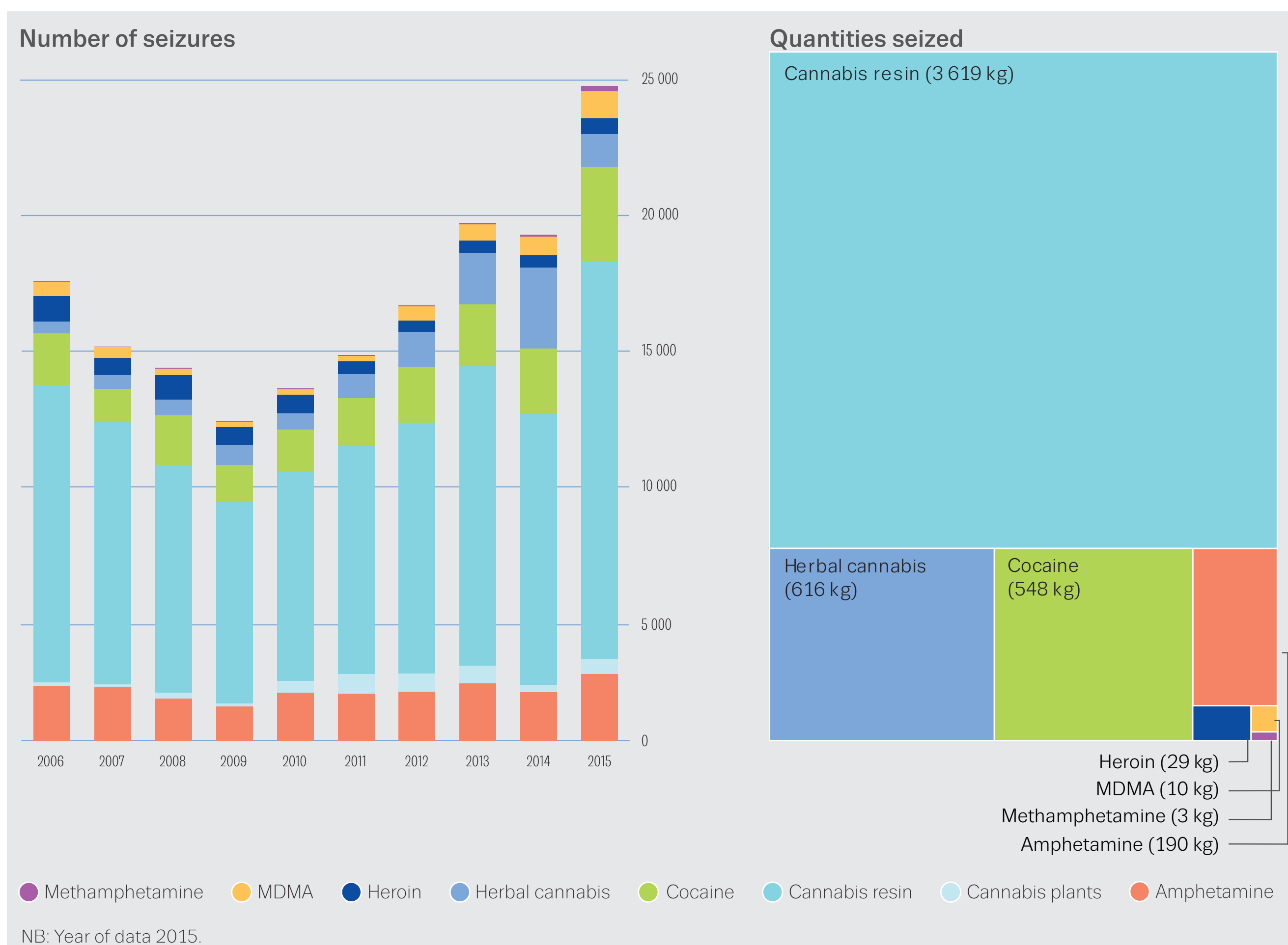
Cannabis remains the most frequently seized drug in Denmark and, in 2015, a record number of cannabis resin seizures for the last 15 years was reported (Figure 17). Morocco continues to be the primary producing country for the cannabis resin that reaches the Danish market. Domestic production of cannabis resin has been reported, albeit on a very small scale, based on few seizures of 'home-made' resin. In recent years, there has been a moderate increase in the reported indoor cultivation of cannabis. Investigations indicate that most of the herbal cannabis seized is from domestic cultivation. In some cases, there has been occasional distribution of domestically grown cannabis to neighbouring countries, such as Sweden and Germany.

In 2015, cocaine was the second most frequently seized substance in Denmark. Cocaine seized in Denmark originates from South America and is trafficked into the country via the Netherlands, Spain and the Balkans by land, or, on a lesser scale, by air via West Africa. However, cocaine has been increasingly reported to be trafficked directly from producer countries by sea or air. Available information suggests that some of the cocaine seized in Denmark is intended for distribution to other European countries.

Amphetamines seized in Denmark are produced in the Netherlands, and, to a lesser extent, in Poland and Lithuania. The trafficking of amphetamines is mainly organised by domestic criminal groups, such as outlaw motorcycle gangs, and amphetamines are typically smuggled in motor vehicles and trains. Small 'kitchen' type laboratories that produce synthetic drugs (methamphetamine and various types of NPS) are occasionally seized by police. Despite a recent increase in the number of seizures of amphetamines, in 2015, the amount seized was the lowest for the previous five years. The majority of heroin seized in Denmark is reported to originate in Afghanistan or Pakistan, and is trafficked via the

FIGURE 17

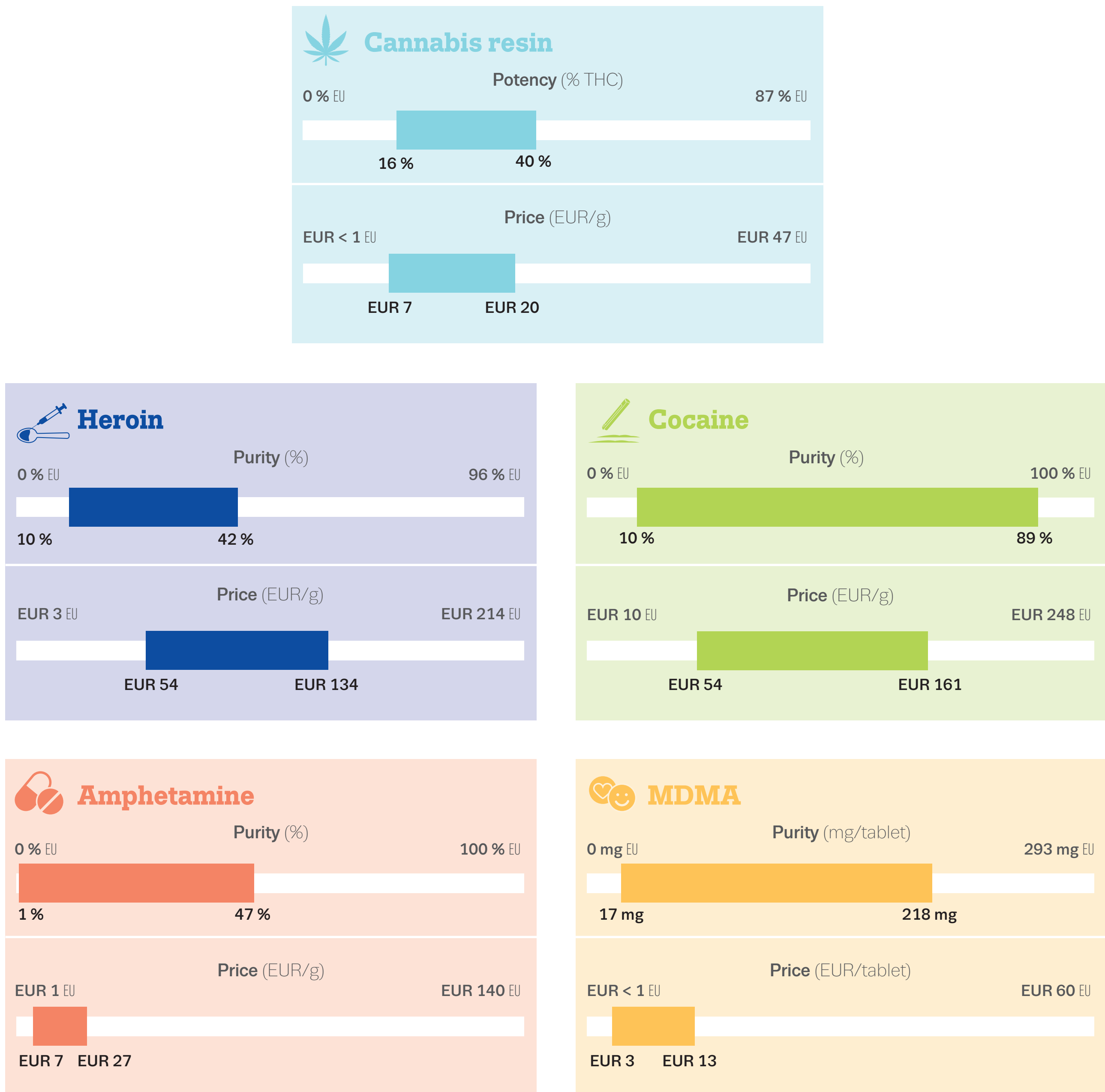
Drug seizures in Demark: trends in number of seizures (left) and quantities seized (right)



NB: Year of data 2015.

FIGURE 18

Price and potency/purity ranges of illicit drugs reported in Denmark



NB: Price and potency/purity ranges: EU and national mean values: minimum and maximum.
Year of data 2015.

Balkan route, primarily its northern branch. Heroin trafficking is carried out by small organised groups, individuals or family groups with ethnic connections to Pakistan or countries along the Balkan route. In the last decade, the number of heroin seizures has almost halved; however, in 2015 the amount seized was double that reported in 2014.

NPS are usually purchased through the internet and are shipped by mail from other EU countries.

MDMA seized in Denmark originates from the Netherlands and Belgium, and the number of MDMA seizures has been rising in recent years.

Retail price and purity data of the main illicit substances seized are shown in Figure 18. The data indicate that the levels of tetrahydrocannabinol in cannabis resin and the purity of cocaine have increased in recent years.

KEY DRUG STATISTICS FOR DENMARK

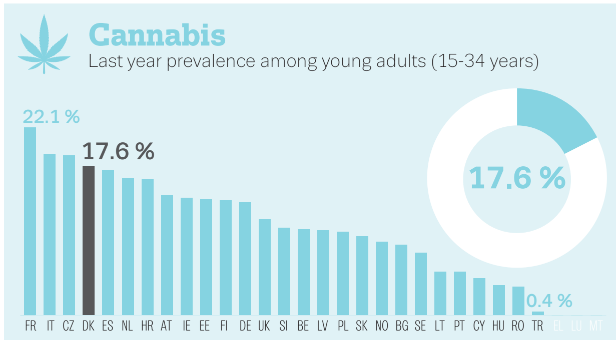
Most recent estimates and data reported

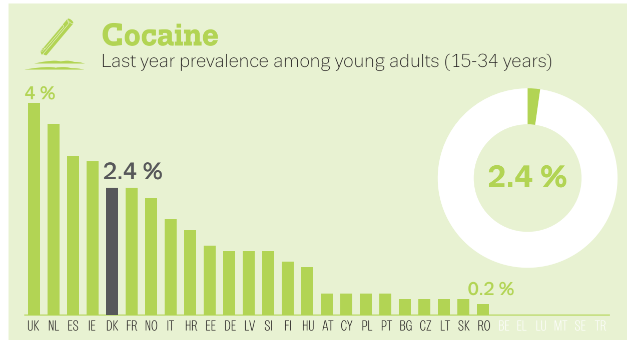
	Year	Country data	EU range	
			Minimum	Maximum
Cannabis				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	12.5	6.5	36.8
Last year prevalence of use — young adults (%)	2013	17.6	0.4	22.1
Last year prevalence of drug use — all adults (%)	2013	6.9	0.3	11.1
All treatment entrants (%)	2014	71	3	71
First-time treatment entrants (%)	2014	79	8	79
Quantity of herbal cannabis seized (kg)	2015	616	4	45 816
Number of herbal cannabis seizures	2015	1 214	106	156 984
Quantity of cannabis resin seized (kg)	2015	3 619	1	380 361
Number of cannabis resin seizures	2015	14 680	14	164 760
Potency — herbal (% THC) (minimum and maximum values registered)	No data	No data	0	46
Potency — resin (% THC) (minimum and maximum values registered)	2015	16-40	0	87.4
Price per gram — herbal (EUR) (minimum and maximum values registered)	No data	No data	0.6	31.1
Price per gram — resin (EUR) (minimum and maximum values registered)	2015	6.8-20	0.9	46.6
Cocaine				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	1.8	0.9	4.9
Last year prevalence of use — young adults (%)	2013	2.4	0.2	4
Last year prevalence of drug use — all adults (%)	2013	0.9	0.1	2.3
All treatment entrants (%)	2014	6	0	37
First-time treatment entrants (%)	2014	6	0	40
Quantity of cocaine seized (kg)	2015	548	2	21 621
Number of cocaine seizures	2015	3 470	16	38 273
Purity (%) (minimum and maximum values registered)	2015	10-89	0	100
Price per gram (EUR) (minimum and maximum values registered)	2015	54-161	10	248.5
Amphetamines				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	0.9	0.8	6.5
Last year prevalence of use — young adults (%)	2013	1.4	0.1	3.1
Last year prevalence of drug use — all adults (%)	2013	0.6	0	1.6
All treatment entrants (%)	2014	7	0	70
First-time treatment entrants (%)	2014	6	0	75
Quantity of amphetamine seized (kg)	2015	190	0	3 796
Number of amphetamine seizures	2015	2 443	1	10 388
Purity — amphetamine (%) (minimum and maximum values registered)	2015	1-47	0	100
Price per gram — amphetamine (EUR) (minimum and maximum values registered)	2015	6.7-27	1	139.8

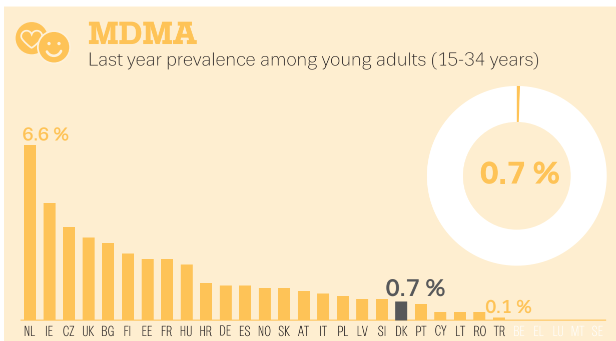
	Year	Country data	EU range	
			Minimum	Maximum
MDMA				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	0.5	0.5	5.2
Last year prevalence of use — young adults (%)	2013	0.7	0.1	6.6
Last year prevalence of drug use — all adults (%)	2013	0.2	0.1	3.4
All treatment entrants (%)	2014	0	0	2
First-time treatment entrants (%)	2014	0	0	2
Quantity of MDMA seized (tablets)	2015	70 244	54	5 673 901
Number of MDMA seizures	2015	1 005	3	5 012
Purity (mg of MDMA base per unit) (minimum and maximum values registered)	2015	17-218	0	293
Price per tablet (EUR) (minimum and maximum values registered)	2015	3-13	0.5	60
Opioids				
High-risk opioid use (rate/1 000)	No data	No data	0.3	8.1
All treatment entrants (%)	2014	13	4	93
First-time treatment entrants (%)	2014	5	2	87
Quantity of heroin seized (kg)	2015	29	0	8 294
Number of heroin seizures	2015	571	2	12 271
Purity — heroin (%) (minimum and maximum values registered)	2015	10-42	0	96
Price per gram — heroin (EUR) (minimum and maximum values registered)	2015	54-134	3.1	214
Drug-related infectious diseases/injecting/deaths				
Newly diagnosed HIV cases related to injecting drug use (cases/million population, Source: ECDC)	2015	1.4	0	44
HIV prevalence among PWID* (%)	2006	2.1	0	30.9
HCV prevalence among PWID* (%)	2008	52.5	15.7	83.5
Injecting drug use (cases rate/1 000 population)	No data	No data	0.2	9.2
Drug-induced deaths — all adults (cases/million population)	2014	57.6	1.6	102.7
Health and social responses				
Syringes distributed through specialised programmes	No data	No data	164	12 314 781
Clients in substitution treatment	2014	6 268	252	168 840
Treatment demand				
All clients	2014	6 275	282	124 234
First-time clients	2014	2 756	24	40 390
Drug law offences				
Number of reports of offences	2014	26 290	472	411 157
Offences for use/possession	2014	21 412	359	390 843

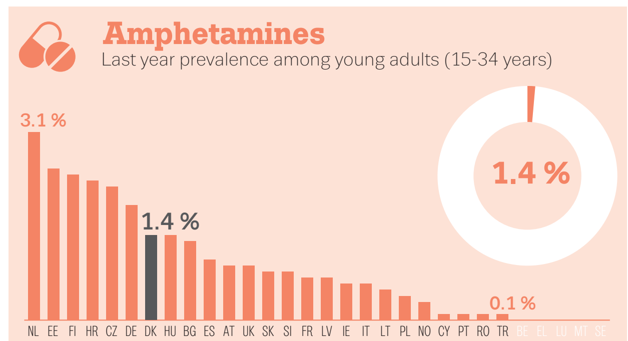
* PWID — People who inject drugs.

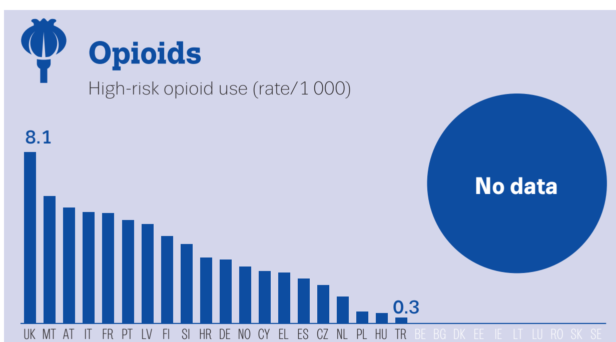
EU Dashboard

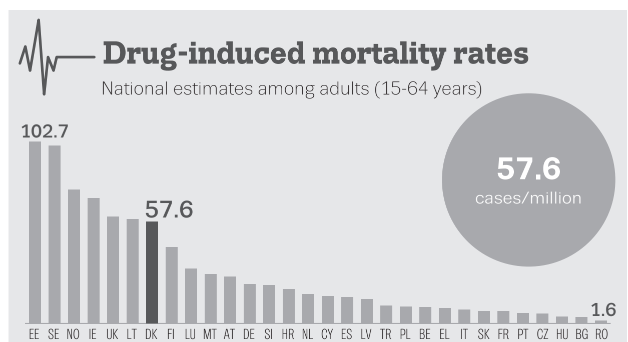


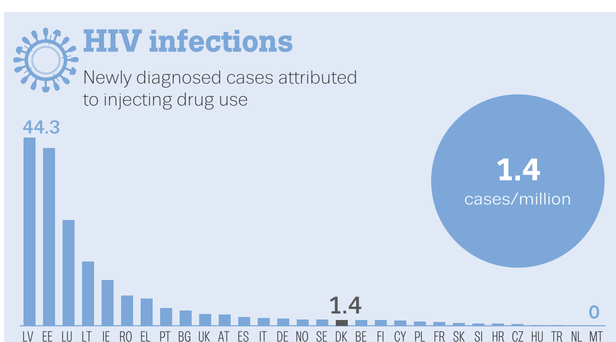


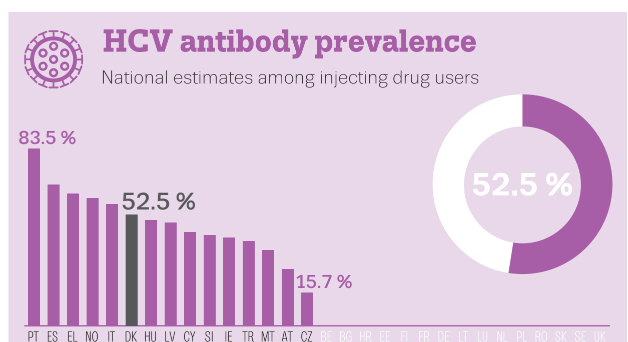












NB: Caution is required in interpreting data when countries are compared using any single measure, as, for example, differences may be due to reporting practices. Detailed information on methodology, qualifications on analysis and comments on the limitations of the information available can be found in the EMCDDA Statistical Bulletin. Countries with no data available are marked in white.

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About our partner in Denmark

The national focal point is located within the Danish Health Authority, an autonomous Government agency linked to the Ministry of Health. The Danish Health Authority is made up of a number of divisions and centres, each dealing with its own area of expertise.

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